Personalisation and the Co-operative Tradition

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There is growing interest in how enterprises based on co-operative values can help to meet needs relating to welfare and re-energise public services. The objective of this article is to examine critically the intersection of personalised adult social care services and the co-operative tradition, which emphasises mutual aid and value-led enterprise. We do this by retelling the story of personalisation through a co-operative lens, and ground this reading in case studies of two new co-operative enterprises that were supported under a Department of Health programme in England (2006–2009) intended to demonstrate how personalised adult social care could be extended by developing collaborative, co-operative organisational forms.

Key words: Social care, individual, collective, values, co-production.

Introduction

The co-operative movement as we know it today emerged in the nineteenth century, with self-help businesses set up by people so that they could secure access to goods and services they could not afford individually (Birchall,1997; Ridley-Duff and Bull, 2011). Members of these early co-operatives thus gained control over their lives through collective self-help (Woodin *et al.*, 2010). There is growing contemporary interest in how enterprises based on co-operative values and principles can help to meet needs relating to welfare, and re-energise public services (Mayo and Moore, 2001; Mills and Griffiths, 2009; Woodin *et al.*, 2010; Bland, 2011). In the UK, the Prime Minister and Deputy Prime Minister jointly declared in May 2010 that 'we will support the creation and expansion of mutuals, cooperatives, charities and social enterprises, and support these groups to have much greater involvement in the running of public services' (Cabinet Office, 2010).

'Social enterprise' has become an umbrella term for organisations that trade for social purposes. Co-operatives have a much longer history. The first successful modern type of co-operative was set up by the Rochdale Pioneers in 1844 and became the basis for co-operatives globally (Birchall, 1997; International Co-operative Alliance, 2005a). There is no universally accepted definition of a social enterprise, despite calls to prevent opportunistic misuse of that label in the light of the political attention it currently attracts (Social Enterprise Coalition, 2010). Co-operatives, in contrast, are distinctive because the way that they do business is driven by specific values and principles set at an international level and overseen by the International Co-operative Alliance (ICA). There is a

well-established retail co-operative sector in the UK, but relatively limited experience in public service markets (Bland, 2011). This article is concerned with the co-operative tradition in relation to one aspect of contemporary public service reform, 'personalisation' in the form of self-directed support and individualised funding. We examine co-operative provision in the context of adult social care in England, where personalisation has been implemented and expanded by the transfer of financial resources from local authorities to service users since direct payments (cash sums in lieu of directly provided services) were introduced in 1996.

Personalisation in social care now has widespread support and the political case for its implementation may be said to be won (Glasby *et al.*, 2009; Needham, 2011). There are nevertheless dissenting voices at both practical and ideological levels. The former tend to emphasise risks and burdens for service users (Ali, 2009; Beresford, 2009) and poor working conditions for paid carers (Scourfield, 2007). The latter cohere around loss of collective ethos linked to critique of the neoliberal agenda to expand market relations and reduce public service (Burton and Kagan, 2006; Roulstone and Morgan, 2009). These challenges may be seen as counter to the dominant narrative of personalisation that celebrates individual needs and choices. By foregrounding one kind of social care provider – the co-operative – we offer a new contribution to thinking about contested relationships between the state, market and individual in personalised services. We do this in two ways. We retell the personalisation story though a co-operative lens, and we report on a Department of Health pilot programme intended to demonstrate how personalised adult social care could be extended in practice through co-operative organisational forms (Co-operatives UK, 2010).

We open the next section with a discussion of the supply side of the market for personalised care. Then we offer a version of the personalisation narrative which positions claims for individual choice and control against counter claims that personalisation brings unintended drawbacks including reduced collective action. This culminates in a short reflection on the resonance of these debates with the collective principles and values that underpin the co-operative movement, and a prima facie case for thinking seriously about co-operatives as providers. In the next section, we turn to qualitative evidence from a small-scale study in which we followed up co-operatives that participated in the Department of Health programme, and we explore their achievements and struggles as new social care providers. In the concluding section, we discuss the potential implications opportunities and barriers associated with personalisation for co-operatives.

Personalised social care: markets, tensions and values

Personalisation is an international phenomenon with roots in the struggle of physically disabled people for control over the support they need to live independently (Williams *et al.*, 2008; Glendenning, 2008). At its heart, for advocates, is a positive change in the relationship between citizens, communities and the state (Carr, 2010). Fundamental principles are choice and control for service users, with a shift of power to them from professionals employed by the state (Hutton and Waters, 2009; Baxter *et al.*, 2011). The nature of this shift has been articulated more conceptually by Duffy (2005) who contrasts the traditional 'professional gift' model (in which decisions are made for service users by professional gatekeepers) with a 'citizenship model' putting users at the centre of the process, choosing and organising their own support.

Personalisation of adult social care implies less local authority provision, fewer block contracts between local authorities and providers and an increase in individuals selecting and purchasing their own services, either directly or through intermediaries (Institute of Public Care, 2009). In addition to direct payments, further individual models of financial control were introduced in the last decade. Personal budgets were initially trailed for learning disability service users in 2003 and later made available to everyone receiving publicly funded adult social care. Individual budgets were launched in 2005 and intended to bring together all funding available to the individual. All this potentially brings new opportunities for providers of many kinds, large and small, from the private and voluntary sectors (Bartlett, 2009; Baxter *et al.*, 2010; Dickinson and Glasby, 2010). In other words, personalisation contributes to an increasingly mixed economy of care (Baines *et al.*, 2011; Hardill and Dwyer, 2011). According to the Department of Health (2010), councils have a role in stimulating, managing and shaping this market, 'supporting communities, voluntary organisations, social enterprises and mutuals to flourish and develop innovative and creative ways of addressing care needs' (para. 5.2). Some councils, however, have been reluctant to move in this direction and relinquish their provider role (Samuel, 2010; Audit Commission, 2010).

The evidence is that the provider market for personalised social care is as yet undeveloped (Institute of Public Care, 2009). It is unclear which types of organisations will wish or be able to seize opportunities to supply the market. For some service users, the fear is that it will be predominantly large commercial providers who rely on standardised services and economies of scale (Beresford, 2009). To deliver on the promises of personalisation, there is a need for a varied market with more suppliers so that choices are not restricted to services that were already being commissioned by local authorities (Bartlett, 2009; Bradley, 2010).

In some versions of personalisation, the emphasis is on consumers being able to choose and purchase from any provider. In more radical (some times called deep) versions, service users are not so much consumers as co-producers in equal and reciprocal relationships with professionals (Leadbetter, 2004; Needham, 2007). The sharing of expertise and responsibilities can also be seen as a way of building social capital, with service users becoming participants in designing producing and managing their services (Bartlett, 2009; Carr, 2010).

Critics have expressed alarm that personalisation depletes possibilities for collective action, with neoliberal notions of stimulating a more commercial orientation within public services (Burton and Kagan, 2006). Personalised support solutions have been said to foster 'enforced individualism and isolation' (Roulstone and Morgan, 2009: 343) and 'reduced scope for risk pooling and collective service allocations' (Needham, 2011: 64). The focus of personalisation upon the preferences of those individuals who exercise choice, it has further been argued, potentially implies that the most disadvantaged will lose out if, for example, services such as day centres and respite care are displaced (Ali, 2009; Manthorpe *et al.*, 2009). The consequences of such collective provision withering away look alarming in the light of tighter budgets and narrower eligibility criteria, with the likelihood that obligations will increasingly fall on informal family carers (Beresford, 2009).

The most popular option for people in receipt of payments in lieu of services has been direct employment of personal assistants. This has been called a strange hybrid of 'citizen-as-consumer-as-service-user-as-employer' (Scourfield, 2005: 481). There is potential for

exploitation in the employer/employee relationship and the employee is isolated from opportunities for training, improved status and negotiation of working conditions. Tom Shakespeare, an academic and campaigner for disability rights, acknowledged that, while direct payments were important for the independence and empowerment of disabled people who need support, there are serious dangers for carers in 'an unreflexive reliance on a servant/employer solution' (Shakespeare, 2000: 63).

Personalisation is overwhelmingly narrated as a story of progress that encompasses 'the dignity and autonomy of the individual, the power of consumer choice and the failure of bureau-professional welfare states' (Needham, 2011: 65). Needham calls this a dominant story-line, one which, citing the words of Hajer (1995: 63), 'provides a compelling account of policies that 'sounds right'. Another way of expressing the notion of a dominant story-line is the grand narrative described in Dey and Steyaert's (2010) critical narrative approach to social enterprise. In the discussion above, we have highlighted elements from evaluations and commentary that signal issues absent from the grand narrative of personalisation. These include the status and working conditions of employees, and fears that individual empowerment through consumer models risks depleting possibilities for collective action and democratic accountability (Burton and Kagan, 2006; Newman *et al.*, 2008). Foregrounding such concerns can be seen as a counter narrative that questions 'the novelty and "taken-for-grantedness" of the grand narrative' (Dey and Steyaert, 2010: 93). Co-operative approaches have been suggested as a way of addressing these issues (Fergusson, 2007; Scourfield, 2007). These writers however do not elaborate in any detail on the fit between the self-help business models of the co-operative movement and the aspiration of personalisation for sustainable, equitable outcomes and new relationships between service providers and service users. In order to begin to fill that gap we now turn to a brief overview of co-operative principles and values.

Co-operatives today, as in the past, are trading organisations with strong values. They include worker co-operatives that replace employment with 'member-ownership' as well as consumer and multi-stakeholder co-operatives. Mutuals comprise co-operatives and associations, all of which are membership-based organisations with a prime purpose to benefit their members. All mutuals have a set of practicing principles that can be weak or strong with co-operatives adhering to the strongest and most rigorous principles and values, overseen by the International Co-operative Alliance (ICA) (Birchall, 2008). Defined within the Statement on the Co-operative Identity, the values are: 'self-help, self-responsibility, democracy, equality, equity and solidarity' (International Co-operative Alliance, 1995). The first principle, 'Voluntary and Open Membership', states: 'Co-operatives are voluntary organisations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination' (ibid.). The ICA's 'member economic participation' statement embeds the idea that members should contribute to, and then share in, the economic surpluses generated by their enterprise (International Co-operative Association, 2005b, Co-operatives UK, 2008). Co-operative identity as defined by ICA with regard to economic surplus and democratic control stands in sharp contrast to the charities, community groups and other voluntary associations that are usually said to form the third sector or civil society (Ridley-Duff and Bull, 2011).

Our claim is that a co-operative approach to personalised social care is yet another story that potentially offers a different way of way of thinking about services and those who use them. It offers, in other words, a little narrative with alternative interpretations that

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can accommodate the 'everydayness' of activity and interaction (Steyaert and Landstrom, 2001). In this little narrative, the contested claims and counterclaims of personalisation are retold through the distinctive co-operative values and principles. We now turn to new evidence about the everyday struggles and achievements of social care co-operatives that were recently created specifically to respond to the agenda for personalised care.

Co-operative providers of personalised care: two case studies

One of the authors worked in close collaboration with Co-operatives UK to explore and assess the opportunities for co-operatives as service providers within personal budgets in social care. This work was undertaken as an ESRC funded placement with Co-operatives UK from March to June 2010. It was designed to follow up the Department of Health funded pilot programme, *Self-Managed Care – a Co-operative Approach* (Co-operatives UK, 2010). The Department of Health funded the programme to support its priority to extend the uptake of direct payments and individual budgets. In particular, it was intended to attract new users to these funding mechanisms from underrepresented groups who may be deterred by the perception of associated risks and burdens. The programme was delivered by the co-operative consultancy Mutual Advantage. It ran from 2006 to 2009 during which time Mutual Advantage assisted five pilot projects to develop co-operatives involving service users, carers, or both, to facilitate mutual support and to meet aspirations to improve working conditions for paid carers (Co-operatives UK, 2010).

The study used qualitative methods, taking two of the pilot co-operatives as case studies. Case studies are widely used in social research as they allow an in-depth investigation of contemporary phenomena within a real-life context (Ragin, 1989; Yin, 2003). The case study approach is sensitive to context, detail and complexity, and case studies can encompass multiple, complementary forms of data collection. These two pilots were identified as case studies by Co-operatives UK and the researcher. One was chosen because it was the most successful in that it was the first to achieve registration as a care provider, and it developed a way of organising care that Mutual Advantage recommends as a model. The other was chosen for its different ownership structure and contrasting geographical location.

Site visits to the co-operatives were undertaken by the researcher and interviews with the co-operative stakeholders were conducted either face-to-face or by telephone using a semi-structured questionnaire, and transcribed from recordings, supplemented with the researcher's notes. The resulting data are in the form of accounts of those who have been closely involved in setting up and running the co-operatives, and based on their experiences. The interviewees were provided with copies of the interview accounts and asked to suggest amendments and remedy omissions. This ensured that data were corroborated with the interviewee. Meetings were held with key staff at Co-operatives UK and telephone interviews conducted with a consultant from Mutual Advantage (again notes were written up). In addition, the authors attended the Co-operative UK annual conference 2010 and a 'roundtable' on personalisation organised by the Association of Chief Executives of Voluntary Organisations (ACEVO). Secondary research was undertaken in the form of analysis of documentary material (reports, working documents, meeting minutes, organisations' websites and media publicity).

Thematic analysis was used to analyse these data (Braun and Clark, 2006). This resulted in the identification of three key themes: services that are personalised but not

individualised; rhetoric versus reality in relation to central and local government; and reliance on unpaid work. These themes are presented and discussed below. Prior to this a brief description of the two pilot co-operatives is provided for background information.

Workers' Co-operative is located in the North West of England. It was established in 2008 as a Community Interest Company by a group of four women home care workers employed by the local authority. These workers were concerned about the potential impact of personalisation on their clients, and their own pay and conditions. Further, they wanted to be able to influence the care they provided and ensure a flexible service to meet their service users' needs. Currently the co-operative has five customers and two employees. On completion of six months employment, staff are eligible for membership of the co-operative. Establishment of the organisation has been a lengthy process. The members received a small grant from the local authority to fund office space. Volunteers and family members have supported the co-operative.

Stakeholders' Co-operative is an Industrial and Provident Society for the benefit of the community with exempt charity status, located in a London borough. The founders were two women, one of whom, Maria, was a service user who had MS. Maria, who died in 2009, was a committed socialist and political activist all her life and the co-operative model was in line with her personal ethos and values. It is a multi-stakeholder co-operative and the quality of service it provides is underpinned by a governance structure in which employees, families and service users are able to influence decisions. Stakeholder Co-operative has developed a cluster-based operational model, where care is provided by personal assistants for a group of up to fifteen service users within a small geographical area. Customers include direct payment recipients and private funders. All employees are trained by the organisation in the ethos and values of co-operatives.

Personalised not individualised care

A key motivation for establishing both co-operatives was a lack of satisfaction with existing care provision. Maria received care from her husband, but she had a very poor experience in a care home when she needed help after he was injured and temporally unable to care for her. This episode gave her the idea of founding the Stakeholder Co-operative. Workers' Co-operative members stated that as local authority care workers they were frustrated with the quality of care provided and voiced concerns about lack of flexibility and choice for the service users regarding the time of visits and type of care. Their view was that it was important for users to be able to develop and maintain relationships with their carer and this was not possible within local authority care provision. They described local authority practice that did not fit with users' wishes, for example the 'putting to bed system' and the fit with a user's wish to go to the pub one night and have a carer be there at 10.00pm instead of the usual 7.30pm. Workers' Co-operative identified issues with the local authority practices of monitoring care workers' work by a 'clocking on and off' process. When a local authority carer enters a service user's home they are required to telephone a number on arrival to log the care, even before wishing the user 'good morning'. From the co-operative perspective, this is at odds with notions of empowerment and meeting clients' needs. This is how one of the members expressed the contrast between their service the local authority's, 'we are a small organisation and can offer a personal service and have time to listen to what people want'.

These observations reflect general claims for personalisation, in particular the meeting of individual needs and desires in contrast to standardised services where the user is expected to fit the provider's requirements. In Stakeholder Co-operative, services were much more proactively reshaped as a result of users and workers thinking through together how to improve their experiences as recipients and providers of care.

The 'cluster' idea used by Stakeholder Co-operative was developed in response to Maria's experience of having a team of ten people care for her. Each cluster has a part-time support worker and overheads are kept low by support workers being home-based. Benefits of the cluster model include a reduction in travel expenses and time for workers, which is important in a large outer London borough affected by heavy traffic congestion. According to Maria's widower, who still works with the Co-operative as an unpaid supporter, matching personal care assistants with a small group of service users in this way 'engenders a spirit of community'. The cluster facilitates development of a longer-term relationship between user and carer and flexibility to cover holidays and sickness. This model has been copied by some of the other pilots and is strongly advocated by Mutual Advantage. They recommend that it could be adapted for other contexts, for example by basing the clusters on types of need or medical condition rather than geographical proximity.

Rhetoric versus reality

Co-operative members were unanimously positive about the opportunities that personalisation offered in improving care provision and the service users' quality of lives. However, they universally agreed that the local authority culture and systems contributed significantly to their challenges in establishing the co-operatives and operating within the provider market. The local authority preferred provider list, the main source of information that supported service users' choice, was highly contentious. One interviewee stated:

> We are a group of home care workers who used to work for the local authority. We set up Workers' Co-operative to provide a more personal service, but now we find ourselves running into problems as our size and short track record as a co-operative mean the local authority doesn't tell service users about us. We don't know of a single local provider on our local authority's preferred provider list.

In spite of government rhetoric about opportunities for small localised providers of social care provision to compete in the market, those interviewed stated that they did not have the resources or scale to compete with the larger providers. They could not match the pay offered by local authorities to carers, due to their focus on personalised care and relatively high unit costs. Ensuring that the carers received a higher rate of pay and holiday pay was fundamental to their reasons for establishing the co-operatives but this was proving highly problematic due to slow recruitment of customers and cash flow.

Social workers were considered to be gate-keepers within the personalisation of care and did not encourage users to explore alternative providers. Co-operative members commonly stated that social workers were unaware of the potential benefits provided by social care co-operatives located in communities and, moreover, did not promote individual budgets as this would take more of their time.

The co-operatives needed to meet the costs associated with the compulsory registration process for care providers, and these costs are exactly the same as for large commercial agencies. Yet the direct payments their customers receive are significantly lower than the authorities pay for agency care. According to Mutual Advantage, the one-size-fits-all national registration process is 'crushing small organisations to death'. Direct payment amounts paid to users do not reflect the full organisational costs to the co-operatives and they are forced to look to other revenue, for example private clients or clients and families able to pay for additional care. In the case studies, this was a practical solution for Stakeholder Co-operative which is in an affluent location, but much less so for Workers' Co-operative.

Interviewees highlighted delays in the direct payments system and, in one authority, even reported that there was a shortage of forms for service users to apply. 'People we know can't get hold of the forms, they keep ringing and are told the forms haven't arrived.' Delays in direct payments had affected the co-operatives' ability to employ staff to meet the demand for short-notice care and offer staff permanent employment contracts. There was some optimism, however, in that all those interviewed anticipated that wider use of Individual Budgets (IBs) would be more beneficial to the co-operatives as they were more flexible and would enable them to provide new care services, for example shopping trips and social activities. By encouraging service users to combine their IBs, they would be able to deliver weekly activities for a group of users.

Reliance on unpaid work

It was evident from the interviews that all members had contributed considerable amounts of unpaid work in the development and running of the co-operatives. The members do not get paid for their work and the founders of Workers' Co-operative, at the time of the interviews, were still in employment with the local authority as personal assistants in order to earn a living. As one of the founders old us:

> It has been a long haul and taken over our lives. We did not realise how hard it would be and how much time it takes.

Friends and family members had provided significant amounts of support and time. Workers' Co-operative's offices had been renovated by family and friends. Family members support the administrative work of Stakeholder Co-operative. Significant unpaid amounts of time are spent networking nationally and locally and this has been of benefit to the co-operatives. Through use of extensive networks they have acquired access to gratis training for the staff from a neighbouring local authority and a college, and use of public meeting rooms. Workers' Co-operative members also respond flexibly to service users' demands for increased support on some days and this is usually provided free of charge.

Discussion and conclusions

We have noted from the literature on personalisation that despite the influential grand narrative, some issues are uncertain and highly controversial. Particularly contested are

the status and working conditions of employees, and fears that individual empowerment through consumer models risks depleting possibilities for collective action and democratic accountability (Burton and Kagan, 2006; Newman *et al.*, 2008). The self-help business models of cooperatives seem closely aligned with the aspirations of personalisation for sustainable, equitable outcomes and new relationships between service providers and service users. The empirical findings presented in this article are from in-depth studies of two co-operatives and key stakeholder interviews. The co-operatives in this small-scale study demonstrated approaches to social care provision that would enable those involved to share employment responsibilities, and avoid the isolation noted by some critics of personalisation. Their successes suggest that social care co-operatives have the potential to develop and innovate in local provider markets with collective models of care that can be a practical alternative to more individualised versions. The Self-Managed Care programme demonstrated the possibilities of providing a collective and community-based service in ways that seem to reflect Duffy's (2005) 'citizenship' model of service. Moreover, the stories of the two co-operatives we visited could be read as exemplars of the Department of Health (2010) 'Big Society' approach to social care. The case study co-operatives are extremely proactive in involving the users, their carers, families and members of communities in all aspects of the organisation, in line with proposals for 'a personalised, community-based approach for everyone' (Putting People First, 2010).

Although the co-operatives achieved some success, they were much slower to become established than anticipated. They are vulnerable to competition from larger providers and unable to recover all the costs of administration, training, travel and management, as has been noted elsewhere of third-sector care providers (Hardill and Dwyer, 2011). Their survival depends heavily on unpaid work and family members' support. This seems to be rather a contradiction to some interpretations of Co-operative Alliance's insistence on equitable compensation for each member's labour as a statement opposing uncompensated labour, which is seen as characteristic of much less business-like voluntary and community organisations (Ridley-Duff and Bull, 2011). It is however entirely in keeping with the survival strategies of many small businesses where self-exploitation and unpaid work from family members can help alleviate the enterprise's economic vulnerability (Ram and Holliday, 1993; Baines and Wheelock, 2000). This little narrative of everyday experience on the front-line does not fit comfortably into either the ideals of personalisation or cooperative values.

Local authorities have a significant role in stimulating, managing and shaping the market for social care. Yet some of the most difficult barriers the co-operatives in our study said they faced were from local authorities (for example the preferred provider lists and delayed payments). These observations raise significant questions about who the 'customer' actually is in the current state of personalisation. According to Putting People First (2010), 'Organisational and professional culture and practices will need to adapt to facilitate greater freedom for people and their communities to shape their support'. The evidence from the case study co-operatives is that the close alignment between co-operatives values and the philosophy of personalisation is not understood within their local authorities. Indeed, from the perspective of these co-operatives their capacity to make a contribution to a diverse market in a mixed economy is not supported by the practices of their authorities. This is in contrast to other countries. In Italy, for example, co-operative care providers are reported not only to have strong and positive relations with local authorities, but to be involved in joint planning of services (Bland, 2011).

The fieldwork for the research took place during a change in government and prior to the release of *A Vision for Adult Social Care* (Department of Health, 2010). It was during an election year, and many policy changes have since been made, accompanied by new strategies and consultations. The Big Society and localism agenda have been launched with an emphasis on empowerment, local social action and public-sector reform (Rutherford, 2010). This has been within a context of profound decreases in public expenditure (Dorling, 2010). Mutualisation of public-sector services is on the current government's agenda (Cabinet Office, 2010).

Personalised social care (now being extended to some health services) implies revising how people and communities work together in ways that are both welcomed and feared. This is extremely challenging and will become more so in the light of cost cutting and tighter budgets. Lessons from co-operatives operating within the social care sector are still tentative as the phenomenon is very new. It seems however that small-scale co-operatives have a great strength over individual employment of personal assistants. That is they enable service recipients to retain control over their care (as promised in consumer versions of personalisation) while sharing organisational tasks and responsibilities in ways consistent with notions of co-production, citizenship and community. They do this however at significant cost to members (and their families) in terms of unpaid work, and often in the face of poor understanding by local authorities tasked with advancing diverse supplier markets.

Acknowledgements

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