

Grass Roots Entrepreneurship and Innovation: Micro-Enterprise in Social Care

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Abstract

In recent years, the UK social care sector has seen a massive growth in the number of micro-enterprises which are defined as very small organisations with five or fewer workers. Micro-enterprises are usually grass roots organisations established and run by local people, including those who are themselves disabled, and often combine paid and unpaid care provision. The informal nature of micro-enterprises means that they challenge traditional conceptions of social care and have been promoted by the UK government as highly innovative, personalised and empowering for service users. However, little empirical evidence means that the benefits of micro-enterprises are often assumed rather than proven. This paper reports early findings from an ESRC funded study that is evaluating the performance of micro-enterprises within adult social care in England focusing on the extent to which they outperform larger care providers in delivering valued, innovative, personalised and cost-effective services. This paper focuses in particular on the extent to which micro-enterprises are innovative by drawing on an evidence review of the role of small community organisations in supporting marginalised communities. It also draws on early empirical interview findings with micro-enterprises co-ordinators from across three locations in England.

Introduction

English public services have been through a series of reforms over the past few decades. This includes the modernisation or 'marketisation' of services driven by neo-liberal ideas around 'market rationalism'. Central to this was the notion that public services need to become more efficient and break away from inefficient and inflexible bureaucracy (Kirkpatrick, 2006). In social care, such reforms were reflected in the NHS and Community Care Act 1990 (implemented in 1993) which provided the framework for a 'mixed economy' of service provision within adult social care (Baxter et al., 2011). Local authorities were urged to move away from providing their social care services 'in-house' and instead commission them from the independent sector. A social care 'market' subject to competition between providers was therefore developed as a way to ensure good quality provision and choice at the same time as good value for money (Means et al, 2008). The Third Sector now play a considerable role in the delivery of public services as they are seen to deliver more cost-efficient, effective and innovative services that are more responsive to the needs of service users (Buckingham, 2012). As they are considered to deliver more user-centred and personalised services, the UK government has also looked to third sector organisations to deliver on the 'personalisation' agenda (Needham, 2011). In particular there has been optimism about the scope for very small community-based providers (so-called micro-enterprise) to offer personalised care and support (DH and NAAPS, 2009). Micro-enterprises are defined as very small local enterprises with five or fewer workers (Community Catalysts, 2011; 2014).

This paper discusses the extent to which these micro-enterprises offer more innovative approaches to social care than larger care providers. We also look at the link between innovation and improved outcomes. The paper sets out the gaps in what is currently known about micro-enterprise and innovation in social care. The first section provides the context of personalisation in social care and the role of micro-enterprise within the sector. The second section considers innovation and performance in social care. The third section sets out a research design for studying micro-enterprise innovation and performance in ways that fill these evidential gaps. The final section draws on early findings on micro-enterprise innovation from a two-year evaluation of micro-enterprises, funded by the Economic and

Social Research Council (ESRC). The discussion of innovation draws on anonymised interview data with four micro-enterprise co-ordinators in three sites in England.

Reforming the Social Care Market: Marketisation to Personalisation

Personalisation has been driven by a growing recognition that Local Authorities as purchasers of care could have divergent experiences and interests from the consumers of care services (Needham, 2011). Making the service user both the purchaser and consumer of care has the potential to overcome this problem leading to better targeted expenditure that meets needs at a lower cost (HM Government, 2007). Personalisation means that cash is devolved to individuals who act as micro-commissioners (Dickinson and Glasby, 2010). Known as 'personal budgets', this money can be utilised by users of social care services more flexibly according to their needs and desired outcomes. Personal budgets may therefore be spent on personal care and domestic help, as well as social, leisure and educational services (Glendinning et al., 2008). Individual budget holders can purchase services from anyone they choose, including public, private or third sector providers of care. Money can be managed by people using services, as a direct payment, or can be retained by the local authority as a managed personal budget. Third parties can also help with management of some or all of the budget (Glasby and Littlechild, 2009). The strongest evidence for improved care outcomes has come from people who receive direct payments, such that local authorities are encouraged to make direct payments the default arrangement (Hatton and Walters, 2013).

Personalisation has been slow off the ground, yet there has been a considerable increase in the number of direct payment users over the last few years. The number of direct payment recipients tripled between 2008 and 2012, which in 2012 stood at 193,000 people (Skills for Care, 2013). The key aim of personalisation is to move away from block purchasing arrangements and instead give service users more control over the services they use thereby enabling care to be tailored towards their individual needs and circumstances. For example, under personalization a Local Authority will no longer be able to bulk purchase nursing home places which they slot individuals into, instead the focus will be on the individual and what they want and need rather than what is available. Personalisation works

with the notion of 'active citizens' and empowers those needing care to 'co-produce' the support they need (Glasby and Littlechild, 2009). To be successful, personalisation requires a transformation in the supply side of social care services. The social care market has previously been driven by Local Authorities as bulk purchasers who must now respond to the needs of individual service users. The UK government have therefore been keen to stimulate and extend the social care market bringing with it new opportunities and challenges for social care providers.

Large block contracts previously tended to favour large providers who could deliver the economies of scale required by Local Authority commissioners. Personalisation may remove the monopoly created under this system and enable smaller providers to compete. Personalisation therefore leads to new opportunities and roles for small third sector organisations to deliver more innovative and flexible services. Smaller social care providers who could not compete for large contracts as they lacked the capacity or tendering skills to deliver large quantities of care, are therefore likely to benefit from an increase in the number of individual purchasers (Baxter et al., 2011). It may also make it easier for new providers to enter the market especially for smaller providers, as rather than looking to secure large contracts (which require significant inputs of money and skills), providers can build capacity one client at a time (Baxter et al., 2011).

Personalisation therefore brings new opportunities for innovation, especially for non-traditional social care providers. Whilst government reforms have shifted the demand side of social care by allowing service users to 'commission' their own services through personal budgets, such reforms do not on their own create change in the social care market. Supply side reforms are also needed to bring about change and choice for these newly 'empowered' 'consumers' of social care (Fox, 2013). One key way in which the supply of social care services has been expanded and diversified is through micro-enterprises which have become vital elements of this market to provide choice and individualized solutions at a small scale (NAAPS, 2008).

Micro-Enterprises

Micro-enterprises are very small organisations that are usually defined based on the number of employees. On a global scale, micro-enterprises tends to refer to enterprises in the developing world that use microfinance (Gosen, 2009); however, in the UK there are a growing number of micro-enterprises in the housing, leisure, health and social care sectors. Within the social care context, micro-enterprises have been defined as very small local enterprises with five or fewer workers (Community Catalysts, 2011; 2014). They are usually independent of any larger organisation and are offered by a range of people and organisations in the community, including people who are disabled or themselves need some support. They may be run from people's own homes and often employ family members. Moreover, a micro-enterprise may be developed out of a wish to help out a neighbour or friend (DH and NAAPS, 2009) and as such delivered on an occasional basis according to the needs of the people they support. Their flexible nature also means that running a micro-enterprise can be combined with other employment, personal caring responsibilities or study (DH and NAAPS, 2009). They therefore arguably bridge the third and fourth sectors.

In fact, micro-enterprises may be grass-roots organisations that are operating 'under the radar'. This is a term applied to small voluntary organisations, community groups or other informal activities in the voluntary sector that do not appear on national datasets and often have limited/uncertain incomes (McCabe et al., 2010). Many micro-enterprises fall outside of social care regulation, or outside of what is traditionally seen as 'social care' altogether (Fox, 2013). A review of 'under the radar' services by McCabe et al. (2010) found that such services can be crucial to fill the gaps in public services where mainstream provision has failed to meet needs. They can also be instrumental in recognising and promoting cultural solidarity or identity. Marginalised groups including Black and minority ethnic (BME) communities, lesbian, gay, bisexual and transgender (LGBT) people, asylum seekers and refugees who often feel excluded from mainstream care services, often establish their own care and support services as a response to gaps in service provision (Manthorpe et al 2010; Truswell 2011; Moriarty 2008; Cant and Taket 2005; Sin 2006; Carr, 2014). Small community micro organisations are also established as a response to geographical marginalisation, especially by older people living in rural areas (McDonald and Heath 2008).

Micro-Enterprise and Innovation in Social Care

There has been great optimism about the scope for micro-enterprise to bring innovation to social care. The informal and often fluid nature of micro-enterprises means that most look nothing like traditional health and social care services (Lockwood, 2013). Donahue (2011) notes that micro-enterprises are very different from the formal and professional environments of larger organisations. Daly (2013) shows that traditional day or domiciliary care is being replaced for some people by more innovative micro-enterprise services. This for example includes disabled-led dance workshops or a pedal-powered smoothie bar, both of which help learning disabled people to develop independence, social and work skills. They may also span the boundaries of the traditional domiciliary, residential and day care sectors. However – outside of a few transformative vignettes – there has been little systematic study of the extent to which these enterprises are bringing innovation to the social care sector.

Williams defines innovation as ‘a process through which new ideas, objects and practices are created, developed or reinvented, and are new for the unit of adoption...’ (Williams, 2010, p. 145). He distinguishes between *what* innovations (what service is delivered) and *how* innovations (how a service is delivered), whilst recognising that improvement requires these types of innovation to be kept aligned (Williams, 2010, pp. 146-7). A *what* innovation is concerned with new types of goods and services, whereas a *how* innovation relates to organisational process change affecting communication and relationships inside and outside the organisation (Williams, 2010, pp. 146-7).

Propensity to innovate has been associated with a range of management characteristics, including size. In a meta-review of the literature on innovation and size, Greenhalgh et al (2004) found:

...one of the most commonly observed findings about organisational innovation is the positive correlation with large size. Organisational theorists continue to debate why size is generally associated with innovativeness. Rather than size per se (for example, number of employees), explanations include that larger size increases the likelihood that other predictors of innovation will be present, including the

availability of financial and human resources (organisational slack) and differentiation or specialisation.

Williams suggests that the risks of innovation may be particularly stark for very small organisations, which lack the financial liquidity to survive failed innovations (2010, p. 157).

However, much of the public management literature on size, innovation and performance is of limited applicability to the study of micro-enterprise in social care. First, very few of the existing studies have focused on very small organisations, characterised by extremely low staff numbers. The low visibility of such organisations, which often operate 'below the radar' may explain part of this neglect (Soteri-Proctor, 2011). However it may be that these organisations, with few or no staff, have distinctive features which means they perform qualitatively differently than organisations that are slightly larger. A second limitation is that the literature tends to consider innovation in terms of an existing organisation doing things differently, be it in relation to a product or process. The context of new start-ups, whose approach is innovative in the sense of challenging a sectoral norm or traditional way of providing services is somewhat different. A third limitation of innovation studies is that generalised accounts of innovation may be of limited value in understanding the distinctive context of care. In human welfare services, in which relationships between staff and service users are key to successful delivery, size operates differently than in transactional services such as waste or tax collection where economies of scale are easier to realise (Bovaird, 2013).

To assess the extent of micro-enterprise innovation within social care and its link to outcomes, it is important to consider the dominant service models which innovation would be departing from. Dominant models in English social care services are residential care (including nursing and non-nursing care), domiciliary care (i.e. personal care in the home) and day services (which may be based at a day centre or facilitate access to a range of services). Innovation in this sector could mean a deviation from one of these service models (which could be called a *what* innovation), or it could mean deviation in the ways in which one of these models is delivered (which could be termed a *how* innovation).

Researching Micro-Enterprise Innovation and Performance

Addressing the low visibility of micro-enterprises and in particular the lack of formal evidence around their performance, levels of innovation and outcomes, the University of Birmingham is leading a two-year evaluation of micro-enterprises in adult social care. This study aims to generate a better understanding of the impact of micro-enterprises on service users, compared to larger organisations. In doing so it hopes to build more refined knowledge about: the nature of innovation in micro-enterprises; whether claims to distinctiveness are met in practice; and how innovations can lead to better experiences and outcomes for service users.

The starting point for assessing innovation was a mapping exercise concentrating on the extent of 'non-traditional' services offered. The research has therefore begun to explore the realities of innovation and distinctiveness and their potential for positive impacts through an evidence review on the role of small community organisations and networks in supporting marginalised communities (Carr, 2014). With a focus on black and minority ethnic (BME), lesbian, gay and bisexual (LGB), refugee and faith communities, it examines how small community services are responding to unmet needs. Findings suggest individual and community outcomes of empowerment that would be unlikely to have been achieved through mainstream provision alone. As Carr (2014) notes:

While each group had their own particular issues, there were common experiences and responses, most notably self-organisation and mobilisation of social capital to compensate for gaps in mainstream support provision.

This review, undertaken in the initial stages of the study, illustrates ways that small community organisations have innovated to provide appropriate services within marginalised groups who would not otherwise have accessed services. Such novel initiatives are frequently self-led, designed to fill gaps in existing provision that can only be identified from within these communities (Moriarty, 2008). Carr (2014) found small community-based or local initiatives have been found to have benefits not only for the users of the service but for the wider community in terms of social inclusion and social cohesion, particularly for

isolated older people. One study based in rural Ireland showed the wider impact of an older people's group project providing innovative 'intergenerational and intercultural projects, drama, health initiatives, life-long learning, holidays and social events' as well as more traditional 'transport, laundry, chiropody, outreach service, information sessions and information technology tutorials' (Walsh and O'Shea, 2008:797).

Developing an Empirical Evidence Base on Micro-Enterprise

To further explore what innovation looks like within the context of micro-enterprise provided social care, the study is working with micro-enterprises in three English case study sites. In each area the performance of micro-enterprises is being evaluated against small (6-50 employees), medium (51-250 employees) and large (251+ employees) care providers. Interviews will be undertaken with service users and carers in 18 micro-enterprises and 9 larger care providers (3 small, 3 medium and 3 large). Interviews are also being undertaken with micro-enterprise staff and co-ordinators in each of the three areas.

The way the study defines and measures performance is significant for generating meaningful findings around innovation, its relationship to user outcomes and to service provider size. To this end the research methods focus on evaluation criteria which target comparisons of whether different size providers deliver:

- Innovation
- Valued services
- Personalised approaches
- Cost-effective outcomes

These criteria tap into some of the key hypotheses about the qualities of micro-provision, often assumed and espoused in policy reporting (DH, 2010; NAAPS, 2010; NHS Foundation, 2011). In addition to generating evidence to support or challenge current policy rhetoric, the

methodology has attempted to build in some ways of overcoming the problems of studying innovation.

This paper now draws on the findings from interviews with four micro-enterprise co-ordinators from across the three research sites. The co-ordinators are individuals who provide advice and support to micro-enterprises and therefore have considerable knowledge of the role of micro-enterprises, the ways in which they are similar/different to other care providers, as well as understand the challenges that they face. The interviews were conducted over the phone, and were recorded and transcribed. We now present the findings from these interviews, focusing in particular on the ways in which micro-enterprises are innovative or distinctive.

Micro-Enterprise: The Benefits and Challenges around Innovation

The micro-enterprise co-ordinators reported a range of advantages of micro providers over larger care providers. Micro providers were differentiated from larger care providers by their flexibility, person-centred service that is 'co-produced' with service users:

'Most micro-enterprises co-produce their services with the people that use them. That's pretty inherent in all of them. Because they are so small they can be really customer focused and involve people. I think that's the biggest one, that people really feel part of something' (Micro-Enterprise Co-ordinator D, Site 3).

It is this approach to co-production and personalised care that allow micro-enterprises to be creative and therefore innovative:

'They are far more able to be creative and innovative. That is why they are doing it in the first place. Most micro haven't been business minded people...yes they have to make an income...but it's not all about let's make as much as I can but about what can I do to make a difference to the people's lives that I will be supporting' (Micro-Enterprise Co-ordinator C, Site 2).

What is evident from the interviews with the micro-enterprise co-ordinators in the four areas is that they primarily emphasise the value of micro-enterprise in terms of *what* innovations:

‘I think obviously we have got a variety of providers. Some do very different things. You may have fishing clubs, singing and signing, pet therapies, so those are quite different [to traditional care providers]’ (Micro-Enterprise Co-ordinator A, Site 1).

‘So it’s about really different things. There is [a] person who was asked by social workers to support a self-funder who had become visually impaired in her twenties. She was very much a fashionista so she wanted someone to pick out her clothes. The social worker brokered someone in to help choose her clothes and go shopping’ (Micro-Enterprise Co-ordinator B, Site 1).

There are *how* innovations as well.

‘We have got a lot of traditional services, people who do home help, personal care, shopping, meal preparation. But it’s their approach to it that’s different. One of the micros I work with they will do meal preparation but they will sit down and have a meal with that person, interact with that person’ (Micro-Enterprise Co-ordinator A, Site 1).

‘Even where you have more traditional providers, those doing befriending and companionship it feels a bit different because you don’t have the restrictions of a big agency... They can be flexible and responsive’ (Micro-Enterprise Co-ordinator B, Site 1).

These *how* innovations are downplayed, both in the interviews, where they were reported after the *what* innovations, but also in the literature from the micro-enterprise umbrella group Community Catalysts (<http://www.communitycatalysts.co.uk/case-studies/>). *What* innovations hit the headlines and help to generate excitement about how personalisation can break the mould of social care service-land. However, it is arguably the scope for

process-based *how* innovations that constitute the most radical challenge to the mainstream of social care. People will continue to need help getting out of bed, getting washed and dressed; for some people residential care will continue to be the best place to get this support. If micro-enterprises are an affordable way to get personalised, responsive, dignified, domiciliary and residential support, that would provide a radical alternative to existing social care provision.

Conclusion

This paper has considered the role of micro-enterprises in social care and has begun to identify how they are performing in relation to larger social care providers. The micro-enterprise sector has grown in recent years as a response to the UK government's 'personalisation' agenda. The purpose of this policy is to allow social care service users more choice and control over the services that they use. Micro-enterprises have been promoted as being more innovative and as organisations that provide care services that are more personalised and centred around the needs of service users (DH, 2010; NAAPS, 2010; NHS Foundation, 2011). However, there is currently an insufficient evidence base to support these claims. This study on micro-enterprise begins to fill this gap by asking whether micro-enterprises provide more innovative, valued, personalised and cost-effective services than larger social care providers. In this paper, we have focused on the ways in which micro-enterprises are more innovative by drawing on interviews with micro-enterprises coordinators in four areas of England. We have also begun to 'map' innovation by looking at non-traditional services and service users.

We have identified that small providers are more likely to respond to unmet needs, and the needs of non-traditional service users including BME, LGB, refugee and faith communities who are often excluded from mainstream care services. We could therefore argue that by providing services to excluded communities, micro-enterprises are innovative in terms of *who* their services target. We have also identified that micro-enterprises display both *what* innovations (e.g. creative therapy) and *how* innovations (e.g. more interaction and flexibility in care provision). However, it tends to be *what* micro providers are doing that is more

widely reported, as they tend to provide services that are alternatives to the traditional 'day', 'domiciliary' and 'residential' provision that surround the ethos of social care.

This study will continue to explore innovation in micro-enterprise through interviews with service users. By generating more in-depth evidence on the experience and outcomes of micro-enterprises, we aim to evaluate claims that they are more innovative, valued, personalised and cost-effective than larger and more 'traditional' care providers.

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