The business case for supporting the development of community micro-enterprises

COMMUNITIES CARE

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CONTENTS

1. EXECUTIVE SUMMARY

Community and micro-enterprises (CMEs) use a wide range of business models, with many working as sole traders, or as micro-businesses with very few employees. They usually operate at local neighbourhood levels only, and most choose to stay small and local. They can be easily overlooked by policy-makers, commissioners, and funders, who are seeking to respond to multiple changing needs and concerns in the wider health and care sector.

Separate pieces of research undertaken by the University of Birmingham and the New Economics Foundation, finds that these CMEs can be well placed to deliver support that:

- Generates positive outcomes for the recipient of the care and for their families
- Contributes to wider social and economic policy priorities

They are also able to introduce new services in response to unmet needs in communities more easily.

This paper focuses on the direct contributions that CMEs are creating with regard to a range of priorities. It also recognises that through the way they operate, CMEs are creating secondary and even wider benefits to larger groups and types of other people in the same communities through ‘ripple effects’ (which are often harder to capture and quantify).

This paper summarises the business case for investment in direct support for CMEs through resourced programmes and interventions. It also separately considers the rationale for Community Catalysts being the best placed agency to lead on the delivery of these programmes.

It explains the role of CMEs in:

- Addressing recognised structural problems in current care sector provision;
- Reducing the financial pressure to the state caused by changing public health and care need;
- Supporting local authorities’ own agendas for change in procurement practices;

- Creating jobs that are more inclusive and are of a higher quality;
- Contributing to the recovery of communities and economies from the Covid-19 pandemic.

It also shows how the potential further impact of CMEs is being limited through barriers caused by:

their lack of full engagement in commissioning processes;

the challenges that they face over how to best increase their capacity

the current culture and practice of focusing on targets within a 12-24-month timescale.

2. INTRODUCTION

During 2017-20, the University of Birmingham, and the New Economics Foundation, each separately began to look into better understanding the role and impact of community micro-enterprises (CMEs) delivering health and social care services within the context of defined local authority areas.

Although both studies were undertaken independently of each other they are felt to offer a more comprehensive understanding of CMEs when read together.

For clarity, CMEs are defined as: "*very small […] enterprises that support the health and wellbeing of people in their neighbourhood [...] The business models used […] are on a continuum from fully commercial […] to fully voluntary […]. Only some […] are delivering formal health or social care services that require regulation by the Care Quality Commission.*"

The University of Birmingham based their research on projects that had been funded by the national grant making bodies Power to Change and the Esmée Fairbairn Foundation, and managed by Community Catalysts. The grant from Esmée Fairbairn provided funding for two local programmes designed to help test and prove models of support designed to further encourage the start-up, and impact, of CMEs addressing loneliness and isolation at local and neighbourhood levels.

The New Economics Foundation based their research on existing published studies, interviews, and creation of case studies, and correlated these with wider overarching issues and themes, seeking to identify core common arguments in favour of CME models being more favourably recognised in future commissioning programmes[1]. This was as part of a wider programme of research commissioned by the Barrow Cadbury Trust.

These research bodies reported their findings separately. The purpose of this document is to bring together the recommendations from each report into a coherent business case explaining why commissioners, local authorities, and other funders should specifically prioritise supporting these groups of organisations (at all stages in their development and growth cycles).

[1] Community Micro-enterprise as a driver of local economic development in social care, NEF, May 2020 (in these footnotes 'NEF')

The resulting business case is structured around several overarching themes, within each of which are illustrations of the benefits that CMEs can offer and create and a rationale for the need for CMEs to be further supported. It also separately considers the rationale for Community Catalysts to lead on any such interventions and support.

Where assertions are made, these are referenced against the findings in the reports through footnotes and quotations from different stakeholders. Quotations from CMEs captured through the research programmes are included against these to further illustrate the role and impact of CMEs.

2.1 Existing care sector challenges

There is growing recognition of the erosion of the provision and quality of care services by the business model used by some of the major suppliers of care, which are financed by private equity. Such a wealth-extraction model leads to provision being undermined through practices such as: low pay, weak job security, and a culture of long shift hours, amongst others. And these practices are often attributed to the ongoing loss of skills and expertise in the care sector[2].

CMEs directly address these concerns and proactively mitigate against them as their ownership is predominately local, and has features of the legal forms adopted by larger organisations, that prevent wealth extraction. All are also found to be making formal commitments to focus on the quality of their services over generating profit – and for the larger organisations that deliver personal care, these commitments are further protected through their also being regulated by external bodies.

These commitments and ownership models are important in enabling CMEs to create wider benefits and impacts through their contribution to the economic resilience and capital within local communities.

[2] *NEF, p5*

These structures used by CMEs also see them able to retain twice as many people who would otherwise have exited the care sector, compared to those working in traditional care providers, thus retaining skills and expertise[3].

There is an observed effect amongst CMEs where they cluster, and are supported to network together, in a given local geographic area. Specifically, they mutually encourage and challenge each other to further increase the quality and scope of each of their own provisions – this is particularly of note as it highlights how the quality of provision amongst CMEs is not driven by targets or legislation, but is in direct response to local intelligence about what is most, and best, needed. CMEs can then be more quickly established than traditional models of care provision. This means that where gaps and unmet needs in provision are able to be identified, CMEs are best placed to be able to respond to them speedily. Such peer networks are recognised as being crucial to the success of CMEs.

2.2 Changing public health and care demand

It is widely accepted that the demand for public health and care services is growing exponentially across all communities as people live longer. There is also widespread acceptance that as a result, communities need to see gains in their health and well-being to best manage the impact this is having on the state.

The variety and range in models of support used, and provisions offered, by CMEs to people of all ages and demographics in local communities directly address these issues through their generation of public health savings (typically in the region of £4,000 per CME each year for CMEs delivering homecare) and because of greater health and wellbeing outcomes and gains for all types of people they support[4]. Such outcomes include (but are not limited to):

- Improved physical health and diet

[3] *NEF p20-21*
[4] *NEF p3*

"I want to improve people's health and health inequalities so, you know, if they don't know how to cook then they can't make those decisions for themselves and I hear so many people, even unfortunately people here in Public Health saying, "It costs more to eat healthy," and I want to kind of say, "No it doesn't, but it does take a little bit of planning, it might take a little bit more time, and you do need a certain amount of skills to be able to do it". And I'd like to empower people to be able to have those skills."

CME on how their motivation to establish their service has informed how they approach designing activities to generate wider benefits for individuals.

- Improvements in confidence

"Yes, I'd say I'm more confident than I was a year - than what I was a year ago, because I feel better about myself."

- Better self-management of long-term illness

"[..] I come along and with my illness I do get very tired, but I can come along have my coffee, and have a doze in the corner and it wouldn't matter. I'm very comfortable which I think is a very good thing. There's nothing worse than going to somewhere and not feeling comfortable."

CMEs can also deliver against policy priorities relating to loneliness and social isolation issues that are more likely to lead to poor health and earlier death, especially amongst older people.

"I think it is really important what we do actually. I think there are a lot of people that live on their own, whether they are in care homes or elsewhere, and they are really, really lonely, and really isolated, and culturally have very, very little access. So, if you are actually asking people to do some of the things that we ask them to do, you are really taking them into a completely different space which people are slightly challenged about, but they never say no, ever."

CME reflecting on why they seek to tackle social isolation and loneliness in the design of their services

Through their delivery models, CMEs are found to enable people to create more social contacts, friendships, and connections, in their local communities than they would have otherwise. As well as reducing loneliness and isolation, this builds people's social capital and resilience.

> *"The other people come and talk to you and give you coffee so that's good, they know you, we feel welcomed absolutely, fully part of it, fully part of the village where you could've been stuck just yourself away."*
>
> ***customer of CME***

2.3 Local Authorities' own agenda for change through procurement

Local authorities are increasingly using their procurement services to pursue a number of agendas for change. CMEs are found to be well placed in supporting the realisation of these agendas:

- Risk: commissioning bodies are keen to best mange the risk associated in the awarding of contracts; and one such risk is that the awarded provider will cease to be able to continue to deliver the agreed services at short/no notice. In being smaller, but using collaborative commissioning models, CMEs can directly mitigate against this risk by negating a commissioner's need to be reliant upon a single provider in the marketplace[5].

- Earlier intervention: local authorities have identified that CMEs are better placed than traditional domiciliary care agencies to engage people sooner, and so reduce the need for later more resource intensive support[6].

- Shifting cultures from 'doing thing to', to 'doing things with' local residents: local authorities recognise that CMEs are well placed to help facilitate conversations and co-production practices that enhance adult social care[7].

[5] *NEF p8, p19-10*
[6] *NEF p7*
[7] *NEF p7-8*

- Stimulating innovation: local authorities recognise that there is a need to challenge and recreate older models of care provision, but often struggle to be able to encourage this. CMEs are values for their ability to introduce new models of working and types of service provision[8].

- Rebalancing local provision after the withdrawal of established services due to austerity: CMEs can be quick to establish, and able to operate at hyper-local community levels, ensuring that emergent gaps in provision for neighbourhoods can be best met[9].

[8] *NEF p19*
[9] *NEF p20*

3. THE CASE FOR COMMUNITY MICRO-ENTERPRISE

3.1 Employment and job creation

The agenda around employability is not just related to the creation of jobs, but also increasingly the quality of employment available to people.

With regards to the creation of new jobs and enhancing people's employability, CMEs in the studies:

- Increased volunteering opportunities by 191.5% within a 2-year period, offering people access to training and skills development.

And in relation to the additional agenda relating to the quality of employment within jobs created:

- CMEs can be created by people with disabilities[10], offering them routes into employment that they might have otherwise struggled to achieve;
- CMEs are more likely to be able create employment amongst groups of people who would otherwise face additional challenges in being able secure paid work, particularly for reasons of age[11].

3.2 Wider community benefits and individual well-being (social value)

As highlighted in the preceding sections, CMEs are recognised as being able to create secondary and ancillary benefits beyond the direct health and social care services they offer such as employment and employability, creating stronger links between people living the same community, and tackling loneliness. This is sometimes referred to as the 'ripple effect' of investment in support for CME. This 'ripple effect' is increasingly being recognised as the 'added social value' that commissioners are keen to see being realised in the design and awarding of contracts.

Such 'ripples'/social value include:

[10] *CME case studies no 2*
[11] *NEF p12*

- enabling people in local communities to become more involved in social action and mutual support[12];

- being able to better engage groups in the community who are more likely to be isolated due to cultural stigmas and prejudices, based on the below testimonials:

"Because we're trying to get the women out of the house, because I know as a foreigner, as a woman, that you tend to have more difficulties to get out than men."

CME founder on how they have used their lived experience to design their services to benefit others who would similarly otherwise 'miss out'

"It did make a difference. I really like is we all come from different countries with similar stories and it makes us feel welcome…. this kind of makes you feel welcome you're not alone and you've got a group. It's not only about people who are foreigners, everyone is welcome and that is what I like about it. It don't put oh you're from here or there, we're all welcome. That's why I quite liked it, that's how I felt."

- ensuring a continuation of community 'lower level' services that have been progressively withdrawn by local authorities as a result of central government austerity measures

3.3 Covid-19 recovery

In the wake of the Covid-19 pandemic, many agencies are keen to ensure that whatever they commission or support in 2021 onwards will directly support communities, (both socially and economically), to recover from the impact of this health crisis.

The standards and themes set by government nationally are being seen by many as a core framework for how this can be best achieved[13], and CMEs are well placed to contribute to them through:

[12] *NEF p17-18*
[13] https://www.gov.uk/government/news/new-measures-to-deliver-value-to-society-through-public-procurement

1. Supporting local communities to recover from the impact of Covid

    - CMEs and their services are owned, managed, and delivered by local people, and the larger organisations are usually incorporated with legal forms that prevent the extraction of wealth, meaning that trading surpluses are retained within the local community;

    - Evidence shows that CMEs are able to engage groups that were already 'harder to reach' before the pandemic, successfully acting as bridges to enable them to access other supports from other services

    - CMEs' delivery model for their services are designed to enable people to create more social contacts and connections in their community than they would have otherwise, thus enhancing their personal resilience.

2. Tackling economic inequality through creating new businesses

    - CMEs are able to be more quickly established in comparison with traditional models of care provision[14];

    - CMEs create employment amongst groups of people who would otherwise face additional challenges in securing paid work[15].

3. Tackling economic inequality through increasing supply chain resilience

    - CMEs offer collaborative commissioning models that reduce over-reliance upon single large suppliers[16].

4. Driving equal opportunity by reducing the disability employment gap

    - CMEs are more likely to be established by people with disabilities.

5. Driving equal opportunity by tackling workforce inequality

[14] *NEF p17,*
[15] *NEF p12,*
[16] *NEF p8, p19-10*

- CMEs enable 35% of people who would have otherwise left working in the care sector to carry on working in it through their employment practices[17];
- CMEs create new opportunities for people to gain skills and access training through volunteering roles.

6. Driving equal opportunity by improving health and wellbeing
   - CMEs enable people to live independently in their own homes for longer[18];
   - CMEs generate more positive health and other outcomes for people in comparison with traditional care agencies[19].
7. Driving equal opportunity by improving community integration
   - CMEs' services are designed to increase the social capital of people by supporting them to build new and more contacts and connections with other people in their local community.

[17] *NEF p3, p20-21*
[18] *NEF p17*
[19] *NEF p3*

4. THE CHALLENGES FACING COMMUNITY AND MICRO-ENTERPRISES

The transformative potential of CMEs against the range of policy priorities and community needs is clearly illustrated in this paper. In order to deliver that potential CMEs require resourced support and interventions in the following strategic areas:

4.1 Commissioning, and attitudes to risk within local authorities

Most CMEs only derive a small/negligible amount of their incomes from public sector contracts. They attribute this to the 'siloed' approach within many local authorities to the commissioning and management of services that have multiple impacts, and the focus on targets over outcomes.

"…it was an awful experience. I am not mincing my words"

CME on trying to seek support from their local authority to establish their service and be able to offer it in their local community

Enabling CMEs to better engage with public sector commissioning, would make possible more stable and longer-term financial planning and service development. This in turn would enable them to better achieve their transformative potential.

Part of the reason that CMEs struggle to engage with commissioning is to do with challenges in the current approach to regulation (see 4.4). This struggle is also recognised as being a reflection of the culture of risk that a local authority is able to accommodate and a rigid adherence to procurement processes designed for larger more traditional organisations.

4.2 Capacity

The recognised quality of services offered by CMEs in comparison to traditional care home and other agencies by people using them, means that they frequently operate at capacity. Currently in the region of 50% of CMEs are unable to meet the demand for their support[20].

When the right kind of support is provided locally, CMEs are shown to be able to increase their capacity by over 200%.

4.3 Challenges of target driven systems and cultures

People establishing new CMEs may need several years to work through the processes from idea to being fully established and operational – but the support programmes and resources available to them to progress through these are often linked to shorter 12-24 month timescales.

> *"So, this process of setting up this business has gone on for over a year, it has been a really long process"*
>
> ***individual setting up a new CME***

Interventions and support to CMEs therefore needs to be planned and resourced on at least 36-month timescales.

4.4 Compliance with regulation

Individually delivered CMEs (sole traders) are excluded from registration with CQC. This impacts on how far they are able to engage in local commissioning exercises, and also limits the further development of their support services. There is a need for a more flexible approach that would allow CMEs with this structure to be able to register using processes that recognises they do not have formal management structures in the same way that larger care agencies do.

4.5 Accessing available information and support

[20] *NEF p16*

Because of their size, and the backgrounds of the people establishing them, CMEs often struggle to be able to identify and access information and guidance relevant to their service offers.

"…advice was very useful to us because I don't think anybody really on the management committee had particular expertise…"

local CME reflecting on the importance of having access to relevant information

5. WHY COMMUNITY CATALYSTS?

Community Catalysts is a UK organisation established to catalyse local communities to deliver their own health and social care through building on the strengths of the local people within them.

Community Catalysts allocate local workers to:

- Co-ordinate local authority, health, and VCSE sector bodies in defined geographic areas;
- Work with local commissioners to support changes in systems and practices;
- Support people to develop aspiration for, and subsequently start-up, new CMEs;
- Create new learning and development opportunities for health professionals.

Community Catalysts has worked in approximately 100 local authority areas to date. In the test sites examined by the University of Birmingham the Community Catalysts approach has created:

- A 25% increase in the number of CMEs over a 2-year period
- An increase in CMEs capacity of over 200%
- Twice as many volunteering opportunities being created within CMEs than would have been achieved otherwise.
- A more connected and navigable network and pathways of support and resources from the different local agencies in a given community (these networks would traditionally have been maintained by local VCSE infrastructure bodies, but are increasingly not able to be otherwise managed, meaning people are unaware of the full range of support services from different agencies available to them).

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