

Micro-enterprises: small enough to care?

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Micro-Enterprises: Small enough to care?



Catherine Needham, Kerry Allen, Kelly Hall, Stephen McKay, Jon Glasby, Sarah Carr, Rosemary Littlechild, Denise Tanner and the Micro-Enterprise Project Co-Researchers

A summary of this report, an easy read version and a video of the findings are available from <http://www.birmingham.ac.uk/research/activity/micro-enterprises>

About the Project

This report presents findings of an evaluation of micro-enterprises in social care in England, which ran from 2013 to 2015. Organisations are here classed as micro if they employ five or fewer full-time equivalent staff. The aim of the project was to test the extent to which micro-enterprises deliver services that are personalised, valued, innovative and cost-effective, and how they compare with small, medium and large providers.

Working in three parts of the country, researchers compared 27 organisations providing care and support, of which 17 were micro-enterprises, 2 were small, 4 were medium and 4 were large. The project team interviewed and surveyed 143 people (staff, older people, people with disabilities and carers) who received support from the 27 providers.

The findings presented are relevant to people who use services and their families; social care commissioners; regulators and policy makers at a local and national level; people who provide care services; and social entrepreneurs who are considering setting up micro forms of support.

The research was based at the University of Birmingham. It was funded by the Economic and Social Research Council (ESRC), as part of a project entitled Does Smaller mean Better? Evaluating Micro-enterprises in Adult Social Care (ESRC Standard Grant ES/K002317/1).

For more details about the project see <http://www.birmingham.ac.uk/research/activity/micro-enterprises> or contact Catherine Needham c.needham.1@bham.ac.uk / [@DrNeedham](https://twitter.com/DrNeedham). The project hashtag on Twitter is #microsupport. Join in the conversation!

About the Research Team

The core research team was **Catherine Needham, Kerry Allen and Kelly Hall**, all of whom are based in the School of Social Policy at the University of Birmingham.

Stephen McKay (University of Lincoln) undertook quantitative and financial data analysis.

Jon Glasby (University of Birmingham) advised on project design, data analysis and evaluation.

Sarah Carr (Middlesex University) contributed to the literature review.

Rosemary Littlechild and Denise Tanner (University of Birmingham) evaluated the co-researcher involvement.

All contributed to written project outputs, and sat on the project steering group alongside project partners (**Community Catalysts and Shared Lives Plus**).

People who use services and carers were involved as **co-researchers** on the project, contributing to the design of interview materials, leading interviews, assisting in data analysis and helping to disseminate the findings. The co-researchers were **Tracey Bealey, Isabelle Brant, Hayley Broxup, Roy Doré, Peggy Dunne, Sandra Harris, John Kerry, Simon MacGregor, Adrian Murray, Joan Rees, Anna Stevenson, Brian Timmins, David Walker, Joanne Ward, Gareth Welford and Sheila Wharton**.

Laura Brodrick from Think Big Picture provided the illustrations. The Social Care Institute for Excellence gave support on communications.

Executive Summary

1. Micro-providers offer more personalised support than larger providers, particularly for home-based care

The research found that many aspects of micro-enterprise provision did allow them to offer a more personalised service than larger care providers. This was particularly the case for care and support that is delivered within the home. The more personalised care provided by the micro-enterprises stemmed from three aspects of their approach:

- Autonomy of frontline staff to vary the service being offered
- Greater continuity of frontline staff compared to large care providers
- The high level of accessibility of managers to staff and people using the service.

Differences between micro-enterprises and larger care providers were less evident in relation to day activities. Although there were several examples of micro-enterprises offering highly personalised day activities, we also found examples of larger providers offering a wide range of choices which some people welcomed.

Whilst most people liked the chance to build closer relationships, some micro-providers and some people receiving support from micro-enterprises spoke of concerns about the risks of over-attachment and burnout.

2. Micro-enterprises deliver more valued outcomes than larger providers, in relation to helping people do more of the things they value and enjoy

The outcomes of care and support are closely interwoven with the ways in which care is delivered. Indeed many people did not talk about their support as having a distinctive outcome outside of a personalised experience of care, discussed above. This was particularly the case for home-based support. For activities outside the home there was more likely to be articulation of an end result (making new friends, building confidence, getting fit, finding a job, etc) which was distinguishable from the support that made it happen.

We used the Adult Social Care Outcomes Toolkit (ASCOT) to ask people whether or not the support service they used (i) helped them to do things they value and enjoy with their time and (ii) helped them to have

more choice and control in their lives¹. The findings showed that people using micro-enterprises were more likely than people using larger organisations to report that their provider helped them to do the things they value and enjoy with their time. There was no statistically significant difference between organisations of different sizes on the choice and control dimension.

3. Micro-providers are better than larger providers at some kinds of innovation

The research explored three distinct types of innovation displayed by care providers; what innovations (what service is delivered), how innovations (how a service is delivered) and who innovations (who provides and receives a service). Micro-providers were found to be particularly good at how and who innovations when compared to larger providers, but findings relating to what innovations were inconclusive. In relation to how innovations, micro-providers were more flexible than larger providers in the way in which care in the home was delivered (e.g. staying to have a meal with someone rather than simply preparing food and then leaving). Examples of who innovations include micro-providers which offered support in potentially marginalised communities and others which were set up and run by people with disabilities. Although we heard about some micro-enterprises offering what innovations (for examples see www.smallgoodstuff.co.uk), they didn't have enough established people using the service for us to assess the quality, so we could not include them in the research.

4. Micro-providers offer better value for money than larger providers

The distinctive contribution of micro-providers appears to be the ability to offer more personalised and valued care than

larger providers without a higher price tag. Price data provided by all of the organisations in the research indicated that the hourly rate for micro-enterprises was slightly below that of larger organisations. As we showed above, this was not at the expense of quality, as responses on use of time and choice/control (from the ASCOT questions) were at least as positive as for larger providers. With the larger providers it was easier to identify trade-offs between price and quality: the cheapest prices were offered by those that conformed to the 15 minute care visit model, and the people who used these services reported high rates of turnover among care staff. At the more expensive end of the market, larger providers were able to match the micro-provider offer more closely, providing longer care visits and better staff continuity.

5. Enabling Factors for Micro-enterprises

Factors that help micro-providers to emerge and become sustainable include dedicated support for start-up and development – from organisations which understand the distinctive context of the care sector. Strong personal networks within a locality had also helped micro-providers to get started and market themselves to people who might use the service. Balancing good partnerships (including with local authorities) with maintaining an independent status was also viewed as central to sustainable success. Some local authorities have a quality mark scheme that micro-providers can apply to join. This helps the micro-providers to build local credibility for their enterprise and gives assurance to local people about the quality and safety of the support.

6. Barriers for Micro-enterprise

Inhibiting factors for micro-enterprises include a reliance on self-funders given

RECOMMENDATIONS

- Commissioners should develop different approaches to enable micro-enterprises to join preferred provider lists
- Social care teams should promote flexible payment options for people wanting to use micro-enterprises, including direct payments
- Social workers and other care professionals need to be informed about micro-enterprises operating close-by so that they can refer people to them
- Regulators need to ensure that their processes are proportional and accessible for very small organisations
- Micro-enterprises need access to dedicated start-up support, with care sector expertise, as well as ongoing support and peer networks.

low levels of direct payment take-up in many local areas, and low numbers of local authority referrals; the difficulty of maintaining a staffing base with only a small number of people using the service; and the financial fragility of the organisations, some of which were barely covering their costs. Most of the micro-providers involved in the research, especially domiciliary care providers, felt that they needed to grow

slightly to gain more organisational and financial stability.

Micro-businesses in all sectors are known to find it difficult to survive,² but personalisation reforms in social care have ostensibly made it a supportive environment for micro-scale provision. The case study micro-providers expressed frustration at the rhetoric of individualised commissioning/

market diversity and the reality of managed personal budgets and preferred provider frameworks. Micro-enterprises will only proliferate if potential users of their services know about them and there is a mechanism to pay for them. Listing them on an online directory of services on a website is not going to generate sufficient business - and indeed is not how large providers get most of their referrals.

SECTION 1: About Micro-Enterprises

Micro-enterprises which provide care and support to adults with an assessed social care need are the focus of this report. They are very small organisations, here defined as having five members of staff or fewer (or the full-time equivalent) (See Box 1).³ There has been lots of optimism among policy-makers about the scope for micro-enterprises to provide high quality public services at a human scale, avoiding the alienating experience of some large scale care provision, delivered in a rushed way by a revolving door of low paid staff.⁴ We undertook a research project to find out if this optimism was well-founded by comparing micro-enterprises to small, medium and large enterprises of care and support for older people and people with disabilities. In particular we looked at whether the micro-enterprises are more personalised, valued, innovative and cost-effective than larger care services.

Micro-enterprises vary widely from each other. Some micro-providers employ staff (even ten or more on a part-time basis) or work with volunteers, whilst others are sole traders, working on their own. Some are set up as social enterprises (including Community Interest Companies) or charities; others are limited companies. Our evidence indicates that those who set up micro-enterprises generally aim to make enough out of their venture only to pay the wages of those involved and subsequently, they can be classed as social enterprises or social businesses.

To be included in this research, the micro-enterprises had to be offering a paid-for service and offering services to more than one person (i.e. not operating as a personal assistant). We found case study micro-enterprises using lists provided by local authorities and the micro-enterprise support organisation Community Catalysts.

Box 1: What are Micro-enterprises?

Micro-enterprises (also called micro-providers) are very small organisations delivering social care services that employ five or fewer staff (full time equivalent). 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 need support themselves.

Box 2: Examples of Micro-Enterprises⁷

Micro Domiciliary Service

Full Lives was set up by Janet who worked within local authority care services, and wanted the opportunity to provide a more flexible offer. It now has four members of staff, supporting three people. The work varies between personal care in the home, and support to access activities outside the home. Janet says, 'Because we are a small company we can be more flexible, at the hours people want. We don't have a lot of clients so we get to know the people we work with. You can build up strong relationships.'

Micro Accommodation

'Our House' is a micro-enterprise providing shared accommodation to men with learning disabilities. The owner provides low level support beyond the landlord role, including social support and activities, as one tenant explains: 'He does things out of his way to get you out the house. He'll... come round once a week and just check in with us...and he's very protective as well, because say if you wanted a mobile contract...he goes "right, well give me about two days, I'll look it up", he'll come back with a better deal.'

Micro Day Support

Pam runs a day service with six part-time staff. Their small size allows them to support the social integration of people with learning disabilities, including Pam's daughter. Pam explains 'I set up Woodlands because day centres were closing...and there wasn't anything [else]. Woodlands is based in a semi-rural community, and aims to connect people to the community: 'our members go out and get recognised by the shopkeepers and people and they develop relationships with folks in the community,' says Pam.

Micro Support in the Home

Barbara works on her own, providing help in the home to 14 people in her local area. The support she provides is very flexible, from preparing food to cleaning out cupboards and taking people to the doctors or to concerts. She said: 'We had our redundancy [from a care agency]. I was always getting in trouble for doing too much, like cooking meals and doing somebody's washing. And when I was made redundant, that was it. I just made me mind up I was going to do it.'

This means that we only included organisations that were visible to one of these parties. Other colleagues at the University of Birmingham have investigated 'below the radar' groups which operate informally within communities, often on a voluntary basis, and are largely invisible to formal organisations like local government.⁵ However here we were primarily interested in micro-enterprises as a type of formal or semi-formal care provision, lacking the informality of much below-the-radar work, but avoiding the intensification and commodification associated with some large-scale care provision.

We planned to focus on the three main types of care service for older people and people with learning disabilities: residential care, domiciliary care and day activities. This would enable us to do like-for-like comparisons with larger providers of these services. However whilst we tried to identify micro-enterprises in each of these categories, many provided more flexible care that spanned the boundaries of traditional care categories (which indeed has been argued to be one of their strengths).⁶ We subsequently introduced a fourth category of 'support in the home' which was a flexible service, covering a wide range of

tasks, usually in the home but sometimes in the community (e.g. accompanying someone to a doctor's appointment). This type of support differs from domiciliary care, a regulated service which usually encompasses washing and dressing. Lots of micro-enterprises provided this 'support in the home' whereas few provided residential care. Box 2 provides examples of four different types of micro-enterprises.

SECTION 2: How we did the research

This section sets out details of the research design.

The co-research approach

The project design encompassed a local asset-based approach, working with co-researchers with experience of care in the three localities. A co-research approach was adopted as it is understood to have benefits for both the validity and relevance of research findings and for the individuals involved.⁸ Seventeen co-researchers were involved and they helped to design the research, led interviews, supported the interpretation and analysing of data and helped to disseminate the findings. Of those, nine were older people and six were self-identified as having autism, learning disabilities or mental health problems. The two remaining co-researchers were paid personal assistants (PAs) for three of the co-researchers.

The involvement of the co-researchers was evaluated by a separate team during the project. The evaluation suggested benefits for both the individuals involved in co-research and for the research findings. However, the evaluation also explores a series of issues linked to the complexity of implementing co-research approaches. These evaluation findings contain useful learning for those undertaking similar projects or co-producing services.⁹

Research questions

To begin building an evidence base on the performance of micro-enterprises, we derived four testable hypotheses from

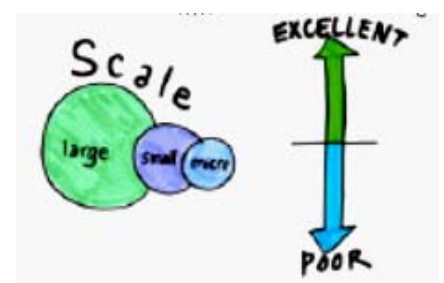


arguments made in existing policy reports about micro-providers:

- (1) They deliver services which are **personalised** to the individual.
- (2) They deliver more **valued outcomes** for people who use the service than larger organisations.
- (3) They are **innovative**, developing creative alternatives to traditional care services.
- (4) They deliver more **cost-effective** outcomes than larger providers.¹⁰

Research sample

To test these hypotheses a mixed methods approach was used, undertaking qualitative and quantitative research with 17 micro-providers, comparing them with 4 small, 4 medium and 2 large providers. We planned to use UK Companies Act 2006 definitions of



small, medium and large size organisations, but found that these were difficult to apply to the social care sector.¹¹ For example, using the Act definition of a large organisation as 250 employees would have resulted in no organisations fitting into this category. Based on social care providers' staffing levels from Skills for Care we used relative definitions of size adapted for particular types of care service (for example average staffing levels

in day services are lower than in domiciliary care organisations).

Twenty seven organisations took part in the study overall. Ten of the selected organisations offered support to older people and 12 to adults with disabilities (primarily, though not exclusively, learning disabilities), with the remaining 5 supporting both groups. The organisations that took part were spread across three localities: a metropolitan borough council in the North West of England, a mixed urban and rural setting across two boroughs in the West Midlands, and a county in the East Midlands. The sites were selected as having a known network of micro-enterprises but also differing from each other in their regional/demographic profiles.

Case selection was deliberately asymmetric, involving more micro-enterprises than larger organisations, reflecting the weak knowledge base about micro-enterprises and performance compared with the relatively extensive data on larger care

providers. It meant that we spoke to more people using micro-enterprises than using larger organisations (66 and 40 respectively). However many of the people we spoke to had used (or were currently using) a range of care providers, and this meant that they were able to reflect on their experiences of organisations of different sizes, adding their own comparative insights to the research.

An initial scoping exercise of care provision in the three sites was used to identify the case study organisations and the following sampling criteria were used:

- Coverage of the three main types of care provision (residential, domiciliary and day activities).
- Offering services to older people and people with learning disabilities.
- Mix of local authority, private and third sector providers.
- Some organisations providing support to 'seldom heard' groups, such as Black and minority ethnic (BME) and lesbian, gay, bisexual and transgender (LGBT).

The flexibility of the micro-enterprise offer meant that it was not always easy to slot organisations into these categories. As discussed above, we added a fourth category of 'support in the home', as well as the three traditional types of care service (domiciliary, residential and day services). The limited provision of residential care in the micro-enterprise sector meant that we only included one larger comparator on this. The sample, by type of service is shown in Table 1.

In addition, the micro-enterprises did not always tailor their offer to particular 'client groups', and therefore to speak to the people using its services we had to go outside the older people and learning disability categories and include people with other impairments such as autism and physical disability. Some micro-enterprises operated inside local authority premises, blurring the lines between sectors. We were not able to find any organisations that provided LGBT-oriented support, and were only able to include two organisations that had a BME focus.

Table 1: The Sample of Organisations, by type of service

	Domiciliary	Day activities	Residential	Support in the home	Total
Micro-enterprises	3	8	1	5	17
Small organisations	3	1	0	0	4
Medium organisations	0	2	1	1	4
Large organisations	1	1	0	0	2
Total	7	12	2	6	27

Data gathering

A total of 143 people were interviewed for the project. This included 32 interviews with staff members from the 27 organisations, usually the manager and/or person who had set the organisation up (in some interviews there was more than 1 person, hence the n is higher than 27). Staff interview questions were open-ended, asking about why they had set up the organisation, what services it provides, how much they charge, what relationship they have with the local authority, and what if anything they see as distinctive in the support they provide. A total of 106 people using services and carers were also interviewed about their experience and views of the organisation (approximately 4 for each of the 27 organisations), including why they selected the care organisation, what relationships they have with staff, how much the provision is tailored to their needs and what they perceived to be the strengths and weaknesses of the service. This included 30 older people, 49 people with a disability and 27 carers. We had intended to interview people who used services separately from family carers, but this wasn't always appropriate so the total number of

interviews (n=95) is lower than the total number of interviewees (n=106).

Participants included a mix of self-funders and people funded by local authorities. Interviews took a peer-approach and were led by local co-researchers, many of whom had equivalent experiences of using services. We also interviewed five co-ordinators who were active in supporting micro-providers in each of the selected areas. Interviews were audio recorded and transcribed.

At the end of each interview participants were asked to complete a short survey (derived from the Adult Social Care Outcome Tool (ASCOT)).¹² The ASCOT survey has nine domains, allowing people to score the quality of service they receive in various aspects relating to care. To avoid overloading respondents at the end of an interview, we limited the survey to two of its nine domains (focused on choice and control and how people spend their time) which were relevant for all the different types of provider organisations. The ASCOT survey was completed by the 79 people

who use services. Where carers were interviewed separately (in 16 cases) we also asked them to score the service on the ASCOT domains, bringing the total of completed surveys to 95. All participants were given an easy-read information sheet about the project and asked to sign a consent form before the interview started. People who did not have capacity to consent were not included in the project, as advised by the national Social Care Research Ethics Committee which provided ethical approval for the research.



Data analysis

Interview notes and transcripts were uploaded into QSR-NVivo 10, a qualitative data analysis software programme, for coding. An initial coding tree was developed deductively from the hypotheses, reflecting

the primacy of organisational size as an explanatory variable, and each transcript was coded according to these codes. To enhance inter-coder reliability, the early stages of coding were undertaken by hand as a team, working off printed out transcripts. A second thematic analysis was undertaken, deriving new codes inductively based on discussion among team members about emergent themes. First phase findings and second phase themes were discussed with co-researchers at analysis sessions in each location to test their face validity with people who had taken part in the interviews. In the writing up phase, quotes were selected for inclusion in written outputs on the grounds that they were indicative of the patterns found in stage 1 or stage 2 of the analysis.

ASCOT survey responses were analysed using IBM SPSS v22 to generate descriptive statistics and crosstabs to compare people's social care-related quality of life (SCRQoL) and their expected SCRQoL in the absence

of service. The data was analysed to identify any particular quality issues (codes within appropriate and plausible ranges). The main analysis was conducted by comparing key outcomes (our dependent variables) by size of provider (our key independent variable) and other key background data. The provider's size was coded as a dichotomy (micro and others) as well as the full range of size coding, in the initial analysis. The main limitation is our sample size (N = 95) which means that rather large differences in outcomes, by size of provider, would be needed for results to be statistically significant at conventional levels.

Value for money was measured by comparing prices (what it costs to purchase services from micro, small, medium and large providers in a given area) with ASCOT survey findings and interviewee narratives about that organisation. It is important to emphasise that a simple measure of cost, such as the hourly price, needs to be contextualised with the other

data concerning the nature of the service. Otherwise there is the risk that low cost is simply low quality.

The Scope of the Research

The research aims to build the evidence base about micro-enterprises, as well as to undertake comparative research with small, medium and large care providers. This is reflected in the presentation of the findings (with more examples given of micro-enterprise activities than of larger organisations), as well as in the research sample itself where micro-enterprises are over-represented.

We found examples of good quality care and support offered by organisations of all different sizes in the research. Here we present the overall findings which show that micro-enterprises (on the whole) performed better than larger organisations across the measures we tested.

SECTION 2: PROJECT FINDINGS

1. Micro-enterprises offer more personalised support than larger providers, particularly for home-based care

The first question we tested in the research was whether micro-enterprises are more personalised than larger enterprises. We found that there were aspects of micro-enterprise provision which did allow them to offer a more personalised service, particularly for care and support that is delivered within the home. Small organisations also performed well on this measure, whereas medium and large organisations did less well. For day activities, the difference between organisations of different sizes was less clear: there were several examples of micro-enterprises offering highly personalised day activities, but we also found examples of larger providers offering greater choice. This section sets out examples of the more personalised support offered by micro-enterprises before going on to look at some of the limitations of micro-enterprises in relation to being personalised.

Defining personalised support

The term personalisation has been used a lot in English social care services in the last



decade, and has been interpreted in various different ways.¹³ It usually refers to a sense that services are tailored to the individual. In the interviews, respondents gave four different accounts of what it meant for services to be personalised:

- Providers are willing to be flexible about the sort of support that is offered on a particular day.
- Providers anticipate the needs of individuals.
- Providers act in a way more akin to being a family member or a friend.
- Providers allow individuals to have choice and control in relation to their activities or support.

Personalisation as types a-c seemed to be particularly important to the activities that go on in people's homes (i.e. domiciliary care and the more generic 'support in the home'). In day activities, personalisation as type d was the most often invoked. This fits with the notion of the home as a distinctive private space in which intimate 'body work' is undertaken and different sorts of interpersonal engagement are appropriate.¹⁴

Evidencing personalised support

The more personalised care provided by the smaller scale providers was attributed by interviewees to three aspects of their approach:

- Autonomy of frontline staff to vary the service being offered
- Greater continuity of frontline staff compared to large care providers
- The high level of accessibility of managers to frontline staff and people using the service

The first of these – the **autonomy** of frontline staff – was demonstrated in interviews with people running micro-enterprises and people using the services, where care and support was defined in very flexible terms.

One micro-provider providing a support in the home service as a sole trader explained how she had gone into someone's home to provide a meals service, and then went further than that because of the perceived need:

Took this new man on. Dementia. It was a, like, holiday cover. His sister's gone away. Says, 'Will just go and, you know, do his dinner for me? Just put the vac round?' He's got a dog. Cause he's got dementia, every time the dog barks, he feeds him. So he's just barking all the while, so he's just giving the dog food. And [his sister] says, 'Just do his dinner and go.' So now, what I do, put his dinner in when I get there, wash up, wipe the sides down, put it on the plate, put the vac round, and when that's cooled down, give him his dinner and take the dog a walk. Stops the dog barking and he can eat his dinner in peace. And he's ate at least three-quarters of his dinner every day.
(Staff, micro support in the home)

One of the people receiving services from another micro-enterprise explained the flexibility of what was provided:

She's having a go at painting this [wall], she hasn't finished it yet... I call her 'Odd Job' I do because there ain't much she can't do, she's a smasher of a girl, really is. (Older person, micro support in the home).

For people receiving domiciliary care services (usually encompassing washing and dressing), smallness was seen as synonymous with the personalisation of services around the individual:

If it gets bigger you lose some of the intimacy that you have now.
(Older person, small domiciliary care)

The staff from micro-enterprises frequently evoked metaphors of family and friendship, whereas this was less evident with the larger organisations:

You just do things for them as you would for your own parents, family
(Staff, Micro support in the home).

The 'time and task' model is well known (and much criticised) as the dominant approach to domiciliary care delivery, denoting very short care visits to undertake highly specified tasks.¹⁵ This model was one that the staff in the micro-enterprises – and indeed the small organisations – define themselves in opposition to:

Being a small company...you don't have to be so task-driven. This is the list of things that we're supposed to do on the care plan for whoever, but when you go in if you can see that they're down and they need you to sit and have a cup of tea with them, have a cup of tea with them. You know, that's absolutely fine. 'Cause you'll go and visit your mother and your mother's looking like, you know devastated about something and just start Hoovering or ironing, would you? You wouldn't do it would you?
(Staff, small domiciliary care).

Family carers valued the more personal connection offered by the smaller providers:

I've not come across anything yet that I've asked [service provider] and she's said, 'No, we can't do that.' Do you know what I mean? So they'll stand and do a bit of my mum's ironing and chat to her and just engage in conversation with her really. Which is what I want, I want them to talk to her and be in the house and be company as well as doing care. I think that's the more important thing so I'm happy if I go in and they're sat on the settee and they're chatting to my mum, that's fine.
(Family carer, small domiciliary care)



One person contrasted the support that she used to get from a previous provider with what she now gets from a large domiciliary care agency, affirming the importance of staff continuity and personal relationships:

When I used to have [a previous care agency] she knew where to get my cream out and get this and that, put it away and get a clean towel if there wasn't one out, you know. She used to do all that, no problems at all. This lot [from a large care agency] they just look at you.
(Older person, large domiciliary care)

This interviewee also described the inflexibility of the large provider immediately after the death of her husband. She called the agency to ask if for one week following her husband's death they could call earlier than her normal 10.30am slot. She describes the phone call:

And I heard her saying, she said you can tell [older service user] her times half past ten and not a minute before. And do you know for two days after that it was half past eleven when they came.
(Older person, large domiciliary care)

Box 3 gives an example of a micro-enterprise offering personalised care and support.

Box 3: Personalised care and support on a micro-scale

John set up his micro-enterprise My Support four years ago. He had worked in the IT departments of large care agencies and has over twenty years of experience as a family carer. As he puts it, 'as a parent, as a purchaser of services and also purchasing services for two elderly relatives...I thought, I can do better than this. I can certainly do it different and more person-centred.' His agency grew through local advertising and word of mouth recommendations until it was supporting 12 people. His aim was to be able to offer everyone a service that he would want for his mum and his son. This included breakfast at a reasonable hour, and care that was consistent and high quality. Visits are for a minimum of 30 minutes, as John didn't believe that good quality support could be offered in a shorter time. People using the service rate it highly. One explains the difference between My Support and the care they received in the past:

'The people I were having from social services weren't very satisfactory. In fact they weren't very satisfactory at all. ... I have cried when they've gone sometimes, because I felt so, you know, this isn't what our last life, our last hours on this earth or days should be you know...'

'When My Support came in, I thought it was fantastic. The hour they sort of treated us like we were special and we felt better about it. We didn't feel a pest and in the way at all, because they didn't make you feel as though, you know, you feel above them looking after old people.'

A member of John's team recently won a regional award at the Great British Care Awards.

The second aspect of the personalised offer from micro-enterprises was that they offered **continuity** of staffing. For people using micro-enterprises, this was the key aspect that they drew out:

I think it's quite nice it's small cos you're not gonna get loads of different people coming, are you?

(Older person, micro domiciliary care)

The number of different staff coming in from large agencies was reported by interviewees as being higher than for the micro-enterprises. In one case, a family carer whose spouse was supported by a large care provider felt the numbers to be extremely high:

Interviewer: When [the carers] come, is it normally – how many different people would you get? Is it normally the same one or two, or could it be lot?

Respondent: Oh it could be dozens, because there's that many

(Family carer, large domiciliary care).

Another family carer set the number lower but still felt troubled by the lack of continuity presented by the staff team at the large agency:

Interviewer: How many different people do you have coming in?

Respondent: Six... And it's getting me down
(Family carer, large domiciliary care).

Although drawn from a small number of interviews with people using large agencies (sometimes in addition to a micro-enterprise), this account substantiates the well-established profile of large care agencies, in which pressures on unit costs can lead to high staff turnover rates.¹⁶

A third aspect of micro-enterprises that people using the service valued was the high level of **accessibility** of managers. People using micro-enterprises appreciated the close contact they had with the people running the organisation (indeed for the sole traders in the sample, there was no management structure at all).

There's room out there for a few more like [the agency], they are more personalised and friendly, they know his needs. Because they are small you see everyone, they come to the house, it's not just someone stuck behind a desk. They'll run things past us, let us know what's going on. They give us plenty of feedback, make sure we're satisfied with what they are upto
(Family carer, micro day activities).

For this family this communication was in marked contrast to the experience they had had with a larger support provider:

I've never been let down...Which used to happen with [the larger provider]. I mean, we'd get a phone call off my brother 'Nobody's called. I've got no tea.'
(Family carer, micro day activities)

A personalised ethos

For many of the micro-providers, a desire to do things differently was a core motivation for setting up the organisation. Several talked of their family experiences as carers, or of their dissatisfaction with the work they did as an employee of a larger care organisation or local authority care service. As a co-ordinator who supported the development of micro-enterprises in one of the localities put it:

I can only speak from my own experience of the people that I've worked with and a lot of their passion and drive has been from maybe their own personal experiences and that might be that they've got family members who need support and they feel



that they can do something different, or they've been able to try and find something in the market that's not there so they want to offer it. Or they themselves may have worked in the industry and they feel that they can do something better.

(Micro-enterprise Co-ordinator)

One provider – classed as small by its full-time equivalent staff numbers – was a franchise of a national care organisation, but identified closely with the micro model:

Our ethos is very much like the micro-providers in that sense. I know every single one of our clients, I interviewed every single one of our care givers and know every single one of our care givers...It's very much like an old fashioned family business.

(Staff, small domiciliary care).

Managers in the large organisations that we spoke to did not frame their offer in such relational terms. One large domiciliary care agencies we included in the study had 135 staff and 350 people who used the service. When asked about its distinctive offer, the response had a different emphasis:

'We have call monitoring/alerts so if someone hasn't visited we know about it, and we will get someone there within 45 minutes, even if it is 11pm at night... We have electronic rostering, and not text messaging.'

(Staff, large domiciliary care)

The presentation of the organisational offer in technological rather than human terms marked a point of differentiation with many of the smaller organisations we spoke to, reflecting the complexity of operating on a large scale.

Advantages of larger providers

A modifying factor of the small=personalised, large=impersonalised story, is that it seemed to apply most intensely to the activities that took place in people's homes: i.e. domiciliary care services and other kinds of support in the home. When it came to activities outside the home, some interviewees argued that a larger scale enabled more diversity of provision and therefore potentially a better responsiveness to individualised need:



She also has mobility problems, restless legs and things so they'll give her a massage, you know, they'll massage her legs...So that in a smaller place they wouldn't ... have that level of expertise to do that level of care on an individual basis (Family carer, large day activities).

Larger day centres were usually able to provide a greater range of activities each day, including for example baking, mood rooms, computer rooms, music activities, drama groups, arts and crafts. One provider, which runs a large day service, suggested that the bustle of a large, busy day centre was what people came for. When the numbers of people using the service had dropped at weekends, *'gradually [people] started to transfer into the week because it was boring because there wasn't enough people about. They couldn't, you know there was one activity basically because there was one room'* (Staff, large day activities).

In one case study area, the closure of several local authority day centres led to the establishment of one large centre providing day services for older people, people with learning disabilities and people with physical disabilities. Despite being criticised at the outset, staff running the centre have found this has led to enhanced social integration, by breaking down the barriers between older people and people with learning disabilities that were previously ingrained in social care provision:

When I thought God, this is working, I was in the coffee bar and I was sitting having my lunch and I just looked and all the chairs had been moved around and people had pulled them together to sit together. And there was the guy with early onset dementia, he had his iPad out and he was showing some photographs of his motorbike and there was a couple of older people that were saying 'I used to have this motorbike when I was young' or 'I remember my husband and I ...' and there was a couple of people with learning disabilities saying 'I'd love to ride

on a motorbike' and they were all talking, it was an actual conversation that was criss-crossing and going all over and I thought this is working, this is how it should be. (Staff, large day activities).

The large day services in our sample showed examples where they were able to offer more choice of activities, whilst micro-enterprises offering day activities were more targeted in their approach, matching activities to the interests and needs of the people in the centre each day on a more ad hoc basis. Box 4 shows the different kinds of offer provided by very small and much larger day services.

For services that were offered in people's homes, there were also some aspects of micro-enterprise provision that could be problematic. For example some people were concerned that over-attachment could occur as a result of the smaller numbers of staff involved. As one family carer put it,

[S]he doesn't like one person coming all the time cos obviously they can get an attachment, can't they? Then, if for whatever reason they're not able to come then, you know, you've got a fresh face, whereas if there's a few people bobbing in and out they get to know that person, aren't they, over the time and know their ways and what they've got to do and where things are. (Family carer, medium support in the home).

In summary then, operating at a micro scale can provide more personalised support, in ways that seem to be particularly valued in people's homes, but the wider range of services on offer in larger organisations, and the ease of maintaining boundaries, was appreciated by some interviewees.

Box 4: Comparing micro and large day activities

Micro-enterprise Day Support

Small Steps day service is a micro-enterprise employing two members of staff and providing a community-based day service for older people. The service supports approximately 10 people a day and runs a range of activities tailored to whoever is in the centre that day. The service is very personalised, flexible and works closely with family carers as explained by the owner:

'I think we offer a more personable service for people, especially for the carers...they talk to us and you know they see us hopefully as, I wouldn't say friends but you know somebody that they can trust ... one lady came with her husband for the first time cos he'd got Alzheimer's and he wasn't sort of settling in places. And she was helping wash the pots and that and she just broke down in tears. She said "I'm so glad I've found somewhere that, somebody that I can talk to".'

Large Day Support

Sunnyville Day Centre is a large local authority day service and supports over 100 people a day. People who attend include older people, people with learning disabilities and people with physical disabilities. They offer a range of activities everyday enabling people to tailor their activities according to their needs and interests:

'We offer a choice of things to do on each day... the coffee bar ...we have a hair salon and our therapy room we'll do foot massages, nails, beauty sort of stuff so there's that side...we need to be offering lots of different styles of things to motivate people or make people feel nice about their selves and feel cared for. So we do lots of beauty therapies, lots of foot massage. We've got a Reiki Master and she does Reiki with some people, hair, make-up. Then we have art & craft sessions, card making sessions, cookery, basic cookery...We have sports, we have, chair keep fit and stuff like that and you know, karaoke, sing-alongs, bingo.'

2. Micro-enterprises are more valued than larger organisations, in relation to helping people do more of the things they value and enjoy

The research looked at how far micro-enterprises delivered more valued outcomes for people who use their service when compared to larger organisations. Of course, this is not entirely separate from being personalised since for many interviewees the personalised nature of the service was integral to the notion of a valued outcome. However, here we separate out the two, using personalisation as a process measure (a means) to achieving a valued outcome (an end).

We explored the capacity for micro-enterprises to help people to achieve valued outcomes in two ways. The first was to ask people using the standardised survey tool ASCOT (Adult Social Care Outcomes Toolkit) whether they felt that using the service gave them more choice and control and more opportunity to spend time doing what they enjoyed than would be the case without the service. Second, in the qualitative analysis, we looked at the extent to which people talked about being able to achieve a valued outcome, separate from the process of care itself.

Findings taken from the ASCOT-based questionnaire show associations between the size of the provider and selected ASCOT outcomes data (for the full data see Table 1 in the appendix). The first set of questions related to the extent to which the provider helps people using the service to do more of the things they value and enjoy with their time. Those receiving care services from a

micro-enterprise did tend to be able to do more of these things, and to a significant degree. These respondents also reported an ability to spend time doing such activities to a greater degree than in the national Adult Social Care Survey 2013-14: 50% of those receiving care from a micro-enterprise in our study were able to spend their time as they wanted, compared with 33% in the national survey.¹⁷

In terms of the second set of questions (which aimed to surface whether people had more choice and control as a result of receiving services from a given provider) the findings were less conclusive. The data showed that there were some signs that people using micro-enterprises had greater control over their lives than people using larger services – and that the care provider was making a difference to how much control they felt they had. These variations between providers are not large enough to have confidence in any statistical differences. Even so, the answers provided for the micro-providers in our study (41 per cent having as much control as they would like) were somewhat above the national average, of 33 per cent.¹⁸

In analysing the interview data we used the category of being valued to mean that there had been a tangible improvement or benefit to using the service, which could be classified as an improved outcome (or conversely a worsened outcome due to a problem with the service). However it was clear from the interviews that for many people there was no real articulation of a particular outcome separate from the process by which the care was delivered.



This was particularly the case for the older people in the study. In the interviews with younger people or their carers there was more likely to be discussion of an end result (making new friends, building confidence, getting fit, finding a job) which was distinguishable from the support that made it happen (see Box 5). This was also more the case with the older people who attended a day activity, who for example placed value on getting to know people or gained personal satisfaction from engaging in memory workshops or art classes. However there was no clear pattern about whether these outcomes were achieved better by using micro-enterprises or by the larger organisations.

Box 5: Valued outcomes from a micro-enterprise

Your Support is a micro-enterprise that was set up by an autism specialist and provides employment experience for people with different educational needs. The organisation uses a co-production model and employs one of the people who also uses the service. The overarching aim of this micro-enterprise is to empower people with autism and make connections to similar networks in the region. The micro-enterprise offers one-to-one sessions which vary greatly from person to person. Activities can include: goal setting and working toward employment; physical activities and days out; and social and peer group activities. This interviewee describes how he gets to choose the activities he enjoys most and how the service has supported him to achieve the personal goal of having more friends: *'It's more choice in what you want to do. Whereas before I've not always had that, you know. I have a weekly planner what I want to do....I mean the goals are getting more friends, things like that...you know just being happier really. I just wanted to be settled and I have got more friends now.'*



Three further points emerged from the data which have a bearing on issues of size. The first is that where the process of care is more personalised – and trusted – there is scope for family carers to achieve a valued outcome of their own. As one spouse carer, looking after a husband with dementia, put it:

Well it's just lovely for me to sit down for half an hour. I write letters to other carers. I've got 5 ladies I write to. And it's just my time and while I'm sitting here they're tidying the kitchen up and it's just wonderful.
(Family carer, Micro domiciliary care).

A **second** pattern was that, whilst there were examples of valued outcomes being achieved across all the different sized organisations, this was contingent on there being a particular individual who had taken the time to support people towards a mutually identified goal:

[H]is support worker realised that [the person using the service] likes – he's quite big on the cleaning side of it. He started volunteering to clean people's cars. He's now got his own cul-de-sac of people that he spends his day cleaning their cars, he

does a bit of gardening, he puts the bins out... And the community have all chipped in and bought him some gear to do it and we're now hoping that he's going to become self-employed.
(Staff, large day activities).

Again, this quote reinforces the importance of secure and consistent interpersonal relationships, which can sometimes be achieved by larger providers.

An example of micro-enterprises providing valued consistency of care can be seen in this interviewee's account of the support received from a micro-enterprise offering accommodation (the landlord), compared to support he received from a local authority team following the death of his father:

[H]e [the landlord] could say 'well it's not my problem, you're on your own', but he's actually sticking his neck out and helping me out, whereas [the local authority] team, I feel as though they have abandoned me, just keeping on the books to make them look good.
(Person with a learning disability, micro accommodation)

A **third** factor is that micro-enterprises may be best placed to support valued outcomes when people are at a low to moderate level of need. Some carers felt that micro-providers could not cope as well as larger providers with the intensity of supporting someone whose needs were more complex:

I think they do an excellent job of supporting [someone with dementia], but I think as the needs get higher and it's perhaps becoming more complicated and you probably need staff who need specific dementia care training, maybe [the micro] are not quite at that level yet.

(Family carer, micro domiciliary care).

Several of the micro-enterprises gave examples of having to turn down work because they were unable to provide the 24 hour or multi-person support that was needed, further supporting this point. As one staff member said:

[T]he problem with buying care from a small business is that they haven't got the resources and they haven't got the backup. That is the problem. And there is going to be the odd occasion where they'll say, 'I'm really sorry. I can't cover Sunday. You know, because we haven't got anyone'.
(Staff, micro domiciliary care).

In summary then, micro-enterprises are more effective than larger organisations at helping people do what they value and enjoy with their time, but survey data about whether or not they give people more choice and control than larger organisations is inconclusive. The interviews showed that the process of care and the ends of care (a valued outcome) are very closely interwoven. Many people did not talk about care as having a distinctive outcome outside of a personalised experience. For those that did, outcomes were linked to close interpersonal relationships. These outcomes were sometimes for family members as well as for the person supported.

3. Micro-enterprises are better than larger organisations at some kinds of innovation

Innovation has been defined as 'a process through which new ideas, objects and practices are created, developed or reinvented, and are new for the unit of adoption.'¹⁹ Literature on micro-enterprises has suggested that they can be more innovative than larger organisations by offering alternative solutions to social care needs. Here we explored three distinct types of innovation displayed by care providers: what innovations (what service is delivered), how innovations (how a service is delivered) and who innovations (who provides and

receives a service) (see Box 6). Micro-enterprises were found to be particularly good at how and who innovations, but findings relating to what innovations were less conclusive.



Box 6: Micro-Enterprise Innovation

Micro-enterprises display three types of innovation:

What Innovations – Creative and alternative solutions to care

How Innovations – More rapid, flexible and responsive care

Who Innovations – Inclusive of potentially marginalised groups

What Innovations

It was evident that the co-ordinators who supported micro-providers in each locality saw their distinctive contribution as being about what innovations: creative and holistic solutions that differed from the 'traditional' offerings of day, domiciliary and residential care:

So smaller organisations and micro services tend to think more innovatively and outside the box and think of different ways of delivering services. And a lot of the micros ...they don't always perceive themselves as social care organisations so, you know, we've got people like photographers... we've got somebody who does fishing, we've got somebody who does beauty therapy...we've got lots of different services but it's all linked to social care, but it's sort of looking at the holistic approach and not just the traditional methods.

(Micro-enterprise co-ordinator)

The care and support offered by micro-enterprises, especially for people with learning disabilities, was often based around the enhancement of social networks and social inclusion. Examples of social activities provided by micro-enterprises were walking clubs, meals out, playing golf, drama clubs, visiting stately homes, television studios or holidays in the UK and abroad. Micro-providers often focused their activities around community integration, especially those operating within a small geographic area and for people with learning disabilities:

All sorts of different projects we've done and we are fortunate where we are in a little village. And so people do come together so



we're very, we're fortunate in that position that we can do it, but it means our members go out and they get recognised by the shopkeepers and people and they develop relationships with folks in the community. Which if you're just going out with a PA on a one to one it doesn't, isn't really possible. (Staff, micro day activities)

For older people, what innovations were less evident as care most frequently revolved around domiciliary care and support in the home. Where activities did happen they were on a more ad hoc basis. This included trips out to local cafes, parks or for those who were house bound, having a drink or meal in the older person's home, providing valued social interaction. Box 7 provides an example of a micro-enterprise offering a range of services for older people using a creative approach to care.

Box 7 – Demonstrating What Innovation

Creative Vision is a micro-enterprise that was established to deliver creative activities to older people in nursing/residential homes. Activities in the nursing homes are varied depending on the needs of the people being supported and include reminiscence, sensory workshops, arts and crafts etc. The activities are broad ranging and designed to enhance social wellbeing. This includes arranging for the older people to display and visit their own art work in a local library. The organisation also provides opportunities for older, socially isolated people to volunteer in nursing homes, for example as a singer. As the owner explains: 'So it's about using activity and using not necessarily creative activity but creative ideas, you know, so often people think of creative then think oh it's card making, but it's about creative thinking... I can see this as a value led organisation and that's at its core I think, you know, if it just becomes another provider then it's going to lose the whole point of what it was doing or just sit alongside them rather than offering anything new or different.'

Larger day centres often had more resources, including money and staff, which could sometimes allow greater investment in what innovations than micro-enterprises. This included having the time and knowledge to bid for contracts or grants, as well as invest in partnerships and networks. For example, one large local authority day centre manager talked about the future of its centre as a hub for a range of care services including micro-enterprises:

I can see us becoming a little market place almost in a way so that...the council building if you like becomes the hub and within that you've got like little providers. I mean we also knit with some of the other micro-providers to currently provide some of the activities, so we're slowly becoming like a little market place for micro-providers' (Staff, large day activities).

'How' Innovations

Although micro-providers did give some examples of what innovations, it was in relation to how innovations that they were found to be particularly innovative compared with larger care providers. How innovations relate to the process through which a

service is delivered. In this sense it overlaps with the earlier discussion about micro-enterprises being more personalised in their delivery of care, going into homes with a less task-based and more holistic approach.

The micro-providers also felt that they were able to do things more rapidly and responsively than larger organisations, working in more person-centred ways. They felt that they were more 'available' than larger services and could respond to the needs of people very quickly:

'[T]here's also that they can get hold of me 24 hours a day 7 days a week, unless I'm on holiday or something, whereas sort of social services and council services seem to shut down at five o'clock or six o'clock, so if they want to go to the cinema at eight o'clock at night it's generally they can't, they're not very flexible, and they get the certain hours and they get like one o'clock every Wednesday and they might not want to do something at one o'clock every Wednesday, whereas with me they can sort of let me know at the beginning of the week 'can we do this on such a day' and I can sort of schedule myself around them.'
(Staff, Micro day activities).

These how innovations – encompassing a more personalised process of care and more flexible delivery systems – were



often downplayed, both in the interviews, where they were reported after the what innovations, but also in the literature on micro-enterprise.²⁰ What innovations hit the headlines and help to generate excitement about how personalisation can break the mould of social care services. However, it is arguably the scope for process-based how innovations that constitute a more significant challenge to mainstream social care services (certainly in the home), and micro-enterprises are well placed to offer these innovations (see Box 8).

Box 8: An example of How Innovation

Elect is a micro-enterprise that specialises in supporting women, often from black and ethnic minority communities, who have high levels of need. It works with a small number of people on a one-on-one or small group basis supporting them to communicate and take part in different activities. This dedicated approach is made possible because of the small group size which is focussed on support for people within a specific community. This family carer tries to explain the unique appeal of this small organisation: *'I think because it's a smallish group...all of the women... they look after each other. It's like a little family.'*

Micro-providers felt that they could be more responsive, because they did not have the layers of management that can slow down decision making within larger organisations and statutory services. One person who had set up a micro-enterprise explained how she saw her role as innovator:

I worked within a bigger organisation, I was the same person but you're not able to do as much as you want to do when you're kind of swallowed up amongst all that red tape and often people's ideas kind of get a bit lost or there'll be, I don't know, red tape around oh you can't do this, so there's lots of barriers I think within big organisations that stop people, so there's lots of creative people within those organisations but they're not able to do perhaps what they want to do.
(Staff, micro day activities).

Another person similarly felt that she was not held back by the constraints imposed within larger organisations. Using similar language to the previous interviewee, despite being in a different organisation and locality, she said:

You know you're not going through a load of red tape, you're not saying 'I'll have to ask my manager' we just crack on with it you know. I mean we follow all Health and Safety guidelines so we're safe, but there's no constraints on us like there can be in a big organisation. You know 'you can't do this because of this or you're short staffed' or whatever, we just crack on.
(Staff, micro day activities)

The innovation displayed by micro-enterprises therefore stems from the

flexibility of the owner (and small staff group) to run the organisation as they choose. They see themselves as being able to try out new ideas and develop services that are more flexible, responsive and centred around the needs of those they support. Most micro-enterprises are not registered with the Care Quality Commission, since they are not providing regulated services such as domiciliary or residential care. The lack of regulation – the ability to 'just crack on' – could be seen as a weakness of the micro-enterprise sector. However we did not encounter any unsafe practice during the research, nor were any safety concerns raised with us by the people using the services (micro or larger). We did find that several micro-providers said they wanted to get CQC registration where appropriate (which would allow them to offer a wider range of services) but felt that the process of doing so was too lengthy and costly for them. The need to ensure that regulation is proportional for very small organisations is a theme returned to again in Section 3 below.



'Who' Innovations

The research also highlighted an additional way in which care services can be innovative, which we term who innovations and relates to the people with which the organisations engage. Who innovations were displayed in two ways. The first relates to the extent to which micro-providers were able to support a more diverse range of people than larger care providers. The second relates to the involvement of people using the services in the running of micro-enterprises.

In relation to diversity, we had hoped to recruit several micro-enterprises working with black and minority ethnic (BME) communities and also to include micro-enterprises working with other 'seldom heard' groups such as lesbian, gay, bisexual and transsexual (LGBT) communities. We included two organisations which were primarily oriented to people from BME communities, but did not find any LGBT-oriented organisations with an established set of people using the services, which would have allowed us to assess its quality.

Due to the limited diversity of our sample we supplemented the fieldwork with a

literature review which highlighted the role that small, community-based organisations such as micro-enterprises can play in supporting people from seldom heard groups.²¹ The literature review highlighted the low levels of provision for people from these groups, finding that community-based responses often emerge because of a lack of engagement by statutory services. It also found that specialist and community based micro-enterprises can contribute to a wider range of choices for people who feel larger, mainstream services are not suitable or accessible. However, the types of compensatory activity identified in the research need recognition and investment, and its existence does not imply that the mainstream should not address marginalisation.

In the research interviewees, a total of 9 out of 79 people that we spoke to were from BME communities. Workers from the micro-enterprises supporting people from BME communities included in the research talked about how they felt that they provided a unique offer for people from their community.

Because it reaches out to women from the South Asian culture because a service has closed, there was nothing there for these women and it's all around like having female support basically and being with other females. So it's sort of – I suppose it's become our unique selling point really. (Staff, micro day activities).

The micro-enterprises were at times also able to bridge the boundaries between BME communities and statutory care providers, not only by breaking down language barriers, but also through the generation of trust and shared understanding (see Box 9).

The second type of who innovations were evident in the ownership and governance of micro-enterprises, which often involved people who use services, especially those with learning disabilities (see Box 10). Services that were run or co-produced with people who use services facilitated the empowerment of otherwise marginalised people by integrating the service itself more effectively into the community it serves. Enabling people with experience of using care services to establish and run care services can arguably unlock innovation by allowing those who understand and experience the needs of people in the local area to develop more responsive services:

Part of the reason for setting up my own company was to actually employ people who had different and unique needs to a) get work experience b) to set up a micro-enterprise, a co-operative. I'm not aware that [the local area] has a co-operative micro-enterprise with people who experience different needs. And I wanted to really empower people from the beginning. (Staff, micro day activities).

Involving people who use services in the running of the organisation does however bring potential disadvantages. In one micro-enterprise, a person using the service commented that the owner, a person with learning disabilities, did not have the business skills and discipline required to run the service indicating a possible need for additional training and support for micro-enterprises:

[The owner] is a nice person, but sometimes he doesn't always have the control that it needs. I think he needs someone in there with him as well to help him out. (Person with learning disabilities, micro day activities)

In summary our findings indicate that micro-enterprises are more innovative than larger care organisations, especially in who and how innovations. The micro-providers feel that being small allows new ideas to be developed and implemented quickly, responding to the needs of those they support. The people who use micro-enterprises similarly appreciate the greater flexibility in what is offered. For some micro-enterprises, the direct involvement of people who use services in the running of the care services helps to facilitate innovation.

Box 9: Supporting Diverse Communities

Abdul left social work to set up Active Support, an agency supporting young people with autism and learning disabilities. Most of the people supported are from South Asian communities. As well as offering day activities, the organisation provides support in the home for people with complex needs. In one example, Abdul and his staff have been working with a family for several months to address the continence issues of the adult son who has autism. A community nurse, who has been supporting the family over a longer period, spoke to us when we visited the family home, explaining that it was not until the involvement of Abdul that progress had been made:

The fact that [Abdul] knows the family and can speak the language has really helped to make progress on the continence issue. I had been to visit the family a couple of times with an independent interpreter but I wasn't really able to establish a relationship with them that way. With [Abdul], they know and trust him and that makes a big difference. And also with the client himself, if he sees me and knows that I come with [Abdul] then he thinks I'm ok, he doesn't mind me being there.

What seems to have made the difference here has been the combination of a shared language and culture with the personalised scale and familiarity of a micro-enterprise.

Box 10: Involving people with learning disabilities in running a micro-enterprise

The A Team is a football club, set up and run by someone with learning disabilities. The leader of the club saw the need for the service because of his own negative experiences of other football groups that excluded people with disabilities. He felt a more relaxed approach was needed to allow people with disabilities to fully enjoy their active time as he explains: *I went in as a footballer [to another local football club], tried it for myself and the coach we didn't get on, me and him, and basically I tried to look elsewhere to open up something else that was for me. In our club I'm laid back enough to let them free, you know do what they want, up to a certain extent. In other clubs people told players what to do, really be very, very more or less vicious to them and I'm not like that.*

4. Micro-enterprises offer better value for money than larger organisations

To assess the extent to which micro-enterprises offer value for money we gathered price data from all of the 27 organisations included in the research, and then looked at it in the context of the measures of service quality (including ASCOT scores and the qualitative interview data). It is important to note that the study only includes organisations that charge for their services. Many charities and social enterprises work on a voluntary basis and are free (or very low cost) for disabled and older people using them, but they are not included in this research.

Analysis of the pricing data from the case study organisations indicated that micro-enterprises were slightly cheaper in their



hourly rate than small, medium and large care providers (see Figure 1).²² The relatively small sample size means that we cannot generalise from this to say that micro-enterprises are always cheaper. However it does indicate that economies of scale arguments do not necessarily hold within the care sector: the larger organisations in our study were rarely able to offer a service at a lower rate than a comparable micro-enterprise.

framework, appeared to have found a distinctive space in the market as a high-price, high-quality offer for self-funders.

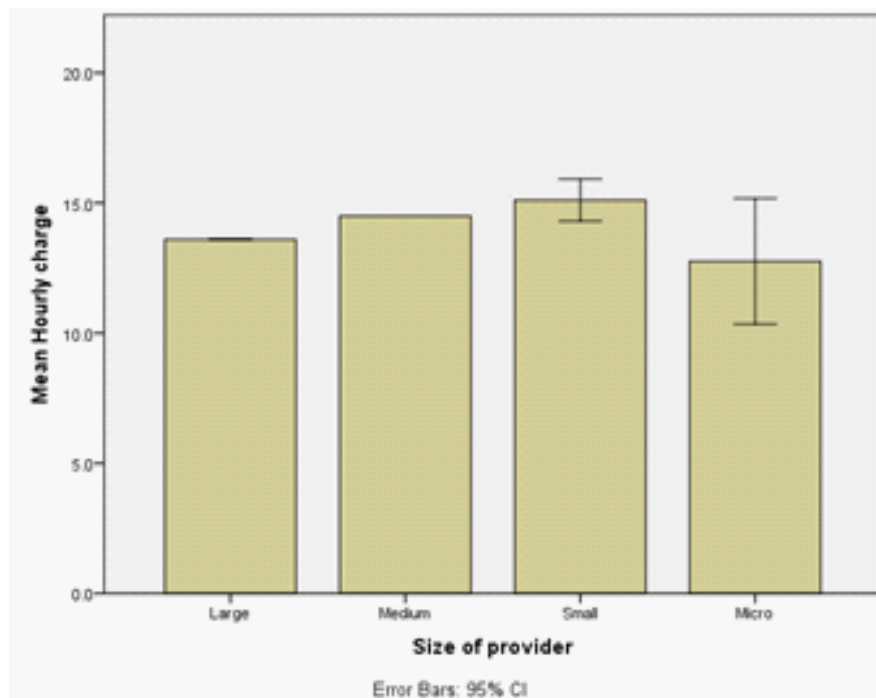
This point highlights the complex relationship between price and quality. Self-funders (i.e. the more affluent people in an area) have the opportunity to opt for a higher price if they feel it secures them a better quality service. Direct payment holders have some flexibility to do the same, although this may be limited in practice by what overall financial allocation they have been given. For people whose care is purchased for them by the local authority, the cost/quality trade-offs are much more intense, since these people are reliant on services that can be delivered at the set local authority price.

The findings reported earlier in this report (that micro-providers outperform larger providers in being personalised, valued and in part more innovative) suggest that micro-enterprises offer value for money, and that the lower cost is not suggestive of a lower quality service.

This does not necessarily mean that micro-enterprises will always be cheaper than larger organisations, because length of call also needs to be taken into account. When providing domiciliary care, the micro-enterprises (and indeed some of the small providers) would only undertake calls of 30 minutes or longer, making them more expensive to commission per visit than larger companies operating on a 15 minute per call basis. For some organisations this was a matter of ethos:

They're given 15 minute calls or, you know, a very short amount of time where you can't value somebody and respect them. So I decided that I wouldn't do anything less

Figure 1: Hourly costs for different providers

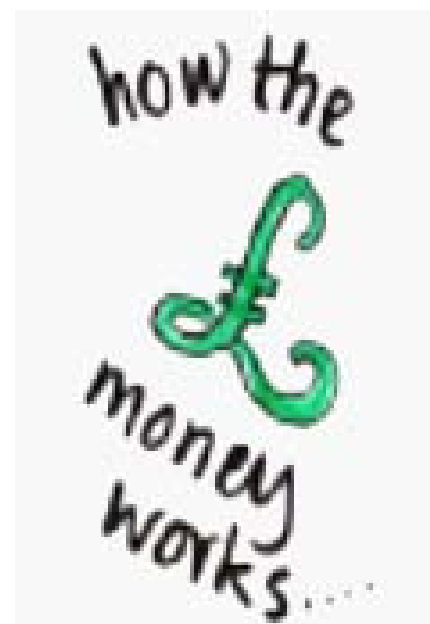


The most expensive providers in the sample were the small and medium organisations. Again, it is difficult to generalise from such a small sample, but it can be hypothesised that small/medium organisations face a particularly difficult financial context. They don't have the economies of scale of the large organisations, and they also don't have the low overheads of the micro-enterprises, most of which worked out of their homes or very small office spaces.

In all localities the costs of care were shaped by the hourly rate which the local authority was willing to pay for care services. Most of the larger providers situated themselves exactly at this rate, since the majority of their care work was generated

by local authority referrals. Many of the micro-providers offered a slightly lower rate, perhaps reflecting their low overheads. However, they also strove to be competitive in an environment in which they struggled to access local authority preferred provider lists. The financial risks attendant in this approach are discussed in the next section.

The small and medium providers often priced themselves slightly above the local authority rate, for the reasons discussed above. They tended to have a higher proportion of self-funders, in comparison to the large providers. One of the most expensive organisations in the study, whose higher prices meant that it too was excluded from the local authority's preferred provider



than 30 minutes. If it's personal care I won't anything less than an hour. I'd rather not have a business than do something that isn't right.

(Staff, small domiciliary care).

The longer calls were also driven by practicality, given the small staff base and the difficulties of moving staff to a different location after 15 minutes.

There has been a national emphasis on eradicating 15 minute care visits which are offered by around three quarters of local authorities.²³ Research indicates that 15 minutes is not long enough to provide good quality care and time constraints deprive people of their dignity and act as a barrier to the development of good relations between people who use the service and the care worker.²⁴ As there is more pressure on local authorities to stop commissioning 15 minute

visits, the lack of such provision by micro-enterprises may be less of a limitation.

In summary then the pricing data gathered here indicates that micro-enterprises are no more expensive than other care providers in the study and offer good value for money given the evidence presented in earlier sections about the more personalised, valued and innovative aspects of micro-provision.

SECTION 3: SUPPORTING MICRO-ENTERPRICE

The research findings presented above highlighted the positive contribution that micro-enterprises can make to care and support services. In doing the research we also identified which factors facilitated and inhibited their operation (see Box 11). There is some important learning here if micro-enterprise is to move from the fringes of provision to the mainstream.

Box 11: Summary of Micro-enterprise enablers and barriers

Micro-enterprises are enabled by:

- Financial and business support specific to the care sector to enable them to start up and develop.
- Collaboration and partnerships with other care services (including peer networks) and support from the statutory sector.

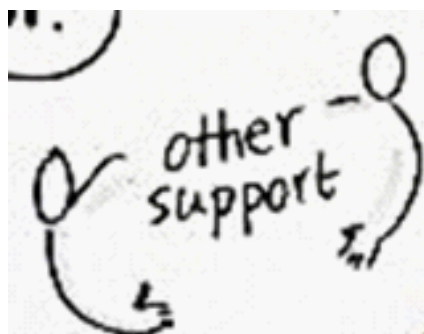
Micro-enterprises are constrained by:

- Lack of visibility to potential users of the service
- Personal and financial risk in setting up a micro-enterprise and limited financial rewards once the business is established.
- The cost and intrusiveness of care sector regulation.
- Small staff size making holiday and sickness problematic.
- Competition from larger providers who can use economies of scale to undercut on price and quality.

Enabling Factors for Micro-enterprises

Findings highlight several enabling factors for micro-enterprise. Dedicated support for business start-up and development was seen as core to the establishment of many of the micro care services. Alongside these support roles wider factors such as strong personal networks had helped micro-enterprises to develop. Balancing good partnerships (including with local authorities) with maintaining an independent status was also viewed as central to sustainable success.

The value of independence from local authorities was that this provided greater autonomy and control for the micro-enterprises. Control includes decisions regarding staff and people to support. Most micro and small providers reported that



they were selective in who they recruited as carers, which in turn decreased staff turnover (which is generally high within the care sector) and enhanced the consistency of care:

The girls we have working for us...some of whom we've worked with and we know them – as we've recruited people, most of them we know through other jobs. So there's a really comfortable feeling about that and not only do they understand me, they wouldn't want it any other way.

(Staff, small domiciliary care)

Collaboration and partnerships were also seen as an important enabler for micro care organisations for two reasons:

(a) Partnerships between the micro-enterprises and other services provided more holistic care for people who use services. Partnerships included health related agencies, social support services and social workers.

(b) Partnership working provided a route to additional funding, organisational growth, greater delivery capacity and visibility. This micro-provider explains the value of working with trainee social workers for attaining resources and keeping linked in with local provision:

[W]e work with social work students and so they're here in and out and they have a range of work so they'll do some day service work and some advocacy work...it gives us the flexibility to do a bit more one to one work and so give individual support, it provides additional funds and resource for the organisation, so I think it just enhances the service that we offer....the reason we went into it in the first place was that the board were so frustrated about the quality of social workers that they'd experienced that they wanted learning disabilities to be up there and understood by people who were qualifying as social workers.

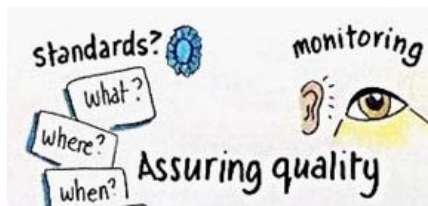
(Staff, micro day activities)

Regarding visibility, micro-enterprise staff stressed the importance of personal contacts with potential users of the service, reputation and word-of-mouth. The following quote from a newly developed micro-provider displays their reliance on personal networks, but also the vulnerability that accompanies this in a market dominated by local authority provision:

Luckily I've generated new business because families know of me and have said [to the Council] 'excuse me, no, it's our first choice is [the micro-enterprise] and if that doesn't work out then we would look at the Council's trading arm'. But that's only done not because I'm marketing but because of personal reputation and because of people who happen to know me and I can't really risk growing on such scanty threads really.

(Staff, micro day activities)

One of our case study areas has awarded Quality Marks to some micro-enterprises, which was appreciated by micro-enterprises themselves, and was a good way to inform both people who use services and commissioners that the micro-enterprise provides a quality service (see Box 12).



Box 12: The Micro-enterprise Quality Mark

A Quality Mark - gold, silver, bronze – is awarded to micro-enterprises based on compliance with procedures and feedback from people who have used the service. The Quality Mark appears in the local online directory so that people who use services, their carers or professionals are able to filter services based on their quality level. A local Micro-enterprise Co-ordinator explains how this gives people more information about the services: 'it enables people on a direct payment [to] have more choice of choosing a quality service that's been assessed and monitored and they'll be monitored like we monitor our contracted services.'

Barriers for Micro-enterprise

Some of the limitations facing micro-enterprises are intrinsic to operating at a small scale, whereas others relate particularly to the nature of the care market.

1. Visibility of Micro-Enterprises

Most of the micro-enterprises recognised and valued the help they had received from the Micro-enterprise Co-ordinators in their area. However they were also aware of the limitations they faced in competing with larger providers for visibility in referrals. Many were unable to get onto framework agreements and preferred provider lists with their local authorities. Some of the micro-enterprises had CQC registration, but for most the cost and complexity of the process was prohibitive, or they did not provide an activity that required registration

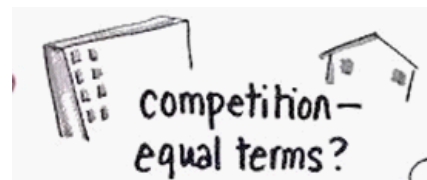
There were two problems resulting from this:

a) A shortage of people using the service: Some of the micro-enterprises were under-utilised and critical of the unwillingness of the local authority to refer to them. One of the micro-enterprises said: *'The council like big agencies, they can just make a phone call and put things in place.'* (Staff, micro domiciliary care)

At its most extreme, ineffective relationships with local authorities were seen to be slowing the development of both individual micro-providers and the micro-enterprise sector. One micro-enterprise staff member describes a conflict of interest for local authorities caught between utilising the 'market' of providers and promoting their own in-house provision:

'It's been very difficult to move to any kind of pace really ... because of [this locality's] policy currently of social workers only referring people to in-house services, because they've just set up their own in-house trading arm and families have been directed to that'

(Staff, micro day activities)



Micro-enterprises struggle to market themselves to potential users of the service, which again can be a barrier to achieving the required growth (see Box 13). The research team were given several examples of how local authorities gave out alphabetical lists of providers, leading some people simply to call the first one on the list in the absence of any other information about quality.

b) Restrictions on the type of service that could be offered. For some of the micro-enterprises without CQC registration there was frustration at the limits this placed on the support which they could provide. The sole traders in the study did not offer personal care, and therefore didn't require registration. For the larger micro-enterprises, the cost of CQC registration alongside other costs was a barrier:

The insurance started to rise. We had a 30% increase in our insurance. We pay the same insurance and the same CQC licence as a much larger business.

(Staff, micro domiciliary care).

c) An over-reliance on self-funders due to the limited take-up of direct payments (particularly by older people) may limit the scope of micro-enterprises to be part of the core social care offer to people across different socio-economic groups. Whilst direct payments can be a mechanism through which people purchase services from micro-enterprises we found few examples in the research of people doing so.

Box 13: The consequences of micro-enterprise invisibility

John from the micro-enterprise My Support has begun to wind the business down. Although committed to the ethos of staying small, John needed to grow slightly larger so that he could give sufficient hours to staff and make the business financially viable. However he was not getting enough new people contacting the service and ultimately decided that he couldn't continue to operate at a loss. He feels that the local authority support was concentrated on helping him to get started (registering with the Care Quality Commission as well as gaining the local authority Quality Mark) but that commissioning practices remain unhelpful to micro-enterprises: *'[W]e've been on their system – on the community information directory now for three years, and I have not had one single client through it. Every single client we get is through our graft and word of mouth locally. Whereas the big boys...you know, they're on the approved lists...'*

2. Boundaries

Earlier in the report, we talked about the potential for over-attachment to be a concern amongst people using services. These boundary issues are also an issue for the people running services. For some of the micro-providers, the boundary issues were about an unwillingness to say no to people, such that they were always on call:

Our mobiles are our business so even on holiday we cover phone calls and we don't turn anyone away just because we are on holiday. Sometimes people just need a natter.

(Staff, micro support in the home)

Staff also reported the difficulty of multi-tasking, of running a business whilst also being involved in the day to day provision of care. One manager of a micro-enterprise explained:

[T]here was a young gentleman I took on for about a year with severe learning disabilities...And I'd be out with him...for a coffee or whatever – ten-pin bowling – I'd be ten-pin bowling; my phone's ringing and it's either the council, potential clients, CQC, staff with problems, the accountant, and it's just not fair.

(Staff, micro day activities)

3. Staffing

Micro-enterprises with staff experience specific types of staffing issues. They need to give staff sufficient hours to retain them, without leading to staff burnout. The sole traders and partnerships had an advantage here since their time imposed a limit on their activities (although some were working 7 days a week, including some evenings).

For very small organisations, absences have a strong impact on the service and need to be carefully planned. This partner from a micro-enterprise explains the difficulties of arranging cover to accommodate staff sickness and holiday leave:

The buck stops with you at the end of the day. If there's something wrong then it's down to myself and my partner you know so that's it. It seems like if you're sick you know you've got to try and get in whether you're poorly or not. Touch wood we're lucky neither of us have been. Annual leave, taking a holiday can be difficult because you want people covering you that you trust.

(Staff, micro day activities)

Some micro-providers saw this as a tension to be managed. Others were seeking a solution to this staffing issue based on flexible expansion. One micro-provider was adopting a community cohesion approach, with the family members of people who used the service covering absence and leave. This carer, the sister of someone with complex communication and learning difficulties, explained how she felt part of the micro-enterprise and enjoyed covering staff absences occasionally:

I know that [the staff member] trusts me enough to say "[the usual care giver] is not in next week can you do 2 days for me?", "Yeah, of course I can no problem". And I love it.

(Family carer, micro day activities)

Many of the micro-enterprises were wary of more formal growth, feeling that it was not compatible with maintaining their ethos of personalised care. Although two of the micro-enterprises ultimately wanted to franchise their operations, the rest wanted to grow only enough to give themselves more stability. For one provider, this was to have 10 members of staff, for another it was to draw a salary and not keep ploughing his savings into the business to keep it afloat.

Some of the small organisations that we spoke to had recently been micro-enterprises themselves, but had quickly grown in size. Whilst these organisations were wary of growth and reluctant to grow

any further, they had found that operating at a micro level had left them unable to respond to demand, especially from people with complex needs. One expressed her continued frustration:

I can't get onto that [council preferred provider] list. I've tried for three years to get onto the list...We're too small and we – they feel, generally, that the micros haven't got the wherewithal and haven't got the stability.

(Staff, small domiciliary care).

However there was a paradox here for the micro and small organisations, in that they were only able to take on people who could fit within their existing workload. For domiciliary services this often resulted in turning away people with the highest level of need as there were insufficient staffing resources to provide the number of care hours needed. This member of staff explains the frustration of turning away work, even at a time that they are needing to grow as an organisation to be financially viable:

We were offered a client just before Christmas that we couldn't do, 'cause it was 24/7, two-to-one. I mean, we haven't got the staff to cover it...We don't do nights.

We're not big enough.

(Staff, micro domiciliary care)

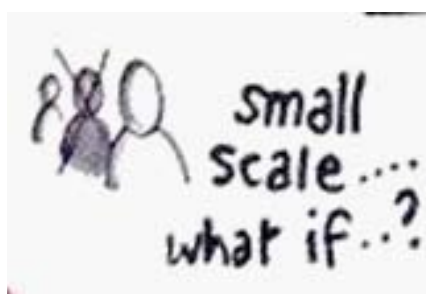
Micro-enterprises like this need support to grow slowly and in a sustainable way, which can be a difficult balance to strike for local authority commissioners looking to assign high volumes of care work.

4. Finance

People that initiate micro-enterprises often take a significant pay cut in real terms, especially those moving away from equivalent management roles in larger organisations. Economies of scale of larger care companies mean they can undercut micro-enterprises on service price for short visits:

We could only drop our prices if we multiplied our business by a factor of five or six. And put, you know, volume into it. Then there's economies of scale. But at the levels we're running at, we can't.

(Staff, micro domiciliary care)



Specific barriers related to finance were associated with:

(a) The perceived risk involved in setting up a micro-enterprise. Starting up micro-enterprise care services was viewed as a gamble by many interviewees; something that required an entrepreneurial mind set as well as support, often provided by regional Micro-enterprise Co-ordinators. Micro-providers sometimes described absorbing the financial deficits as personal costs especially in the initial phases of business development. One member of staff demonstrates clearly how their personal wages are used to provide flexibility for any financial shortcomings:

You don't want to think of it like a business but then you're thinking well if that money's not coming in how am I going to afford to pay the insurances and then, and it's just a constant worry, it really is. But we just end up taking less wages.

(Staff, micro day activities).

According to a small organisation:

I've kept this going by my personal funds... I've ploughed in money, so when we're not making money, I've propped it up. I think we're in our fourth year now.

(Staff, small domiciliary care).

(b) Processing personal budgets with local authorities. This can be a lengthy and bureaucratic process with funds often taking a long time to reach the services. This was a particular finding for learning disabilities services which tended to be funded through personal budgets. This micro-enterprise staff member talks about added complications for

people who use services following changes to prices:

We put the price up they have to go back to panel to have their budget increased or reallocated. So although it's their [personal] budget, the Council is the administrator, and so some of them manage their own money but, you know, a £3 increase means that they need to go back to get it approved.'

(Staff, micro day activities)

Other financial barriers were generated by local authority processing of personal budgets. These included capped prices for services and the costing in of brokerage services whether used or not. As this micro-provider describes, it is sometimes difficult for those running micro-enterprises to speak up about these problems as they feel vulnerable and dependent on their good relations with local authorities:

I charge £11.50 an hour for specialist work. But the Council don't want to pay PAs any more than £10 an hour and then they top slice money off that to pay for brokerage

even if brokerage isn't needed. So I don't always get £11.50 an hour...So sometimes I will settle for £10 or £8 an hour because there's two rates...And nobody can tell me why and nobody can tell me how the pricing works...And then of course I'm not – I don't have the same job security in a big company now. If I put my head above the parapet that's me gone'

(Staff, micro day activities)

In summary, the enabling factors for micro-enterprises are connected to their ability to build partnerships and collaborations, particularly with the statutory sector, whilst maintaining their autonomy. Key barriers relate to access to potential users of the service, managing staff and making the financial aspects of running a business work in the cash-strapped, rule-bound context of care. These factors reinforce those found in other studies, but progress towards addressing them has been slow.²⁵



SECTION 4: Conclusions

The findings of the research project suggests that micro-enterprises can deliver more personalised services, particularly in the home, and that they are more innovative in relation to how and who innovations. They offer better outcomes (measured as enabling people to do what they value with their time) than larger providers for a similar or lower cost. These benefits seem to be based on their greater continuity of staff, greater staff autonomy and greater accessibility of managers, combined with the low overheads of operating at a very small scale. Micro-providers did on the whole want to grow, but only slightly larger to a point where they could combine organisational and financial stability with an ethos of personalised support.

Some of the issues identified here relate to the advantages and disadvantages of running very small organisations, irrespective of whether they are care organisations or not. However there are some themes which are distinctive to the

care sector: the potential vulnerability of people who need support; the intimacy of the support given in the home; the labour intensive nature of care work, and its emotional intensity; the role of the local authority as the commissioner of care services; and the highly regulated nature of the sector. Some of these create particular opportunities for micro-enterprises, whereas others put a strain on people trying to operate at a micro scale.

Micro-enterprises often operate outside of local authority commissioning practices. In this study, micro-enterprises were selected from areas that are largely supportive of micro-enterprises and have some infrastructure in place to support them (including a Micro-enterprise Co-ordinator working with the local authority in each of the areas). Despite this, few micro-enterprises were receiving referrals from the local authority and some felt that commissioners favoured larger and more well-known care providers. Most found that

word-of-mouth and local advertising was a more reliable route for gaining people to support. These routes may be adequate if people needing care have direct payments and support to use them to make local care choices; however the relatively low take-up of direct payments by older people highlights the need to provide alternative routes into micro-enterprise.

The introduction of the Care Act 2014 requires local authorities to develop a market that delivers a wide range of high quality care and support services, which combined with the personalisation agenda, should support more micro-enterprise provision. Some of the support in the home provided by micro-enterprises is at the early intervention stage, and has the potential to play a key role in the broader prevention agenda.

The overall key research findings are briefly summarised in Box 14.

Box 14: Key Findings:

1. Micro-enterprises can deliver more personalised, innovative and valued support for a similar or lower cost than larger providers.
2. Micro-providers market themselves through word-of-mouth and local networks within the localities in which they operate, providing services for self-funders and people with direct payments. They struggle to get local authority referrals or to support people on managed personal budgets.
3. The most stable operating scale for micro-enterprises is as sole traders and partnerships. Micro-enterprises that employ staff can struggle to be organisationally and financially stable, facing competition from larger providers with a lower cost/quality operating model. Many of these micro-enterprises were trying to grow slightly larger to become more stable.

Next steps

Are you a person using services, or do you care for someone that does so? Are you a local authority commissioner of care services, or a national policy-maker encouraging market shaping at the local level? Are you an existing provider of services or a social entrepreneur thinking of setting up your own micro-enterprise? Whatever your interest in the issues discussed in the report, you can tell us what you think of the findings by following us on **Twitter (@DrCNeedham #microsupport)** or by emailing Catherine on **c.needham.1@bham.ac.uk**. If you are particularly interested in social enterprise and innovation, email Kelly **k.j.hall@bham.ac.uk**. For more information about participatory research methods and the co-research approach, email Kerry **k.allen@bham.ac.uk**



Catherine



Kelly



Kerry

Appendix

Outcome	Micro (n=58)	Others (n=37)	All (N=95)
Do you do things you enjoy and value with your time?			
Able to spend as much time as wanted, doing things valued or enjoyed	50	22	39
Able to do enough of the things valued or enjoyed	33	46	38
Do some things valued or enjoyed	17	30	22
Don't do anything valued or enjoyed	-	3	1

* **Chi-sq(3) = 8.9, p<0.05**

Do the support and services from <provider> affect how you spend your time?			
No	16	7	11
Yes	93	84	89

Fisher's exact test, p = 0.18 (2-sided)

Do you feel you have control over your daily life?			
No control	-	6	2
Some control (not enough)	21	25	22
Adequate control	38	39	38
As much control as I want	41	31	37

Chi-sq(3) = 4.1, p = 0.25

Do the support and services from <provider> affect how much control you have over your daily life?			
No	34	28	32
Yes	66	72	38

Fisher's exact test, p = 0.65 (2-sided)

Note '-' means no cases observed.

Notes

- ¹ ASCOT is a standardised toolkit developed by the Personal Social Services Research Unit at the University of Kent. The toolkit enables people using care services to give a numeric score to how satisfied they are with aspects of their life (e.g. if they have as much choice and control as they would like), and then to indicate whether the score would change if they no longer had support from their existing care provider. For more details see <http://www.pssru.ac.uk/ascot/>
- ² See the Royal Society for the Arts project The Power of Small, <https://www.thersa.org/action-and-research/rsa-projects/economy-enterprise-manufacturing-folder/the-power-of-small/about/>
- ³ This is the definition of micro-enterprises developed by Shared Lives Plus and Community Catalysts and used in publications by the Department of Health and Think Local, Act Personal.
- ⁴ Department of Health (2010) Supporting Micro Markets, London: Department of Health.
- ⁵ Phillimore et al (2009) Under the radar? Researching unregistered and informal third sector activity, Birmingham: University of Birmingham.
- ⁶ NAAPS/Department of Health (2009) Supporting Micro-Market Development: A detailed practical guide for local authorities, London: Department of Health.
- ⁷ All organisations, locations and individual names have been changed to preserve anonymity.
- ⁸ INVOLVE (2012) Briefing notes for researchers: involving the public in NHS, public health and social care research. INVOLVE, Eastleigh⁹
- ⁹ See <http://www.birmingham.ac.uk/research/activity/micro-enterprises>
- ¹⁰ These claims are derived from a range of sources. For a useful overview see NAAPS/Department of Health (2009) Supporting Micro-Market Development: A detailed practical guide for local authorities, London: Department of Health.
- ¹¹ The UK Companies Act 2006 defines small companies as having fewer than 50 staff and medium companies as having fewer than 250 staff.
- ¹² For more information see <http://www.pssru.ac.uk/ascot/>
- ¹³ See Needham, C. (2011) Personalising Public Services: Understanding the Personalisation Narrative, Bristol: the Policy Press.
- ¹⁴ Twigg, J. (2000) 'Carework as a form of bodywork' Ageing and society, 20(4), pp. 389-411.
- ¹⁵ Equality and Human Rights Commission (2011) Close to home: an Inquiry into older people and human rights in home care of, London: EHRC, <http://www.equalityhumanrights.com/publication/close-home-inquiry-older-people-and-human-rights-home-care>
- ¹⁶ Bolton, S. C. and Wibberley, G. (2013) Domiciliary Care: The Formal and Informal Labour Process, Sociology, pp. 1-16; Leece, J. (2003) The development of domiciliary care: What does the future hold? Practice: Social Work in Action, 15 (3), pp. 17-30.
- ¹⁷ Health and Social Care Information Centre, HSCIC, Personal Social Services Adult Social Care Survey, England. 2013-14 Final Release [published December 09, 2014], p.5.
- ¹⁸ Health and Social Care Information Centre, HSCIC, Personal Social Services Adult Social Care Survey, England. 2013-14 Final Release [published December 09, 2014], p.4.
- ¹⁹ Walker (2014) Internal and External Antecedents of Process Innovation: A review and extension, Public Management Review, 16(1), pp. 21-44.
- ²⁰ See for example the case studies on the Community Catalysts website: <http://www.communitycatalysts.co.uk/case-studies/>
- ²¹ Carr, S. (2014) Social care for marginalised communities: understanding self-organisation for micro-provision, Policy Paper 18, Birmingham: Health Services Management Centre.
- ²² The analysis of value for money used pricing data rather than cost data, because of the relative transparency and availability of the former compared to the latter. Also we have used the lowest hourly rate quoted when a number of different prices applied.
- ²³ Unison, 2014, 15 minute home care visits in England on the rise, <http://www.unison.org.uk/content/conNewsArticle/5637> Accessed 24 April 2015.
- ²⁴ National Institute for Clinical Excellence (NICE) (2015) Home care: delivering personal care and 10 practical support to older people living in 11 their own homes, Draft Guidance, <http://www.nice.org.uk/guidance/gid-scwave0713/documents/home-care-draft-full-guideline2> Leonard Cheshire Disability (2013) Ending 15 minute care, London: Leonard Cheshire Disability <http://www.leonardcheshire.org/sites/default/files/15%20min%20care%20report%20final.pdf>; Walsh, K. and Shutes, I. (2013) Care relationships, quality of care and migrant 13 workers caring for older people. Ageing and Society 33, pp. 393-420.
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