Social enterprise, social innovation and self-directed care: lessons from Scotland

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Published in:
Social Enterprise Journal

DOI:
10.1108/SEJ-12-2018-0080

Publication date:
2019

Document Version
Author accepted manuscript

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Purpose: This study aims to explore the opportunities and challenges SDS policy has presented to Scottish social enterprises, thereby increasing understanding of emerging social care markets arising from international policy-shifts towards empowering social care users to self-direct their care.

Design/methodology/approach: This study used guided conversations with a purposive sample of nineteen stakeholders sampled from frontline social care social enterprises; social work; third sector; health; and government.

Findings: An inconsistent social care market has emerged across Scotland as a result of policy change, providing both opportunities and challenges for social enterprises. Social innovation emerged from a supportive partnership between the local authority and social enterprise in one area but elsewhere local authorities remained change-resistant, evidencing path dependence. Challenges included the private sector 'creaming' clients and geographic areas, and social enterprises being scapegoated where the local market was failing.

Research limitations/implications: This study involved a small purposively sampled group of stakeholders specifically interested in social enterprise, and hence the findings are suggestive rather than conclusive.

Originality/value: This paper contributes to currently limited academic understanding of the contribution of social enterprise to emerging social care markets arising from the international policy-shifts. Through an Historical Institutionalism lens, this study also offers new insight into interactions between public institutions and social enterprise care providers. The insights from this paper will support policymakers and researchers to develop a more equitable, sustainable future for social care provision.

Keywords: Social enterprise; social innovation; social care; self-directed support; historical institutionalism

1. Introduction

For social enterprises in Scotland delivering social care services through local authority contracts, the introduction of the Social Care (Self-directed Support (SDS)) (Scotland) Act 2013 (henceforth referred to as the Social Care Act) has provided both opportunities and challenges. The policy entrenches the rights of state-funded social care consumers to have choice and control over their own care. Before the policy was implemented in April 2014, social enterprises in Scotland had already begun proactively adapting their services and commercial activities to make their services sustainable in this new personalised market (Henderson et al, 2018). However, a decade after the first pilot studies of this transformative social care policy, there remains little academic evidence of the experience of social enterprises operating in this personalised social care landscape. This paper therefore responds to this gap by exploring the opportunities and challenges that self-directed care has presented to social enterprises in Scotland.

The principles of empowering social care users to direct their own care which are inherent in the Social Care Act have been reported across Europe, Australia, Canada and the USA (e.g. Needham and Dickinson, 2018; Pearson et al, 2018; Power, 2014). Since the 1990s, policy makers in the UK have increased opportunities for social care users to have greater control over their own care. However, the scope of such *personalisation* policies has accelerated since the 2008 recession and, while such policies are 'impossible to disagree with' (Pearson and Ridley, 2017, p.1055), the widespread introduction of similar SDS policies across recession-hit countries suggests such policy initiatives were driven at least in part from a political cost-efficiency agenda.

Social enterprise is a contested concept (Teasdale, 2012) and in the UK it has been argued to be the latest manifestation of principles already existing within Western social economies and exhibiting practises that date back to the 19th Century (Sepulveda, 2015). Since the 2008 recession, social enterprises have become increasingly prominent in the UK's politically-driven austerity agenda as an alternative form of public service delivery (Hazenberg & Hall, 2016), leading to the suggestion that

the UK is undergoing a 'social enterprization' of its' welfare system (Sepulveda, 2015). Yet in Scotland there remains a lack of evidence from social enterprises themselves to demonstrate whether such a shift is occurring, and whether it is successful. Limited evidence from upstream Scottish public sector stakeholders has shown that anticipated transformative change in the social care market as a result of the Social Care Act has yet to emerge in response to SDS policy (Pearson et al, 2018), despite social enterprises positioning themselves to exploit the policy (Henderson et al, 2018).

Early anticipation that the Social Care Act's personalised budget system (SDS) would generate social innovation has yet to be academically supported. What little evidence exists is anecdotal and focused only on those organisations that are highly successful (Vickers et al, 2017). Greater academic understanding of the emergence of social innovation in social enterprise as a result of the Social Care Act is therefore needed, particularly around the influences and interactions between public institutions, social enterprise and Scotland's social care sector quasi-market (Vickers et al, 2017). This study offers the beginnings of an academic evidence base addressing these multiple gaps in current understanding, and demonstrates the need for a more systematic investigation of social enterprise, social innovation and Scottish self-directed care. It aims to explore the opportunities and challenges that SDS policy has presented to social enterprises in Scotland, using the lens of Historical Intuitionalism to explore whether SDS has enabled or stifled innovation in social enterprises.

2. Literature Review

Social enterprises are market-driven organisations that balance their commercial trade of goods and services with their underpinning social mission to benefit society (Henderson et al, 2018; Gras & Mendoza-Abarca, 2014). The social purpose of social enterprises are wide ranging in the UK, and can include the reduction of inequalities, for example through providing social housing (e.g. Fitzpatrick & Watts, 2017), increasing opportunities for marginalised populations (e.g. Gidron & Monnickendam-Givon, 2017), and providing social services (e.g. Henderson et al, 2018). In Scotland, social

enterprises are supported and promoted by the devolved Scottish Government through a 10-year Government-led Social Enterprise Strategy (Scottish Government, 2016). The Scottish Social Enterprise Census (Social Value lab, 2017) found Scottish social enterprises '…often fill a market gap that the private sector cannot (profit margins too low and risks too high) or that is beyond the statutory responsibilities of public authorities' (2017, p. 34). The Social Care Act devolved responsibilities for managing care to individuals (reducing the statutory responsibilities of public authorities) in an austerity-led climate of budget cuts and reduced profit margins, leaving the market ripe for social enterprise to fill gaps and generate social innovations in response to demand.

2.1 SDS budgets and social enterprise

The uptake of SDS remains low across Scotland, with a national average uptake of approximately 40% (Scottish Government, 2018a), suggesting the market is taking time to mature. Demand for services continues to grow, regardless of whether they are paid for privately or through the welfare system. This demand is driven in large part by an increasingly aged Scottish demographic (Audit Scotland, 2017a).

SDS is a direct payment policy with four options[1] which intends to encourage individuals to exercise more choice and control over their care (Audit Scotland 2017a).The core SDS principles empower people to have choice and control over the services they receive, so it was expected that the social care market would become driven by the needs of the individual consumers rather than dictated by local authority contracts. Consequently, the influence of local authorities on the market would lessen. However somewhat counterintuitively, despite a growing number of social enterprises delivering health and social care, Audit Scotland found that changing from state provision to SDS has in fact generated *less* choice and control amongst some budget holders, particularly those who don't have personal support from carers (e.g. Personal Assistants, friends or family) and those aged over

[1] The four SDS Options are: Option 1) the individual manages their own budget; Option 2) the individual decides the care they want and who from whom, and the local authority arranges it; Options 3) the local authority discusses what care the individual requires then arranges the support itself and 4) a combination of the above three options (Scottish Government, 2013).

85 (Audit Scotland, 2017a). As yet no academic evidence has been gathered to explain the processes that created this unexpected effect.

2.2 SDS and Social Innovation

SDS has created opportunities for social innovation in social care and this has been actively supported by the Scottish Government through the Self-directed Support Innovation Fund. In 2015-16 (Year 1) it granted £1.25million to 21 projects, most of which were social enterprises/third sector organisations (Scottish Government, 2015). Whilst some of these newer social enterprises are offering 'traditional' care services, such as support with household tasks, shopping services, and 'meals on wheels', other new social enterprises are also emerging in response to an increased demand from SDS budget-holders for non-traditional activities. These new social enterprises may offer socially innovative activities e.g. language classes to improve cognition amongst people with dementia and daytime discos for older people. Participating in these more innovative activities offers opportunities for increased social connections, physical activity and self-worth (Henderson, 2018).

Evidence of the emergence of social innovation amongst social enterprises delivering social care in Scotland does however continue to be largely anecdotal and focused only on those enterprises that are highly successful (Vickers et al, 2017). There remains a gap in academic understanding of how social innovation emerges in the public domain, especially in relation to SDS policy, and particularly around the interplay of public institutions, social enterprise and quasi-markets like Scotland's social care sector (Vickers et al, 2017).

2.3 Historical Institutionalism and social care

Third sector organisations have long been involved in supplementing the state's provision of welfare services to vulnerable communities (Esping-Anderson 1990) particularly in times of recession, so it is unsurprising that UK governments have promoted social enterprise as a sustainable socially-driven

alternative for the provision of some welfare services (Henderson et al, 2018; Sepulveda, 2015; Featherstone et al., 2012). This shift to promoting social enterprise as a solution to social need has been both swift and explicit under austerity, leading to some attributing the increased *marketization of social care* to a neoliberal agenda (Henderson et al, 2018). The shifting of responsibility away from the state towards the individual through new policies like the Social Care Act has been described as a manifestation of neoliberal ideology (Power, 2014; Ferguson, 2012).

However, a shift from state provision to individual responsibility also requires public authorities to evolve their processes and procedures as they relinquish some control over budgetary decision-making. Yet as Historical Institutionalism theory explains, generating change at institutional level is complex as attempts to respond to contextual change in a timely and efficient manner are vulnerable to continually shifting social and political structures (Cappocia, 2016; Thelen, 1999).

Public institutions are fundamentally change-resistant (Pierson, 2000) and designed to remain stable regardless of changes in prevailing politics or policies (Cappocia, 2016). As a result, they will maintain a similar pattern of decision-making and governance that repeats across time, demonstrating *path dependence* i.e. the persistence of organisational behaviour over time regardless of its efficacy or efficiency (Vergne and Durand, 2011). Path dependence can impact on quasi-markets like social care because the market is largely governed and operated by public institutions. Pierson (2000) notes '…institutions are hard to change, and they have a tremendous effect on the possibilities for generating sustained economic growth. Individuals and organizations adapt to existing institutions.' (Pierson, 2000, p.256). Scottish local authorities are therefore embedded in their political and social context, and 'cannot be understood in isolation' (Thelen, 1999, p.384). While these institutions may attempt to evolve in response to policies like the Social Care Act, their development is constrained by 'past trajectories' (Thelen, 1999, p.387). Clients, service providers and markets relying on Scottish local authorities for care services, funding and stewardship of the social care market will therefore adapt to the local authorities requirements. This adaptation might in turn curtail innovation and prevent approaches which challenge the existing operational structure.

Historical Institutionalism theory also suggests policies which require institutional change can be ineffective if the timing of their introduction is wrong (Cappocia, 2016; Pierson, 2000). The introduction of the Social Care Act demanded local authorities change multiple systems to enable clients to be offered choice and control over their own care. However Scottish local authorities were simultaneously enduring significant cuts to their budgets (Audit Scotland, 2017b). In addition, existing procurement legislation meant the Social Care Act was immediately "…in opposition to current procurement practice where the individual's choice would be secondary to the requirement to (re)tender in line with public procurement regulations" (CCPS, 2018; Kettle, 2012). The timing of the introduction of the policy was therefore made more challenging by the simultaneous cuts to Scottish local authority budgets and a lack of resources to swiftly evolve procurement legislation.

2.3 Local authorities' role in implementing the Social Care Act

Local authorities have been slowly evolving from care providers to managers of social care since the introduction of Direct Payments across the UK in the 1990's. Since the Social Care Act was first proposed, Scottish local authorities, like their UK counterparts, have been forced to rapidly increase their role and responsibilities in co-ordinating public, private and third sector social care providers in the market (Land and Himmelweit, 2010).

Traditionally Scottish social care clients could expect their care package to cover some personal needs e.g. administering medication (known as registered care), and homecare services such as shopping and cleaning. However the implementation of the Social Care Act changed the expectations of social care clients and service providers as individuals were now given a budget which the Scottish Government suggested they could choose to spend on the social care activities they wanted (Scottish Government, 2018b). However local authorities implementing SDS under austerity had to manage such high expectations and so, following policy implementation, some local authorities began producing lists of 'permitted' or sanctioned activities only which clients could purchase through their SDS budgets. Scottish local authorities are able to exert this control over individual's SDS decision-

making and spending as, to minimize risk, all services and activities must be approved by the local authority before SDS funds are released. This control over permitted spending in turn impacts upon and differentiates local social care markets across each of Scotland's 32 local authorities, as service providers reliant on SDS payments will therefore adapt (Pierson, 2000) to the local authority's requirements.

In the UK, social work departments have traditionally been resourced and managed by local authorities and hence have not been immune to austerity cost-cutting. Personalisation policies across the UK home nations have challenged these social workers to work in new ways with reduced resources to ensure positive outcomes and maintain good practice whilst minimising risk (Stevens et al, 2018). In Scotland, the timing of the implementation of the Social Care Act has been challenging for social work, and when coupled with 'past trajectories' (Thelen, 1999), have added to the failure of the policy to generate transformative change in the social care market (Pearson et al, 2018).

The following study aims to explore the opportunities and challenges that SDS has presented to social enterprises in Scotland through examining the experiences of a cohort of social enterprises providing activities and services paid for through clients' SDS budgets. To investigate the influence of local governance systems upon these social enterprises, additional insight is captured through the narratives of public institution stakeholders, social enterprise network representatives, and organisations which advocate for SDS clients. This study then examines the participants' narratives to explore the emergence of social innovation in local care markets.

3. Method

3.1 Sample

This study sought the perspectives of a range of stakeholders to give insight into the current social enterprise social care landscape, including nine social enterprise representatives who deliver frontline social care; four public sector representatives from social work, the National Health Service

(NHS), and SDS procurement governance; four stakeholders from regional and national third sector social care advocacy organisations; and two social enterprise network stakeholders who are in regular contact with hundreds of social enterprises across Scotland. Participants came from seventeen different organisations and were sampled from seven of the thirty two local authority regions across Scotland including areas in central, western, northern and eastern Scotland. In addition, five stakeholders represented national organisations that worked across all Scottish regions (see Table 1). Participants were purposively sampled. Six participants were recruited initially through the research team's professional networks, and through the snowball technique those six participants recruited a further 13 stakeholders.

[Insert table 1 about here]

3.2 – Measures

All participants were interviewed once using a guided conversation technique (Rubin and Rubin, 2005). The guided conversation approach allows the interviewer to ensure the participant remains on-topic by using broad thematic prompts while allowing the emergence of unexpected themes during the participant's open narrative (Henderson et al, 2018). The interviews were therefore structured around four broad themes, namely 1) the participants' role and their experiences of the Scottish social care market; 2) their experience/perceptions of social enterprise operating in the current social care market; 3) their experience/perceptions of local authorities' role in the implementation of the Social Care Act; 4) their awareness of social innovation emerging in social enterprises as a result of the Social Care Act.

The interviews were open-ended and participant-led, ranging in duration from 45 minutes to 120 minutes depending on the individual. Two of the authors conducted the one-one-one interviews. The location of the interview was chosen by each participant, and took place either in University

meeting rooms or in the participants' workplace. All participants completed consent forms prior to interview, including indicating whether they gave permission for their interview to be audio-recorded. Due to sensitivities around the research topic, four stakeholders did not wish to be audio-recorded but still consented to participate in the research. Where interviews were not audio-recorded, the researcher took extensive notes of responses during the interview. Ethical approval was granted from the University's Ethics Committee.

3.3. Analysis.

The interviews and noted conversations were organised in QSR Nvivo using the four broad guided conversation themes. Each member of the research team then conducted their own review of the data and coded it using deductive manifest themes, for example polarity i.e. positive or negative statements, before running a second analysis in which they coded inductive emergent themes such as explanations of challenges within the SDS-funded social care market (Braun and Clarke, 2006; Joffe and Yardley, 2004). The team then came together to discuss and reflect upon their findings before comparing them with relevant literature (McKeever et al, 2015). The results of this analysis are presented in the following sections.

4. Results

The following results section considers four deductive themes. Firstly, the analysis of social enterprises' experience and perception of SDS and the current social care market is presented. Secondly, social enterprises' experience and perceptions of local authorities' implementation of the Social Care Act are described. Thirdly, the influence of SDS and the Social Care Act on social enterprise-led social innovation in social care is explored before fourthly, the perception of social enterprise as the 'last resort provider' is examined.

4.1 Experience of the Social Care Act

The participants in this study all stated that the implementation of the Social Care Act and the SDS system was problematic and uneven across Scottish regions. A representative of social enterprises providing social care across Scotland noted:

> "It just seems very messy everywhere, from one area to another…I'm working nationally so I'm kind of dipping in and out of what folk are saying in different areas...*(but)* nobody seems happy with it…it's all coming back to me through (social enterprise) members and what their experience is." (GC, national social enterprise network)

This 'messy' picture was reported to have arisen from the timing of the Social Care Act's introduction in 2014, when annual significant cuts to Scottish local authority budgets were already challenging service provision:

> "…they did it at the worst possible time.....(putting) pressure on local authorities to deliver it according to legislation at a point where services would be strapped for cash…because they did it at the same time, it meant that everyone was blaming Self-directed Support on cutting budgets which is ridiculous*…(had they)*…waited until there was money available you could have had a far greater perception of Self-directed Support as something which truly enables people to have a choice." (DR, national disability advocate)

The timing of SDS's introduction had generated a tense relationship between social enterprise and frontline social work staff who were responsible for implementing the policy:

> "…because of the nature of SDS and how it was implemented…local authority staff didn't always take to it from the start because it was a completely different way for them to work…I think there was often a feeling that we were encroaching on what they

were doing, rather than working harmoniously alongside them." (AD, social enterprise SDS lead)

Social enterprises not only had to negotiate with social work staff but also navigate the local authority procurement system. Local authorities in Scotland maintain a system of allowing only through 'approved providers' to be paid for delivering care. Approved providers are organisations which have been vetted by the local authority and have demonstrated their sustainability e.g. by their age, size and/or turnover. When the Social Care Act was implemented, local authorities often continued to rely on existing approved providers to deliver care to SDS budget-holders. This acted as a barrier to new social enterprise providers entering the market, in particular small new social enterprises that could not meet the sustainability criteria local authorities required:

"…amongst the (national network) members, the big issue for them is just they can't get a look in…it's the big care providers in terms of third sector that take…(SDS)…up." (GC, national social enterprise network)

Contrary to the suggestion that SDS would give clients' greater choice and control, participants reported that service diversity had decreased since the Social Care Act was implemented. BHA, an urban home care service manager, reported clients were no longer allowed the range of services they had enjoyed under pre-SDS local authority care contracts, such as care workers delivering and putting away food groceries for those clients physically unable to do so themselves. She stated the SDS system had increased the control of the local authority over her clients' care rather than giving her clients more choice and control. However, others suggested this change in service provision was an artefact of austerity-driven financial cuts rather than local authorities' attempts to control spending:

295 "I think the failings would be the lack of resources from central government…they're just
296 not…feeding adequately into the local authority purses to run the services that they
297 need." (SW, social worker)

298 CL, a Community Links worker based in an urban health centre, agreed the cuts were the cause of
299 service reduction. She reported an increase in social exclusion amongst her clients as a result of
300 these financial constraints:

301 "…with people's packages being cut to a minimum one of the first things to go is the
302 social aspect of it. So the people used to get support to go shopping or they would get a
303 kind of respite-type thing where they could go to the pictures one day a week. They're
304 not getting that anymore." (CL, Community Links worker)

305 Money and budget cuts were recurrent themes emphasised by the study's participants. This
306 manifested itself beyond service provision. SW (social worker) stated the local authority social
307 care assessment form did not have the 'deep analysis into…day to day life" necessary to
308 properly assess an individual's care requirements:

309 "…in fact the actual biggest part of the form is usually about the financial bit because
310 that's going into the nitty gritty to see how much the local authority can save if the
311 person's got more savings." (SW, social worker)

312 *4.2 Local authorities' implementation of the Social Care Act*

313 Several participants noted that the size and longevity of social enterprises impacted upon their
314 success when trying to enter the approved provider system in order to access SDS clients. For
315 example, BB managed a large social enterprise (c.£1.5million turnover) which was well-established
316 (>20 years). His organisation had operated in the local social care market before the SDS budget
317 system was implemented, and he reported his organisation already had the business networks, scale
318 and local authority experience to immediately recruit SDS clients. He reported however that his

social enterprise was one of just eight approved providers in his local authority area, and that his local authority stipulated that those eight providers could only deliver specific care activities which were pre-determined by the local authority rather than chosen by the SDS budget holders. This was consistent with evidence from other participants who reported local authorities controlled not only the organisations that gained approval, but also the type of activities those organisations delivered, regardless of which SDS Option the budget-holder had selected. BB and other participants stated social care markets in their areas were continuing largely unchanged from before the Social Care Act.

For those living in remote Scottish rural areas and islands, there was often no social care provider at all. Where there was some provision, choice was limited. NN, the CEO of a new (<3 years) small social enterprise, operated her organisation in an urban area and was successfully specialising in another social care activity without any full-time staff when she was approached by a family to deliver homecare to a client residing on a remote Scottish island. The potential client had fallen and couldn't be released from hospital without homecare in place but the island had no social care provision. The client's family and the local authority agreed that care was best paid for through an SDS budget. However, the island was frequently cut-off by bad weather, leaving workers stranded for days, and so had proved unattractive to other social care providers. NN's organisation was the only social care provider prepared to operate there. This left the local authority with no choice but to approve this new small social enterprise:

> "We're not a big large organisation that provides care and that's the mainstay…Just getting around that took a while for them *(the local authority)* to grasp and release the money to the client. They *(the client)* needed to get home so I think that sped up the process and released the bed from where they were in hospital….Local authorities say they work with social enterprise, but it's not as simple or straightforward as that." (NN, social enterprise CEO)

NN's case study demonstrates that local authorities are able to take the risk and approve new small social enterprises if they so choose, suggesting legislation and internal local authority procedures do not inevitably preclude small new social enterprise from entering the market.

4.3 SDS and social enterprise-led social innovation

The emerging evidence in this study suggested that SDS has both promoted and stifled social innovation, depending on whether the local authority was urban or rural. As NN reported, a rural local authority granted a new small social enterprise approved provider status despite the procurement difficulties. While NN did not interpret the social enterprise's SDS-funded social care delivery as socially innovative, another external stakeholder implied it was:

> "…the *(island)* nurse approached me and said…"you should try and develop this service so that you take over the island…there are so many people…*(that)…*need the support…nobody can get here."…She pulled me aside as though it was something really transformational…" (NN, social enterprise CEO)

LCB managed social care service provision in a large (60+staff), well-established (over 20 years) urban social enterprise. Following the loss of their local authority contract to the private sector, the organisation developed socially innovative registered and homecare services for SDS budget-holders which involved matching a named worker to each client in a manner similar to matching befrienders to vulnerable people. Backed by large cash reserves and already advantaged by operating in an affluent urban area, the social enterprise was able to recruit enough private clients to cross-subsidise clients waiting months for SDS payment decisions. However this model was not without its challenges, particularly the unexpected high hidden costs involved in signposting, advocacy and support to ensure clients were able to access their SDS budgets.

While LCB reported signposting and advocacy as an unexpected cost, another social enterprise embraced signposting and advocacy as part of their marketing strategy. CO, the Development

Manager of a rural social enterprise, explained the organisation's business strategy involved campaigning for a wider interpretation of SDS policy amongst local authority staff, and that this repeated contact had led to the creation of a supportive positive relationship between the social enterprise and the local authority. Two other participants in this study, both of whom were unconnected to CO's social enterprise but knew of its' activities from their national remits across Scotland (GC, national social enterprise network; SW, social work union representative) reported that local authority area as being the most supportive of SDS budget-holders in Scotland. Both GC and SW further stated that this view was based on witnessing an emerging socially innovative local social care market driven by SDS budget-holders there. This new market was successfully offering alternative physical and mental health therapies to SDS budget-holders alongside more traditional care provision.

CO reported the local authority's co-operation was a practical solution to recognised gaps in local provision:

> "So *(the local authority),* mostly under the Self-directed Support agenda, realised that if you were in a rural area and you chose Option 1, a direct payment to buy in your care and support, there was nothing to buy in. So, they gave…a little bit of money to stimulate small enterprises to start looking at care and support…" CO (social enterprise development manager)

CO's organisation also recognised that this interplay of organisational agenda and local opportunity also existed in the social enterprise:

> "…the fact that there was nothing provided created an opportunity for us, and I don't think we would've got so far so quickly had there been competition or had there been other people doing what we do. When you've got nothing…you've got need…." CO (social enterprise development manager)

Other social enterprises reported a very different experience when interacting with their local authority, and that such experiences impacted upon their ability to deliver socially innovative activities. For example, PA's social enterprise activities were cited by national stakeholders and her peers as being socially innovative (e.g. DB, national advocacy; GC, national social enterprise network; NN, social enterprise CEO). However PA (social enterprise CEO) reported that her organisation had to curtail its socially innovative activities to ensure they fitted the local authority's stipulations:

> "…they (the local authority) don't like you doing anything that doesn't fit their boxes…It's a limited resource…there were younger people that wanted to join us but because my remit was only over-65, they were not allowed to come." (PA, Social enterprise CEO)

Parameters on the delivery of PA's social innovation limited its ability to reach the broadest possible number of SDS budget holders. Another barrier to the wider adoption of socially innovative activities was the approved provider system. As demonstrated by BHA (social enterprise service manager) and NN's (social enterprise CEO) case studies, approved provider status was difficult to obtain for new, innovative and small social enterprises.

GV, the national procurement stakeholder, reported a potential solution to such constraints is under development, namely a national Scottish approved provider database funded by the Scottish Government. He stated22 of the 32 Scottish local authorities had already agreed to this national procurement framework and more were expected to join. GV suggested the framework will allow SDS budget holders greater choice and control through expanding the pool of approved organisations available to them, including social enterprises. However, whether this database would resolve the issue emerging earlier of service homogeneity or embrace nascent socially innovative activities is unclear. As noted earlier, BHA (social enterprise service manager) and CL (Community Links worker) observed the provision of services was currently homogenised and focused on 'traditional' homecare services in some regions, undermining attempts by innovators

like PA (social enterprise CEO) to widen access to new innovative activities. Discussing such constraints led AA (regional social enterprise network manager) to reflect upon the relationship between social enterprise and local authorities:

> "One of the challenges that I think a number of the social enterprises face, probably a most difficult challenge actually, is not necessarily about direct market competition…but actually in the dealings they have with…the local authority." (AA, social enterprise network manager)

This difficulty in managing the relationship between social enterprise and the local authority is explored in more detail in the following section.

4.4. Social enterprise – the last resort in a 'messy' market?

Difficult relationships between local authorities and social enterprises were reported by several stakeholders, including concerns about ongoing access to local authority funding. This made speaking truthfully or making demands of the local authority challenging:

> "…there are a few organisations that are funded…to support people with SDS and I don't think that they *(social enterprises)* would be open with them *(the local authority)* about their concerns or some of the negative stories that they hear because they worry that that will impact on their continued funding." (HP, regional advocacy)

A power imbalance was referenced whereby social enterprise providers are viewed as 'less' than the public or private sector providers:

> "…we *(social enterprise)* are just at the bottom of the pile…some of them go to us directly because they see they can palm them *(difficult clients)* off onto us and they don't have to worry anymore. And I think some of them see us as a last resort, or they don't think of us at all." (HC, social enterprise development manager)

In addition, HP (regional advocacy) reported an expectation amongst the public sector that social enterprises could deliver services more cheaply or even for free. She noted a failure to appreciate the high level of expertise in social enterprise and the wider third sector, and the public sector's assumption that social enterprise has lower expertise than the private sector. HC supported this:

> "…I would go and see social workers and…they all thought I was 'just' the third sector volunteer…they kept telling me that they were professional social workers. I never said I was one, but I never said I wasn't. What I said was, "As you are a professional, so am I, and we're sitting here on equal partnership." Now the word got around that I was a social worker…I've never changed that view. I'm not!" (HC, social enterprise development manager)

BB (social enterprise manager) reported that his organisation was perceived to be 'a provider of last resort' and he felt this was in part due to the organisation's social mission, which required his enterprise to support all clients, regardless of their vulnerability or the cost of doing so. He stated this commitment to deliver care to everyone that needed it meant his organisation cannot refuse a potential client. BB witnessed private providers 'cherry picking' clients while his social enterprise was being sent particularly difficult clients that other providers had refused or abandoned. This was also noted by AZ (social enterprise CEO), who reported that his highly successful rural social enterprise was invited to work in an urban local authority's area. On arrival the organisation found the provision of services in that area was dominated by the private sector. His social enterprise also became the provider of last resort and was allocated the 'hardest' clients that private providers had either abandoned or refused to take. AZ's organisation's social mission prevented it from refusing any client if it had capacity. This aligned with NN's (social enterprise CEO) experience of providing a service on a remote island, where weather stopped the ferry leaving and the costs of service provision made it unattractive to the private sector:

463 "We need to have the flexibility of allowing a carer to stay if they can't get off the island
464 and somebody else can't swap. That sort of thing is difficult to manage…it also makes it
465 very difficult to recruit because not many people want to lose that freedom of getting
466 home when they want to." (NN, social enterprise CEO)

467 The private sector's reluctance to enter such geographically difficult and hence potentially costly
468 rural areas was clear:

469 "Some of the providers in the central belt and some of the national providers would not
470 come into our area because it's not viable." (AZ, social enterprise CEO)

471 Yet several stakeholders reported that such difficulties did not prevent the private sector from
472 bidding for contracts in those areas. In three rural regions, stakeholders reported examples of
473 private sector organisations that were given contracts for a geographic area only to withdraw
474 provision from unviable areas despite contractual obligations:

475 "…his health condition was deteriorating, and the family had been assessed by social
476 work and were waiting for six months for support to come in…There was a contract to
477 provide homecare in that area but the contractor had no staff for that area and were
478 unwilling to send someone out..." CO (social enterprise development manager)

479 CO reported that in remote areas in her region, clients were being given an SDS Option 1 budget to
480 control and purchase their own care despite none being available. This effectively removed any
481 legislative responsibility of the local authority to ensure the client had adequate social care
482 provision. HC (social enterprise development manager) also reported the SDS system was used in
483 this way in her region. In both these areas, the finance for a social care market was made available
484 by the respective local authorities for those particular remote rural sub-areas CO and HC cited, but
485 there was no provider to exploit that.

A circular problem in the relationship between the local authority and social enterprise emerged in the narratives of rural social enterprises that successfully delivered social care through SDS budgets in areas where previously no social care had been available. This new provision inadvertently created an unexpectedly high local demand for the new services, as a new client group of individual residents emerged that urgently required care but who had not previously presented their needs to the local authority. The consequence of these pressures was difficult relationships between the social enterprise sector and their respective local authority in some areas:

> "…*(the local authority was)…*trying to get people out of hospitals, so they delayed discharges and they were contacting *(social enterprises)* who were unable to take them on. The *(local authority)*…were implying that *(social enterprises)* were responsible for the delayed discharge because of their delays in recruiting enough workers." (HP, advocacy network)

One new social enterprise was struggling to cope with its' success in the face of the unexpected demands from previously-unknown residents, combined with the urgent care demands of those about to be discharged from hospital: :

> "They've done an amazing job…everybody sees them as the answer…It *(the social enterprise)* could end up folding because it's just too much. Or getting a bad reputation because they won't be able to keep up within what they're given. And I think that would be a real shame, because…they are very good." (HP, advocacy network)

HC (social enterprise development manager) suggested that local authorities attempted to transfer both responsibility and blame to the social enterprise sector:

> "They're *(the local authority)* seen as the baddies because they can't provide it, *(so they say)* "If we give it to *(social enterprise)* it's *(their)* problem and it's down to them!" (HC, Advocacy/SE development manager)

Despite these tensions, one national stakeholder was particularly optimistic that the landscape was changing for the better:

> "…you have a mixed market. You have third sector provision. You have big organisational provision down to very, very local provision…that segmentation I think has made the social care market…much more powerful and much more responsive to individual need…I think that provides a fertile landscape for a social innovation or a social innovator." (DQ, national disability advocacy)

DQ's enthusiastic optimism was not shared by the majority of participants, particularly those working in the frontline of social care, who reported concerns about the sustainability of social care in Scotland. HC held a particularly bleak belief about the current Scottish social care market's sustainability:

> "…if I really want to be honest, I think euthanasia will come in and that will be the way to solve it….I don't see how they can do it any other way." (HC, social enterprise development manager)

5. Discussion

This study explored the experiences of social enterprises delivering social care in Scotland, and found mixed evidence of transformation in the Scottish social care market. The Social Care Act has led to increased opportunities and greater organisational sustainability for some social enterprises, but for others it has created fragmented regional social care markets and maintained the ongoing tense relationships with local authority and public sector staff. While there is some evidence of social enterprise-led transformation in the market, e.g. new social care provision where previously there was none, it is not transforming at the pace or with the consistency across geographic regions anticipated by the Scottish social enterprise social care sector.

Explanations for the delay in transformation comes in part from barriers to social enterprises' market inclusion, including size and scale precluding approved provider status, and an attitude in the public sector that social enterprise care providers are somehow 'less' specialised or skilled than other organisational forms. These attributions, and the misconception that social enterprises can deliver services free or more cheaply, were found to undermine the place and importance of social enterprise in the market, regardless of the promoted and well-publicised political enthusiasm supporting social enterprise in Scotland (Scottish Government, 2016). Yet despite such misperceptions, some rural Scottish local authorities were found to rely entirely on social enterprises to deliver social care in difficult-to-reach areas and to small, isolated communities, while some urban local authorities allocated social enterprises difficult clients who had been rejected by private sector providers.

Under the Social Care Act, the SDS budget system offered new opportunities for clients to gain control of their care budgets and make greater choices over their care and support, and evidence of this occurring emerged in this study. However, there was also strong evidence of local authorities controlling social care provision to people who received SDS through their management of the approved provider process. This in turn hampered social innovation in the market.

The timing of the Social Care Act was recognised elsewhere as challenging due to budget cuts in local authorities (e.g. Stevens et al, 2018), and in this study social enterprise staff and other frontline and strategic stakeholders highlighted the impact of fiscal constraints on the social care market. However, one local authority used the opportunity presented by the new policy to reduce its role in the market, freeing organisations to develop activities which responded to local needs. More commonly, local authorities remained faithful to traditional types of social care services like homecare, manifesting their change-resistant path dependence (Pierson, 2000). This is consistent with previous evaluation evidence that concluded changing from state provision to individual budgets through the SDS system was generating less choice and control amongst some budget

558 holders (Audit Scotland, 2017a). Drawing on a lens of Historical Institutionalism helps us to
559 understand how local authorities may be slow to change and adapt to new circumstances and
560 policies even under favourable conditions, and instead remain biased towards 'past trajectories'
561 (Thelen, 1999).

562 The national procurement framework is still under development but offers the potential to remove
563 some barriers to social enterprises' involvement in the social care market through its nationalising of
564 the approved provider process. Should this happen, social enterprise could play an important role in
565 transforming the social care market through providing services that address local needs, developing
566 social innovations, and harnessing the power of local volunteers. The introduction of the national
567 procurement framework could act as a systemic 'shock' to current local authority processes and
568 circumvent the ordinarily slow pace of institutional change identified by Historical Institutionalism
569 theory (Cappocia, 2016).

570 This study extends theoretical understandings of how social innovation emerges in the public domain
571 and the interplay of public institutions, social enterprise and quasi-markets like Scotland's social care
572 sector (Vickers et al, 2017). The findings demonstrate that where there are already existing gaps in
573 social care provision, then a change in policy, in this case the Social Care Act, can combine with other
574 contextual factors i.e. austerity and increasing demand, to generate an internal shift in a local
575 authority's historic approach to the provision of social care. This was particularly well-evidenced in
576 one region where a social enterprise worked closely with their local authority to co-produce a new
577 social care quasi-market. The local authority supported social enterprise and small providers as the
578 solution to pre-existing need in the area following proactive campaigning by local social enterprises
579 at a time when social care needs in that area could no longer be met by the local authority, and the
580 local authority was aware some communities in the region were without any social care provision.
581 The introduction of the Social Care Act presented a timely opportunity to interpret the policy and
582 use its associated budgetary innovation (SDS) to achieve better social care coverage. The absence of
583 any competitive market therefore created a vacuum which became a landscape of opportunity.

584 Contextual factors i.e. policy change, new budgetary systems, fiscal constraints, emerging social
585 enterprise advocates, the absence of a competitive market) combined to drive a shift in the local
586 authority's procurement and approval process, resulting in the emergence of socially innovative
587 social enterprise structures, activities, and social care provision.

588 In other regions, however, social enterprises reported that they did not have the relationship with
589 their local authority to enable them to work together to co-produce the local social care quasi-
590 market. This was regardless of the success or failure of social enterprise providers operating within
591 those regions, as demonstrated by the very successful social enterprise that was at risk of failing
592 through overwhelming demand.

593 This study found evidence that some staff in local authorities and the public sector viewed social
594 enterprises as 'providers of last resort'. This misperception supports uneven competition in the
595 marketplace, enabling the private sector to continue to 'cream' off easier and hence less costly
596 clients to maximise their profits whilst more difficult clients were 'parked' (Carter and Whitworth,
597 2015). Due to the commitment to the organisation's social mission, social enterprises in this study
598 reported they could not refuse even the most difficult clients. In this study, these less 'attractive'
599 clients were those that cost the organisation more due to travel and logistics, and clients who had
600 complex needs (e.g. addiction issues; chaotic lives). This phenomenon of 'creaming' has long been
601 evidenced across a number of quasi-markets, from prisons (e.g. Johnston, 1990) to welfare-to-work
602 (e.g. Carter and Whitworth, 2015). In social care, the refusal of some profit-driven private sector
603 organisations to refuse services to some clients, despite being contracted to do so, raises pressing
604 questions about the governance of the social care quasi-markets in Scotland, and presents a valid
605 concern about human rights to policymakers.

606 The stakeholders' perception that local authorities' view social enterprises as 'providers of last
607 resort' requires further exploration, as does the 'scapegoating' of social enterprise for wider market
608 failures. Poor relationships and lack of co-operation between social enterprises and their local

authorities was evident in some regions, allowing scapegoating to flourish. Co-operation between local authorities and social enterprise is essential to transforming and innovating the social care market. National and international policymakers must therefore recognise and support such co-operation while being mindful of the wider context surrounding policy implementation, and ensure they surmount legislative barriers within any involved institutions and departments before the policy is introduced.

6. Conclusion

This study found that the Scottish personalised social care market is 'messy', and a lack of consistent approaches to the implementation of the Social Care Act was evident across Scottish regions. Local authorities were found to largely constrain their social care markets through controlling the choices individuals could make over their care, including the types of activities they could purchase and the types of organisations they could purchase them from. Such constraint was found to be an artefact of both existing procurement legislation and internal local authority change-resistance. This resistance to change also hampered social innovation and the growth of small, new social enterprise entrants. While the timing of the introduction of the Social Care Act and the pressures of austerity did little to support local authorities to consistently implement the policy, it could not explain local authorities' failure to recognise the added value and expertise social enterprises could bring to the social care sector The findings presented here are of relevance to policymakers nationally and internationally, as they offer an increased understanding of emerging social care markets arising from policy-shifts towards empowering social care users to self-direct their care.

This study is limited to the views of a purposively selected group of people currently engaged in social care in Scotland who have an interest in social enterprise, itself a contested concept (Teasdale, 2012). A larger systematic investigation with a broader range of stakeholders is urgently needed to give greater insight into the range of issues presented here, including the ongoing lack of social care

provision in some areas; the local authority governance of social care quasi-markets; the relationship between local authorities and the social enterprise sector; the lack of personal choice over care; and the constraint on social innovation through an overdependence on historic processes and traditional care activities.

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Table 1: Sample description by pseudonym

	Pseudonym	Role/Service	Service delivered/central organisational activity	Organisation	Sector	Area
1	BHA	Service delivery manager	Homecare services (managed by BB)	Social care provider	Social Enterprise	Urban (West Central Scotland)
2	LCA	Service delivery manager	Homecare services (managed by LCB)	Social care provider	Social Enterprise	Urban (East Central Scotland)
3	NN	Chief Executive Officer (CEO)	Homecare	Social care provider	Social Enterprise	Rural (North West Scotland)
4	PA	Chief Executive Officer (CEO)	Older people alternative therapy	Alternative therapy provider	Social Enterprise	Urban (West Central Scotland)
5	BB	Social enterprise manager	Registered & homecare services (manages BHA)	Social care provider	Social Enterprise	Urban(West Central Scotland)
6	LCB	Social enterprise manager	Homecare services (manages LCA)	Social care provider	Social Enterprise	Urban (East Central Scotland)
7	AZ	Chief Executive Officer (CEO)	Support and training	Social care provider	Social Enterprise	Rural (North West Scotland)
8	CO	Social enterprise manager	Multiple services including care, befriending and alternative therapies	Social care provider	Social Enterprise	Rural (Northern Scotland)
9	AD	Social enterprise SDS Lead	Personal SDS advocacy services	SDS advocacy service provider	Social Enterprise (Policy)	Rural/Urban (N.E. Scotland)
10	CL	Community Links worker	Medical services & care in the community outreach	NHS/Social Work	Public (Health)	Urban (West Central Scotland)
11	AA	Rural regional social enterprise network manager	Social enterprise support	Regional social enterprise network	Social enterprise (Network)	Rural (Northern Scotland)
12	HP	Regional older people's network advocate	Regional social care advocacy	Regional older people's network	Third (Advocacy)	Rural/Urban (Northern Scotland)
13	HC	Regional carers' network advocate & SE development manager	Personal and regional carers support	Regional disability and social care network	Social Enterprise	Rural/Urban (Northern Scotland)
14	AP	Regional SDS network co-ordinator	Health and social care partnership	Regional network	Public/Third sector partnership	Rural/Urban (N.E. Scotland)
15	GC	National social enterprise health and social care officer	Health and social care sector social enterprise advocacy and support	National social enterprise network	Social enterprise (Network)	National
16	GV	National Procurement Manager	Governance of SDS procurement	National public sector procurement	Public (Governance)	National
17	SW	Social worker; social work Union representative	Social worker; advocacy & support	National social worker network	Public (Social Work)	National
18	DR	National Disability Rights Policy Officer	Disability rights advocacy and support	National disability rights network	Third Sector (Advocacy)	National
19	DQ	Chair, National Advocacy Charity	Disability rights advocacy and support	National disability rights network	Third Sector (Advocacy)	National