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From charity to social enterprise: the marketization of social care

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Structured Abstract:

Title: From Charity to Social Enterprise: The Marketization of Social Care

• Purpose: In Scotland the Self-Directed Support (SDS) legislation is a catch-all payment system which brings challenges to local authorities, service delivery organisations, and the service users it is intended to empower. Set against a backdrop of cuts to local authorities and third sector funding, this policy presents third sector organisations with both the opportunities and challenges of commercialising their activities to become more sustainable. This paper provides evidence of the challenges faced one charity as engages in a process of hybridity to accommodate changes in its funding due to the introduction of SDS.
• Design/methodology/approach: This qualitative case study of one charity presents the experiences of a purposive sample of managers, staff and parents advocating for their children. The challenges of gathering data and giving a voice to parents advocating for children with complex needs are discussed.
• Research limitations/implications (if applicable): This study used a small purposive sample of individuals who were prepared to talk about the challenges of SDS in one national Scottish charity.
• Practical implications (if applicable): Organically arising barriers to organisational transition from charity to social enterprise are presented, as staff and caregivers react to the prospect of SDS uptake affecting their organisation. Proactive attempts to embrace a hybrid approach by the organisation, are analysed.
• Social implications (if applicable): Understanding how social care organisations and clients are reacting to the implementation of individual payments is crucial as the sector faces very real prospects of established organisations failing and the market becoming dominated by fewer providers delivering cheaper, lower quality social care. Therefore a policy based on choice for the consumer risks removing choice through a loss of appropriate services in the marketplace, leaving vulnerable populations at risk.
• Originality/value: This paper makes a unique contribution to the fields of social enterprise and social care as no other research has been done exploring the transition to hybridity of charities serving children with complex needs in anticipation of SDS creating an open market. The paper further provides evidence of underlying issues which need to be addressed if SDS is to become a successful policy transforming vulnerable individuals' lives. The paper further identifies that a specific challenge facing hybrid organisations, not articulated in the current literature, is the need to maintain the support of existing clients through the transformation of the organisation.

1. Introduction

The business model of social enterprise i.e. a social purpose-driven organisation that trades goods and services commercially and reinvests any profit, is regarded politically as an attractive economic solution to delivering public services, particularly in health and social care (Mazzei & Roy 2017; Hazenberg & Hall, 2016; Roy *et al.,* 2016; Roy *et al.,* 2013). Scotland has an active social enterprise sector (Coburn, 2015), with an engaged political will to support, invest in and grow the sector (Mazzei & Roy, 2017) and now has its own 10-year Government-led Social Enterprise Strategy (Scottish Government, 2016a). This support has not emerged organically based on evidence of effectiveness from the sector. Instead, just as the efficiency drive of New Public Management was pursued at the expense of other classic values like quality and resilience (Jørgensen & Anderson, 2011), the political pursuit of neoliberalist shrinking of the state through austerity measures adopted by the UK Government has facilitated the marketization of social care. The epitome of this shift is presented in the evolution of the personalisation agenda from disability activists demanding choice and control in the 1970's through to today, where policy legislates choice and control through devolving an individual's budget, thus facilitating a commercial market for health and social care delivery (Williams-Findlay, 2015; Boxall *et al.,* 2009; Roulstone & Morgan, 2009). Social enterprise's involvement as a political tool and commercial model for this shift from state provision to third sector delivery has been described as the *social enterprization* of welfare systems (Sepulveda, 2015). Exploration of the marketization of welfare is not new, however, and Self-Directed Support (SDS) in Scotland offers just one current example of its manifestation.

Whilst Scotland has secured control over some policy decisions through devolution, it is still dependent on Westminster for much of its budget. Scotland is facing a real term budget reduction of 12.5% by 2020 (Scottish Government, 2015). The Scottish government, similar to other governments across Europe, has been seeking ways to deliver essential services at a reduced cost as a result. In social care, the personalisation agenda has provided an opportunity to both satisfy the demands for more choice and control by the disabled community and cut state costs, both through reducing state-run services and through cutting the amount of money which might be spent on each individual case.

The political support for SDS policy has become synonymous with the marketization of care as clients of previously state-provided care now find themselves as individual consumers who must make decisions about what care they require, and who they purchase that care from. In response, some third sector organisations decided that to become sustainable they must 're-invent' themselves, and shifted their focus on to how they deliver their service. Increasing commercial activities presented one solution, the result of which would evolve the third sector organisation into a social enterprise.

This paper provides an analysis of one such organisation as it begins its transition into greater hybridity whilst still delivering its service to children with physical and learning difficulties. This transition was deemed essential by the charity's management as the organisation faced an open and competitive environment for services which it previously delivered almost entirely through more secure local authority 'block contracts' i.e. 'a payment made to a provider to supply a specific, usually broadly-defined, service' (British Medical Association, 2015, p.2). Block contract payments are normally annual but are independent of client number or volume of activity undertaken (British Medical Association, 2015).

It is a debatable point whether SDS implementation provides an entrepreneurial opportunity for such organisations to become more sustainable, or forces entrepreneurialism upon these third sector organisations as block contracts are increasingly cut in the social care sector. The charity researched here

has a high price point due to fixed costs, including training staff and professional registration, and faces future competition from potential new entrants to the market such as already-trained individuals operating as sole traders.

This paper proceeds with a literature review of SDS and its introduction in Scotland. It then explores theoretical underpinnings of this policy and how the policy creates new opportunities for increased marketization. To maximize these opportunities third sector organisations may have to transform themselves, a process which has become known as hybridity. This academic literature is considered in light of evidence from our investigative case study before conclusions are discussed.

2. Literature review

The personalisation agenda has been viewed as neoliberalist policy which opens the market to competition by reducing the role of the state in social care provision while exploiting that as an opportunity to cut budgets (e.g. Roulstone & Morgan, 2009; Featherstone *et al.,* 2012). This literature review presents the development of the personalisation agenda in the UK, before considering the discourse of neoliberalism and how terms like neoliberalism and austerity draw critical focus away from the issues around the poor implementation of policies in social work (e.g. Duffy, 2010). The review then proceeds to explore the organisational response to this 'new' situation through the lens of hybridity.

2.1 The development of personalisation in the UK & Scotland
Personalisation policy in the UK began with the Community Care (Direct Payments) Act in 1996. In Scotland the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 promotes four options for SDS[1], and since April 2014 requires new cases applying for adult or child social care to be offered opportunities for personalising of their care. In England, SDS is an umbrella term within the personalisation agenda which includes personal budgets; individual budgets; direct payments and personal health budgets (In Control, 2015). Figures monitoring SDS adoption amongst groups and services can only be estimated in some statistical outputs in Scotland, as some local authorities are still piloting Option 2 and differing interpretations of Option 3 exist across regions (Scottish Government, 2016b).

Personalisation policy is variously perceived as either responding to or exploiting the call from disability activists for choice and control over decisions about their own lives (Williams-Findlay, 2015; Boxall *et al.,* 2009; Roulstone & Morgan, 2009; Ferguson, 2007). Personalisation's aim of empowerment is captured in its lesser known name, 'self-determination' (Wehmeyer & Abery, 2013; Algozzine *et al.,* 2001). Yet in reality this empowerment is limited by legislation which allows the local authority to police personal expenditure, including the right to refuse choices made by the individual, leaving the market and the individual with little more control or power than under the old system (Kendall & Cameron, 2014). In the UK, the uptake of direct payments has been low amongst people with learning disabilities since its inception in the 1990's, possibly because of their perceived lack of capacity to consent (Boxall *et al.,* 2009). Further, as vulnerable groups are often overlooked in policy development, wider uptake might also be compromised by its lack of suitability (Milne *et al.,* 2007; Hardill & Dwyer, 2011).

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[1] There are 4 options available in Scotland: 1) the individual takes a direct payment; 2) The individual decides the support organisation they want and the local council arranges it; 3) The local council discusses the individual's needs with them, then arranges the support; and 4) the individual uses a mix of these other 3 methods in the support choices (Scottish Government, 2013)

Audit Scotland reported that despite over £42million being spent between 2011/12 and 2014/15 to assist the implementation of the policy, local authorities still had "a substantial amount of work to do to fully implement SDS." (Audit Scotland, 2014, p.7). Meanwhile local authority budgets in Scotland have been cut by 8.5% in real terms between 2010/11 and 2013/14 (Audit Scotland, 2015). Councils are expected to fund the changes required to implement SDS from within these tightened budgets, yet evidence suggests that personal budgets do not create better outcomes on the same or lower budgets, but instead 'where better outcomes do occur, better funding levels are a factor' (Slasberg *et al.,* 2012a, p1033).

Caregivers and guardians of children with complex needs entering the system post-April 2014 must be offered the choice of a SDS budget, and while there is some evidence suggesting this has led to some increase in uptake, monitoring and reporting issues mean that these figures include estimates and must be viewed with caution (Scottish Government, 2016b). Further, with particular reference to our case study, spending on children with disabilities in Scotland is 'almost impossible to identify' (Children in Scotland, 2013 p16), therefore for this vulnerable group quantifying any savings may prove impossible.

It has been shown that the bureaucratisation around the implementation of SDS has had a substantial cost in efficiency within local authorities, and that the burden of administrating the policy locally does not diminish as advocates had hypothesised (Slasberg *et al.,* 2012b). However there is still optimism that SDS will be less resource intensive as it becomes mainstreamed and the necessary systems for more efficient processing are put in place (Hunter *et al.,* 2012; Manthorpe *et al.,* 2011).

Scotland rolled out SDS later than England, and it has been argued that Scotland has failed to "effectively apply policy lessons that led to improved outcomes for social care users from England" (Rummery & McAngus, 2015, p237). This may in part explain why Scotland lags behind England in uptake of individual budgets (Payne, 2012). Another explanation may lie within Scotland's traditional ideological opposition to anything perceived as privatisation (Rummery & McAngus, 2015), suggesting the lack of uptake of SDS could be a result of *passive resistance* to the policy by some stakeholders.

The Scottish Government trumpeted the control clients would have through SDS budgets, claiming that "through a co-production approach to agreeing individual outcomes, options are considered for ways in which *available resources* can be used so people can have greater levels of control over how their support needs are met, and by whom" (Scottish Government & Cosla, 2010, p.229; *emphasis ours*). Yet *available resources* are in decline (Audit Scotland, 2015), so individuals could be left to manage a reduced budget to purchase the same level of necessary care and support. It has also been argued that SDS restricts choice by undermining collective provision and hence risking the loss of local services (Roulstone & Morgan, 2009), and that the consequence of losing these local services is a reduction in the social inclusion of vulnerable groups (Kendall & Cameron, 2014). Nevertheless, SDS is now policy within both Scotland and England, creating a market for the delivery of social care services and driving an evolution within organisations that previously delivered services under block contracts.

2.2 Neoliberalism - a contested concept
The marketization of social care through personalisation has been widely linked to the neoliberal agenda behind the discourse of austerity (Sepulveda, 2015; Featherstone *et al.,* 2012). However this marketization carries the risk of "additional fragmentation and short-cuts in welfare provision and a further transfer of responsibilities (but not resources)…the morality of…(which)…is highly questionable" (Sepulveda, 2015, p.857). Whilst it is acknowledged that SDS is being introduced as a neoliberalist austerity-driven macroeconomic policy, the precise nature of neoliberalism is not always clearly defined. Yet the use of the

neo-liberalist attribution is growing rapidly across the social science literature despite its definition being "…intellectually unsustainable, particularly where it functions as an all-purpose denunciatory category or where it is simply invoked as 'the way things are' (Flew, 2014, p.51). This failure to adequately define neoliberalism whilst applying it to a large variety of studies across the social sciences leaves it as little more than "a set of polemic generalities…dispensing with nuanced descriptive investigations" (Ashbee, 2015, p.12).

Klein (2007) argues that the definition of the neo-liberal concept depends on the context in which it is used. Defined as a form of governmentality (Springer, 2012; Dey, 2014), it can helpfully frame the shift of responsibility from governing organisations, institutions and agencies to the individual and individual communities (e.g. Power, 2014; Ferguson, 2012). Dey (2014) suggests that neoliberalistic narratives are moving austerity from an economic problem to a social issue, and this is evidenced within the personalisation agenda through the shift of decision-making to the individual and their consequential demand for a more flexible, less institutionalised localised workforce to deliver their care. The impacts of this shift from the economic problem to a social issue have been described as part of *project austerity localism* (Featherstone *et al.,* 2012), i.e. the creation of tension between the state and local authorities to facilitate cuts in services through supposedly devolving power, which has itself been described as "the latest mutation of neoliberalism" (Featherstone *et al.,* 2012, p.178). This mutation explains in part the suggestion that "the distinctiveness and legitimacy of the sector are diminished when VCSOs choose to (or are constrained to) deliver the state agenda" (Baines *et al*., 2011, p. 338).

2.3 Hybridity
Social enterprise exploits the markets in a similar way as commercial organisations, but trades for explicitly social purposes rather than shareholder profit maximisation (Mazzei & Roy, 2017; Ridey-Duff and Bull, 2011). The implementation of SDS presents an opportunity to witness organisational transition from social-mission-driven non-profit-making charities to social enterprises, where commercial sustainability can balance and subsidise the philanthropic aspects of the organisation, creating a 'hybrid' (Seanor *et al.,* 2013; Dees, 1998).

Although this linear model of a social enterprise spectrum from purely philanthropic to purely commercial is a gross over-simplification (Seanor *et al.,* 2013), it is a useful conception nonetheless as it presents the tension between delivering a social mission and sustaining the organisation. Therefore as social hardship increases but available resource lessens, entrepreneurial behaviour is being forced in organisations whose social mission is perhaps contrary to the classic entrepreneurial drive to exploit the value in goods or services by selling them for greater than their cost (Shane & Venkataraman, 2000). There is a danger that this transition could lead to 'destructive entrepreneurial activity' (Baumol, 1996) as commercialisation leads to organisational cost cutting and quality reduction. Those who endeavour to maintain a quality service may find themselves becoming financially unsustainable, leading to the loss of service provision by such organisations.

The organisation in this paper is undoubtedly subject to 'hybridiality'. Whether all organisations can be described as 'hybrid' (Bransden *et al*., 2005) is a debateable point beyond the scope of this paper. Suffice to say that social enterprises/third sector organisations that become sustainable have demonstrated their capacity to change and adapt. Doherty *et al.* (2014) note the distinction between 'organic hybrids' i.e. social enterprises that have evolved from other organisational forms such as voluntary organisations, and 'enacted hybrids' i.e. those that have been established as social enterprises from the outset. The organisation within this paper is a potential 'organic hybrid'.

For third sector organisations delivering services in health and social care, the transition to a more dominant economic hybridity will inevitably lead to increased challenges (Doherty *et al.,* 2014). These challenges are evidenced in a number of different ways, including the 'double' or 'triple' bottom line that the social enterprise faces as a result of its social mission i.e. the social enterprise seeks to achieve its social goal(s) whilst at the same time engaging in market based activities in order to make a profit (Zahra *et al.,* 2009). This duality can lead to restrictions in the pursuit of profit through operational compromises by constraining both potential opportunities and profit distribution within the organisation, and through its focus on the social objectives it is pursuing (Austin *et al.,* 2006). Therefore the ability to maintain a working alignment between such conflicting goals will enhance the ability of the social enterprise to achieve sustainability (Dacin *et al.,* 2011).

A further challenge for organisations displaying the characteristics of hybridity is the management of the workforce, including volunteers and sessional workers. Due to the restricted nature of the commercialisation process within social enterprises outlined earlier, social enterprises tend to pay wages and salaries below the market rate (Austin *et al.,* 2006), and rely on salaries to be compensated for by 'psychic income' (de Ruyter and Whittam 2012) If there is a change in emphasis in the social mission of the organisation then the 'psychic income' may become 'devalued', leading to disenchantment and reducing motivation. This could lead to an exit of volunteers and sessional employees in particular, an important issue if the social enterprise organisation is reliant on volunteers and sessional employees to fill skills gaps (Salamon *et al.,* 2003). Whilst it might be more difficult for paid employees to exit due to finding alternative suitable employment, demotivated staff may lead to poorer productivity and an expression of dissatisfaction through voice (Hirschman 1970). Further, a change in emphasis of the strategic direction of the social enterprise organisation may result in the recruitment of more specialist staff, particularly to leadership positions. If these new recruits are from a private sector background it might pose a challenge for the dominant culture of the social enterprise organisation (Battliana and Dorado, 2010)

2.4 Clients Demands- impact on workforce

Despite already poor wages in the sector, there is still tension about the affordability of social care (Power, 2014). It has been suggested by policy-makers in Canada, the USA and England that costs could be reduced in part by social care becoming even less professionalised and training becoming even more informal (Power, 2014). Some evidence of this de-skilling as already emerged (Cunningham, 2016). Therefore although the 'freeing' of the social care market under the neoliberal agenda seemingly intends to increases competition to better serve the client community, costs including deskilling and quality reduction are already emerging (Power, 2014). Further, demands clients-as-consumers might make on services, such as an increase in flexible care, could increase the precarious work conditions that care professionals currently experience, including the increased use of zero hours contracts and pay below public sector levels (Power, 2014).

The call by policymakers to manage the expectations of those with disabilities and their families, "particularly around the extent to which they can set the pace of change" (Power, 2014, p.843) directly contradicts the individual choice and control the policy is meant to enshrine. Therefore while the policy might increase zero hours contracts and reduce sector wages by reducing the formal skills and training required from staff, it also does not serve the client or their caregivers with the choice and control it intended. The following case study examines this paradox and highlights an under-recognised aspect of hybridity in the current literature, namely ensuring the continued loyalty of existing clients (customers) as the organisation increases its commercial activities and moves away from a charity ethos.

3. Methodology and data collection

The research team were given access to the managers, staff and clients of a national Scottish charity over a four-month period. Amongst a range of services provided by the charity across Scotland, it delivers residential and respite services to children with physical and learning disabilities in three Scottish rural local authorities. This care was at the time of data collection delivered almost entirely under a block contract from the Local Authority. The organisation then liaised with caregivers to plan their care timetable for the year, including respite.

This study aimed to gain greater insight into the implementation of SDS, particularly how it was impacting on the Scottish organisation, making it suitable for a case study approach (Yin, 2014). The case study method facilitates an iterative research process which allowed the research team to reflect upon findings as the research progressed. The researchers used 'guided conversations' (Rubin and Rubin, 2005), a method previously used in research on choice-making in the context of people with learning disabilities (Stalker, 1998). This semi-structured approach allowed the interviewer to probe unpredicted emergent themes during their conversation with each stakeholder, whilst still guiding the interviews so they remained on-topic through the use of two pre-determined dimensions, specifically 1) prompts to encourage individuals to convey their experience of the charity, and 2) prompts to elicit their experience or anticipation of the impact of SDS.

Work by Booth (1996) on self-advocacy amongst adults with learning disabilities highlights the need for ethical representation of the view of the participant with learning disabilities. As this study focused on services delivered to disabled children, the research fieldwork with the organisations clients was undertaken with parents, who would ultimately be responsible for their children's SDS budget and service choices. To ensure ethical accountability and representativeness, (Booth, 1996; Stalker, 1998) care was taken in this study to reflect upon the narratives of those representing the voice of the individual, both by the research team about their own influence during data collection, analysis, and reporting, and also, again by the research team, about the account given by the parents of their perception of the experience of the individuals.

Recruiting parents to this study was difficult due to the sensitive nature of the topic and the already considerable time burdens on both the parents giving care to these children, and the staff who support them. A small purposive sample of four parents was convened, providing an exploratory insight into experiences and views.

This paper draws on further interviews with three Service Managers, the Head of Business Development at the charity, and the Chief Executive of a charity in England whose organisation had already started to experience the implementation of SDS in the care of children with complex needs.

All participants received a pre-prepared outline of the study at the start of the interview to ensure they understood its aims. The interviews were not audio recorded due to the highly sensitive data involved and to protect individual clients' anonymity. Instead full written notes were taken of each interview by a member of the research team. Charity staff and managers consented to being quoted with their job title as an identifier, while the parents were assured of anonymity.

The data was analysed using a constant comparative approach, comparing the initial interviews with those undertaken subsequently (Glaser & Holton, 2007). This approach is borrowed from the early emergence of Grounded Theory (Glaser, 1965), and facilitates an iterative process of reviewing the data whilst it is being collected and comparing it across emerging concepts and themes, whilst also holding it against existing

knowledge and literature. This inductive approach enabled the research team to reflect upon the emerging data at each stage whilst being mindful of existing theory.

4. Emerging themes

This section introduces findings which have arisen because of the proposed changed in strategic direction of the organisation due to the introduction of SDS and are all related to hybridity. The findings are arranged in four sub-sections based on themes that emerged from the qualitative data generated from the interviews: the practical delivery of care; tensions between care and quality, the care workforce, and the parent perspective. Each sub-section uses direct quotes from research participants to highlight key points, apart from the parent's perspective where to preserve anonymity no quotes are used in case these can identify the individual. These key themes are linked back to the relevant literature in the following discussion section

4.1 The practical delivery of care

A key challenge raised by all stakeholders was that of the organisation of care under a SDS model of delivery. For Service Managers, this took the form of concern about the impact on their future organisation of services and staffing. Service Manager B noted the complexity of planning care for children with complex support needs:

"When children are allocated respite, we try to place them with their key worker, staff, manager and other children to suit. For a particularly challenging child we might need a particular manager on shift. It's not just the staff gender that is important, the skills and competences are important too. Sessional staff are brought in based on relationships with children, as and when required….parents may request particular staff and they can't be here all the time." (Service Manager B)

Feedback from parents supported this view. All parents wanted greater flexibility and more hours of care, and they were aware that planning their own budget using SDS might supply that. In general, the Service Managers were positive about the concept of giving parents more control over their child's care. Service Manager B raised concern, however, at how they might manage this:

"I'm not worried that people don't want to use the service, more concerned about how a parent will choose to spend their budget. They might want different hours from the hours we work to, at the moment we have standard pick up and drop off times and a parent might want these times to suit them which would have knock on effects on staff rotas." (Service Manager B)

None of the parents interviewed had direct experience of buying care through direct payments. However, Service Manager C reported that some clients had used direct payments in the past, and that this had presented a considerable logistical challenge due to the rural location:

"In terms of existing direct payments, we had a parent with additional money to spend. They wanted someone to come into the home for an hour in the morning to get the child ready, and an hour later on. There was no-one from (here) who could do those hours, particularly with the travel involved." (Service Manager C)

4.2 Tensions between cost and quality

While being aware of the possibilities of a more personalised service, the parents interviewed expressed several reservations about SDS and its impact. Firstly, their children were settled and well-cared for by the organisation, and they would not consider disrupting that relationship. Secondly, SDS was regarded by the parents as something which could have a negative impact on them by jeopardising the organisation's

sustainability through competition and, if the organisation folded, taking away the high quality care their child currently receives. Thirdly, they saw the introduction of SDS as an attempt to save money by the local authority.

Importantly, parents were found to be aware of existing cost-cutting by their local authority, and its impact on the care provided by the organisation. Service Manager B noted that this was impacting on parents' relationships with the organisation as they saw the service changing in response to financial pressures:

"The financial climate has had an impact on the way parents feel. For example, the service had more money in the past which meant there was more staff to each child." (Service Manager B)

These pressures were echoed by Service Manager A:

"Currently (we) have a big waiting list of 40. We might lose some as a result of SDS but expect to get busier. The residential respite is over-subscribed" (Service Manager A)

However with the sector already undersupplied, SDS provides an opportunity to bring new providers in to ease demand. Evidence from the Chief Executive of an English Charity suggests that this is not happening as quickly as expected:

"The progress on SDS has been slow, we thought we would see a surge in Direct Payments, but this hasn't happened yet." (Chief Executive, English charity)

This leaves organisations in a difficult position as they ready themselves for the increased adoption of SDS. They could potentially reduce their waiting lists by marketing their services as something caregivers could purchase using SDS. However, this would not only promote the SDS system, it would also position the organisation as an economic as opposed to social concern, an issue that the Head of Business Development viewed as problematic:

"There is something distasteful about selling. There's a view that in social care we don't need to do this particularly as we have had contracts… philosophically the organisation wants to grow but don't want to go out selling…." (Head of Business Development)

This challenge to commercialise the service led to tension for the staff. All Service Managers interviewed mentioned 'selling' the services of the organisation and appeared acutely aware that the charity was now being forced into a commercial position. However after reflecting upon this they each mentioned a different organisational strength, including creativity (Service Manager C), quality (Service Manager A), and flexibility (Service Manager B).

Although flexibility of offer can be managed through creativity, fixed costs cannot be avoided by larger organisations such as this, and in the English organisation was already facing challenges, despite describing the charity as already 'on the bottom rung of costs':

"Fixed costs are difficult, as well as central costs such as HR/IT/Payroll which are spread across the organisation. If we bring in less money overall, of course savings will have to be made." (Chief Executive, English Charity).

Organisational challenges of balancing cost and quality in response to this policy are considerable, and the staff in this study demonstrated an awareness of these. Solutions were less clear, particularly as uptake cannot be predicted.

4.3 The care workforce

Fixed costs also include training, particularly where the care is on a one-to-one basis, and staff must have a high level of training and skill. The Head of Business Development at the charity explained that their staff were very well-trained to enable them to deliver a high quality service, but that this training was an expensive fixed cost. The Chief Executive of the English charity also agreed that mandatory staff training was a significant cost for the organisation.

At the time of interviewing, the organisation paid its relief workers the same as permanent staff, a policy which one Service Manager described as 'ridiculous.' She stated they need lower paid workers in the organisation because clients will not pay a high hourly rate for community-based care. She did acknowledge however that all relief staff they employ must have a qualification or be working towards one. Despite these good pay rates, the organisation reported a high turnover of sessional workers.

Service Manager A pointed out that the legal need for organisations providing registered care to pay fees to, and be inspected by, statutory agencies added further fixed costs which sole traders in the same market would not face. This quality control process was described as a 'weakness' in terms of marketing their services competitively:

"(Our) weaknesses include the cost of being registered with the SSSC (Scottish Social Services Counci) and Care Inspectorate which means that (we) can't easily compete with neighbours or similar service providers." (Service Manager A)

Service Manager A stated she was anxious about retaining staff after the full implementation of SDS, noting that parents and children become attached to particular staff members. She advised clients of the risks involved in employing personal assistants:

"Families have approached staff to do Direct Payment work but I point out to them that if it is not through (us) they are on their own with regard to coverage and insurance. So families might then approach us and request that particular worker. Staff prefer the backup of (the charity) and so have shied away from doing independent work." (Service Manager A)

Service Manager B was more explicit, and named a member of staff who at least one family would like as their personal assistant. Speaking of strategically dealing with the potential threat to staff retention, this manager chose to become involved in the direct payments journey with clients:

"Parents may want an individual carer....Staff would be concerned about self-employment but may jump ship due to uncertainty. Job security is a huge issue, but the worst case scenario is that they leave the sector for Tesco. Staff get approached by parents, although I don't encourage it. I offer to help parents find a way to spend direct payments although they are not currently spent with (us)." (Service Manager B)

The experience of the English organisation is similar, with both employer and staff facing challenges:

"In terms of staff leaving, it is clear that the worker develops a relationship with the child, and then when the parent gets direct payments, they hire them directly which can be cheaper. However, they need to look out for maternity leave, insurance, sickness and so on, whereas we would always cover holidays and sickness with another member of staff." (Chief Executive, English Charity)

Organisations currently providing care through block contracts are also in danger of being forced to reduce their terms and conditions for employees, which for some is difficult to reconcile with their social mission: as the following quote makes clear: 'They (the staff) may have chosen to work in a third sector organisation because they want to do good rather than working where profit is king.' (Head of Business Development)

Further challenges to already pressured working terms and conditions in the sector, such as the equality of relief staff pay in the Scottish charity, have impacted the English charity. While they have not had to make redundancies or change terms and conditions for existing staff, they have been forced to increase their use of zero hour contracts for new staff in order to be responsive to need, thus increasing precarious working conditions.

"As an organisation, it is difficult to cope with the uncertainty… we recruit staff on (zero hours contracts) as it puts some of the risk down to them. If people were reliant on work from us, this would be difficult. This hasn't come about from SDS, we already had the practice, but it has escalated. We have not made staff redundant or forced changed terms on staff, we are moving them on to new contracts as they join the organisation." (Chief Executive, English Charity)

Uncertainty can impact on goodwill, as identified by the Head of Business Development, who paid tribute to the commitment of his staff:

"Staff are highly committed, go the extra mile, show determination with challenging behaviour, particularly given the contract uncertainty." (Head of Business Development)

Time will tell if that extra mile can cover the distance between the delivery of quality social care today and the economically-driven service SDS might mandate in future.

4.4 The parental perspective
The parents in this study reported that the staff provided additional and unpaid support to their children and to their wider family unit. While this intangible support is not accounted for anywhere in SDS legislation it is highly valued by parents and is evidence of that 'extra mile' the staff in the organisation are committed to delivering, as described earlier by the Head of Business Development.

However parents did state that there was potential for improvements to the service. All mentioned they would like greater flexibility and more hours from the service, and all appeared aware that SDS might supply that to them. Despite seeing that potential benefit, however, the parents expressed several reservations about SDS and its impact on their lives. Firstly, parents were clear that they would not consider another provider because their children were settled, safe and well-cared for by this organisation, despite the current lack of flexibility.

Secondly, the parents required safe care of their child, regardless of cost, but searching for providers of that safe care was something parents did not have the time nor the qualifications to do. One parent raised concerns about the potentially negative impact of giving parents/caregivers responsibility for finding care, particularly as they already felt under significant pressure due to wider family and caring responsibilities.

Thirdly, the parents were concerned that SDS would result in a reduction in the quality of their child's care, and they noted they had already experienced a tightening of resources including staff reductions by the organisation in this study. Parents stated that they believed that the introduction of SDS was an attempt to save money by the local authority.

Finally, parents expressed concern about the level of influence they would have as a single purchaser in the event that something went wrong, noting that currently the local authority as a block purchaser has the power to insist that any problems are addressed i.e. the loss of that collective power under individual purchasing arrangements could undermine the safety or quality of the services they receive.

5. Discussion

This paper examines the beginning of a transition towards greater hybridity in one national charity in Scotland, and uncovers considerable reluctance to this forced marketization of social care delivery to children with complex needs. This reluctance is evidenced in the comments of staff and parents interviewed in the study. Parents expressed concern that SDS is a way for local authorities to save money, and the slow uptake of SDS suggests that these parents are not alone in their resistance to taking up the SDS option. The parents in this study attributed SDS policy to local authorities instead of the government, supporting Featherstone *et al.'s* (2012) suggestion that a neoliberalist government's approach to devolving power to local authorities can enable the responsibility and accountability to be placed at local level, leaving the national policymakers disassociated from blame and/or failure and allowing them to retain their power.

Parents reported several significant concerns. Firstly, the potential threat of the quality of service being provided to them post-SDS uptake. Secondly, they were concerned about the potential threat to the existence of the organisation in the longer term. They valued the care and quality provided by the charity, but understood that such care and the training behind it was expensive. Challenges of choosing care were perceived to have been passed on from social work to the parents of disabled children regardless of their capacity for decision making, budgeting and management of care for their child. Parents also raised concerns about the risks inherent within selecting and organising their child's care, but evidence suggests that local authorities are now policing payments more to prevent such risks (Kendall & Cameron, 2014). This unseen increase in state involvement, contrary to the policy's intention to reduce costs, highlights a point made by Hood *et al.* (2015) regarding the results of the New Public Management approach being 'premature' with anticipated cost savings being more likely to appear after a 'bedding down period'.

While the central tenets of personalisation are choice and control, the reality of this policy is competition to provide a broader range of services for less cost, creating a tension around the quality of care. Staff concern about the impact of SDS on the organisation's ability to continue offering a unique service while adapting to the new model of funding echoes Baines *et al.* (2011) argument that delivering the state agenda can compromise the distinct identity of organisations in the third sector. It further highlights the challenge of hybridity, namely a shift in the emphasis of the operational goals of the organisation with an increase in the necessity for financial sustainability at the expense of the social mission (Zahra *et al.,*2009).

The emergent tension in this sample around the idea of selling is supported by work on the narratives on social enterprises, particularly that 'some perceived enterprise as undermining the trust and the social nature of services' (Seanor *et al.,* 2013, p. 332) where two 'different hats' must now be worn by the evolving hybrid organisation, a 'social hat' for the delivery of services, and a 'market hat' to do business. Cornforth (2014, p15.) describes this as 'combining different institutional logics' which can create 'tensions and instability', thus suggesting that the process of evolving towards greater sustainability may cause a destabilising of current relationships, strategies and processes.

Managers in the organisation studied here are facing the challenge of direct payments by raising awareness informally amongst clients and employees of the responsibilities and risks of managing their own care, and for some they chose to emphasise that risk to protect their organisational interests. This strategy may preserve their workforce as they are approached by the clients, and hence is a useful tool of resistance to SDS policy implementation. This *passive resistance* by managers to the policy undermines personalisation's principles of choice and control. In this study, managers were concerned about clients getting greater flexibility (control) over when their care was delivered, and about losing staff who may go to work directly for clients. The potential of greater rewards both in terms of salary and 'psychic income' may prove

attractive to the employees of the organisation leading to 'exit' rather than 'voice' (Hirschman 1970), providing a further challenge for managing the hybrid organisation (Austin *et al.*, 2006).

6. Conclusions

The reduction in available financial resources (Scottish Government & Cosla, 2010; Audit Scotland, 2015) puts all affected institutions and organisations under pressure, and this study found the effects of this were seen by both parents and staff in the organisation even before the introduction of SDS. This may have influenced the emergence of what this paper terms *passive resistance* to SDS policy which emerged amongst the stakeholders, including staff and parents. Five reasons for this resistance were found, namely:

1) Protecting the current service and the staff's jobs within it;

2) Concerns over the quality of care of their child;

3) Disagreement with local authority funding cuts;

4) Responsibility on the parents to selecting a safe, quality service for their children themselves;

5) The loss of a collective voice reducing care givers real power over the service provider.

These five reasons can be seen to be emerging due to the increased hybridity of the organisation as it moved from charity status to social enterprise.

The future *social enterprization* (Sepulveda, 2015) of social care in Scotland will result in challenges of hybridity amongst third sector organisations throughout the country, challenges that all such transitions face (Doherty *et al.,* 2014). Further this burden will weigh heavier as SDS uptake is uneven, as will planning staffing, services and systems to cope with future demand while maintaining current delivery of reduced-value block contracts. The ability to maintain the support of current clients through this 'hybridity process' is a challenge not articulated in previous research but evident here, where parents can effectively 'poach' staff from the organisation to become their own employees paid for by SDS.

More evidence of attitudes towards and experiences of SDS should be collected from all users of personal budgets, including from the parents of children with complex conditions, to ensure that vital services remain available to them. The opinions of social workers and other frontline staff should be collected.

In conclusion, when change in legislation gives rise to new openings, whether by necessity or opportunity, there will be a transition within existing third sector organisations as they attempt to exploit it. However, within a more market-based environment there will be winners and losers. In the implementation of SDS budgets for the care of children with complex needs, new challenges are faced by responsive hybrid organisations as they attempt to balance financial acumen with social goals. This paper has evidenced these challenges and by so doing has reinforced and added to our existing knowledge.

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