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Social Care Co-operatives in the UK

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SUMMARY

Exploration of the impact of co-operatives in the adult social care sector is timely. The sector is presented as 'in crisis', and co-operatives are emerging in policy documents and local authority practice as a promising model for improving outcomes for people drawing on care and the care workforce.

This report draws on a mixed-methods study combining a literature review, 12 interviews with sector leaders, three case studies of social care co-operatives, and an online survey. It was commissioned by Co-operatives UK and Cwmpas and prepared by the Centre for Health Services Studies at the University of Kent in partnership with the Centre for Care, IMPACT, and the Centre for Adult Social Care Research (CARE). The paragraph on the next page summarises the key findings and concludes with recommendations for national and local decision-makers.

KEY MESSAGES

WHY SOCIAL CARE CO-OPERATIVES MATTER

The social care sector is often described as being under severe pressure. Social care co-operatives are organisations democratically owned and/or controlled and managed by their members. They are increasingly recognised in policy debates and local authority practice as a means of improving outcomes for people drawing on care and the care workforce. However, they remain unevenly available to people drawing on care across local care markets.

A SECTOR WITH LIMITED SCALE BUT A BROAD AND DIVERSE CARE OFFER

Around 25 social care co-operatives are registered as members of Co-operatives UK and deliver regulated adult social care services. Although this figure is unlikely to capture the full extent of co-operative activity, care co-operatives still represent a very small share of the overall provider market. Despite this limited scale, the seven survey respondents supported over 3,000 people in a single year (50 to 1,200 users per organisation), delivering domiciliary and residential services to older people and adults with physical, learning, and mental health needs.

CO-PRODUCED AND PERSON-CENTRED CARE AS A DEFINING FEATURE OF PROVISION

Care quality was defined not only by task delivery but by enabling people to live the lives they value, with an emphasis on co-production, relationships, and continuity. People drawing on care are involved in shaping services through formal governance structures and tailored participation mechanisms. Appropriate oversight supports user-led co-operatives in maintaining care standards.

COMMITMENT TO WORKERS' MATERIAL WELLBEING AND FAIR EMPLOYMENT PRACTICES

All the organisations paid at or above the Living Wage and supported worker voice, conditions which contribute to staff retention. Survey respondents employed almost 3,000 staff (83% in frontline roles). They reported reduced recruitment pressures, improved gender balance, and success in attracting younger workers.

SOCIAL VALUE THROUGH COMMUNITY SUPPORT, LOCAL REINVESTMENT, AND SERVICE INNOVATION

Co-operatives generate social value by supporting unpaid carers and individuals previously in receipt of care, as well as promoting a range of inclusive activities. In 2024, Cartrefi Cymru delivered the equivalent of £250,000 in unpaid assistance. Social care co-operatives also reinvest locally and contribute to sector innovation through redesigned organisational models and care delivery approaches.

COMMISSIONING PRACTICES ARE KEY ENABLERS OF CO-OPERATIVE CARE AND SECTOR CHALLENGES

Because access relies primarily on local authority and NHS referrals (78% and 14%, respectively), commissioning practices shape market entry and provider diversity. Shifts toward ethical, outcome-focused, and participatory commissioning are therefore promising. Perceptions of co-operatives as equivalent to for-profit providers, alongside limited access to start-up and stabilisation resources, continue to constrain sector development.

RECOMMENDATIONS AND STRATEGIC ACTIONS

Based on these findings, a phased set of short-, medium-, and long-term recommendations and strategic actions is proposed to support the establishment and growth of co-operative approaches to adult social care. These actions and co-operative practice should be integrated with healthcare policies, to support the early identification of needs.

SHORT TERM (1–2 YEARS)

- Encourage local authorities to include specific commissioning criteria relevant to social care co-operatives, and use the Procurement Act's light-touch regime to enable proportionate, flexible procurement;
- Create a national strategic platform for social care co-operatives to align priorities, set milestones, and define success measures, building on existing sector relationships and evidence. In parallel, pilot tailored capacity-building support for existing and emerging social care co-operatives, laying the ground for the subsequent development of regional support hubs.

MEDIUM TERM (3–5 YEARS)

- Pilot regional commissioning partnerships to support collaborative market shaping and entry pathways for co-operatives, modelled on Regional Care Co-operative pilots in children's services;
- Strengthen provider capacity through regional or national care co-operative support hubs and improved access to public and social investment instruments adapted to care co-operatives' operating realities.

LONG TERM (OVER 5 YEARS)

- Complement legal reforms with targeted support and fiscal incentives to create an enabling ecosystem for co-operative care providers;
- Invest in long-term research and evaluation to strengthen the evidence base on outcomes, impact, and system-level change.

EXECUTIVE SUMMARY

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This report draws on a mixed-methods study combining a literature review, 12 interviews with sector leaders, three case studies of social care co-operatives, and an online survey. It was commissioned by Co-operatives UK and Cwmpas and prepared by the Centre for Health Services Studies at the University of Kent in partnership with the Centre for Care, IMPACT, and the Centre for Adult Social Care Research (CARE). In this section we summarise the key findings and concludes with recommendations for national and local decision-makers.

SCALE, REACH AND PROVISION OF SOCIAL CARE CO-OPERATIVES

Around 25 social care co-operatives are currently registered as members of Co-operatives UK. This figure is unlikely to capture the full extent of co-operative activity and represents a very small share of the approximately 19,000 providers operating in England alone. Despite their limited number, the seven co-operatives responding to the survey supported 3,133 people between April 2024 and March 2025, with an average of 448 people per organisation. Provision covered older adults and people with physical, learning, or mental health needs. Services included personal and domiciliary care, support for independent living, and social inclusion activities, alongside complementary provision such as reablement, information and advice, and carer support.

DELIVERING QUALITY AND RELATIONSHIP-FOCUSED CARE

Social care co-operatives adopted a care model focused on quality, relationships, and co-production. Care quality was defined in terms of enabling people to live the lives they value, extending beyond task-based provision to include group and community activities that strengthen social inclusion. This approach was underpinned by a committed workforce and long-standing local presence. These characteristics supported trust and continuity for people drawing on care, their carers, and referral partners. Co-operatives delivered person-centred and flexible support, with choice and control embedded in service design. People drawing on care were involved in shaping or co-producing support through formal governance mechanisms and participation methods adapted to different abilities. These translated organisational values into tangible improvements in lived experience of care and care quality.

WORKFORCE AND EMPLOYMENT CONDITIONS

The size of co-operatives' workforce is indicative of the sector's employment potential. The seven responding co-operatives employed 2,919 staff, with an average workforce of 417, of whom 83 per cent were frontline care workers. Co-operatives paid at or above the National Living Wage and demonstrated a commitment to workers' material wellbeing. Respondents reported that these conditions supported staff retention and reduced recruitment pressures. Co-operatives also reported success in attracting younger workers and improving gender balance. Workers had an active voice in organisational decision-making, and some co-operatives were exploring ways to increase worker autonomy through flexible care delivery approaches.

ADDED SOCIAL VALUE

Care co-operatives supported wider community wellbeing by extending assistance beyond those in receipt of formal care packages. This included the provision of support for unpaid carers and individuals with past care relationships, as well as the organisation of activities open to the wider community. In 2024, Cartrefi Cymru Co-operative estimated that it delivered the equivalent of £250,000 in unpaid assistance, illustrating the scale of this contribution. Social care co-operatives also contributed to local economic activity through reinvestment in nearby businesses, such as sourcing equipment and services locally, and through employment practices that anchored spending locally. Additional value was generated through organisational innovation, including redesigned service models and digital tools developed in co-production with people drawing on care and their carers.

ENABLERS OF SOCIAL CARE CO-OPERATIVES AND PRACTICES FOR SUSTAINABILITY

Organisational, community, and policy-level factors enabled social care co-operatives' development and sustainability. Enablers of co-operative organisations included values-driven cultures, leadership combining entrepreneurial capacity with social purpose, and governance models balancing participation with operational effectiveness. At the community level, collaboration with anchor organisations, championing within local authorities, and trusted local networks supported outreach and engagement. At the policy level, legislative recognition of co-operative models and a more level playing field with commercial providers were a facilitator, although access to finance remained critical. To strengthen financial sustainability, co-operatives pursued collaboration - including forming joint organisations with other co-operatives- diversified their services, generated income by using internal capabilities, and engaged with people self-directing care through Direct Payments.

CHALLENGES FOR ESTABLISHING AND GROWING SOCIAL CARE CO-OPERATIVES

Across the evidence reviewed, social care co-operatives face structural barriers to establishment and growth. The co-operative model remains poorly understood and is frequently assessed as equivalent to for-profit provision in funding and commissioning decisions, while access to finance is insufficient to support start-up, stabilisation, or growth. While in some cases legislative recognition of co-operative models has acted as an enabler, co-operatives continue to operate within a limited legal framework. As access to services relies primarily on local authority and NHS referrals (78% and 14% respectively), commissioning practices are a key driver of market development. Current models concentrate demand among large providers, reward task-based delivery, and undervalue social value. However, shifts toward ethical, outcome-based, participatory, and longer-term commissioning are emerging.

RECOMMENDATIONS AND STRATEGIC ACTIONS

On the basis of the evidence collected, this research proposes a package of short-, medium-, and long-term strategic actions to support the development of co-operatives delivering regulated adult care services. This would expand choice for people drawing on care and help consolidate a promising segment of the UK care economy.

In the short term (1–2 years), priority should be given to improving commissioning practices, strengthening strategic planning, and providing early-stage capacity-building.

Local authorities should be encouraged to **adopt commissioning criteria that better reflect the contribution of social care co-operatives**, with greater emphasis on criteria such as co-design, sustained independent living, and fair work. This would support national objectives on prevention and population health, while enabling more transparent and equitable competition with for-profit providers.

Strategic use of the light-touch regime under the Procurement Act would enable more proportionate and flexible procurement, reduce barriers for co-operative providers, and support place-based care models.

Alongside this, **a national strategic platform for social care co-operation** could help align stakeholders' priorities, translate shared objectives into concrete actions, and define sector-specific success measures. Building on relationships and evidence developed by Co-operatives UK, Cwmpas, and other relevant organisations, the platform would strengthen the sector's visibility and recognition.

Finally, **targeted capacity-building support for existing and emerging social care co-operatives** should be piloted, focusing on governance, regulation, commissioning readiness, workforce conditions, and financial sustainability. This would create the conditions for more structured regional support hubs in the medium term.

Over the medium term (3–5 years), the focus should shift towards creating better defined market-entry routes for social care co-operatives and addressing scale constraints within local care markets.

Piloting commissioning partnerships between neighbouring local authorities could facilitate collaboration on joint market shaping and demand forecasting. By pooling commissioning capacity, these partnerships could create clearer pathways into commissioned local care markets for social care co-operatives and other not-for-profit providers.

In parallel, the **development of regional care co-operative support hubs** would strengthen organisational capacity across the sector. By offering shared administrative, financial, and legal services, alongside incubation and mentoring for new providers, such hubs would lower operating costs and accelerate the formation of new co-operatives. Supported through blended funding models, they would mobilise existing expertise and generate economies of scale for small providers.

Improving access to long-term, mission-aligned capital is also critical in the medium term. This may require adapting existing public impact and social development investment instruments to reflect the operating realities of social care co-operatives. In parallel, there would be scope to strengthen specialist financial institutions serving the co-operative and social economy, for example through co-investment mechanisms.

In the longer term (beyond 5 years), these measures should be complemented by structural reforms aimed at creating an enabling ecosystem for co-operative care. While ongoing legal reforms may **modernise the co-operative framework**, they are unlikely on their own to overcome the structural disadvantages faced by not-for-profit providers. **Targeted tax and financial incentives, alongside recognition of social care co-operatives within sector-relevant legislation and guidance**, would help embed these models more firmly within the care system. Further long-term reforms could include **removing profit extraction in adult social care**, to protect service quality and reduce the distortive effects of extractive practices. Finally, sustained **investment in research and evaluation** would be essential to build robust evidence on the outcomes and impacts of social care co-operatives to care, and to inform future social policy interventions.

Together, these recommendations outline a phased and coherent pathway for supporting social care co-operatives, aligned with national and local health and care priorities and oriented toward prevention, quality, and fairness.

INTRODUCTION

The Centre for Health Services Studies (CHSS) at the University of Kent, in partnership with the Centre for Care (CfC), IMPACT (IMProving Adult Care Together), and the Centre for Adult Social Care Research (CARE) at Cardiff University was commissioned to examine the role and contribution of UK co-operatives delivering regulated adult social care services.

Co-operatives are essentially organisations that are democratically owned and/or controlled by their members. Around 25 registered co-operatives are currently operating in adult social care in the UK, a figure that likely understates the full extent of co-operative activity. Even so, they represent a very small share of provision within a sector that, in England alone, comprises approximately 19,000 providers (Skills for Care, 2024). It has been argued that the co-operative model has potential to expand, address key sector challenges, and broaden choice for people who draw on care (ILO, 2017). International experience reflects this potential, with social care co-operatives recognised as key partners to the delivery of core objectives of the European Care Strategy (CECOP, 2022).

Adult social care across the four UK nations is frequently described as being 'in crisis', due to chronic underfunding (Dodsworth & Oung, 2023a; ADASS, 2025), alongside rising demand from population ageing and increasingly complex care needs (HoCL, 2024; POST, 2024; ADASS, 2025). The sector also faces acute workforce pressures: in England, the adult social care vacancy rate reached 8.3% in 2023/24, nearly three times higher than the wider economy, while staff turnover remained high at 24% (Skills for Care, 2024). Inequities linked to means-testing and concerns about care quality persist within a quasi-market system in which the state funds and purchases most services and independent regulators provide oversight (Dodsworth & Oung, 2023b; Needham et al., 2023). Services are often outsourced through competitive tendering based on the lowest bid, a commissioning model that has contributed to market instability, encouraged contract hand backs, and accelerated the growth of for-profit provision at the expense of non-profit providers. This has reinforced a transactional logic in which cost and contract compliance frequently outweigh care continuity and quality (Bach-Mortensen & Barlow, 2021; Bach-Mortensen et al., 2024).

However, social care should not be viewed only as a set of challenges or a fiscal burden. It is also a strategic area of investment with major implications for individual and collective wellbeing (#SocialCareFuture, 2019). Social care co-operatives can help redesign delivery models and reframe care as a route to a good life. Small-scale studies and documentary evidence suggest promising outcomes (for example, Fisher et al., 2011; Conaty, 2014; Whittam & Talbot, 2014; Brentnall et al., 2016; Brindle; 2016; CC & CAGEnts, 2017, VCC 2021; CCIN, 2022), although there has been no systematic assessment of the role co-operatives play within adult social care, nor of the measures needed to support their development and expansion.

Co-operatives in social care have also been an area of policy focus across the UK. Recent policy developments include the UK Government's commitment to doubling the size of the co-operative and non-financial mutuals sector (HoCL , 2025), the independent review of the Casey Commission on adult social care, and the ambitions set out in the 10-Year Health Plan for England. In Wales, the Social Services and Well-being (Wales) Act 2014 requires local authorities to promote the local development of co-operatives, social enterprises, user-led services and third-sector organisations (Social Care Wales, 2025b). This approach has been further supported by the National Framework for Commissioning, which emphasises social value and outcomes-based commissioning, and by the Health and Social Care (Wales) Act 2025, which aims to eliminate private profit from the care of looked-after children by 2030. In Scotland, the Care Reform (Scotland) Bill 2025 establishes a National Care Service, with potentially transformative implications for service commissioning. Northern Ireland has published a Social Care Workforce Strategy 2025–2035, setting priorities for valuing and developing the social care workforce. These developments make it timely to explore the potential role co-operatives can play in the future of adult social care.

This research examines:

- The contribution co-operatives can make to addressing current challenges in the social care system;
- The barriers and enablers to setting up and developing social care co-operatives, including those arising from commissioning arrangements;
- The approaches and actions that underpin the financial sustainability of this model of care;
- The practice and policy changes needed to facilitate the growth of social care co-operatives.

This report is intended for national and local policymakers, commissioners, care providers including existing co-operatives, people drawing on care and support and their carers. It begins by defining co-operatives - and specifically care co-operatives, before providing an overview of the experiences of UK councils that are exploring co-operative approaches to care delivery. We then present our research approach, comprised of a literature review, semi-structured interviews, case studies and an online survey. The key findings are presented in relation to quality of care, employment conditions and the added value of social care co-operatives, followed by an exploration of the factors that enable and constrain their establishment and operation.

1. SOCIAL CARE CO-OPERATIVES: DEFINITION AND EMERGING LOCAL AUTHORITY PRACTICE

1.1. SOCIAL CARE CO-OPERATIVES: DEFINITION, PRINCIPLES, AND MODELS

A co-operative is an autonomous association of persons who unite voluntarily to meet common economic, social, and cultural needs through a jointly owned and democratically run enterprise (ICA). Box 1 defines social care co-operatives and explains how co-operative values and principles are applied to enhance care quality, the participation of members and non-members, and community benefit.

Box 1: What are social care co-operatives?

Social care co-operatives promote co-operative values of care for others, democracy, equality, equity, self-help, honesty, openness, self-responsibility, solidarity and social responsibility (Conaty, 2014). They apply the seven internationally recognised co-operative principles in ways that directly enhance care quality, accountability, and community benefit:

- **Voluntary and open membership**: Inclusive participation is promoted for workers, service users, family members, and community stakeholders
- **Democratic decision-making**: All stakeholder groups are given a meaningful role in shaping and overseeing services
- **Member economic participation**: Profits are reinvested into service improvements, fair pay, or distributed to members directly involved in the social care co-operative. Investment in co-operatives may take the form of Community Shares
- **Autonomy and independence**: Decision-making control is maintained when working in partnership with other bodies
- **Education, training, and information**: Members are equipped with the skills to make decisions effectively and to deliver high-quality care
- **Co-operation among co-operatives**: Working with other co-operatives enables the sharing of resources and expertise, joint problem-solving, and the ability to scale activities that would be difficult for a single co-operative to deliver alone
- **Concern for community**: Services are designed to build inclusion, community engagement, and local service provision. Economic benefits generated by the co-operative are reinvested within the community, supporting its development

TYPES OF SOCIAL CARE CO-OPERATIVES

Social care co-operatives operate through a range of organisational models (Table 1). The three most referenced are user-led, multi-stakeholder, and worker-led co-operatives (Roulstone & Hwang, 2015; ILO, 2017). The sector is also evolving and recent digitalisation has prompted growing interest in Platform Co-operatives, with examples beginning to appear in social care.

Table 1. Social care co-operatives: organisational models

User-led social care co-operatives	Governed and managed by people drawing on care (often disabled or older adults), these co-operatives place empowerment, autonomy, and choice at the centre. Rooted in the Independent Living Movement and the social model of disability, they focus on removing structural and attitudinal barriers rather than addressing individual deficits. Users typically pool personal budgets or direct payments to employ personal assistants or contract with self-employed support workers. One example is Friends United Together.
Multi-stakeholder co-operative	Brings together diverse member groups, such as people drawing on care, care workers, community members and families, each holding a formal role in governance and decision-making. Stakeholder groups are represented through board seats and voting rights, distributing authority across members to enable democratic governance. Ten such co-operatives are currently members of Co-operatives UK, with employee numbers ranging from 1 to 1,167. Examples include Cartrefi Cymru and Co-operative Care Colne Valley.
Worker-led co-operative	Owned and democratically governed by care workers. They aim to improve working conditions, job security, and the overall care quality. These co-operatives often emerge in response to low pay and insecure contracts in conventional care settings. They offer a model based on solidarity, fair wages, and opportunities for professional growth. In some cases, worker-led co-operatives provide services to people receiving direct payments. Fourteen such co-operatives are currently members of Co-operatives UK, with employee numbers ranging from two to 711. Examples include Be Caring and Leading Lives.
Platforms co-operatives	Digital platforms owned and governed by the individuals who use or provide their services. Platform co-operatives vary in form and membership. Common typologies include multi-stakeholder and producer-led platforms, worker consortia, and data co-operatives. This model has been applied across a range of sectors and was introduced into UK social care by Equal Care Co-op.

THE CO-OPERATIVE ADVANTAGE IN CARE

There is some available evidence which suggests social care co-operatives offer a range of advantages for workers, people drawing on care, and their carers. A literature overview by the International Labour Organization identified several such benefits (ILO, 2017; Box 2). However, the extent of these advantages varies according to co-operative type, ownership structure, and study design.

Box 2: Social Care Co-operatives – Advantages

- **Co-operatives reinvest profits into worker wages and benefits.**
  Care workers employed by co-operatives often receive higher wages than those working for other types of providers. Co-operatives also offer benefits such as health insurance, guaranteed hours, and retirement plans, provisions that are uncommon across much of the care sector. However, other ILO research (2016) indicates that some co-operatives operate under financial constraints, which can limit their capacity to offer higher pay and enhanced benefits.
- **Improved worker retention rates**
  Co-operatives appear to have a positive effect on workers' retention, likely driven by the higher wages and benefits they offer, as well as the sense of loyalty and ownership fostered by the model.
- **Supporting Safer Working Practices in Care Delivery**
  Strengthening workers' collective voice plays an important role in improving working conditions in the care sector. As worker-members, care workers are better positioned to negotiate fairer and safer employment terms, particularly in risky settings such as home-based care. Co-operatives help mitigate risks by introducing safeguards often absent in household workplaces. These include assessing the suitability of homes for care work and requiring transparency about conditions affecting workers' health and safety. Through these practices, co-operatives may address gaps in regulation and oversight across the care chain.
- **Care worker professionalisation and training**
  Co-operatives invest in workers' professional development and training, offering opportunities that span technical caregiving skills, vocational courses, and broader life skills. They also involve members in delivering training through approaches such as group facilitation and peer mentoring. This investment, in turn, strengthens the quality of care provided and enhances wellbeing of the workforce and service users.
- **Preference over public, private and other not-for-profit services**
  People turn to co-operative models when they perceive the quality of co-operative services to be superior to public, conventional private, or other not-for-profit alternatives. Unlike other provider models, co-operatives do not merely deliver services, they co-produce them.
- **Participation and democratic inclusion in co-operative care**
  Co-operatives encourage active participation in care among beneficiaries. Whether through day-service curricula built around collaboration and shared decision-making, or through approaches that engage people in designing their own support plans, co-operatives shift from a task-centred model to one that gives voice to everyone involved. This approach based on inclusion and respect allows them to meet people's physical, mental and social needs.

1.2. POLICY AND PRACTICE CONTEXT. EXAMPLES OF LOCAL AUTHORITIES MOVING TOWARDS CO-OPERATIVE APPROACHES TO CARE DELIVERY

This section outlines the experience of UK councils that have begun to adopt co-operative models of service delivery in regulated adult social care and presents relevant case studies. The first part focuses on councils developing commissioning tools and approaches that support the contribution of co-operative providers. The second examines how Wales has promoted co-operatives and co-operative arrangements. The third explores the theme of co-production and its connection to user-led co-operatives. The final part highlights cases of councils which have supported the creation of employee-driven organisations that follow co-operative principles.

UK LOCAL COUNCILS SUPPORTING CO-OPERATIVE CARE PROVISION

Over the past decade, local councils' interest in co-operative approaches to care delivery has grown steadily. This trend is reflected in the expanding membership of the Co-operative Councils Innovation Network (CCIN), which by July 2024 comprised more than one hundred Full, Associate, and Affiliate Members across the UK, all operating according to values rooted in the co-operative movement. Between May 2014 and April 2025, the CCIN recorded 590 case studies, underpinned by co-operative principles. However, only 16 involved regulated services for older adults, indicating that this area remains largely unexplored. This emerging interest is further visible in the assessment of 15 small, locality-based projects designed to test how co-operative principles can drive innovation in social and health care (CCIC, 2022). The case studies highlighted that councils wishing to embed co-operative principles need commissioning and market-shaping approaches that actively support the growth of community providers, including co-operatives organisations.

Reflecting this approach, several local authorities have adopted ethical commissioning frameworks designed to widen participation among co-operatives and other value-led providers.

- Oldham Council has long positioned itself as a co-operative council. Its commissioning strategy goes beyond contracting adult social care services to co-operatives or mutuals. Working co-operatively means empowering residents, strengthening community capacity, and maximising the value of public and local resources. Oldham's Ethical Care Framework places quality, fairness, and user choice at the centre of home-care commissioning.
- Wigan Council's Ethical Homecare Framework, launched in 2014, replaced price-driven procurement with a values-, place-based commissioning model closely aligned with co-operative principles (Box 3, Appendix 1).
- Birmingham City Council undertook an independent, co-produced review of day opportunities by recruiting and training a lived-experience group (the 'Empowering People Team') to lead engagement and inform the development of a new commissioning strategy.
- Stevenage Borough Council has adopted a Co-operative Procurement Strategy which commits the council to identifying local social enterprises - including mutuals, co-operatives, and community interest companies, and to conducting targeted procurements in line with legislation.
- The London Borough of Lambeth has streamlined pre-qualification and tender processes to reduce barriers for small businesses, social enterprises, and community organisations, including co-operatives.
- North Ayrshire Council has a Sustainable and Ethical Procurement Policy that commits to the Co-operative Party's Modern Slavery Charter, adopted by approximately 120 local authorities.
- Belfast City Council's social value procurement policy explicitly names co-operatives, social enterprises and small businesses as priority suppliers, with the aim of supporting locally reinvesting organisations and inclusive employment outcomes.
- Mid Ulster District Council is developing a community-wealth-building procurement framework that will include co-operatives in its supplier base
- Oxford City Council, and the City of Westminster have developed tools that measure social value in ways more aligned with democratic businesses and the co-operative sector (Box 4, Appendix 1). Additional tools developed by consultancy agencies can be found in this CCIN toolkit (2025).

Several local authorities have also pursued strategies to expand their local co-operative sectors. In some areas, this has formed part of broader regeneration agendas, such as those in Preston and Birmingham (CCIN, 2020b; p. 23). In others, it has been driven by explicit commitments to develop a co-operative economy, as in Manchester and Glasgow (CCIN, 2020b; pp. 26, 27). Yet, relatively few councils have applied these approaches specifically to adult social care provision. Among these are the Royal Borough of Greenwich (2025) and Kirklees Council (CCIN,

2020a). In Greenwich, social care features within a wider strategy to cultivate co-operative business. Similarly, Kirklees is exploring co-operative solutions within adult social care as part of its broader effort to building a local co-operative sector (Boxes 5, 6; Appendix 1).

SUPPORTING CO-OPERATIVES THROUGH SOCIAL POLICIES IN WALES AND LOCAL COUNCILS' PRACTICE

In Wales, social-care policies explicitly support the development of co-operative approaches in delivering regulated adult social-care services. The Social Services and Well-being (Wales) Act 2014 reshaped the organisation of social services across the country. Section 16 places a legal duty on local authorities to promote the development of social enterprises, co-operative models, user-led organisations, and third-sector providers in the delivery of care and support. The aim is to expand the presence of not-for-profit organisations in care provision and to diversify the available options. The Act also requires local authorities to involve people who use care and support services in shaping, designing, and operating them. This approach is intended to strengthen people's voice and control and to ensure that services genuinely reflect their needs (Social Care Wales, 2025b). The wider ambition of the legislation is to ensure that care and support services help people achieve outcomes that support their life quality and daily living. This requires commissioners and providers to embed four core principles into service design and delivery: voice and control; co-production; prevention and early intervention; wellbeing (Social Care Wales, 2025b).

Welsh local authorities are now integrating these principles into commissioning and procurement, including by supporting care co-operatives and other community-based models. Several initiatives and guidance documents on social value in care and support services have been developed. Pilot projects have further explored how commissioning can drive investment in social value–led models (Box 7, Appendix 1).

Section 16 of the Social Services and Well-being Act has encouraged greater engagement with not-for-profit organisations operating on co-operative principles. Several Welsh councils have formed partnerships with third-sector providers to co-design and commission regulated adult care services. For example, Gwynedd Council has a longstanding collaboration with co-operative and community organisations working through Mantell Gwynedd (third sector umbrella organisation) to jointly design, commission, and deliver support.

THE EMERGENCE AND DEVELOPMENT OF USER-LED CO-OPERATIVES IN THE UK

Co-production refers to collaborative working in which people drawing on care, their carers, families and other citizens, share power and participate as equal partners in shaping support (SCIE, 2022). This approach enables everyone who has an interest in a service to be involved with making decisions about a service.

Co-production can be facilitated and strengthened when people drawing on care pool their Individual Service Funds or personal budgets to self-direct their care by purchasing goods or services of mutual benefit. This approach can be used to develop different co-operative models (Glasby & Taylor, 2006):

- Citizen-directed or user-led co-operatives. These are well placed to apply co-production principles, as they are run in a democratic way. One example is Friends United Together (Section2, Case study 3).
- Multi-stakeholder co-operatives involving service users, informal carers, staff, and community organisations. For example, Cartrefi Cymru Co-operative and Northwest Care Co-operative are organisation supporting people who use Direct Payments and personal budgets.
- Employee-owned co-operative homecare providers delivering services to direct payment recipients on a contracted basis. Be Caring, formerly Care and Share Associates (CASA), is one of the UK's largest employee-owned homecare provider. In 2013, the organisation developed the CASA PA Consortium (Roulstone & Hwang, 2013). The project aimed to facilitate the use and pooling of direct payments to sustain group arrangements, develop new services, provide employment assistance for disabled people and personal assistants, and maintain friendship networks.

Evidence shows that these models enable self-directed care by promoting choice and control, building autonomy, strengthening relationships, and reducing reliance on professional support (including for people with fluctuating conditions). When linked with local micro-enterprises, they offer providers new business opportunities, improved cash flow, greater flexibility, and alignment with best practice (IMPACT, 2023).

COUNCILS SUPPORTING EMPLOYEE-DRIVEN CO-OPERATIVE MODELS

Employee ownership refers to an organisational model in which staff hold a meaningful ownership stake, either directly as shareholders or collectively through an employee trust. The employee-owned sector has grown from approximately 150 firms in 2014 to over 2,200 by late 2024 (Care England, 2025).

Three forms of employee-owned organisations can be linked to the co-operative approaches:

- Worker-led co-operatives, where employees own the enterprise and take part in strategic decision-making (Section 1.1);
- Public service and non-economic mutuals, which have moved out of the public sector but continue to deliver public services. They pursue social impact and give employees a significant voice in how the organisation is run. Around 115 mutuals operate in England, over a quarter of them in social care (SEUK, 2018). Although not co-operatives in a legal sense, they share core features such as collective management, shared responsibility and a strong social purpose. Box 8, Appendix 1 illustrates how Rochdale Council contributed to the creation of PossAbilities.
- Micro-providers, namely community-based organisations, usually with no more than five workers (Needham & Carr, 2015). These have a direct role in shaping support, organising their work and co-designing services with people drawing on care. Several UK councils including Somerset, Rotherham, Portsmouth, and Flintshire have developed programmes to support micro-providers (Box 9, Appendix 1).

Because employee-owned organisations are inherently centred on the workforce, they invest in employees' wellbeing, reward and development. This strengthens staff engagement, recruitment and retention, which in turn drives measurable business gains. Across the employee owned sector, productivity is estimated to be 8–12% higher than in non-employee owned firms, a relationship that is particularly impactful in labour-intensive sectors such as social care (Care England, 2025). Realising these benefits requires coordinated support from local authorities, the NHS and central government to raise awareness, enable transitions and position employee ownership as a viable option.

2. RESEARCH APPROACH AND METHODOLOGY

The study was conducted between June and September 2025 and adopted a mixed-methods research design (Appendix 2). Following an initial review of the literature, the research combined semi-structured interviews with 12 key sector leaders and informants (Appendix 2, Table 1), an analysis of three social care co-operative case studies, and an online survey. Data and evidence from these sources have been integrated and triangulated to report against the research questions (Figure 1) .

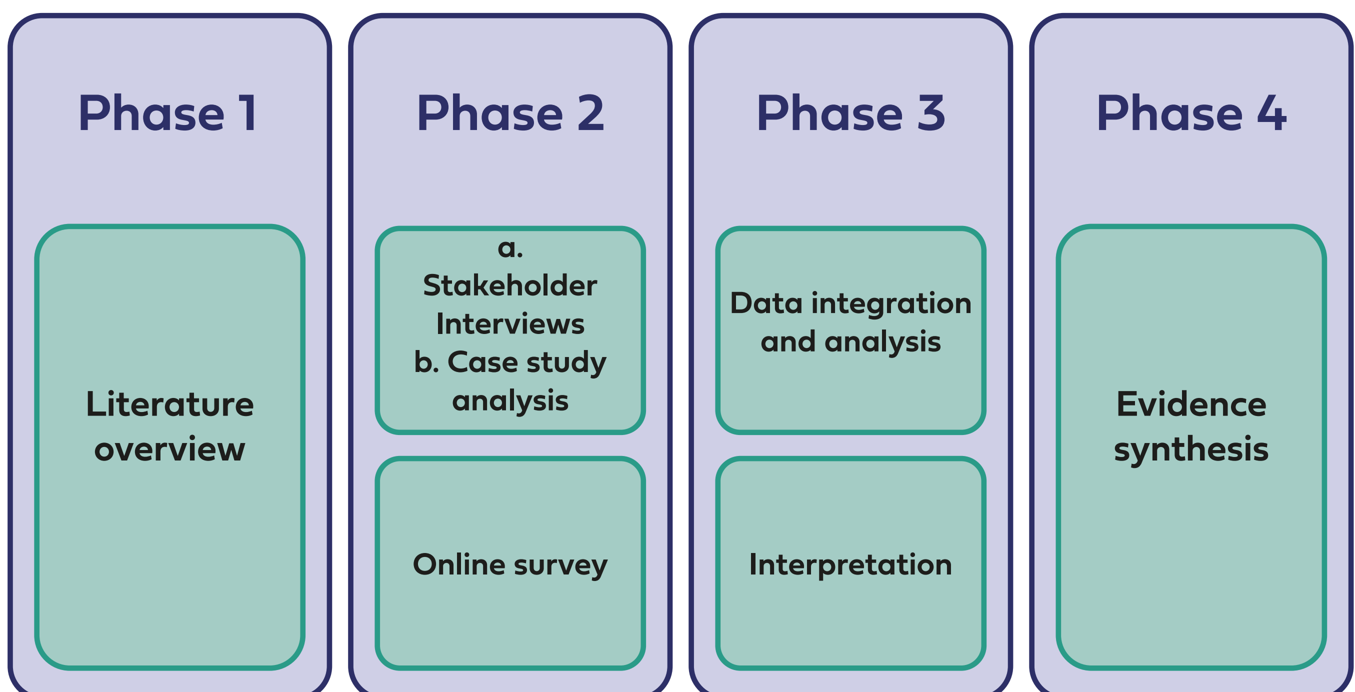


Figure 1. Research process

Data were collected from eight co-operatives: five in England, two in Wales, and one in Scotland. One operated at the national level, two at the regional level, and five at the local level. All had a physical base of operation. Two were multi-stakeholder co-operatives (MSC), two were service-user or user-led, and four were employee-owned.

CASE STUDY 1 - CARTREFI CYMRU CO-OPERATIVE

Cartrefi provides care and support to adults with both physical and learning disabilities with the ethos of promoting independence to enable those who draw on care and support to lead engaged lives in the community. Cartrefi transitioned from a charity provider to multi-stakeholder co-operative in 2017 with the aim of promoting care users voice to enhance person-centred and co-designed approaches to care. Cartrefi employs over one thousand employees and operates across Wales. As an MSC it extends membership rather than ownership to balance the interests of users, employees and the wider community in the governance of the organisation. Key to this approach is the development of Co-operative Forums bringing together the stakeholders to make decisions.

CASE STUDY 2 - EQUAL CARE CO-OP

Equal Care Co-op is a multi-stakeholder, platform co-operative based in Calderdale, West Yorkshire, created to transform how social care is organised, governed, and experienced. Equal Care uses technology and distributed decision-making practices to enable transparency, participation, and collective agency. At the centre of its model are Teams and Circles. Each person receiving support leads their own Team, choosing who participates- care workers, relatives, friends, or volunteers. Circles provide the scaffolding that helps Teams form and develop. This structure redistributes power by enabling those most affected by care decisions to shape them. The co-operative also responds to the wider crisis in social care, including worker shortages and low pay. Equal Care seeks to stabilise the workforce by offering fair pay, team-based support, flexible work organisation, and an environment in which workers can develop skills.

CASE STUDY 3 - FRIENDS UNITED TOGETHER CO-OPERATIVE

The Friends United Together Co-operative are a group of four adult friends with a learning disability who established their own user-led care co-operative in Swansea, South Wales. The process of establishment began in 2019 when their local authority introduced a new approach to commissioning care. In response, the Friends sought advice about how they could better exercise their own voice, choice and control to commission their own care. The outcome was to move to direct payments, but also to pool these payments together to share their care and support when appropriate and to become a co-operative structure.
The Friends established the co-operative in 2022 and became directors of their own company, making decisions for themselves in cooperation with those who support them. Becoming a co-operative has enabled them to become more independent and for their support to flexibly reflect their individual and collective needs.

3. NEEDS ADDRESSED AND CARE QUALITY

KEY FINDINGS

- Co-operatives reached a diverse user base. From April 2024 to March 2025, they supported 3,133 people, with 50 to 1,200 users per organisation and an average of 448.
- Provision covered older adults and people with physical, learning, or mental health needs. Co-operatives primarily offered ongoing personal and domiciliary care, support for independent living, and social inclusion activities. They also offered short-term or complementary services such as reablement, information and advice, and carer support.
- Social care co-operatives provided person-centred support that enables individuals to pursue meaningful goals. Choice and control are core features of user-led co-operatives, supported by oversight and regulation to ensure care standards.
- Co-production was central. People drawing on care were involved in decisions about their support through organisational mechanisms (such as forums and assemblies) and participation methods tailored to members' abilities.
- Quality care was supported by staff commitment, skills, and continuity, as well as by the co-operatives' long-standing presence in their communities.
- Quality care extended beyond formal service provision through participation in group and community activities, which helped foster social inclusion and a sense of belonging.

SERVICE REACH AND SCOPE OF SUPPORT PROVIDED BY SOCIAL CARE CO-OPERATIVES

Social care co-operatives supported a substantial and diverse user base, delivering a wide range of care and support services across multiple areas of need. The following findings are drawn from survey responses completed by seven co-operatives.

- The number of people who accessed the co-operatives' services from April 2024 to March 2025 was 3,133, with users per co-operative ranging from 50 to 1,200 and an average of 448.
- Areas of social care need addressed by the co-operatives included older adults (seven co-operatives), people with physical or functional disabilities (seven), individuals with learning disabilities or neurodiversity (six), and people with mental health conditions (five). One co-operative planned to extend its remit to support young people.
- In terms of type of support provided, co-operatives primarily offered personal care activities, such as assistance with washing, dressing, and getting out of bed, often as part of ongoing domiciliary care (seven co-operatives). All organisations provided support to help people remain active in their communities, including independent living assistance (e.g. help with shopping, cooking, attending appointments) and activities to promote social inclusion. Co-operatives also provided time-limited care packages (five co-operatives), information and advice services (five), and reablement support to help people regain independence (four). Four co-operatives supported unpaid carers, three delivered services in day centres and two in residential or nursing home settings.

FROM PERSON-CENTRED SUPPORT TO CHOICE AND CONTROL: LIVING THE LIFE PEOPLE CHOOSE

Social care co-operatives provided person-centred support flexible and tailored to each individual. In one co-operative, "supporting people to live the life they choose" was the guiding principle for delivering care. The organisation adopted a person-centred approach that enabled people to pursue personal ambitions and meaningful experiences. For example, staff supported people with complex physical or learning disabilities to climb a mountain or celebrate their marriage. Another participant explained that when an early member asked for a personal assistant who was "fun to be around", the organisation adjusted its recruitment approach. It now prioritises staff who combine technical skills with the ability to build meaningful relationships.

Choice and control over the care received were key motivations behind the creation of user-led co-operatives. A personal budget holder explained that she decided to set up a co-operative because it could place people who receive care at the centre of decision-making, make care fairer, and give workers a stronger voice.

Case study example: Friends United Together Co-operative

The principle of user control is most clearly demonstrated by Friends United Together, where a group of people with a learning disability moved from being service recipients to decision-makers by establishing their own organisation. As directors, the Friends meet regularly to assess what works, what does not, and what should change. They hold the contractual relationships and the right to withdraw from providers if needed. Unlike traditional arrangements, where budgets are controlled by local authorities or agencies, the Friends collectively manage their pooled Direct Payments and decide how funds are spent. This autonomy allows them to adapt support to individual and group priorities (staffing, holidays, or redirecting unspent funds) so that money becomes a tool of agency. Having gained control over governance and budget, the group now plans to apply for external grants in its own name. Previously managed through the Community Lives Consortium, this marks a clear step toward greater self-sufficiency and collective empowerment.

VOICE AND CO-PRODUCTION - HAVING A REAL VOICE IN CARE

Co-operative mechanisms of participation and co-production placed the views of people drawing on care and support at the centre of decision-making. Rather than being imposed through external inspection, quality appeared as a cultural practice, sustained through trust relationships and feedback loops between service users, staff, and governance structures.

All the co-operatives had systems for gathering feedback from people drawing on care. These ranged from regular surveys and structured feedback tools to direct involvement in decision-making bodies, with participation methods tailored to members' abilities. In one co-operative, formal meetings were replaced with micro-consultations adapted to neurodivergent and non-verbal members, ensuring genuine participation and avoiding what the respondent called a "paper democracy".

Participants highlighted that in user-led co-operatives, having a real voice in decisions fosters confidence and empowerment. One of them noted that this marks a shift from the paternalistic traditions of the charity sector, where disabled people typically held advisory roles. In contrast, the co-operative structure enables people drawing on care to directly shape how support is designed and experienced.

However, participants also described the challenges facing user-led co-operatives. These include balancing empowerment with the administrative demands of running an organisation, that may become unsustainable without external support. In addition, achieving consensus within small groups is difficult, as different priorities and interpersonal tensions may delay decisions. Continued guidance and oversight are therefore essential to prevent these co-operatives, designed to promote autonomy, from becoming isolated. Several interviewees warned that this risk increases when the model lacks regulation or dedicated resources.

Case study example: Cartrefi Cymru Co-operative

Cartrefi's representative described decision-making mechanisms which ensure meaningful participation for those who wish to engage and fair representation for those who cannot. Users who want to be involved can do so directly, while others are represented by elected peers who speak and vote on their behalf. This safety net ensures that all users' interests are considered, regardless of confidence, time, or personal circumstances. Governance structures such as elected representatives, layered forums, and rotating roles help prevent domination by a few "louder voices" and sustain balanced participation. The co-operative thus embeds shared decision-making and reciprocal oversight among users, workers, and community members. As one member observed, inclusivity itself requires constant reflection: the board was "constantly looking at what matters, taking feedback, learning, and changing." Such ongoing effort yields tangible benefits in inclusivity, accountability, and responsiveness to what people need.

Participants described a range of co-produced, user-led, and user-designed activities. In a multi-stakeholder co-operative, people who use services and their carers took part in a procurement exercise to choose vehicles for the organisation's mobile fleet, testing different models and voting on their preferred option. On another occasion, members of the same co-operative reviewed and voted on a major investment to establish a new community hub. Their contribution also extended to everyday activities: members designed initiatives that reflected their own interests and capacities, including Zumba sessions led by a member with a disability, as well as walking, running, and football groups.

COMMITTED AND SKILLED STAFF AS A FOUNDATION OF QUALITY CARE

Staff commitment, skill and consistency were central to sustaining quality in co-operative care models. One participant noted that their organisation was "absolutely committed to best practice and maintaining, upholding, delivering with very high standards," a claim supported by Care Inspectorate reports.

Staff commitment is reinforced by consistent investment in training and development. Organisations regularly update their training programmes to reflect effective, evidence-based practice. One participant explained that they invest heavily in staff skills. This helps care workers maintain people in a stable and positive state, reducing anxiety and escalation and ensuring care remains safe and responsive. As the participant summed up, **"the quality of care comes from the level of training that we provide"**.

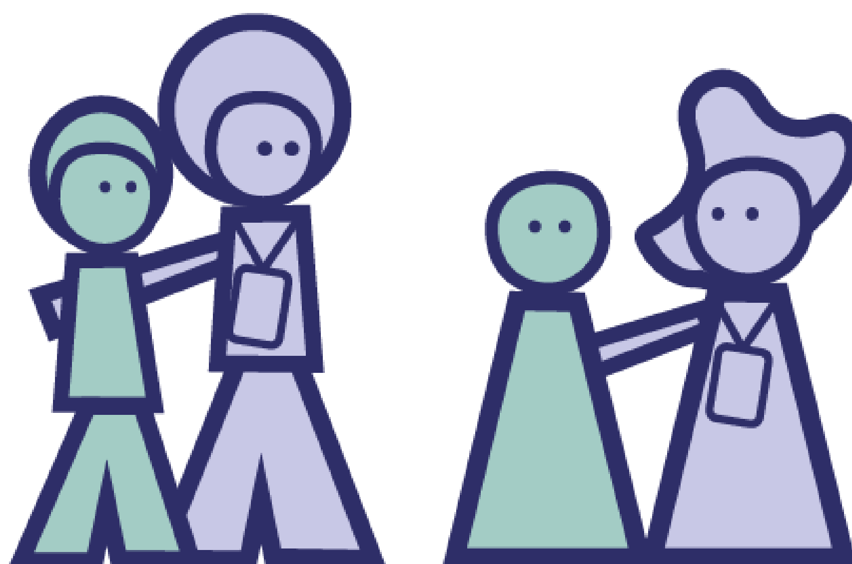
RELIABLE CARE, ROOTED IN COMMUNITIES

Participants reported that co-operative care was defined by its reliability, reflected in stable relationships and a long-term community presence. Many people drawing on care and their carers remained connected to co-operatives even after they no longer received direct services. One participant noted that people receiving support often stayed with the organisation for many years, even when local authorities attempted to reassign services. When such changes occurred, they often worked to keep the co-operative as their provider because they felt invested in the organisation and trusted the quality of care it delivered.

Reliability was closely linked to the co-operatives' local roots. One organisation was described as "**part of the fabric of local health and social care in its communities**" and committed to being "**there for the generations**." Unlike external, for-profit providers, the co-operative based its purpose on permanence and community stewardship, offering reassurance to families and commissioners that it would remain a stable presence

COMMUNITY AND SOCIAL LIFE - BUILDING BELONGING AND SOCIAL CONNECTIONS

Across co-operative models, quality of care extended beyond the delivery of practical support and was grounded in relationship-building and participation. One interviewee explained that informal group activities had developed into a core element of the co-operative's approach. Members now take part in community fundraising, volunteering, and social events such as bowling, pub visits, and park parties. These activities help reduce isolation and build confidence, pride, and new forms of participation — as illustrated by a wheelchair user who joined a daily walking challenge. To ensure these activities remain well supported and accessible, the co-operative has appointed a staff member to plan and coordinate them. In another co-operative, local circles and forums provide spaces where friendships and shared interests naturally emerge. One interviewee recalled how two members discovered a shared passion for trains during a coffee meeting and now regularly meet as a small 'train group'. The growth of these micro-interactions reflects the organisation's ability to cultivate belonging beyond formal care provision.



4. WORKFORCE AND EMPLOYMENT PRACTICES IN CO-OPERATIVE CARE MODELS

KEY FINDINGS

- The size of co-operatives' workforces is indicative of the sector's potential. The seven survey respondents employed 2,919 staff, with an average workforce size of 417, of whom 83% were care workers.
- All co-operatives reported paying at or above the National Living Wage and demonstrated a commitment to supporting workers' material wellbeing.
- Survey respondents reported that employment conditions in co-operatives supported staff retention and minimised recruitment pressures. They also highlighted success in attracting younger workers (under 30) and improving gender balance. These findings are reinforced by qualitative evidence.
- Formal and informal participation mechanisms gave workers real influence over organisational decisions. The co-operatives' organisational culture promoted workforce recognition and supported meaningful work.
- Despite operating in a highly regulated environment, some co-operatives were exploring ways to give workers greater control over their work than the time-and-task model allows.

EMPLOYEE VOICE AND PARTICIPATION

Figures 2 and 3 summarise the working conditions and workforce composition reported by the participating care co-operatives. The survey respondents employed a total of 2,919 staff (ranging from 44 to 1,183 employees, with an average workforce size of 417), of whom 65% worked part time and 83% were care workers.

All the co-operatives involved employees in organisational decision-making. Voice - the ability of staff to contribute their perspectives to organisational choices- was enabled through democratic participation and operated through formal and informal participation mechanisms.

Formal voice mechanisms include shareholder councils, elected board representatives, staff subcommittees, and opportunities to vote on key organisational matters. In one organisation, employees could buy a share in the business, which granted them voting rights and made them eligible for election to the board of directors. Over time, the organisation also established a Shareholder Council made up of staff representatives from each operational team, which operates as a board subcommittee. This provides a channel for consultation and ensures that frontline workers' views are reflected in higher-level planning. Examples of staff involvement in decision-making ranged from participation in early decisions on the co-operative's name and branding, to deliberation on pay and benefits through subcommittees and structured consultations, and consultation on practical organisational matters such as the timing and location of the annual meeting.

In another organisation, three of the six board directors were elected by the workforce, ensuring direct representation at the highest level of governance. Exercising effective voice was closely linked to the board's practice of consensus-building. By seeking consensus, the organisation ensures decisions are collectively owned and that each member feels their views have been considered

Several organisations offered ongoing training on co-operative principles, organisational values, and voting and board responsibilities. This helped employees understand how to exercise their rights effectively and the importance of being active members.

Alongside formal participation structures, informal communication mechanisms and organisational cultures based on trust sustained open exchange within co-operatives. Staff were able to share ideas, offer suggestions, and raise concerns through open-door leadership styles that took workers' views into account. Employees were encouraged to give positive or critical feedback, which informed the shaping of the organisation.

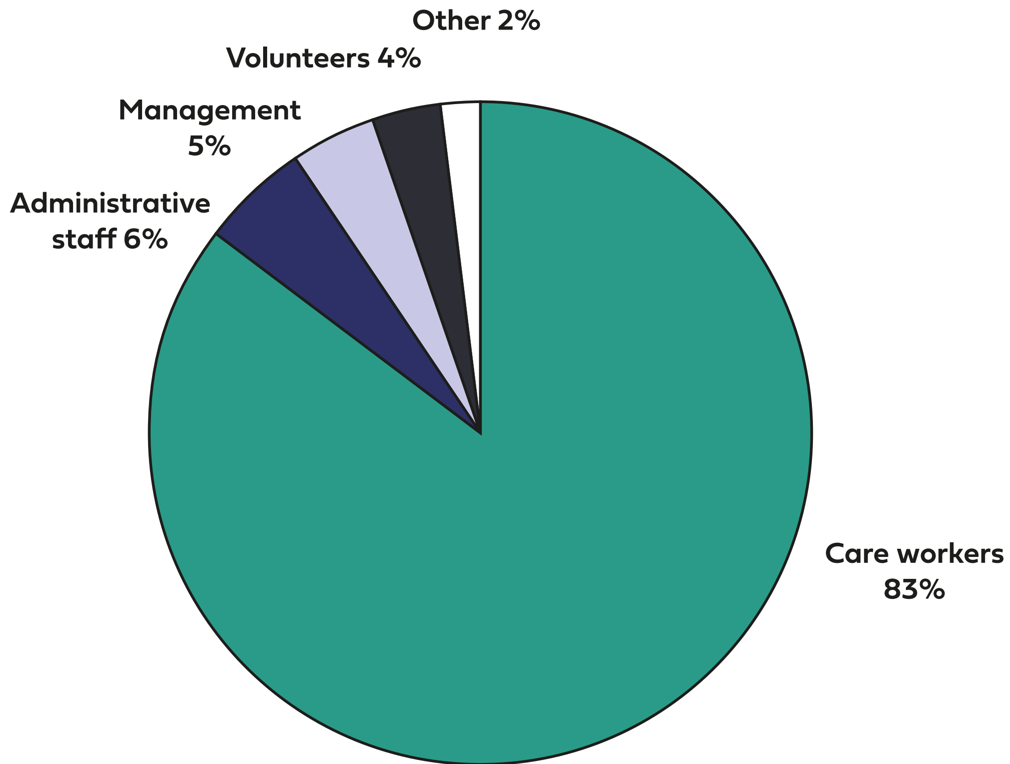


Figure 2. Staff composition. Responses from seven UK social care co-operatives, with a combined workforce of 2,919 employees (average size: 417), April 2024 – March 2025

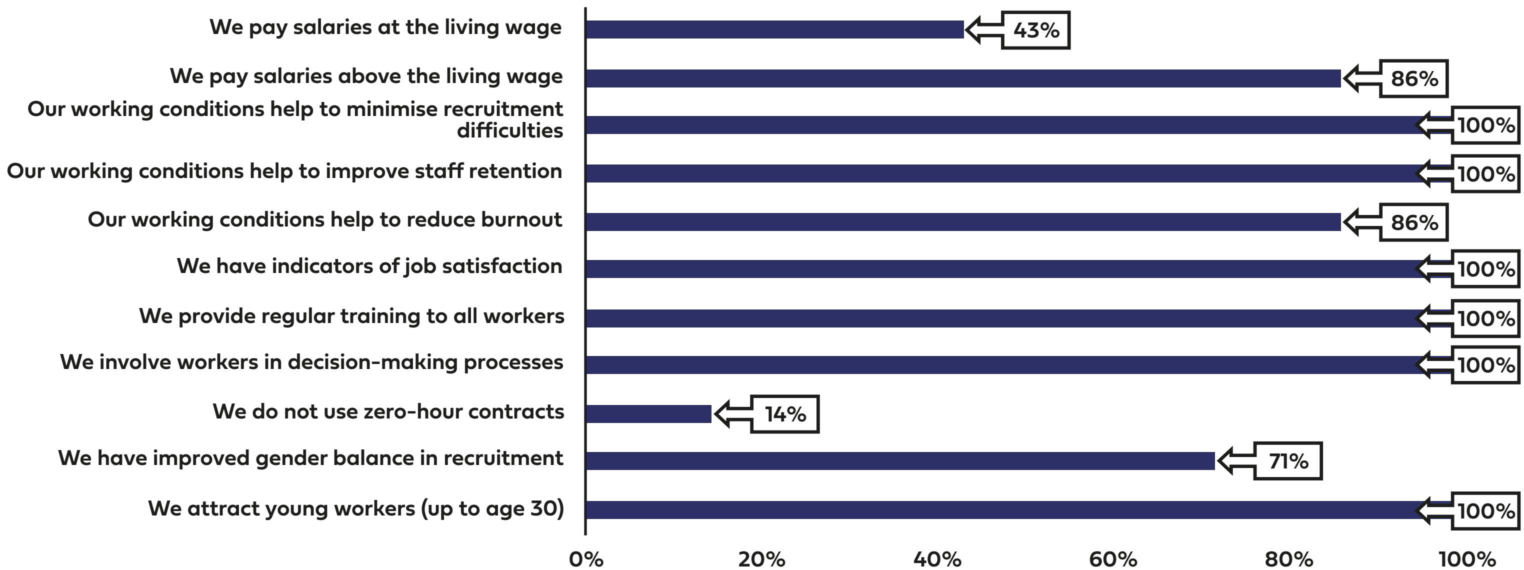


Figure 3. Employment conditions. Responses from seven UK social care co-operatives, with a combined workforce of 2,919 employees (average size: 417), April 2024 – March 2025

PAY AND CONDITIONS

All the co-operatives involved in the study reported paying at or above the National Living Wage. Participants regarded fair pay as a non-negotiable principle and described measures to support workers' financial security.

Interviewees explained that co-operatives offered employees benefits packages that improved working conditions compared to the fragmented arrangements common across the care sector. Many workers had previously operated as self-employees, juggling multiple clients, irregular schedules, and inconsistent payments. In the co-operatives, payroll was consolidated into a single system, ensuring regular monthly pay on a fixed date and enabling workers to plan household finances, secure mortgages, and access credit. Co-operatives often guaranteed a minimum number of hours per week and enrolment in pension schemes, opportunities largely absent under self-employment. Staff also benefited from enhanced conditions, including paid bank holidays, flexible leave, and the option to cash out unused annual leave.

Case study example: Cartrefi Cymru Co-operative

The Co-operative Forum was instrumental in giving staff and those they support a voice, for example, in 2024 there was a collective agreement to raise pay, whereas, this year, they had recommended to exceed the statutory rights on maternity and sickness provision. One suggestion was to rebalance the sickness policy to prevent the decline in pay support after the first few weeks of absence and better protect those facing serious illness. Cartrefi also created a benevolent fund for care workers managed with The Care Workers' Charity in response to staff concerns about financial hardship. Initially capitalised at around £20,000, it provides small, non-repayable grants to employees facing sudden financial strain. Beyond financial support, the forums fundraise to support local food banks and community organisations, showing how co-operatives can translate shared values into practical mechanisms of mutual care and collective responsibility

AUTONOMY IN JOB ORGANISATION

Some co-operatives were exploring ways to give workers greater control over their daily activities compared with the 'time-and-task model'. In this approach, support is scheduled and paid for in fixed time slots linked to specific actions rather than to outcomes or relationships. As the participants noted, this model compresses visits and reduces workers' roles to task delivery rather than meaningful care.

Case study example: Equal Care Co-Op

Equal Care Co-op delivered care through small self-managed teams, led by the person receiving care. These were small, locally based groups of care workers who collectively coordinate schedules, share clients, and make decisions about how care is delivered. Rather than being directed by external managers, team members organise rotas, agree visit lengths, match themselves with clients, and manage day-to-day communication with those they supported. Teams operated with a high degree of autonomy within shared co-operative principles, supported by digital tools for booking, care recording, and accountability. The co-operative also enabled workers to take on and experiment with new areas of responsibility, enabling them to develop new skills and participate in meaningful decision-making.

It was highlighted that in user-led co-operatives staff may experience an unusual degree of professional autonomy. Unlike the rigid demands of the time-and-task model, workers can decide how best to achieve the outcomes and priorities agreed with people drawing on care. In Friends United Together, staff exercise judgement by responding to what is working and making adjustments when it is not. The Friends, who act as the co-operative's directors, were described as "good managers", as they create conditions that support employees' initiative and creativity.

MEANINGFUL WORK AND RECOGNITION

While pay and conditions matter, a culture in which employees feel valued, respected, and able to focus on care is equally important in making work meaningful. Across the co-operatives, meaning and recognition emerged from organisational practices that supported relationships, development, and mutual appreciation. These included matching workers and clients to ensure compatibility and relational continuity. The idea of meaningful work grounded in relationships was echoed in Friends United Together Co-operative. Here, care work is co-produced, and workers can see the direct impact of their actions on members' wellbeing, developing a sense of fulfilment and purpose.

Recognition of care work also took place through peer-led activities that strengthened mutual appreciation and celebrated individual and collective achievements. For example, in one co-operative, staff achievements were formally recognised during the annual meeting, where peer-nominated awards showcased individual and collective successes and reinforced a shared identity within the workforce.

RECRUITMENT AND RETENTION

All survey respondents reported that their co-operatives' working conditions helped improve staff retention and minimised recruitment difficulties. They also stated that they attract young workers (up to 30 years) and, in the majority of cases, have improved the gender balance in recruitment.

One participant reflected that, in their organisation, staff turnover had fallen and retention had improved in recent years. Although it is difficult to attribute these outcomes solely to the co-operative model, its values, culture, and participatory ethos were seen as central. These elements foster a sense of being valued and supported which strengthens long-term commitment. In line with the survey results, representatives from all co-operative types reported that, once recruited, employees tend to stay.

Case study example: Friends United Together Co-operative

At Friends United Together, the same team of support workers has worked with the same group of members for over twenty-five years, sustained not by formal incentives, but by relationships of trust and shared purpose. This sense of belonging contrast with the typically high turnover in the care sector and illustrates how user-led co-operatives can generate personal and organisational commitment.

Similarly, the representative of one long-established co-operative described the workforce as "extremely loyal and long-serving," with retention well above sector norms. Attracting new staff, however, remained difficult because pay and conditions set by external commissioning frameworks leave limited room to compete with higher-paying employers. Another interviewee noted that the co-operative employment model directly supports workforce stability, with turnover between 12.5% and 15%, well below the regional average of 35%.

5. THE ADDED VALUE OF SOCIAL CARE CO-OPERATIVES

KEY FINDINGS

- Care co-operatives fostered wider community wellbeing by supporting unpaid carers and individuals with past care relationships, as well as by organising activities open to the wider public. In 2024, Cartrefi Cymru Co-operative estimated that it delivered the equivalent of £250,000 in unpaid assistance.
- The co-operatives contributed to the local economy by reinvesting in nearby businesses, such as sourcing equipment and services locally, and through employment practices that anchored spending locally.
- Innovation emerged from the redesign of service models and the development of digital tools, undertaken in co-production with people drawing on care and their carers. In doing so, they improved the system's responsiveness to emerging needs.
- Added value was also generated through attention to the promotion of values through lived experience of care, systematic collaborative practices, and resource sharing with other organisations.

A COMMUNITY APPROACH TO WELLBEING AND PREVENTION

Co-operatives undertook activities that went beyond delivering care tasks and often extended these to people without commissioned care packages. This allowed many individuals to receive unpaid support through inclusion in the events and activities offered to members. Cartrefi Cymru Co-operative has estimated that, over the past year, it provided the equivalent of £250,000 worth of unpaid assistance, a figure expected to double as its community activities expand. Another initiative outside formal contractual arrangements concerns support for unpaid carers. For these families, co-operative forums and events offer informal respite and peer support. To meet this need, Cartrefi has created family-only forums linked to each local co-operative forum, enabling relatives and unpaid carers to meet, share experiences, and organise activities together.

Case study example: Cartrefi Cymru Co-operative

An important part of Cartrefi's activity is grounded in the work of its local forums. A substantial part of their work- around 60–70% of their activity- focuses on planning and creating opportunities for people, including day trips, walks, and other social activities. These forums have matured into open community spaces that attract not only those supported by Cartrefi but also individuals who participate independently because the opportunities offered are valued locally. Over the past year, this strand of work has grown significantly, supported by new investment in facilitation capacity across Wales.

ECONOMIC REINVESTMENT AND SUSTAINABILITY IN THE LOCAL ECONOMY

Reinvestment in the local economy emerged as a distinctive added value of the co-operative model. Co-operatives structured their operations so that resources, decision-making, and economic benefits remain within the communities they serve, thereby contributing to their stability and cohesion.

Case study example: Cartrefi Cymru Co-operative

With a budget of £43 million, Cartrefi prioritises sourcing goods and services from within Wales and, where possible, from businesses near its offices, reflecting a commitment to reinvesting resources where value is created. Cartrefi prioritises sourcing goods and services from within Wales and, where possible, from businesses near its offices. This hyper-local approach keeps economic benefits circulating within the same communities it serves. The co-operative's local forums strengthen these connections, embedding the organisation within its neighbourhoods and supporting community wealth building. Cartrefi exemplifies the idea of the "co-op pound," because the aim is for every pound that passes through the co-operative to remain circulating in the local economy for longer than it would through a conventional provider.

This locally oriented approach was contrasted with the volatility of investor-backed providers, who may withdraw when margins tighten. One participant noted that their co-operative does not "come and go," but remains part of the community's long-term fabric. The co-operative reinvested resources locally, directing financial surpluses toward fair work and the enhancement of professional standards. It was observed that public funding should not be directed towards providers whose primary objective is to generate returns for offshore investors, but should instead be "reinvested to support wealthier, healthier communities by strengthening local people and economies".

INNOVATION IN SERVICE DESIGN AND MODELS OF CARE DELIVERY

The interviews revealed a view of innovation closely tied to the way services are designed. It involved rethinking the architecture of care organisations to make them more inclusive, responsive, and person-centred. Innovation was also seen as a necessary adaptive response to funding constraints, and a means of revitalising the social care sector through participatory approaches. From local authority spin-offs to multistakeholder co-operatives supporting people with Direct Payments, co-operatives emerged as experimental platforms for developing new organisational forms and care models.

Case study example: Equal Care Co-op

Equal Care was founded as a platform co-operative. Equal Care's platform comprises a set of services, designed and built largely in-house, that works across desktop and mobile. Some of the core features are:

- Detailed profiles for people giving and drawing on care
- Tools that enable Teams to coordinate care
- A system that pairs people based on needs and preferences to help form care Teams
- A calendar tool linked to the financial system to ensure accurate charging and payment
- A secure, and compliant model for handling sensitive personal data, supported by integrated encrypted messaging for internal team communication
- A system for invoicing, payments, income tracking, and tax guidance for care workers
- Equal Care continues to develop and improve the platform based on co-production principles. The co-operative is committed to sharing this platform with other co-operatives and care organisations as it evolves.

Case study example: Friends United Together Co-operative

Friends United Together has pioneered the user-led co-operative model in the UK, and its approach is now inspiring the creation of other co-operatives. It has also helped develop organisational models capable of managing Direct Payments in an ethically rigorous and financially efficient way, delivering benefits for both members and staff

6. SUPPORTING DEVELOPMENT, GROWTH AND SUSTAINABILITY OF SOCIAL CARE CO-OPERATIVES

KEY FINDINGS

- Organisational enablers included a culture driven by co-operative values, and an inclusive leadership, capable of combining entrepreneurial thinking with social purpose. Equally important was the adoption of governance models combining meaningful participation with operational effectiveness.
- Community-level enablers comprised collaboration with anchor organisations, championing within local authorities, and trusted community networks to facilitate outreach and member engagement. Sector bodies and membership organisations are key to provide consultancy, information, and specific training.
- Policy-level enablers focused on legislative frameworks that explicitly recognise co-operative approaches and level the playing field with larger providers in care markets. Access to finance and investment remains a critical enabling factor.
- Actions to strengthen financial sustainability included inter-organisational collaboration and the development of shared support hubs; financial discipline and streamlined operations; service diversification; conversion of internal competencies into income streams; engagement with people who self-direct care through Direct Payments; and initiatives linking member participation with income generation. Financial sustainability challenges risk stagnation or contraction within the sector if unaddressed.

6.1. ENABLERS SUPPORTING THE DEVELOPMENT AND GROWTH OF SOCIAL CARE CO-OPERATIVES

VALUE-DRIVEN FOUNDATION

Values were a central motivation behind the establishment of social care co-operatives. These were described as “the hidden humanity holding the care system together”, emerging from the everyday ethics of care already present within communities.

For Direct Payment users and disabled people, the main impulse was the pursuit of empowerment and self-determination, expressed in the principle ‘Nothing about us, without us.’ In Friends United Together, long-standing personal relationships and a shared history created trust and cohesion needed for collective decision-making. Their mobilisation was driven by a determination to preserve those bonds and maintain care continuity. In Cartrefi Cymru Co-operative, the transition from charity to a multi-stakeholder co-operative gave legal and institutional expression to long-standing values of empowerment, inclusion, and collective participation in governance.

INCLUSIVE AND ENTREPRENEURIAL LEADERSHIP

Participants emphasised that effective leadership is an underpinning element of the successful experiences of social care co-operatives, and highlighted three attributes:

- **Strategic entrepreneurial capability.** Leaders were valued for their ability to combine entrepreneurial thinking with social purpose. Skills development in governance, budgeting, and sector-specific regulation was seen as essential to achieving this.
- **Inclusive approach**. Effective leaders acted as facilitators. They created space for diverse voices and aligned them around shared values, turning diversity into a source of creativity rather than fragmentation.
- **Generative perspective**. Effective leadership invests in succession planning and co-operative education. By doing so, leaders ensured continuity as membership changed and enabled the organisation to evolve while remain aligned with its founding principles.

ACCESS TO FINANCE AND INVESTMENTS

Access to finance emerged as an with essential condition for growth (see Section 7). Publicly funded pilot programmes appeared effective in encouraging local innovation but insufficient to address organisational needs in the start-up phase.

IDENTIFYING A SUITABLE GOVERNANCE MODEL

The choice of mechanisms through which members of a social care co-operative participate in decision-making determines its capacity to endure. Governance models may emerge gradually or result from deliberate planning. One organisation designed its governance to combine lived experience, community support, and legal robustness. Its structure distinguished between principal members (disabled people) and supporting members (families and allies). This ensured that decision-making remained grounded in the perspectives of people drawing on care, while also benefiting from supporters' organisational knowledge and advocacy capacity. To complement this model, the founders sought legal advice and adopted a hybrid structure. A not-for-profit company handled contracts, liability, and regulatory compliance, while an unincorporated co-operative oversaw decisions about service design and care quality. This governance model provided a stable legal base for trading and meeting statutory requirements, without diluting member control.

COMMUNITY AND INSTITUTIONAL PARTNERSHIP

Social care co-operatives often grow from existing relationships with trusted organisations and community networks that provide credibility, visibility, and access to members.

One co-operative was launched through a partnership of three well-established Disabled People's Organisations. The largest included 4,000 members and promoted the new co-operative within its network, creating visibility and engagement from the outset. This institutional backing enabled the co-operative to engage a wide range of people and build trust within the community.

Another co-operative project was anchored in a broad partnership that combined technical, academic, and community expertise. Funded by a local council, the lead organisation promoted the project in collaboration with a university, which contributed academic experience in participatory methods, and Community Catalysts, specialists in micro-enterprise care. They worked with two trusted grassroots organisations to deliver workshops, discussions, and public events that explored local care needs and introduced participants to co-operative principles. More than seventy people took part in these sessions, including care users, family carers, and frontline workers, and several expressed interest in joining steering committees. The involvement of these community partners was crucial, as their credibility within minority groups helped reach workers who are often excluded from engagement.

SKILL BUILDING AND AWARENESS RAISING FOR THE GROWTH OF SOCIAL CARE CO-OPERATIVES

Expanding the co-operative model requires widening understanding of this approach among prospective founders and the wider public. Three enablers were identified:

- **Consultancy provision**. Sector agencies and membership organisations provided targeted support on option appraisal, business planning, and governance design, alongside guidance on regulatory and operational requirements in adult social care, including local authority fee rates and Care Quality Commission standards. This support helped groups assess the economic viability of co-operative initiatives.
- **Awareness-raising**. In Wales, the three-year Care to Co-operate programme aimed to increase understanding of Section 16 of the Social Services and Well-being Act and stimulate discussion of co-operative care models. However, limited staffing and resources restricted its reach. Participants also highlighted the importance of embedding co-operative principles within school and university curricula.
- **Training for new entrants**. Training for frontline workers and individuals unfamiliar with the care sector was identified as essential to build understanding of how the care system operates and what effective co-operative governance entails.

Case study example: Friends United Together Co-operative

The Community Lives Consortium and the Care to Co-operate programme provided targeted development support for Friends United Together. Membership of national bodies such as Co-operatives UK and Social Enterprise UK facilitated peer exchange, access to resources, and insight into practical models of co-operative governance. This support was complemented by technical guidance from institutional champions within the local authority and informal mentorship from individual advocates. This network illustrates how the development of a co-operative depend on the synergistic involvement of multiple actors and areas of expertise.

LEGISLATIVE AND POLICY FRAMEWORKS

Social policies play a decisive role in the diffusion of co-operative organisations. Some of the measures discussed suggest that, despite uneven implementation, the legislative foundations for co-operative care are strengthening:

- **Social Services and Well-being (Wales) Act 2016, Section 16**. Emerging from the Agenda for Change movement, Welsh legislation has fostered a policy environment in which co-operative and user-led solutions are recognised as desirable care options. However, ongoing ambiguities risk excluding social care co-operatives from commissioned service delivery.
- **Personal budgets and individual service funds** may support the development of user-led organisations and the expansion of co-operative activity. People drawing on care can access guaranteed funds to purchase support, creating more stable demand for co-operatives.
- **Procurement Act 2023**. The Act aims to rebalance procurement markets in favour of small businesses and voluntary, community, and social enterprises. However, it does not explicitly clarify whether co-operatives are included within these categories.

6.2. ACTIONS AND STRATEGIES TO SUPPORT FINANCIAL SUSTAINABILITY

WHAT DOES 'GROWTH' MEAN FOR SOCIAL CARE CO-OPERATIVES?

'Growth' was not considered as commercial expansion, but as a balance between operational scale and the values of community benefit, democracy, and care quality. Interviewees stressed the importance of finding the 'right' organisational size: large enough to absorb financial fluctuations, yet still attuned to community needs. They described efforts to reconcile organisational reach with community cohesion and a shared sense of belonging. Some were experimenting with decentralised models that preserved accountability and identity while extending their scale, such as local replication or federated franchising. This balance depends on several factors, including economic resilience. Many co-operatives have therefore developed specific strategies to strengthen their financial sustainability.

INTER-ORGANISATIONAL COLLABORATION AND DEVELOPMENT OF SHARED SUPPORT HUBS

Co-operatives are increasingly working collaboratively with other organisations to share costs, reduce duplication, and build collective capacity. Partnerships include technology firms, housing associations, learning institutions, and peer social care co-operatives. For example, one co-operative described developing a joint training initiative with another care provider to co-design and co-own training services, ensuring both benefit from shared resources and expertise instead of running parallel programmes. Some co-operatives are evolving into 'umbrella bodies' offering shared infrastructure, governance, and technical capacity across multiple local initiatives.

Case study example: Cartrefi Cymru Co-operative

In Wales, Cartrefi Cymru Co-operative is exploring how its administrative systems (including HR, payroll, procurement, and digital infrastructure) could be shared with smaller providers that cannot sustain these functions independently. This approach maintains local choice in care provision by enabling smaller organisations to benefit from economies of scale and reduced administrative burden.

Case study example: Equal Care Co-op

Equal Care Co-op plans to extend its digital platform to connect local care circles across different regions, creating a shared digital and governance infrastructure for co-operative care. The platform is increasingly conceived as a shared asset, capable of supporting the growth of locally embedded co-operative provision. Several established groups in other parts of England have approached Equal Care to join the platform as local circles.

Through this model, Equal Care aims to lower barriers to entry for new or smaller co-operatives by centralising high-cost functions, such as digital development and back-office coordination. Interviewees emphasised that this federated approach is critical for achieving scale and sustainability, given that trading surpluses in the sector are typically insufficient to fund major infrastructure investment independently.

FINANCIAL DISCIPLINE AND STREAMLINING OPERATIONS

Several participants emphasised the ongoing need for financial discipline and operational efficiency. Some organisations have introduced modest surplus targets across all business lines to strengthen financial resilience and create reinvestment capacity. Although certain service lines may underperform against these targets, the overall surplus provides scope for reinvestment across the wider co-operative. Co-operatives are investing in digital tools and limited applications of artificial intelligence to align staff time and resources more effectively with organisational priorities. The technologies adopted are designed to accelerate data collection, improve communication, and reduce administrative burdens.

DIVERSIFICATION

Co-operatives are diversifying their services in response to changing demographics and unmet local needs. One interviewee described the development of new initiatives for people with dementia and learning disabilities designed to address major gaps in local provision (dementia cafés, early-stage support, and housing-based care models). In parallel, several co-operatives were exploring community services readily funded through personal budgets, such as companionship, social activities, and group volunteering. Diversification also extended to long-term planning and housing innovation. One interviewee described a programme designed to support families concerned about the future care of their relatives once they are no longer able to provide it themselves. The initiative explored trust arrangements, supported housing models, and the acquisition of housing assets as ways to combine social purpose with financial sustainability. Another co-operative was increasingly integrating housing within its social care mission. The co-operative was working with housing associations to develop projects that connect care services with access to stable and affordable homes for people with learning disabilities, an area underserved by the private rental market.

LEVERAGING INTERNAL EXPERTISE TO SUPPORT FINANCIAL CAPACITY

Several co-operatives are mobilising internal expertise and converting existing competencies into mission-aligned revenue streams to generate supplementary income. One has become a leading training and learning provider through the Adult Social Care Academy, an accredited centre delivering vocational qualifications, apprenticeships, and specialist training to staff and external clients. Another co-operative has leveraged staff qualifications to create new paid services, such as careers advice for young people with special educational needs entering employment or apprenticeships. A third aimed to expand into alternative education, and registered as a provider for young people who no longer fit within mainstream schooling.

SUPPORTING INDIVIDUALS WHO RECEIVE DIRECT PAYMENTS OR INDIVIDUAL SERVICE FUNDS

Several co-operatives were considering supporting people who self-direct their care through Direct Payments or Individual Service Funds, as a means of enhancing financial stability and addressing gaps in provision. This model aligns with co-operative values but also introduces regulatory and safeguarding complexities. Pooled arrangements can empower communities but, in the absence of oversight, risk producing fragmented and unregulated provision.

LINKING MEANINGFUL PARTICIPATION WITH INCOME GENERATION

Many organisations were developing activities that linked members' participation with income generation. These included running a pottery and painting shop with an attached café that serves as a creative space and community hub; community outreach initiatives tied to fundraising and sporting events; and a pop-up café that allows members to gain hands-on work experience in a supportive environment.

WHEN FINANCIAL UNSUSTAINABILITY INHIBITS CO-OPERATIVE CARE GROWTH

Financial sustainability reflects not just managerial competence, but the extent to which the system upholds the organisations' founding values. Some committed co-operative providers expressed the view that they might need to change their business model because it no longer supported (and in some cases hindered) the goals for which the social co-operative had been created. Contrary to the objectives set out in social policy discourse, the constraints discussed in the next sections risk causing contraction or stagnation within co-operative care. Yet, care needs remain high, and the potential for growth appears significant.

7. CHALLENGES TO ESTABLISHING, SUSTAINING, AND SCALING SOCIAL CARE CO-OPERATIVES

KEY FINDINGS

- Social care co-operatives operate within a limited legislative framework. Currently, organisations tend to trade off social purpose against member governance, as no single legal form reflects their dual mission.
- The co-operative model is poorly understood. Social care co-operatives are often seen as commercial, for-profit providers. This misrecognition shapes funding and commissioning decisions, which tend not to consider co-operatives' broader societal contribution.
- Access to finance remains a critical constraint for all social care co-operative types. Funding is limited to member contributions, grants, and local council support, insufficient for start-up, stabilisation, or growth. Capital needs become particularly acute when investment in equipment or digital systems is required.
- Access to services occurred mainly through local authority (78%) and NHS (14%) referrals, making commissioning practices a key driver of sector development. Current approaches concentrate service procurement among large providers, incentivise task-based service delivery and are perceived as transactional. These practices disadvantage co-operatives, whose operating models prioritise quality and social value alongside cost-effectiveness, and are often not aligned with current commissioning frameworks.
- There are positive signs of change in commissioning practices, including a shift toward ethical commissioning, increased use of social value measures, market diversification objectives, emerging coordination and learning infrastructures, and piloting of participatory and longer-term commissioning models.

7.1. STRUCTURAL, INSTITUTIONAL, AND FINANCIAL CONSTRAINTS ON SOCIAL CARE CO-OPERATIVES

LIMITED AWARENESS OF HOW CARE CO-OPERATIVES OPERATE

Co-operatives remain relatively little known and are often perceived as marginal. As a result, policymakers, funders, investors, business advisers, and people drawing on care frequently treat co-operatives as equivalent to conventional commercial enterprises, or do not view them as a viable option. This misrecognition shapes funding, commissioning, and partnership decisions, as co-operatives are assessed primarily through commercial criteria rather than their broader societal impact and community contributions.

REGULATORY AMBIGUITY

While the Law Commission's review of the Co-operative and Community Benefit Societies Act 2014 is ongoing, the UK lacks a clear legislative framework for social care co-operatives. In many countries, these are recognised as democratic, member-controlled organisations that also generate public value by reinvesting surpluses into welfare services. However, current national legislation often requires organisations to choose between existing primarily for wider social benefit (through legal forms that allow asset locks, profit locks, and explicit social purpose), or existing primarily for member benefit (without the ability to introduce asset locks, profit locks, or legally guarantee social purpose).

This tension becomes evident when organisations try to identify a legal form that reflects their aims. As one interviewee explained, the legislation fragments co-operative care providers across several ill-fitting categories, none of which fully capture the dual mission of a social care co-operative. Organisations can register as a co-operative society, Community Benefit Society (CBS), Community-Interest Company (CIC), or charitable company, each with different fiscal and regulatory obligations. In practice, many groups adopt the CBS form or register as charitable bodies. These provide a more secure cultural, legal, and fiscal status. For example, charities benefit from corporate tax exemptions, up to 100% business-rate relief, and access to targeted grants. Several interviewees noted that what ought to be an administrative decision tends to become a trade-off between economic sustainability and adherence to co-operative principles.

FUNDING GAPS AND CAPITAL CONSTRAINTS

Securing finance is a major barrier for all types of social care co-operatives. Unlike investor-backed care companies, co-operatives typically have access only to limited member contributions, grants, and local authority support.

- The establishment of user-led co-operatives is often financially fragile, as their viability depends on members' Direct Payments. The creation of Friends United Together, for instance, was made possible only through the support of their care provider, which covered start-up costs.
- Worker-led co-operatives emerging from public or private divestments also face inherited financial burdens. One organisation had to take on pension liabilities, lease public buildings, and inherit outdated equipment, all while operating within funding envelopes that required annual savings. With little autonomy to reinvest surpluses, the co-operative was established with high fixed costs and few assets. This created an immediate need for capital investment without the reserves to meet it, making the early phase financially very challenging.
- Multi-stakeholder co-operatives highlighted the importance of access to early-stage finance. Targeted start-up support covering community engagement, consultancy, or registration costs can make a significant difference. Yet such seed funding is typically small and time-limited; once initial grants expire, co-operatives often face uncertainty around the stabilisation of their operations.

7.2. COMMISSIONING PRACTICES: CONSTRAINTS AND SIGNS OF CHANGE

COMMISSIONING PRACTICES: LIMITS AND IMPLICATIONS FOR SOCIAL CARE CO-OPERATIVES

Commissioning was a key area for social care co-operatives. Access to services occurred mainly through local authority and NHS referrals, accounting for 78% and 14% respectively (Figure 4). These were also the organisations with which co-operatives most often held formal agreements. The interviews highlighted the following issues:

- **Current commissioning processes are designed to suit large-scale providers, rather than smaller, community-based organisations**. One participant cited a homecare contract model in which 80% of provision was allocated to four large providers, leaving the remaining smaller ones with 2% each. Such arrangements prevent small providers from growing and expose local care systems to risk in the event of market exit by a major contractor.
- **The prioritising of the lowest bidders disadvantages social care co-operatives, as their operating models limit their capacity to compete through intensive cost-cutting**. Larger providers often secure contracts by offering lower prices, but these efficiencies are frequently achieved by shifting costs onto care workers and service users. While some organisations can cross-subsidise low hourly rates with income from private clients or other business lines, co-operatives typically lack the scale and financial capacity to do so.
- **Commissioning frameworks rewards task-based delivery, rather than community impact or experimentation**. Overly prescriptive service specifications and bureaucratic contract monitoring shift provider effort away from innovation and outcomes toward meeting administrative and contractual requirements. In addition, the full organisational costs, (including training, travel time, administration, supervision, and relational work to build trust with clients) remain largely unrecognised.

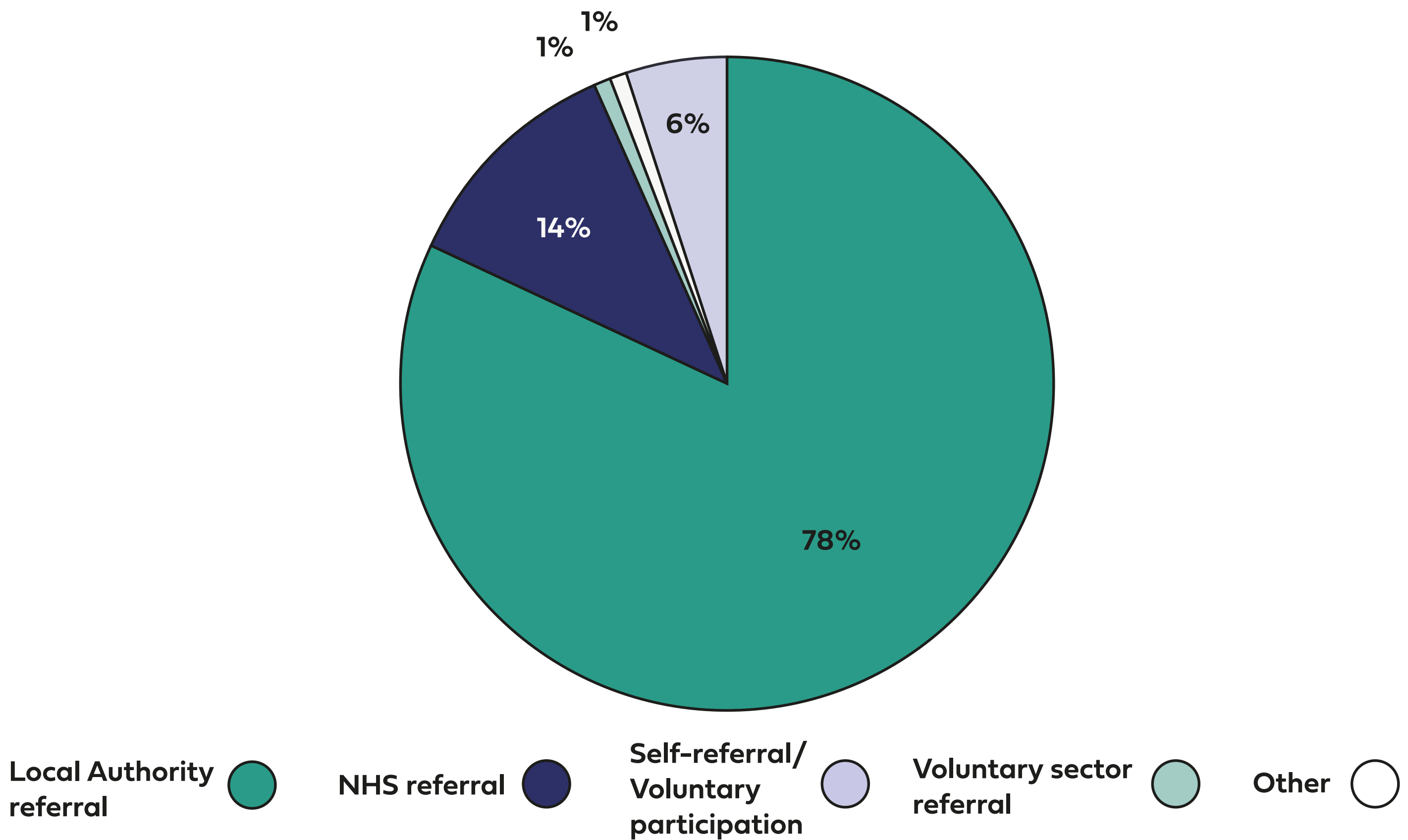


Figure 4. Referral to Social Care Co-operatives. Responses from seven UK social care co-operatives, with a combined number of 3,133 users, April 2024 – March 2025.

COMMISSIONING PRACTICES: SIGNS OF CHANGE

Across interviews, participants expressed cautious optimism about emerging reforms and cultural shifts that could reshape how social care is commissioned and delivered. Four broad themes stand out:

A move toward ethical commissioning and the recognition of co-operatives as value-driven providers. Interviewees described the Scottish Care Reform Bill as potentially transformative because it marks a shift away from lowest-price contracting toward a framework that prioritises quality, fair workforce conditions, and collaboration. The Bill aims to publish national principles on ethical commissioning and procurement, and to develop guidance and tools to support their local delivery. In this way, co-operatives, mutuals, and employee-owned organisations can be formally recognised and rewarded for their distinct contribution to public value within a more inclusive commissioning system.

Similarly, in September 2024 the Welsh Government launched its new National Framework for Commissioning (NOCS, 2024), which also emphasises the importance of social value principles to ensure commissioning decisions are based on quality and people's experiences and outcomes from services. Ethical practices are also enshrined in the new framework, in relation to the requirement to commission services based on fair work principles to improve status, wellbeing and working conditions in social care to achieve parity across (statutory, private and third) sectors. Additionally, statutory partners must evidence that the commissioning of care and support services is co-designed, co-delivered and co-evaluated with individuals in need of care and support, their advocates and carers.

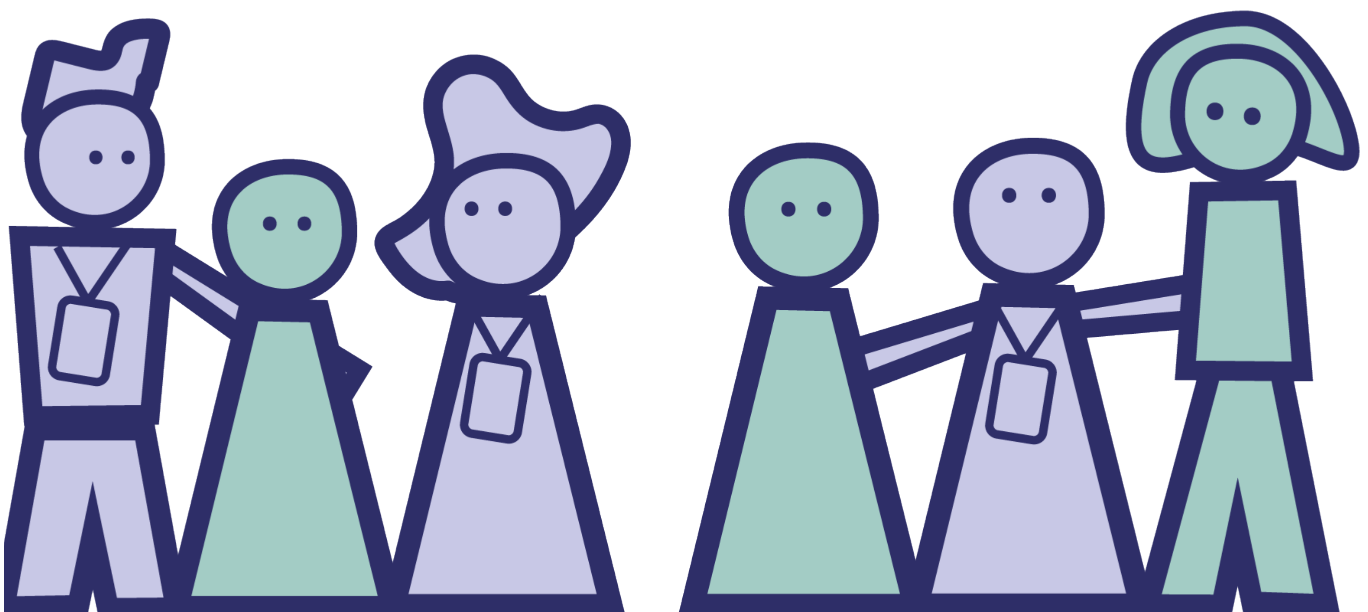
Several local authorities already incorporate Key Performance Indicators of social value, reflecting outcomes such as wellbeing, inclusion, and community contribution. This trend aligns with wider reforms, such as the Health and Social Care (Wales) Act 2025, which phases out for-profit organisations from providing care for looked-after children and promotes contracting based on added social value. However, co-operatives are still excluded from the list of eligible not-for-profit providers, indicating that recognition of their role remains incomplete.

Growing recognition among local authorities of the need to diversify the care market. Several councils now view the inclusion of social value–oriented providers in their commissioning frameworks as a way to rebalance markets long dominated by private contractors. Co-operatives are valued for their responsiveness, person-centred approach, and ability to deliver tailored support at an affordable cost. Commissioners also turn to them for their capacity to design and manage care for individuals with complex needs within the price limits set by Direct Payments.

Emergence of infrastructures for more coordinated and learning-oriented commissioning. These efforts are developing at national and local levels, reflecting a broader drive to reduce fragmentation in the care system. The National Care Office in Wales was identified as a hub for mapping activity, sharing good practice, and improving coherence across regions. While this vision of greater coordination attracted interest, interviewees questioned whether such bodies would have sufficient mandate to influence local bureaucracies, and emphasised the importance of maintaining a diverse mix of providers to protect user choice.

Piloting new forms of participatory commissioning in England and Wales, involving people drawing on care, carers and providers earlier in the design process. Although these initiatives remain constrained by financial, legal, and procedural limits, they represent a meaningful cultural shift toward openness and experimentation. There are also indications of a shift toward more stable commissioning models. Multi-year contracts allow providers to plan beyond short-term funding cycles, and offer greater continuity, collaboration, and scope for innovation.

These trends point to commissioning as the mechanism through which social care co-operatives can fulfil their potential, and show that existing practices are already tracing a feasible path for change.



8. POLICY RECOMMENDATIONS

Across all UK nations, policy developments are currently underway to implement system-level interventions aimed at supporting the social care sector, including co-operative providers. Alongside this, the research identifies a set of specific short-, medium- and long-term recommendations and strategic actions to facilitate the establishment and growth of co-operative approaches to adult social care. The proposed measures may provide a framework for developing an additional care option that expands people's choice and control over their care and supports a promising segment of the UK care economy.

SHORT -TERM RECOMMENDATIONS (1-2 YEARS)

Establish a strategic platform for social care co-operation to identify shared priorities, translate them into concrete actions and related milestones, and define sector-specific measures of success.

The platform could build on and mobilise existing relationships, initiatives, and evidence developed by Co-operatives UK and Cwmpas and other relevant membership and support organisations. In doing so, it would avoid duplication and strengthen strategic alignment.

The platform should convene relevant decision-makers, representatives of people drawing on care and their carers, leaders from established care co-operatives, and other key stakeholders. Engagement should be tailored to different stages of the process and to the objectives pursued. By grounding strategy in lived experience and operational knowledge, the platform would support a coherent agenda for the sector, strengthen its collective identity, and contribute to its recognition within the wider adult social care system.

Encourage local authorities to include specific commissioning criteria relevant to social care co-operatives, that would also help diversity local care markets and support a more resilient provider base.

This recommendation concerns the criteria used in social care commissioning decisions. Currently, commissioning practices are predominantly oriented toward unit cost, activity-based metrics, and short-term budgetary considerations. Evidence from social care co-operatives instead indicates the value of prioritising commissioning decisions based on demonstrable care quality (for example, co-design and co-evaluation of interventions, sustained independent living, and reductions in avoidable hospital admissions). Commissioning should also take account of fair working conditions and social value indicators such as wellbeing, community contribution, and social inclusion. Initiatives signalling the appropriateness of this direction include the Welsh National Framework for Commissioning (NOCS, 2024) and the sustainable and ethical commissioning guidelines adopted by several UK councils (Section 1.1). Placing greater weight on these criteria would directly support the objectives of the NHS Long Term Plan on prevention, neighbourhood health, and population health improvement. This shift would enable the distinct

contribution of social care co-operatives and other value-driven providers to be formally recognised. It would also establish more transparent and equitable conditions for competition with for-profit providers, supporting a more diverse and resilient provider base.

Encourage local authorities to make full and strategic use of the "light-touch regime" introduced under the Procurement Act.

This recommendation focuses on the mechanisms through which commissioning decisions are implemented. Commissioning practices frequently rely on standardised and prescriptive procurement processes, limiting flexibility across different service contexts. While such approaches can offer consistency in processes, they may be poorly suited to co-operative models to care delivery, which rely on person-centred interventions and outcome-based performance. The light-touch regime provides a flexible procurement framework that allows English public sector bodies to commission certain services (particularly social, health, and care services) using procurement approaches that are proportionate to contract size, service characteristics, and local market conditions. By lowering procedural barriers that disproportionately disadvantage smaller providers, strategic use of the light-touch regime can enable commissioning outcomes to be shaped by care quality and local impact. Ensuring that smaller providers, including social care co-operatives, are not marginalised by large national and international organisations would help to rebalance the market and retain social and economic value within local communities. In devolved administrations, local authorities should pursue equivalent flexibilities available within their respective procurement frameworks to achieve similar outcomes

Pilot tailored development and capacity-building support for existing and emerging social care co-operatives.

The support could focus on areas including governance, regulatory compliance, commissioning readiness, employment conditions and wider workforce issues, as well as financial sustainability. The pilots could be financed through a mix of national and local funding. Delivery could involve membership bodies and specialist co-operative development organisations. This initiative would generate practical learning and provide a foundation for the subsequent development of regional care co-operative support hubs in the medium term.

MEDIUM -TERM RECOMMENDATIONS (3-5 YEARS)

Establish pilot commissioning partnerships in adult social care to overcome fragmentation and diversify local care markets

Such partnerships would enable neighbouring local authorities to collaborate on market shaping and commissioning, addressing the constraints created by fragmented demand and limited scale and capacity at individual authority level. Drawing on the experience of the Regional Care Co-operative (RCC) pilots in children's services (EcoRys UK, 2025), these formal collaborations could support the entry of care co-operatives and other not-for-profit providers into local care systems. The partnerships could develop shared demand projections and map regional provision gaps, informed by integrated health and social care planning; coordinate commissioning activity; and undertake joint market-shaping with providers. By pooling commissioning capacity across authorities, they could also create a pipeline of value-led providers by offering targeted support to co-operatives and other not-for-profit organisations (for example, business development support and mobilisation funding). In addition, the partnerships could introduce defined commissioning pathways (such as social value weighting and longer contract terms that enable investment), improving contract viability for co-operative organisations. As pilot initiatives, these partnerships would allow approaches to be tested, refined, and evaluated before wider rollout, thus limiting financial and delivery risk.

Develop regional care co-operative support hubs, to strengthen the capacity of social care co-operatives and other not-for-profit providers.

Given the scale and capacity constraints faced by individual frontline organisations, such hubs could provide shared administrative, financial, and legal functions across co-operatives and other not-for-profit providers, reducing duplication and lowering entry and operating costs. Established organisations within the sector, such as Cartrefi Cymru and Equal Care Co-op, could play a supporting role in this model.

The hubs could also perform an incubator function for new social care co-operatives, other voluntary,

community and social enterprises, and micro-providers. Supported through blended funding arrangements combining time-limited public investment with earned income from shared services, these hubs could offer ready-to-use templates, financial models, shared services, and mentoring from established care co-operatives and providers. By pooling expertise and professional capacity, this infrastructure would enable better use of existing sector expertise and accelerate the development of new co-operatives.

Facilitate access to long-term capital, compatible with the characteristics and objectives of social care co-operatives.

Strengthening the financial foundations of co-operative and social enterprises requires improved access to long-term, mission-aligned capital. This could involve adapting existing public impact and social-investment funding (including local authority loan funds, government-backed investment via the British Business Bank, impact investment vehicles, and social-investment budgets) to better reflect the operating realities of co-operative models. Such adaptation may include longer repayment periods, more flexible security requirements, and financial products specifically designed for social care co-operatives and other value-led, not-for-profit providers. In parallel, there is scope to strengthen specialist financial institutions serving the co-operative and social economy, for example through co-investment mechanisms. These instruments should support co-operatives' start-up and stabilisation, share risk proportionately, and ensure that public capital delivers lasting social benefit.

LONG -TERM RECOMMENDATIONS (OVER 5 YEARS)

Complement current legislative reforms in the co-operative sector with targeted tax and financial incentives for social care co-operatives, to support the development of a not-for-profit segment of the care economy.

Recent reforms, including the Law Commission Review of the Co-operative and Community Benefit Societies Act 2014 and the Mutuals and Friendly Societies Act 2023, could improve legal clarity and modernised the co-operative framework. However, they do not address the structural barriers faced by social care providers. Co-operative approaches to care delivery remain small-scale and insufficiently embedded within the social care system, meaning that legal reform alone is unlikely to unlock their full potential. Social care co-operatives should be recognised as not-for-profit providers within sector-relevant legislation (such as the Health and Social Care Wales Act 2025), and associated commissioning guidance.

In addition, international experience, particularly from Italy and some parts of Canada, where social care co-operatives are well established, suggests that statutory recognition should be complemented by targeted tax incentives, access to appropriate finance, and specialist development support. These measures would create a far more enabling ecosystem, supporting the development of an important segment of the care economy.

Remove profit on adult social care to protect service quality and ensure fair competition.

The removal of profits would mitigate the distortive effects of extractive for-profit providers within the social care market. Social policy measures aimed at restricting profit in social care activities have already been introduced in Wales, where the Health and Social Care Act 2025 will remove profit from the care of looked-after children by 2030. By removing financial extraction, such reforms would create greater space for social care co-operatives and other not-for-profit providers to grow as sustainable alternatives.

Invest in long-term research, evaluation, and evidence-building on co-operative and community-led care models.

The co-operative sector, alongside public and charitable research and innovation funders such as the National Institute for Health and Care Research, the Economic and Social Research Council, and Nesta, could support research that systematically analyses outcomes and impact produced by social care co-operatives. This would enable co-operatives to review and adapt their offer in response to identified needs, and provide evidence to inform appropriate policy interventions.

These recommendations set out a phased pathway for supporting co-operative approaches to adult social care, with the potential to reshape local care markets in ways that enhance quality, choice, and fair work. Where relevant, these actions and co-operative practice should align with national and local health policies, adopting a preventative and early-intervention perspective.

APPENDIX 1. CASE STUDIES AND EXAMPLES

Box 3: Wigan Council's Ethical Homecare Framework

Wigan Council's Ethical Homecare Framework is a leading UK example of values-based, collaborative commissioning. Launched in 2014 as part of the Wigan Deal, it emerged from two pressures: severe austerity (the council lost over 40% of its budget between 2010–2017) and recognition that traditional, task-focused homecare was inflexible and unsustainable.

Redesigning the Model | Commissioners identified key weaknesses in the local care market: instability, workforce shortages, long travel times, and fragmented, price-driven provision. The council responded with a redesigned model covering homecare, end-of-life support, supported living, and day opportunities. Extensive pre-market engagement with providers, community partners, and people receiving care clarified fair unit costs, logistical constraints, community strengths, and desired outcomes. It also generated core ethical principles: open-book accounting, payment of the Real Living Wage, local contribution, and commitment to high-quality, relationship-centred care.

Values-Based Procurement | The borough was divided into fourteen neighbourhood zones to reduce travel and improve continuity. Unit costs were fixed, removing price competition and allowing assessment based on alignment with Wigan's ethos. Small providers received targeted support. A multi-agency panel, including people who use services, selected eight providers on the basis of values and community commitment.

Outcomes and Impact | A decade on, results include no waiting lists for homecare, the highest proportion of CQC Good and Outstanding services in the Northwest, reduced travel times, improved retention, and a workforce where 86% live in the neighbourhoods they support. Providers now collaborate rather than compete, and the Framework functions as a flexible market-shaping tool. Wigan shows how councils can move from transactional procurement to place-based, ethical commissioning that strengthens local economies and improves care quality.

Box 4: Local authority tools for measuring social value aligned with co-operative and community-based providers

Oxford | Extended TOMs Framework | Tool that helps councils recognise and assess the forms of social value often delivered by co-operatives, social enterprises, and community organisations. It provides outcomes and measures aligned with local priorities and the scale of each contract.

Westminster | Supplier charters | A set of expectations that all suppliers, ranging from for-profit providers to Voluntary, Community and Social Enterprises (VCSE) (including co-operative social care providers), are required to meet when bidding for council contracts. Requirements are adapted to the type, scale, and duration of each contract.

Birmingham | Social Value Rationale template | For procurers and commissioners to consider social-value opportunities at the outset of the procurement process. The tool acts both as a prompt and as a recorded account of that early-stage thinking.

Box 5. Royal Borough of Greenwich – Advancing co-operative approaches to adult social care

In 2024, the Royal Borough of Greenwich took a significant step in developing a strategy to grow co-operative businesses. Social care is one element of a broader co-operative agenda, alongside supporting new and existing co-operative start-ups and businesses, and advancing community energy.

To redesign adult social care, the borough convened an independent Co-operation Commission. To examine how co-operative principles could address the challenges facing the borough's care market and support a more resilient, community-anchored model of provision.

A Co-operative Care Compact, a shared agreement between residents, carers, providers, unions, and the borough was proposed. The Compact set out co-operative values, clarifies desired outcomes, and signalled a long-term shift toward relationship-based, community-focused care. It also called for clearer articulation of service gaps and local needs to guide commissioning priorities.

The Commission also recommended a full review of future commissioning to identify where co-operative or democratically owned models may be better suited to the borough's objectives. This included examining opportunities in home care and considering where existing services could be adapted to reflect co-operative principles. Commissioners are encouraged to use the flexibilities in the Procurement Act to remove barriers for smaller, value-driven providers and reward commitments to social value and workforce wellbeing.

To build a more diverse and resilient provider landscape, the role of micro-businesses in delivering personalised, community-led care was highlighted and the need for targeted support.

Box 6. Kirklees – Building a community-rooted co-operative ecosystem in cocial care

Kirklees Council is developing a model of community-rooted social care by nurturing an ecosystem of micro-enterprises, community anchor organisations, and emerging social care co-operatives. At the centre of this ecosystem is Co-operative Care Colne Valley (CCCV), a multi-stakeholder co-operative and community business established to deliver high-quality domiciliary care for older and disabled residents. CCCV has developed an operational model that integrates paid care with community and family volunteer support to reduce isolation and strengthen local social ties.

The creation of CCCV was supported by both Kirklees Council and an independent charitable trust that supports and promotes community businesses. The council provided early start-up grants and assistance with staffing, recognising the value of place-based, community-led approaches to care. Power to Change offered early-stage capacity-building support, enabling the co-operative to develop its legal and financial structure.

Box 7. Applying co-operative principles and social value–led practices in adult social care commissioning (Wales)

Pembrokeshire County Council leading Change in Furzy Park

Furzy Park is an area of Haverfordwest in Pembrokeshire where two men with learning disabilities receive 24/7 support in their rented accommodation. Until recently, both commissioners (Pembrokeshire County Council) and providers saw this arrangement simply as a focused contract in which the only assets involved were the commissioner's funding and the provider's staff. Re-examining the situation through the lens of co-production and collaboration has shifted this perspective. The initiative began with a small act of helping a neighbour each week by putting out their rubbish and recycling bins. From this, an idea emerged for a neighbourhood-wide crisp and snack-packet recycling scheme to strengthen the men's connection to their community. They are now recognised not just as recipients of support, but as assets to their neighbourhood, with contributions that enhance their own well-being. This shift also allows the staff team to be seen not solely as support workers for the two men, but as a resource for the community. In the process, agencies and community groups operating in the area have started to share resources and combine efforts to address shared community needs.

Cwmpas – Supporting Commissioners in Carmarthenshire and Powys

Cwmpas worked with commissioners, managers and service providers in a structured programme to refocus local practice around the five wellbeing principles. Participants remained engaged throughout and reported that this shift broadened their ambitions and understanding of wellbeing-led commissioning. In

Box 7. continued

Carmarthenshire and Powys, teams collaborated to reshape care services, make fuller use of community assets and strengthen partnership working to build an ecosystem of support centred on local wellbeing. The programme enabled commissioners to reflect on strategic challenges and consider how preventative, community-based models could replace siloed service approaches.

Box 8. Rochdale's public service mutual: the PossAbilities case

PossAbilities was created in April 2014 as a public service mutual, spun out of Rochdale Borough Council's adult social care services. Prior to the transition, its services, primarily supporting people with learning disabilities and older residents, were delivered directly by the council's Adult Social Care team. Faced with mounting financial pressures, the council and staff agreed on the need for a new model that could safeguard provision while also giving greater influence to those delivering and using the services. Rochdale Council played a central role in enabling and supporting this process. The borough council worked closely with staff to maintain continuity of provision during the transition, while shifting ownership and accountability towards the frontline. The borough council was supported in this work by a social enterprise consultancy, which provided expertise in business planning to ensure the new model was viable. Although the transformation has presented challenges, the outcomes to date have been highly promising. In its first four years, PossAbilities grew its turnover from £6 million to £11.5 million and expanded its workforce from 220 to 550 employees. This commercial performance has been matched by sector recognition, with the team receiving multiple industry awards and the organisation achieving an Outstanding CQC rating for its supported living and Shared Lives services in Rochdale.

Box 9. Local authority programmes supporting micro-providers

Somerset Council, in partnership with Community Catalysts CIC and the Community Council for Somerset, has developed the Somerset Micro-enterprise Programme. As of January 2022, the programme has enabled over 400 micro-enterprises to deliver more than 9,000 hours of support per week across the county. Community Catalysts also collaborated with Rotherham Metropolitan Borough Council to develop small enterprises offering innovative, community-based daytime support for adults with learning disabilities.

Portsmouth City Council's Micro-Enterprise Programme supports individuals interested in working as self-employed support or care workers. The programme offers guidance on setting up a micro-business, registering as a micro-provider, finding clients, and meeting quality and safety standards. Participants join a local network of micro-providers, with access to ongoing advice, peer support, mentoring and opportunities to share learning.

The Wales Co-operative Centre and ADSS Cymru worked with Flintshire County Council to examine in depth how new micro-care providers can be commissioned and procured. Flintshire stands out in its aim to commission micro-care providers directly, and has used this approach as a strategic response to service shortages in rural areas. The pilot report explores the commissioning process in detail. It covers procurement and related areas including regulation, inspection, and workforce registration. Acknowledging the potential of micro-care, local partners have started to build the structures needed to support its continued development.

APPENDIX 2. RESEARCH METHODS

LITERATURE REVIEW

A literature overview (Booth, 2009) was conducted to examine the contemporary sector landscape, map the relevant evidence, and review the experiences of UK local authorities that have recently adopted co-operative approaches to service delivery. To identify academic and grey literature publications, the literature was retrieved using a range of methods, including: screening the reference lists of key reports; citation searching; searching relevant electronic databases; reviewing sector-specific publications; and consulting organisational websites, including Co-operatives UK, Cwmpas, Co-operative Alternatives, and the Co-operative Councils' Innovation Network. Eligible evidence included peer-reviewed and grey literature (reports, presentations, case studies, guidance) in English, published in the UK or other countries between 2018-2025. The documents retrieved informed the report's introductory section and formed the basis of the bibliographic resources listed in Appendix 3.

1. QUALITATIVE COMPONENT: INTERVIEWS AND IN-DEPTH CASE STUDY ANALYSIS

The qualitative phase included two parts: the first was based on semi-structured interviews with social care co-operative leaders (online and in-person), the second draws on three case study examples of social care co-operatives.

a. Semi-structured interviews with key leaders and informants

Twelve semi-structured interviews were conducted with key leaders and informants in the social care co-operative sector. A purposive sample of eight co-operatives (six operating and two being established) was identified through existing connections and networks of care co-operatives. The sampling strategy was informed by Roulstone & Hwang's (2015) categorisation of social care co-operative models into service-user, employee-owned, and multi-stakeholder. This approach supported a comparative understanding of the distinctive contributions made by different co-operative types to the care sector, as well as how challenges and potential solutions varied by organisational model.

The sample also included two representatives each from Co-operatives UK and Cwmpas, interviewed to gather the perspectives of organisations representing the sector and to explore possible differences between England and Wales.

The interview topic guide covered the following themes: organisation description and background to the co-operative's establishment; barriers encountered and enabling factors during development; evidence on the advantages and disadvantages of the co-operative model for people drawing on care, their carers, and workers; strategies to support co-operative growth and sustainability; perspectives on the sector and strategic priorities.

Three interviews took place in person and nine online. They lasted between one and two hours. Participants were offered a £25 voucher in recognition of their time and expertise. The research was approved by the University of Kent's School of Social Sciences Ethics Committee.

b. Case studies

From the sample above, we selected three case studies to provide a more in-depth assessment of the similarities and differences among co-operative organisational forms, and illustrate these through relevant examples (Yin, 2014). The three cases are draw from qualitative data collected in earlier studies conducted by the research team members (Table 1). The insights from the case studies are presented alongside the evidence gathered from the interview data to support the arguments with relevant examples.

Table 1. Case studies and data

Co-operative	Case Study Data
Friends United Together User - led co-operative	Interview and observational data collected as part of an IMPACT project and supplemented with further research with the co-operative in Wales.
Equal Care Co-op Multi-stakeholder, platform co-operative committed to better working conditions	Nine interviews conducted as part of a Centre for Care project on social care workforce innovation in the UK.
Cartrefi Cymru Co-operative Multi-stakeholder co-operative	Thirty interviews conducted with care staff and managers in Wales, with further interviews with organisational leaders to reflect current co-operative developments.

2. QUANTITATIVE COMPONENT: ONLINE SURVEY

An online survey was developed to collect descriptive information about co-operatives' activities. The format and length were designed to maximise accessibility and response rates. The survey was distributed to 15 co-operatives and completed by seven (47%).

The co-operatives were asked to provide information referring to the last financial year (May 2024 – April 2025) on: the type of activities provided; motivations for establishment; the area(s) of social care need addressed; types of services offered; the number of people drawing on the service; the number of staff and their socio-demographic breakdown; funding sources; and collaborations. The survey results were used to describe the sample and provide evidence on the themes explored in the report. Table 2 illustrates the data collected for each co-operative.

Organisation	Online survey	Interview
Co-op 1	✓	✓
Co-op 2	✓	✓
Co-op 3	✓	✓
Co-op 4	✓	✓
Co-op 5	✓	✓
Co-op 6	✓	
Co-op 7	✓	
Co-op 8		✓
Co-op 9- being established		✓
Co-op 10- being established		✓
Cwmpas		✓
Cwmpas		✓
Co-op UK		✓
Co-op UK- Guild		✓

DATA ANALYSIS

Qualitative evidence from interviews was manually transcribed from audio files and imported into Nvivo. The analysis has been conducted using the framework approach, suitable for describing and interpreting what was happening in a given context rather than generating theories (Ritchie et al., 2003). Regarding the case studies, a narrative analysis of the available data was conducted to identify elements in the organisational stories that illustrate co-operatives' contributions, the barriers and enablers they encounter, and the strategies used to support their development and sustainability.

The quantitative evidence was transferred into a spreadsheet for analysis. The analysis generated descriptive and summary statistics, including counts, prevalences, means, and ranges.

EVIDENCE GAPS AND FUTURE RESEARCH PRIORITIES

This research has some limitations. The sample is limited to a small number of co-operatives, from which rich qualitative data were drawn. Activity of emerging and unregistered organisations is under-documented. Second, much of the qualitative evidence is based on self-reported accounts from co-operative leaders. To address potential bias, findings were triangulated across methods. Thirdly, further quantitative evidence could link co-operative models to measurable outcomes for people drawing on care, carers, and public services. These limitations highlight the need for sustained research to inform social policy and the development of social care co-operative approaches.

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REPOSITORIES AND RELEVANT WEBSITES

- CICOPA (International Organisation of Industrial and Service Co-operatives) – https://www.cicopa.coop/category/publications/
- Co-operatives and Mutuals Canada – https://canada.coop/en/research/
- Co-operatives UK – https://www.uk.coop/resources Co-operative Councils' Innovation Network – https://www.councils.coop/
- Cwmpas – https://cwmpas.coop/what-we-do/policy-publications/
- IMPACT - https://impact.bham.ac.uk/2023/12/13/friends-united-together/
- Equal Care Co-op – https://play.equal.care/ International Co-operative Alliance (ICA) – https://ica.coop/en/online-library/resources
- National Cooperative Business Association CLUSA International (NCBA CLUSA) – https://ncbaclusa.coop/resources/
- Social Enterprise UK – https://www.socialenterprise.org.uk/reports/
- The Plunkett Foundation – https://plunkett.co.uk/reports/
- The Young Foundation (Institute for Community Studies) - https://www.youngfoundation.org/institute-for-community-studies/repository/
- UK Society for Co-operative Studies – https://www.ukscs.coop/
- Valley Care Co-operative – https://handbook.valleycare.coop/

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