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Research Article

Exploring the Distinctiveness of Social Enterprises Delivering Adult Social Care in England

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Social enterprises, which are businesses with social objectives, have been championed by the UK government as an opportunity to deliver more innovative, socially oriented, and commercially sustainable public services. However, very little is known about them, especially in a social care context. This paper therefore aims to answer the following three questions: (1) What are care social enterprises?, (2) What are their distinctive qualities?, and (3) How can they contribute to the adult social care sector? It presents evidence from a "mapping" of care social enterprises in three English local authorities, and from interviews with 35 stakeholders from across the social care and social enterprise sectors. Drawing on an institutional logics framework, we explore the influence of different norms, goals, and practices on care social enterprises and the extent to which they are aligned with those of the public, private, and not-for-profit sectors. We found that their unique combination of business and social logics, along with an entrepreneurial mindset, may make them more flexible, innovative, and able to diversify their income than public and not-for-profit care organisations. They were also considered more trustworthy than private care services. However, their competing social and business logics can create internal tensions and bring uncertainty about what organisational model they are. These tensions can make it challenging for us to define what a care social enterprise is and in turn for social enterprises to promote themselves and attract funding.

1. Introduction

Adult social care in England (support and practical help for frail and disabled people) is organised locally by councils and mostly delivered by the private, for-profit sector, with some public and voluntary sector provision. Underpinned by neoliberal principles of marketisation and competition, this model of social care has been widely criticised for leading to a focus on competition and profit over quality of care [1]. Therefore, increasing demand for social care from older and disabled people combined with growing pressure on public finances, have for over a decade, led to calls from both government and service users for more innovative care services that are both cost-effective and responsive to user need [2, 3]. Social enterprises, which are "hybrid" organisations, due to their combination of business and social objectives [4] have emerged within this context. They have been championed by the UK government as an opportunity to empower staff, and deliver more innovative, socially oriented, and commercially sustainable care services [5]. Social enterprises can take a variety of legal forms (e.g., Community Interest Company or Industrial and Provident Society) making it difficult to know how many of them exist [6], but there are an estimated 5,000 social enterprises operating in the social care sector ("care social enterprises" from here on in [7]). However, very little is known about them.

This paper aims to address this gap by exploring the following three questions: (1) What are care social enterprises?, (2) What are their distinctive qualities?, and (3) How

can they contribute to the adult social care sector? It draws on a mapping of care social enterprises in three English local authorities, and interviews with 35 stakeholders from across the social care and social enterprise sectors. We draw on an institutional logics lens to explore the influence of different norms, goals, and practices on care social enterprises [8, 9] and the extent to which they are aligned with those of the public, private, and/or not-for-profit sectors. In doing so, we unpack their perceived distinctiveness in relation to their coexisting "social" and "enterprise" logics.

1.1. English Care Markets and Social Enterprise. Since the early 1990s, governments have accepted and adopted the idea that increasing market competition and user choice in social care will drive up quality and result in services that meet user needs [10–12]. Social care in England is therefore a quasimarket as the state continues to fund and purchase a majority of social care services, but services are delivered by a range of providers, with quality and safety independently regulated by the Care Quality Commission [13, 14]. The private, for-profit sector now delivers around 78% of all adult social care services, with 18% in the voluntary sector and 4% in the public sector [15]. Despite strong regulation, some argue that the care system is increasingly moulded to suit the priorities of private investors rather than social care users, leading to the under provision and/or poor quality of services, as well as low pay, poor working conditions, and high staff turnover [14]. Subsequently, there is widespread criticism of "profit-making" in social care and demands not only for more financial investment in social care but a radical rethink of the ways that the most vulnerable in our society are supported [16].

Social enterprises that straddle the well-established models of business and charity emerged in English health and social care in the early 2000s. They are broadly defined in the UK policy as "businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners" [17]. Despite the introduction in 2004 of a specific organisational form for social enterprises, the Community Interest Company (CIC), they can take a variety of legal forms leading to ongoing debates about how these hybrid organisations are defined [6, 8]. Nonetheless, the UK government has led significant investment into supporting social enterprises, and the health and social care sectors have been at the forefront of such strategies. Since 2008, government policies and programmes have actively supported new and existing social enterprises delivering health and/or social care services in England [18, 19]. These programmes largely focused on NHS and social care staff "spinning-out" services from the public sector into social enterprises and aimed to empower public sector staff to tackle social problems in an innovative, socially oriented, and commercially sustainable way [5]. More recently, policy and practice have focused on using social enterprise as a vehicle for care innovation, with "relationships" and staff "empowerment" at the forefront [20, 21].

1.2. The Distinctiveness of Care Social Enterprises. Government investment in social enterprises is linked to their reported distinctiveness over other organisational forms and sectors; however, there is a clear lack of research in this area. Evidence on social enterprises in the healthcare sector is expanding [18, 22–25], but evidence of social enterprises in the adult social care sector is limited to a small number of academic studies [26, 27], sector reports [7], and government documents [5, 28]. Furthermore, there is a good understanding of the distinctiveness of not-for-profit or third sector organisations, e.g., charities in delivering social care [29, 30], but this does not specifically explore social enterprises. Instead, existing research (e.g., [30, 33]) often combines social enterprises with other not-for-profit or third sector models (using the term "voluntary, community, and social enterprise" organisations) or fails to acknowledge them at all.

Existing evidence, primarily from the health sector, suggests that social enterprises can offer added value when compared with the public and for-profit sectors. It points to their distinctive qualities being higher quality care and more positive outcomes for users, particularly in relation to strong service user and carer involvement, higher community engagement, trust, access to hard-to-reach groups, innovation, and cost-effectiveness [18, 22, 29]. They are also reported to deliver better outcomes for staff including higher staff satisfaction and lower turnover than other organisational models [18, 27]. The reported distinctiveness of social enterprises stem from their "hybridity" of three coexisting institutional logics: (1) a public sector logic linked to a commitment to public values; (2) a business logic relating to commercial opportunities and financial efficiency; and (3) a civil society logic emphasising a social ethos and staff/user empowerment [8, 25, 31]. These combined institutional logics arguably lead to more flexible business models, the reinvestment of profits into a social mission, reduced bureaucracy compared with the public sector and strong engagement with staff and users [5, 7, 18, 22, 28].

Whilst there are some evidence that social enterprises (and the third or not-for-profit sector more broadly) have clear advantages over for-profit organisations, it has been widely noted that there is little evidence to support social enterprises as a substitute for public or private health and care services [23, 32]. Indeed, their distinctiveness can vary according to the type of care, with a review by Dickinson et al. [29] pointing out that third sector providers tend to deliver preventative services to people in the community with lower levels of need. The literature also points to a number of threats and challenges to the distinctiveness of social enterprises, largely related to funding and governance. Their commitment to a social mission and (normally) smaller scale also means they can be more expensive than for-profit providers. As Smith [33] notes, this is fine as long as that mission is valued, but there can also be additional costs in using tools that capture their "added value." Challenges also include a lack of understanding of social enterprises by commissioners and policy makers, limited business resources and skills within social enterprises, and organisational tension around conflicting economic and

social goals [18, 22, 34]. Furthermore, the wider political environment has placed increased demands on third sector organisations, including social enterprises, to become more commercially oriented (also see [35, 36]).

A further challenge in researching and funding care social enterprises is that their hybridity makes them difficult to define and identify. This is complicated further when attempting to define the boundaries of adult social care. Existing evidence suggests that the services delivered by social enterprises often span social care, health, wellbeing, housing, mental health, and/or employment (see [8, 22, 23]). Tyrell [34] suggests that one approach is to understand what social enterprises are and do within the context in which they operate and in their relationship with other sectors. This context is therefore the starting point of our paper, which seeks to explore the distinctiveness of care social enterprises through an exploration of their "social" and "enterprise" institutional logics.

2. Materials and Methods

The study utilised a mixed methods approach, comprising a "mapping" of social enterprises in three local authority areas of England and stakeholder interviews.

2.1. The Mapping. To gather a better understanding of what a care social enterprise looks like, we undertook a "mapping" of all social enterprises delivering adult social care services in three English local authority areas. We selected areas purposely to represent a diversity of regional/demographic profiles. Our sites included urban, rural, and semirural locations and those with different political control. We also selected areas where there was evidence of some social enterprise activity (identified in consultation with project partners/stakeholders). Mapping methods have historically been used in health [37], third sector [38], and community development research [39] to understand the nature and scale of particular organisations. In our study, mapping was used to identify as many as possible of the social enterprises in the three areas and gathered additional information on each of them, including the services offered, service user groups, size, and governance arrangements. To identify social enterprises in each area, we used web searches, local authority lists of approved adult social care providers and directories of health and wellbeing services made available for local citizens. Stakeholder interviewees and advisory board members also provided information and lists of social enterprises.

Identifying the larger and more 'formal' social enterprises (including those registered as Community Interest Companies (CICs)) were relatively straightforward, but many small and community-based social enterprises operate "under the radar" and may not appear on any formal datasets or regulatory lists. Therefore, the study also drew on the "street level mapping" methodologies [40] involving a combination of online searching, emailing, and contacting local organisations and stakeholders. The difficulties of defining social enterprise and social care became evident through the mapping, and whilst this led to challenges in deciding which organisations to include/exclude, it did also help us to unpack some of the complexities of the care social enterprise sector. We only included organisations that were CICs, listed on a social enterprise directory (e.g., as provided to the authors by network organisation Social Enterprise UK) or self-defined as social enterprises. Similarly, we only included organisations that self-defined as delivering "adult social care" or were listed on a social care directory (e.g., as provided by a local authority). Whilst we felt we had identified all or most of the social enterprises in each area, gathering additional information on size, legal form, and turnover was challenging due to a lack of publicly available information. Many of the organisations did not have websites and some only had facebook pages; so organisational information was not easily available leading to some gaps in our analysis. Nonetheless, we were able to ascertain a good overview of the sector, which we present in our results.

2.2. Stakeholder Interviews. Semistructured interviews or small focus groups were undertaken with 35 stakeholders, including policy makers, social care, and third sector representatives, trade unions, local authorities (including Directors of Adult Social Care who have responsibility for local authority social services and commissioners of adult social care services), councillors, and social enterprise leaders (Table 1). Twelve of the 35 interviews were undertaken at a national level and 23 from the three mapping sites.

Stakeholders were identified through the project advisory board; the researchers' networks and snowballing from these initial contacts. Interviews were undertaken online using zoom and audio recorded. A topic guide was used to ensure consistency across the interviews, although flexibility was employed to follow-up key issues that arose. The interviews focused on defining and understanding social enterprise and social care, how social enterprises were perceived to compare with other organisational models/sectors and national/local policy contexts.

The interviews were transcribed and coded thematically using NVIVO software by both researchers, as well as a co-researcher with lived experience of care. Discussion among the project team led to the development of an agreed coding framework based on the research questions and key themes from the literature. Intercoder reliability checks took place following the coding of two transcripts where the emergent coding and themes were shared and discussed [41]. Selective coding [42] was used to select the quotes presented as follows.

Ethical approval was obtained from the host university (reference ERN_20-1108) and from the Association of Directors of Adult Social Services (ADASS) (reference RG21-16). All interviewees were provided with plain English information sheets and informed consent was obtained via a consent form or verbally before the interview began. All information remained confidential, and participant's names were removed from publications. The mapping only drew on publicly available information, but to retain confidentiality of local stakeholder interviewees, the names/locations of the local authorities and social enterprises have been anonymised.

Table 1: The stakeholder interviewees.

Third sector stakeholder	9 (5 national, 4 local)
Local authority (including 5 commissioners)	8 (all local)
Social enterprise leaders	8 (all local)
Social care stakeholder	7 (6 national, 1 local)
Councillor	2 (all local)
Trade union	1 (national)
	35

3. Results

3.1. What Is a Care Social Enterprise? A clear finding from the mapping and interviews is that there is no consensus around what a care social enterprise is and does. In defining "social enterprise," most interviewees felt that they are distinct from private, for-profit providers due to profits being reinvested into a social mission, and distinct from not-for-profits due to the centrality of trading and recognition that they can (and should) make a profit. These distinctions are discussed further in the following sections. The definitional difficulties of social enterprises have been widely noted (e.g., [6]), and these challenges can be extended to social enterprises in the social care sector:

> *I find the term a little confusing at times because there are so many organisations that have sprung up with different titles. We have community interest companies; we have those that might call themselves a social enterprise. We have employee-owned organisations. I think the definition of that term needs spelling out a little more because I think it will mean different things to different people.* (Councillor)

We also used the mapping to explore some key characteristics of care social enterprises. In relation to legal form, this varied considerably with only around one-third operating as CICs, with the remaining majority operating as Companies Limited by Guarantee. Legal form was however acknowledged by many interviewees as not in itself being important, and that social enterprises can take a range of legal forms without making any real difference to how they operate in practice. Legal form was simply viewed as a vehicle to enable the delivery of the social mission. This flexibility in organisational models led to some confusion among different stakeholders, who often found it difficult to distinguish them from other for-profit or not-for-profit entities. However, for the social entrepreneurs, this flexibility was mostly seen as a benefit:

> *I think the beauty for me of social enterprise is actually it could be any of those forms. . .It can be a charity. It can be a traditional business. It can take so many different models of the business, but I think the core of it is actually the mission or the aims or the values of that business. That's what makes it really a social enterprise. That's what makes it different.* (Social entrepreneur)

In relation to the size and staffing of care social enterprises, our mapping indicated that around three-quarters of organisations were small and community based, having between 5 and 20 staff and a turnover of less than £100,000. Around a third was run by or had volunteers. We identified only a small number (approx. 20%) of medium and large organisations with more than 100 employees and/or turnover of more than £500,000. We would however expect the number of very small social enterprises to be higher than our analysis suggests, as we could only collect data on size from around 30% of the social enterprises in our mapping. Missing data were due of many organisations having no websites or were missing from existing datasets, both of which are more common among smaller organisations [40]. Our interviews also supported the idea that care social enterprises tend to be small and community based. Some interviewees referred to them as "community businesses," a form of social enterprise that are locally rooted and trade for the benefit of their local community [43]. As a commissioner explained, "*they are often organisations that are grown organically within communities because of a specific need and they've just evolved.*"

In relation to the types of support offered by care social enterprises, we identified that more than half (51%) of care social enterprises offered day support services for people with learning disabilities, autism, mental health needs, and/or older people. We noticed some small differences across the sites, with site 3 providing more services for older people and carers, whilst sites 1 and 2 were more focused on supporting people with learning difficulties and mental health (see Table 2). The higher level of CQC registered social enterprises in site 2 is likely to reflect the higher number of domiciliary and residential services there; but overall social enterprises provided few domiciliary (10%) and residential (9%) services.

Most delivered day services, broadly defined by Orellana et al. [44] as community building-based services that provide care-related activities for people who are disabled or in need, and which support people to remain living at home and enable informal carers to sustain care. The day services offered by the social enterprises spanned a range of activities including horticulture, cafes, arts and crafts, life skills, and employment support. The nature of day support differed from traditional day centres, which tend to be building-based [44], and some interviewees spoke about social enterprises instead acting as "anchor institutions" [45] that bring together community resources to promote the health and wellbeing of individuals. Our interviewees spoke about a key strength of social enterprises being their "asset-based" approach [46], designed to connect people into their local communities and holistically address the social or prevention side of social care, as a commissioner explained:

> *We don't look at social enterprise with a really narrow point of view that it has to involve the formal delivery of social care because community connection and being able to maximise your strengths, assets, loves, and interests is so vital to people living their best life.* (Commissioner)

Table 2: Mapping of care social enterprises.

Sites	No. of care SEs	% that are CQC inspected	Main service areas based on 133 SEs (91% of total)	Service user groups based on 125 SEs (86% of total)
1 (large city)	62	19%	Day services (49%) Domiciliary (11%) Residential (8%) Advocacy support (8%)	Learning disabilities (25%) Mental health (15%) Older people (13%) Autism/carers (both 8%)
2 (postindustrial town)	60	31%	Day services (55%) Domiciliary (16%) Residential (8%) Advocacy support (9%)	Learning disabilities (25%) Dementia (14%) Mental health (13%) All user groups (13%)
3 (rural area)	24	8%	Day services (44%) Domiciliary (0%) Residential (8%) Advocacy support (17%)	Older people (27%) Learning disabilities (23%) Carers (12%) Mental health (12%) All user groups (12%)
Total (all sites)	146	23% ($n = 33$)	Day services (51%) Domiciliary (10%) Advocacy support (10%) Residential (9%)	Learning disabilities (25%) Older people (14%) Mental health (14%) All user groups (10%)

NB: CQC is the care quality commission, the independent social care regulator.

An interviewee provided an example of how a social enterprise café was a community "anchor," established to address local social care needs:

> *Running a café isn't in itself social care, but actually it's the things that café enables that make it social care.* (Social care stakeholder)

This broad definition of social care was seen as a benefit to most interviewees who felt that social enterprises often straddle not only health and social care, but also housing, education, and employability services. It was also suggested that social enterprises are well placed to deliver on the integration agenda, especially as some larger social enterprises were reported to have service delivery contracts with both local authorities (social care) and clinical commissioning groups (health):

> *Commissioners have brought (social enterprises) together in an integrated fashion. So they'll be delivering community nursing services, podiatry services, and all sorts of clinic-led services, but with a social care element to them as well, like dementia care services in the home or in housing.* (Councillor)

Care social enterprises are therefore not a clearly defined sector, so to further our understanding we now explore their norms, goals, and practices, as well as the context within which they operate. To achieve this, we unpack their "social" and "enterprise" logics and perceived distinctions from other sectors and organisational models.

3.2. The "Enterprise" Logic: Distinctiveness from For-Profits. Social enterprises were widely viewed by interviewees as a positive alternative to the private, for-profit sector, which is often associated with "scandal" and "low quality" due to the profit motive:

> *If you mention the words "private sector" in the context of social and healthcare, you would be turned out of town by some people who would say we're speaking the words of the devil.* (Councillor)

Whilst interviewees felt that social enterprises can and should make a profit, they also said that "*profit is not the bottom line*" (third sector stakeholder) in a social enterprise as it is in for-profit organisations. A social entrepreneur explained the importance of maintaining a "double bottom line," which involves a fine balance between financial and social logics:

Interviewees spoke about the characteristics of social enterprises that are shared with the private sector, including their entrepreneurial mindset, innovative approaches, risk-taking culture, and investment in new projects. However, the key distinction was that any risk-taking would need to bring both social and financial benefits. For example, a social entrepreneur from a larger organisation explained how they had used their profits to set up a garden centre, residential care home, and supported-living service that would generate financial resilience for the organisation, as well as meet their social mission by holistically supporting the care needs of local people:

> *We now own the building that I'm sat inside, headquarters office, we own (a garden centre), we're about to buy a care home. We've built and bought and renovated houses right across the whole of the borough that we lease out to service users. So our balance sheet is strong.* (Social entrepreneur)

It was however acknowledged that this dual mission can make social enterprises more challenging to run than for-profits, especially in a financially stretched social care sector:

> *The choices that someone makes to run a social enterprise are different from running a mainstream business, and it's much harder because of your commitment to address a social issue.* (Third sector stakeholder)

Other interviewees, including the social entrepreneurs themselves, questioned what an acceptable level of profit is in social care. There was a general acceptance that the higher the profit, the higher the social return should be. Others took a much more critical stance and felt that there is no place for profit in social care due to the financial aims always taking precedence over the social in any profit-making organisation:

> *I would say that an organisation that is seeking to make a profit couldn't be a social enterprise. . .If you're making a profit, then that ends up being your primary purpose even if you claim it's something else.* (Trade union)

Therefore, a dual social and financial mission was considered difficult to achieve in practice and also led to misunderstandings about what type of organisation a social enterprise is, leaving them in what one social entrepreneur referred to as "no-mans-land." Social entrepreneur interviewees also explained that their hybridity and lack of organisational clarity could lead to challenges accessing funding and contracts. Similarly, their commitment to a social mission could create high levels of pressure for the social entrepreneurs and their staff who are often willing or forced to take on additional work to deliver their aims:

> *Because of the way that social enterprises are flexible. . .it puts the individual who runs it at risk of suffering with their own mental wellbeing because they really don't operate on a 9:00–5:00 day. You'll get some groups supporting people at 8:00 at night, or 6:00 on a Saturday. . .they're responding to calls in the middle of the night. It's great for reducing the number of suicides, for example, but then you start to worry about the individuals in that organisation suffering themselves.* (Third sector stakeholder)

It was also recognised that a fine line exists between social enterprises and for-profit organisations. Like social enterprises, some businesses in the care sector reinvest their profits into socially oriented projects (e.g., via corporate social responsibility) and also like social enterprises, some for-profits deliver public service contracts:

Therefore, despite the social logics of social enterprises being a key distinguishing feature from their for-profit counterparts, this distinction was not always straightforward.

3.3. The "Social" Logic: Distinctiveness from Not-For-Profits. Interviewees found that distinguishing social enterprises from both public services and not-for-profit charities was even more challenging. The centrality of trading to social enterprises was however contrasted with charities that were viewed as being largely dependent on donations and volunteers:

> *I guess it's a business mentality and that ability to use any surplus profits to reinvest in it, which you wouldn't in a traditional charitable model because there's lot of focus on raising money from grants.* (Third sector stakeholder)

However, as many interviewees noted, many charities do also trade, making this distinction even less pronounced. The number of trading charities has increased as a result of marketisation policies which pushed nonprofit organisations to adopt commercial strategies [4] and as one- third-sector stakeholder noted, *"(some) voluntary organisations are operating as social enterprises, they just simply don't regard themselves as doing so."* However, it was felt that social enterprises have more freedom and flexibility to innovate than both charities and public services. Charities were seen as less flexible organisational models with more restrictive bureaucratic governance structures and regulation from the Charity Commission. Charities were also viewed as being less able to "invest and grow" than social enterprises due to their reliance on donations and more "limited business mentality." Similarly, "red tape" in the public sector was seen as particularly restrictive and social entrepreneur interviewees who had previously worked in the public sector spoke about the social enterprise model giving them the freedom and flexibility to "do things differently:"

A third sector interviewee also explained how less regulation and a more entrepreneurial mindset within social enterprises make them able to identify and exploit gaps in the care market. They go on to provide the example of a care social enterprise using its surplus from social prescribing and garden centre services to set up a childcare service that delivers a social return in two ways: one, by addressing local childcare and employment gaps, and two by making a profit that is reinvested back into the social enterprise.

Care social enterprises were also referred to by interviewees as "fleet of foot" and well connected to a range of other public, private, and third sector organisations locally that they can draw on as needed to deliver their social and financial goals. Their adaptability and flexibility was noted as particularly prominent during the COVID-19 pandemic, and interviewees explained that some care social enterprises switched their in-person day services to online or outdoor support, and even moved from social care into food and prescription deliveries. Despite the obvious challenges that social enterprises faced during the pandemic, including a loss of funding and closure, many interviewees spoke about how the pandemic had highlighted the local embeddedness of care social enterprises and also created new opportunities for them to collaborate:

When push comes to shove, like the onset of COVID, it does make it much easier to actually come together. However, that was definitely proved to be the case. Because we all know one another and there's sufficient trust for us to know one another's weaknesses and strengths, that at the end of the day, we will do what needs to be done. (Social entrepreneur)

A commissioner explained that it was this community embeddedness of social enterprises that distinguished them from public services:

I think in operating in that way, which differs from the larger businesses, they're also more likely to be better trusted, like more effective at performing certain roles, designing and delivering those bespoke services because they know the community really well. And we know that's not traditionally been a strength of the public sector. (Commissioner)

This highlights the ways in which social enterprises can act as community anchors and develop community-asset-based approaches that empower people to meet their own needs.

4. Discussion

Our findings draw attention to a complex care social enterprise landscape, a sector we previously knew very little about through empirical research. We found that most care social enterprises are small scale and community-led, delivering what we could term "day" services, and focusing on social support, wellbeing, and employability. Their emphasis on enabling independence, empowerment, and relationship building align with movements away from institutional practice in social care to those which shift power to people and communities [47]. Our stakeholder interviewees spoke extensively about social enterprises being instrumental in building asset-based approaches that focus on addressing local needs, as well as reviving and protecting local relationships and services [48–50]. This emphasis also aligns with the prevention agenda, defined through the Care Act 2014 as activities designed to promote wellbeing and to prevent, reduce, or delay the need for social care services, as well as ease pressure on unpaid family carers [46]. The localised and small-scale approaches of social enterprises may also bring additional benefits including the delivery of more flexible and person-centred care. This then raises the question of whether it is the organisational model or size of care social enterprises that make them distinctive, reflecting prior research findings that very small "micro" enterprises in the care sector deliver more person-centred and flexible care than larger organisations [51].

In addressing the question of how social enterprises are distinctive from the for-profit and not-for-profit sectors, our findings suggest that the "profit bad, not-for profit good" assumptions that underpin social care provision are not straightforward and social enterprises are a good example of where those boundaries are blurred. Social enterprises are "hybrid" organisations that do not fit neatly into the conventional sectoral categories of public, for-profit, or non-profit [4], and their distinctiveness stems from their coexisting business and social institutional logics [8]. Our stakeholders felt that care social enterprises are underpinned by a stronger entrepreneurial mindset than their charity and public sector counterparts which plays out in a focus on cost-effectiveness and the exploitation of new opportunities. Organisation size did again appear to make a difference, with the business logic of larger organisations focused on scaling up through growth and expansion, e.g., by opening garden centres or childcare services, whilst the smaller social enterprises focused on local innovations and scaling out, e.g., switching their day service to food delivery during the COVID-19 pandemic. Care social enterprises were however viewed as more flexible and adaptive than both public services and charities which were felt to be bound up in "red-tape." Some of the social entrepreneurs spoke about how their frustration with public sector bureaucracy was the primary motivation to set up the social enterprise in the first place.

Social enterprises are therefore arguably at an advantage due to the flexibility of the organisational models and governance structures available to them; yet competing social and market logics can also create tension both internally and externally to the organisation [52]. These competing logics can bring uncertainty over what social enterprises are and what they can contribute to social care. Commissioners and other stakeholders expressed a lack of clarity around social enterprises which in turn makes it challenging for social enterprises to promote themselves and attract funding. English social care is currently underpinned by a market-based logic, as commercial, for-profit providers dominate the sector. Social enterprises are therefore competing with for-profit providers to achieve financial sustainability and deliver cost-effectiveness, whilst also competing with not-for-profits to deliver social value. This tension can lead to mission drift [52] where social objectives are sacrificed to achieve financial sustainability [4, 53]. Conversely, we found that some social entrepreneurs are so passionate about delivering their social mission and were under pressure from funders to deliver both financial and social sustainability, that they were themselves working in unsustainable ways.

Therefore, whilst there appears to be an opportunity for social enterprises to tackle the social care crisis, they do face a number of challenges and barriers. They are an organisational model that already play a crucial role in the social care market but may not be the "one size fits all" solution. Whilst they may be preventing the need for more costly domiciliary and residential social care services, there will always be the need for these more formal care services, and further evidence is needed to understand social enterprise in this space. Our research also indicates that it is not necessarily the social enterprise organisational form that is the solution, but what is important is the delivery of good quality care for the people who use services. As one social care stakeholder commented "*at the end of the day, if it meets your needs, then as an individual you probably don't really*

care if it's a social enterprise." Therefore, whilst our research provides a much clearer understanding of the care social enterprise landscape, more research is needed to understand their outcomes, especially in comparison with other organisational models. Existing research suggests higher quality in not-for-profits than for-profits [30], but this analysis has not yet been extended to organisational models that include social enterprises.

5. Conclusion

The contribution of social enterprises to the care sector remains an under-researched area and most evidence remains anecdotal and reported by social enterprises themselves. Our research begins to fill this gap and suggests that social enterprises can offer added value to the social care sector due to their unique combination of social and business logics. However, a fuzziness surrounding the different sectors [32] and competing institutional logics can also be a disadvantage [8] as they compete in an increasingly profit driven social care market, leaving them in what they themselves refer to as "no-mans-land." It is therefore difficult to draw a boundary around what they are and therefore what their contribution is. Furthermore, there is a lack of research evidence that directly compares social enterprises with other organisational models and a lack of outcomes evidence from the people who use services. This is a noted limitation of our study, and so we suggest further research is urgently needed to explore the experiences and outcomes of social enterprises for service users and carers, as well as the staff that work in them.

Data Availability

Data are available from the authors on request.

Additional Points

What is known about this topic and what this paper adds? What we know: (i) the UK government have led significant investment in social enterprises in the health and care sector. (ii) There are currently around 5,000 social enterprises operating in the social care sector, but little is known about them. What this paper adds:(i) through their focus on social support, wellbeing, employability, and community asset building, care social enterprises are felt to be promoting wellbeing and preventing or delaying the need for social care services. (ii) The entrepreneurial mindset of care social enterprises may make them more flexible and cost-effective than their not-for-profit and public sector counterparts. They are considered more trustworthy than private, for-profit care services. (iii) It is difficult to define and identify care social enterprises which can lead to a lack of understanding by commissioners and other funders.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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References

[1] D. Button and S. Bedford, "Ownership in social care: why it matters and what can be done?" *New Economics Foundation*, vol. 9, 2019.

[2] Department of Health and Social Care (DHSC), "People at the heart of social care: adult social care reform," 2022, https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform#executive-summary.

[3] Department of Health (DH), "Social enterprise – making a difference. A guide to the right to request," 2008, https://www.dhcarenetworks.org.uk.

[4] B. Doherty, H. Haugh, and F. Lyon, "Social enterprises as hybrid organizations: a review and research agenda," *International Journal of Management Reviews*, vol. 16, no. 4, pp. 417–436, 2014.

[5] Department of Health, *Making Quality Your Business: A Guide to the Right to Provide*, The Stationery Office, London, UK, 2011.

[6] S. Teasdale, "What's in a name? Making sense of social enterprise discourses," *Public Policy and Administration*, vol. 27, no. 2, pp. 99–119, 2012.

[7] SEUK, "No going back: state of the social enterprise sector 2021," 2021, https://www.socialenterprise.org.uk/wp-content/uploads/2021/10/SEUK-SOSE-Report-DIGITAL-1.pdf.

[8] I. Vickers, F. Lyon, L. Sepulveda, and C. McMullin, "Public service innovation and multiple institutional logics: the case of hybrid social enterprise providers of health and wellbeing," *Research Policy*, vol. 46, no. 10, pp. 1755–1768, 2017.

[9] P. H. Thornton, W. Ocasio, and M. Lounsbury, *The Institutional Logics Perspective: A New Approach to Culture, Structure, and Process*, Oxford University Press, Oxford, UK, 2012.

[10] R. Rodrigues and C. Glendinning, "Choice, competition and care—developments in English social care and the impacts on providers and older users of home care services," *Social Policy and Administration*, vol. 49, no. 5, pp. 649–664, 2015.

[11] J. Lewis and A. West, "Re-shaping social care services for older people in England: policy development and the problem of achieving "good care"," *Journal of Social Policy*, vol. 43, no. 1, pp. 1–18, 2014.

[12] D. Brennan, B. Cass, S. . Himmelweit, and M. Szebehely, "The marketisation of care: rationales and consequences in Nordic and liberal care regimes," *Journal of European Social Policy*, vol. 22, no. 4, pp. 377–391, 2012.

[13] C. Needham, K. Allen, E. Burn et al., "How do you shape a market? Explaining local state practices in adult social care," *Journal of Social Policy*, vol. 18, pp. 1–21, 2022.

[14] I. Bode, L. Gardin, and M. Nyssens, "Quasi-marketisation in domiciliary care: varied patterns, similar problems?" *International Journal of Sociology & Social Policy*, vol. 31, no. 3, pp. 222–235, 2011.

[15] J. Kearney and A. White, "The economic value of the adult social care sector – UK," 2018, https://www.skillsforcare.org.uk/Documents/About/sfcd/Economic-value-of-the-adult-social-care-sector-UK.pdf.

[16] K. Bayliss and J. Gideon, "The privatisation and financialisation of social care in the UK," 2020, https://www.soas.ac.uk/economics/research/workingpapers/file150390.pdf.

[17] Department for Trade and Industry (Dti), *Social enterprise: A Strategy for success*, Department for Trade and Industry, London, UK, 2002.

[18] K. Hall, P. Alcock, and R. Millar, "Start up and sustainability: marketisation and the social enterprise investment fund in England," *Journal of Social Policy*, vol. 41, no. 4, pp. 733–749, 2012.

[19] R. Hazenberg and K. Hall, "Public service mutuals: towards a theoretical understanding of the spin-out process," *Policy & Politics*, vol. 44, no. 3, pp. 441–463, 2016.

[20] V. M. Drennan, M. Calestani, F. Ross, M. Saunders, and P. West, "Tackling the workforce crisis in district nursing: can the Dutch Buurtzorg model offer a solution and a better patient experience? A mixed methods case study," *BMJ Open*, vol. 8, no. 6, p. e021931, 2018.

[21] TLAP Think Local Act Personal, "6 Innovations in Social Care," 2018, https://www.thinklocalactpersonal.org.uk/Latest/Six-innovations-in-social-care-/.

[22] M. J. Roy, C. Donaldson, R. Baker, and S. Kerr, "The potential of social enterprise to enhance health and well-being: a model and systematic review," *Social Science & Medicine*, vol. 123, pp. 182–193, 2014.

[23] F. Calo, M. J. Roy, C. Donaldson, S. Teasdale, and S. Baglioni, "Exploring the contribution of social enterprise to health and social care: a realist evaluation," *Social Science & Medicine*, vol. 222, pp. 154–161, 2019.

[24] D. Kelly, A. Steiner, M. Mazzei, and R. Baker, "Filling a void? The role of social enterprise in addressing social isolation and loneliness in rural communities," *Journal of Rural Studies*, vol. 70, pp. 225–236, 2019.

[25] K. Hall, R. Miller, and R. Millar, "Public, private or neither? Analysing the publicness of healthcare social enterprises," *Public Management Review*, vol. 18, no. 4, pp. 539–557, 2016.

[26] M. Powell, A. Gillett, and B. Doherty, "Sustainability in social enterprise: hybrid organizing in public services," *Public Management Review*, vol. 21, no. 2, pp. 159–186, 2019.

[27] F. Henderson, K. Hall, A. Mutongi, and G. Whittam, "Social enterprise, social innovation and self-directed care: lessons from scotland," *Social Enterprise Journal*, vol. 15, no. 4, pp. 438–456, 2019.

[28] Department for Digital, Media and Sport (DCMS), *Growing up Together: Evaluation of the Mutuals Partnership Support Programme*, Department for Digital, Media and Sport (DCMS), London, UK, 2019.

[29] H. Dickinson, K. Allen, P. Alcock, R. Macmillan, and J. Glasby, *The Role of the Third Sector in Delivering Social Care*, NIHR School for Social Care Research, London, UK, 2012.

[30] A. M. Bach-Mortensen and P. Montgomery, "Does sector matter for the quality of care services? A secondary analysis of social care services regulated by the Care Inspectorate in Scotland," *BMJ Open*, vol. 9, no. 2, Article ID 22975, 2019.

[31] K. Peattie and A. Morley, "Eight paradoxes of the social enterprise research agenda," *Social Enterprise Journal*, vol. 4, no. 2, pp. 91–107, 2008.

[32] E. Heins and H. Bennett, "Best of both worlds"? A comparison of third sector providers in health care and welfare-to-work markets in britain," *Social Policy and Administration*, vol. 50, no. 1, pp. 39–58, 2016.

[33] Smith, "Not-for-profit organisations work well in caring services LSE Blog," 2011, https://blogs.lse.ac.uk/politicsandpolicy/not-for-profit-caring-services/.

[34] S. Tyrrell, *The Potential of Social Enterprise for Social Care: Literature Review*, Swansea, Swansea, UK, 2018.

[35] M. Mazzei and M. J. Roy, "From policy to practice: exploring practitioners' perspectives on social enterprise policy claims," *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, vol. 28, no. 6, pp. 2449–2468, 2017.

[36] L. Huckfield, "The rise and influence of social enterprise, social investment and public service mutuals," 2014, http://www.independentaction.net/wpcontent/uploads/sites/8/2011/03/Social-enterprise-final.pdf.

[37] J. Foot, "What makes us healthy? The asset approach in practice: evidence, action, evaluation," 2012, http://www.assetbasedconsulting.co.uk/uploads/publications/wmuh.pdf.

[38] A. McCabe and J. Phillimore, Eds., *Community Groups in Context: Local Activities and Actions*, Policy Press, Bristol, UK, 2018.

[39] M. Hawtin, G. Hughes, and J. Percy-Smith, *Community Profiling: Auditing Social Needs*, Open University Press, Milton Keynes, UK, 1994.

[40] A. Soteri-Proctor and P. Alcock, "Micro-mapping: what lies beneath the third sector radar?" *Voluntary Sector Review*, vol. 3, no. 3, pp. 379–398, 2012.

[41] J. Attride-Stirling, "Thematic networks: an analytic tool for qualitative research," *Qualitative Research*, vol. 1, no. 3, pp. 385–405, 2001.

[42] J. Fielding, "Coding and managing data," in *Researching Social Life*, G. N. Gilbert, Ed., pp. 323–352, Sage, London, UK, 3rd edition, 2008.

[43] S. Bedford and A. Harper, "Sustainable social care: what role for community business? New Economics Foundation," 2018, https://neweconomics.org/uploads/files/Sustainable-social-care.pdf.

[44] K. Orellana, J. Manthorpe, and A. Tinker, "Day centres for older people - attender characteristics, access routes and outcomes of regular attendance: findings of exploratory mixed methods case study research," *BMC Geriatrics*, vol. 20, no. 1, p. 158, 2020.

[45] C. Green, K. Orellana, J. Manthorpe, and K. Samsi, *Caring in Company: A Pre-covid Snapshot of Day Centres in South London: Report of a Mapping Exercise of Publicly Available Information from Four South London Boroughs*, NIHR Applied Research Collaboration South London, London, UK, 2021.

[46] J. Tew, S. Duggal, S. Carr et al., "Implementing the Care Act 2014: building social resources to prevent, reduce or delay needs for care and support in adult social care in England," 2019, https://www.birmingham.ac.uk/documents/college-social-sciences/social-policy/publications/prp-prevention-pdf-121219-acc.pdf.

[47] Social Care Future, "*A vision for the future of social care*, Social Care Future," 2021, https://socialcarefuture.blog/2021/04/29/a-vision-for-the-future-of-social-care/.

[48] F. Verity, J. Richards, S. Read, and S. Wallace, "Towards a contemporary social care "prevention narrative" of principled complexity: an integrative literature review," *Health and Social Care in the Community*, vol. 30, no. 1, pp. e51–e66, 2022.

[49] Social Care Institute for Excellence, *Preventative Support for Adult Carers in Wales: Rapid Review*, Social Care Institute for Excellence, London, UK, 2018.

[50] L. Richards, D. Vascott, C. Blandon, and L. Manger, "*What works: Successful health and wellbeing community businesses.* Power to Change Research Institute report no. 15," 2018, https://www.powertochange.org.uk/wp-content/uploads/2018/03/Report-15-Success-Factors-Health-Wellbeing-DIGITAL.pdf.

[51] C. Needham, K. Allen, and K. Hall, *Micro-enterprise and Personalisation: What Size Is Good Care?*, Policy Press, Bristol, UK, 2016.

[52] A. C. Pache and F. Santos, "Inside the hybrid organization: selective coupling as a response to competing institutional logics," *Academy of Management Journal*, vol. 56, no. 4, pp. 972–1001, 2013.

[53] A. M. Eikenberry and J. D. Kluver, "The marketization of the nonprofit sector: civil society at risk?" *Public Administration Review*, vol. 64, no. 2, pp. 132–140, 2004.