BAXENDALE

Department
for Culture
Media & Sport

GROWING UP, TOGETHER

Case studies

Baxendale

July 2019

Introduction

This document is a companion document to the report ‘Growing Up, Together: Evaluation of the Mutuals Partnership Support Programme’.

It describes in detail the features and outcomes of the three projects supported by the Department for Digital, Culture, Media and Sport (DCMS) under the ‘Mutuals Partnership Support Programme’ (MPSP) from January 2018 to March 2019.

The aim of the paper was to review the success of the MPSP programme through the analysis and evaluation of the three projects it supported, which are as follows:

- **Data drive community care,** which supported City Health Care Partnership (CHCP), Anglian Community Enterprise (ACE), Medway Community Health (MCH), described on page 2.
- **Care at home,** which supported Rochdale Boroughwide Housing (RBH), described on page 6.
- **Integrated care partnership,** which supported First Community Health and Care (FCHC), described on page 9.

The evaluation of those projects against the programme objectives is done in the main document, ‘Growing Up, Together: Evaluation of the Mutuals Partnership Support Programme’.

Project 1: Data Driven Community Care

Context

While there has been significant progress made in data quality, data-driven insights and standardisation across the acute sector to improve patient safety and offer more efficient services, a similar approach has not yet been adopted within community health provision. Investing in technology to increase productivity and improve health outcomes is essential in the context of an ageing population and a broader policy drive towards the digitalisation of the NHS.

In this context, three providers of community health services,

- Anglian Community Enterprise (ACE);
- City Health Care Partnership (CHCP) and
- Medway Community Healthcare (MCH)

each faced similar challenges around the use and optimisation of their data, and wanted to collaborate in order to jointly identify and execute solutions.

Project description and objectives

This project involved the establishment of a knowledge-sharing and pilot delivery partnership between ACE, CHCP and MCH. By first sharing research and experience of innovations they had been pursuing independently, the providers were able to learn from each other and identify shared opportunities for development in three priority areas: **logistics, data analytics and self-care.** They then developed and delivered several pilot projects, each co-led by Baxendale and one provider, with all learnings and outputs shared across the partnership.

Key Information

Organisations involved

ACE, CHCP, MCH

Nature of the partnership

Shared pilot development and execution in three focus areas: logistics, data analytics and self-care technology. Knowledge sharing.

Time scale

August 2018 to March 2019

Support provided

Gap analysis; supplier and provider market research; partnership development; development of pilots; project management and coordination.

Objectives met?

Yes, strong collaborative relationships have been built. Some parts of the project are still under way.

Next steps

Relationships will continue. Possibility to look at joint procurement in the future.

Summary of the support received

For this project, the three providers received consultancy support from Baxendale in the following areas:

- **Programme management**: setting up the partnership framework, project management, development of an MOU, an agreed framework for partnership working and a programme board;
- **Partnership development**: developing a shared understanding, finding common strengths and gaps, defining partnership behaviours and processes, enabling collaboration;
- **Market research** into three priority innovation areas (data analytics, logistics and self-care) to identify and review suppliers and examples of best practice from other health system providers;
- **Development and rollout of pilots**: project scoping and development, supplier engagement, evaluation design, project management, rollout of new technologies.

> *"It has been really good working with Baxendale, especially the market research. We've done lots more than what we could have done individually."* - Rob Howard, MCH

Outcomes: where are they now?

To date, the organisations have made significant strides towards improving their use of data and information and rolling out applied technology in logistics and self-care. Regarding the different workstreams:

- **Data analytics**: the market analysis provided the organisations with an overview of the most suitable business intelligence, data visualisation and risk stratification tools for community health. Baxendale facilitated a shared dashboarding exercise where the providers jointly developed a dashboard for Board and service-level reporting, readying themselves for future benchmarking.
- **Logistics:** the three organisations now have an overview of the suitable e-rostering and e-scheduling tools for community nursing services. CHCP was identified as the lead for piloting two e-scheduling tools, one of which (Malinko) is launching imminently. As an existing user of Malinko, ACE was able to add value to CHCP's process by sharing its own experience, reducing the time required for the design phase. MCH has sat alongside the process to take learnings from the pilot.
- **Self-care**: the organisations have an overview of approaches to self-care, enabling technology and appropriate tools for evaluation. Baxendale are supporting CHCP in leading the rollout of myCOPD – a self-management portal and app for patients with Chronic Obstructive Pulmonary Disease (COPD).

The three providers had an existing but limited previous relationship, but found that by setting up a formal partnership they now have a solid foundation to explore further opportunities such as potential future joint procurement. Working together on a number of key topics has given the providers learning opportunities that they might not otherwise have had. The shared approach to pilot development, rollout and feedback has helped them become more resilient. Where a pilot proves successful, it can then be rolled out to the others. This allows each organisation to share the benefits of running multiple pilots in parallel, expediting the speed of progress, whilst at the same time reducing their exposure in terms of operational time and cost.

> *"The biggest benefit for us has been the possibility to talk to others working in the same space and facing the same issues. It has led to conversations about staffing and other problems we encounter. It has created invaluable links with people we may not have known otherwise."*
> – Sharon Charlton, ACE

All three providers now boast a better knowledge of the market place and a better understanding of the methods and opportunities of better data analytics and technology-enabled self-care. They have evolved quickly both as a collective and as individual organisations, getting them to a place where they do not believe they would have got to by themselves.

Lessons learnt

- *Knowledge transfer and commercial skills*

The project sought to transfer knowledge wherever possible. The project team developed replicable materials which can be used in the future e.g. an MOU, pilot evaluation frameworks and pathway mapping.

According to CHCP, the team that worked with Baxendale are now more informed about the commercial landscape and the decisions taken by NHSE and NHS Digital and how they can position themselves to get a benefit. However, they have not yet reached the point where they have put those skills into practice. MCH also believe that they have gained commercial depth thanks to the project.

> *"We didn't have a forum where we could talk about our anxieties as comfortably as we could with Baxendale. There have been a lot more discussions around things that we experience as providers. An opportunity to communicate opened up that hadn't been there previously."* - Giles Bridgeman, CHCP

- *Improved visibility*

ACE found that the project allowed them to meet with NHS Digital and find a more affirmed space in the healthcare sector.

They argue that the social enterprise sector tends to be forgotten by the NHS and this project has enabled them to gain visibility.

- *General feedback*

Another element of success was the reasonable equitability of the relationship: all organisations provided their share of information and experience, with a recognised lack of competition which is sometimes felt amongst community providers competing for contracts. Having a neutral third party like Baxendale who is independent from the three organisations enabled this.

Have the objectives been met?

The main objective of creating a collaborative relationship between the three providers has been achieved. There is now a robust approach to procurement and clinical roll-out, and there has been good progress in several pilots. The providers have a shared dashboard for Board level and service-level reporting which is in the final stages of development, a CHCP Malinko pilot will launch imminently, and myCOPD is due to be rolled out at CHCP (and subsequently MCH) in April/May 2019.

Next steps

The immediate next steps are to finish the myCOPD and Malinko pilots – and for the three providers to internally work through how the insights and outcomes gathered throughout the project and pilots can be fully implemented across the partnership.

All three providers are confident that the relationship will continue and evolve. They expressed concern that without the constant steering from an independent advisor they might not be able to achieve the same things. However, there are now established lines of communication and clear examples of things they are successfully doing together, which means that a collaborative framework is now entrenched and will likely enable them to continue working together in the future.

In the longer term, the group is considering joint procurement around IT systems and processes. Despite operating in different geographies, they provide similar services and thus could benefit from using their collective buying power to realise cost savings and other efficiencies.

Project 2: Care at Home

Context

Rochdale Boroughwide Housing (RBH) is a tenant and employee co-owned mutual housing society. Whilst it provides accommodation to people of all ages, most of its tenants are 55 or over. In its flats and bungalows, it provides three different types of care services: sheltered housing with an independent living scheme (ILS) based on informal care provision to allow people to live independently at home; a responder service to dispatch help to tenants when they request it; and an extra care service for older people, with 24/7 on-site support and designated care.

In the context of an ageing population with increasingly complex care needs, RBH is faced with the need to rethink its service offer to combine care provision with housing. Its tenants have increased care needs that RBH has not been able to fulfil on its own. Thus, RBH decided that there was a need to look at how it delivered care and develop a service that was modern and equipped to deal with the change in landscape described above. The aim was to modernise those services, evaluate their sustainability and prepare them for the future.

Project description and objectives

This project aimed at helping RBH step outside of its core activity as a social landlord and partner to offer CQC-regulated formal care to its vulnerable tenants, and potentially a wider marketplace. The overall objective was to explore whether a model of partnership working was feasible with a regulated care provider, as well as explore the appetite for it in the organisation and how it might be funded.

Key Information

Organisations involved

- RBH
- Potential partner (regulated care provider)

Nature of the partnership

Partnership agreement for the provision of care by an external partner.

Time scale

March 2018 to March 2019

Support provided

Financial modelling, service evaluation, strategic advice, partnership support.

Objectives met?

Yes. RBH has identified a potential partner and will be able to pilot this in the near future.

Next steps

Review and reconfigure service provision and set up a partnership.

In order to do so, RBH decided to look for partners in the system who would share similar values and a similar approach and who would be better equipped to provide care than RBH would be on its own.

Before entering a partnership with a care provider, the project first consisted in looking in detail at RBH's current extra care provision to establish the level of care need across the rest of the tenant population.

Summary of the support received

- **Partnership scoping**: Exploration of potential partners in the market, facilitation of negotiations between RBH and a potential local care provider to establish areas for partnership.
- **Review of existing support services** for vulnerable tenants before moving to hard terms with a proposed partner.
- Working alongside an ILS specialist, **creation of a clear baseline of understanding across what the organisation currently has in place** to support vulnerable tenants.
- **Provision of a comprehensive set of insights** that RBH did not previously have into their current support provision and possible opportunities for improvement.
- **Strategic thinking** about what RBH would like to achieve and what its future services should look like.

Outcomes: where are we now?

The project is not yet over. Progress has suffered due to unpredicted movement in key client personnel, which means that data sharing and decision-making have been slower than usual.

> *"Getting the right people in the room and doing the right research has been really helpful."* - Sheena McDonnell

However, RBH now has a good overview of the service it is currently delivering and the potential options to change it as well as a good sight of who it could partner with in the future. RBH subsequently took the detailed analysis of its current offer to its Board, who accepted the need for a change in care provision. The Board is now clear that RBH is not going to hire in its own care capability and invited solutions which see those care needs met through partnership with a regulated care provider. It is now in the process of determining its partnering options to decide who could provide this extra care. More work is needed to actually make it happen.

The project has also enabled knowledge transfer and capacity-building within the mutual. The analysis done by Baxendale was shared with RBH, and it is going to be able to use that work going forward to sharpen its focus. Tools have been established and the work has been captured in a way that will be accessible later. However, one of the challenges has been the inconsistency in the individuals that worked with Baxendale, which may make the actual transfer of capabilities less substantial.

Lessons learnt

It would not have been possible for RBH to achieve the same clarity around what its service provision and what it needs to do in the future without the analysis done by Baxendale. The support provided enabled it to understand what the key issues around service provision were and what strategic direction it should take. Support has also given RBH a better view of the market place and who it can partner with. The feedback has been very positive: it challenged the mindset around how the organisation worked and what was possible. The project has also built capacity within RBH, it now understands what it wants and who might be able to help in order to get there. Thanks to the analysis done by Baxendale, it has been able to unpick the inefficiencies in service provision.

> *"Anything that can enhance the capacity in the sector is going to be welcomed. The model of mutuals is all about recycling resources and efforts. Everyone in the sector has the same ethos and values but doesn't have the same commercial expertise: that's what's been helpful, emphasising the commercial capacity that we can lose focus of because we tend to concentrate on doing the right thing..."* - Sheena McDonnell

Have the objectives been met?

Yes. RBH has identified a potential partner and will be able to pilot a formal partnership in the near future.

Next steps

The project team recently presented the range of options available to RBH Board. The next step of the project is taking these options forward, first through reviewing and reconfiguring the responder service, then repurposing the extra care service. RBH has discussed making changes with the local authority, who are now open to examining how services are delivered. The next element of the project will be to create some detailed modelling to support RBH to understand what it can feasibly deliver with a care partner so that the Board is equipped to decide to partner and act on it immediately.

Although RBH has not been able to bid for a larger contract through this partnership, it may be able to use the fact that it is moving towards a partnership agreement to provide care on its own terms. In the future, RBH will have a more efficient service to meet a range of different and evolving needs, its residents will be able to stay at home for longer and receive better care. Although it is not there yet, RBH is convinced that it now understands what it needs to do to achieve this.

Project 3: Integrated Care Partnerships

Context

The *NHS Long Term Plan* confirms a shift towards an integrated care and place-based system, of which integrated care systems (ICS) and Primary Care Networks (PCNs) are key building blocks. ICS are areas of collaboration between NHS organisations and other local health and social care providers to provide more joined-up care for patients. PCNs are networks of GP practices coming together to cover patient populations of 30,000 to 50,000. PCNs also encourage the joint working of those practices with community services and hospitals in local areas. These two policy trends indicate a duty for providers to collaborate on integrating care and providing comprehensive care services to meet patient needs and improve population health.

First Community Health and Care (FCHC) delivers community health services in East Surrey, which is part of the northern area of Central Sussex and East Surrey intending to form an integrated care system. The ICS area extends across the current footprints of two community health services providers: FCHC and Sussex Community Foundation Trust (SCFT), as well as three historic CCGs, resulting in inconsistency in the scope and model of community services with which the acute provider interacts.

The project started in September 2018 with the original idea to create a community partnership arrangement that would be a precursor to the integrated care partnership (ICP), through a more cohesive community offer.

Project description and objectives

The project set out to bring together the community providers, primary care through the GP Federation, as well as a fourth organisation as a provider of urgent care. The four organisations involved in the

Key Information

Organisations involved

- FCHC
- Sussex Community Foundation Trust
- Alliance for Better Care
- Queen Victoria Hospital Foundation Trust

Nature of the partnership

Partnership programme design as pre-cursor to Integrated Care Partnership

Time scale

September 2018 to March 2019

Support provided

Programme set-up and planning, programme management, target model design support

Objectives met?

Yes. Formal working relationships and joint workplans have been established.

Next steps

Integrated Care Partnership development underway.

partnership are: FCHC, Sussex Community Foundation Trust, Alliance for Better Care (GP Federation) and Queen Victoria Hospital Foundation Trust.

The purpose of the partnership programme was to identify community-based solutions addressing shared priorities across the ICS geography, and explore and test partnership arrangements to facilitate these. This would enable community and primary services to offer a more joined up, coherent community contribution within the future ICP.

A group, including commissioners, was convened to scope out the work with the support of Baxendale and it was decided that the partnership would focus on delivering tangible outputs in three focus areas:

- **Respiratory**: articulating a pathway design that can reduce avoidable admissions and address variation in quality and experience of care;
- **Primary care networks:** developing a unified approach to the development and delivery of around ten PCNs that provides the best conditions for individual PCNs to develop and mature;
- **Integrated primary and urgent care:** designing a networked delivery model and a structural solution to deliver it.

A Partnership Board was established to provide programme oversight – with governance and reporting aligned to existing system improvement programme infrastructure.

Summary of the support received

- **Programme planning and set-up**: establishing the programme governance and the workstream groups with clear terms of reference and capturing objectives and plans in project documentation,
- **Programme management**: Support for monthly partnership board and workstream meetings and reporting, working alongside the SRO for each workstream and First Community's Project Management Office (PMO) to drive progress,
- **Target model design support**: facilitating partners to describe shared ambitions for pathways, operating models and PCN development, informed by market research where required.
- **Formalising partnership commitments**: drafting the Memorandum of Understanding (MOU) for the development of Primary Care Networks, capturing a Compact to collaborate with the acute trust and providing legal advice on scoping collaboration agreements.

Outcomes: where are they now?

The Partnership Board is established, meeting monthly to provide programme governance including coordinating responses to emerging risks or issues.

Each of the partners has demonstrated commitment to the partnership programme by taking the lead on one of the three projects, supported by cross-organisational working groups.

The three projects have advanced at different paces:

- **Respiratory**: specialist community provision across the ICS geography has been mapped to understand gaps and variation and the acute provider has been engaged to enable a more whole-system approach.
- **PCNs**: most of the objectives have been met: an MOU has been created capturing shared aims and a joint programme plan supporting PCN development is already being implemented.
- **Integrated primary and urgent care network**: the need for clarification of the commissioning model has delayed this project, but a robust project structure is in place with collaborative design work on the Target Operating Model underway and the organisations have found a collective voice.

By working alongside First Community's transformation team, the knowledge to maintain management of the programme has been embedded in the organisation. Products such as Terms of Reference and MOUs have equipped partners with replicable tools to use across projects.

In developing First Community's 'provider intentions', the project has helped the organisation to scope out wider opportunities for partnering and who it can work with. Through the MPSP project, the organisation has also been able to formally capture principles and priorities for collaboration with the local acute provider.

Lessons learnt

The fact that each organisation took the lead on a different project has enhanced partnership development by avoiding a dominant organisation – each organisation was able to take ownership of a specific area of work. Baxendale worked with each SRO rather than just FCHC, which contributed to a more resilient and equal partnership where every organisation is able to work on an equal footing with the support of a neutral advisor.

The project has been a success though it took longer than expected to bring all the relevant people together and clarify the commissioning context in order to establish partnership working. Therefore, FCHC believes it would have benefited from receiving the same amount of support but spread over a longer period of time.

Have the objectives been met?

Yes, although the delivery of final planned outputs is expected at the end of June. The first three months were a challenge in terms of getting the organisations together, causing some delays, but significant progress has been made since.

The process has successfully mobilised joint resources and is delivering outcomes and a more cohesive community voice. The partnership board is working well and has established channels for partners to discuss challenges and test solutions with each other, and ways of working together that will carry on through the creation of an integrated care partnership.

> *"Partnership meetings can be talking shops. Thanks to consultancy support, we have been able to actually productise some of the work. It has also given us pure capacity to drive things forward between meetings. In the first three months, we just needed people to get comfortable with the idea. Now that we are in the second half, having the capacity to help move things forward and turn it into a list of options has been really helpful."*
>
> Sarah Billiald, FCH&C

Next steps

The three projects are progressing towards their defined deliverables which will include proposals for implementing service developments. It is expected that these packages of work will be integrated into a new programme overseen by the emerging ICP governance structures, with a first Board meeting taking place in May.