Final report of the Mutuals in Health Pathfinder programme

1. Foreword

This report summarises the results of the Mutuals in Health Pathfinder programme. It describes progress in the programme and draws out lessons for the future of mutuals in health and care. In so doing, it highlights significant barriers that need to be removed if mutualisation in health is to be extended beyond the community health and social care providers who have already gone down this route.

In chairing the expert panel advising on the programme, I have been struck by the enthusiasm of the Pathfinders for increasing staff engagement and exploring what it would mean for some or all of their services to become mutuals. I have also been struck by the barriers that prevent rapid progress in this direction, most notably the requirement on mutuals to pay VAT and Corporation Tax, and uncertainties about access to capital. Unless these barriers are removed, there is little prospect that mutualisation for whole trusts will move from the drawing board into practice any time soon.

One of the most interesting ideas to emerge from the work of the Pathfinders was how to develop staff engagement within trusts and foundation trusts. This would focus on strengthening staff engagement within the existing legal framework, for example by establishing an elected staff council and staff forums within NHS organisations, as well as by encouraging the development of autonomous teams. There are some parallels here with the experience of the John Lewis Partnership, whose chairman, Sir Charlie Mayfield, contributed to the work of the panel and the Pathfinder programme.

One of the Pathfinders, University of Leicester Hospitals NHS Trust, is currently taking autonomous teams forward through its orthopaedic services. This will involve these services becoming a business unit within the trust with delegated decision-making powers and a commitment to staff in these services having more control over their affairs. If this approach works for orthopaedic services it could be extended to other areas of care, although the option of the whole trust becoming a mutual will depend on the barriers identified in this report being removed.

During the period covered by the programme, NHS England and other national bodies published the *NHS five year forward view* (Forward View), setting out a number of new care models. As these care models are taken forward, it is likely that new organisational forms will be needed, for example to enable GPs to work with other providers and for health and social care services to be integrated. Options such as community interest companies offer one way of putting these models into practice, and they are already being explored in some areas. This holds out the prospect that the Forward View may provide a particularly receptive context for the further development of mutuals in health and care.

One of the attractions of mutuals is their potential to introduce greater plurality into the provision of health and care without sacrificing the values that lie at the heart of public services like the NHS. Evidence of growing stress among mainstream NHS providers, whether trusts or foundation trusts, underlines the need for fresh thinking about organisational options for the future and particularly how the power of staff can be

mobilised and aligned to meet the challenges that lie ahead. The message of this report is that the government should make mutuals the easy thing to do by creating a level playing field and actively supporting organisations that wish to go down this path.

Chris Ham
Chief Executive, The King's Fund
September 2015

2. Executive summary

In July 2014, the government announced the Mutuals in Health Pathfinder programme in response to the findings of the Review of Staff Engagement and Empowerment in the NHS. The objectives of the programme were to support interested organisations to explore how a mutual model might increase staff engagement. Critically, the government wanted to understand the benefits of this model, and the barriers that would need to be addressed to enable organisations to adopt this where they wished to do so. Pathfinders looked at the potential of mutualisation for either all (whole-trust mutualisation) or part of their services, eg, a pathway of care.

During the three-month programme, the Pathfinders received tailored advice from expert advisory firms. They were also provided with access to an expert panel for support on specific issues through a series of interactive workshops and meetings.

This report draws together the findings from each of the participating organisations.

Benefits

Pathfinders highlighted a range of benefits from the mutual model including more accountable leadership, greater freedom to innovate, and increased staff engagement and productivity. Foremost among these was the scope for increasing levels of staff engagement by strengthening the formal role of staff within their organisations, and by providing them with real influence over the management of the organisation.

Barriers

The programme also highlighted a set of technical challenges, which, unless addressed, represent significant barriers to the adoption of a mutual model for an NHS trust or foundation trust. One of the most significant was the additional tax costs incurred by a mutual as a result of no longer being part of the NHS. Losing access to public sector sources of finance, particularly in the wider system context of financial distress, was also highlighted as a significant barrier. Other challenges included uncertainty over commissioner behaviour and contract award, and in relation to the treatment of assets.

Pathfinders worked with their advisers to begin exploring solutions to these challenges. However, the relatively short duration of the programme did not allow for all issues to be resolved and consequently further work (involving other stakeholders such as HM Treasury) would be required to take this to the next stage.

Pathfinders noted other challenges, in addition to the technical barriers, such as engaging staff in the case for change, and a number reported staff concerns about the implications of moving to a mutual model and leaving the 'NHS family'. In particular, Pathfinders found that while staff were supportive of having an increased voice within their organisations, they did not see this as necessarily being dependent on a new organisational form.

Context

It is important to note that a number of the barriers identified in relation to implementation are associated with change more broadly, and are therefore likely to apply to any new model. However, these highlight the role that external factors played in shaping the organisations' conclusions. Notably, Pathfinders cited the absence of a clear rationale for change as a further obstacle to implementing the new model and building staff and stakeholder buy-in. Pathfinders also found that the impact of growing financial and operational pressures, currently facing all providers in the NHS, significantly affected their organisations' decision-making on possible mutualisation. On a more practical level, these pressures also affected the time and resources they had available to focus on the programme.

Models explored

In addition to exploring mutualisation, all Pathfinders also looked at a range of other models, determined by their local context. These alternative options, for example, a mutualised management company or an 'NHS mutual', were assessed against a range of criteria, including how far they might achieve some of the same benefits as a mutual.

Many of the Pathfinders were understandably drawn to the concept of 'FT plus' as a model that does not require structural change. This was described in different ways by different organisations, but the common starting point was the sense that more could be done to strengthen staff engagement within the existing foundation trust structure and that mutualisation was not necessarily a prerequisite for achieving some of the benefits highlighted above. Given the challenge of engaging staff in the case for change, many also concluded that this option would cause the least disruption.

Next steps

Pathfinders' interest in the FT plus model should not be interpreted as a lack of interest in the mutual model. Indeed, a number of Pathfinders indicated that they would continue to explore mutualisation over the longer term and that, should the key technical barriers be addressed, this would be a more feasible and attractive option.

Given this, the FT plus model might be a practical 'stepping stone' between existing foundation trust structures and a fully mutualised model. This concept of a staggered approach towards mutualisation was popular among several Pathfinders, and warrants further exploration.

The *NHS five year forward view* identified a number of new care models that could help transform the way in which care is delivered across the NHS. Both the vanguard sites and the acute care collaboration workstream provide an excellent platform for further testing of the mutual model.

Recommendations

Throughout the programme, Pathfinders expressed a keen interest in exploring the mutual model further, were the main barriers to be removed. In recognition of this, the panel set out four recommendations.

- The Pathfinder programme has made clear that there is little prospect of a large trust or foundation trust adopting the mutual model unless the major technical barriers identified in this report are addressed. Her Majesty's government should explore the steps required to level the playing field for mutuals by minimising the impact of those barriers, in particular: VAT, Corporation Tax, access to capital and the use and ownership of assets.

- The *NHS five year forward view* vanguard sites are at the forefront of work to transform models of care. This includes reviewing new or different organisational arrangements. NHS England should encourage and support any of the vanguard sites interested in considering mutualisation as part of their plans, including those participating in the Acute Care Collaboration phase, which seeks to support providers of acute services to develop new models to improve their quality, productivity and efficiency.

- Her Majesty's government should undertake further work to explore the potential characteristics, benefits and risks of the other models identified by the Pathfinders, namely: FT plus, mutualised management contract model, NHS mutuals, and autonomous teams.

- Her Majesty's government should establish a clear and robust national policy position on mutuals within health and care, and take steps to ensure this is communicated effectively across the system, drawing together work undertaken in response to each recommendation above.

3. Overview of the programme

a) Background

The Review of Staff Engagement and Empowerment in the NHS, carried out in 2014, found compelling evidence that organisations with high levels of staff engagement – where staff are strongly committed to their work and involved in decision-making – can deliver better quality care. These organisations also reported lower patient mortality rates, better patient experience, and lower rates of staff sickness absence and turnover, as well as increased efficiency. Recent analysis of trusts rated by the Care Quality Commission (CQC) demonstrated a correlation between staff satisfaction and the quality of care. It found that trusts rated 'outstanding' by the CQC had an average of 88 per cent of employees recommending the trust's care in the 2014 NHS Staff Survey. This compared with an average of 51 per cent at trusts rated 'inadequate'.

The Review's final report *Improving NHS care by engaging staff and devolving decision-making* made a series of recommendations for increasing levels of staff engagement within NHS organisations. This included the recommendation that there should be greater freedom for NHS organisations to become employee owned and led, on a strictly voluntary basis, where their leaders and staff wish to do so.

This recommendation was grounded partly in the emerging evidence from public service mutuals (PSMs), in particular those delivering NHS services within the community sector. The term 'public service mutual' refers to an organisation that has spun out of the public sector, continues to deliver public services and involves a high degree of employee control. This employee control can take the form of ownership, but might also manifest itself through enhanced governance arrangements, including employee councils and elected board members.

The public service mutual model encompasses a broad range of employee-led structures, including (but not limited to) charities, social enterprises, community interest companies, partnerships, and joint ventures. It also covers multi-stakeholder models that include the community or service users in the governance alongside employees.

b) Objectives

In response to one of the Review's specific recommendations, in July 2014, Francis Maude (then Minister for the Cabinet Office) and Norman Lamb (then Minister of State for Care and Support) announced that a £1 million fund would be made available to support NHS trusts and foundation trusts in exploring the potential benefits of mutualisation for all or part of their services. The objectives of the programme were to:

- support interested NHS trusts and foundation trusts to explore how mutual models could increase staff engagement across their organisations through greater staff control and/or ownership

- build an understanding of the practical, regulatory and legislative steps needed to enable new governance and ownership models.

In addition, participants in the programme had their own specific objectives for the work, for example, to support better integration of services.

The findings set out in this report contribute to the wider ongoing dialogue on new models of care including, for instance, those set out in the Sir David Dalton's review and by the *NHS five year forward view*. The overarching objective is to identify a range of new organisational models that can help providers of NHS services meet the current and growing financial and operational pressures, and that are clinically and financially sustainable.

c) Programme scope

Ministers wrote to all NHS trusts and foundation trusts in July 2014 inviting them to apply to the programme. Applicants were asked to consider how outcomes for staff and service users would be enhanced through partnership working, engaging and empowering staff and other stakeholders, and through a commitment to innovation.

Following a competitive application process, the following nine trusts were selected as Pathfinders:

- Cheshire and Wirral Partnership NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- Tameside Hospital NHS Foundation Trust
- University Hospitals of Leicester NHS Trust.

Working closely with each trust, the Cabinet Office and Department of Health subsequently ran a procurement exercise to identify an expert advisory firm (or group of advisory firms) to support each Pathfinder.

In addition to consultancy support, Pathfinders had access to an expert panel for advice on specific issues through a series of interactive workshops and meetings. A list of panel members is included (*see* Appendix 1).

Work undertaken by the Pathfinders as part of the programme varied, and organisations opted for different approaches. Examples of activity carried out include:

- the establishment of a dedicated project team/board
- focused workshops or meetings with a small group to agree on options and assessment criteria, and to evaluate different proposals
- larger workshops to communicate the objectives and progress of the work with staff and other stakeholders and to collect general feedback

- discussions with local and/or regional staff-side representatives.

During the course of the programme two Pathfinders – Norfolk and Norwich University Hospitals NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust – withdrew from the programme (the reasons for this are discussed in more detail below), and consequently seven Pathfinders completed the programme.

d) Outcomes

Each Pathfinder was required to produce a report summarising its key findings and next steps. A summary of Pathfinders' conclusions is included (*see* Appendix 2).

Within the short timeframe of the programme, none of the Pathfinders progressed to a decision to implement a mutual model in the short term. However, there was interest in exploring the model again in future, and potentially in adopting a staged approach towards mutualisation. These options are outlined in further detail in later sections of this report.

Overall, Pathfinders felt their participation in the programme raised awareness within their organisations about the opportunities for increasing staff engagement. A number of Pathfinders commented that being part of the programme had itself helped increase engagement of staff and other stakeholders with their organisation's values and objectives. One Pathfinder, for example, noted that its involvement in the programme had led to a greater understanding of the 'mutual' concept within its trust, a commitment to delivering some of its benefits, and that it had moved staff from a 'position of concern and anxiety' to one where they were interested in exploring the model further in the coming months. In other organisations, however, staff remained concerned throughout the programme (this is discussed in later sections of the report).

The Pathfinders' main criticism of the programme was that the timetable was too short: once advisers had been selected, Pathfinders had three months in which to complete the work. Many felt that the time did not allow for proper engagement with staff and other stakeholders and that, in relation to some of the more complex issues, there was not enough time to examine these issues (and the potential solutions) in the level of detail they would have liked. It is important to note however, that the Pathfinder programme was always intended to be a first step in a much longer process exploring the mutual model, and as such was not expected to identify and resolve all issues.

Finally, the timing of the programme was also questioned by some as it came at a point of significant financial and operational pressure across the NHS (particularly during the winter months) that might have limited organisations' capacity for focusing on the programme.

4. What we've learnt about mutualisation in the health sector

Pathfinders identified a number of benefits that the mutual model might bring to their organisations, in particular in relation to staff engagement. However, as anticipated, organisations also identified a set of technical barriers that would need to be addressed before they considered mutualisation to be a viable option.

a) Benefits

As set out in *Improving NHS care by engaging staff and devolving decision-making*, there is evidence to show that staff engagement has a positive impact on organisational performance and that, in the context of health care organisations, it can lead to better clinical outcomes, improved patient experience, and increased efficiency.

Given that existing evidence on outcomes for health care organisations is drawn primarily from community care providers, a specific objective of the Pathfinder programme was to understand the potential benefits for larger acute, specialist and mental health providers. Local circumstances meant that the nature and extent of the benefits identified in relation to the mutual model varied between Pathfinder organisations. However, there were a number of common findings.

Improved staff engagement

All trusts identified increased staff engagement as a key benefit of the mutual model. Although the existing foundation trust structure supports a key role for staff and other stakeholders, Pathfinders felt that these mechanisms were not always fully effective; one noted that, in practice, meaningful engagement with staff and patients was often limited, particularly when organisations were facing operational and financial pressures, requiring difficult decisions.

Some Pathfinders highlighted the greater scope within the mutual model to provide staff with a 'vote', giving them the opportunity to effect change on important issues. For example, one trust highlighted the increased 'democratic influence' within mutual organisations, as a result of formal and informal voting mechanisms for staff. Further, they also noted that, by engaging staff in this way, mutuals have the ability to make 'tough decisions', for example, in relation to sickness terms and conditions, that NHS organisations often find difficult.

Improved patient outcomes

Pathfinders highlighted evidence that demonstrated that increased staff engagement can lead to improved patient experience and better clinical outcomes, including by increasing the direct voice of patients within a mutual, and further embedding existing activity to engage patients and carers in the co-design of services. Further, Pathfinders concluded that the model of staff engagement within a mutual could play a valuable role in achieving more integrated, patient-centred care.

Leadership accountability

Leaders of mutuals delivering NHS services in the community sector argue that their ownership and governance arrangements have altered the relationship they have with staff, and ensure ongoing and transparent dialogue.

During the programme, Pathfinders identified accountable leadership as a key benefit of the mutual model, on the basis that giving staff the opportunity to influence decisions, and potentially membership of the leadership team, helps ensure leaders act responsibly. Currently the regulatory system is designed to require boards to look to Monitor in certain areas and to give Monitor certain responsibilities in relation to foundation trusts. NHS trusts are also required to answer to the NHS Trust Development Authority. Foundation trusts are answerable to their governors but not directly to their staff. It was suggested that this could have a 'disempowering' impact on organisations.

As providers of NHS services, mutualised NHS trusts and foundation trusts would continue to be regulated by Monitor through the provider licence. However, under the current regime, Monitor is not responsible for ensuring that non-foundation trusts are well led. One Pathfinder highlighted the benefits experienced by mutuals within the community sector as a result of stepping outside the NHS, and consequently being able to spend less time 'responding to the requirements of the system and more time focused on the service users and staff'.

Greater freedom to innovate

Several Pathfinders pointed to the increased flexibility community sector mutuals experienced on leaving the NHS, leading to more opportunities to innovate, for example, by developing partnerships in order to deliver an extended range of services.

Pathfinders found that leadership culture within mutual organisations tended to be more open to innovation and willing to learn from failure than is typical within NHS organisations. However, one Pathfinder also noted that this cultural change may not be a direct result of staff ownership within a mutual structure (and conversely, that this structure may not necessarily be enough to achieve the desired culture change).

Improved productivity and financial savings

A number of the Pathfinders highlighted the potential for the mutual model to help their organisation achieve financial savings through increased productivity.

Pathfinders concluded that the mutual model could bring about recurrent productivity savings through a decrease in the use of agency staff, a reduction in staff sickness and absenteeism, and a decrease in error rates. These indicative figures range from £0.5 to £9.1 million. This variation may, in part, be attributable to the differing sizes of trusts, however, the main reasons for the range are likely to be the use of different measures of productivity and variations in the way that these were applied. In addition, one trust also estimated that if staff engagement increased to 90 per cent (from its current figure of 69 per cent), it could make further recurrent non-pay savings of between £0.5 million and

£1 million. Given that it is intrinsically difficult to estimate the level of likely savings in the early stages of exploration, these figures serve only as an indication of potential savings and efficiencies. Based on the experience of community health mutuals, the potential for savings could in fact be significantly greater.

One of the Pathfinders acknowledged that, although not a feature unique to the mutual model, the changes required as part of mutualisation would provide an opportunity to 'redefine' the trust's activities with greater flexibility over the use of surpluses, for example, enabling them to invest elsewhere in the wider local health economy with a view to reducing inappropriate admissions.

b) Challenges with the mutual model

A primary objective of the programme was to understand the main challenges for trusts and foundation trusts in adopting a mutual model, where they wish to do so. As far as possible, Pathfinders and advisers were expected to identify options for addressing these challenges.

It is worth noting that these challenges and barriers currently apply to existing health and care mutuals, such that any action to level the playing field for mutuals would apply more widely, rather than purely to those in the programme. Indeed, if solutions were to be agreed to the barriers outlined below, many existing small health and care mutuals would likely find themselves in a far stronger financial position.

VAT, Corporation Tax and business rates

Nearly all Pathfinders identified Value Added Tax (VAT) as one of the most significant barriers to mutualisation. Under the current tax regime, unlike trusts and foundation trusts, mutual organisations (like other independent providers of NHS services) are not entitled to reclaim VAT on contracted-out services and therefore are liable for significant additional costs. This is because mutual bodies are not included within the scope of Section 41 of the 1994 VAT Act – this is the section that concedes that 'any body of persons exercising functions on behalf of a Minister of the Crown' can reclaim VAT that relates to their non-business activities under the Contracted Out Services guidelines. In addition, were a mutual to lease land and buildings from another body (*see* asset section below), it would also incur VAT on the transaction.

Pathfinders quoted figures of up to £20 million as the possible VAT liability they would face should they spin out of the NHS as a mutual organisation. Having carried out cost–benefit analyses, some Pathfinders found that the expected VAT liability outweighed the likely increases in productivity and efficiency gains of becoming a mutual.

In addition to VAT, independent providers of NHS services, such as mutuals, are also subject to Corporation Tax (on any surpluses) and business rates. These liabilities tend to be of a smaller order than VAT but on aggregate can still represent significant new costs. If the new entity were to register as a charity some of these costs may be avoidable (however, exploring the charity model in detail was outside of the scope of the programme).

A possible solution might be to extend the scope of Section 41 of the 1994 VAT Act to those mutuals that have spun out of the NHS, although this would need further consideration and testing with stakeholders, including HM Treasury. There are also questions as to whether such broadening of scope would apply to only those bodies that have spun out of the NHS, or whether it might apply to all public service mutuals.

Access to finance

Pathfinders highlighted the higher cost of finance as a potential obstacle to mutualisation. Currently, trusts and foundation trusts have access to funding from central government which is provided on the advice of the Independent Trust Financing Facility. This funding is provided at a rate lower than available in the commercial sector. The government has also typically provided emergency funding (in the form of Public Dividend Capital) to NHS organisations in distress.

Under current arrangements, independent providers of NHS services, such as mutual organisations, would be unable to access these sources of finance. Instead, independent providers of NHS services have to raise finance from commercial markets at a higher cost than NHS trusts and foundation trusts. At the scale required for large acute or complex specialist services, this would be likely to prove a significant barrier.

One solution to this issue would be to make government funding available to these organisations, although the implications of this would need to be explored in detail and tested with other stakeholders, in particular HM Treasury.

Insurance costs

Some Pathfinders also noted that public service mutuals cannot currently access all the NHS Litigation Authority's insurance schemes, and therefore would be required to seek more expensive insurance from commercial markets. However, they also anticipated that these costs would not be significant and therefore were unlikely to be a significant barrier.

If further analysis of the likely cost implication proved it to be a fundamental barrier, one potential solution would be for the NHS Litigation Authority to provide open access to all its schemes for all independent providers of NHS care, although again further work would be required to determine the full implications of this.

Regulatory regime and failure

Although Pathfinders anticipated additional freedoms associated with a reduced regulatory burden, they also identified some disadvantages for mutuals in being outside the regulatory regime.

As the sector regulator, Monitor has oversight of all licensed providers of NHS services (excluding NHS trusts overseen by NHS Trust Development Authority and exempted organisations), including in the case of provider failure. For all licensed providers,

including independent providers of NHS services, services deemed essential (or 'Commissioner Requested Services') are protected. This means that, should their services be at risk as a result of organisational failure, Monitor would step in to help local commissioners find a resolution. However, under current arrangements, a mutualised trust would not automatically be subject to the Commissioner Requested Services regime.

Additionally, they would not have access to the distress finance that is available to NHS trusts and foundation trusts. The lack of certainty regarding the process if a mutual were to fail made it difficult for Pathfinders to determine accurately the level of risk in spinning out of the NHS. This would need to be clarified to allow for a robust analysis of the magnitude of this challenge.

Use and control of assets

The treatment of assets was also raised as an issue by some Pathfinders. Some made the assumption that, were they to adopt the mutual model, their assets would be transferred to another body (such as NHS Property Services, another trust or the Secretary of State). However, there were also alternative options proposed whereby the organisation remained an entity for the purposes of owning property. One trust also noted that were a mutual to enter into a lease arrangement with another body for land and buildings, it would be required to pay VAT on the transaction.

The experience of existing mutuals has also demonstrated the importance of having a strong balance sheet (or being seen as 'bankable') in order for the organisation to be able to secure inward investment.

As with the regulatory regime (*see* above), there needs to be further clarity on the likely policy position of government on the treatment and control of assets.

Contracting and procurement

Pathfinders noted that the mutual model might present some perceived risks in relation to contracting and procurement. For instance, in a scenario where an organisation had spun out as a mutual and lost a significant service contract, it would no longer able to look to the NHS for support. However, this was balanced against a mutual's greater freedom to innovate and generate additional income, as described above.

Attempting to transfer or novate an organisation's existing service contracts to a new mutual organisation may also have procurement implications. In this scenario (depending on the nature of the contract, and whether it constituted a significant variation), commissioners might run a competitive tender exercise, causing uncertainty for the trust about its future income. This could, in theory, be assisted by making the new procurement directive's mutuals reservation available to NHS commissioners (allowing them to limit a competition to mutuals). However, this would be in tension with HM government's policy that commissioners should look for the best providers of services for patients, regardless of ownership, and would require changes to the law that

currently oblige NHS commissioners to treat all providers of health care equally when procuring services.

A further concern among some Pathfinders was the implications for their relationship with commissioners, and the potential challenge of engaging them in new or different contractual relationships as an independent provider of NHS services. For example, some of the Pathfinders' proposals depended on commissioners moving from block to outcomes-based contracting. It also seemed that the challenges faced by Hinchingbrooke, such as receiving lower than expected income from provision of their services due to contract disputes with a clinical commissioning group, could have an impact and result in Pathfinders taking a more careful and cautious approach to mutualisation. These issues require further consideration and testing.

c) Challenges with implementation

Pathfinders also identified a set of potential barriers regarding implementation. These were factors which, while significant, would be unlikely to persist once a new mutual model was implemented and in a 'steady state'. It is important to note that a number of these barriers are associated with structural change more broadly and therefore might apply to the implementation of any new model.

Engaging staff in the case for change

One of the most common and significant challenges identified by the Pathfinders regarding implementation of a mutual model was that of positively engaging staff in the change. For a number of the Pathfinders, the process of exploring the mutual model (and other structures) during the programme raised concerns among staff. While staff were supportive of efforts to increase their voice and influence within the organisation, many Pathfinders found that staff did not see this as being dependent on adopting a new organisational model or on staff ownership. Pathfinders noted the huge importance of strong leadership to 'take staff on the journey' through a change programme and beyond. Similarly, there was a mixed feedback from organisational boards who queried how the mutual model would impact on them. In practice moving to this model would mean that boards would be more accountable to staff, as co-owners, with regard to how the organisation is run, how the services are delivered and the outcomes for patients.

In almost all organisations, staff expressed concern about leaving the 'NHS family'. This comprised various elements: a sense of loyalty to the NHS brand and public service; fears over any potential departure from NHS terms and conditions; and a feeling that winning contracts would be far more challenging for an independent provider of NHS services (*see* above). It is also worth noting that continued access to the NHS pension scheme was seen as absolutely vital, and therefore it would be essential to maintain the current regulations that allow for this. Linked to this, some Pathfinders also noted that the mutual terminology and connotations were not helpful and that, for some staff, mutuals were associated with privatisation. For similar reasons, a number of Pathfinders experienced strong resistance to the mutual model from staff-side representatives at a regional level in particular. However, this was not universal and there were examples of local staff-side representation being actively and positively involved in the programme.

In response to this issue, Pathfinders called for more proactive government support, including steps to help raise awareness about mutuals and their objectives, and to address some of the common misconceptions about what is involved for staff. Some also highlighted the need for a coherent narrative at a national level on the role of mutualisation within the broader context of new models of care. They felt this needed to be supported by a clear evidence base on the impact of mutualisation against some key measures of success including staff engagement, sickness absence, and financial and quality metrics. One Pathfinder described this as 'creating realistic building blocks to mutualisation'.

Pathfinders also reported general 'change fatigue' among staff; the perception that the NHS is subject to cycles of change that do not allow new initiatives to bed in properly. In some trusts, there were a significant number of change programmes already underway, and proposals for any further change would need to consider the strategic fit.

Consequently, a number of Pathfinders concluded that while staff were clear on the potential benefits offered by improving staff voice and engagement, they also remained unconvinced that the only way of achieving these was through mutualisation.

Cost and capacity

As with any programme looking at organisational change, mutualisation would have transition costs, in terms of time, effort and money. For example, one Pathfinder estimated that transition costs might total in the region of £4 million, with additional requirements to divert resource and management capacity on to the change at a time when there were conflicting imperatives to focus on operational pressures.

Pathfinders also noted that managing a transition to a new model would require a wide range of specific skills and experience that should not be underestimated.

5. Importance of context

Over the course of the programme, it became clear that, in addition to the challenges identified above, a number of external factors – both local and national – had a significant role in shaping Pathfinders' conclusions.

For most organisations, their experience of the programme was shaped by the current operational and financial climate. Some Pathfinders were experiencing specific challenges or had other priorities that affected their ability to explore the mutual model, for example, a focus on achieving foundation trust status, or on pursuing integrated services across one pathway of care.

As indicated at the beginning of this report, two of the nine trusts originally selected for the programme withdrew before it was complete. In both cases, this was in part a

response to huge operational and financial pressures, which significantly limited the organisations' capacity to focus on the programme.

Interestingly, a number of Pathfinders that remained within the programme felt that efforts to move to a mutual structure would be hindered by the absence of a 'burning platform', or clear rationale for change. The vast majority of existing community service mutuals were created as a result of the 2009 Transforming Community Services policy, which required all primary care trusts (PCTs) to divest themselves of their provider arms. Establishing a mutual model was one of a number of possible arrangements available to PCTs, but preserving existing structures was not an option. Within the current context, despite being able to point to the potential benefits of mutualisation and the difficulties facing the NHS more generally, Pathfinders felt that providing a clear case for change would be more challenging. For example, one Pathfinder noted that, given that the services considering mutualisation were already operating successfully, they saw no real risk in remaining as they were, a factor which in practice might impact on the service's appetite to move to a mutual model.

6. Some possible models

Given that the primary purpose of the programme was for Pathfinders to explore the mutual model as a means of increasing staff engagement within their organisations, and partly in recognition of some of the challenges identified, most participants explored a range of models (alongside mutualisation) that might be able to achieve some of the same objectives.

a) *Mutual models*

The Pathfinders explored a range of mutual models. Experience outside the programme shows that form follows function and therefore a degree of variety is to be expected. Some of these variations included:

- a range of possible legal structures including – community interest company (CIC); charity; co-operative and community benefit society; and joint venture
- a combination of ownership compositions including full or partial ownership for – staff, the community, patients and partnership organisations.

However, overall, the models proposed had a number of common features. The common features were:

- a degree of staff ownership or control through governance
- the creation of a new legal entity
- new governance structures and decision-making mechanisms
- an increase in staff engagement
- greater autonomy balanced with appropriate regulation.

b) A contracted/franchising model

Some Pathfinders explored a model whereby the organisation remains a trust or foundation trust, but its operational management is contracted to a staff-owned management company. This would have the advantage of introducing staff ownership while retaining the trust model.

This model could involve the following:

- a contractual relationship between the trust and management company
- the trust's status as an NHS body would not be affected, and it would continue to provide services via the standard NHS contract
- a small number of staff would transfer to the new entity in the short term (although over time this number could increase) but the majority of staff would remain within the NHS
- all trust assets would remain within the NHS
- the trust board would have a reduced role (as some functions would have transferred to the management company) but this could include monitoring the financial and clinical performance of the foundation trust.

Under current arrangements, however, it would not be possible to implement this model for foundation trusts. For trusts, in theory, there is scope in the legislation to introduce this model, but the powers that would enable the Secretary of State and NHS Trust Development Authority to do this apply only in cases where an organisation is failing.

Giving foundation trusts and NHS trusts the option of establishing this type of model would therefore require changes to current legislation. There are also a number of technical and legal issues which would need to be addressed, and consequently this model requires further consideration.

c) The 'NHS mutual'

Several Pathfinders explored the hypothetical concept of an 'NHS mutual'. This might have the following characteristics:

- membership that includes a minimum number of staff members with the NHS (either NHS England or – if a service level mutual – the former host trust) also having a stake. Ultimately, however, the entity would be able to make its own decisions through its members
- a governance structure that may resemble that of an foundation trust with a council of governors, but again the entity would decide on staff representation and on accountability arrangements
- it would be not for profit, and therefore likely to take on the structure of a CIC, or co-operative or community benefit society
- it would derive a minimum of 50 per cent of its income from the provision of NHS services

- property assets could be held by a separate entity.

The anticipated benefits of this model are that, for VAT and Corporation Tax purposes, the entity could be treated as an NHS body (although more detailed work is required to confirm this, including discussions with HM Treasury). It would also enable staff to decide on the extent to which transferring to the new model would impact on their terms and conditions, although the NHS mutual could be designed in such a way that employees retained access to the NHS pension scheme should they want it.

However, it is important to note that some of these features already exist within the foundation trust structure. For example, foundation trusts have a minimum requirement on staff membership, a council of governors, and a 50 per cent minimum threshold on NHS income. There is also comparatively limited evidence to support the benefits case for this new hypothetical model. The additional features of this model would require primary legislation, but may in practice therefore end up simply adding complexity to the existing foundation trust structure without securing substantive improvements in clinical outcomes or efficiency.

d) FT plus

Some Pathfinders explored a form of FT plus model. This was described in different ways by different organisations, but the common starting point was the sense that more could be done to strengthen staff engagement within the existing foundation trust structure, and that the mutual structure was not necessarily a prerequisite for achieving many of the benefits identified earlier in this report.

Although some descriptions of the FT plus model involved making amendments to foundation trust legislation, several organisations believed that they may be able to achieve some of the benefits of a mutual by trying to encourage a mutual culture and replicating aspects of the governance arrangements within their existing structures. The model could take a variety of forms, however some possible features are included below.

- Increase opportunities for staff membership – the employee constituency could be extended to include, for example, staff from partner organisations working closely with the foundation trust and on their premises (under current rules, these staff would need to be exercising functions of the foundation trust).

- Increase staff representation on the council of governors – achieved by specifying a minimum number of staff-elected representatives within the foundation trust constitution (this should take into consideration the number of patient representatives). Under current legislation, the number of staff governors must remain less than half of the total number.

- Establish an elected staff council – to sit alongside the council of governors and represent the foundation trust's staff, and to influence and challenge (but not bind or overrule) the board. This could be achieved through amendments to the foundation trust constitution.

- Elect staff forums at a local level – with autonomy over local priorities and processes. At least one representative from each local staff forum would be a member of the staff council.

- Establish a clinical senate – elected by and from the consultant body to increase clinical participation in key organisational strategies and decisions. However, steps would need to be taken to ensure that non-clinical staff were not disenfranchised through this model.

- Establish and encourage the development of autonomous teams – where particular teams are given delegated powers to run themselves.

Pathfinders felt a major advantage of the FT plus model was that it preserved the foundation trust structure (meaning that the organisation remained within the NHS) and therefore many of the challenges identified earlier, particularly regarding tax and access to finance, would not apply. Several Pathfinders suggested that this model would also require a change in the existing relationship between foundation trusts and regulators, with a shift towards more accountability to staff balanced by a reduction in external regulatory oversight.

Implementing this model would be less disruptive than implementing a mutual model, or any alternative. Of course, as with any new model this would require meaningful consultation with staff and staff-side representatives to ensure that they were fully engaged in the case for change.

However, Pathfinders also noted that the model would not allow for staff ownership as in a mutual model and that the role of staff within an FT plus model was more dependent on the commitment of managers (compared with a mutual structure which 'locked in' a role for staff) and therefore was vulnerable to senior management support. In practice, a number of existing foundation trusts have achieved high levels of staff engagement within their current structure and have also scored highly in relation to staff satisfaction. In addition, the existing quality inspection regime places a strong emphasis on evidence of staff engagement in organisations providing NHS services through CQC's 'well-led' domain. However, this needs to be balanced against the reality that staff engagement has been a longstanding challenge for many parts of the NHS. At a time when improvements in NHS productivity are going to be vital to its sustainability, there is arguably a good case for trying a fundamentally new approach to achieving a step change in staff engagement.

7. Conclusions

Pathfinders' exploration of the mutual model during the programme identified a number of potential benefits, in particular in relation to staff involvement and therefore clinical outcomes and efficiency. Their findings support the existing evidence that mutual organisations can help support higher levels of staff engagement, in turn leading to better performance.

However, the programme has also highlighted a clear set of technical challenges for any large NHS trust or foundation trust considering adopting the mutual model. The most significant of these appears to be the additional tax costs incurred, and it is clear that this issue would need to be resolved before any organisation made a decision to pursue mutualisation in future.

An equally clear message from the Pathfinders' exploratory work was that, in addition to the financial and other challenges posed by the mutual model, there are a set of challenges associated with change and transition. While some of these implementation challenges would apply to structural change more broadly, the programme demonstrated the critical role played by external factors. Many Pathfinders concluded that, in the context of current financial and operational pressures, whole-trust mutualisation in the short term would be challenging.

Some Pathfinders concluded that some of the benefits of the mutual model may be achievable within their existing structures (although this has proven to be a challenge for the NHS to overcome to date). As a next step, there was therefore significant interest in exploring the option of an FT plus model that seeks to replicate many of the features of a mutual model with no or minimal changes to structure.

This is not to say that there was no appetite for moving towards a mutual model in future, should some of the key technical barriers be addressed. Indeed, a number of Pathfinders indicated that they would continue to explore mutualisation over the longer term. Recognising the scale of the change involved in a trust or foundation trust transitioning to a fully mutual model (in addition to the need to address some specific technical barriers), the FT plus model could act as a practical 'stepping stone' between the two. This concept of a staggered approach towards mutualisation was popular with several Pathfinders.

The other models identified by Pathfinders, for example, the staff-owned franchising model, require further exploration in order to fully understand the benefits and challenges, as well as any legislative implications. With this, as with the mutual model, there is still a large degree of uncertainty over the extent to which the desired benefits would be achieved when applied to a large trust. However, within the context of the *NHS five year forward view* and the recommendations of the Dalton review, now is the right time to begin testing them.

8. Recommendations

- The pathfinder programme has made clear that there is little prospect of a large trust or foundation trust adopting the mutual model unless the major technical barriers identified in this report are addressed. Her Majesty's government should explore the steps required to level the playing field for mutuals by minimising the impact of those barriers, in particular, VAT, Corporation Tax, access to capital, and the use and ownership of assets.

- The *NHS five year forward view* vanguard sites are at the forefront of work to transform models of care. This includes reviewing new or different organisational arrangements. NHS England should encourage and support any of the vanguard

sites interested in considering mutualisation as part of their plans, including those participating in the Acute Care Collaboration phase, which seeks to support providers of acute services to develop new models to improve their quality, productivity and efficiency.

- HM government should undertake further work to explore the potential characteristics, benefits and risks of the other models identified by the Pathfinders, namely: FT plus, mutualised management contract model, NHS mutuals, and autonomous teams.

- HM government should establish a clear and robust national policy position on mutuals within health and care, and take steps to ensure this is communicated effectively across the system, drawing together work undertaken in response to each of the recommendations above.

Appendix 1: Expert panel

Panel members were:

- Chris Ham, Chief Executive, The King's Fund (Chair)
- Tim Decamp, Head of Mutuals Programme, Cabinet Office
- Claire Stoneham, Deputy Director, Department of Health
- Sir Charlie Mayfield, Chairman, John Lewis Partnership
- Andrew Burnell, Chief Executive, City Health Care Partnership
- Jonathan Lewis, Chief Executive, Bromley Healthcare
- Bob Ricketts, Director of Commissioning Support Strategy and Market Development, NHS England
- Craig Dearden-Phillips, Chief Executive, Stepping Out
- Ralph Coulbeck, Director of Strategy, NHS Trust Development Authority
- Richard Peden, Director – Independent Providers, Monitor.

Appendix 2: Summary of Pathfinders' conclusions

Pathfinder organisation	Outcomes from the programme
Cheshire and Wirral Partnership NHS Foundation Trust (CWP)	CWP explored the option of mutualisation in two areas, rather than for the whole organisation: child and adolescent mental health services (CAMHS); and substance misuse services. CWP concluded that there was no appetite for change within their CAMHS but that, although it was not an option in the immediate term, there may be an option to continue exploring the mutual model. In the short term CWP will consider options for embedding mutual principles in the substance misuse services, and then decide on whether a different form is required.
Liverpool Heart and Chest Hospital NHS Foundation Trust	The foundation trust's preferred option was to improve staff engagement and empowerment as an FT plus which might require various legislative changes, for example, to increase the number of staff governors within the council of governors.
Moorfields Eye Hospital NHS Foundation Trust	The foundation trust considered three options: • an FT plus model – involving a governance system which gives staff formal control, alongside existing governance and ownership arrangements • a staff-led mutual model – development of a formal organisation with ownership shared between staff and the community • a contracted/franchise model – operational management of the trust by a staff-owned company. The FT plus model received the highest score but notably it was assessed as not achieving as many benefits as mutualisation. Moorfields concluded that further work was required before moving to any of the models explored.
Oxleas NHS Foundation Trust	Oxleas intends to pursue some of the key features (and benefits) of mutualisation within its existing foundation trust structure.
Surrey and Sussex Healthcare NHS Trust (SaSH)	SaSH is an aspirant foundation trust and intends to undertake an options appraisal once foundation trust status is achieved. However, the trust's preferred model

	would be an evolution of the foundation trust model, involving: • more power for elected representatives, increasing their oversight responsibility (resulting in a decrease in the oversight responsibility of regulators) • flexibility to include partner employees or organisations in governance structure • a re-definition of its constituencies, for example, enabling locally appropriate definitions to accommodate partnership models.
Tameside Hospital NHS Foundation Trust	Unlike the other Pathfinders, Tameside explored the option of a mutual model for a pathway of care (heart disease services), rather than for the whole organisation. The trust's preferred option was to establish a new entity separate from the foundation trust, responsible for co-ordinating all services along the pathway. The entity would have its own management structure, and some staff would be transferred to it from within the trust and some staff from outside of the trust would be involved in the pathway of care. As a result of VAT implications, the trust-owned option was deemed the most attractive in the current conditions. Tameside concluded that before mutualisation could be explored further, discussion around the full pathway across all sectors would be required.
University Hospitals of Leicester NHS Trust (UHL)	UHL opted for a staged approach that would enable the trust to achieve some of the benefits of mutualisation, with the possibility of the whole trust becoming a mutual in the future, if the playing field is levelled. In light of this, the trust has announced a pilot to move its elective orthopaedic, trauma, and theatre units into their own autonomous teams within the trust. If the pilot successfully improves staff performance and patient outcomes, the trust would consider devolving other of its services.