MUTUAL VENTURES

BAXENDALE

OUR MUTUAL INTEREST IN HEALTH AND SOCIAL CARE

Routes to replicate mutual models at scale within health and social care

September 2019

Foreword

Government has supported the growth of public service mutuals as part of a broader push to create a more diverse marketplace for public services. In this context, it is important to understand ways to reduce the time and resources required to spin out a mutual and to replicate successful mutual models at scale.

This independent report has been commissioned by the Department for Digital, Culture, Media and Sport with the purpose of identifying the quickest and most cost-effective methods of successfully replicating mutual models in health and social care, and to provide recommendations to government as to how it can best provide support. Each route to replication recommended in this report should be considered and developed in response to the local context, needs and priorities.

48% of public service mutuals operate in health and social care. Most of them are high performing organisations and score higher than average in their Care Quality Commission ratings[1]. Early evidence suggests mutuals are well suited to being successful in health and social care, and government continues to build and assess the evidence base on mutuals as their role in public services increases.

[1] Social Enterprise UK (2019). Public Service Mutuals: The State of the Sector.

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Edited by: Saimah Heron

Authors: Agata Miskowiec, Claire Bonsignori and William Carruthers, with support from Campbell McDonald, Andrew Laird, Tom Davis, Ceri Jones and Mia Vigar.

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Glossary of terms and abbreviations

Alternative delivery models	Public service delivery models that do not rely solely on in-house delivery (e.g. local authority trading company, public service mutual, joint venture)
APMS	Alternative Provider Medical Services, a type of primary care contract
Blended finance	Complementary use of grants (or grant-equivalent tools) and other types of financing from private and public sources to provide financing to make projects financially viable and/or financially sustainable
BMA	British Medical Association
CCG	Clinical Commissioning Group
CIC	A Community Interest Company is a business whose surpluses are principally reinvested in the community
CQC	Care Quality Commission
DCMS	Department for Digital, Culture, Media and Sport
DES	Direct Enhanced Services
DHSC	Department of Health and Social Care
Enabling services	Services that support delivery of core health and social care organisations core services (e.g. estates, procurement, HR and finance)
EOA	Employee Ownership Association
FTE	Full Time Equivalent
GMS	General Medical Services, a type of primary care contract
GP	General Practitioner
JV	Joint Venture
LA	Local Authority
LTP	The NHS Long Term Plan
Mutual (or Public Service Mutual)	An organisation which spun out of the public sector, continues to deliver public services, and has a significant degree of employee control

NAPC	National Association of Primary Care
NHSE	NHS England
NHSI	NHS Improvement
OCS	The Office for Civil Society, sitting within the Department for Digital, Culture, Media and Sport, is responsible for policy relating to young people, volunteers, charities, social enterprises and public service mutuals
PCN	Primary Care Network
PMS	Personal Medical Services, a type of primary care contract
Public services	Services which support public policy (whether they are funded and delivered by public sector organisations or not)
RCGP	Royal College of General Practitioners
Replication	Spreading the mutual models that work or have a high potential to work through enabling their implementation in other places or on a larger scale, either via establishing new mutuals or expanding the activities of existing mutuals
SEIF	Social Enterprise Investment Fund was a DHSC fund which provided from 2007 to 2011 investment to assist social enterprises delivering health and social care services.
SEUK	Social Enterprise UK is a network of social enterprises in the UK.
Social franchising	Replication of a proven business model with clear social benefit embedded within the business objectives, run according to the parameters prescribed by the originating organisation (franchisor) with compliance agreements in place.
STP	Sustainability and Transformation Partnerships are partnerships of NHS and local councils to develop proposals to improve health and care by running services in a more coordinated way and agree to system-wide priorities.
Teckal	The Teckal exemption from public procurement applies where a contracting authority contracts with a legally distinct entity that the authority has set up; it allows the direct award of public contracts if certain requirements around control and relevant activity are met
VAT	Value-Added Tax

Executive Summary

1. **The mutual model is well established in the delivery of health and social care services, however the number of mutuals in this sector remains modest.** The sector includes c.60 staff-led organisations delivering health and social care services that have spun out from the public sector since 2008. These organisations report higher staff engagement[2], greater productivity[3] and reduced inefficiencies compared to their public sector counterparts, allowing them to deliver more responsive, innovative services[4]. Importantly, mutuals are financially independent organisations: whilst around half of NHS Trusts expected to end 2018/19 in deficit[5], 96% of mutuals are profitable with 92% of surplus being reinvested into their organisation, mission or development[6].

2. **Mutuals support the strategic objectives within health and social care.** The NHS Long Term Plan sets out an aspiration for more integrated care, delivered out of hospital. Mutuals can further this agenda by using inclusive governance arrangements that support partners to collaborate with ease. Further, they offer the potential to address some workforce challenges by providing a compelling employment offer: ownership, influence, professional development, social impact and job satisfaction.

3. **Mutuals could offer GP partners a way to address their pressing concerns around workforce and risk.** The Watson review of GP partnerships[7] highlights the need to develop an attractive alternative to the traditional partnership model. Mutuals allow GPs, clinical and support staff to collectively shape how services are delivered to maximise productivity, whilst also potentially sharing benefits and limiting personal risk. Granta is a practice leading the way by working with NHSE and CCGs to navigate complex contractual arrangements. There may be scope for clearer national guidance supportive of the mutual model, taking account of how GMS contracts can be transferred and held.

4. **Mutuals could help embed staff and user-led governance within Primary Care Networks**. Primary Care Networks are a cornerstone of the NHS Long Term Plan,

[2] CIPFA (2017). *Research into the Public Service Mutuals Sector*.
[3] Wanna, J. (2017). *Are 'Public Service Mutuals' a Good Thing?.* ANZSOG , https://www.anzsog.edu.au/resource-library/news-media/public-service-mutuals-julian-le-grand
[4] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*
[5] Kings Fund (2018) Trusts in deficit, https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/trusts-deficit
[6] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*
[7] N. Watson, (2019) *GP Partnership Review.*

formalising partnership arrangements between GPs and other out of hospital providers to meet the needs of the local population. As mutuals excel in offering bottom-up involvement in decision making, we argue mutual models could be an attractive option for Primary Care Networks looking to formalise their partnership arrangements.

5. **Mutuals could enable the integration of care at a local level.** Developing closer alignment between NHS and Local Authority services is another priority within the NHS Long Term Plan. Mutuals are one possible delivery model that can help achieve this, by supporting multi-organisational governance and ensuring that all views are represented. The ability to innovate and experiment safely, which is commonly associated with mutualisation[8], enables best-in-class user-focused services to be developed.

6. **Mutuals create a new workforce offer for enabling services.** Staff working in support services such as estates and facilities report lower engagement than other parts of the NHS. Spinning out into a mutual offers an opportunity to engage and invigorate back-office staff to take ownership of a function that is critical in supporting the delivery of clinical services.

7. **Mutualisation can help address the staffing and funding crisis in social care.** Demand for social care services is rising, whilst capacity is falling due to workforce pressures. Mutuals operating in this sector show that by amplifying staff voice and sharing reward, recruitment is easier and retention levels are higher than elsewhere – generating some savings and supporting their financial viability. At the same time, the necessity of running a business instead of managing to a budget typically drives innovation and commercial growth, creating financially sustainable organisations.

8. **Growing the mutuals sector has been a government commitment since 2010**, and the Office for Civil Society within DCMS has a clear mandate to support the development and growth of new and existing public service mutuals. However, **replication cannot happen without the will and the means.** Our research demonstrates that historically, the successful growth of public service mutuals has relied on the combination of a clear policy framework, a blueprint to follow and funding for transition support. This remains true today.

[8] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector*

Key recommendations

Primary Care

- Progress the recommendation in the GP Partnership Review to illustrate how GP partnerships can hold a GMS or PMS contract under a different legal model and actively raise awareness of this possibility. (DHSC)
- Develop a dedicated support package for primary care organisations exploring alternative delivery models for working together in the context of Primary Care Networks, potentially delivered alongside the Primary Care Network Development Programme. (DHSC)
- Develop a how-to guide explaining how to form alternative delivery models (including for Primary Care Networks), presenting an overview of benefits, key risks and mitigations, practical steps to launching and template documents. (DCMS/DHSC)

Local health and social care integration models

- Provide examples of where the formation of alternative delivery models (e.g. mutuals) has successfully supported integration within local care systems. (DCMS/DHSC)

Adult social care

- Reference the role mutuals can and do play in delivering innovative, high quality social care services within the forthcoming Green Paper. Provide case studies of adult social care mutuals that are CQC outstanding and making a surplus which is then reinvested further improving delivery. (DHSC)

Whole sector

At a more centralised level, we also advise the below:

- Create a coalition of committed stakeholders from key departments and other organisations to progress the agenda, which could work with DCMS to raise awareness of their initiatives to support mutuals. (DCMS/DHSC/NHSE/[RCGP]/[BMA]/[NAPC])
- Provide technical support and funding to support the creation of new mutuals. This is particularly crucial to support GP partnerships and Primary Care Networks which typically have limited resources available to implement new models due to lack of host or parent organisation. (DCMS/DHSC)
- Further build evidence base on impact and cost-effectiveness of mutual models. (DCMS)

Fundamentally, the active engagement of DHSC working in partnership with DCMS is essential to create new mutuals within health and social care. There is a firm link between the government's desire for a more balanced public service marketplace and mutuals, which needs to be recognised when developing and implementing policies across various departments. More detailed recommendations are presented in the section **How to replicate mutual models at scale**.

INTRODUCTION

Definition

The government's existing definition of a Public Service Mutual ('mutual') is "an organisation which:

1. Has left the public sector (also known as 'spinning out')
2. Continues to deliver public services and aims to have a positive social impact; and
3. Has a significant degree of staff influence or control in the way it is run"[9].

Legal forms

Mutuals can take a range of legal forms and ownership models. Over half of mutuals are Community Interest Companies (CICs), and this is especially prevalent in the health and social care sector, where 82% are CICs. Other legal forms include charities, community benefit societies and private limited companies[10].

Ownership models

Mutuals are not necessarily employee owned. What they have in common, however, is a significant degree of employee control or influence, which can either be reflected in the ownership or in the governance structure. 57% of mutuals are at least partially formally employee owned, usually following the distribution of nominal £1 shares, with 50% being fully owned by their employees[11]. In all cases, there is a formalised structure for employee engagement, which can range from simple feedback surveys to representatives on the organisation's board and engagement forums. Many mutuals are also owned by or engage with their wider community of users, with 14% having community members as shareholders[12].

Policy context

The Office for Civil Society within the Department for Digital, Culture, Media and Sport (DCMS) is responsible for taking forward the government's commitment to supporting the development, growth and sustainability of public service mutuals throughout England[13].

Since January 2018, DCMS has launched a £4 million package of support for new mutuals to emerge and existing ones to grow, including:

[9] https://www.gov.uk/guidance/introduction-to-public-service-mutuals
[10] CIPFA (2017). *Research into the Public Service Mutuals Sector*
[11] *Ibid*.
[12] *Ibid.*
[13] https://www.gov.uk/guidance/introduction-to-public-service-mutuals

- The Mutuals Support Programme 2 (MSP2), offering professional advice to organisations wishing to create new mutuals, and to existing ones to grow.
- The Mutual Partnership Support Programme (MPSP), exploring the potential for mutuals to form proactive partnerships as a route to growth and diversification.
- The Mutuals Mentoring Scheme, connecting the leaders of new mutuals with experienced professionals across the social sector.

Objectives

This report examines the place for new public service mutuals within health and social care, more than a decade on from the emergence of the first mutuals in the sector.

It draws from relevant literature and the experience of existing mutuals and sector experts to:

- identify the most successful mutual models in specific service areas;
- assess the viability of replicating these models at a scale; and
- establish the most promising channels to drive widespread take-up.

Above all, this report is designed to equip policy-makers with an understanding of the role mutuals can play as one model of service delivery within health and social care, and to provide practical guidance on how to support the creation of new mutuals.

While this report highlights the key risks and benefits of mutualisation, we recommend that individual services should develop a full business case to understand the implications of pursuing mutualisation or any other alternative delivery model. Mutualisation will not fit every context and each organisation needs to choose the model most appropriate for them and their service area.

The recommendations presented in this report were informed by a literature review supplemented by over 20 in-depth interviews with subject matter experts and practitioners, and further validated by an expert advisory panel. Please refer to **Appendix 1** for more information on the research approach.

Structure of the report

This report is organised into three sections:

- **Mutualisation within health and social care**: This section outlines a brief introduction on mutuals, specifically their history in the health and social care sector, and an overview of their benefits. It provides insight into how mutuals align with the current health and social care policy direction. It also shows how mutuals can help tackle the current pressures in the care sector.
- **High potential service areas:** This section presents service areas with the highest potential for mutualisation. It provides a detailed discussion of the key drivers and opportunities for mutualisation as well as risks and barriers. Examples of high-level replicable mutual models are presented for all short-listed service areas.
- **How to replicate mutual models at scale**: This section investigates successful approaches to support creation of a scaled up and sustainable mutual sector in general, and in the short-listed area of health and social care in particular. It includes a series of practical recommendations to encourage wider implementation of mutuals in public service delivery.

Supporting materials and additional information is included in appendices:

- **Appendix 1.** gives a summary of the **research methodology** underpinning the report.
- **Appendix 2.** provides a **conceptual framework** for the **Section on How to replicate mutual models at scale** of this report. It sets out in brief what routes to replication are in the context of mutuals and provides a high-level framework for their appraisal.

Four in-depth case studies of selected successful mutuals operating in the health and social care sector have been developed and are available as **a separate document**. This document describes what is believed to be contributing factors to success, then illustrates this with four mutual success stories, highlighting their lessons learned from the perspective of leaders who were responsible for guiding their organisations through transition. The aim for this separate document is to foster the spirit of shared learning throughout the system.

MUTUALISATION WITHIN HEALTH AND SOCIAL CARE

A brief history

Whilst mutuals do not exclusively operate within the health and social care sector, there have been a number of policy initiatives over the past decade specific to health and social care which have encouraged the spread of mutuals.

In 2008, the (then) Department of Health established the Right to Request scheme, offering Primary Care Trust staff the chance to spin out of the NHS to form social enterprises. This resulted in almost 25,000 community NHS staff spinning out into social enterprises to deliver community health services via a new model[14]. This scheme was then replicated to include the rest of the health and social care via the Right to Provide and to the rest of the public sector through the Cabinet Office-led Pathfinder Programme.

Later, the Coalition Government's vision of a Big Society[15] included a mixed model of public service delivery, with charities, social enterprises and mutuals all playing a part. Notably, the Social Value Act of 2013 aimed to create a level playing field by encouraging commissioners to also consider social value when choosing a provider[16].

Today, there are approximately 60 mutuals in the health and social care sector.

[14] Department of Health (2011). *Making Quality Your Business: A Guide to the Right to Provide.*
[15] R. Hazenberg, K. Hall & A. Ogden-Newton, (2013). *Public Service Mutuals: Spinning out or standing still?* Enterprise solutions. RSA 2020 Public Services
[16] *Ibid.*

Mutualisation: an overview of known benefits

Research around the effectiveness of mutuals in public service delivery is still in infancy but has already showed that these models have real potential to deliver cost-effective services that result in improved staff and service user satisfaction. However, success of new delivery models is not a given. It has been most frequent when the mutualisation process has catalysed opportunities to improve organisational cultures and decision-making processes while engaging with stakeholders and transforming operating models to best meet need.

The existing body of evidence shows that mutuals present advantages in the following areas:

Strong growth platform

Mutuals have been demonstrated to be successful and growing organisations, with turnovers growing on average by 50% since launch[17]. Moreover, 68% of public service mutuals report expanding their services into new areas, winning new customers and developing new products and services[18]. They are also financially sustainable and commercially viable: 96% of mutuals were profitable in 2018, with an average profit margin of 1.5%[19]. This compares favourably to social enterprise sector more widely where 70% of organisations were profitable over the same period[20].

Rapid decision making

Because of their relative freedom from public authorities, mutuals have the ability to make faster decisions[21]. Our interviews support this. One interviewee stated that if a staff member had an idea that could improve service provision, they were able to implement it almost immediately, whilst the same change would have taken months to be put in place in the

> "Mutuals are probably led by people that wouldn't have stood a chance inside the public sector, especially in the NHS. Many of those people in the past would have been quite vocal, they would have been described as mavericks because they were willing to take risks but also have a passion which is about improving care for patients and the services that they provide." – Andrew Burnell, City Health and Care Partnership (CEO)

[17] Social Enterprise UK (2018). *Public Service Mutuals: The State of the Sector.*
[18] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*
[19] *Ibid*.

[21] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*

public sector. Thanks to this agility, mutuals can respond quickly to changes in their environment and in the needs of their community.

Employee engagement and satisfaction

While mutualisation does not necessitate formal ownership from staff, it does require the development of enhanced avenues for employee engagement, such as staff representation on the company Board, staff advisory groups and staff engagement forums. This wider engagement and increased control act as motivators for staff. Because they are more engaged in the financial state of the organisation, staff develop a new set of values, based on delivering the best quality in the most cost-effective way. These elements lead to a happier and more engaged workforce, increasing staff retention and reducing absenteeism, which in turn drive an impressive 4-5% growth in workforce productivity[22].

More responsive, innovative and flexible services

Mutuals can be more innovative and more flexible than equivalent public sector organisations, thanks to a more engaged and more entrepreneurial staff[23]. Indeed, 82% of mutuals boast more innovative services, and 76% claim they are able to provide better quality services than those they were delivering while part of the public sector[24]. Those benefits are driven by faster decision-making and reduced bureaucracy[25]. These characteristics allow mutuals to identify gaps in service delivery and work freely with partners to fill those gaps without additional costs to commissioners.

Supporting communities

92% of mutuals reinvest their profits into their organisation or their community, with mutuals typically being social enterprises or cooperatives.[26] The fact that mutuals need to be financially sustainable means that they can pursue a mission-driven investment strategy, but it is local communities and service users who benefit from this investment, rather than private shareholders. For example, **Community Dental Services (CDS**), which delivers special care and pediatric dentistry services in central and eastern England, have been able to reinvest their profits into oral health education and training programmes in schools.

[22] J. Le Grand and the Mutuals Taskforce (2012). *Public service mutuals: the next steps.* Cabinet Office. London, UK
[23] CIPFA (2017). *Research into the Public Service Mutuals Sector*.
[24] *Ibid.*
[25] *Ibid.*
[26] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*

The case for mutuals in health and social care

Health and social care organisations are facing increasing levels of demand, whilst simultaneously wrestling with growing financial pressures. Adopting a mutual model in the health and social care sector is often driven by a need to address these challenges.

Retaining staff

The health and social care sector is facing well-documented staff shortages. The NHS employs over 1.5 million staff (not including GPs) in England, with a similar number working in adult social care[27]. In 2018 there were around 110,000 vacancies at any given time in adult social care and NHS Trusts reported over 100,000 unfilled posts[28]. These staff shortages are exacerbated by high attrition rates in adult social care and nursing, with one out of four social care workers leaving the sector every year[29].

The health and social care sector needs to provide a more attractive and rewarding source of employment to aid workforce retention. The NHS Long Term Plan and Interim People Plan demonstrate a commitment to doing this, but there is scope to consider how other models may also be able to help. Mutuals have demonstrated the ability to reduce attrition rates in health and social care by giving staff ownership and/or influence, while preserving a public sector ethos. Not only that, potential employees are often retained by a culture of more transparent and accountable leadership, reduced bureaucracy and improved freedom to innovate.

Finding better ways of spending limited financial resources

The NHS is under increasing financial pressure. Health spending grew by 1.9% in 2018/19, not enough to cover growing demands linked to an ageing population with increasingly complex health needs.[30] The NHS now accounts for 30% of public spending[31]. The government has promised an additional £20 billion to the NHS over the next five years[32], judged by many health and social care practitioners to be the 'bare minimum' commitment in terms of keeping the NHS on track with current demand.[33]

[27] Skills for Care (2018). *The state of the adult social care sector and workforce in England.*
[28] *Ibid.*
[29] The Health Foundation, Key facts on current state of social care, https://www.health.org.uk/news/key-facts-on-current-state-of-social-care

[30] NAO (2019) *Financial Sustainability in the NHS*
[31] https://www.bbc.co.uk/news/health-42572110
[32] The NHS Long Term Plan (2019)
[33] https://www.bbc.co.uk/news/health-44495598

In this context, mutuals could provide local areas with another option when considering how to provide quality care in tight financial circumstances.

Recent research found that mutuals tend to be financially sustainable, with 96% of mutuals being profitable in 2018/19[34] and reinvesting those profits to further improve services. Our interview participants made clear that the pressures of financial sustainability and efficiency typically became higher priorities for them after mutualisation, compared to when they were operating within the NHS or Local Authority. Mutuals are still able to deliver high quality services, with better CQC and NHS Friends and Family Test ratings than the average for health and social care sector[35].

Reconnecting the healthcare system with its users

Health and social care organisations are increasingly unable to meet public expectations, with public satisfaction with the NHS falling to 53% in 2018, its lowest in ten years. In social care, only 26% of people are satisfied with the services provided[36]. While the reason for falling satisfaction rates are complex, there is a need to reconnect services with the people they serve to build better understanding of service pressures and co-develop solutions accordingly.

Thurrock Lifestyle Solutions, whose Board of Directors is made up of service users, is one of many examples of how mutuals meaningfully and successfully involve community and service users in service development.

However, mutuals are not a panacea for the health and social care sector. In choosing a mutual as its delivery model, each organisation will need to weigh the benefits of mutualisation against the financial and wider resource costs of establishment.

There are also issues with perception: 'privatisation' remains a contentious issue, and the establishment of mutuals in the sector has been challenged as an attempt to privatise the NHS. Proponents argue that mutuals can usefully be considered as an "alternative to the binary choice between public sector in-house monopoly providers or full-blown commercial privatisation"[37], as the majority reinvest profits into the communities they serve.

The next section demonstrates how mutuals can enable organisations to deliver key elements of current policy.

[34] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*
[35] Social Enterprise UK (2019). *Public Service Mutuals: The State of the Sector.*
[36] Kings Fund, (2018) *Public Satisfaction in the NHS and social care* - https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-social-care-2018
[37] Francis Maude, quoted in LGiU (2015). *Public Service Mutuals: an LGiU essential guide.*

HIGH POTENTIAL SERVICE AREAS

Our research focused on finding the service areas with the greatest scope for adoption and replication of alternative delivery models. However, it should be noted that mutualisation is frequently an attractive model for many diverse services and is not limited to the service areas outlined below.

To identify which areas within health and social care would most benefit from introducing mutualisation at scale, we held in-depth interviews with existing mutuals and experts, convened an advisory panel of sector specialists and conducted a comprehensive literature review.

Further details of our methodology are outlined within **Appendix 1**.

Summary

We consider the following areas to offer the highest potential for widespread mutualisation.

- **Primary Care** (including both GP services and wider primary care services)**.** GPs are looking for alternatives to the traditional partnership model, which they perceive offers an unpalatable exposure to risk pressures and limited flexibility to work with other providers. A mutual model could reduce risk whilst offering a more attractive work proposition to many GPs and other primary care professionals.
- **Adult Social Care**. The sector is experiencing a workforce crisis and mutuals could be used to offer more attractive models of employment. There are several successful mutuals in the sector that have a strong track record of bringing in new talent.
- **Enabling Services**. Staff within enabling services typically report lower levels of engagement than elsewhere in the NHS. A mutual focused on one or more enabling services could improve engagement and increase staff voice.
- **Primary Care Networks (PCNs).** The NHS Long Term Plan identifies PCNs as a key route to delivering better out-of-hospital care and NHS England is due to establish PCNs across the country in the coming months. If partners choose to consider a new vehicle for their PCN, a mutual 'umbrella' company operating as a PCN could be used as a vehicle for integrating primary and community care.
- **Local Health and Social Care Integration Models.** The continued shift towards increased integration is also outlined within the NHS Long Term Plan. Mutuals could perform a central role in bringing together different types of services and users.

The following section offers a detailed assessment of why each area has been selected.

Primary Care

Across the UK, primary care is under ever-increasing pressure, with activity on the rise, growing patient expectation of rapid access to GPs, reduced funding and insufficient workforce. The number of patients registered with a GP rose by 1.4 million between April 2016 and April 2018, and this trend of growth will continue.[38] Challenges faced by primary care are heightened by patient needs becoming more complex and occurring over longer periods of time. This is mainly due to an ageing population and increasing numbers of people with co-morbidities.

There is a clear need for alternative delivery models, transformation at scale, and greater incentivisation for GPs to innovate, as has been recognised by the NHS Long Term Plan, the GP Partnership Review and the GP Five Year Contract Framework. To this end, our research has identified opportunities within the primary care sector for mutuals to play a role as a real alternative to the traditional partnership model and to address some of the major challenges present for primary care today.

Key drivers and opportunities for mutualisation

- **Workforce**

  Portfolio careers: The landscape within primary care is changing. Young GPs are less likely to want to become partners, and instead are increasingly keen to explore working across additional clinical areas, beyond general practice.[39] Mutuals enable salaried GPs to play a role in governance while pursuing more diversified professional careers. A mutual which offered multidisciplinary services could enable portfolio GPs to pursue these goals within one organisation.

  New generation: Mutuals also redress the balance between partner and salaried GPs, which has historically given the latter a lesser status. Empowering young and non-partner GPs to be more involved in the running of organisations may improve retention rates.

  Reducing personal risk**:** The partnership model is increasingly under strain as GPs become more reluctant to accept the personal risk associated with the position of partner: in an unlimited liability partnership partners are personally responsible for the

[38] N. Watson, (2019) *GP Partnership Review*
[39] Kings Fund, (2016) *Understanding pressures in general practice*, - https://www.kingsfund.org.uk/publications/pressures-in-general-practice

liabilities associated with such as medical indemnity, premises including leasing agreements, and staff costs.[40] This is particularly relevant when one or more partners retire and the practice is unable to recruit new partners.[41] A model which transfers liability to the organisation rather than individuals is potentially more attractive, and, importantly, does not require staff to make the financial commitment of buying into a partnership. Mutuals could therefore, be an attractive delivery model not only for new practices but also for well-established organisations that struggle with replacing partners who retire or leave the organisation for other reasons.

- **Opportunities for integration:** The partnership model in its current form does not reflect the changing landscape of out-of-hospital care. A wider delivery team is increasingly the preferred model of delivery and while the GP remains integral to the delivery of these services, evolving patient needs require a multidisciplinary team, incorporating clinicians with other expertise to provide all-encompassing care for patients. Mutuals can offer a unique option as more healthcare professionals become involved in primary care. They have the potential to 'break hierarchies' for employees working alongside GPs, and allow clinicians with a preference for integrated, team based working a sense of ownership and increased personal commitment to the practice.

Case Study: Granta Medical Practices

Granta consists of four merged practices moving from a traditional partnership model to an Employee Ownership Trust that will hold a single GMS contract. All staff will become co-owners of a limited liability company and will share in the success of the organisation. A Board will be established to make business decisions, and which will be accountable to all staff through a Staff Committee.

Granta hopes the move to a mutual model will encourage the delivery team with a wider set of expertise to engage in and progress the business.

Risks and barriers to increased use of public service mutuals

- **Lack of awareness:** As with many of the service areas mentioned in this report, there is a lack of awareness among policy makers and individual practices that mutuals can offer an alternative model of delivery for primary care services. The GP Partnership Review recommends mutuals as a potential alternative to the traditional partnership model, and proposes DHSC investigate the benefits and risks of available options of

[40] N. Watson, (2019) *GP Partnership Review*
[41] This situation is referred to in the GP Partnership Review as the risk of 'last partner standing'.

'opening up the market' to different legal structures, but this is the only mention of mutuals in this context in recent literature.[42]

- **Legal challenges:** The GMS contract has historically been an issue for alternative delivery models, as contract holders have been unwilling to forgo the lifelong benefits offered by it, and because it offers a limited number of legal structures under which GP practices can operate[43]. There is no clear guidance on legal options available for primary care organisations to mutualise and this area requires clarification.

- **Financial incentives and capital investment:** The traditional partnership model is viewed as being financially attractive since it offers a secure income. The transition into a mutual would require GPs to forgo significant financial incentives received through the partnership model and reinvest profits into a mutual with benefits shared more widely. Even if current partner GPs were willing to give up their stakes, the mutual organisation would still need to 'buy them out'. This could represent a significant capital outlay that many organisations looking to mutualise simply do not possess.

- **Workload associated with transition:** Workload for GPs is increasing in line with demand, and over the previous 5 years, there was a 15% increase in patient contacts in general practice.[44] This workload is considered unsustainable with strain falling disproportionately on those who are partners in organisations. Our respondents indicated that transitioning to a new model significantly increased their workload in the short term, and work is often taken on 'on top of the day job'. This highlights that costs and benefits must be carefully balanced when choosing whether to mutualise.

> "As GPs, we didn't know what we didn't know. We required a lot of commercial support to get us up and running." - Anna Hiley, Inclusion Healthcare (CEO)

[42] N. Watson, (2019) *GP Partnership Review*
[43] However, it includes a company limited by shares under several conditions, including that at least one share in the company is owned by a medical practitioner. In this context it is worth noting that mutuals can pursue various legal models and a mutual can operate as a company limited by shares. The exact details of this process are being worked through by Granta and NHS England.
[44] Kings Fund, (2016) *Understanding pressures in general practice*, - https://www.kingsfund.org.uk/publications/pressures-in-general-practice

Potential models of delivery

The below model shows how a mutual could operate within primary care. It is a simplified representation of one potential model, allowing for either formal ownership from all clinical staff, or employee engagement achieved through other means such as a staff sub-committee to the board or an employees' forum. There are other governance models which could be pursued in primary care, depending on differing local demands. Local demand would also dictate the specific legal form each mutual would enter in to.

Figure 1: Potential model of delivery for Primary Care (GP Partnerships or Federations)

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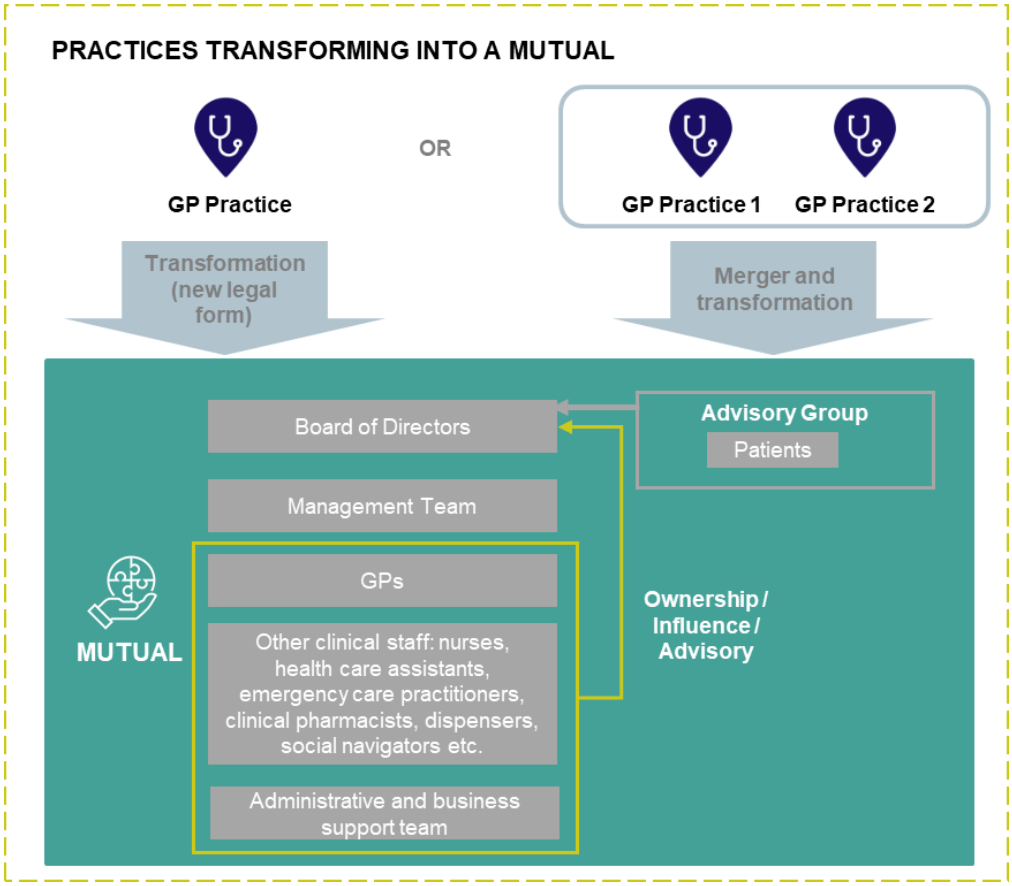


Participating organisations	Existing GP Practice or federation transforms into a mutual or several practices merge and transform into a mutual.
Ownership	Range of models possible including full employee ownership (e.g. Employee Ownership Trust – 100% staff owned limited liability company).
Scope of services	Mutual delivers primary care services across singular practice or a number of practices.
Contractual arrangements	GMS, PMS or APMS contract is transferred to a new entity as agreed by the commissioner. Staff are TUPEd to a new entity.

Adult Social Care

Key drivers and opportunities for mutualisation

- **Workforce:** There is a significant workforce crisis across the social care sector (including independent providers) and a nationwide reduction in capacity for provision at a point where demand is rising. Social care mutuals have found they are better able to attract staff, to offer them more attractive packages, and to make them feel valued in a way which supports their recruitment and retention.

> "Staff are really invested in the organisation, and that drives productivity. We recognise our staff do a really tough job and we reward them for it. We hold an annual awards night to recognise the excellence of our staff." - Rachel Law, PossAbilities (CEO)

- **Success:** There are a number of highly successful mutuals operating in the adult social care sector, whose success stories provide a firm foundation for replication, and a diverse range of lessons learnt. One of these is PossAbilities, an adult social care mutual, which has more than doubled its turnover since spinning out in 2014. PossAbilities highlighted in their interview for this report that a mutual model gave them the ability to diversify funding streams, pursue new commercial opportunities, reinvest surpluses back into the organisation and subsequently provide improved services to users.

- **Innovation:** Mutuals currently operating in the adult social care sector have been able to innovate and access diverse streams of funding, reducing reliance on block contracts. One such way has been to obtain funding directly from users through Local Authority personal budgets. By helping to implement the national personalisation agenda, these organisations have lowered their reliance on a single core contract with the Local Authority, the loss of which could be very damaging, while empowering service users to choose the care they want. The personalisation of health is a key policy initiative for the NHS. The flexibility and agility of a mutual to offer services to appeal to users is a real opportunity when delivering on this personalisation agenda.

- **Strain on the system:** Local Authorities must provide or arrange services that help prevent people developing care needs or delay people deteriorating to a point where they would need ongoing support. Local Authorities are also required to help develop a market that delivers a wide range of sustainable, high-quality care and support services for their communities, and operate within a tight financial envelope. Whilst

they do not provide a 'silver bullet' to the issues facing social care, the success of many social care mutuals in providing high quality and sustainable care to their communities make them a real and viable alternative to traditional models of delivery.

Risks and barriers to increased use of public service mutuals

- **Support:** Our research suggested there was appetite for mutualisation within Local Authorities, but there is a perception of lack of support from central government to push through this change. Notably, a number of our respondents who operate within the adult social care sector were unaware of the government's Mutual Support Programme 2[45].

- **Financial pressures on Local Authorities:** Funding for Adult Social Care has fallen by 5.2% since 2010-11.[46] Changes in demographics, inflation and the introduction of a higher National Living Wage (which affects a significant number of workers in the adult social care sector) has caused the Local Government Association (LGA) to suggest that an additional £3.6bn will be required by 2025 to prevent a fall in the quality of service delivered.[47] This lack of funding means social care services within Local Authorities are struggling to keep their heads above water. In this context, many organisations prioritise their survival and have little scope to 'look up' and consider potential alternatives models of delivery. There is also a risk that mutuals entering this space will be affected by the same pressures, unless they successfully diversify their revenue streams and identify new commercial opportunities.

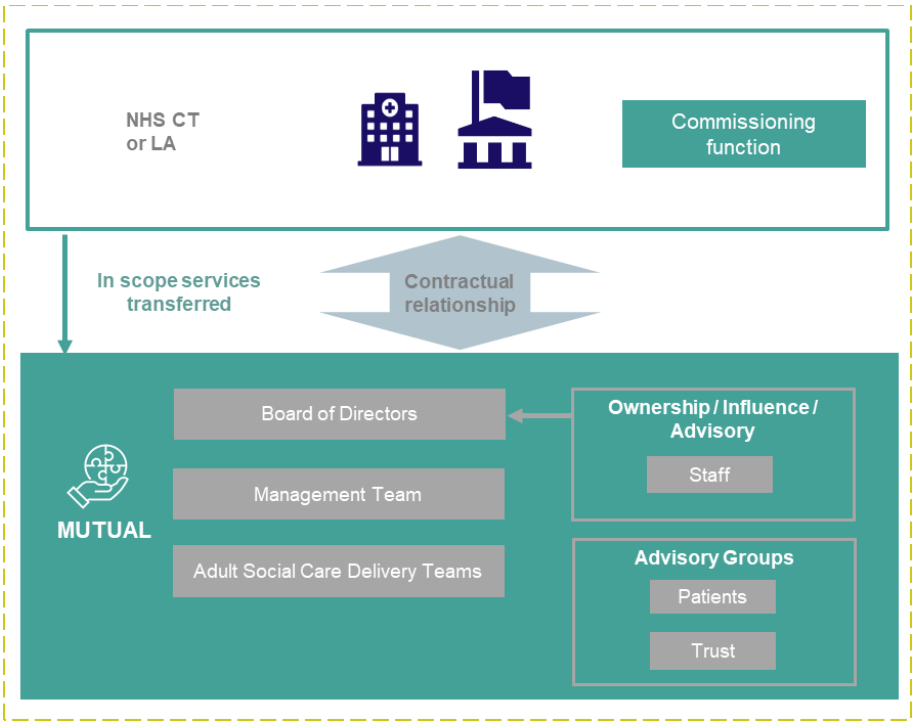
- **New entrants:** There are wider commercial opportunities within the adult social care sector, as demand continues to rise at a pace which current provision cannot match. As established players in the sector become more financially squeezed, new entrants to the sector are emerging with significant capital to invest, particularly in the Care Home market, on the assumption that funding from central sources will at some point flow back towards the sector. Mutuals do not usually have the financial clout to compete with these new private entrants to the market.

[45] More information on the MSP2 programme: https://www.gov.uk/guidance/mutuals-support-programme-2
[46] NAO (2018) *Adult Social Care at a glance*
[47] Ibid.

Potential models of delivery

The below model shows how a mutual could operate within adult social care sector.

Figure 2: Potential model of delivery for Adult Social Care.



Participating organisations	The simplest model assumes a local authority or a community trust transfers an element of its social care services to a mutual.
Ownership	Variety of models possible, the mutual could be wholly staff owned or include elements of staff ownership on the board.
Scope of services	Potential to incorporate a range of social care services under one multidisciplinary organisation, including services for adults with learning disabilities and care for the elderly.
Contractual arrangements	Traditional: Procured either through open competition or directly awarded under the Teckal exemption. Alternative: Users pay for services directly using personal budget

Enabling Services

Amongst the services that support front line delivery, from estates and facilities services to HR, finance and procurement, our research shows there is appetite to develop new models to facilitate increased innovation, staff engagement and commercialisation of services. Our key takeaway from research and experience is that staff engagement and satisfaction is historically a huge challenge for management of enabling services providers.

To some extent this reflects the NHS's focus on clinical operations. This leads to Enabling Services staff feeling that they are not as valued as other members of the NHS family, and Estates and Facilities staff typically have lower staff engagement scores than other staff groups, ultimately contributing to significant difficulties in recruiting and retaining staff.[48]

Key drivers and opportunities for mutualisation

- **Quality:** To support the improvement of enabling services, healthcare organisations nationwide have begun to explore new models of delivery in a bid to improve the standards of services, particularly in the estates and facilities sector.
- **Financial viability:** Mutuals offer healthcare organisations the opportunity to develop new sources of income from increased traded services while maintaining NHS values and a strong public service ethos.[49]
- **Workforce:** Staff engagement and experience are especially low in back-office areas such as estates and facilities[50]. The mutual model offers an opportunity to invigorate back-office staff to engage more widely in a function that is critical to supporting the delivery of clinical services in hospitals.

Risks and barriers to increased use of public service mutuals

- **Regulation:** Potential new models of delivery for enabling services are on the national agenda for NHS regulators. An NHS Improvement consultation paper in October 2018 set out that 'there are circumstances where subsidiary companies are appropriate and can help drive innovation'[51]. Further guidance was released in November 2018 to

[48] May & Askham (2005), *Recruitment and Retention of estates and facilities staff in the NHS*
[49] Grant Thornton (2017) *NHS Companies – An enterprising approach to health*
[50] NHS Staff Survey Results, 2018
[51] NHS Improvement (2018), Consultation on our proposed extension to the review of subsidiaries, October 2018, https://engage.improvement.nhs.uk/subsidiary-companies-review/extension-to-review-of-subsidiary-companies/supporting_documents/Subsidiary_companies_consultation_Oct%202018%20Final%20v2.pdf

provide clarity to Trusts who were exploring the possibility of establishing subsidiary organisations to provide a range of services, but has paused progress on exploring external models of delivery for most Trusts nationwide until a definitive position has been reached.

- **Pace of change:** The aforementioned guidance stipulates that all NHS Foundation Trusts looking to establish subsidiary companies are required to submit a Trust Board approved business case to NHS Improvement for the regulator to review. This guidance has created an extra step in the process for the creation of alternative delivery models, but also ensures an appropriate level of scrutiny over structural changes to Trusts.
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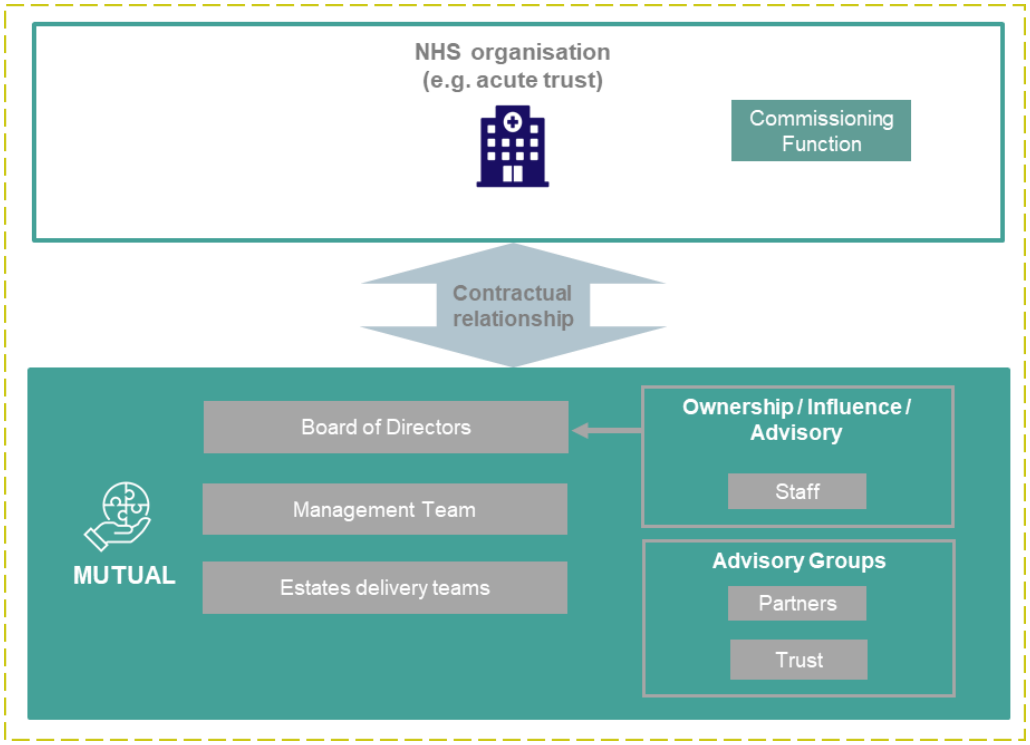
Potential models of delivery

The below model shows how a mutual could operate within the estates and facilities sector. This is a simplified representation of one potential model, to demonstrate the levels of governance and participating organisations. There are other models which could be pursued for estates and facilities services, depending on differing local demands.

Figure 3: Potential model of delivery for Enabling Services.



Participating organisations	The simplest mutual model assumes there is one commissioning organisation, such as a Foundation Trust, that transfers a range of enabling services to a new mutual. There is potential within this model to incorporate a range of participating organisations to achieve bigger economies of scale.
Ownership	Variety of potential mutual models, including wholly NHS owned with significant staff engagement or partially staff owned.
Scope of services	Specialist model focusing on one service, such as estates and facilities, or a broader offering encompassing a range of back office services, including HR, payroll and finance.
Contractual arrangements	Procured either through open competition or directly awarded under the Teckal regulation.

Primary Care Networks

> "Primary care networks are the key opportunity for mutuals – it's a perfect fit." – Gerard Newnham, Granta (Strategic Director)

To meet the evolving needs of the population, the NHS Long Term Plan sets out that networks of GPs will work more closely together in Primary Care Networks (PCNs). These PCNs, typically spanning populations of 30,000 – 50,000 people, will be funded to work with community, mental health, pharmacy and voluntary services to provide integrated care to their local populations.[52] PCNs will be contracted by CCGs under a Directed Enhanced Services (DES) contract, as a variation to their existing GMS/PMS/APMS contracts. Key to the delivery of PCNs is the employment and empowerment of a wider group of healthcare professionals, beyond general practitioners. It is not expected that practices will need to create new organisational or legal structures to form PCNs, and there is plenty of flexibility for PCNs to choose the most appropriate model for them and their communities. The mutual model, currently spearheaded by Granta, is one of the options available to PCNs, and our research suggests it could deliver significant benefits as PCNs are developed over coming years.

Key drivers and opportunities for mutualisation

- **Workforce:** It is increasingly recognised that traditional workforce arrangements in primary care do not benefit staff or service users to the extent they could. To that end, the greater integration of primary and community care services is being encouraged, in part through PCNs. The integration of services as a PCN focuses primary care more around the user, whilst aiming to reduce some of the pressures on GPs through supporting them with a wider network of clinicians.

- **Governance:** The exact nature of PCNs has yet to be defined, and to this end we have designed several models which could be replicated by PCNs, shown below. An organisation operating as a mutual could provide oversight of the organisations falling within the PCN. Our interviewees indicated that a new delivery model to bridge the gap between the CCGs and the GP surgeries within the PCN is likely to become essential Additional governance to support the establishment and growth of PCNs would be useful, especially if these are to operate at scale, and potentially interact with one another..

[52] NHS England (2019) *NHS Long Term Plan*

- **Community focus:** PCNs will be locally-run and operated organisations, aimed at improving care services within a particular community. This local focus aligns with the mutual ethos of empowering the community to be engaged in the services provided to it, through staff and user advisory groups feeding into more formal governance arrangements.

> "An organisation sitting between the CCG and GPs with a strong community ethos would have a real impact on primary care delivery". – Anne Talbot, Bolton Community Practice (CEO)

- **Risk and employment arrangements:** Key to the delivery of PCNs is the employment and empowerment of a wider group of healthcare professionals, working across a range of services. A mutual model could provide the parent organisation under which these employees can be contracted and could hold the contract for the wider PCN. This would significantly reduce the risk encountered by individual partners, addressing a key worry for GPs and offer wider employees the opportunity to be partners in the PCN.

- **Enabling services:** To facilitate the delivery of PCNs at scale, there will be a need for high quality support services. As PCNs grow, the services which support them, such as procurement, HR and finance, will need to grow or consolidate to facilitate this. A centralised corporate support function would provide this additional capacity, as well as opportunities to realise economies of scale.

- **Staff uncertainty:** New roles will be required to make the delivery of PCNs successful, for instance social prescribers will be required to work for multiple GPs, making staff nervous about new governance arrangements[53]. A formal operating model, such as a mutual, governing their employment, could go some way to ensure job security, with the added benefit of providing staff with greater control through a more formal ownership role.

- **A united voice:** GPs have sometimes struggled to find a voice in the wider healthcare system, and operating as part of a network allows primary care organisations a more unified voice, and thus greater opportunity to influence local agendas.[54] Mutuals can

[53] NHS England, *Primary Care Network - Webinar*
[54] N. Watson, (2019) *GP Partnership Review*

establish governance structures that allow professional groups such as GPs to have equal representation and voice alongside local system partners.

Risks and barriers to increased use of public service mutuals

- **Alternative arrangements:** The Primary Care Network Maturity Matrix indicates that networks need to identify a business model under which to operate, specific to each locality. The mutual model may not be appropriate for every locality.

- **Awareness:** There is a relatively low awareness of mutuals in the primary care sector. Our respondents indicated that, after the Cabinet Office Mutual Pathfinder Programme, central government support for the establishment of social enterprises and mutuals has dwindled. More should be done centrally to raise awareness of mutuals as one of the options for PCNs. The crucial period for this intervention will be post July 2019. At this point, PCNs should have been formally established, and will begin to receive additional funding and may start looking forward to the next step of formalising their operating models should they choose to do so.

- **Sovereignty:** GP practices operating under the traditional partnership model are used to working with a high degree of independence and autonomy. Integrating individual services under a formal governance model may be seen as giving up control, and losing the independence to make decisions which suit the individual practice.

- **NHS England support:** Primary Care Networks are a relatively new initiative within the NHS. Currently, networks are expected to be informal arrangements between localised GP organisations, with more concrete plans for operating models to be defined in time. There is no requirement for a new organisation to be implemented to coordinate the delivery of services in a PCN, and as such there is no policy direction which states these organisations, when they are formed, could be mutuals, which may reduce the number of organisations likely to consider the model.

- **Existing partnership working:** GP organisations have been encouraged to work in Federations and latterly, as part of Primary Care Networks. As such, there seems to be a general belief among GPs that they are already working in partnership with other surgeries. Indeed, NHS England figures propose that 93.4% of GPs currently work in partnership.[55] As such, there is a question over whether mutuals or other alternative delivery models could fit into this agenda to act as an agent for integration, or whether

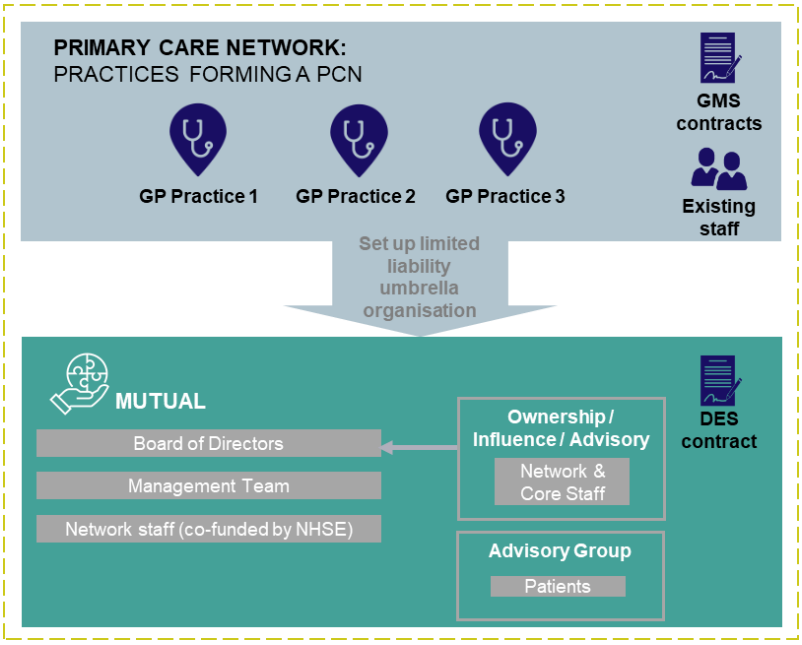
[55] General Practice Forward View, *Monitoring Survey* (2018)

they simply add a layer of bureaucracy to a sector which is already providing more integrated services.

Potential models of delivery

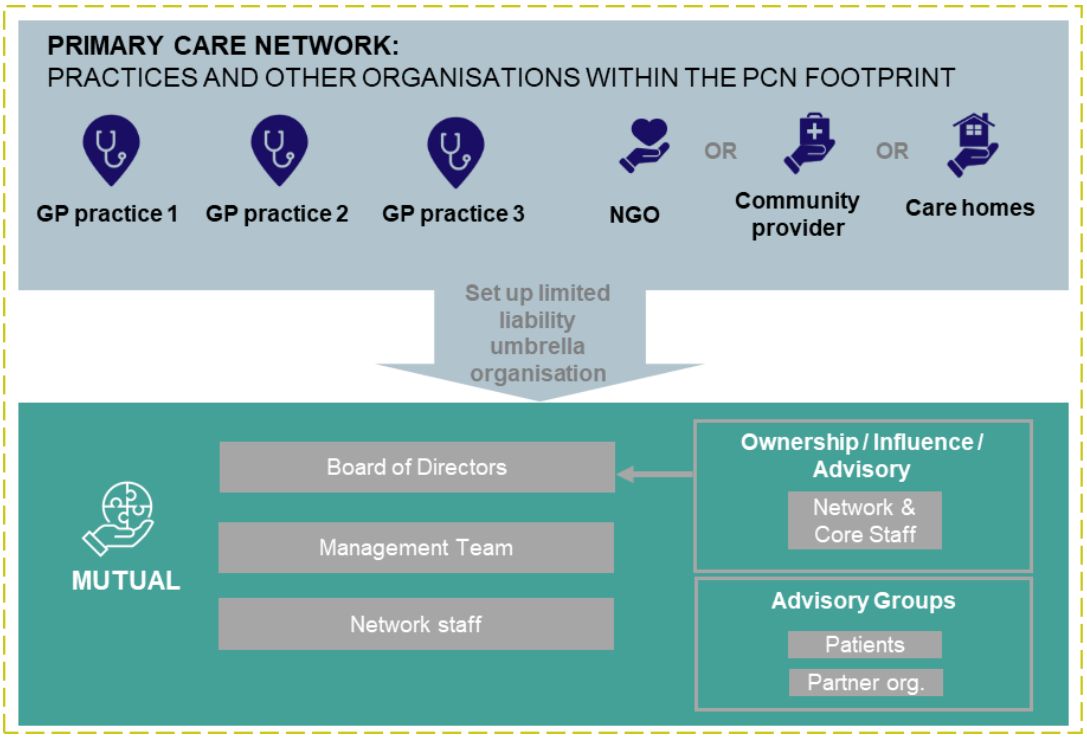
The below models show how a mutual could operate within Primary Care Networks. These are simplified representations of three potential models, to demonstrate the levels of governance and participating organisations. There are other models which could be pursued for Primary Care Networks, depending on differing local demands and priorities.

Figure 4: Potential model of delivery for a basic Primary Care Network.



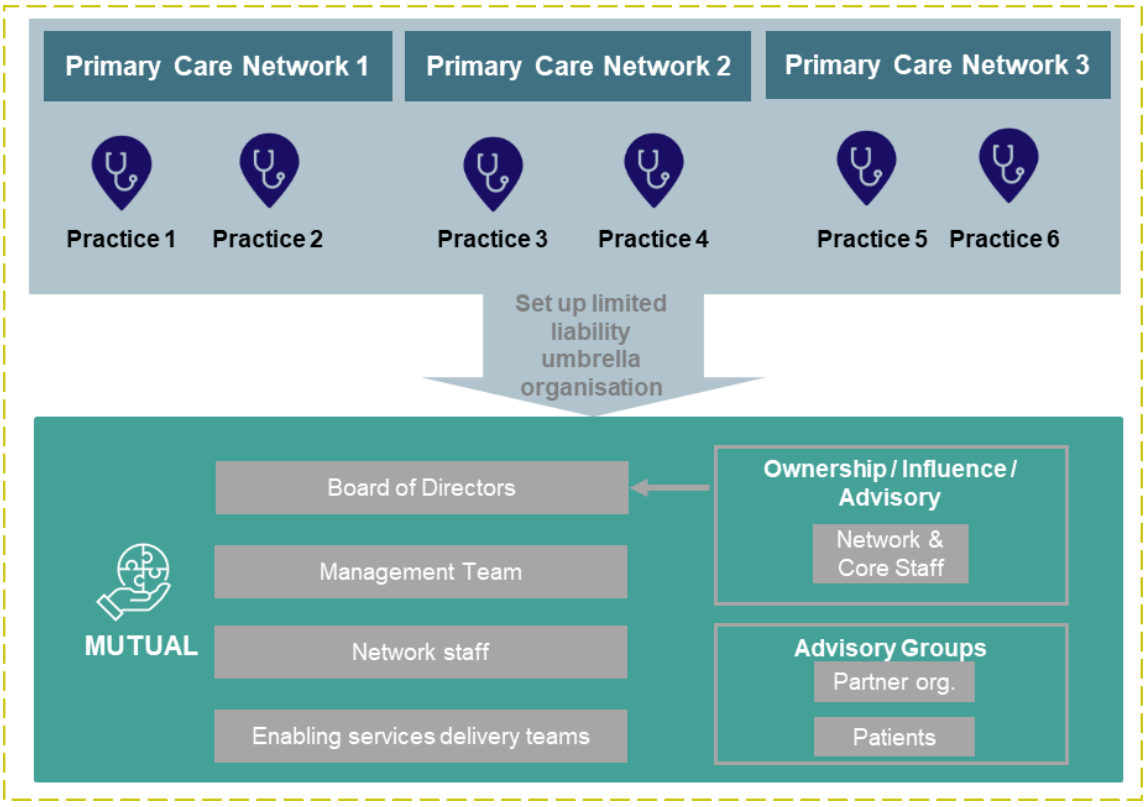
Participating organisations	Practices forming a PCN (that set up a mutual to provide an additional governance structure responsible for the network contract).
Ownership	Variety of models, including full staff ownership, or joint ownership between practices.
Scope of services	The mutual delivers services under the DES contract and employs network staff (staff of the umbrella organisation, including staff co-funded by NHSE: clinical pharmacists and social prescribing link workers starting from 2019/20, physiotherapists, physician associates and paramedics in subsequent years).
Contractual arrangements	Individual practices hold and remain responsible for delivery of their contracts (e.g. GMS contracts). If the mutual is party to a primary medical services contract, it signs the DES contract commissioned by local CCG. If the mutual is not eligible to hold the DES contract, it is subcontracted to deliver services required by the DES.

Figure 5: Potential model of delivery a Primary Care Network with multiple stakeholders.



Participating organisations	Practices forming a PCN and other organisations within the PCN footprint.
Ownership	Variety of potential models possible; the mutual could be owned by all the participating practices, a Joint Venture between practices, or by staff.
Scope of services	The mutual is responsible for delivery of services under the DES contract – either holding the contract directly or through subcontracting arrangements, as discussed above – and employs network staff. The mutual could also deliver social prescribing. In a model including care homes, the mutual could deliver the Enhanced Health in Care Homes service.
Contractual arrangements	Similar to the above model, with additional contracts commissioned by the local CCG or LA dependent on the scope of services delivered.

Figure 6: Potential model of delivery for a Primary Care Network with multiple PCNs.



Participating organisations	Practices forming several PCNs within one CCG area.
Ownership	Variety of models possible, the mutual could be owned by all the participating practices or owned by staff.
Scope of services	The mutual is responsible for delivering services under the networks DES contract (either holding the contract directly or through subcontracting arrangements, as discussed above) and employs network staff. The mutual could potentially deliver a range of enabling services.
Contractual arrangements	Similar to the basic model, with additional SLAs with individual practices for relevant enabling services.

Local health and social care integration models

The integration of local services across NHS and local authority bodies is a key priority for the health and social care sector, as set out in the NHS Long Term Plan.

The NHS Long Term Plan pledges an additional £4.5bn a year by 2023/24 for community and primary medical services. This ringfenced funding will directly incentivise cross agency working on a local and regional level to deliver more joined up care to patients. Alternative delivery models could usefully play a part in this integration, as new delivery models will be required to provide robust and informed governance to partnerships which emerge, whilst empowering staff to take ownership of newly integrated services. One example of this is Sussex Primary Care, a mutual and a true example of integration between community and primary care providers – see case study box.

Case study:
Sussex Primary Care

Sussex Primary Care is a new mutual formed in 2019. The organisation was developed with the purpose of integrating primary care services across the Sussex STP.

Sussex Community Health Trust are the commissioners for the project. This integration between community and primary care at this scale is the first of its kind. SPC will enable the wholesale integration of primary care in Sussex, which will in turn enable the wider integration of primary and community care in the area, under an umbrella organisation operating as a mutual. As a first step, SPC will provide operational governance to GPs, and provide integrated back office support. In time SPC will provide a route to integrating primary care and community health services.

Key drivers and opportunities for mutualisation

- **Demand:** There is high demand within the wider integration agenda in the health and social care sector for tested and pragmatic delivery models to enable integration in practice. Our research concluded that mutuals are particularly well positioned to enable integration in community services.
- **Nimble governance structures:** Developing seamless pathways for patients between various services is one of the priorities within the NHS Long Term Plan. Mutuals can support integration by providing umbrella structures that protect the sovereignty of each party, with nimble governance arrangements for partners to collaborate with ease.
- **Innovation:** There are several mutuals operating at the forefront of community-led innovation and currently implementing pioneering service delivery models. For

example, community providers in Essex have formed alliance partnerships with Local Authority to join up elements of adult social care provision in order to improve performance and outcomes for patients.

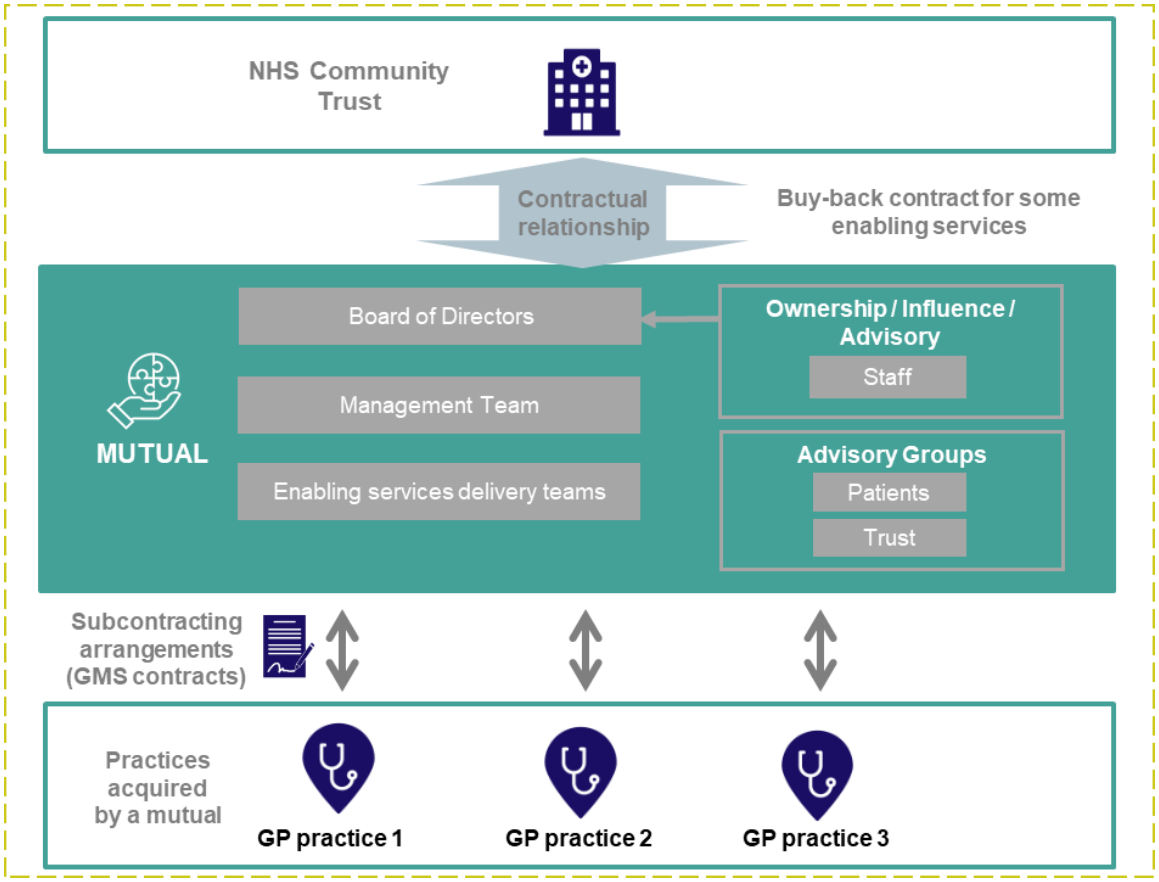
Risks and barriers to increased use of public service mutuals

- **Lack of awareness:** There are pockets of innovation involving mutuals, but there is not widespread awareness or take up of the model. This is in part due to perceptions that mutualisation increases service fragmentation by creating additional bodies that sit on the edges of the NHS, which is at odds with the wider push towards reducing organisational barriers set out in the Long Term Plan.
- **Resource intensity:** Integration projects of this scale are complex and expensive. The implementation of any new organisation is extremely resource intensive, and when integrating across Local Authorities and NHS organisations, there are additional costs and considerations which must be made.
- **Complexity:** Many organisations are still at the stage of considering integration as a partnership arrangement between existing organisations, be that through contractual joint delivery or a less formal agreement. To add the establishment of another organisation to this creates additional complexity which many NHS organisations and Local Authorities may be unwilling to consider, especially given the lack of awareness among commissioners as to the benefits of the mutual model.
- **Evidence base:** There are currently very few mutuals that operate at the requisite scale to enable this wider system integration. As such, there are a lack of case studies through which to explore the full benefits and challenges of the mutual model in this context. To ensure future replication of these models, those organisations which are acting as ‘trailblazers’ in integrating these services should be supported to capture learnings to share with others.

Potential models of delivery

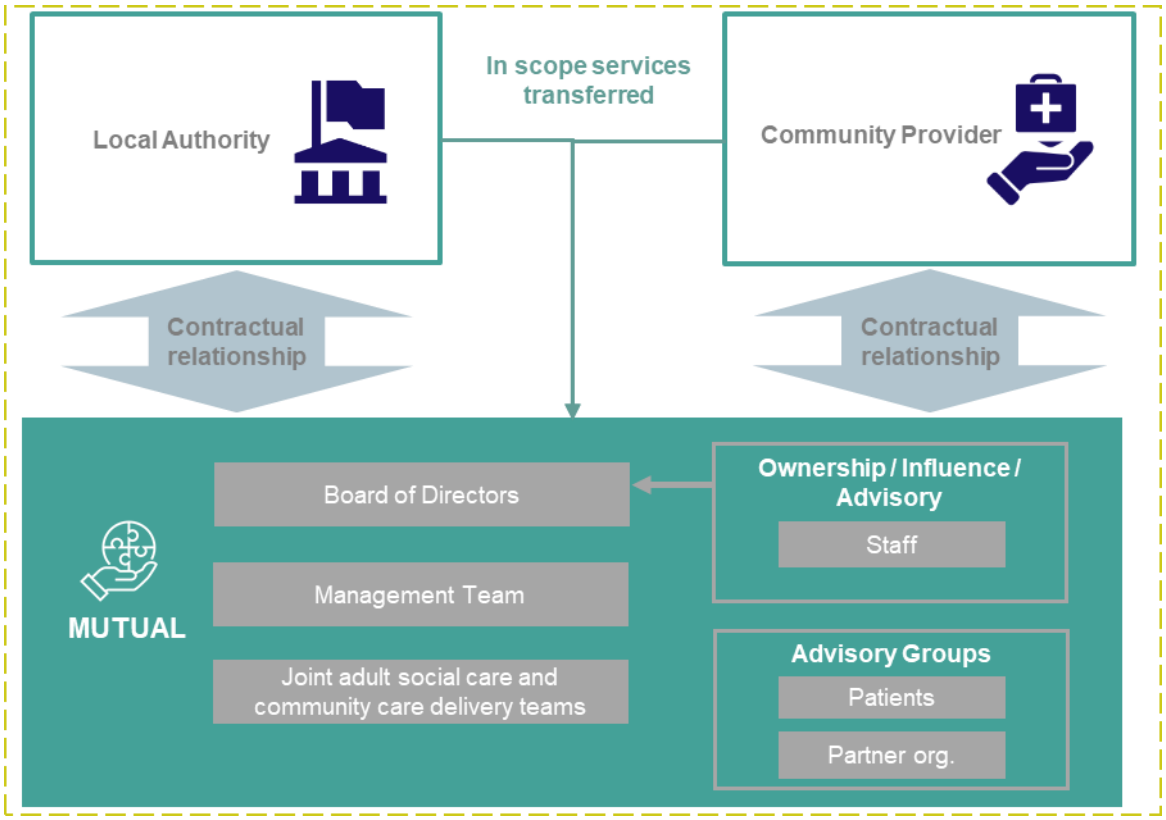
The below models show how a mutual could operate within the context of the integration of local services. This is a simplified representation of two potential models, to demonstrate the levels of governance and participating organisations. There are other models which could be pursued when integrating local services, depending on differing local demands.

Figure 7: Potential model of delivery for Primary and Community Care Integration.



Participating organisations	Community trust establishes a mutual that acquires GP practices to deliver primary care at scale.
Ownership	Range of models, including wholly owned subsidiary or 100% staff owned model.
Scope of services	The mutual takes on responsibility for delivery of primary care services. The mutual provides operational governance and back office support (enabling services – e.g. procurement, HR, quality improvement, clinical governance, emergency planning, communications, CQC support, financial management, information governance, stakeholder engagement). The mutual owns or leases premises, and provides access to flexible bank of staff.
Contractual arrangements	The new entity cannot hold a GMS contract directly, but can deliver services through a sub contract with individual practices. Enabling services can be delivered directly by the mutual or bought back.

Figure 8: Potential model of delivery for Adult Social Care and Community Care Integration.



Participating organisations	Community provider and local authority transfer elements of service to a new entity to deliver integrated care.
Ownership	Range of models possible, including a formal Joint Venture, or a 100% staff owned model.
Scope of services	Mutual takes on responsibility for adult social care and a range of community care services, grouped around certain pathways or around geographies.
Contractual arrangements	Local Authority commissions social care services, local CCG commissions community care services. Alternatively: lead commissioner model with one organisation procuring services.

HOW TO REPLICATE MUTUAL MODELS AT SCALE

Summary

The aim of this section is to set out what replication means in the context of mutuals, and investigate successful approaches to replication.

Our research identified a range of replication approaches that can be used to grow mutual models across the health and social care sector which were supported by the feedback from the market and experts. Below are the key findings on how to replicate mutual models. The full list of recommended actions is presented throughout this section:

- Mutuals are at a relatively early stage of development in some service areas within the health and social care sector. A variety of activities aimed at sharing knowledge and supporting organisations adopting new delivery models (i.e. **dissemination activities**) are needed to drive replication. The priorities include:
    - Developing a dedicated support package for primary care organisations exploring alternative delivery models for working together in the context of Primary Care Networks, preferably delivered alongside the **Primary Care Network Development Programme** that NHSE is establishing. It should include a practical toolkit with template documents;
    - More broadly, continuing **technical and financial support for mutuals**, not only during the spin out phase but also for more established organisations, to help develop sustainable mutuals for the long-term;
    - **Raising awareness** and re-energising leaders in the sector to reinforce the message that mutuals are a viable delivery option in the current policy context;
    - Consistent **communication about mutuals' benefits** across the wider health and social care sector;
    - Supporting **development of visionary leaders** who can effect change across the social care and health sector.
- There is a strong case to leverage the position of successful existing mutuals to build up the mutual sector size, capacity and resilience through various **affiliation models**. This is especially relevant to models that allow all the affiliated organisations to maintain their independence and ability to respond to specific local needs.
- In the mid- to long-term, **consolidation** through acquisitions of new services and organisations can be an effective route to replicating mutual models. While it is important to recognise that not all mutuals have the ambition or strategic plans to expand their

business, encouragement and support could be provided to those who are seeking to consolidate their business and expand to new service areas.

Our research has also identified a number of replication enablers. These are tools or activities needed to build the right infrastructure around mutuals to 'scaffold' their development and facilitate replication:

- **Continuing to build an evidence base, especially around Primary Care and PCN's:** Strong evidence of cost-effectiveness and impact is critical to replication at scale. Visibility of high-performing organisations on a national scale should be increased. Mutuals should also be encouraged to evaluate and demonstrate positive impact and value for money.
- **Policy changes**: Mutuals will only take off at scale in the health and social care sector if there is a supportive regulatory and public policy environment, or at least one that does not create additional barriers and risks for mutuals. It is important to ensure that mutuals are not negatively impacted by the proposed NHS legislation on procurement of health services in the NHS.
- **Creating a coalition of committed stakeholders from key departments to progress the agenda**: Central government leadership and coordination across multiple departments that are relevant for the mutualisation agenda is critical to provide greater momentum and support for organisations that wish to go down this path.
- **Simplifying the language of mutuals**: The current terminology is confusing to many stakeholders, including existing mutuals. To address this challenge, the government has launched sector consultation on the public service mutual definition, as promised in the Civil Society Strategy. It is also important to make sure the new definition is widely communicated, including clear messaging on characteristics and benefits of mutuals.
- **Voice and engagement of the sector:** Replication of mutuals at scale requires not only a commitment from government, but also the whole mutual community. There is a strong case for either strengthening existing organisations that represent mutuals or exploring creation of a new national mutual membership body that focuses entirely on public sector mutuals. The aim would be to provide a strong voice and practical, sector-led support.
- **Educating commissioners:** There is a clear case to develop commissioners' understanding of mutuals as well as provide them with guidance on how to shape procurement processes that are open to alternative delivery models.
- **Lowering financial barriers:** New funding mechanisms that facilitate access to capital for new and growing mutuals should be unlocked.

What do we mean by replication?

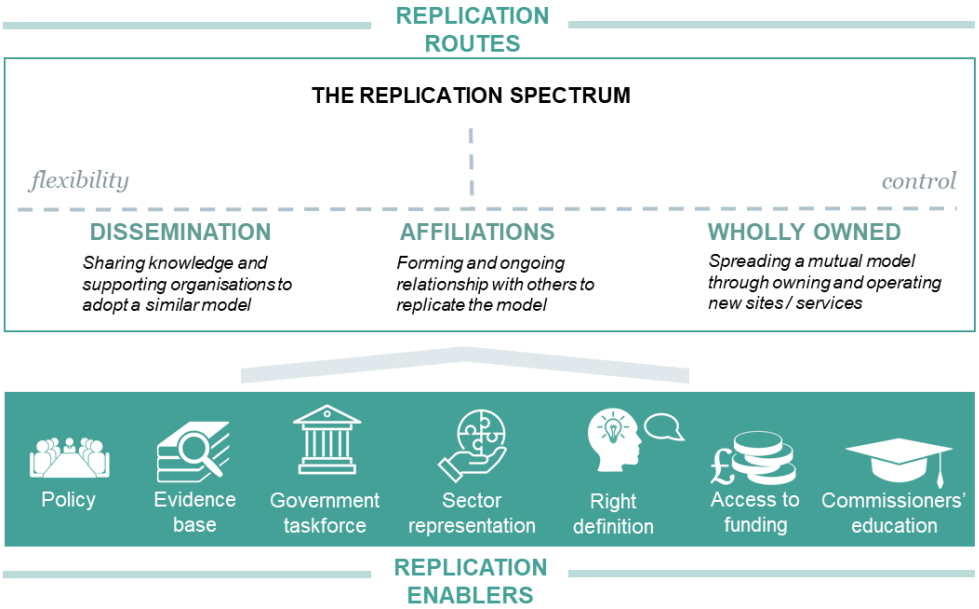
There are various approaches to replication, which have been well tested and described in the context of social enterprises[56]. However, there is almost no research on replication specifically in the mutual sector. Therefore, for the purpose of this research we proposed a replication framework, which builds on existing definitions and experiences of the VCSE sector, but also considers specific needs of the mutual sector (see below and **Appendix 2. Replication framework** for more details). The framework gives a high-level conceptual structure for the recommendations presented below.

Our framework distinguishes between:

- **Routes to replication** i.e. various approaches that could be applied to expand mutual models to new organisations, and
- **Replication enablers** i.e. tools that could be used to facilitate replication across all the routes and a range of activities needed to build the right infrastructure around mutuals to 'scaffold' their development and growth.

There are three key routes to replication: dissemination, affiliations and wholly owned models. Our research showed that given the relatively early stage of development of mutuals in some service areas within the health and social care sector, there is a need to focus initial replication activities on dissemination and support initiatives (including e.g. policy support).

Figure 10: The replication spectrum.



[56] For more information on social replication, please see for instance: L. Mavra (2011) or Spring Impact Social Replication Toolkit (2018).

Routes to replication

Replication through dissemination

What is it: sharing knowledge and supporting organisations to adopt a mutual model.

Advantages

- Includes some less costly initiatives (e.g. toolkits)
- Helps build additional capacity within the sector by supporting grassroots initiatives
- Helps eliminate barriers to replication across the whole system e.g. through increased awareness of mutuals

Disadvantages

- Does not guarantee change
- Gives limited control over how resources are used
- Gives limited control over quality of new models

Key success factors

- Building and using evidence base
- Practical policy guidance
- Availability of technical support
- Availability of financial support
- Education of commissioners, service leaders and politicians

Specific objectives that could achieved through dissemination: increased awareness of mutuals, imporved availability of resources to organisations considering mutualisation, support to strengthen existing mutuals and ensure new ones are set up for success

By dissemination we mean a variety of activities that are aimed at sharing knowledge about mutuals and supporting organisations already planning on adopting a mutual model. This includes promoting the mutual model and advising how to implement it through events, training, publications, dedicated technical support and sharing good practice.

The mutuals and experts engaged during this research were of a consensus that opportunities and benefits of mutuals are still not well rehearsed and shared throughout the health and social care sector. More needs to be done to engage with the sector to promote the concept of mutuals and support newly created and existing organisations. Importantly, any package of available initiatives should be broad enough to meet the differing support needs of organisations at various stages of transition. Whilst some of them will require significant hands-on support to take-off, others will have more specific or light touch support needs. The respondents commended the current government approach to supporting mutualisation as following this ‘no one size fits all’ approach. Some even indicated that all the elements of the support package for mutuals are already available, they just need to be scaled up and better communicated to the wider sector.

Specific support for Primary Care Networks

Our research highlighted that mutual models within the context of Primary Care Networks require a more targeted support approach and dedicated resources.

This is driven by the below factors:

- As PCNs are new structures, there are no existing examples of mutuals in this area that could be used as case studies. There is therefore a strong case to support mutual vanguards in this area to develop best practice, inform potential policy changes and contribute to a wider understanding of alternative delivery models in primary care.
- There is an opportunity to link support for mutuals with the wider PCN Development Programme when educating the primary care sector about various alternative delivery models for integrated working. Such an approach will provide greater economies of scale.

The Primary Care Networks Development Programme is currently under development with significant engagement with the sector, e.g. through regular webinars. NHS England presented initial thinking on how the Programme could be structured, indicating that it could include three pillars:

- enabling mature PCNs (an organisational development programme aimed at supporting PCNs move across the PCN maturity matrix);
- technical support;
- primary care leadership programme.

A similar comprehensive package including organisational development, technical support and leadership support would be useful to support the replication of alternative delivery models within Primary Care Networks. It is important however that the support is not limited to mutuals – a range of legal and organisational models should receive the same treatment and access to support. This would then provide a platform to articulate the respective benefits of each organisational form.

Based on lessons learned from previous support programmes, the PCN alternative delivery model technical support should be preceded by official guidance on the most problematic and common issues (e.g. contracts, shared ownership, pensions, VAT). The guidance should be made available in the form of a toolkit or ‘how to’ guidance that interested organisations could adopt and adapt to their local needs. This would ensure the support programme is less resource intensive and more cost efficient.

Additionally, a leadership and organisational development programme should include among its objectives raising awareness of alternative delivery models that networks can consider when they move across the PCN maturity matrix.

It is worth noting that primary care (both in the context of the PCNs and new delivery models as alternatives to the traditional GP partnership model) has been indicated in our research as an area that would benefit from a 'mutual toolkit'. This is in contrast to the other areas, in particular those where mutuals are more established, where the idea of toolkits seemed to have less traction. The toolkit should present a best practice response to the most common challenges and include template documents to streamline the process of adopting a new delivery model.

Recommendation 1: Design a dedicated support package for primary care, in particular organisations exploring alternative delivery models in the context of Primary Care Networks and as an alternative to the traditional GP Partnership model.

Who	What	Focus
NHSE	1.1. Explore options for bringing in support for alternative delivery models (including mutuals) as part of the PCN Development Programme.	
DHSC and/or NHSE and/or DCMS	1.2. Identify the most challenging issues or policy barriers that primary care organisations may face in their transition to a mutual and prepare a toolkit or national policy guidelines with practical solutions on how they can be approached. These toolkits could be tailored to both individual providers and Primary Care Networks.	
NHSE	1.3. Once the toolkit or policy guidance is published, launch a pathfinder programme for alternative delivery models in PCNs, preferably as part of the PCN Development Programme.	

Technical and business support

Several respondents identified the original Mutuals Support Programme as an instrumental initiative for allowing mutuals to get off the ground. The Programme has been revived as

Mutuals Support Programme 2 ('MSP2'). However, only some of our interviewees were aware of its existence, indicating a need for renewed communication on the availability of support.

When asked about recommendations for the future, our participants indicated that upfront support such as that provided by MSP2 would be helpful, particularly when focussed on:

- Technical support especially legal and VAT advice;
- Business support, including business planning, change management and growth support for existing mutuals focused on commercial strategy development, bid writing, revenue diversification and customer-centred service design.

Additionally, given the priorities of the NHS Long Term Plan, technical support on digitalisation such as designing customer-focused digital strategy or testing and implementing new digitally-enhanced service pathways would be welcomed.

Recommendation 2: Continue to support mutuals, not only during the spin out phase but also once established. This will allow for capacity-building and help develop sustainable mutuals for the long-term, which will then be able to take a more active role in sector-led replication of mutual models.

Who	What	Focus
OCS	2.1. Continue Mutuals Support Programme 2 as a valuable initiative that is critical for getting mutuals off the ground.	
OCS and / or national mutual body	2.2. Organise an information campaign on wider support available to transitioning and existing mutuals. This could include well positioned internet portal, national roadshow, speaking at events or using ambassadors of the programme, e.g. previous beneficiaries, to actively promote it.	

Leadership development

Running a successful mutual requires strong leadership. Our interviewees had typically received support in this area before spinning out, and greatly valued how it gave them confidence and prepared them for their mutualisation journey.

Suggested approaches to enhance leadership capability include:

- Ad-hoc training, both in person and online, to build leaders and senior management's business acumen and facilitate their transition from clinicians / service leaders to more

commercially minded entrepreneurs. This should include training on business management, revenue diversification and customer-centred service redesign;

- Mutuals Leadership Academy / Academy of Skills: a more formalised and structured programme of comprehensive training for mutuals' leaders;
- Business mentoring and coaching schemes.

It is recommended that leadership development, coaching and upskilling initiatives should be delivered by the mutual sector in cooperation with experts from business and potentially the OCS. This would allow the leveraging of existing sector potential and build on several leadership support activities already developed by mutuals.

It was also recognised that leadership development is an ongoing process that should start as early on as possible. There is a strong case to include teaching on alternative delivery models in healthcare / social care service leader educational curriculum. Emerging public service leaders would benefit from a curriculum equipping them to think more commercially about services. A curriculum on alternative service delivery models could be jointly developed and delivered by existing mutuals and higher education institutions (with support from the OCS and leveraging work that has been already done in this area, e.g. a toolkit for senior managers and leaders of mutuals)[57].

Recommendation 3: Support development of visionary mutual leaders, both existing and emerging, through a wide portfolio of collaborative initiatives designed to meet various support needs and learning styles.

Who	What	Focus
OCS and / or national mutual body	3.1. Take stock of mutual leaders training and development needs (e.g. through sector survey) and develop training curriculum in response to the needs analysis, including a mix of online and classroom training.	
OCS and / or national mutual body	3.2. Maintain up-to-date centrally managed and regularly refreshed online training repository (e.g. webinars, case studies, masterclasses).	
OCS and / or national mutual body	3.3. Facilitate business coaching and mentoring scheme, matching existing mutuals' leaders with individuals from the business sector and aspiring	

[57] B. Hawkins et al, (2018) *Leadership Development in Public Service Mutuals: A Practical Guide*

	mutuals' leaders with more experienced peers operating in the same service area.	
OCS and / or national mutual body	3.4. Establish an Academy of Skills for leaders of newly created mutuals, which would provide a more formalised training programme in conjunction with peer-led support.	 Mid-term
OCS and / or national mutual body	3.5. Engage with higher education institutions to encourage the inclusion of information on alternative delivery models (and mutuals in particular) in existing public service qualifications, to support formation of a new generation of public service leaders well versed in various service delivery models.	 Mid-term

Consistent communication and raising awareness

There is a relatively low level of awareness within the wider health and social care sector that mutuals are a viable delivery option in the current policy context of integrating care and population-based approaches to health. Many interviewees believed that mutualisation has fallen down the government agenda.

That is why a greater push from the government is needed to raise awareness and re-energise leaders in the system, both providers and commissioners, on the benefits of mutuals. In particular, more robust communication, commitment and endorsement from the DHSC and NHSE is needed before mutuals could be replicated at scale in health and social care sector. However, to achieve this, the OCS working together with the mutual sector will need to improve awareness of mutuals and their benefits among civil servants and engage the key stakeholders responsible for health and social care policy.

> "The government should present options, not a single approach that someone thinks works best. But you do want to have mutuals 'on the shopping list". – Glen Garrod, President of the Association of Directors of Adult Social Services

The approach to supporting mutuals should not be prescriptive. Discussion about mutuals should be a part of a wider information campaign or a development programme focused on alternative delivery models: the goal should not be to impose one particular model. This is especially relevant, given that our interviewees noted that there may be some disappointment in the sector with an overly ambitious government mutualisation agenda in the past that has not been fully realised.

Recommendation 4: Raise awareness and re-energise leaders in the system around the concept of mutuals to reinforce the message that mutuals are a viable delivery option in the current policy context. Disseminate knowledge around mutuals and their benefits across the wider health and social care sector both at a central and local level.

Who	What	Focus
DHSC	4.1. Reference the role mutuals play in delivering innovative, high quality social care services and showcase various alternative delivery models within the forthcoming Green Paper. Provide case studies of adult social care mutuals that are CQC outstanding and financially sustainable.	
OCS	4.2. The OCS should identify relevant individuals and teams within the key stakeholder organisations for the health and social care sector (e.g. DHSC, NHSE, BMA, Royal Colleges, NACP, LGA) to engage them on the mutual agenda.	
OCS	4.3. The OCS should develop educational resources and deliver a targeted education programme on alternative delivery models (and mutuals in particular) for civil servants and other key individuals from prominent stakeholder organisations to enable them to take a more active part in driving the policy forward.	
DHSC, NHSE and OCS	4.3. The government needs to ensure that, going forward, mutuals are featured in all the key relevant policy documents regarding service delivery models. Mutuals should be presented as one of the alternative delivery models that can facilitate integration within the health and social care sector, e.g. through exhibiting case studies and successful examples of mutuals.	

Replication through affiliations

What is it: Forming an ongoing relationship with other organisations to replicate a model.

Advantages

- Allows quality to be maintained
- Allows smaller organisations access innovation or skills they lack
- Allows the financial burden of replication to be shared among stakeholders

Disadvantages

- More complicated approach
- Not widely understood
- Perceived by some as a fad (social franchising)
- Requires additional coordination

Key success factors

- A higher level of sector maturity and strong successful organisations that will act as sector integrator

Specific objectives that could achieved through affiliations: replication of successful mutual models at scale, strengthened market position and diversified revenue strams for organisations that drive affilations, additional support and increased sustainability for other participating organisations

Affiliations may include various types of collaboration arrangements or membership organisations with varying governance and scope (e.g. associations, alliances, federations, strategic partnerships, joint ventures) where multiple organisations collaborate to adopt and replicate the mutual model. We have also distinguished social franchising as a distinct form of affiliation strategies that could be leveraged to grow the mutual sector at scale.

Affiliations would usually require a legal framework to define the nature of the relationship, roles and responsibilities, and potentially also financial obligations. Affiliations can be driven be a leader organisation that acts as an originator and is often tasked with providing support to other participants or could be established between peers with equal status.

Social franchising

Social franchising was mentioned several times during interviews as a potential route to replication. Our interviewees believed it would need to be supported by central government, as it is unlikely that commercial or a sector-led social franchising within the health and social care sector would be successful. Some suggested setting up a ‘social impact bond’ type of governance and organisational framework, which includes a commissioner, an investor and an intermediary organisation that supports the process. However, feedback from the sector on social franchising was mixed. Some interviewees indicated that there is limited appetite in the system to pursue it. Others were interested in social franchising, however they mentioned

that similar results can be achieved in pursuing more straightforward affiliation models. Given the mixed feedback from the sector and limited resources available, we do not recommend focussing resources on social franchising, at least in the short term.

Other collaborative / affiliation models

While the idea of social franchising was met with a mixed reaction from mutuals operating in the sector, other affiliation models had strong advocates among our interviewees.

Several potential models have been mentioned in this context as potentially well-suited to the mutual context, including arm's-length organisations[58] and networks, e.g. as employed by Mind[59] (a mental health charity).

Case study: Mind UK

Mind is a network of approximately 130 local organisations across the UK providing mental health services that all adopted the same branding, mission and key delivery model. Every local Mind organisation is an independent charity (e.g. responsible for its own funding) and can flexibly react to the local needs. The central Mind organisation provides additional support to all the organisations within the network. It also assesses the quality of local Mind organisations through the Mind Quality Mark.

Respondents stressed that affiliation models can provide an effective route to strengthen the sector and replicate successful mutual models at scale. In addition, they also create mutually beneficial arrangements for all participating parties. A leader who decides to package their support offer and pursue an active go-to market strategy with this new offering can strengthen their market position and diversify revenue. At the same time, other participating organisations, e.g. new or smaller mutuals, receive support without which they might not be sustainable in the long term. The interviewees indicated that support provided to affiliated mutuals could include inspection preparation, contracting or regulatory support.

Recommendation 5: There is a strong case for leveraging the position of successful existing mutuals to build up the mutual sector size, capacity and resilience through various affiliation models. Mutuals should explore affiliation models that allow all the participating organisations to maintain their independence, while at the same time gaining access to skills, capacity and capability they lack internally.

Who	What	Focus

[58] An arm's-length organisation is a term used to describe a formally independent organisation that is subject to control and influence exerted by another organisation (e.g. through funding, quality standards, board representatives).
[59] More information: Building on change, Mind 2016-2021 strategy https://www.mind.org.uk/media/4205494/building-on-change_booklet_final_pdf_21march16.pdf

OCS and / or mutual membership body	5.1. As a part of the broader support offer for mutuals, specific training, capacity building and expert advice should be provided to organisations that are willing to take on a more active ‘champion’ role in the sector.	

Wholly owned approach to replication

What is it: Spreading a mutual model through owning and operating new sites/services.

Advantages
- Economies of scale
- Simplifying complex organisational environments and decreasing transaction costs
- Supporting integrated care

Disadvantages
- Might supress innovation and local sense of ownership
- Time consuming
- Additional set up costs (e.g. legal fees)

Key success factors
- Good business case
- Robust change management and communication
- External technical advice (e.g. on TUPE)
- Access to capital

Specific objectives that could achieved through the wholly owned replication models: scale up of existing mutuals (including increased market share, broader service offering, increased balance sheets and financial stability), consolidation of services around one pathway or needs of a particular population

Under the wholly owned replication models, we distinguish two key mechanisms that can be used by the originating mutual organisation to spread its operating model:

- **Branching out to spread geographically**, i.e. acquiring or setting up branches in new locations to have a bigger regional or national geographic footprint: This was the main strategy of the staff-led leisure trust that spun out from Greenwich Council in 1993 – Greenwich Leisure Limited. The trust now manages more than 250 public sport and leisure centres, 57 libraries in partnership with more than 30 local councils, public agencies and sporting organisations, and is still looking to expand its business[60].

> "We have been all over the country talking about our model. However, it is based heavily on local community and couldn't be easily replicated elsewhere by us. Instead of branching out, we focus on a community-based replication model. We have supported the set up of a local school for social entrepreneurs, and we allow people to pitch their social ideas at a soup event, with winners getting funding. Our strategy also includes buying local businesses." – Neil Woodbridge, Thurrock Lifestyle Solutions (CEO)

[60] More information: Greenwich Leisure Limited internet portal, https://www.gll.org

- **Consolidation, i.e. diversifying service portfolio by acquiring complementary services or organisations and consolidating them in one offer**: Mutuals, being agile organisations, are well positioned to offer services that cut across traditional public sector silos, especially organised around one pathway or needs of a particular population. For example, community services mutuals providing services for individuals with complex needs can expand their operations through acquiring other organisations spanning across health, social care, housing, advocacy or employment support.

Our research found that within the mutual sector there is a much higher appetite for local consolidation than branching out to new geographic markets. This is mainly due to the fact that mutuals are usually highly localised organisations, taking an asset-based approach to their operations, which places emphasis on local networks and community resources.

The wholly owned approach to replication assumes the originating organisation has formal ownership and full control over the expanded operations. As such, it may be appropriate for mature organisations that are ready to pursue complex ventures that may result in a significant increase in scale. There are two main drivers for consolidation. It allows for improvements to efficiency, especially where consolidation generates economies of scale, allows for more joined up service delivery from users' perspective, simplifies the fragmented organisational landscape and reduces transactional costs. Under some circumstances, it can also

Wholly-owned approaches examples

1. When in November 2018, the CQC issued a Stage 6 Notice for the homecare provider, Allied Healthcare, **Norfolk and Suffolk County Council** acted to protect the continuity of care in the region. This included the creation of an alternative delivery vehicle, **Home Support Matters CIC** (a wholly owned subsidiary of the mutual Independence Matters), which took over both services and employment of the entire staff group previously employed by Allied Healthcare in Norfolk and Suffolk.

2. **Inclusion Healthcare**, A primary care mutual providing services to homeless and vulnerable people in Leicester, has been approached by other general practices operating locally that are interested in joining them or in adopting a mutual model for their own practice. GPs believe that consolidation with a mutual would allow them to operate efficiently, especially where they consider a traditional partnership model is no longer practical (e.g. due to senior partners retiring).

provide an effective response to marketplace failures, e.g. when a struggling provider is at a risk of losing contract or needs commercial support. Real life examples in the case study box provided by our research participants illustrate both types of drivers for the wholly-owned approach to replication.

Driving sector consolidation by financially strong and more mature mutuals is in line with the current national policy agenda towards increased efficiency (especially in healthcare, as evidenced by the Carter and Dalton reviews).

Consolidation is mainly a route for existing mutuals with appetite for growth and access to capital. Our research showed that the latter factor is one of the key reasons why consolidation within the mutual sector has not happened at scale yet, especially in the context of taking over struggling organisations to turn them around (see section below on Replication enablers for recommendations on facilitating access to capital for mutuals). Many mutuals operate within tight financial envelopes and taking risks on acquisitions of failing organisations could put them under financial strain. There is a case for the government to actively support these explorations through providing financial and expert support, especially if acquisition of a failing organisation by a mutual will help ensure continuity of service for customers. It is becoming increasingly important in the wake of Carillion's collapse, as the government is more actively looking for strategies to pre-empt and react to failures in the marketplace for public services.

Recommendation 6: Consolidation can be an effective route to replicating mutuals. While it is important to recognise that not all mutuals have the ambition or strategic plans to expand their business, encouragement and support should be provided to those who are seeking to consolidate their business and expand to new service areas.

Who	What	Focus
OCS and / or mutual membership body	6.1. Provide additional technical support to mutuals exploring various expansion strategies and consolidation initiatives. Facilitate access to external capital funding (see paragraph on funding in the Replication Enablers section below).	
Government	6.2. Explore a comprehensive policy package to facilitate transforming failing outsourced services into successful mutuals (including a review of outsourcing contractual provisions and insolvency rules).	

Replication enablers

Central Government support

Our research confirmed that a strong central government support is absolutely critical to enabling replication of mutual models at scale.

Some interviewees indicated that the stakeholder environment for mutuals at the central government level lacks transparency and could be simplified. For instance, some organisations we interviewed who are currently transitioning into a mutual indicated that navigating between two departments (DCMS and DHSC) put an additional strain on their already stretched resources.

Our respondents suggested how support infrastructure for mutuals at central government level could be organised to improve its efficiency and impact:.

- **Coalition:** Given the interdisciplinary character of mutuals, a broad group of committed stakeholders from across various departments should be set up to drive the mutualisation agenda forward. This would help mutuals navigate the complex organisational landscape. This team could be responsible for clearing any policy barriers and ensuring new policy proposals do not create an uneven playing ground or barriers for mutuals.
- **Scope**: In recognition that unprecedented challenges within the public sector require new ways of delivery of services, the government should support a wide range of organisations to pursue alternative delivery models regardless of their type, legal form or specific ownership and governance arrangements, rather than championing one particular delivery model.

Recommendation 7: Increased central government leadership and coordination of efforts across multiple departments that are relevant for the mutualisation agenda is critical to provide greater momentum and a higher profile for the mutuals agenda.

Who	What	Focus
OCS	7.1. The OCS should develop a group of committed stakeholders from across various departments to drive the agenda forward.	 Short-term
Government	7.2. The government should consider expanding the OCS to focus on various alternative delivery models.	 Key priority

Public Service Mutual definition

The mutual sector naming conventions and their perception have been raised frequently in our interviews and indicated as one of the barriers to replication. Many interviewees mentioned that the language of mutuals is not sharp enough and not widely understood in the health and social care sector. It was suggested that a change in definition and overall language used to describe mutuals may be beneficial for the sectors' growth.

This conclusion is not new – in fact the government has already initiated a consultation process on the definition of public service mutuals. Below we present the key messages from the research that are important for the replication efforts.

- **'Spinning out' vs 'spinning off':** The existing definition of public service mutuals includes organisations that spin out from the public sector, which brings two major challenges. Firstly, the concept of spinning out is not relevant for primary care. Additionally, there are opportunities for privately-owned organisations to 'spin off' teams of employees or whole businesses into staff-owned mutuals. This may be of particular relevance to community or adult social care organisations, whether non-profit or for-profit, that struggle to deliver services or consider closure of non-core services. These services could benefit from joining forces with successful mutuals. Expanding the definition would allow such organisations to access some support targeted at mutuals.
- **Unclear status of wholly owned subsidiaries:** Creating a mutual organisation that remains a wholly owned subsidiary of the parent organisation could be an attractive option, especially for Local Authorities and larger acute providers, who may be reluctant to cede full control over the services that are spinning out. This model provides incubation support; whereby it offers a newly created mutual an opportunity to test the commercial viability of the business model. This could be the first step in a gradual transition to a more independent mutual organisation. Formally recognising (e.g. through a change in the public service mutual definition) that a mutual organisation may operate as a wholly owned subsidiary, would be beneficial.

> "We had been trading as a CIC for five years before we finally spun out from the Local Authority. It was a blessing – our business model had been commercially tested before we won the local services and a culture of independence started." – Neil Woodbridge, Thurrock Lifestyle Solutions (CEO)

Recommendation 8: Clarification on what public service mutuals are could remove one of the barriers to their growth. A two-pronged approach should be used to achieve this:

revisiting the definition and making sure it is clearly and widely communicated, including a clear messaging on benefits of mutuals.

Who	What	Focus
OCS	8.1. Continue sector consultation on the public service mutual definition with an aim to eliminate challenges caused by an overly narrow and unclear definition.	 Short-term
OCS	8.2. Prepare and distribute a succinct FAQ document on what mutuals are with definitions, examples and benefits. Adjust the document to various audiences, including staff, regulators, commissioners, etc.	 Key priority

Policy and regulatory context

In the past, there has been significant policy support for the creation of mutuals, notably in the health and social care sector. Policy initiatives that have intentionally supported the development of the mutual sector (such as the Right to Request or the Right to Provide) were extremely successful and resulted in the creation of the first wave of mutuals. Currently wider healthcare policy puts more focus on integration within the health and social care sector. There is evidence based on existing mutuals that mutualisation can facilitate integration and could help to support many priorities set out in the NHS Long Term Plan. Though more evidence is needed to demonstrate that mutuals could achieve this at scale, initial successes suggest it should be higher up on the government's agenda.

A supportive regulatory and public policy environment, or at least one that does not create unintended barriers, is important for health and social care providers wishing to become mutuals. This could be achieved by government undertaking a clarification of several policy issues presented in more detail below. In order to ensure policy consistency going forward, a 'level playing field test' could be introduced, to ensure that new regulations do not create additional barriers to alternative delivery models such as mutuals.

Our research identified the below areas where additional policy guidance would be most beneficial for the mutual sector:

NHS procurement and best value test

NHS England proposed targeted amendments to primary legislation to support the implementation of the NHS Long Term Plan[61]. Several of the proposed legislative changes focused on procurement rules and were intended to free the NHS from overly rigid procurement processes and wasteful administration costs. The proposed new regime would give NHS commissioners discretion to choose either to award a contract directly to an NHS provider or to undertake a procurement process and engage more widely with existing providers. The decision should be based on the best value test.

This proposed regulation change was met with some level of nervousness by our interviewees who indicated that this is a potentially significant barrier to the replication of mutual models at scale. They pointed out that mutuals could lose contracts and be pushed out from the marketplace if the commissioners decide not to pursue the competitive route.

Additionally, there is currently limited information as to what the 'best value test' will be based on. It is recommended that the 'best value test' takes into account social value and there is clear national guidance on how it should be applied.

GP delivery models

General practices considering alternative delivery models would benefit from clearer national guidance about the available delivery options, including mutuals, with guidance explicitly addressing the treatment of GMS and PMS contracts. Our research highlighted that a lack of clarity in this area creates a significant barrier to replication of primary care mutual models.

Personalisation agenda

The NHS Long Term Plan makes specific proposals to strengthen patient choice and control, including the roll out of personal health budgets. Mutuals already have a track record of delivering services that support the personalisation agenda that closely align to these proposals. Additional policy guidance would be useful to empower and facilitate delivery of the personalisation agenda by various organisations, including mutuals.

In social care, our research has highlighted a need for additional policy guidance on Local Authorities market shaping responsibilities. The guidance could highlight that one of the potential routes to market shaping is supporting organisations that embraced alternative delivery models in order to deliver more person-centred care to their service users.

[61] NHS England (2019), Implementing the NHS Long Term Plan: Proposals for possible changes to legislation, NHS England, February 2019, https://www.longtermplan.nhs.uk/wp-content/uploads/2019/02/nhs-legislation-engagement-document.pdf

In health, clear policy guidance is needed both for providers (including those pursuing alternative delivery models) and commissioners. It should offer practical direction on how to strengthen patient choice and control under the existing commissioning rules. It should also provide guidance on how to shape local commissioning practices to create favourable environments for locally-based organisations (including mutuals) employing more person-centred care delivery models and implementing personal health budgets.

Recommendation 9: Organisations considering alternative delivery models would benefit from supportive regulation and clearer national guidance about the options available and how to pursue them.

Who	What	Focus
Government	9.1. Introduce a 'level playing field test' across all the relevant cross-government legislative processes, to ensure new legislative proposals protect mutuals' fair opportunity to compete and do not introduce barriers or disincentives to commissioning health and social care services from mutuals.	
Government and existing mutuals	9.2. Investigate legal, regulatory and policy issues, create a comprehensive list of barriers (other than those mentioned in this report), identify actions necessary to remove them and define a clear roadmap to achieve this.	
DHSC and NHSE	9.3. Ensure that mutuals are not negatively impacted by the newly proposed legislation on procurement of health services in the NHS. Ensure the 'best value' test takes into account social value.	
DHSC and NHSE	9.4. Provide policy guidance with practical examples showing how integrated mutual models could be used to support integrated care.	
DHSC	9.5. Progress the recommendation outlined in the GP Partnership Review to ensure that primary care organisations pursuing an alternative delivery model can hold GMS or PMS contracts.	
DHSC	9.6. Provide additional policy guidance to support the personalisation agenda and personal health budgets, including guidance on LA market shaping duties and guidance on healthcare commissioning that strengthens	

	patient choice. Include practical examples how mutuals can facilitate delivery of personalised care.	
DHSC and NHSE	9.7. Issue comprehensive policy guidance supporting alternative delivery models to realise significant opportunities for integration and efficiency.	 Mid-term

Sector representation: national mutual body

Public service mutuals are a relatively large (representing a combined turnover of £1.6 billion), diverse and profitable sector. Our research clearly indicated that there is significant potential and willingness within the sector to take a more active part in driving its expansion and 'bootstrapping' sector-led replication. The respondents gave us multiple examples of local initiatives of peer-to-peer knowledge transfer, mentoring and support. However, they noted a visible lack of an organisation that would be able to scale up and coordinate these local efforts, as well as, one that could act as an ambassador for the sector. It was suggested that given the increasing maturity of the sector there is a scope for creating a national membership body for public service mutuals or strengthening the role of existing groups that represent the sector e.g. Social Enterprise UK SEUK or the Employee Ownership Association.

A number of the recommendations presented throughout this report are in fact addressed to this national membership mutuals organisation. This is not to say that their implementation is conditional on creation of a new membership body. In its absence, most of the proposed actions could be undertaken by different entities – individual mutuals, existing third sector organisations, or the government OCS. However, establishing one organisation that would hold a whole portfolio of initiatives would increase coordination and cost-efficiency as well as allow to unleash resources that are within the system.

Recommendation 10: The mutual sector should have a strong, consistent and fully representative voice at national level.

Who	What	Focus
Existing mutuals	10.1. Explore the viability and desirability of setting up a national mutual membership body or expanding the role of existing organisations	 Mid-term
OCS	10.2. Investigate opportunities for initial set-up funding or infrastructure support for the newly created organisation (subject to positive outcome of 10.1)	 Mid-term

Building an evidence base

There is a significant and growing body of evidence that mutuals generate positive social and economic value. This should be more broadly shared. Additionally, our research identified several areas that would benefit from more in-depth research. These are:

- **Comparative research on economic advantages of various alternative delivery models;**
- **Additional evidence base on the benefits mutuals bring to their workforce**: building on the existing body of research, with focus on mutuals potential role in helping to address workforce shortages, improve recruitment and retention and adapt to new workforce models;

> "You need to sell cost efficiency. Unfortunately, in the current climate selling a philosophy has limited possibilities. The economic advantages of various alternative delivery models is an interesting field for further exploration." – Glen Garrod, President of the Association of Directors of Adult Social Services

- **Standardised approach and tools to measure mutuals' social value:** The Public Services (Social Value) Act 2012 requires commissioners of public services to consider how the services they procure might improve the economic, social and environmental well-being of the area. This has been further reinforced by a package of measures launched by the then Minister for the Cabinet Office, David Lidington MP in 2018. The new policy makes social value an explicit requirement in commissioning and applies to all central government departments, executive agencies and non-departmental public bodies. As David Lidington made clear: "That means government doing more to create and nurture vibrant, healthy, innovative, competitive and diverse marketplaces of suppliers that include and encourage small businesses, mutuals, charities, cooperatives and social enterprises – and therefore harness the finest talent from across the public, private and voluntary sectors."

> "There is a need for very robust impact measurement to demonstrate positive impact of mutuals. Having data on social impact for the whole sector would be useful for lobbying the government and securing support for mutuals." – Dr Richard Hazenberg, University of Northampton

There has been a vast body of research providing evidence that mutuals deliver substantial benefits to a wide range of public service stakeholders, including service users, employees

and wider communities they serve[62]. However, many mutuals and experts we interviewed reported challenges with demonstrating social value and uncertainty in how best to measure it. Respondents indicated that it would be useful to develop a clear framework to measure and monitor social value tailored to the specific needs of mutuals and build sector capacity to confidently use it on regular basis. The tool would be useful for existing mutuals to understand how they generate value for various stakeholders and support their contract bids. A similar challenge faced by the mutual sector in Australia led to a development of a Mutual Value Measurement framework (see more information in the case study box)[63].

Case study. Mutual social value tool.

Monash Business School's Department of Accounting in Australia partnered with the Business Council of Mutuals and Cooperatives to create an industry framework for measuring mutuals social and economic value: The Mutual Value Measurement framework. The creators of the Framework saw a lack of knowledge within the system on how to carry out 'social bookkeeping'. They noted that while many reporting frameworks had been developed to measure social value, an industry framework for mutuals was not yet available, which was one of the sector's strategic challenges.

Recommendation 11: Strong evidence of cost-effectiveness and impact is critical to replication at scale. Visibility of high-performing organisations on a national scale should be increased. Mutuals should be also encouraged to evaluate and demonstrate positive impact and improved value for money.

Who	What	Focus
OCS	11.1. Collate existing evidence on the benefits of mutuals and prepare materials for wider distribution (succinct and easily digestible for lay audience).	
OCS	11.2. Commission comparative research on cost efficiency and economic benefits of various alternative delivery models.	
OCS and / or national mutual body	11.3. Develop a mutual sector tool or framework for measuring social value, build sector capacity to use it and encourage data collection on a regular basis.	

[62] J. Le Grand and the Mutuals Taskforce (2012). *Public service mutuals: the next steps.* Cabinet Office. London, UK

[63] *More information: Monash Business School internet portal, https://www.monash.edu/business/news-and-events/2017/measuring-the-value-created-by-australias-cooperatives-and-mutuals*

Access to finance

Gaining access to business planning funding, early-stage seed capital and growth capital is a significant barrier to some mutuals, especially smaller ones or those that are willing to explore more complex and more innovative models. Our respondents indicated that although funding available through the Mutuals Support Programme had been very helpful to bridge that gap for some mutuals, it only 'scratches the surface' and in its current form is not set up to support replication on a wider scale. Our research identified several approaches to unlock funding for the mutual sector.

Investor education and blended finance

Mutuals are often relatively small organisations that struggle to attract long-term capital and develop bankable projects. At the same time, despite growing momentum within the mutual sector, there is a limited flow of private and institutional investment, as investors struggle to understand business models, risk profiles and performance of mutuals. It has been also difficult to attract social investment to the sector.

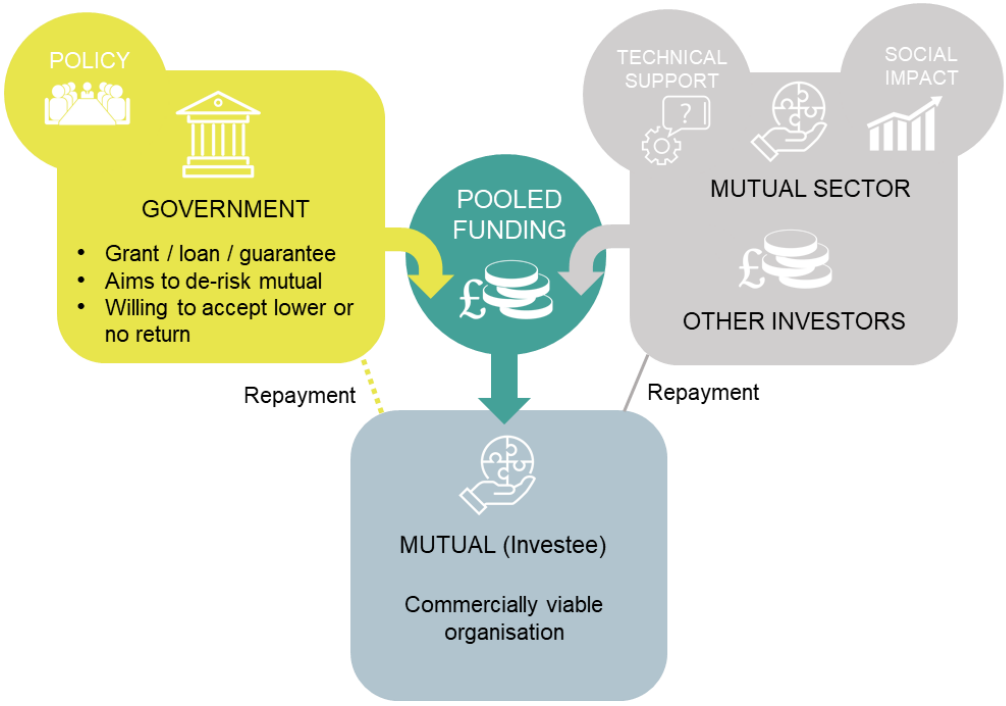
Some respondents mentioned that banks and other institutional lenders are not familiar with mutuals, do not have the experience and information needed to assess risk in this sector and therefore have no formulas for funding them. This is particularly true for GP Partnerships transferring into mutuals, as in the process they need to buy out existing partners and look for other ways of capitalising their organisations. The interviewees suggested that the government could provide an information package for investors to educate them about alternative delivery models.

Going a step further, blended finance has been mentioned as a potential solution to funding challenges. Blended finance requires pooling public and private resources to create an investment package aimed at social projects and organisations. The investment package will typically involve a loan matched with a grant, however many other instruments could be also used in conjunction or instead of loans and equity capital. This can include guarantees and insurance products, which could be used as credit enhancement tools that de-risk mutuals in order to incentivise private financing. The package could also include elements of advisory and business support. This funding could be used to accelerate scale and efficiency within the mutual sector.

Traditionally blended finance assumes participation of the government to lower the risk of the investment for other lenders. However, our respondents also suggested that blended financing could be offered by the mutual sector (either individual larger mutuals or the mutual membership body). Although lenders from within the sector may require external expertise to

assess the financial position of the borrower, they are often in a better position to understand and evaluate business models and associated risks of mutuals that seek financing. Additionally, they are also better equipped to understand potential social impact of the borrower.

Figure 12: Blended finance.



Recommendation 12: Access to funding is critical to support growth within the sector. New funding mechanisms that facilitate access to capital for new and growing mutuals should be unlocked, including those that leverage the existing financial potential of the mutual sector.

Who	What	Focus
OCS	12.1. Provide more information to institutional lenders and banks on alternative delivery models to help them understand mutuals and their associated risk profile.	Short-term
OCS	12.2. Engage with the existing mutual sector (and potentially also other investors) to assess their readiness to participate in blended finance and the feasibility of such initiatives.	Mid-term
OCS	12.3. Identify best-practice standards in blended finance, including scope for enhanced regulatory treatment of	Mid-term

	blended financing tools as well as regulatory constraints (subject to positive outcome of 12.2).	
Existing mutuals / national mutual body	12.4. Create and oversee mutuals blended finance facility (subject to positive outcome of 12.2).	 Long-term

Peer-to-peer lending for struggling organisations

Our research showed that there is a relatively high sense of collective responsibility for the performance of the mutual sector as a whole, and a role for a sector-led initiative to provide support to struggling mutuals. Peer-to-peer lending could be used as a way of raising credit. Funding would be used to capitalise high potential mutuals that need one-off financing to overcome short-term financial difficulties, not to bail out organisations whose business models cannot guarantee long-term economic and social value. An example of a potential borrower who would benefit from peer-to-peer lending that was raised in our research was a successful mutual that lost its premises and could not afford to secure new estate in a relatively short term at high market prices.

This last resort lending would improve the overall sector's stability and attractiveness in the eyes of other investors. A national mutual body could create and manage a syndicate fund, manage the borrowing and loan repayment processes, as well as, arrange necessary legal documentation. Our respondents indicated that similar arrangements are already successfully used by cooperatives in the UK.

Recommendation 13: Explore the sector's appetite to provide funding to struggling mutuals in order to increase long term stability in the sector.

Who	What	Focus
OCS	13.1. Engage with the existing mutual sector to assess their readiness to participate in peer-to-peer lending and the feasibility of such initiatives.	 Mid-term
OCS	13.2. Identify regulations and practices that allow co-operatives to operate peer-to-peer lending. Investigate how they could be adapted for the wider mutual sector (subject to positive outcome of 13.1).	 Mid-term
Existing mutuals / national mutual body	13.3. Design and operationalise peer-to-peer syndicate fund for financially challenged but commercially viable mutuals (subject to positive outcome of 13.1).	 Long-term

Commissioning support and education

While the education of commissioners in relation to viability and benefits of mutuals is ongoing, our respondents stressed that there is scope for more action in this area. Low awareness of commissioners remains a barrier to expansion of mutuals. Even though the research undertaken to date shows that mutuals have the potential to generate improved social outcomes, many respondents indicated that there is still a lack of understanding and awareness of the mutual model among commissioners.

It would be useful to raise commissioners' awareness that mutuals can provide an important third way of delivering public services and are a proven alternative to traditional outsourcing or providing services in-house. This is especially relevant in the context of changes to the commissioning landscape following the Carillion collapse as our respondents pointed out that commissioners now tend to display more risk-averse attitudes.

Recommendation 14: While there is an evidence-base that mutuals can provide better outcomes, procurement processes are not always geared to recognise it. There is a clear case to develop commissioners' understanding and skills to design commissioning processes that are open to alternative models of service provision.

Who	What	Focus
OCS	14.1. Develop an evidence-based information pack on alternative delivery models including mutuals for commissioners in health and social care.	
OCS and mutuals sector	14.2. Undertake or commission a review to identify commissioning policies or processes that are discriminatory against mutuals (e.g. do not allow a diverse range of providers have a fair opportunity to compete). Engage relevant stakeholders at central and local level to eliminate them.	
OCS / NHSE	14.3. Ensure that alternative delivery models feature in existing commissioning development programmes (e.g. LGA Commissioning for Better Outcomes Framework, NHSE Commissioning Capability Programme).	
OCS	14.4. Organise commissioning masterclasses or events on alternative delivery models.	

Conclusion

This report was commissioned to identify where mutualisation could be introduced at scale within the health and social care sector and to provide practical suggestions on how to do so.

The sector was chosen because organisations are facing increasing levels of demand, whilst simultaneously wrestling with growing financial pressures. Whilst mutuals should not be seen as a panacea for all the problems faced by the sector, early evidence suggests they bring clear benefits, are well suited to being successful in health and social care, and could help to support many priorities set out in the NHS Long Term Plan.

We identified four key areas within the sector where mutual models have a higher potential of being successfully replicated at scale:

- Primary care, including in particular Primary Care Networks;
- Adult social care;
- Enabling services which support the delivery and integration of frontline services e.g. estates and facilities management, human resources or legal services; and
- Local service integration models that involve any combination of primary care, community care and adult social care;

Our research showed that each service area requires a different set of targeted interventions to open up the possibility of introducing large numbers of mutuals. For instance, developing a dedicated support package for primary care organisations is anticipated to deliver high impact if investment is provided in the short term.

A complete list of priority actions for each area are listed in **'Key recommendations'** at the start of this report.

Beyond the individual service areas, a variety of activities aimed at building the evidence base, sharing knowledge and supporting organisations adopting new delivery models are needed to drive replication. Additionally, continuing to build strong evidence base of cost-effectiveness and impact is critical to replication at scale. Visibility of high-performing organisations on a national scale should be increased. Mutuals should also be encouraged to evaluate and demonstrate social impact and money-saving.

It is important however that the support is not limited to mutuals or overly prescriptive. Growing awareness or different delivery models and providing support to investigate their respective benefits and constraints will enable more services to find the organisational form that best suits their needs.

About us

Baxendale is a specialist management consultancy driven to enable public services, businesses and communities to do more of what they love. We're small but have big impact. We've helped our clients win £1.5 billion in contracts and raise investment of over £50 million; and have helped more than 100 businesses to become employee owned, like us. We specialise in alternative delivery models, service transformation, bid support, employee ownership & engagement and commercial growth. Everything we do is about supporting engaged teams to achieve their outcomes today, and in the future, for stronger communities and better lives.

Mutual Ventures are a management consultancy, who are passionate about better, more sustainable public services. Mutual Ventures work with local authorities, the NHS and other public bodies as well as VCSEs to transform public services. Mutual Ventures have a wide range of experience and expertise in conducting detailed research, designing new delivery models, business and transition planning/implementation, organisational development and cultural change. Through their work to develop better, more sustainable public services, they have supported over 150 local authorities and NHS bodies to investigate, design and/or establish new and sustainable delivery models, including mutuals.

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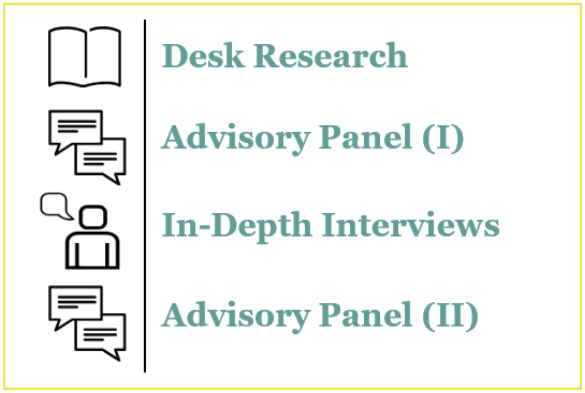
APPENDICES

Appendix 1: Methodology



We used a mixed-method approach to data collection, combining:

- A desk-based review of existing **literature** on the mutual and the health and social care sector;
- Two **advisory panel** meetings with experts and practitioners from the sector;
- In-depth **interviews** with 15 individuals in leadership positions at health and social care mutuals and social enterprises, and six sector specialists.

Data and information obtained from the advisory panel, the interviews and desk-research has been triangulated to validate our findings in the three key areas of the report:

- Identifying specific **service areas** within the social care and health sector that have significant potential for mutualisation given the current policy direction and wider challenges within the sector;
- Exploring illustrative **mutual models** in these sectors; and
- Producing recommendations as to the best **approaches to replication** of these models and factors that enable replication at scale.

Advisory panel

Our advisory panel was made up of six individuals who are experienced mutual, NHS and local government services leaders reflecting the breadth of health and social care.

The group met twice at key points of the project.

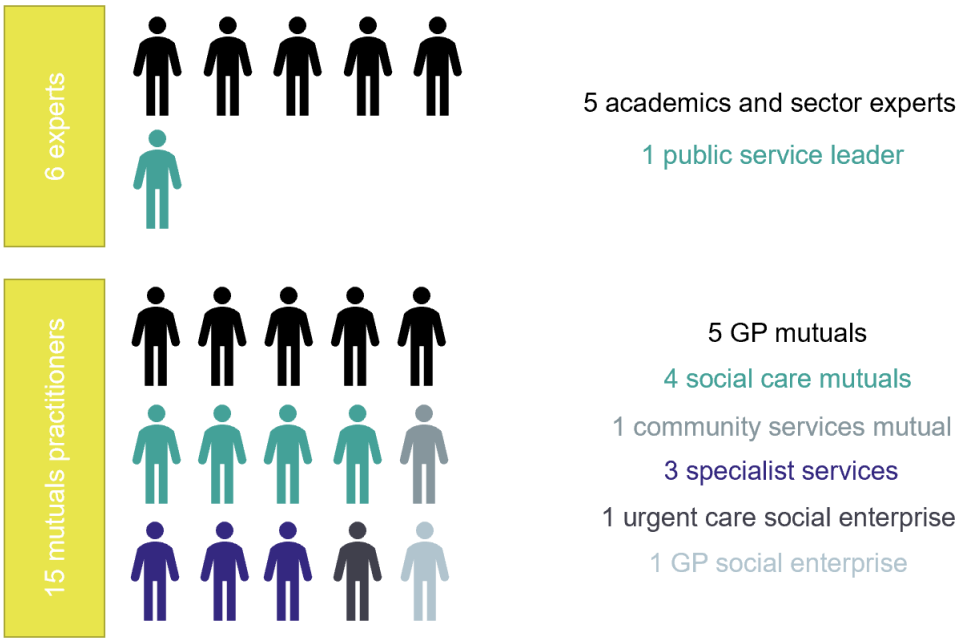
The first meeting was an early conversation targeted at identifying initial key discussion points, short-listing exemplars of successful mutual models and contributing hands-on knowledge to our analysis of challenges and opportunities in the sector.

The second meeting was a debate in the later stages of the project in order to comment and complete interview findings, interrogate and appraise options for replication and co-develop recommendations to address key challenges.

In-depth interviews

Following the first advisory panel, we invited selected individuals to participate in structured 45-minute-long interviews. We chose interviewees based on referrals by advisory panel members of sector experts or best-in-class examples of successful mutuals; or based on a selection criteria of year-on-year turnover growth since spinning out.

Out of the total of 21 interviewees, the distribution is as follows:



We chose interviewees from a wide range of service areas in order to capture the diversity of the health and social care mutual sector. During the interviews, we asked the mutuals about their business model, spin out process and their main lessons from mutualisation.

All participants provided consent to be named in the report. For any quote, participants were contacted separately to seek explicit consent.

Appendix 2: Replication framework

This appendix outlines key routes to replication and provides a conceptual framework for their appraisal. It links the two key areas of the research: service areas within health and social care sector with the highest potential for mutualisation, and approaches to replicating mutuals.

To facilitate the use of the framework, it is organised around 4 key research questions that guide the reader through it step by step:

1) What are the routes to replication discussed in this report?
2) What do the routes to replication look like in practice in the context of mutuals?
3) What are the factors that differentiate routes to replication between various service areas in which mutuals operate?
4) What are the recommended routes to replication for mutuals operating in various service areas?

1) What are the routes to replication discussed in this report?

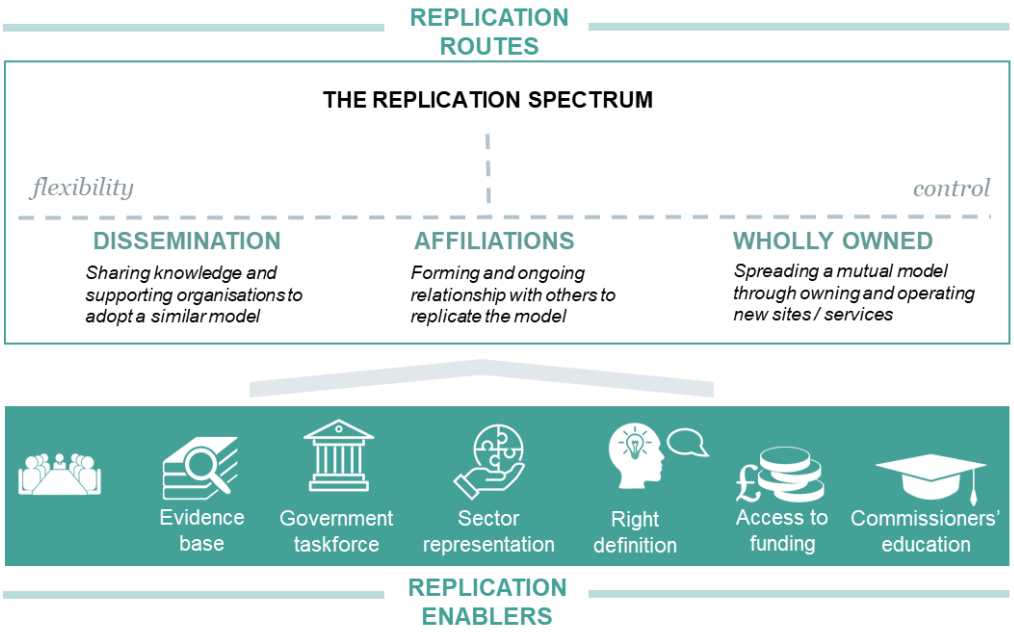
The literature offers a wide array of definitions of replication of business models / social replication. However, our respondents often found this term to be opaque and were unsure what it meant in practice in the context of mutuals. Therefore, for the purpose of this report we have applied a very simple definition of replication:

> Replication means spreading the mutual models that work or have a high potential to work through enabling their implementation in other places or on a larger scale, either via establishing new mutuals or expanding the activities of existing mutuals

In this report we have used the standard replication framework developed from practice and existing literature[64]. In line with the existing well-established replication frameworks, it includes the three key routes to replication: **dissemination**, **affiliations** and **wholly owned models**.

To address the specific needs of the mutual sector, we have added another dimension to the standard replication framework: replication enablers. These are tools and approaches that could be used to facilitate replication across all the routes and a range of activities needed to build the right infrastructure around mutuals to 'scaffold' their development and growth.

Figure 13: High-level replication framework.



[64] See: L. Mavra (2011) and Spring Impact Social Replication Toolkit (2018).

Motivation is key: push vs pull

In the context of replication, we have also considered various motivating factors for establishing a mutual: either choice (pull factors) or necessity (push factors). The majority of interviewees agreed that 'pull factor spin-outs', such as providers willing to adopt more innovative delivery models and improve outcomes for service users / patients, seem to be more successful and resilient. This view is confirmed by research[65]. Spinning out to avoid the alternative or as a result of a top-down mandate (push factors) may result in lack of a wider strategic direction and models that do not survive within a competitive marketplace.

With this in mind, we have focused the report on the opportunity-driven 'pull' approaches to replication, in particular we have identified multiple 'pull' drivers for mutual models within the health and social care sector. We also believe this is more aligned with the current policy direction which focuses on locally-driven change, as long as it is in line with the key priorities set out centrally. And while there may not be an appetite at the central level (and for very good reasons) to mandate or push the benefits of one particular delivery model, there still is and should be an appetite for exploring alternative delivery models that support the key health and social care sector priorities. Our research explored what role the government could play in facilitating and unleashing the grassroot-up approach to replication of mutuals[66].

We have categorised routes to replication into three broad groups:

1. **Loose forms of dissemination (that give organisations interested in becoming mutuals flexibility over the model they decide to adopt).**
2. **Affiliation strategies.**
3. **Tightly controlled wholly owned approaches (which assume expansion of mutual models through ownership).**

Given mutuals are a relatively young sector, we have also identified multiple replication enablers. These activities are necessary or highly recommended to develop an ecosystem for mutuals where they can grow at scale.

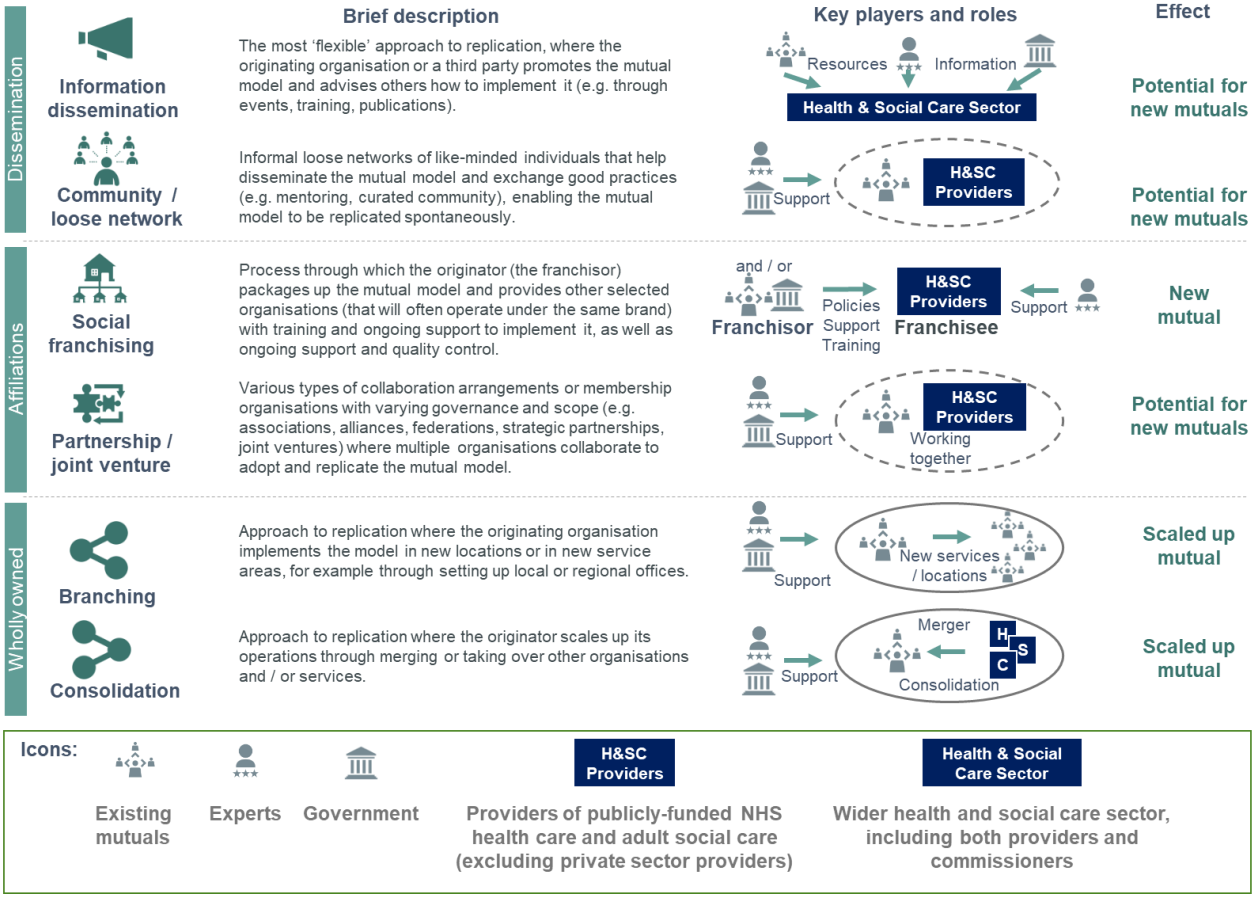
[65] See R. Addicott, R., Social Enterprise in Healthcare: Promoting organisational autonomy and staff engagement, The Kings Fund, 2011 and R. Hazenberg. et al, Public Service Mutuals: Spinning out or standing still?, Enterprise Solutions, RSA 2020 Public Services, 2013

[66] However, it is worth mentioning that a more top down agenda has been also mentioned by our respondents as a possible (and – as some argued – the only viable) way of ensuring mutualisation at very large scale. This argument has been mentioned particularly in relation to clinical support services, where there may be a conflict of interest between a service that is willing to spin out and a parent organisation. Audiology has been given as an example of a service area where a central mandate to create a national audiology service spun out from acute providers and organised in line with the mutual ethos would be beneficial. Even though mutualisation has brought excellent results in this service area, the central mandate is believed to be the only possible route to mutualisation at scale. This is mainly due to the fact that providers may be unwilling to let go what is a highly profitable service. While we recognise that central mandate could be an effective replication route, we have made a conscious decision to focus our report on replication routes that seem to be more achievable in the current policy context.

2) What do the routes to replication look like in practice in the context of mutuals?

The Figure 14 below breaks down the high-level conceptual framework into more granular replication approaches, providing examples of how they could work in practice.

Figure 14: Routes to replication in the context of mutuals.



Under each route to replication (dissemination, affiliations, wholly owned models) there are a range of practical strategies that could be employed to expand the mutual models. It is worth noting that their end results may differ:

- **dissemination activities usually allow reaching out to a wider target group, however they do not guarantee new mutuals will be established;**
- **affiliation models, depending on a selected strategy, allow for a more tightly controlled replication process and increase chances of creating new mutuals;**
- **wholly owned models on the other hand usually lead to expansion of a mutual model without creating new mutuals (services are delivered under one roof by a scaled up mutual).**

What they have in common, is that for best results they require involvement of a range of stakeholders, including the government, sector experts and the mutual sector itself.

3) What are the factors that differentiate routes to replication between various service areas in which mutuals operate?

Replication in the context of health and social care services should not be thought of as a 'cookie cutter' process. This is especially true for the mutual sector, which is fragmented, often focused on specialist services and highly localised. However, reaching scale within the mutuals sector will require a more structured and replicable approach to growth.

With that in mind, we tried to identify the factors that may make particular routes to replication better suited to our short-listed service areas within the health and social care sector with high potential for mutualisation. The key factor that we have found to have a significant impact on which route to replication could be successfully applied is the number of existing mutuals within a given service area (and closely linked level of mutuals maturity).

Some service areas within the wider health and social care sector have a good track record of establishing mutuals. Most of the health and social care mutuals existing today spun out over the past decade in what we call the first wave of mutualisation. This 'wave' was triggered by a number of policy initiatives aimed at encouraging mutualisation (e.g. the Right to Request, Right to Provide – see Figure 15 below). They operate in service areas which include **adult social care, community services and more specialist primary care services**. In these service areas mutual models are more mature, which means there is greater potential for replication strategies that are driven from within the sector (e.g. affiliation or wholly owned strategies).

Currently, with the right level of support, there is potential to kick start a new 'wave' of mutualisation as one of many delivery models that enables greater efficiencies and integration within the health and social care sector. Many of our short-listed service areas fall under this category: they have a high potential for mutualisation in the current policy context, even though so far, they are characterised by very low number and maturity of mutual models. This is relevant for **integrated care models, enabling services and primary care (as alternatives to GP practices) and Primary Care Networks**. More effort is needed to kick start mutualisation in these high-potential but less explored areas and approaches to replication should focus on dissemination strategies (see Figure 16 for examples).

Figure 15: Policy drivers for 'waves' of mutualisation.

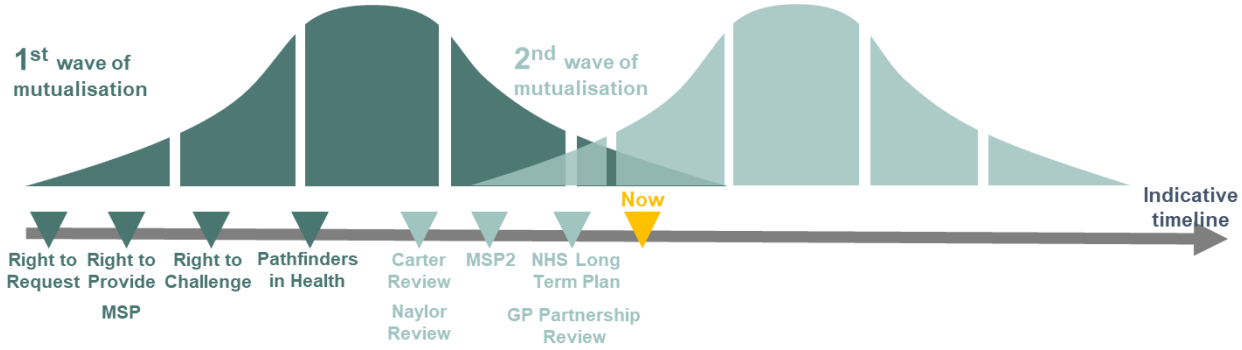
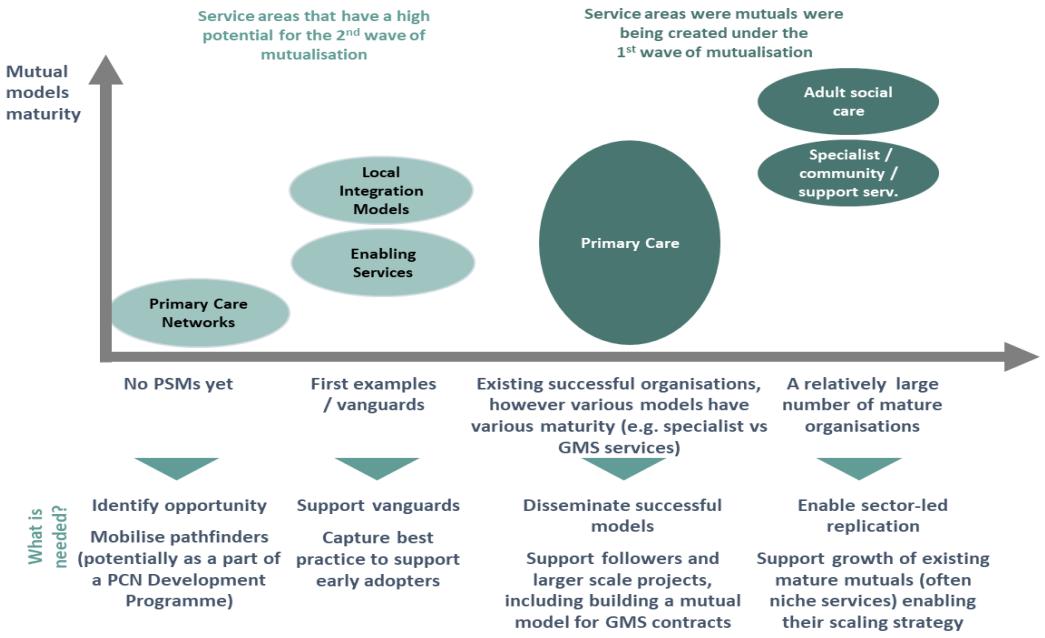


Figure 16: Diversification of approaches to replication in various service areas based on their maturity and number of mutuals.



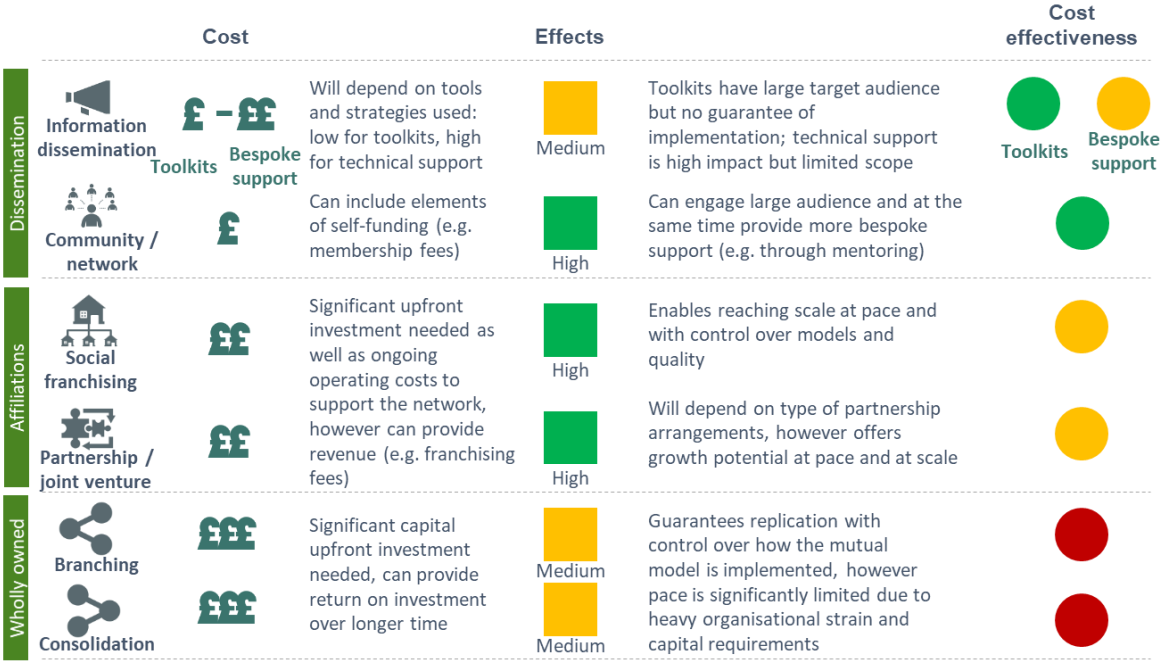
As the mutual models in various service areas are at various stages of maturity, they will require different approaches to enable their replication at scale. Replication approaches need to be fit for purpose, i.e. adjusted to different phases of mutuals development in various service areas.

4) What are the recommended routes to replication for mutuals operating in various service areas?

The diagram below shows a high-level cost effectiveness analysis of growing the mutuals sector through a replicable models approach. On the cost side, we looked at whether presented approaches are costly both in terms of one-off and ongoing funding requirements, and balanced this with a potential for self-funding or revenue generation, which is relevant for replication approaches that will include membership payments. We weighted costs against the potential effect of every strategy, which is understood as a potential to deliver growth at pace and at scale.

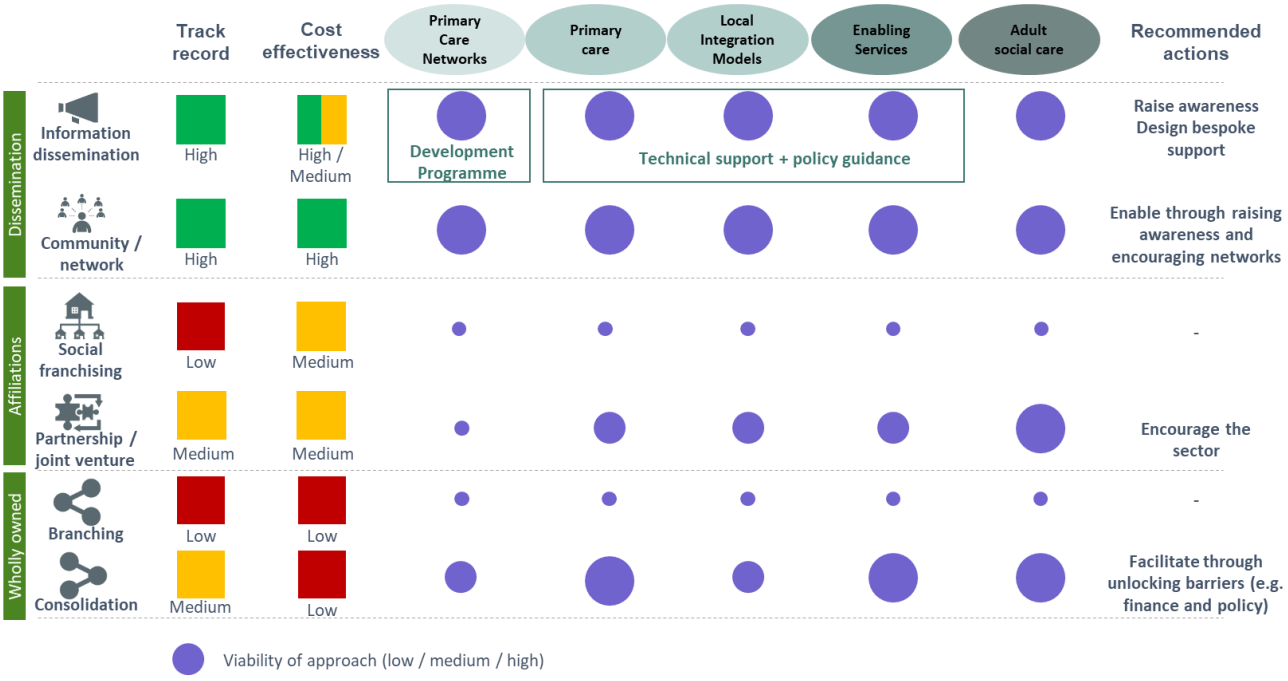
It is important to recognise that cost effectiveness analysis in the context of multi-stakeholder, public services approaches is a very complex undertaking. This is especially true as some of the analysed routes to replication have not been tried at scale in the mutuals sector. We therefore have not quantified the cost or monetised the benefits. The analysis is based on feedback from the respondents and authors' expertise and previous experiences in this field.

Figure 17: Cost-effectiveness analysis.



In the next step, we have combined the results of the above cost-effectiveness analysis with other criteria assessing viability of various routes to replication in the shortlisted sectors. The Figure 18 below is a graphical representation and a high-level summary of our findings. The main body of the Report includes more detailed actionable recommendations on how to achieve replication in practice.

Figure 18: A spectrum of interventions available to replicate mutuals in different phases of maturity.



Our research confirmed that awareness raising and dissemination strategies are needed across all the short-listed service areas. However, some service areas may require a more bespoke approach to replication. This is particularly true for Primary Care Networks, where a comprehensive Development Programme including a toolkit, organisational development programme and pathfinder support (potentially a part of the wider NHSE programme) would be beneficial. There are other more sector-driven routes to replication (e.g. affiliations or consolidation) that could be useful for scaling up mutuals especially in more mature service areas (like adult social care).