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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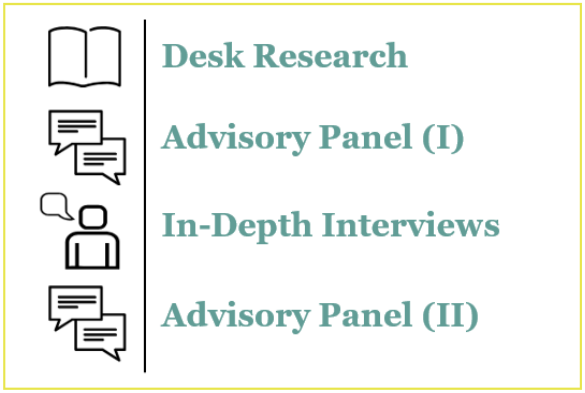
APPENDICES

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.

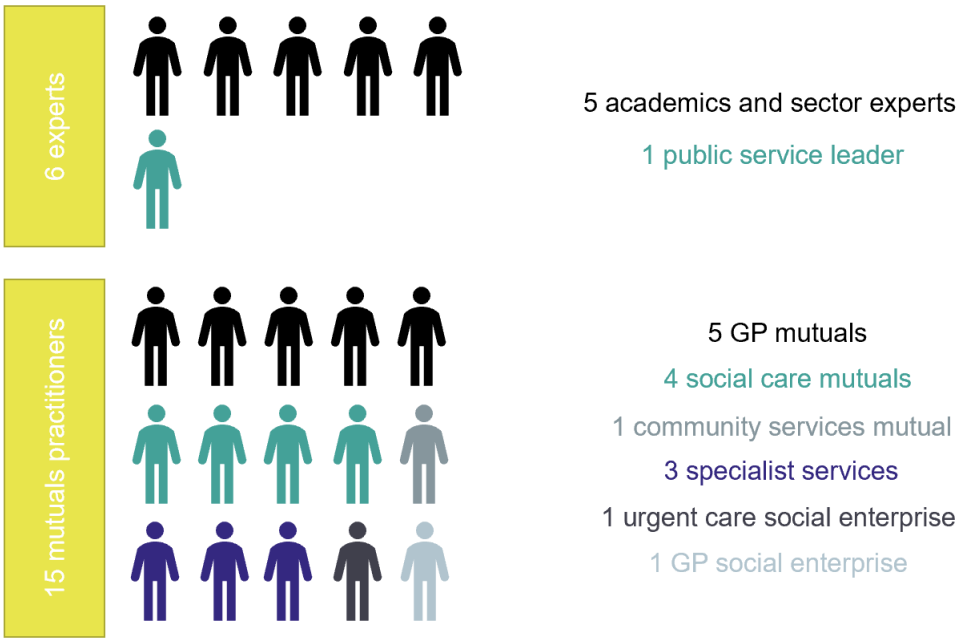
The first meeting was an early conversation targeted at identifying initial key discussion points, short-listing exemplars of successful mutual models and contributing hands-on knowledge to our analysis of challenges and opportunities in the sector.

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?

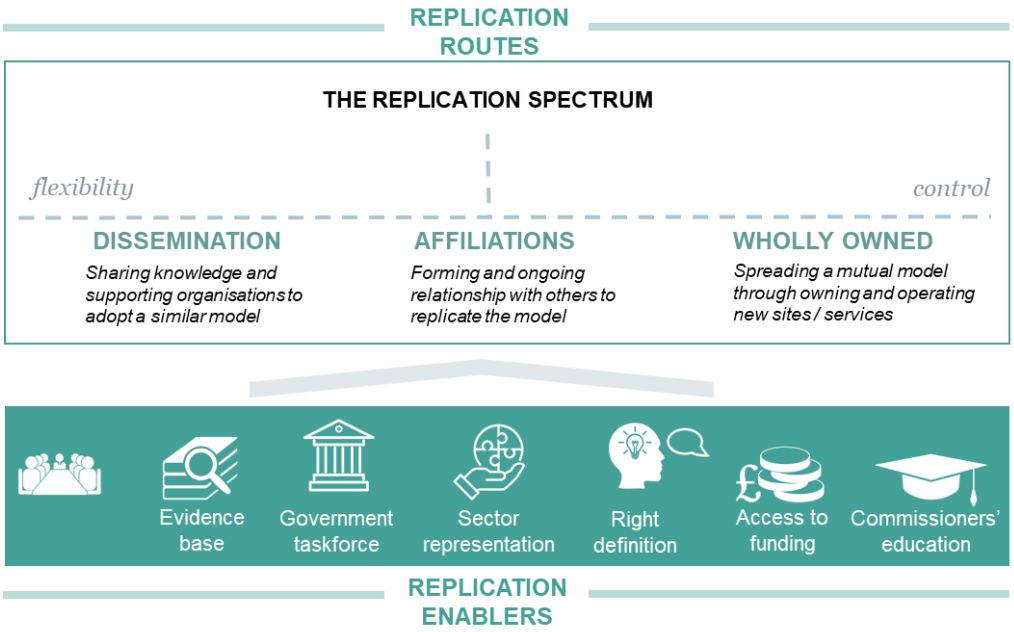
The literature offers a wide array of definitions of replication of business models / social replication. However, our respondents often found this term to be opaque and were unsure what it meant in practice in the context of mutuals. Therefore, for the purpose of this report we have applied a very simple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

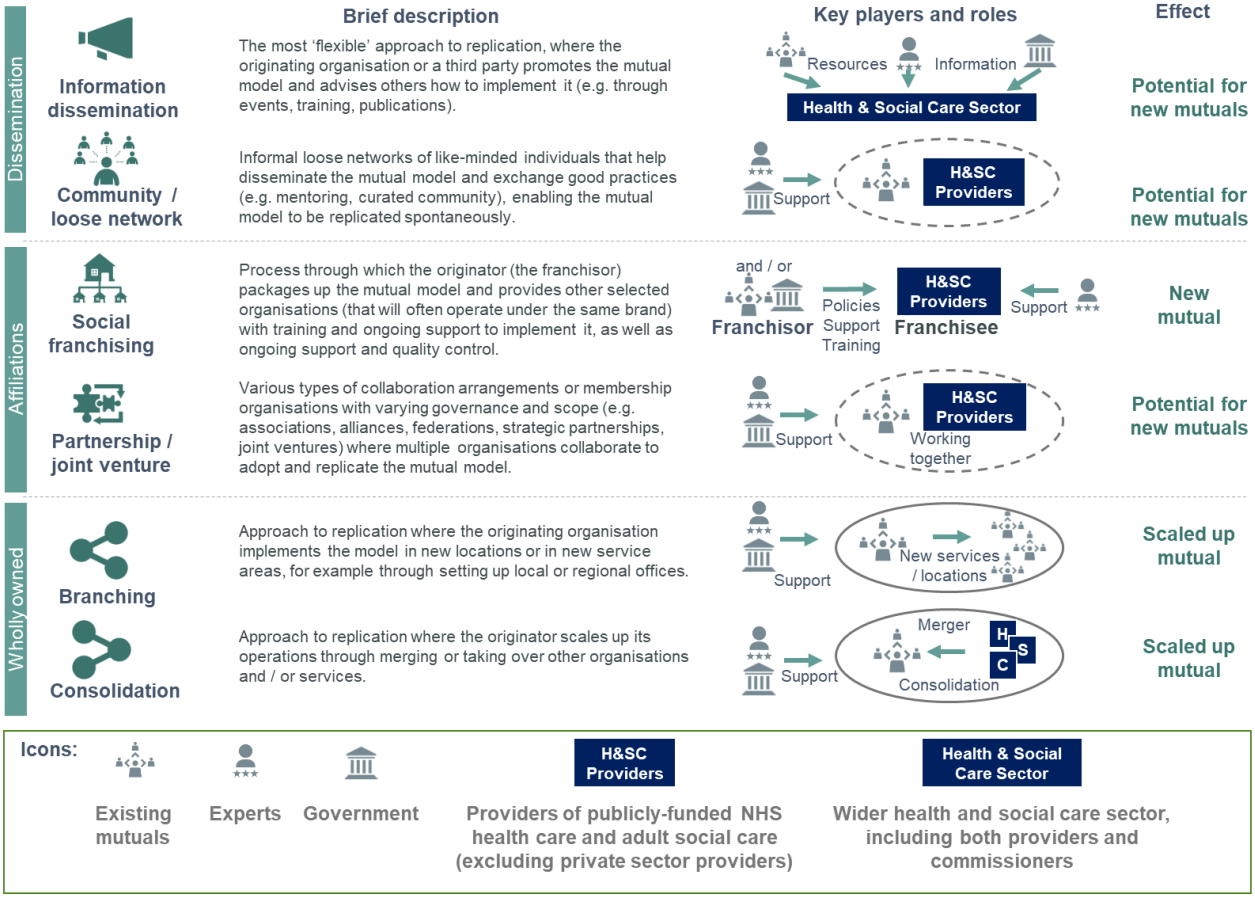
[65] See R. Addicott, R., Social Enterprise in Healthcare: Promoting organisational autonomy and staff engagement, The Kings Fund, 2011 and R. Hazenberg. et al, Public Service Mutuals: Spinning out or standing still?, Enterprise Solutions, RSA 2020 Public Services, 2013

[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.

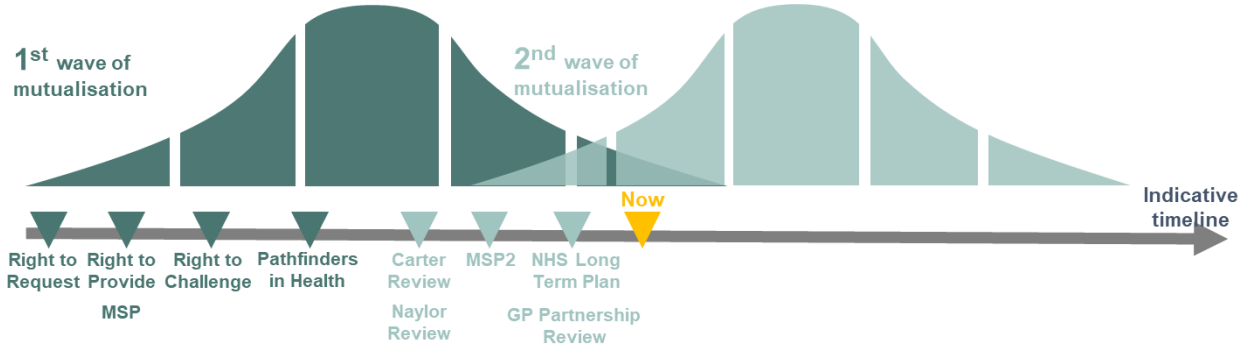
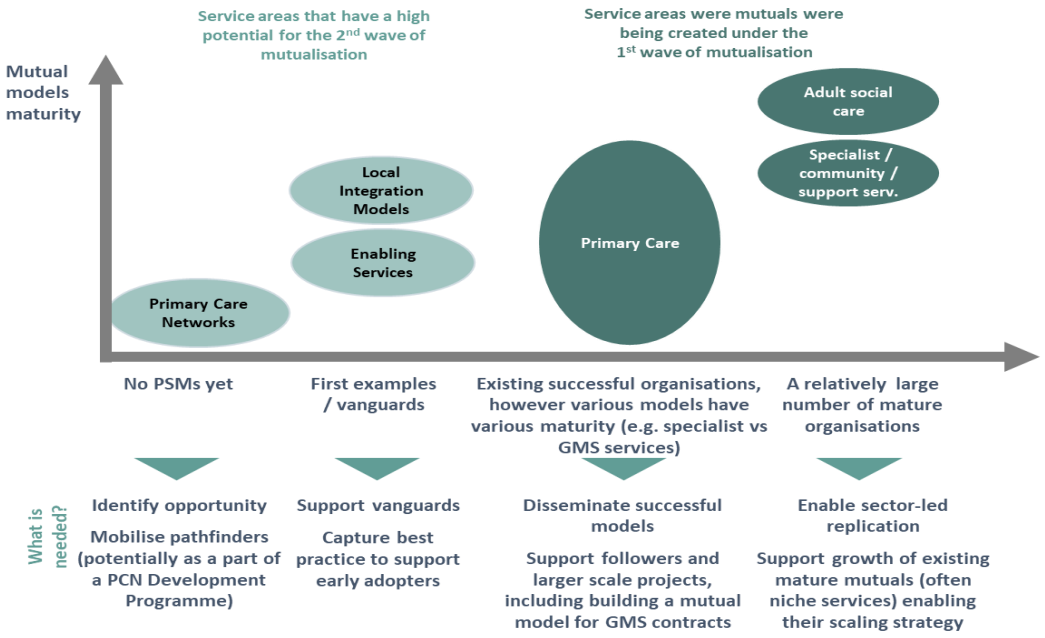


Figure 16: Diversification of approaches to replication in various service areas based on their maturity and number of mutuals.



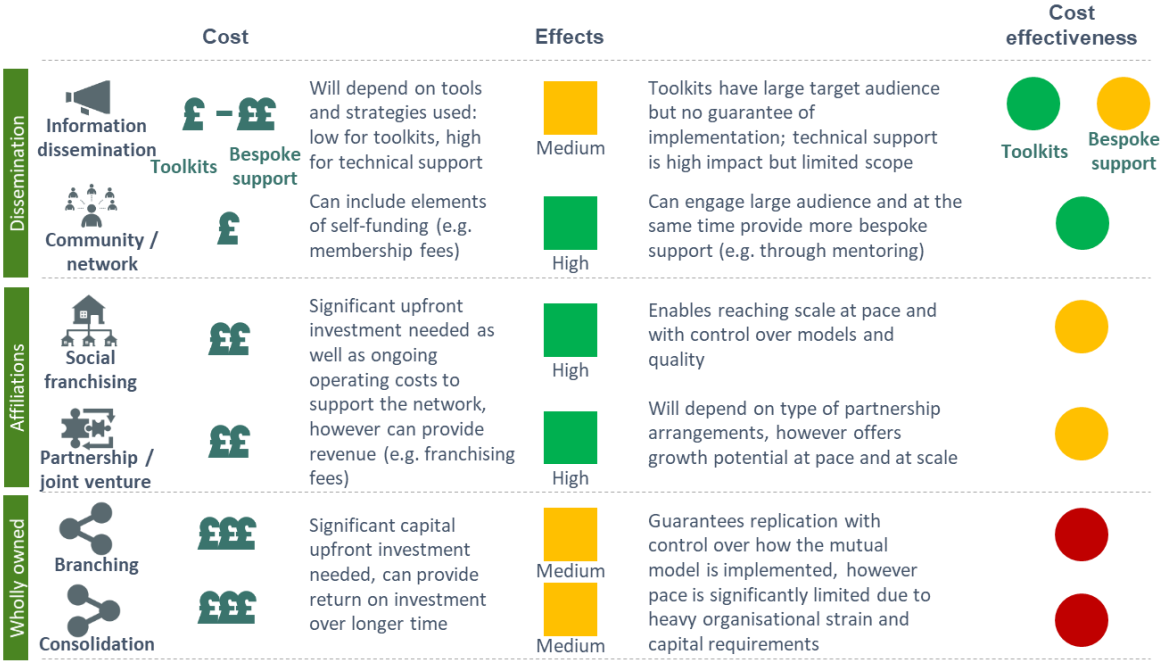
As the mutual models in various service areas are at various stages of maturity, they will require different approaches to enable their replication at scale. Replication approaches need to be fit for purpose, i.e. adjusted to different phases of mutuals development in various service areas.

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.

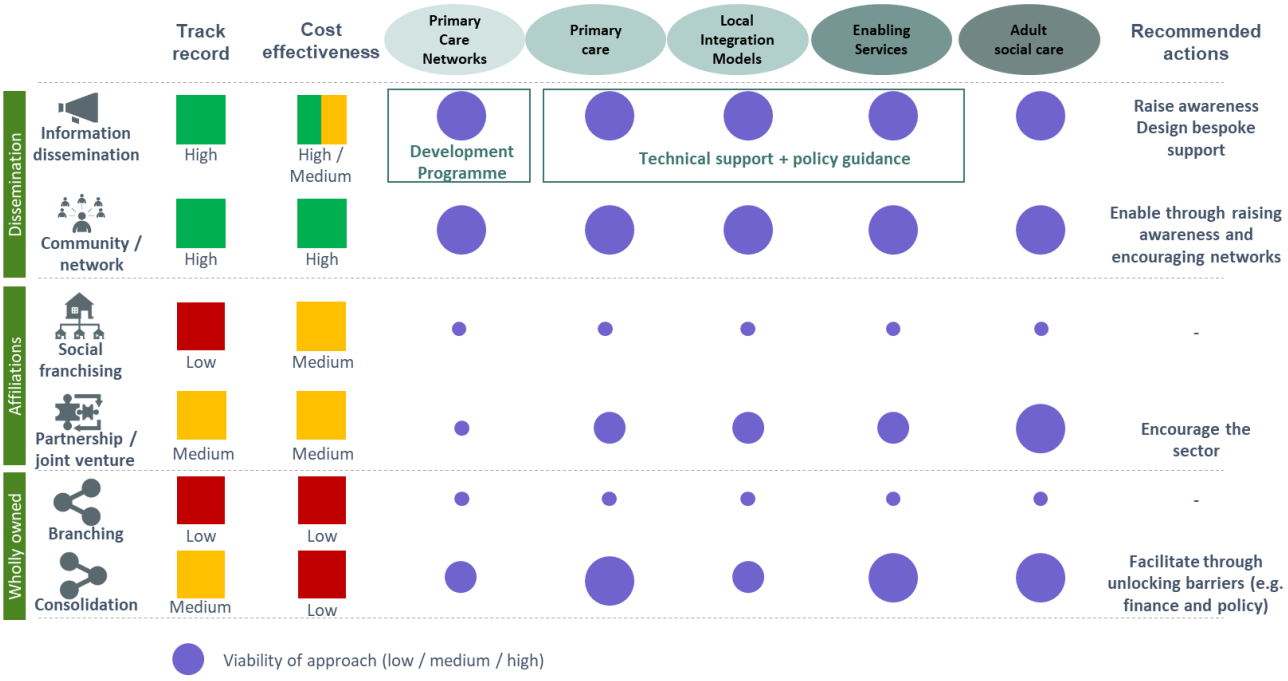
It is important to recognise that cost effectiveness analysis in the context of multi-stakeholder, public services approaches is a very complex undertaking. This is especially true as some of the analysed routes to replication have not been tried at scale in the mutuals sector. We therefore have not 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).