

• **SOCIAL ENTERPRISE AND COMMUNITY- BASED CARE**

**Is there a future for mutually owned organisations
in community and primary care?**

Richard Lewis

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Social enterprises are businesses that deliver goods and services but in pursuit of primarily social objectives. The government is committed to supporting social enterprise in the economy at large and in its recent White Paper has suggested that social enterprise models of service delivery can be part of the provider market in primary and community care. This paper considers how social enterprises, particularly those with a 'mutual' structure, might add value to the provision of primary and community care as well as practice-based commissioning. It sets out action that will need to be taken if this innovation is to be successfully implemented.

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Introduction

A major focus of recent governmental reform of the NHS has been the desire to enhance the role of patients as ‘consumers’ of health care, by offering them the right to choose where they receive treatment and by taking other measures designed to make services more responsive to what patients want. However, at the same time, a less overt strand of policy has been emerging. This has focused on a ‘citizen’ model of patient involvement, in which members of the public (whether or not they are patients at the time) have the right to influence the planning, design and delivery of health care services (Mills 2005).

This policy has been pursued through the creation of patient and public involvement forums and, more recently, through developing NHS foundation trusts that are ‘owned’ by a membership that comprises patients, the wider public and staff. Foundation trusts have taken public engagement to a new level. They are ‘mutual’ organisations, where the members have become the legal ‘owners’ of the hospitals that serve them, or within which they work.

This form of ‘mutual’ organisational structure fits within a wider model of ‘social enterprise’. Social enterprises are businesses that deliver goods and services but which do so in the pursuit of primarily social objectives. They are subject to normal business disciplines, but they reinvest financial surpluses for the purpose of those social objectives. The social enterprise sector is very diverse and operates in all parts of the economy. The government is committed to increasing the scope and strength of social enterprises in the economy (Department of Trade and Industry 2002).

The decentralisation of control in public services has begun to take shape, through greater independence for public services with a stronger emphasis on community representation (for example, through foundation hospitals). This process offers a new vision of public ownership – and one that is very different to the highly centralised ‘nationalised industry’ model that has characterised the NHS to date.

This paper explores why such an approach to public ownership is beginning to emerge in the health sector, and what if any benefits it could bring. This discussion is particularly pertinent to primary and community care, where opportunities are emerging for new types of providing and commissioning organisations. A catalyst for this was the announcement in 2005 that primary care trusts (PCTs) may divest themselves of responsibility to provide community or other services (Crisp 2005), creating a new market of provision in community health care.

Since then, the government has signalled in its recent White Paper that ‘social enterprise’ models of service delivery in primary and community care can form part of a strategy to develop providers that are responsive to, and engaged with, patients and the public.

Social enterprise models are one means of giving people a ‘voice’ (that is, a direct say in the planning and delivery of services), as well as ‘choice’ (Secretary of State for Health 2006). Meanwhile, the early development of practice-based commissioning appears to be resulting in a growth in ‘commissioning clusters’, in which groups of general practices explore the possibilities of commissioning services collectively, and within some form of co-operative organisational structure.

Taken together, the current raft of government policies suggest that a new range of community services and primary care providers (and, perhaps, commissioners) will enter the marketplace to increase patient choice and competition. The government has welcomed, in principle, the prospect that such a development might be linked to a growth in social enterprises. However, as yet there has been little consideration as to what these new organisations might look like, and how their entry to the marketplace might be managed practically. Currently, there are a number of barriers that prevent the development of social enterprises. Unless these are addressed, private for-profit providers are likely to increase their market share by default, and the government’s goal of full diversity among primary and community providers will be missed.

This paper seeks to answer two key questions:

- would social enterprises, particularly those with a ‘mutual’ structure, add value to health service provision?
- if so, what action needs to be taken now to promote this relatively radical innovation in health care delivery?

The wider policy context

Since 1997, the primary focus of government health policy has been the reform of the way care is provided to service users (Lewis and Dixon 2005). This focus has shown itself most clearly in the drive to reduce waiting times for treatment. The government has employed different levers for change to improve hospital performance – for example, creating the Modernisation Agency to introduce new techniques for hospital management. However, the role of ‘patient choice’ and associated competition between alternative providers (often referred to as ‘contestability’) has been growing steadily in importance (Lewis 2005).

Patient choice is part of a wider stream of policy activity designed to reform the extent to which, and ways in which, patients and the public are involved in the NHS. This can be seen as a ‘demand-side’ strategy that complements earlier reforms relating to the way care is supplied. Patient choice is avowedly a consumerist approach to engaging patients and the public in the design, delivery and monitoring of health care. It is underpinned by the belief that market forces will act as a stimulus for improving quality and minimising costs.

However, at the same time that patient choice has emerged as a major theme of policy, the government has also given some attention to developing a ‘citizen’ model of involvement, by reforming public-engagement mechanisms. Through the citizen model, patients and the wider public have the opportunity to influence health services as an inherent right of citizenship, rather than as a by-product of their receiving services (Mills 2005).

The most obvious example of this is provided by NHS foundation trusts. The first foundation trusts were created in 2004 following the Health and Social Care (Community Health and Standards) Act 2003, and there are currently 32 foundation trusts in operation. Foundation trusts are not directly accountable to the Secretary of State for Health. Instead, they are accountable to members drawn from the trust’s patients, staff and the wider public. Foundation trusts are regulated by an independent regulator called Monitor, which authorises the creation of individual new foundation trusts and has powers to intervene if they depart from the terms of their authorisation (including in the case of financial failure).

In *Commissioning a Patient Led NHS* (Crisp 2005), the government indicated that all PCTs would cease to provide community health, primary care and other services. Following public disquiet, and a highly critical inquiry (House of Commons Health Committee 2006), this position was subsequently softened. PCTs are now able to decide for themselves whether or not to cease to provide services (Department of Health 2006b). However, the government’s long-term policy appears to be for PCTs to concentrate on strengthening their commissioning role, and for primary and community health services to be provided by a greater diversity of providers.

The recent White Paper on primary, community and social care (Department of Health 2006a) has signalled that a new balance between 'voice' and 'choice' is to be achieved. Patients can expect more opportunities to express their preferences as consumers of services, but they can also expect a greater direct say in how health care is planned and delivered. They are to be given this additional 'voice' through a variety of mechanisms, including greater powers for the oversight and scrutiny committees of local authorities, and more direct assessment of community views through surveys.

However, the government has also made clear that it expects new and existing providers to be more rigorous in engaging patients in discussions around how they should provide services. One opportunity for this lies in the type of provider that is selected to provide care. The White Paper signals a desire to reduce barriers that prevent 'third sector' providers from entering the market. The third sector can be defined as comprising organisations that are not profit distributing, are constitutionally independent of the state and benefit from voluntarism via donations or volunteering (Kendall and Knapp 2000b). These barriers mean that the NHS cannot take full advantage of the links that third sector organisations enjoy with different communities, nor their specific skills and knowledge

The third sector is already prevalent in social care but, by international standards, makes a relatively small contribution to health care following the nationalisation of hospitals in the 1940s (Kendall and Knapp 2000b). The government is to encourage a growth in social enterprise organisations in the provision of health services through a new Social Enterprise Unit within the Department of Health. The unit will co-ordinate policy in this area and provide a support network to encourage the wider use of social enterprises. In addition, from April 2007 the government will establish a fund to offer advice to social entrepreneurs, provide access to finance and help develop viable business models.

What are ‘social enterprises’ and ‘mutual’ organisations?

According to the government’s definition, social enterprises are businesses ‘with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners’ (Department of Trade and Industry 2002, p 7). The Prime Minister refers to social enterprises as offering ‘high quality, lower cost products and services’ while at the same time creating ‘real opportunities for the people working in them and the communities they serve’ (*Ibid*, p 5).

There are many different approaches to and organisation of social enterprise and social enterprise is not defined by its legal status (Mills 2002, Social Enterprise Coalition 2003).

Indeed, the terminology in common use can confuse more than it enlightens. As described in the previous section, many ‘third sector’ organisations can be considered social enterprises where they operate according to business disciplines to provide services (for example, a trading company established by a charity or a care service offered by a voluntary organisation).

One particular organisational form that can be used to create a social enterprise is the ‘mutual’. There is no single definition of a mutual organisation, but existing mutuals share a number of common features (see the list below). Mutual organisations have members, rather than shareholders. These members may be the direct beneficiaries of the work of the organisation, such as patient members of a foundation trust. Alternatively, members may act on behalf of another group of stakeholders, for example, a mutual may have a small group of members whose job it is to represent the interests of the wider community (see box Glas Cymru (Welsh Water), p 8). However, not all mutuals are social enterprises; some may have been created simply to serve the interests of their members with no wider community purpose.

Characteristics of mutual organisations are as follows.

- Mutuals are established to serve a specific community or interest group.
- Mutuals are all ‘owned’ by their members. This ownership is vested in the membership community of each mutual, and is expressed commonly. In other words, no individual can take away their ‘share’ of the assets. Each generation is a custodian of the organisation for the next. There are no equity shareholders, and mutuals do not belong to the government.
- Mutuals all operate democratic voting systems, with all members having equal power – one member, one vote.
- Mutuals have governance structures that formally incorporate stakeholder interests, and seek to ensure that these different stakeholders have an appropriate role in running the organisation proportional to their relative stake.

Most people recognise the UK mutual sector through building societies, co-operatives, friendly societies, mutual insurers and NHS foundation trusts. Many UK citizens are members of one or more of these organisations, and most of these types of mutual have been around for 150 years or more. In fact, one in three people in the UK is a member of at least one mutual organisation, resulting in 19 million individual members of mutuals (Michie 2004).

The extent to which an individual member is involved in a mutual will depend on the governance structure in operation, and on the relationship between members and the executive decision-making body. For example, members of mutual building societies are not actively involved in the actual work of the organisation. However, other mutual organisations, such as football supporter trusts, childcare co-operatives and local government leisure service providers, have sought an active membership.

What might the benefits of mutuality be?

Because mutuals are based on a membership approach, they are of particular interest in considering the potential role of social enterprises in the NHS. In theory, a mutual approach to social enterprise could offer a vehicle for providing stakeholders with a 'voice' in the running of health services.

There are a number of different goals that might be pursued through a mutual model:

- giving a greater say to frontline professionals in the strategic management of health care organisations
- formally engaging patients and the wider public in the work of health care organisations and giving them rights to control activities and hold managers to account
- creating a renewed sense of community 'ownership' of health care organisations by replacing the traditional model of state ownership characterised by highly centralised political control with a model based on local ownership and accountability.

Health care mutuals may offer a structure to achieve all of these aims. Indeed, NHS foundation trusts have been created in an attempt to give precisely these benefits (see below for further discussion).

Maltby (2003) argues that a mutual structure might be particularly beneficial in the delivery of services if one or more of the following conditions apply:

- if a monopoly of essential services exists
- if services are underpinned by a high degree of public subsidy
- when contracting for complex public services, as relying solely on contracts may be insufficient to protect the public interest or deal with issues such as safety
- where a key policy aim is to increase 'social capital' (in other words, the networks, values and relationships that make up social co-operation) and promote public involvement.

In this context, mutual arrangements with an active patient and public membership may allow service users to play an important governance role. They may also ensure that any policy objectives that do not feature on a financial balance sheet are appropriately delivered. These objectives can encompass intangible assets such as trust, feelings of citizenship and social engagement; sources of social capital, which has been identified as contributing to a wide range of economic and social benefits (Putnam 1993). This is akin to what economists refer to as 'externalities', where costs and benefits fall on those not directly consuming a good or service but which are important to wider society.

It has been proposed that membership activities and participation can equip people with skills that empower them and make them more productive in economic, political and social contexts (Kendall and Knapp 2000a). In its review of social capital, the Prime

Minister's Performance and Innovation Unit suggests that one option to increase social capital may be to create community ownership of local public assets (Performance and Innovation Unit 2002).

Externalities can also be negative – such as public unease over inequitable access to health services, which might apply if external regulation is insufficient. Where effective external regulation may be difficult to achieve or may incur a significant economic burden, mutual status may act as an additional safeguard through an additional form of governance. Glas Cymru (Welsh Water) is one example of a large not-for-profit company that has used a membership structure to protect the interests of consumers where monopoly conditions apply (see box below).

Glas Cymru has proved successful, achieving the best performance of any water and sewerage company as measured by Ofwat's performance assessment in 2002/3 and 2003/4. Glas Cymru has distributed a proportion of its surpluses to customers in the form of a 'customer dividend' (£18 per customer from April 2005) (Glas Cymru 2005).

GLAS CYMRU (WELSH WATER)

Glas Cymru was established in 2000 to finance and manage Welsh Water, the sixth largest water and sewerage company in England and Wales. Welsh Water is a monopoly that serves 1.2 million households and more than 110,000 businesses and has the sole focus of providing high quality services to its customers at the lowest sustainable cost, while meeting regulatory standards and ensuring capital investment and long-term efficiency.

As a company limited by guarantee, there are no shareholders or share capital. The Board has appointed approximately 50 members who carry out the corporate governance duties of shareholders, but who receive no dividends or have any other financial interest in the company. Members are selected to represent the key stakeholder interests of Welsh Water and with skills and knowledge in corporate governance.

Adapted from Glas Cymru. Briefing on membership, January 2005. (Available online at: http://www.dwrcymru.com/Glascymrusite/English/membership/Become_Member/_pdf/Glas%20Cymru%20membership%20briefing%20Jan%2005.pdf)

These arguments in relation to monopolies are pertinent to health service provision. In recent years there has been an increase in the number of independent-sector providers involved in the NHS. Nevertheless, health services are very largely provided by major public sector providers, often acting in monopoly or near-monopoly conditions (although this is less the case in out-of-hospital care, where independent contractors are already a common feature). In addition, where there is less than total confidence that a contractual relationship between a purchaser and a provider can be specified so that all the purchaser's needs are met, mutuals may be particularly attractive as a means of ensuring that services are responsive to consumer needs.

In the case of health, there are significant uncertainties over the nature of the service that is required. For example, it may take time to establish a patient's diagnosis and treatment plan. There is inevitably a significant information imbalance between the care provider and its 'purchaser' (here, the patient), in that the care provider will usually know more about an appropriate treatment than the patient will. In these circumstances, the patients cannot secure their own best interests as they might if they were procuring a different sort of service requiring less technical knowledge.

These power imbalances will still apply to any agent, such as a PCT, that purchases care on behalf of patients. While PCTs may be skilled in purchasing, and knowledgeable about health care, the provider controls the diagnosis and treatment plan for each patient. Purchasers may put in place mechanisms often known as 'utilisation management' to control and monitor the actions of providers. This may include setting agreed protocols of care and carrying out spot checks to make sure providers are providing, or billing for, only what is required. However, even significant utilisation management is unlikely to address fully the imbalance of information and power between purchaser and provider (Arrow 1963). A mutual structure for a health care organisation, with citizen membership and governance, could in theory add an additional safeguard for the patients' interests, over and above that achieved through the contracting process.

The theoretical economic case in support of mutual social enterprises has been described above. However, mutuals are often justified on political grounds.

In this country, the benefit of patient and citizen engagement in planning and delivering health services is often held to be self-evident; on the grounds that accountability will be increased and that citizen involvement in the NHS is an 'intrinsic good'. These assertions are essentially political in nature (that is, based on normative values), rather than flowing from empirical evidence (Florin and Dixon 2004).

Proponents suggest that mutuality may lead to greater efficiency in health services than the current model of centralised accountability. This is because, in theory, effective stakeholder engagement will lead to more responsive services that deliver better value. It has even been proposed that a greater control over one's life (such as might be increased through participation in social organisations) will impact positively on one's health (Bleas 2002).

In introducing foundation trusts the government stressed that these trusts would be 'democratic' and would result in greater local ownership and involvement of local stakeholders (Department of Health 2003.) The consequent decision to remove direct central control over foundation hospitals was not a signal that public accountability was no longer relevant. In contrast, the reasoning was that the health service could more effectively secure engagement and accountability through new, mutual-governance arrangements. The government has ostensibly rejected a centralist model of public ownership – not the concept of public ownership itself.

However, foundation trusts were introduced first and foremost as a means of increasing the freedoms of NHS hospitals in the hope that this, together with greater competition, would increase efficiency and innovation. It is possible that there will be a tension between the drive for greater efficiency and local governance arrangements.

The evidence base

In this country, there is relatively scanty empirical evidence to demonstrate the tangible benefits of social enterprise (mutual or otherwise) in health or other care sectors. This is partly because such organisations are not well represented in the health sector and because there is a need for more research. The Department of Trade and Industry is currently reviewing the available evidence on social enterprise and mapping its value across the UK.

However, some research evidence is available in relation to the provision of residential and day care for the elderly by 'third sector' providers (although it is not known whether or not the providers studied had adopted a mutual form) (Kendall and Knapp 2000b). This suggests that these providers are superior to for-profit private or public sector providers in terms of efficiency and economy in some fields of care. Some of this advantage is attributed to the third sector's ability to call upon a supply of volunteers and its better access to investments, endowments and reserves with which to subsidise fees. The research also finds that the third sector was better than the for-profit sector at engaging residents in leisure and recreational pursuits. However, few other differences were identified (Kendall 2003).

Internationally there is more evidence of differences between the for-profit and not-for-profit sectors in health services (the term 'not-for-profit' broadly relates to that of social enterprise in this country). This evidence supports the notion that a not-for-profit structure may offer a tangible advantage in the provision of health care. A review of research evidence, mostly from the United States, suggests that the not-for-profit sector generally provides services at lower cost, and with greater efficiency, than the for-profit sector (Duckett 2001, Devereaux *et al* 2004). The existing research evidence also tends to support the notion that not-for-profit providers offer higher quality care than the for-profit sector, with better survival rates, and better performance against quality measures (Devereaux *et al* 2002, Rosenau and Linder 2003).

Looking beyond health and social care, Postlethwaite and colleagues found that the employee-owned business sector experiences a significant business advantage compared to traditional shareholder-owned companies (Postlethwaite *et al* 2005). In their review of published research, they found evidence of a positive and causal relationship between employee shared ownership and levels of productivity and financial performance.

This is partly achieved through peer pressure on non-productive employees (in other words, tackling 'free rider' employees within the company). However, they also suggest that performance is maximised where there is a combination of financial participation (with staff sharing ownership) and employee participation in the company's decisions. While shared ownership with employees may often not be within a social enterprise model (in other words, such organisations may be profit-seeking with no wider social objectives), this evidence does suggest that greater organisational control in the hands of the workforce may contribute to higher levels of performance.

Mutual organisations that involve a membership of both staff and the community seek to combine the interests of both these types of stakeholder. This is founded on the expectation that the benefits of engagement will be enjoyed and that any conflicts of interest will be resolved through the governance arrangements. Foundation trusts are an

example of this multiple stakeholder approach and offer an opportunity to judge the impact of a mutual model of healthcare. Foundation trusts offer membership to staff, the public and sometimes patients and carers. Members' interests are, in theory, secured through their election of governors. Governors have a number of defined powers, including the appointment and dismissal of the trust chair and non-executive directors, the approval of the appointment of the chief executive, and the right to be consulted on the strategic direction of the trust. According to the Department of Health, this provides local communities with 'social ownership of their NHS foundation trust' (Department of Health 2003, p 3).

From the evidence so far, it is clear that foundation trusts do have the ability to motivate people to exercise their new rights. Already more than 500,000 people are members of the first foundation trusts (Secretary of State for Health 2006). Of course, while this is a large number of members, it represents only a small proportion of the total eligible membership. This raises an important question of what level of engagement is required to meet tests of community empowerment and democratic representation.

The first wave of trusts has already provided some examples of governor influence over foundation trusts (Foundation Trust Network 2005, Lewis and Hinton 2005). However, in practice, the role of governors has proved difficult to pin down, and so far there is little compelling evidence that members or governors have made a significant impact on the management of foundation trusts (Healthcare Commission 2005, Lewis and Hinton 2005, Day and Klein 2005).

This could simply reflect the fact that foundation trusts have had little time to develop their membership strategies, or that hospitals are highly complex organisations in which it is difficult to cede real control to lay members. It could also reflect that staff, patients and the community have little desire for active control over foundation trusts. It is argued in the next section that primary and community care may offer a more suitable environment in which to engage active membership.

Bringing mutuality to primary and community care

The government has signalled its intention to promote social enterprises in primary and community care. As discussed in the previous section, it is difficult to draw on substantial empirical evidence to confirm that patients, the wider public and NHS staff will benefit from this policy. However, this caveat also applies to the government's parallel strategy for introducing more for-profit enterprises through national and local procurement.

Nevertheless, a theoretical case for social enterprises (and in particular mutual models of social enterprise) can be advanced. This section considers what might be done if the government is to achieve its aims for social enterprise successfully.

The current changes to PCTs and the proposed diversification of providers in primary care present an opportunity to think creatively about future organisational forms.

Potential benefits of the mutual model in primary care

Mutuality may offer a range of benefits for professionals, patients and the wider community.

For patients, a mutual form of social enterprise may make more sense in relation to the provision of community and primary care, where virtually the whole population makes use of the service and develops long-term relationships with providers, than it does for providers of hospital services, which have largely infrequent contact with the patients that they serve. Patients are arguably more able to judge what they want from the primary and community services to which they self-refer and with which they are familiar, than they are in relation to the hospitals they visit only occasionally. Mutual models of primary and community care that provide for community membership offer a vehicle for 'voice' where little has existed before.

Professional staff in primary care may also find the dynamics of an employee-ownership model based on membership and with a public service ethos highly attractive. Professional staff in primary care have hitherto enjoyed a high degree of autonomy (partly as a result of independent contractor status) and a mutual organisational structure would offer them significant influence over organisational strategy and operation, balanced by a collective approach to improving quality of service.

A mutual approach to primary care is one means to establish a sustainable basis for the ownership and delivery of primary care services that retains and builds on the strengths of UK general practice. It seeks to establish locally owned and controlled bodies, each of which provides a framework for a number of existing GP practices to operate together with shared services. This might achieve more effective professional development and support,

consistent clinical practice with resulting improvements in quality of outcomes, a supported working environment, and increased efficiency.

Successful providers are likely to combine a number of common elements, including:

- being large enough to enjoy some economies of scale and share administrative and clinical staff in a way that allows for efficiency and specialisation
- being responsive to local needs
- offering support in a way that clinicians see as being helpful to them in delivering patient care
- allowing clinicians to control the clinical environment, ways of working and treatment paths, in a way that allows them to assure appropriate treatment for each patient
- promoting an environment in which teams of specialists and generalists can operate together to provide mutual support
- encouraging the sharing of best practice to raise the standard in all aspects of the operating model
- offering an attractive mix of work, professional support, reward packages and career paths that will appeal to clinicians
- providing a supportive and developmental employment environment that is consistent with the expectation of a modern workforce
- building on the ethos that is at the core of the NHS of wanting to provide appropriate advice and care for patients.

Putting it into practice

While the potential benefits of mutual social enterprise in primary care may be significant, the government's vision as set out in the White Paper will not come to fruition without significant developmental support and unless a nurturing environment is created. It is not enough to simply wish that mutual organisations will spring up, although encouraging progress is being made in some areas (*see box opposite*).

Creating new organisations, particular those that involve a transfer of staff from traditional NHS employment, and the engagement of the community is complex. There are a number of obvious barriers that will need to be addressed, in particular, continued right of access to NHS pensions for staff transferring from NHS organisations, support in selecting the right legal framework and access to start-up capital.

The White Paper points to a clear process for procuring non-traditional providers in primary care. The move to these providers is likely to proceed quickly, and the indication so far is that there will be significant interest among large for-profit companies. For example, a number of well-known high street companies are reported to be exploring the potential for entering the primary and community care market.

To ensure that mutual organisations are able to take advantage of the new opportunities in primary and community care, the government has announced that a Social Enterprise Unit and development fund will be established. These initiatives should be welcomed. However, there will be a time lag before these initiatives are operational – the development fund will not even come into being until April 2007, and mutual organisations may take more than a year to design and implement.

EXAMPLES OF NHS MUTUAL SOCIAL ENTERPRISES

East London Integrated Care (ELIC)

ELIC is being established as a social enterprise in Hackney, East London with the aim of supporting general practices carry out practice-based commissioning and to provide specialist services by GPs with special interests. ELIC is intended to become a 'society for the benefit of the community' (a form of industrial and provident society) and will have the following characteristics:

- frontline primary care clinicians will shape the organisation and decide its activities and clinical strategy based on their detailed understanding of patient needs
- all 220 GPs, practice nurses and general practice managers in Hackney will be members
- it will be overseen by a Members' Council made up of ten professional representatives and one representative of patients' interests
- ELIC aims to be effective, efficient and economically competitive to win work and generate a surplus
- as a 'not-for-profit' organisation surpluses will be re-invested for the benefit of patients either into the organisation or into primary care in the area.

Rushcliffe Mutual

Rushcliffe Mutual in Nottingham will go live in the spring of 2006 with the establishment of a Transitional Company Board. It will be a not-for-profit Community Benefit Company that will combine the practice-based commissioning budgets of 21 general practices. Rushcliffe Mutual will be accountable to the PCT through an 'alternative provider of medical services' (APMS) contract. The aims of the new organisation are to:

- provide a vehicle for a collaborative approach to practice-based commissioning
- develop a new relationship between general practice and community health staff, including nurses and therapists
- increase accountability to and involvement of the local population in local health services.

Membership of the mutual will be offered to all community-based professionals and local patients and residents. Once the Transitional Board has been established, the company constitution and final governance details will be agreed.

If the government presses ahead with its aim to increase diversity in primary and community care, many contracts may simply pass to the for-profit sector before any social enterprises have had the chance to bid.

The existing third sector organisations will no doubt play a valuable and expanding role in primary and community health care. However, they may be more likely to fill gaps in more specialised services than to provide mainstream services themselves. In particular, some organisations will have no appetite for entering the broader arena of general practice provision, as this would take them away from their organisational aims and objectives. The government has sought to promote social enterprise in the wider economy by establishing Futurebuilders England, a not-for-profit company that assists the third sector to deliver public services. Yet so far it has not brought forward new social enterprises into mainstream primary care.

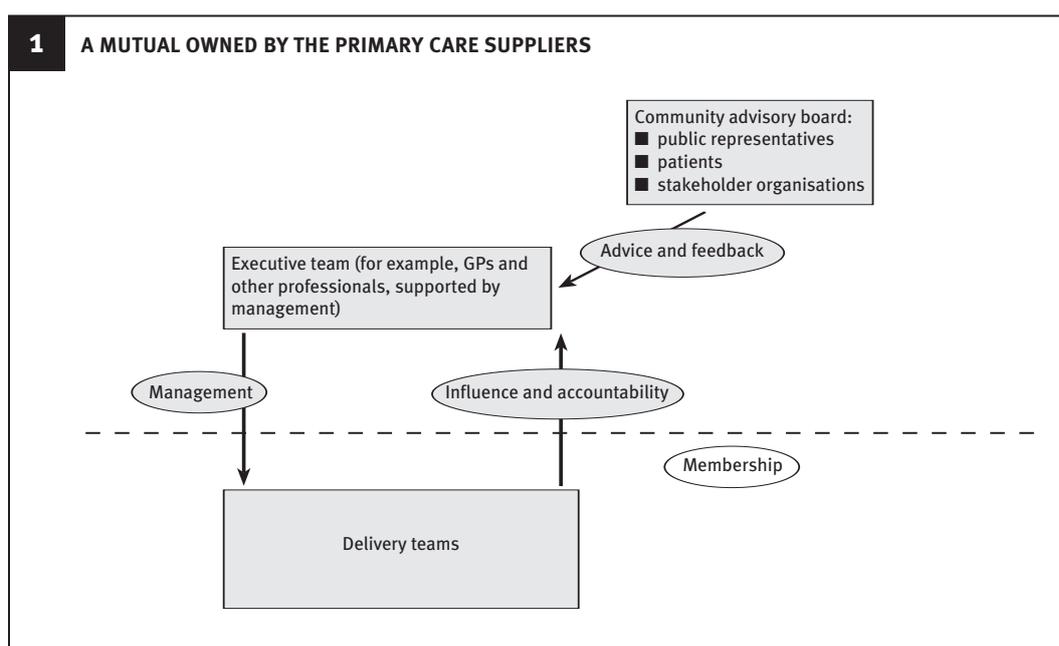
Therefore, the government’s vision for new social organisations to provide comprehensive mainstream primary and community health services will depend – partly, at least – on a range of new organisations that will be built from scratch. If they are to be successful they will need very specific political encouragement and, importantly, developmental support in starting up (see What sort of support will new mutual organisations need?, p 18).

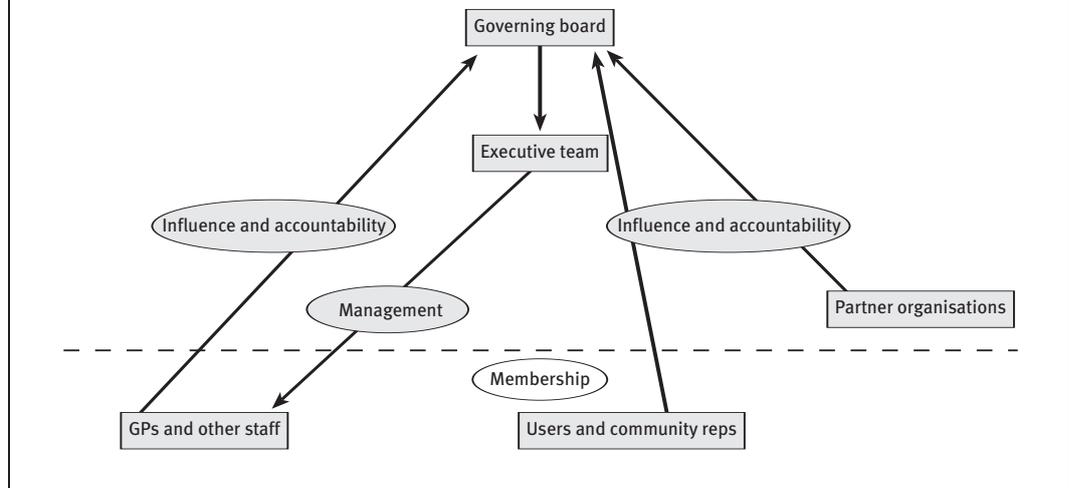
Careful thought must be given to the structure of new social enterprises. For example, simply creating new mutual organisations owned and controlled by staff may not be in the wider public interest. While patients may derive some benefit from care delivered by a workforce that is motivated and empowered, the interests of suppliers and recipients are not always identical. Ideally, patients and the public (or their representatives) should have membership status within any mutual organisation. This would ensure that their interests are served and their sense of engagement with health services promoted. At the very least, patient interests need to be recognised in any formal governance arrangements.

However, offering membership to patients and the community may be easier to engineer in relation to community nursing and therapy services, with their long-standing history of public ownership, than in relation to general practice. For community nursing and therapy services, mutuality would represent an evolution in their public sector status, while for general practice mutuality would represent a radical cultural change.

General practitioners have a small-business culture that is rooted in their independent contractor status, working at arms’ length from the NHS. It is hard to conceive that existing self-employed GPs would volunteer to give away control over their business to other stakeholders in the way that a community membership organisation would require. A more realistic prospect might be to find alternative mechanisms that increase the public voice but within a staff dominated structure. Figures 1 and 2 (below and opposite) set out two alternative governance models that might be adapted in these different circumstances.

In the first governance model, shown in Figure 1, the mutual organisation is owned by the suppliers – in other words, the membership is made up of the teams that deliver care. The





activities of these delivery teams are managed by a management team, made up of key partners in the business, supported by professional management. However, as members, the individuals working within the delivery teams hold the executive team to account for its performance. The mutual organisation could establish a community advisory board made up of a range of interests. This board could have formal governance rights, such as to scrutinise and participate in the planning and monitoring of care. However, unlike governors in foundation trusts, these rights would not extend to hiring and firing the executive team.

In the second governance model (see Figure 2 above), membership is extended to staff, patients and the community. Overall control of the mutual organisation's activities is vested in a governing board made up of representatives of all member interests. This board holds to account an executive team that is responsible for the day-to-day management of the organisation. This governance model provides a more powerful voice for community and patient interests.

The role of mutuality in commissioning

So far, the debate on mutual organisations has focused on organisations providing services. However, mutuals may also make an important contribution to practice-based commissioning.

The commissioning role that has been assigned to general practices (and, potentially, to other community professionals) is one that is carried out on behalf of the NHS and patients collectively. Practice-based commissioning links the clinical activities of general practice (such as chronic disease management or referral of patients to specialist care) with the overall management of NHS resources.

Practice-based commissioning seeks to apply financial incentives to general practice teams so that they substitute care from a hospital to a primary care setting. However, for this to happen, a robust governance framework must be put in place to make sure that such shifts in care are driven by patient needs rather than financial gain to the practice.

Here, the interdependence of primary care provision and practice-based commissioning is both a strength and a weakness. Inevitably, conflicts of interest will exist between the role of commissioner and the role of provider and will need to be addressed.

Early experience with practice-based commissioning suggests that general practices are likely to fulfil their commissioning role by clustering together. Collective commissioning offers the prospect of economies of scale, a greater ability to identify and address population health needs, and opportunities for greater specialisation in delivering alternatives to hospital-based care. However, to date, little thought has been given to how patients, the public and other stakeholders are to be involved in practice-based commissioning decisions.

A mutual structure to link clusters of practice-based commissioners may offer the NHS a number of benefits.

- It could provide an effective way of enhancing public involvement and accountability. As PCTs become larger due to widespread mergers and arguably more distant from their communities, it is increasingly important that local forms of public accountability are developed. A mutual, practice-based commissioning organisation can in theory provide membership to patients and other public stakeholders, as well as formal roles (for example, places on a governing board). This form of mutual structure would add the degree of oversight and governance to the commissioning process that is currently missing. This would help manage the issues of probity and conflict of interest described above, as in this model the public interest is built into the governance of the organisation. A mutual model based on community membership may be more successful in involving the patients and public than was the case under ‘total purchasing pilots’, where public involvement failed to develop strongly (Dixon *et al* 1998).
- It would offer an organisational solution for practices that wished to join together to co-operate on commissioning while protecting the rights of individual practices in non-commissioning functions. In their provider functions, individual practices could continue to be profit maximising as autonomous organisations. This separation of governance between provision and commissioning could reduce the likelihood that they would face accusations of using NHS commissioning funds to further their own aims.

What sort of support will new mutual organisations need?

If the vision for mutual and other forms of social enterprises in primary and community care is to be successfully delivered, the government has a significant development role in the following areas.

- Capacity to manage change in PCTs and general practice will need to be built. The forthcoming ‘fitness for purpose’ reviews of PCTs could incorporate an assessment of the extent to which PCTs are able to fulfil this developmental function. Subsequently, when strategic health authorities performance manage PCTs, they will need to consider the PCT’s ability to support the development of social enterprise providers as part of its responsibility to ensure a diversified market.
- In PCTs and primary care, effective leadership will be key. The lesson of other initiatives in primary care (such as nurse-led personal medical services pilots) is that it is not sufficient to rely on self-sustaining ‘champions’ coming forward (Lewis 2001). If change is to be sustainable and widespread, the NHS must develop and support its leaders.

- A formal developmental process, such as that for foundation trusts, will need to be created nationally. This would provide a structure and a rigour to the development of mutual and other social enterprises in primary and community care. It could also save time and resources by offering a package of key information, such as the different legal and organisational options available, together with templates for governance arrangements. The Department of Health's new Social Enterprise Unit could also provide cost-effective legal advice through a national programme.
- A network to support potential leaders will need to be created, allowing them to share ideas and problem solve jointly.
- National guarantees that NHS pension rights will continue to exist for staff transferring from NHS trusts and PCTs to new community and primary care social enterprises will be needed.
- A cadre of non-executive directors to serve on social enterprises (where governance arrangements do not rely solely on members' representatives) will be needed. Of particular value will be non-executives with experience in the commercial sector, who can provide much-needed advice and guidance on the new operating environment within which social enterprises will exist.
- Access to start-up finance and commercial loans will need to be secured.
- Clear guidance is needed about the requirements for competitive tendering and ongoing financial support in relation to proposals by PCTs to create new social enterprises to manage PCT provider services. There will be a need to balance the competing aims of public probity with the desire to support new types of organisation. If competitive tendering is to be avoided, guidance on an appropriate framework for ensuring best value will be needed. The government has already indicated that intangible assets such as trust and engagement should be valued and recognised in public tendering exercises (Milliband 2006).

Should PCTs create a competitive market in primary and community care?

In *Commissioning a Patient Led NHS* (Crisp 2005), the government proposed that a key benefit of PCTs withdrawing from direct service provision would be that patients would benefit from an increased choice and diversity of provider. However, the divestment of provider services by PCTs may not necessarily deliver these outcomes. For example, the development of Central Surrey Health (the community nursing and therapy services currently provided by East Elmbridge and Mid Surrey PCT) will become a company, co-owned by 700 employees. This suggests that, in effect, the original monopoly will be replaced by another – albeit one controlled by staff. Indeed, the establishment of Central Surrey Health was not prompted by a local concern to increase the contestability of services.

Whether or not this absence of competition is an acceptable outcome depends on the relative value given to two potentially competing governmental objectives. One of these objectives is the development of a social enterprise culture. The other is the existence of choice and competition between providers.

An alternative approach to the divestment of PCTs' provider functions would see PCTs pass on these functions to a number of competing organisations with overlapping geographical areas, to ensure that patients enjoyed choice. This might satisfy those for whom competition is the key to better services, but it is unlikely that there will be the financial

and leadership resources locally to sustain a number of organisations. This kind of strategy may put at risk the broader aim of creating organisations controlled by staff and the community.

This point touches on perhaps a deeper tension in government policy. Mutual social enterprises that incorporate the wider public interest into their mission and invite citizen membership are founded on the belief that a partnership between health professionals and the wider community will deliver high quality, responsive and appropriate services.

Yet this idea of partnership is in some tension with the notion that patients need to decide between alternative providers. After all, if patients are served by several providers, should they be members of all of them? If so, will this rather polygamous relationship not undermine the notion of partnership and engagement? Alternatively, should patients move their membership from one mutual provider to another? If so, might this undermine long-term relationships and loyalty that may well be important in developing a real and enduring partnership between professionals, patients and the public? Mutuality is not incompatible with competition, but it derives its strength from a different source.

Conclusions

Since the 1980s, public-sector reforms have transformed the way in which we think about public services. Increasingly, a new consensus holds that a highly centralised public sector is no longer appropriate and that, instead, flexibility and decentralisation should be the characteristics of the health service, and other public services. Some go further and argue that local engagement of people in shaping health services is critical to making services more responsive, and that there are wider benefits to public engagement. Others favour a more consumerist model, based on competition between providers and choice by consumers as being a better route to more responsive care.

However, rejecting the old structures for delivering public services is not the same thing as rejecting the notion of public service. The public service ethos is very much alive and valued. The development of new social enterprise organisations can be seen as a transformation of the means of delivering public services, while retaining the ideals on which the public sector has always been founded. Mutual forms of social enterprise organisation may well be particularly suited to health care delivery. The aims of developing an active membership chime with those of developing engaged and empowered patients.

By virtue of its strong and continuous links with the community, primary and community care is perhaps the ideal place to begin this transition in public service delivery. Indeed, the government sets this out in its recent White Paper. However, concerns may be raised about whether the practical strategy exists to implement this vision. We have identified that the government will need to provide more active support to promote mutuality and to breathe life into its policy. Without such support, the danger is that progress will be slow and uneven.

The government has outlined a number of proposals to help social enterprises in developing and entering the market for community services. These are welcome and well aimed, but will take time to develop. Meanwhile, the for-profit sector is ready and able to act quickly, and there is a distinct danger that for-profit providers will sweep into primary and community care unchallenged. If too much time passes before staff-led and patient-led organisations take shape, when they finally do enter the marketplace there may be little left for them. This particularly applies to new models of general practice organisation, where competition from the for-profit sector may be fierce.

Social enterprise offers the prospect of a new partnership between professionals, patients and the public. This presents an opportunity to reshape primary and community care and should not be missed.

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