

# CARE ON CALL:

a mutual approach to out of hours primary care services

PETER HUNT | CLIFF MILLS | FOREWORD BY RT. HON. JOHN HUTTON MP



**mutuo**

 **www.natpact.nhs.uk**  
National Primary and Care Trust  
Development Programme

**NAGPC**



## **Care on call – A Mutual Approach to Out of Hours Primary Care Services**

This pamphlet represents the authors' interpretations of the subject, not the collective view of the publishers.

This pamphlet, or any part of it, may not be reproduced without permission of the publishers.

Published by Mutuo  
77 Weston Street  
London SE1 3SD

Tel: 020 7367 4177  
Fax: 020 7407 4476  
Email: [enquiries@mutuo.co.uk](mailto:enquiries@mutuo.co.uk)  
Website: [www.mutuo.co.uk](http://www.mutuo.co.uk)

Editors: Peter Hunt & Oliver Fry

ISBN 0-9544127-5-3

Print and Design: The Studio, 72a Old Dover Road, London SE3 8SY  
Website: [www.thestudio-london.com](http://www.thestudio-london.com)  
Tel: 020 8853 8531  
Fax: 020 8853 8532

Price £10.00

January 2004

**Foreword 4**

Rt. Hon. John Hutton MP

*Minister of State, Department of Health*

**The Challenge for Out of Hours Primary Care Services 5**

- 1 Introduction 5
- 2 Out of Hours today & the new GP contract 6
- 3 Options for maintaining cover 7
  - GP Co-operatives 7
  - Primary Care Trusts 9
  - Stakeholder Mutuals 10

Peter Hunt

*Director, Mutuo*

**Care on call – A new vision for Out of Hours primary care 12**

- 1 The nature of the problem 12
- 2 The wider context 14
- 3 An achievable vision 17

Cliff Mills

*Cobbetts Solicitors*

**Author biographies 23**

It is really important for patients to be able to get a doctor or nurse to see them out-of-hours. One of the main aims of our improved NHS is to ensure that patients have good access to professional primary care when they need it. Sickness and distress knows no timetable so the NHS needs to be there, providing security, 24 hours a day seven days a week.

Yet at the same time health professionals deserve to be able to live a life where they can have some rest and time with their families. So relieving GPs of out-of-hours responsibilities is also important. That is why we have developed the new GP contract which allows GPs to opt out of their 24 hour service responsibility from December 2004.

To help make this happen we are doubling the amount of investment that is going into out-of-hours services to make sure a quality service can continue to be provided to all patients whenever they need it.

To get this right the Department is talking very closely with GPs and primary care trusts, and since the needs of patients are paramount, we won't hesitate to intervene if there is any risk that services to patients are likely to be disrupted.

This publication is a welcome contribution to the debate around how best to maintain high quality out of hours care in the new GP contract environment. We have developed new models of mutualism too for NHS Foundation hospitals. We need to do the same for primary care services I urge all those involved in the delivery of these services to engage positively with the ideas contained in it and look forward to seeing the conclusion of this work.

**Rt. Hon. John Hutton MP**  
***Minister of State, Department of Health***

## **The Challenge for Out of Hours Primary Care Services**

**Peter Hunt, Director, Mutuo**

### **1 INTRODUCTION**

The new GP contract, which comes into force in April 2004 means that doctors will no longer be obliged to provide out-of-hours (OOH) cover and can choose to opt out of the service entirely.

Currently, some GP practices deal with OOH calls themselves, in addition to their normal surgery hours each day; many more contribute to a GP co-op to share the workload, and others pay private deputising companies to provide the cover.

Under the new contract arrangements, the responsibility to ensure OOH cover is available for all patients, transfers to local primary care trusts (PCT).

These changes create opportunities for the NHS to redesign OOH services whilst maintaining adequate and appropriate high quality OOH cover. This publication argues that the challenge for local health communities will be to establish new partnerships that build on the strengths of all providers including GP practices, GP co-operatives, commercial suppliers, community services, NHS Direct, ambulance trusts and acute trusts.

This project seeks to encourage the provision of out of hours cover from local community mutual organisations. New bodies will be established, with a membership drawn from GPs, other healthcare staff, administrative staff, and potentially patients from the local community. Existing GP Co-operatives will also be encouraged to transfer to these new arrangements.

Although many GPs may be planning to opt out they are not going to abrogate their responsibility to their duty of care towards the patients. General Practitioners want an effective OOH system, preventing vested selfish interest and avoiding an adverse impact on day time working.

We believe that by retaining and expanding the core mutuality of GP Co-ops, to include other providers and stakeholders, the future of out of hours care can be secured and indeed enhanced.

In researching this publication, Mutuo facilitated a number of seminars that brought together representatives from GP co-operatives, PCTs, the Department of Health and the mutual sector. This publication has been informed by the discussions that took place at those events.

We would like to thank the following for their contributions to the discussion: Dr Mark Reynolds MBE – Chairman NAGPC; Dr Prasad Rao – Vice Chair NAGPC; Anne Bryant – SEADOC; Dr Jeremy Lade – REDDOC; Mo Girach – SELDOC; Colin Laws- KEYDOC; Mark Featherstone – MKDOC; Edmund Jahn - Harmoni; John Anthony- SUSDOC; Alan Burchette – SEADOC; Logie Kelman – NAGPC; Dr David Carson - Department of Health; Rick Stern - CEO Bexhill & Rother PCT; Dr Jamie Macleod – Secretary NAGPC.

## 2 OUT OF HOURS TODAY AND THE NEW GP CONTRACT

Currently, some two thirds of OOH cover is provided by GP Co-operatives on a collective basis, with the rest provided by the private sector. In urban areas, these providers often coexist and will typically cover more than one Primary Care Trust territory. These are also the main areas in which private sector providers exist.

From April 2004, under the new GP contract the statutory responsibility for providing OOH GP services will be transferred from GPs to Primary Care Trusts. From December 2004, GPs will be given the choice to opt out of providing OOH services. The responsibility for ensuring that services are maintained is to be held by Primary Care Trusts.

It is anticipated that the majority of GPs will choose not to continue to retain responsibility for providing this cover as they do today, leading to a major opportunity for developing integrated provision, commissioned by PCTs. Some co-operatives are making provisions to wind up their organisations in anticipation of the changes, and a few PCTs are planning to act as providers of OOH themselves.

Some providers are however seeking to make changes which will allow them to continue in the mutual sector and provide an attractive organisation for GPs and other staff to continue to work within out of hours provision.

New Department of Health guidance has been recently issued to PCTs outlining the issues they and other providers of local services need to consider when providing high quality OOH care and what staff structures need to be in place.

In terms of the minimum service guaranteed it is written into the contract that PCTs have to ensure Primary Care delivery to their population. The OOH service covers GPs and a range of other services, so instead of there being an obligation on GPs to provide the cover as they have to up to now, the new requirement is to provide overall OOH cover in which GPs are the leading part.

Yet the expectation is that the public should not notice a dramatic difference in the mechanism or style of delivery.

This change needs to be seen in the context of the continuing rapid modernisation of the NHS. Innovations such as the creation of NHS Foundation Trusts are part of this new landscape that aims to create patient-centred services.

## 3 OPTIONS FOR MAINTAINING COVER

The Government's objective is to maintain quality OOH provision. But with a potential exodus of doctors from the service, a difficult problem is created. The fear is that large gaps will appear in the landscape of provision, leading to a loss of service, coupled with increased pressure on the remaining OOH providers. This, should it occur, will lead to a knock-on detrimental effect on in-hours services, with frustrated patients presenting themselves at GP practices.

If this scenario is to be averted, what is the possible alternative future for OOH, and what will the providers look like?

If GPs are the lynch pin of the OOH service, and if their co-ops will disappear as presently constituted, how can PCTs ensure that they meet their obligations? What organisational arrangements are necessary to meet this challenge?

Clearly, there are a number of potential answers to these questions. Some GP co-operatives will continue as before, elsewhere PCTs are considering providing the service themselves. Doubtless, there will be new markets for the private sector providers.

The biggest opportunity of all is that of dovetailing the necessary re-organisation of the OOH service with the policy direction of the NHS, by ensuring that all stakeholders are engaged in OOH provision.

The one thing that is clear is that the ability of producers being involved as members to then innovate and deliver good services has to be retained in any new structure. If there are other stakeholders who could be usefully involved in the delivery and management of this service, then new structures should take account of them too.

But before turning to the potential solutions, we should consider the valuable contribution that GP co-operatives have made to the OOH service and the driving factors for their success. Any new arrangements for OOH provision must seek to make the best of these success factors.

## GP CO-OPERATIVES

**'GP Co-operatives have reduced the doctors' workloads by 75% and increased the efficiency with which we managed our patients, so we always are in a position to deliver a doctor who was more or less awake, at the right place, at the right time, with a far better level of equipment than was offered before. So Co-ops benefited the patients and the doctors and have been a fantastic success.'**

*GP Co-operative member*

GP co-operatives are widely considered to have been a great success over the last few years. Clearly, the change in OOH must seek to retain the best features of GP co-operatives if swift progress is to be made.

# the challenge for out of hours primary care services

We can identify four key factors that have contributed to the success of GP co-operatives:

- They are expert in that the front line healthcare providers also plan the care
- They are innovative and entrepreneurial
- They are flexible and responsive to local health needs
- They have used the inherent self interested mutuality to build strong, cohesive organisations

It is these factors that have helped to create OOH vehicles that are fit for purpose, in that they couple the interests of the producers with the commissioners and are popular with the public.

Some GP co-operatives have already decided to discontinue trading under the new contract, but another group of co-ops will continue to function pretty much as they do today. Despite the obvious reduction in certain motivations, such as the lack of an obligation to do OOH driving the mutual self interest, other motivations will continue. The most enterprising co-ops will continue to view their future pragmatically, building further partnerships with health economy players.

The continuance of existing co-ops is an attractive option in as much as it maintains consistency and quality.

One of the reasons for the success of GP co-operatives is that they are not for profit. Doctors do not have external shareholders looking over their shoulders and they have to provide a quality service to their fellow members. They are also hugely popular with the public as demonstrated in the many surveys of satisfaction that most GP co-operatives have carried out.

Co-operatives are innovators in a much bigger way than any other part of primary care or indeed secondary providers, as is evidenced by their entrepreneurial activity. One of the benefits of the GP Co-operative structure is that it is flexible and promotes entrepreneurialism in marked contrast to the prevailing NHS culture.

The best Co-operatives in operation show that each individual on duty has a sense of ownership, a high level of duty providing the service, and a sense of interest in how the company is managed on their behalf for services given to their patients.

The structure at the heart of a Co-operative is a good management team, involving clinicians working very much as equals; and that is something that can deliver immense synergy. Should those things become too bureaucratic and too stifled, members will not be allowed to be creative and organisational failure could be the result.

The Co-operative is also an excellent vehicle for a large number of other things that GPs have a mutual interest in that they can't do on their own.

We can expect that GPs are going to be in the forefront of actually designing the new model and the delivery of OOH. GP co-operatives should be the core of this new service provision because they have the expertise and interest to deliver the new GP contract, and they form the basis of mutualism in healthcare provision and a core to build something else on.

## PRIMARY CARE TRUSTS - DOING IT FOR THEMSELVES?

Two views were expressed:

**'It could be argued that there is some natural synergy in a PCT and Co-op working together. Co-ops might benefit from human resources and back office support and through the co-op structure the PCT is able to deliver more than Out of Hours.'**

**'But the one thing that would terrify me about integration within the existing PCT structure is the decision making ethos that I see surrounding them within the NHS. And basically it's, 'Thou shall not be wrong.' And therefore the way to avoid being wrong is not to do anything.'**

***GP Co-operative members***

Primary Care Trusts already commission a number of services from ambulance trusts and mental health trusts. However, PCTs do not have a long established track record of successfully delivering primary care services themselves. Most provision is sourced through arrangements with contractors and also commissioned from other trust providers. It is clear that many of the operational, organisational and clinical governance requirements may benefit from operating at a scale greater than the average PCT.

The Department of Health is also committed to expanding the plurality of provision.

One of the perceived potential weaknesses of providing OOH through PCTs is that the service automatically becomes part and parcel of the NHS and the autonomy of GP co-operatives is lost. GPs and other clinical staff retain a strong desire for the independence to make decisions and the freedom to take calculated risks.

Another fear expressed by co-operatives was that the enormous workload and complexity of the range of agenda that PCTs deal with would mean that innovation might stop. The actual or perceived bureaucracy that goes with the PCT is very different from the direct producer culture of GP co-operatives.

The majority of PCTs and Care Trusts were set up with quite a strong sense that they would deliver Primary Care and social care for their local communities. As they have developed it is becoming clear that delivery can be achieved more effectively via networks of provision.

The majority of primary care services are already provided via a contractual relationship with GPs and other contractors as well as with ambulance and acute trusts. An effective OOH provider with good community links would add significantly to the PCTs ability to procure effective integrated services for its population.

In conclusion, PCTs are not structured in a way to be able to replicate the success drivers of GP Co-operatives. Although it is recognised that for some PCTs, self provision may be the only option in maintaining OOH cover in the short terms, it should nevertheless be treated as an interim stage. A managed clinical network with an effective OOH provider working with other provider in the medium and long term is likely to be a more effective solution.

## STAKEHOLDER MUTUALS

**'It is about time some of us in medical management seriously looked at the skills mix we use and the dependence on general practitioners.'**

**'We talked about creating organisations to serve a purpose, and these are already being created with a multi-disciplinary membership. It has been accepted by our health community that we should in future have governance which includes all the stakeholders.'**

***GP Co-operative member***

Many GPs will continue to do shifts because they like doing it or they need the money. There are a whole variety of reasons why they do it, which are still going to be there in the new system. So the issue for GPs is about creating an alternative OOH model attractive both to PCTs as commissioners and to GPs.

GP co-operatives are about member participation. But many GPs will feel uneasy about setting up something as important as OOH care for half a million people with quite a small membership.

If there is going to be a new delivery model that includes the GPs, that includes all the positive drivers that we have identified, can we ask if there are any other stakeholders whose involvement would be beneficial?

It was felt that at the provider end, nurses and paramedics can provide a high proportion of the care required in OOH. Patient transport services were seen as important and in some areas mental health is very important - in Inner Cities in particular, where it can tie up a doctor's time a great deal. Dentist treatment is a constant irritation for GP OOH and social services and immediate support for the elderly is also very important.

The co-ordinating roles for all these services are best carried out by a group of duty clinicians, not just doctors and a management team, but one that really understands the local health network and the local economy.

A real sense of ownership can also encourage creativity and helps to ensure that members feel obliged to do certain things. A robust structure that allows the directors and personnel to move through over a period of years is required. The directors within that organisation would be the ones who are responsible for running the organisation, but they would not have substantial personal liability.

The role of the PCT commissioner is also considered crucial in any stakeholder mutual because of the need to reflect the full range of interests present in the provision of OOH. Cliff Mills examines this in more detail in his contribution.



## Is There a Role for the Patients and the Public?

**'If I put my patient hat on, what's important to me is that there is good emergency cover. I know that as a patient, doctors play a very important part in that, but I also know that there are other providers who also play an important part. So if we're looking at it from the patients' point of view, you see a very different perspective from that of the GP providing Out of Hours cover.'**

***GP Co-operative member***

We asked this question because when looking at other mutual organisations for example, customers play a significant role. The fact that they do, does not necessarily mean that the same structures must be replicated in OOH, but it is interesting that in the case of NHS Foundation Hospitals, for example, the public have become key stakeholders.

It can be argued that having a substantial and institutional buy-in from the local community, could actually put the organisation in a very strong negotiating position in discussions with the PCT.

In some areas where PCTs might not be performing very well, it was felt that the patient's voice would be very strong and will influence the way the PCT reacts or actually models the new Out of Hours service.

Many GP co-operatives distribute questionnaires and conduct focus groups to get feedback from patients. Some have lay people on their councils. It was felt that as long as this was not an elaborate form of tokenism, it could benefit the organisation because they need people to challenge decision makers, 'otherwise we do steam roller stuff.' (GP Co-operative representative)

If it is accepted that there is a need to get a number of the public involved, how many should be selected and by what method? This is a similar issue to that faced by NHS Foundation Hospitals. It is very difficult to fairly represent a million patients and so there are questions about how to get people meaningfully involved.

This raises issues around the tiers of governance and around the appropriate point of involvement for each of the different stake holders. One of the key areas explored by Cliff Mills in this publication is how affinity can be built up with the patients and the public.

Certainly for any stakeholder mutual structure, there are issues about the involvement that individuals can have and whether it should be in proportion to the importance and extent of the job that they do, and their importance as the paying customer.

## **Care on call – A new vision for Out of Hours primary care**

**Cliff Mills**

### **1 THE NATURE OF THE PROBLEM**

#### **Background**

Since the creation of the NHS, GPs have had the legal responsibility to provide General Medical Services (GMS) – 24 hours a day, 7 days a week.

Over the last few years, there have been some changes. Other services have evolved as well, such as walk-in centres and NHS Direct, but the core part of the service still comprises the medical service provided by GPs.

The GP workload has caused concern, especially the out of hours (OOH) work. In order to discharge their responsibility for this service, the majority of GPs have pursued a traditional self-help remedy of setting up a co-operative of GPs. In this way, they have met their need to discharge their legal requirements to provide OOH cover, but in a more efficient and effective way.

Some of these arrangements were little more than small extended rotas. Many of them incorporated as co-ops, which have become respected providers of primary care services in their own right, of substantial size in terms of GP numbers and population coverage. Notwithstanding their size, they have retained a degree of flexibility, which has enabled them to expand and vary their service quickly to meet changing demands. Such flexibility or elasticity is uncharacteristic in an NHS generally characterised by centrally driven control. GP co-operatives have provided a good solution, and brought some real benefits.

However, with the intended introduction of the new GMS (nGMS) GP Contract, which removes the GPs' twenty-four hour responsibility, the glue which binds GPs together in co-operatives has been removed.

#### **The problem**

The legal responsibility to maintain OOH cover has been transferred to PCTs – it is now the PCTs' responsibility which could become a problem for them.

Or rather, it is our problem.

It is our problem, because OOH services are needed by us, and members of our communities. And it is our problem because we are paying for it through central taxation. The simple step of giving the legal responsibility to PCTs does not make the problem go away, or provide a solution. What are the PCTs to do? How are they to provide or procure services? What experience do they have of planning the procurement of such services? More importantly, who will provide those services? In short, what is the vision for the future?

#### **What next?**

One thing is certain: the support of GPs is needed because it is important for them to play a significant role. But it is also important that the delivery of OOH services is planned in conjunction with a number of other bodies. In the Carson report<sup>1</sup> into OOH, wider integration was promulgated as the only sustainable way

<sup>1</sup> *Raising Standards for Patients: New Partnerships in Out of Hours Care – October 2000*



forward. GP co-operatives work well because they have built up relationships with social services, mental health trusts, ambulance services, A and E units, and community nurses (to mention some of them). They have established such relationships because of the support it gives them – enabling them to make better use of their time as GPs, and leaving other specialists to deal with problems which they are more suitably equipped to deal with.

Many GP co-operatives have built up a significant body of employees to support the delivery of the OOH services. These include receptionists, drivers, managers, and nurses. The experience and training that they have received is a valuable asset. These people all have an important part to play in the future provision of OOH services; but they are currently employed by organisations that are likely to cease trading. So what is to happen next?

There are four basic possibilities: (1) carry on with the current arrangements, with GP co-operatives providing OOH cover; (2) the introduction of a significantly increased level of private provision; (3) the PCTs take on the provider role themselves; and (4) new vehicles are established to deliver OOH services.

The first option is not viable, because the deal has been done on the new GP contract, and the Government is committed to giving GPs the freedom to opt out. Save in a very small number of cases, GP co-operatives as currently configured are unlikely to continue to exist and be available to provide the cover. The second option is possible but perhaps not everywhere. That leaves two options.

Some PCTs are already contemplating the option of providing services themselves. Some are working with existing GP co-ops, looking to transfer staff into the PCT to ensure that they will have at least some actual experience and capability. However the signals emerging from the Department of Health are that PCT provision is not the preferred route. Bolting on to a newly created body (PCTs only effectively came into existence in 2002) the responsibility for delivery of such a major service will certainly create a substantial new management responsibility.

The previous section has outlined the benefits of effective innovatory providers and the need to have effective governance and management structures capable of established joint operations with other parts of the EC network.

It is possible to envisage the fourth option – the evolution of a new form of OOH primary care provider, in which GPs play a key role, and other agencies are tied into the structure to support the provision of a broad range of services. But what would such a supplier look like and who will take it forward?

Any model for such a provider needs to be adaptable, in order to suit the varying needs of our diverse communities. The ages, social and ethnic profiles of our communities, as well as geographical differences and rural/urban contrasts, have a big impact on the services needed, and the best means of delivery.

Lawyers can set up the legal structures that their clients ask them to establish. They can advise about the usual options. But in truth that is of little help, because a legal structure does not answer any of the questions – it is no more than a means to an end. The question we are facing is: what is the end we are trying to achieve? What is the vision for the future?

## 2 THE WIDER CONTEXT

### **Blinkered thinking**

One of the problems that afflicts us in facing such fundamental questions in this country, whether in the context of the NHS or in our other key public services, is our narrow view about the options which are available. We are quick to criticise state-owned entities, and to point out the weaknesses of government owned and controlled services. If and when it is decided that state-ownership does not work, we then lurch in the opposite direction and opt for privatisation.

That may be a simplistic description of our national mindset, but I think it is fair to say that we struggle to envisage more than two possibilities – state or private ownership. If one has failed, then it is assumed that the other must be the answer (or at least better).

The debate about ownership is crucial, and although it is not the first question that springs to mind in the context of OOH provision, it is one of the questions which has to be answered in determining the vision for the future. It has to be answered before you can decide what legal structures to set up, and how they are to be governed.

Ownership (and we will come back to what we mean by that) is important because ownership brings with it some degree of control. We own things (or want to own them) in order to derive from them the benefits which ownership brings.

Who should have the ownership of our public services? We may decide that private ownership of a service is inappropriate, because allowing shareholders to control the agenda has an unacceptable impact on the interests of customers, or employees, or future generations. We may decide that state ownership is inappropriate, for example, because other considerations (eg political ones) detract from the delivery of the service.

Are there any other options?

### **Accountability**

Ownership gives control, as already stated, and with it comes the ability to drive the success of an organisation. In a recent publication from the Institute of Public Policy Research entitled “From Welfare to Wellbeing” (the future of social care), Anne Davies commented as follows in writing about public service accountability:

*In a democracy, it is axiomatic that a public service such as social care, which is authorised in statute and publicly funded, must be accountable. This is in order to assess competence, to ensure financial probity, to safeguard administrative propriety and to guarantee responsiveness (on the grounds that there is no point in delivering a service no-one either needs or wants).*

I agree entirely with this – accountability is needed to enable owners to take action, and to use their ownership rights to make changes.

As the legal “owner” of the NHS, the State has the ability to take appropriate actions. Unfortunately, experience has taught us that for a variety of reasons, it is inefficient at doing so.

The true owners of the NHS are the people who pay for it. The State only “owns” or holds the NHS on behalf of the people of this country. On that analysis, the managers of the NHS are accountable via the Secretary



of State to Parliament, which is itself accountable to the electorate. This is a hopelessly remote and unresponsive form of accountability – no wonder many people consider it inefficient.

What is needed is a change of ownership structure, which makes people – communities – the owners, and takes the State out of ownership. By doing this, by empowering local communities and aligning the authority of ownership with the needs of users, a much stronger model is created which contains its own drivers for success. A range of options can be developed, offering different levels of participation by GPs, employees, patients and public, to facilitate the form of local ownership appropriate to different communities, and to meet varying needs.

If people and the communities to which they belong are the owners of the NHS, it will become accountable to them. This is appropriate not only because we are the users, and we want a patient-focused service, but also because as citizens we are paying for this service through general taxation.

People should be the direct owners of the NHS, by giving ownership of its constituent parts to people locally. It will not be a form of ownership that gives them individually the right to sell something and realise its value, but will instead be a form of ownership that gives people a collective ability to shape and control the services provided in their communities.

What does community ownership look like, and what form would it take for an OOH provider?

## **Legal structure**

Basically there are two legal regimes available under which bodies can be incorporated – company law and industrial and provident society law. Both of these regimes provide a mechanism for forming (incorporating) a legal structure (corporation) with limited liability, and its own legal personality.

The company model is the best known and understood, and is therefore the approach most frequently adopted. It has been so successful as a vehicle for ownership because the underlying purpose of the vehicle (generating wealth) is aligned with ownership, and company law as applied by the courts has consistently stuck to the principal that the ultimate duty of directors is to act in the interests of the company and its shareholders.

There are some other forms of company apart from the more familiar company limited by shares, such as the company limited by guarantee (CLG). This form works particularly well in a charitable context where those responsible for the charity (trustee directors) are able to ensure that future appointments are in the same mould. It also works well when seeking to serve the interests of a narrow group of people with a common aim – eg a worker co-operative. The GP co-operatives use this form and it has worked for them.

However the CLG is a comparatively weak form of ownership. Save in situations like GP co-operatives where the members are meeting their own interests and its success or failure is entirely within the hands of its members, the CLG commonly relies upon external or artificial means of accountability to drive the achievement of success. It does not contain within it the mechanism for driving success.

There is a new form of company (the community interest company) being introduced in the Companies (Audit, Investigations and Community Enterprise) Bill. This is intended to provide another type of legal structure with particular attributes to make it appropriate for social enterprises which would otherwise use the CLG form. It may be something to consider in due course, but at this stage it has not been enacted.

## **Strong legal form**

The strong legal forms contain within them the drivers of success. They harness the interest of a particular group or groups of people and use that interest as a tool within the governance structure as a driver for success.

A conventional company is owned by its members or shareholders, and managed by its directors. The directors have a duty to maximise the financial return to shareholders, and are accountable to the shareholders for that. If the company is not doing well enough, the shareholders can change the managers/directors. The structure is therefore designed to achieve the underlying purpose of providing rewards for investor shareholders, who use their ownership powers to drive its success. As already observed, it is a very successful vehicle because the underlying purpose is aligned with ownership.

An industrial and provident society is fundamentally different, but it is also a strong legal form. It is only capable of registration with its registering body (the Financial Services Authority) if it has a social purpose – either being committed to trading for the benefit of the community or as a bona fide co-operative. Whilst it needs to be *profitable* to survive (avoiding insolvency), making a profit to distribute to investors is not its reason for being. It is there in order to provide a service to people who wish to receive that service.

The distinctively different nature and purpose of companies and societies go back to the origins of these two different corporate forms.

Companies were the lifeblood of the industrial revolution, being vehicles designed to encourage investment, generate wealth and economic growth. Societies emerged at the same time, but for a different purpose. Many people found that they were not benefiting from this increased investment, new wealth and economic growth. On the contrary, many suffered from the working conditions that were imposed, were unable to buy basic provisions free from contamination and at a fair price, were unable to protect themselves against misfortune, or unable to borrow money to provide their own housing.

The traditional mutuals were a self-help mechanism by people in communities – providing services for themselves which were not otherwise available. They were based on people getting together to meet their common needs.

## **Modern societies**

Many large (and small) mutual organisations continue to trade successfully today, providing a wide range of services to many communities. Indeed in the last five years or so, there has been a resurgence of interest in this form of ownership, and a growing appreciation of the benefits which it can contribute.

Modern versions of mutuality have emerged, where membership is open to customers, local residents and employees, and a wider group of “stakeholders” or key parties has representation at strategic level. In these new mutual organisations, it is common to see a board comprising elected representatives of customers, local residents and employees, together with appointed representatives of key parties such as public bodies, business interests, and voluntary organisations. Their role is to play a part in the forward or strategic planning, and to have responsibility for hiring and firing a professional management team which itself is responsible for the day-to-day management and delivery of the strategic plan.

Membership of such an organisation gives people the right to participate in the functioning of the society. They can attend members meetings, at which they have the rights to speak and vote on any resolution. They can vote in elections of board members, and seek nomination themselves to serve within the democratic or other participatory structures in the society. These are important rights, which give people ownership of the organisation, and a legitimate and real say in the provision of a service to them or the community in which they live.



Examples of such “modern mutual” structures include foundation hospitals; leisure trusts (community based organisations to which local authorities have transferred their leisure facilities); the new generation of social housing constitution (the Community Housing Mutual); and football supporters trusts.

## **3 AN ACHIEVABLE VISION**

### **A new provider**

Community ownership, structured on modern mutual lines, is a serious option to consider for OOH services.

We need a strong form of ownership, which contains its own drivers for success. We need an approach which will result in local ownership, and will provide a platform for a wide variety of key organisations to play a part. We need a structure which is sustainable, and which can evolve to meet changing needs and changing views about the best means of delivery. We need an organisation with a clear governance structure, which GPs are confident will be an effective delivery vehicle, and which allows professional managers to do their job, whilst remaining accountable to local people.

As already observed, most of the current GP co-operatives will cease to exist in their current form. However these co-ops could provide a stepping-stone to a new or revised structure, in which GPs share their ownership and control with a wider group of participants.

There are also some key criteria from the PCT's point of view. A PCT needs to be able to procure GP services for OOH cover in an efficient way. It needs to be able to do this in a way which satisfies its concerns about clinical governance and broader issues of corporate governance. And fundamentally a PCT needs to deliver a procurement strategy which obtains best value and delivers the service which the community needs.

Work is now underway with NAGPC, the Department of Health's OOH Implementation Team, and PCT representatives to develop a template constitution for OOH provision. Options are needed which provide a range of different levels of participation by GPs, employees and others. Some may wish to adopt a model similar to the current GP co-operatives but with wider participation from other parties. Others may be willing to move to more significant local community participation.

We are talking about a new incorporated legal entity, which will play a key role in the delivery of OOH primary care services. The key features of this model are as follows.

### **The Core Business**

The core business of the new entity will be the delivery of the traditional out of hours GP services. As is already happening in a significant number of areas, the development and training of first contact clinicians and nurses, and the use of triage procedures is resulting in a wider group of clinicians sharing the work-load. However, an extensive programme of recruitment and training will be needed in order to provide a sufficient resource to make a significant impact on the work-load for GPs. For the short to medium term, GPs will be playing a very substantial role in the delivery of OOH services.

In relation to the services provided by A and E departments, ambulance, mental health, social services, and other providers, there are clearly some alternative approaches available. These organisations could enter into service level agreements with the new provider, enabling the new provider to offer to the PCT a comprehensive range of services. Alternatively, the PCT could procure services from a range of providers, and oversee the delivery of those services and the fulfilment of contractual obligations.

The geographical territory to be covered by a new provider will in practice be governed by the way PCTs choose to work together. Strategic Health Authorities have an important role in ensuring appropriate co-operation between PCTs, and a development of sustainable high quality services across their region. The new provider will itself have to determine the optimum size for its territory, based upon a financial assessment. This may result in larger areas than those currently served by some GP co-operatives.

## **Professional management**

Day to day management of the business of the new provider needs to be in the hands of an executive management board.

The management of the delivery of OOH primary care services requires dedicated and appropriately skilled management. The experience of the GP co-operatives shows that the co-ordination skills needed to deliver services with a variety of providers can be effective if located on the provider side. Whether PCTs in their commissioning role have the desire and capacity to take on such a role themselves is a matter for local decision, based on local needs and local resources.

The management skills required at executive level in the new provider will include administration, logistics, clinical, finance, and HR. Representation at executive level by the key disciplines is likely to be appropriate, to reflect the services being delivered.

## **Strategic or forward planning**

Strategic planning needs to take place amongst a wider group of parties, but in consultation with the executive management board. This wider group is given different titles by different organisations. In the new foundation hospitals, the group is called the board of governors. Sometimes it is referred to as a council, to distinguish it from an executive board, and for the sake of clarity I will use that term here.

As well as having a role in relation to strategic planning, the council also has some responsibility for the appointment and removal of members of the executive management board.

It is at council level that the interests of all of the key parties needs to be reflected. Substantial representation is therefore needed here by GPs and the PCTs. It seems likely to be appropriate for every commissioning PCT to have at least one representative.

The other providers who are engaged in the provision of services alongside or as part of OOH primary care could also be represented on the council. In particular this will include A and E departments, and ambulance services whose level of involvement and participation in the delivery of services is extensive. Other services such as social services (including community nurses), and mental health, might be usefully represented, as may NHS Direct, pharmacy, palliative care, and dentistry.

There are two other key groups of people for whom some form of representation at strategic planning level is of real importance.

The first group is employees of the new provider. A provider of primary care services to upwards of 500,000 patients is likely to employ 50 or more people, and over time could employ substantially more, depending upon the approach of the other key bodies. There is no doubt that mutual or community ownership puts a high store on the involvement of staff in its democratic structures and governance. Some representation of employees is therefore appropriate on the council at the outset, and the level of such representation, and possibly the need for representation of different categories of employees may need to be considered in due course.



The second group, and arguably the most important of all, is patients and public. Community or mutual ownership has no real meaning unless representatives of patients and the public are involved at the strategic planning level. More difficult are the questions about how such representation is to be achieved, and what level of representation is appropriate.

The immediate reaction of many people to the idea of public involvement at this level is one of concern or even fear. How can ordinary members of the public make an effective contribution? Will they not be seeking to disrupt the process? What happens if special interest groups infiltrate the process?

Whilst these are questions that have to be treated seriously, there are many obvious ways in which they can be addressed, and the perceived risks minimised. Working with community bodies to identify talented people, encouraging committed people to put their names forward for representation, providing training about the responsibilities of holding positions, a clear constitution setting out in plain English the extent of the role of the body engaged in the strategic planning, following best practice in the management of meetings – all of these are regularly practised by organisations who rely on lay input.

In the very near future, Patient and Public Involvement Forums will exist for every PCT in England. These forums could provide a basis for patient and public involvement with new providers of OOH primary care services. One option would be for the forums to nominate one or more of their members to participate at the strategic planning level and to serve on the council of the new provider.

However, this may not be an ideal approach, as the Patients' Forum is linked to the commissioner, rather than the provider. Another option is to provide that representation should come from patients and public in the region covered by the new provider – in other words patients and public directly choose their representatives who serve on the council.

Patient and public involvement – whether it happens at all, and if so whether it is by direct representation or through the Patients Forums – is a matter which has to be determined locally. Options need to be available to suit varying opinions about this, as well as providing the mechanism to change over time.

## **Membership**

Every corporate entity has members. As already described, the members of a company are its shareholders; the members of the traditional mutual organisations often comprise customers and employees. The members of the new foundation trusts are public, patients and staff (both directly employed and contracted).

The role of members in a corporate entity is, in practice limited, and it is defined in the constitution. It normally comprises:

- the right to receive information about the organisation's performance
- the right to take part in the election of some or all of the board members
- the right to attend and speak at an annual and other occasional or special members meetings
- the right to vote on any resolution put to the members. Usually there are narrow limits on the issues that can be put to the members, namely changes to the constitution, merger with another entity, and the decision whether or not to wind up the organisation.

Whilst these members' rights are limited, they are nevertheless highly significant if combined with open membership. The reason is that members are ultimately the owners of an organisation, and the ability to prevent it being captured by others (including commercial enterprises, the state as well as political or special interest groups), lies in the hands of members. It is these rights which give members a sense of the ownership of the body.

Experience shows that membership-based bodies carry significant weight and credibility, both within communities and in dealing with external bodies. It is more difficult to challenge the aspirations of an organisation based on wide membership, which has used that membership to form its aspirations.

Membership also provides a powerful base for reaching out into local communities. An increasing element of the health agenda now involves educating and informing people about health and healthy living issues. It is right to have ambitious targets for reducing the costs of healthcare by reducing the likelihood of disease, injury or disability, minimising the need for medical intervention, and securing the most effective recovery. Achieving a better understanding of the importance of diet, exercise and other lifestyle issues, and changing attitudes about responsibility for one's own health are important long term aims, and an engaged membership can clearly play a significant part in that.

Who will be the members of the new providers? It would certainly seem to be appropriate that GPs should be members (this would provide a mechanism for them to elect GP representatives on the council) and also that employees should be members (similarly providing a mechanism for electing their representatives).

Patient and public membership needs to be carefully considered. Such membership can bring the benefits just described. It is also a key part of the governance mechanism in driving the success of the organisation – it provides the basis for the ultimate accountability to patients. However it has a financial cost, which must be taken into account. It must also be borne in mind that patients' forums will be in existence, and it may seem confusing to members of the public if they can become members of two bodies in relation to primary care.

As already mentioned, patient and public involvement is a matter which has to be determined to suit local needs. It may be something to introduce at a later stage.

### **Legal structure**

Finally, what sort of legal structure will be most appropriate for the new provider?

If the new provider is to have the trappings of community ownership, and draw on some of the learning and experience of new mutual organisations, then for the reasons set out above, the most appropriate structure is likely to be a society. In practice, it may be sensible to provide a choice between a company and a society. Any company model at this stage will have to be a company limited by guarantee, since the community interest company is not yet in existence and will not be within the timescale needed to establish new providers. In due course, the community interest company may provide an attractive alternative.

### **Procurement issues**

Creating a new entity along the lines described above is only likely to happen if the organisation has a good chance of a relatively stable future. It is not likely to be a sustainable approach if there is an expectation of re-tendering after a short period of time.

However, the need remains for PCTs to ensure that they are achieving best value or value for money, and that the provider is meeting the needs and expectations of the patient community.

The traditional mechanism for achieving this is through the contractual relationship between PCT and provider. This will continue to apply, but is limited by the terms of the contract, and those issues which could



be foreseen at the time the contract is written. The approach we are describing, through providing PCTs with membership of the council of the new provider, is a more dynamic approach, delivering a more engaged and effective mechanism for achieving the PCT's objectives.

For this to work, the PCTs must be satisfied that their role within the structure of the provider vehicle enables them to have an appropriate level of influence in strategic planning, and access to relevant information on performance for them to discharge a valid monitoring role, but without creating a conflict of interest. As members of the council, perhaps with power in appointing and removing executives, and through such tools as bench-marking, they could put themselves in a stronger position to work with other key parties to ensure that the provider is meeting relevant targets.

Significant participation by a local community will also be an important factor for PCTs. If a community really takes ownership of such a provider, issues of performance and efficiency should not result in the PCT automatically and immediately seeking a new provider, but rather in the PCT working with the local community at council level within the new provider to replace management or to buy in the necessary support to deliver proper services. This is the essence of a strategic partnership understood in the commercial sector and encouraged by Government in other areas of public service delivery.

## **Transition issues**

The establishment or incorporation of legal entities for new providers can proceed relatively easily. However it would be premature to proceed with this in isolation from the PCTs and their Strategic Health Authority. The PCTs will be the procurers of services, and it is very important that they are closely involved in any dialogue about the establishment of a new provider, and that their approach to procurement is known to be compatible. The first stage of the process must therefore be that the relevant PCTs get together, and identify the services they need. This has to be based upon a suitable geographical region, for which services can be provided on an economical and manageable basis.

The PCTs then need to decide upon their procurement strategy – whether it is to be based upon buying services from a multiplicity of individual providers, or working with one major supplier. If the latter course is preferred, they can then consider whether they have any preferences for particular types of provider, their own level of participation, and the participation of others. This may lead to supporting the creation of a new vehicle; it may lead to adapting an existing GP co-op which wishes to evolve to meet the changing environment; it may lead to working with another existing provider which satisfies the PCTs through some form of tendering process that it can provide the most effective solution.

It will be important to consider the position of the current GP co-operatives, their liability for redundancies should they plan to cease trading, and the position of their directors in making any decisions about the future. If an appropriate new vehicle is provided, a transfer of staff under TUPE arrangements may be possible. It may also be of benefit to the new provider (and the commissioning PCTs) to purchase assets, know-how and systems from the GP co-operatives. These are certainly significant factors for directors making decisions about the future of their existing co-op.

In practice, the priority now is for a dialogue between all of the key participants to proceed as quickly as possible, in all parts of the country, as encouraged by the recent (October 2003) publication by the Department of Health – “Implementing the nGMS Contract: Out-of-Hours”.

It is hoped that this publication may stimulate discussion, and help some people to develop a vision for the provision of OOH services in their area. Specific practical assistance is now being prepared, which will help to provide a route-map through a period of transition.

## **Conclusions**

The current difficulties faced in providing OOH primary care services create a real opportunity to continue the development of a new approach in the delivery of healthcare. GP co-operatives have demonstrated the advantages of flexibility to meet local and changing needs. They have shown the enduring value of traditional self-help structures.

The introduction of foundation hospitals has been a huge step forward, making the first momentous break away from state-ownership, and opting for community ownership based on modern principals of mutuality.

There is the chance now to do the same in a key part of the provision of primary care services, and to retain the best of what has been learned from GP co-operatives.



## **Peter Hunt**

Peter is the Director of Mutuo. Since 1994, he has worked with the co-operative sector and in 2001, he established Mutuo as the first cross mutual sector project to promote mutuality to opinion formers and decision makers.

Peter is particularly interested in mutuality and has sought to engage the co-operative movement in work to raise the profile of the co-operative and mutual sector.

He was one of the founders of *Supporters Direct*, the football supporters trusts initiative, and has been instrumental in the Parliamentary agenda to modernise Industrial and Provident Society law.

He has co-authored, 'Making Healthcare Mutual' and 'Back Home – Returning Football Clubs to their communities.' 2002 & 2003 respectively, both published by *Mutuo*.

## **Cliff Mills**

Cliff is a Partner at Cobbetts, solicitors in Manchester, Leeds and Birmingham, and he is a leading expert in corporate governance and the law of mutual and co-operative organisations.

Since the mid-1990s, he has advised the leading co-operative retail societies on constitutional and democratic issues, and since June 2001 Cobbetts have been legal adviser to Co-operatives UK.

He was adviser (with Ian Snaith) to Gareth Thomas MP on his private members bill, enacted as the Industrial and Provident Societies Act 2002.

Cliff is at the forefront of designing new corporate constitutions for the ownership of public or community assets. Projects include a constitution for a water utility company, the Community Housing Mutual constitution for the National Assembly for Wales and a childcare model for Mutuo and Social Enterprise London.

He is a member of the NHS Foundation Trusts External Reference Group, and with one of his partners, was responsible for preparing the constitutions of ten of the first wave of twenty-five NHS trust applying to become foundation hospitals.

Published by Mutuo  
77 Weston Street  
London SE1

T: 020 7367 4177  
F: 020 7407 4476  
[www.mutuo.co.uk](http://www.mutuo.co.uk)