

DEVELOPING COMMUNITY OWNERSHIP MODELS IN PRIMARY CARE

Dr. David Carson

Content

- Diversity of provision in the NHS
- Community ownership models and public services
- Community ownership models for primary care
- Community, health improvement and individuals and communities

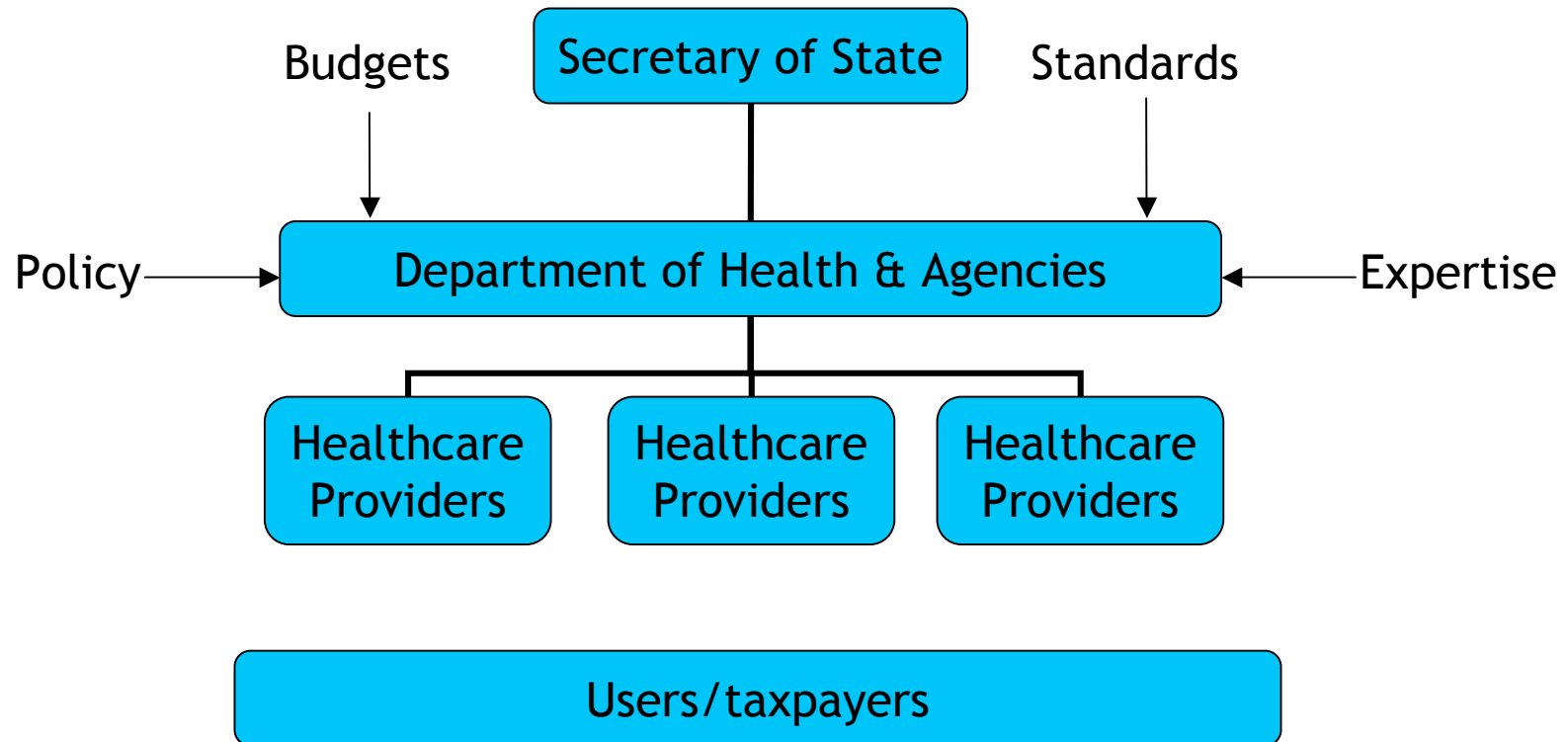


The Public Policy Context

- Fast moving agenda
- Cross party consensus
- Public service reform themes:
 - Citizenship
 - Standards
 - Value for money
 - Popularity of services



How the State NHS Works



Health Service providers fall into 4 broad categories

- Traditional NHS
 - NHS Trusts, PCTs, SHAs
- Independent sector
 - ISTC
 - Private hospitals
- Mutual sector
 - NHS Foundation Trusts
 - OOH, Co-ops
- Potential for mix and match partnerships



There are 3 principle options for future healthcare provision

1. State ownership and control of provider
 - PCT
 - NHS trust
2. Privately owned and controlled provider
 - GP partnership
 - Private company
3. Mutual or community owned entity



State and private ownership have their downsides

- State ownership and control (eg PCT provision)
 - Is a big risk for the state to hold
 - Is susceptible to the State's priorities
 - Counter to current trends
- Private ownership based on
 - External investment (ie profit driven)
 - Is often unpopular politically and organisationally
 - May be undeliverable



Mutual organisations promote local involvement ...

- Community purpose corporation
- Ownership
 - Vested in its members and open
- Democratic
 - One member one vote
- Governed
 - Stakeholder representation

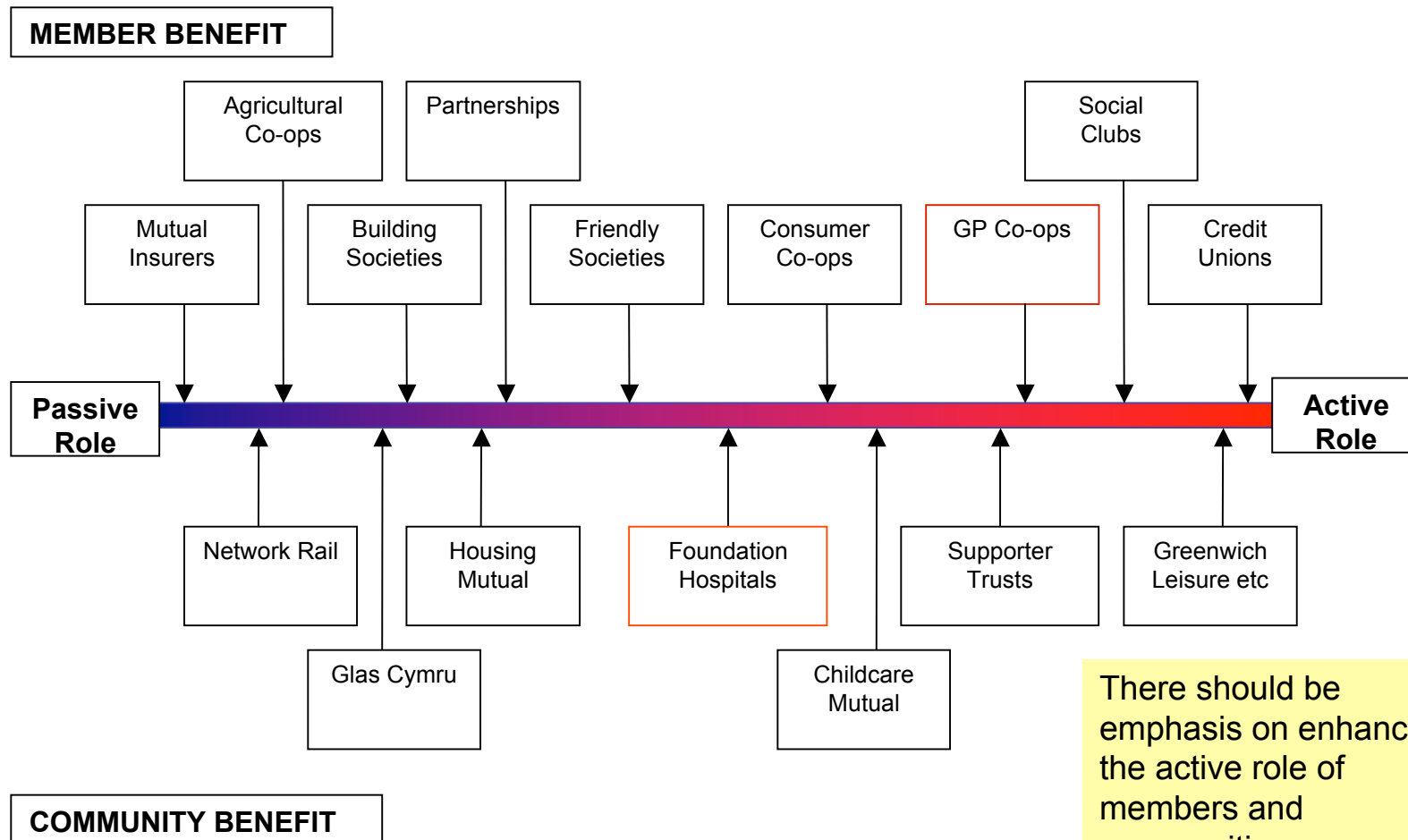


... And exist in healthcare today

- Friendly societies
- Not for profit providers
- 1948 – 3118 independent hospitals
- Today:
 - GP co-ops
 - Care co-ops



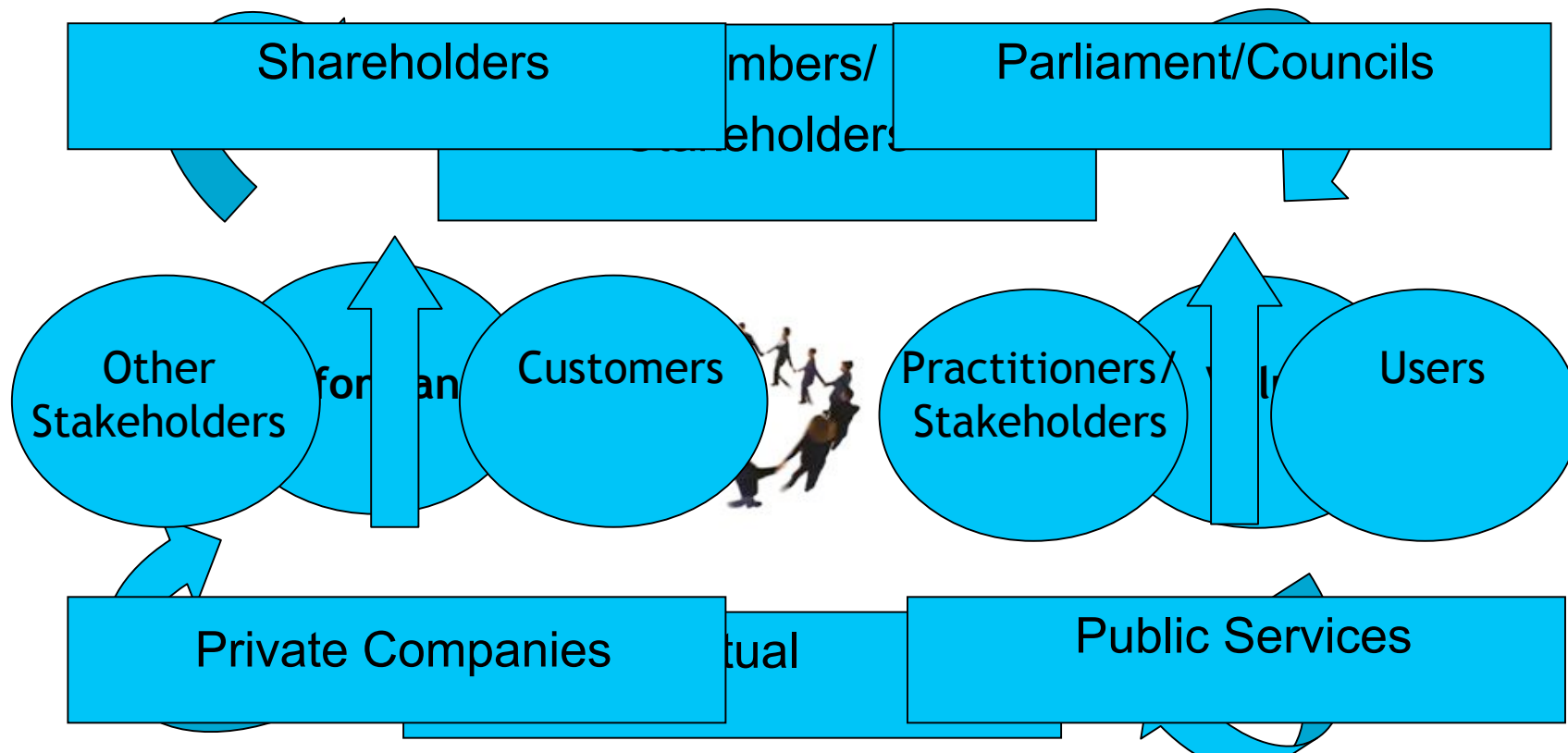
Healthcare mutual organisations have an active role for members and the community



There should be emphasis on enhancing the active role of members and communities



Mutuals redress the balance between beneficiaries and providers



Public and private organisations consider the beneficiaries but report to other controlling authorities

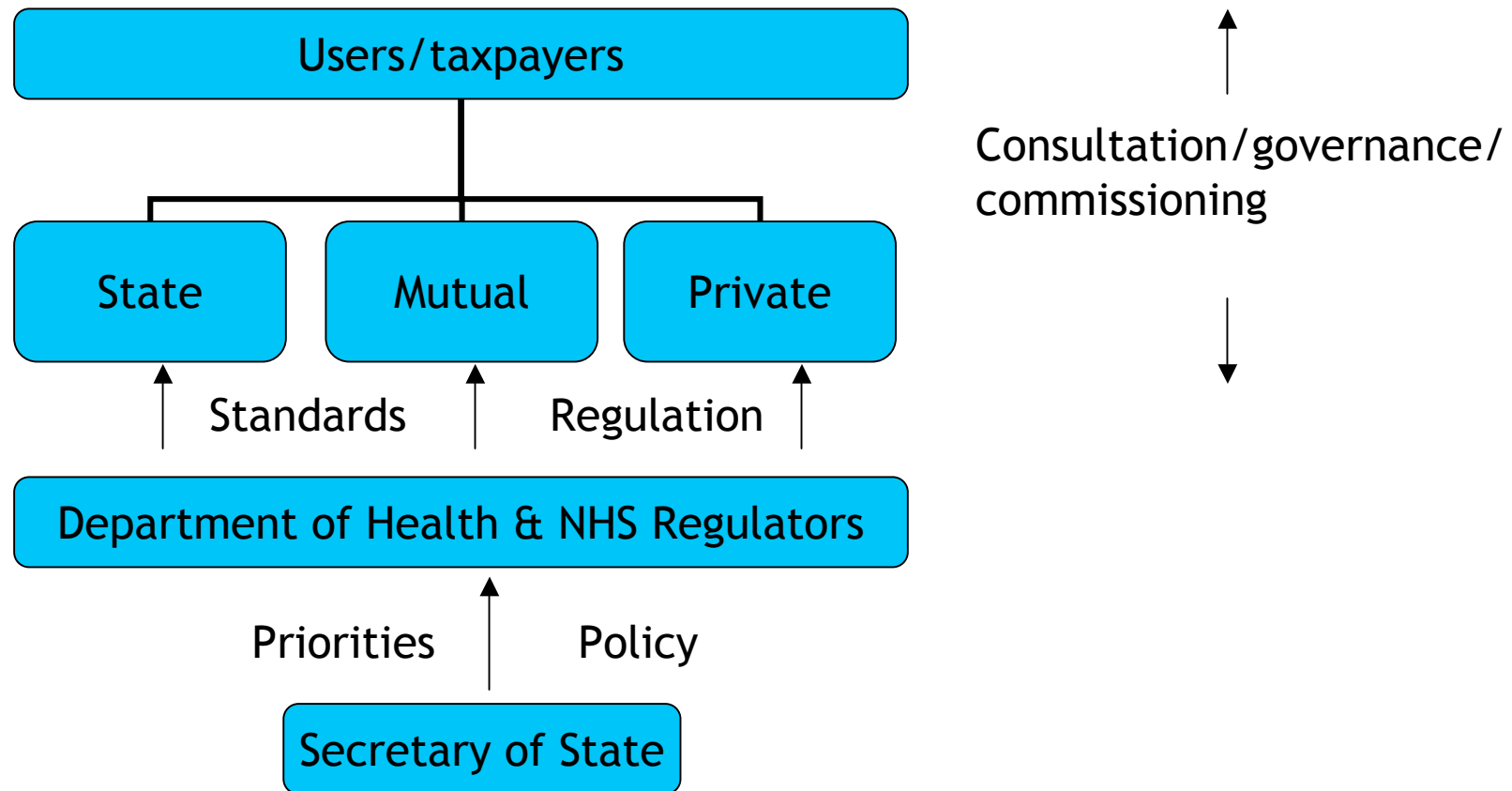


Healthcare mutuals provide 4 direct benefits

- You (clinician or patient) get choices
 - Consumer or professionally driven
 - Or a mix
- Control
 - Strong corporate governance
 - Empower the right people to the right level
- Maintain the NHS ethos
 - An extension/modern interpretation of the NHS
 - It is less threatening – value is re-circulated
- Remain accountable
 - Membership drives accountability - demonstrably



The benefits could extend to the entire health service ...



... With Governmental action

Government must:

- State its preference clearly for a diverse sector of providers
- Understand the importance of smart commissioning as the key to financial accountability
- Identify how to encourage the growth of new providers – not wait for it to happen because it will not
- Provide business support to NHS professionals who wish to establish new mutual providers



Where to start: what potential mutual organisations should do first

- Define purpose and remit of organisation
- Define membership
- Be clear about the motivation
 - Is it to develop a positive, innovative and accountable provider?
 - Or is it to maintain the status quo – same old process and NHS terms and conditions?
- Decide what services will be provided
 - How much
 - How many
 - What value
- Build a proper business case
- Gain support of commissioners (and contracts), potential members and partners
- Establish/incorporate recruit and start



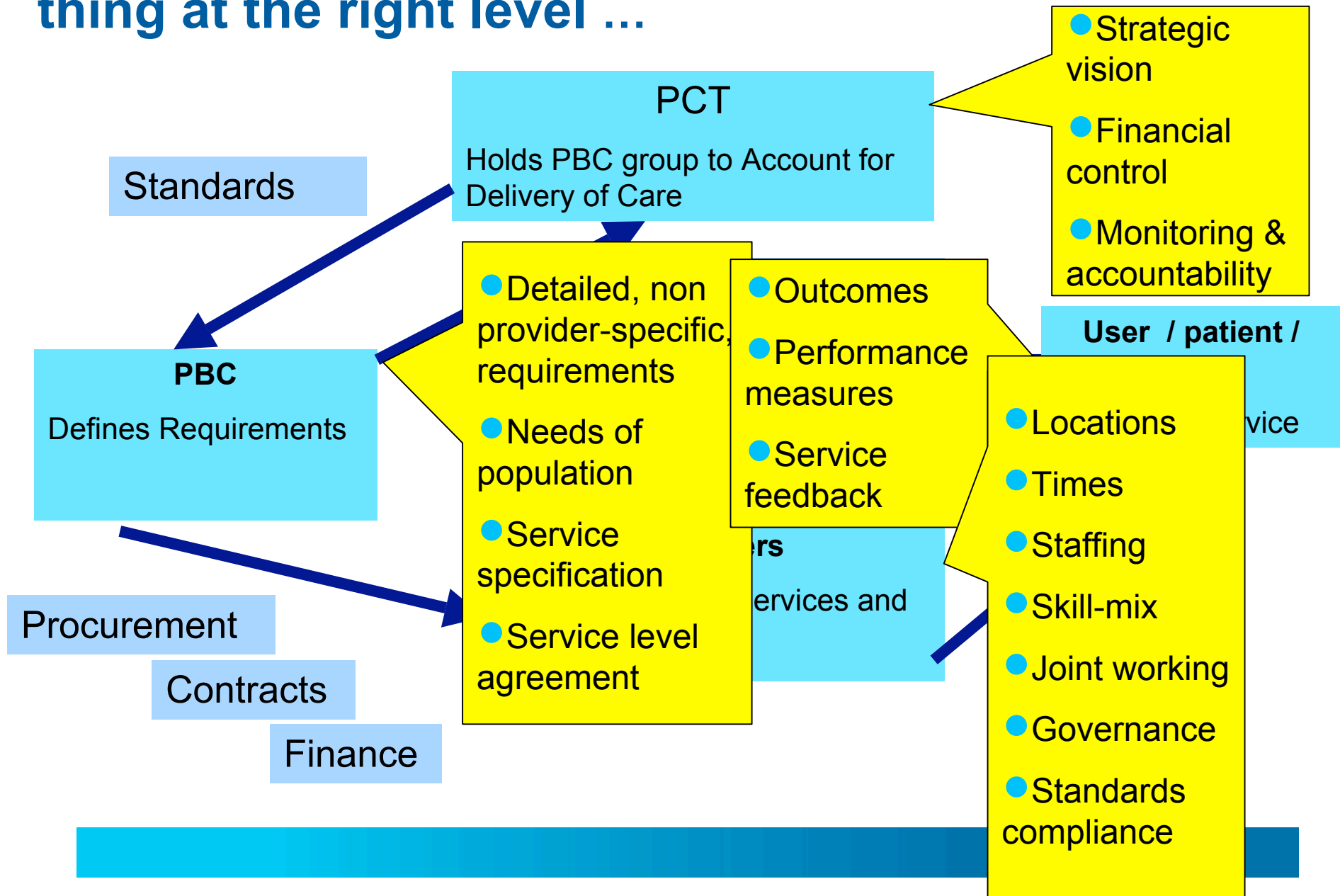
Practice based Commissioning and mutuality

Practice based commissioning and community ownership

- PBC requires GPs to reach population view as well as individual view of health provision
- Secondary to primary care shift will drive new providers in primary care
- Commissioning and provision need clear separation even if same staff are involved
- Mutual provision, influenced by the populous, could be very powerful and a positive force for change

● The Healthcare Foundation is already working with SHAs, groups of PCTs, individual PCTs and GP collectives to develop PbC organisations

...the difficult thing is to do the right thing at the right level ...



... because partners want different things ...

1 What patient wants ...

- To be seen when and where they want
- Get the best possible treatment
- To be treated as a customer not a patient

- Better care
- More balanced working life
- Some savings to reinvest

2 What GP wants ...



- Meeting targets and priorities
- Diversity within an agreed framework
- Good governance – accountability and transparency
- Choice of high quality providers

3 What PCT wants ...



... as do policy makers

4 shift from 2° to 1° care

- Care closer to home
- Focus on who does what best in care pathway
- Best use of clinical skills



5 financial savings

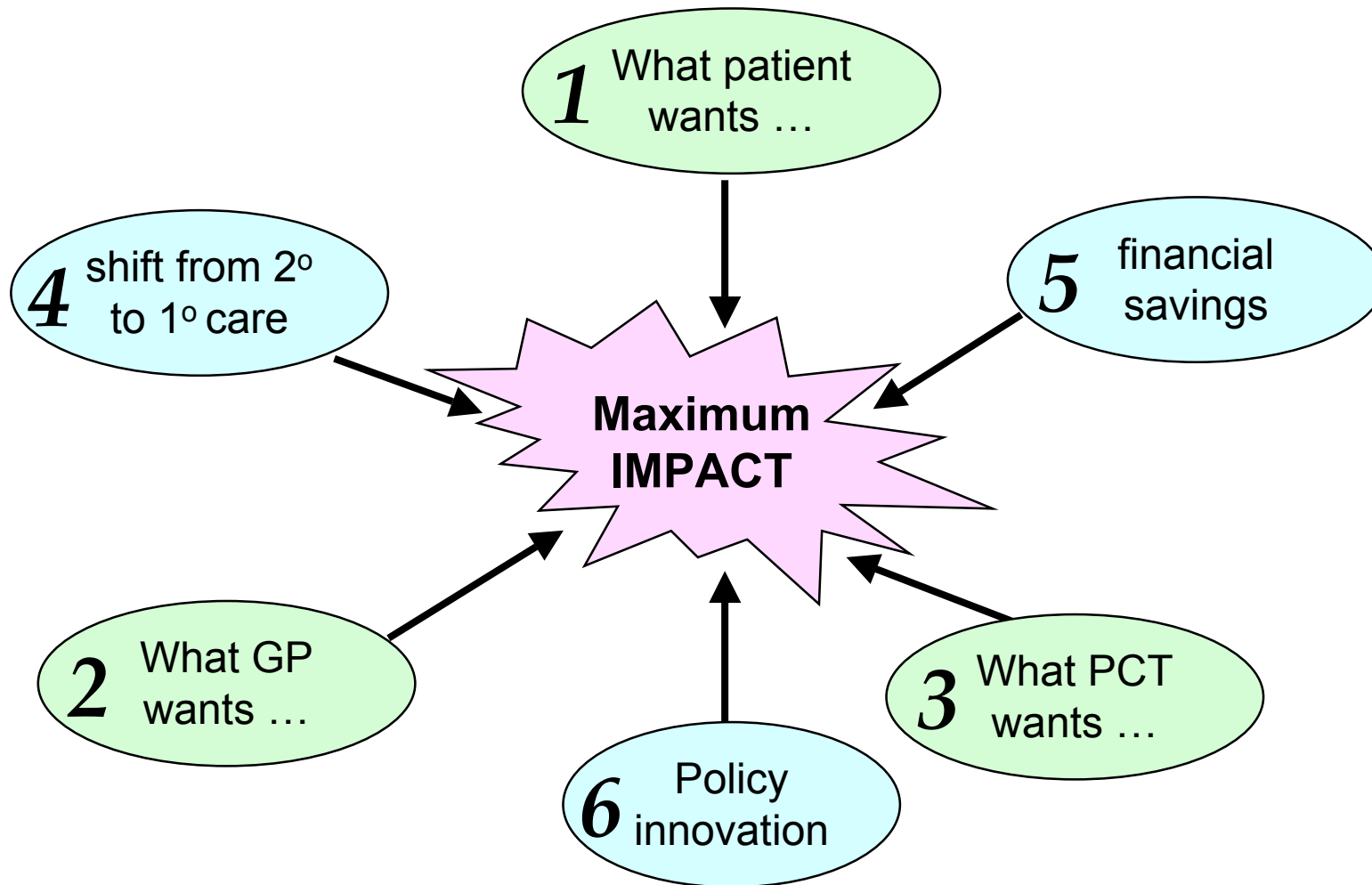
- Highest ever growth yet biggest ever deficits
- Growth from treasury soon to run out

- NHS reconfiguration
- White paper on out of hospital care
- modernisation

6 policy innovation

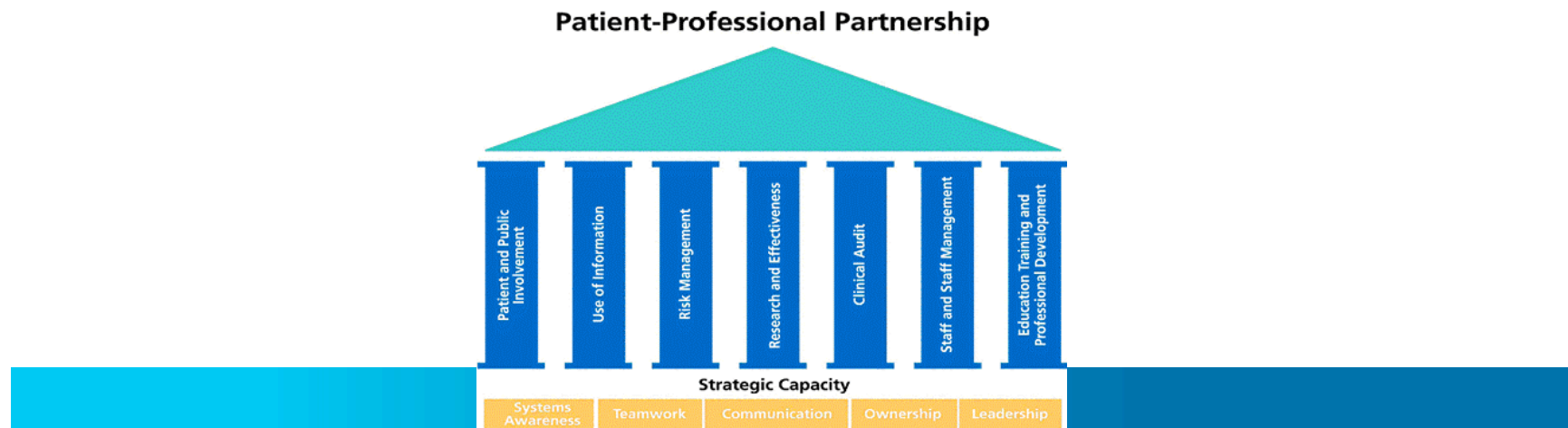


Bringing the needs and desires together will provide high impact commissioning



Mutual governance of providers in the PbC environment has a positive affect on all stakeholders

- Membership allows positive incentives
- Shared sense of ownership drives quality
- Incentives and peer pressure drive quality for all staff
- Clinical staff motivations become more coherent
 - Community staff and GPs in same organisation (for the first time)
- User membership introduces additional dynamics



With the right elements in place and a mutual organisation PbC can deliver 3 major, patient-focused changes

1. Drive change in general practice

- What's done
- By whom
- And when

2. Drive change in providers

- Responsiveness

3. Significant impact on primary care clinical practice

- Best practice for maximum patient health outcomes

