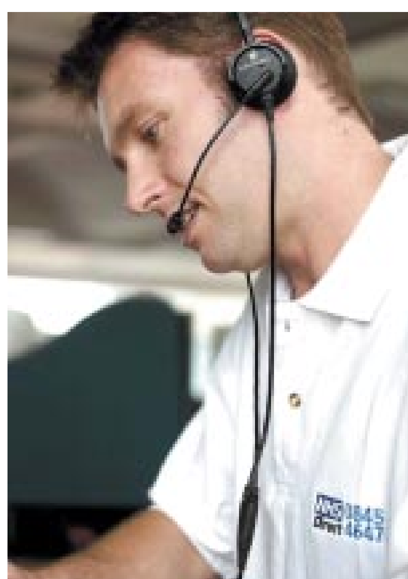
DELIVERING CARE ON CALL

AN IMPLEMENTATION GUIDE FOR PCTs AND GP CO-OPs

CLIFF MILLS PETER HUNT



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Delivering Care on Call - An implementation guide for PCTs and GP Co-ops

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contents

1. Executive Summary 4

2. Care on Call - an achievable vision 5

- A new provider
- The core business
- Professional management
- Strategic planning
- Membership
- Legal structure
- Procurement issues

3. Practical Issues for PCTs & GP Co-ops 9

- Immediate issues facing Primary Care Trusts
- Immediate issues facing GP co-operatives

4. Practical steps to establish a new provider 13

- Procurement
- Incorporation of a new vehicle
- Start-up and transfer from GP Co-ops
- The duties and liabilities of Directors – and of PCTs
- Managing risk
- Planning the transition

5. Mutual Constitution – A Brief Outline of the Model 20

6. Where and how PCTs/GP Co-ops can get help 21

APPENDIX

A. An overview of mutuality 22

- The origins of mutuality
- Features of mutual governance
- Professional service mutuals
- Mutuality and health
- The benefits of mutual structures
- Trust in mutuals

B. Corporate Forms Compared 27

- The Company Limited by Guarantee
- The Industrial & Provident Society

1. executive summary

This document seeks to provide a clear guide for Primary Care Trusts and GP Co-operatives considering the future of Out of Hours (OOH) primary care provision.

It builds on the proposals put forward in 'Care on call - a mutual approach to out of hours primary care services,' *(Mutuo, January 2004)* that new mutual providers may be created to ensure that OOH cover is continued under the new GMS contract.

It outlines the main practical issues that PCTs and GP Co-ops must consider in providing continuing care.

It describes the practical steps to follow in establishing the framework for the new mutual OOH provider.

This includes a methodical approach to dealing with questions around procurement, the establishment of a new corporate entity, and practical issues around the transition of services to the new provider.

The process that is proposed in this document has been road tested with a number of pathfinder projects, where this option is currently being implemented.

Additional information on the mutual sector, the benefits of mutual structures and a comparison between the Company Limited by Guarantee and Industrial & Provident Societies is published in the appendices.

PCTs and GP Co-ops requiring further advice and assistance are recommended to discuss their needs with the partners listed at the rear of the document.

2. care on call - an achievable vision

A new provider

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

Many 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.

New structures 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 have developed 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 Primary Care 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. GPs will continue to play 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 fulfillment of contractual obligations. The former, facilitated by the new organisational form, may result in a more effective integration of services.

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 will probably result in larger areas than those currently served by many average sized current 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. 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 we 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 are to be reflected. Substantial representation is therefore needed here by GPs and the PCTs. It seems likely to be appropriate for every group of commissioning PCTs 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. 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 should be considered and implemented from the outset.

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.

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.

One possible solution 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. The patients are important, but their involvement must be balanced by the fact that most people only call OOH services once every 5 years, so the new organisations should certainly begin by involving PALS.

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, or 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. Changing attitudes about responsibility for one's own health is an important long term aim, 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

If the new provider is to have the features 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.

The traditional mechanism for achieving this stability 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.

Conclusions

The current changes in legal responsibility for 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, and are innovative and flexible service providers.

The introduction of community ownership structures in a range of public services has been a huge step forward, making the first momentous break away from state-ownership.

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.

3. practical issues for PCTs & GP Co-ops

We have presented the vision of a new provider for OOH Primary Care. In this section, we consider issues immediately facing PCTs and GP Co-operatives. Then we look at the practical steps to be followed, under three work streams, where there is a desire to implement the new type of provider envisaged in Care on Call, including the transfer of business and assets from an existing GP Co-operative. Finally we look at the important question of the legal duties of directors.

In appendix B we set out some guidance on the differences between the two main types of legal structure which are available, the company limited by guarantee and the community benefit society, and explain why we recommend the latter. Appendix A provides an overview of mutuality which is the context in which the proposed new provider vehicle has been developed.

Immediate issues facing Primary Care Trusts

PCTs are facing immediate questions about whether and when to grant permission to GP practices to opt out of OOH cover, and whether its existing OOH provider can cease to provide services on their current basis.

In considering these issues, a PCT needs to decide what measures are in place to ensure continuity of service.

Whether it intends to procure the service from a specialist provider or is considering running an OOH service itself, it needs to be confident that it can meet the following criteria:

- **GP cover is adequate** – GP Co-ops will typically have their rotas prepared several months in advance. The legal responsibility of current arrangements means that co-op managers have the ultimate sanction of passing cover back to GP practices if insufficient GPs are willing to work particular shifts. PCTs will not have this power under the new arrangements, and they must be satisfied that in the new contract environment they have sufficient contracted clinicians who will provide cover, particularly on the forthcoming bank holidays. It is not adequate to rely at this late stage on letters of intent to provide shifts from GPs.

- **Call management systems are tested** – PCTs must be satisfied that they can manage the call systems process, with NHS Direct and local call handlers. It is advisable for PCTs to test their proposed systems in advance of going live.

- **Partnership organisations are co-ordinated** – The PCT should have had detailed discussions and agreements in place with all partnership organisations and agencies – ambulance trusts, acute trusts, social services etc., to ensure continuity of service and patient management processes.

If a PCT is considering entering into arrangements with a new provider, it is likely to be appropriate to delay permitting opt out, and to continue the current arrangements temporarily.

Immediate issues facing GP Co-ops

GP Co-ops may be considering winding up their operations at an early stage, possibly from 1 April where permission has already been obtained from a PCT for GP practices to opt out with immediate effect.

GP Co-ops in this situation need to consider various issues.

- Financial impact on the co-operative. Whilst it may currently be trading successfully (and solvently),

the impact of ceasing to trade may result in unplanned liabilities for such things as redundancy of employees. Where there are ongoing financial commitments, for example for premises, vehicles and equipment, these may continue into the future. How are these liabilities to be met?

- Continuity of cover. It is important that this is maintained, and the following questions should be considered:

  - Is the PCT or alternative supplier of OOH cover ready to take on this responsibility?

  - Are their cover arrangements well known to GPs in your area?

  - Can you estimate what proportion of your members is going to work shifts for the PCT/ alternative provider?

  - Have you assessed the impact of any service changes on the in-hours capacity of your members' practices – and if so, are you satisfied that it will not have a detrimental effect on the service you provide?

If any of the answers are unsatisfactory, it may be prudent to meet with the PCTs to re-consider the decision to wind up and perhaps to continue your current arrangements.

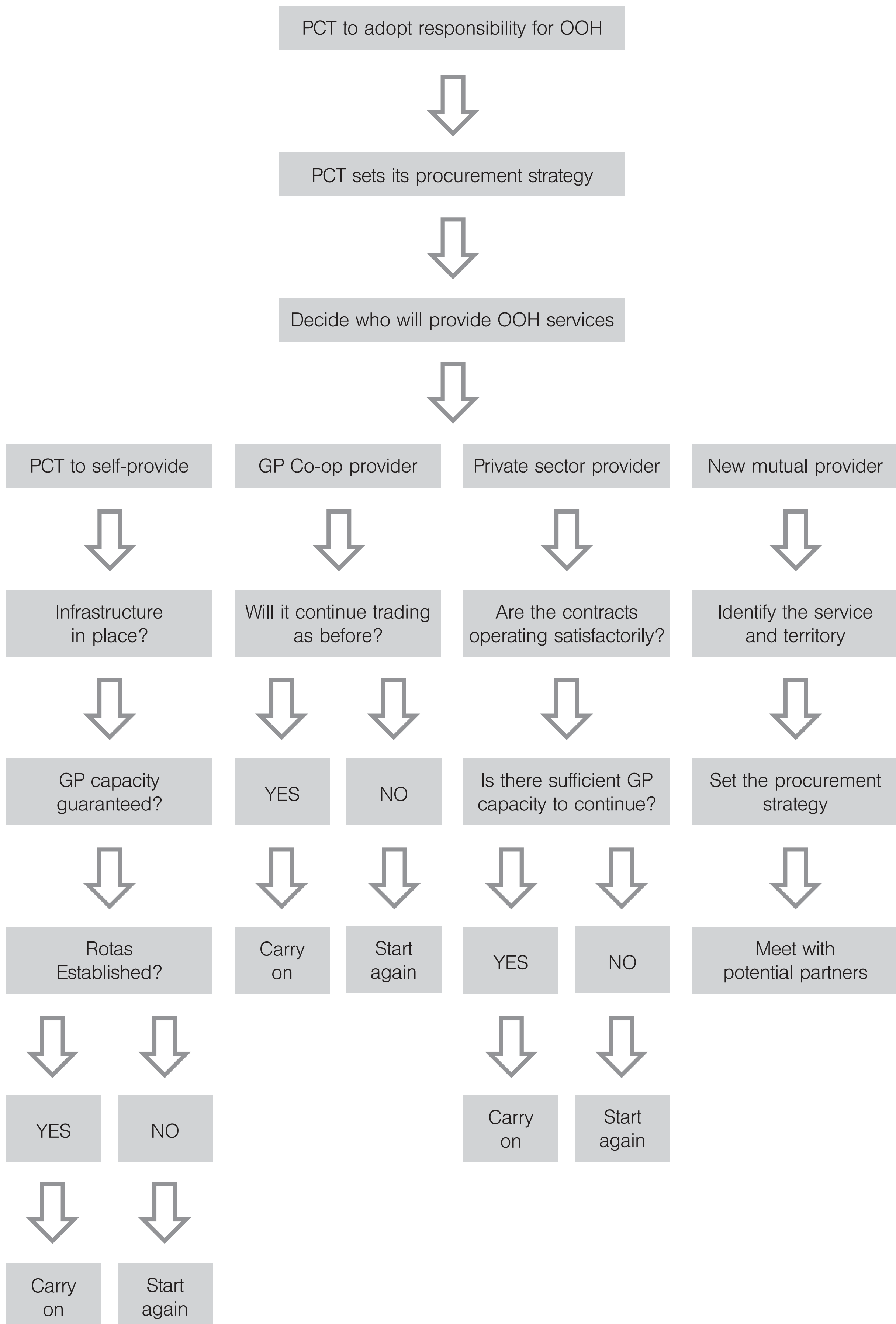
GP Co-ops intending to carry on trading in their current form, whether on the basis that practices do not opt out, or on the assumption that they intend to be a provider to the PCT must consider the sustainability of their business. They will need to have binding commitments from their GP members that they will cover the required number of shifts, such that the Co-operative can take on a contractual commitment to provide cover.

Both PCTs and GP Co-ops should be flexible in considering the period from 1 April to the end of December 2004 as a transition period, during which time all parties take ownership of the responsibility for ensuring that OOH cover is maintained.

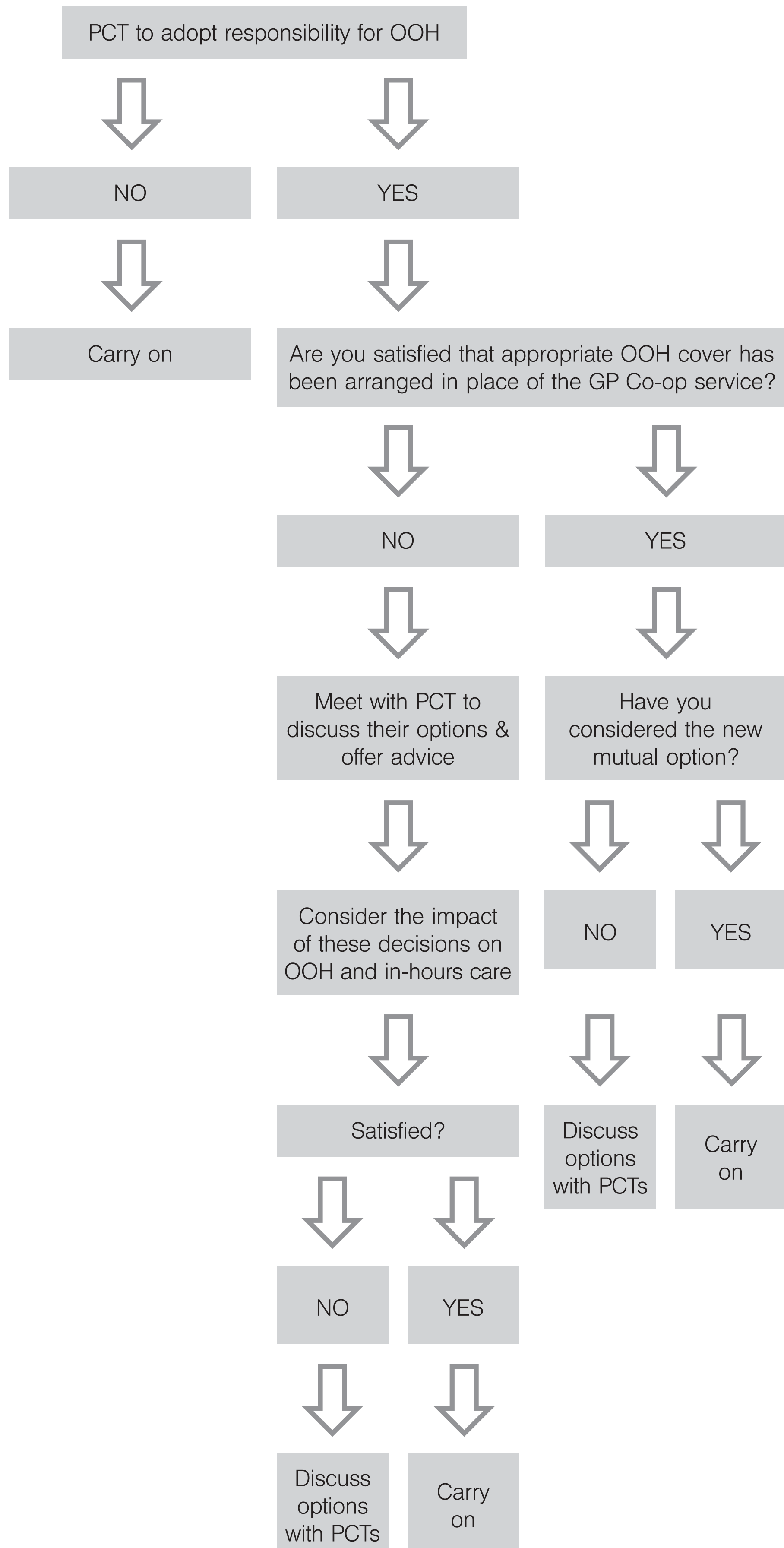
PCTs and GP Co-ops should not rule out the possible good sense in delaying the implementation of any decisions they have already taken.

Once all parties have established a shared understanding of the likely effect of their plans post-April, if they have remaining doubts they should consider making arrangements to establish an alternative mutual provider that the PCT can consider commissioning to provide OOH cover.

Considering the options for PCTs



Considering the options for GP Co-ops



4. practical steps to establish a new provider

The establishment or incorporation of a legal entity for a new provider 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.

Stage 1 – Procurement

The first stage of the process must therefore be that the relevant PCTs get together, and identify the geographical region for which services can be provided on an economical and manageable basis. This may result in approaching other PCTs to cover a larger population base.

The PCTs then need to decide upon their procurement strategy. Are they each to procure individually, or are they to procure jointly, or is one PCT to act as lead procurer for them all, acting as agent for the others?

The next decision is whether procurement 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, the PCTs 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. Whatever procurement process is adopted, it should be transparent to interested parties, and PCTs should be prepared to justify the decisions they make.

Stage 2 – incorporation of new vehicle

If a new entity needs to be incorporated, the parties to be involved will first need to be identified, and agreement reached on the shape and size of the new vehicle. At a minimum, this will require agreement between GPs, and some level of support from the procuring PCTs. It is also likely to involve other parties, including representatives of patients and public.

Agreement is needed about the governance arrangements, the balance of the interests of the respective parties (the number of seats on the strategic board or council), and the initial executive structure.

It may be appropriate to start with a more simple structure which can be expanded over the coming months and years.

A decision is needed as to the type of entity (see appendix B), and then the agreed arrangements need to be incorporated into the constitution when the new body is incorporated.

Stage 3 – start-up and transfer from GP Co-ops

The third area of activity concerns preparation for the commencement of trading, including arrangements with the existing GP Co-ops, and whether there is to be a transfer of their current assets and liabilities.

As already observed, a simple cessation of trade by a GP Co-op may result in new liabilities, or the continuation of existing liabilities. If a new provider is to come into existence, 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 transfer premises, assets, and systems from the GP co-operatives. This is likely to be important in maintaining

cover, in preventing waste, and ensuring that there is an efficient migration to the new OOH arrangements. Such transfers are likely to involve obtaining consents from landlords, and from companies leasing or hiring vehicles and equipment. Transfer of employees is likely to involve a consultation process. Other notifications will be needed e.g. to the local rating authority.

Formal decisions will also be needed in relation to such transfers, by the board of the existing co-op (and possibly its members as well) and the by directors of the new provider.

In addition to dealing with these transfer issues, there are also new arrangements which need to be put in place before trading can commence, including establishing banking arrangements, VAT registration, PAYE, insurances and accreditation.

The most important part of the arrangements to be put in place by the new provider is a contract with the PCTs. This is the point at which the three work streams come together and where they must be coordinated, to ensure that the new entity has been established, resourced and is able to commence trading on the date at which the contractual responsibility for providing OOH cover is taken on.

The duties and liabilities of directors - and of PCTs

The current GP co-operatives operate on the basis that where a GP practice wishes to avail itself of the services of the co-operative, GPs from the practice have to accept that they will work an appropriate number of shifts to enable the co-operative to function. The legal responsibility for providing out of hours care currently rests with GPs, and the co-operative provides a convenient mechanism for GPs to discharge that responsibility more efficiently. It cannot work without their support.

If the co-operative finds that it is insufficiently resourced to operate a roster on a particular shift, it notifies the GP practices, and ultimately it can pass back to the GPs the responsibility to cover that shift. When it does so, the GP practice effectively is given back the responsibility to care for patients, which otherwise the co-operative would have discharged on its behalf. The ability to give back responsibility is a powerful sanction in the hands of the co-operative, and is clearly part of the dynamics underlying the successful operation of GP co-operatives.

Directors’ duties

The directors of a corporate entity owe a duty of good faith to act in the best interests of the organisation (often called fiduciary duty); and they owe a duty to take reasonable care in carrying out their function as directors (duty not to be negligent).

These duties apply to the directors (or medical managers as they are sometimes called) of a GP co-operative. As a result of these duties, those directors have a responsibility to ensure that appropriate cover is available to meet the known demands for shifts.

The power to give back responsibility for cover for a shift to GPs is an important part of the mechanism available to the co-operative to manage risk. If it failed to give back responsibility and under-resourced a shift, resulting in otherwise avoidable injury to a patient through non-attendance, the directors could be liable for breach of their duty of care (ie negligent). By passing back responsibility to the GPs, the co-operative shifts the risk back to the GPs, and if avoidable injury occurs through non-attendance the responsibility lies with the GPs not the co-operative.

Directors' duties under the new arrangements

Now that GPs can elect not to retain OOH responsibility under the nGMS contract, where they make that election, the responsibility for the provision of OOH cover passes to the PCT. Under these circumstances, there is no longer the ability to pass legal responsibility for patients back to GPs during OOH.

This change is an important one for PCTs to understand and to address. Whether the PCT chooses to provide the services itself, or whether it procures or commissions another body to provide those services under a contract, it will still retain statutory responsibility for those services. That means that the PCT will need to consider the risks from its own point of view, both in terms of the nature of any external provider body and its relationship with that body, and separate back-up and insurance cover. There is a retained risk for the PCT which needs to be managed in any event.

Where the PCT seeks to place a contract to provide OOH with a supplier, logically it will seek to pass onto that supplier the responsibility for maintaining adequate cover (to protect itself against negligence liability). This is a significant risk for the supplier to take on. It will either need to know that it has enforceable contractual arrangements in place with GPs to ensure that it can always deliver the necessary level of cover from its own resources, or it will need to have in place contingency arrangements under which it can itself procure additional resources from a third party. The former could include utilising alternative resources (e.g. paramedics).

The latter is likely to be expensive, and this would be reflected in the price which the supplier can offer in bidding for the contract. Additionally, if the supplier found itself making significant use of costly contingency arrangements, this would eventually become a matter of financial concern.

Managing risk

The issue of guaranteed cover is one which any provider needs to take into account in preparing its own business plan, and bidding for any contract from a PCT. A cost effective way for such a supplier to minimise the risk will be to enter into binding contractual arrangements with individual GPs or GP practices (or both) under which they commit to providing minimum levels of support and cover. A new mutual would have the advantage of being able to offer the existing benefits that mutual working brings, this is one of the key strengths of existing GP Co-ops, supported by a variety of contractual arrangements with GPs who work for the organisation. These will need to be underpinned by contractual arrangements which ensure continuity of commitment and could be supplemented by local incentives within the framework of the mutual organisation.

A supplier adopting this approach would, assuming a sufficient level of commitment could be obtained from GPs, be able to bid for a contract under which it assumed responsibility for OOH cover. Logically it would be looking for a forward commitment from GPs which was sufficiently long-term to match the period of contract for which it was bidding. Alternatively, if GPs only give a commitment for a shorter period, the supplier may need an opportunity to renegotiate the contract if onward commitments cannot be maintained and alternative sources of cover obtained.

This approach is a starting point for directors of a new supplier body to minimise the risk of personal liability. They will also need to continue to monitor demand and resourcing to ensure that they are matched. Depending on the terms of the PCT contract and the details of the specification, failure to do so could also result in liability. Maintaining proper procedures for recruitment, training, performance monitoring and following other normal risk management procedures are also important steps to take to minimise the risk of liability.

Finally, it will be appropriate for the supplier to carry directors and officers insurance liability, to protect directors against misjudgements, as well as medical negligence cover for its employees and GP sub-contractors.

Planning the transition

If either a PCT or GP Co-op wishes to pursue the new mutual option, they should meet urgently with their potential partners to plan their transition. It is likely that PCTs will be the drivers of this in many cases, but with GP Co-ops taking the lead in areas where they are strong.

At the outset of the new venture, it will be necessary for potential partners to commit to a common understanding of the objectives of the new arrangements. This must include agreement between PCTs, GP Co-op leaders, A & E departments, ambulance trusts, social services, community nurses, mental health trusts, NHS Direct.

The following draft meeting agenda might be a good guide to beginning the process of transition.

Draft Meeting Agenda to consider establishing a new provider

1
Attendees

You should certainly invite the following to the meeting:

PCT Chair and Chief Execs, GP Co-op leaders, A and E departments, ambulance trusts, social services (including community nurses), mental health trusts, NHS Direct.

2
PCTs to outline the service that they require

3
PCTs to outline their preferred procurement methods

4
Agree who should be members of the new mutual

5
Establish an action group to take this forward

6
Agree a timetable for the transition.

Each participant should consider their attitudes to each question prior to the meeting.

The following diagrams suggest a framework for both PCTs and GP Co-ops who are considering their future OOH arrangements.

The business transfer transaction

In most cases the establishment of a new mutual provider will be a collaboration between existing GP Co-ops and PCTs. The new body will need to be legally established, often using the platform of the GP Co-ops and benefiting from their extant business systems. This section considers in more detail the main factors to be considered in preparing for the incorporation and transfer of business to the new body.

Transfer of Employees & Employee Consultation

Generally speaking when a business is transferred the contracts of employment of all employees involved in the business are transferred automatically to the transferee. The contracts continue as if they were originally made between the employees and the transferee. By law the transferee and transferor have obligations to consult with the employees who are transferring.

Transfer Agreement

The Transfer Agreement is the main document relating to the transfer of the Business and it sets out the terms of the transfer. It will deal with all of the following issues:

Assets and liabilities: It is important for the new mutual to have a thorough understanding of the extent of the GP Co-op's liabilities or potential liabilities as it will assume complete responsibility for these.

Properties: Although the Transfer Agreement will partially deal with the transfer of any property which is occupied, there will be other documentation required, depending on the property type.

- **Freehold property:** If the property is owned, is freehold and its title is registered at HM Land Registry, the basic legal documentation required will be a Transfer and Stamp Duty Land Tax Forms.

- **Leasehold property:** If the property is occupied under a lease, then the consent of the landlord will probably be required in order to transfer the benefit of the lease.

- **Property occupied under licence:** If the property is occupied under licence, the benefit of the licence cannot legally be assigned as it is a personal right. In this situation if new mutual wants to occupy the property it will need to enter into negotiations with the person who has granted the licence.

- **Interim arrangements:** If there is property involved but the timescale for the transaction does not allow the necessary legalities to be completed in time, the Transfer Agreement can be amended to provide that the legalities will be completed afterwards.

Security interests: If any of the assets of the Business are subject to any security interests (e.g. debentures or mortgages) the security will need to be released before the transfer of the Business can be completed. Contact will be required with the holders of any security as soon as possible in order to establish what their requirements are and to obtain the appropriate release.

Consideration (Payment): In general terms it is envisaged that there will be no actual payment from the new mutual to the GP Co-op for the Business. The consideration will be the assumption by the new mutual of the Company's liabilities. If there is additional consideration payable, it may be necessary to apportion this between the various assets forming the Business.

Contracts: There will be a relatively detailed clause in the Transfer Agreement relating to the assignment

to the new mutual of any contracts to which the GP Co-op is a party e.g. customer contracts, supply contracts, hire purchase contracts, licences (but not employment contracts which are dealt with elsewhere).

Intellectual Property: The Transfer Agreement will provide that any intellectual property, whether registered or unregistered, tangible or intangible, or owned or used by the GP Co-op, will be transferred to the new mutual.

Stamp Duty Land Tax: This is a new tax on land transactions which came into effect in December 2003. Generally speaking any land transaction involving a payment by a transferor to a transferee will trigger an obligation on the transferor to notify the Inland Revenue with details of the transaction.

Notice to debtors: In order to effect the legal transfer of the benefit of the GP Co-op's debts, notice of the transfer will need to be given to each of the debtors in question.

Minutes: The board of the GP Co-op and the Management Executive of the new mutual will need to approve the sale and purchase of the Business and will also need to approve the terms of the various documents that will need to be signed.

Member approval: One will need to consider whether member approval for the transaction is required. Member approval may be obligatory e.g. if the directors of the GP Co-op are to be directly involved in the new mutual for example as members of the Management Executive. Even if member approval is not obligatory, it may be that from a corporate governance perspective getting such approval is desirable.

Finances: Banking facilities will need to be arranged. The bank facilities of the GP Co-op may need to be terminated.

Insurance: The new mutual will need its own insurance.

Taxation: The new mutual will need to be registered for PAYE, national insurance and potentially VAT.

Contracts: All contracts (suppliers, leases, maintenance etc.) which will transfer need to be checked to see whether they can be transferred and the other party to the contract may need to be contacted so their consent to the transfer can be obtained or a new contract can be entered into.

Licences: All licences, consents and permissions necessary for carrying on the business need to be reviewed to see if they can be transferred or whether any consents to the transfer or notifications are required. Also consider whether any other licences or consents are required, e.g. Data Protection Act registration.

Administrative Arrangements/Announcements: Review what changes to letterheads, catalogues, sales and marketing material, business cards etc are required. Consider a general announcement as to the transfer, for example, in the local or trade press. Consider in advance who else needs to be notified of the transfer after it has taken place eg: Local Authority, Government Departments (Department of Health, Inland Revenue, Customs and Excise, Vehicle Registration Office) Data Protection Registrar, Suppliers, Directories, Trade Associations, Credit Cards etc., Utilities.

New Contract with PCT

Although this contract is not directly connected with the establishment of the new mutual, it is in fact the primary reason for considering the transfer. This new contract is of paramount importance and one should ensure that it is managed alongside this transaction as it will not realistically be able to be completed without the contract and vice versa.

4. practical steps to establish a new provider

The three stages to establishing a new mutual

Stage One – Procurement

• Relevant PCTs meet to identify the geographical service spread
• PCTs jointly decide their procurement strategy
• Decide if there will be one single or multiple suppliers

Work with other providers
or
Adapt an existing co-op
or
Create a new supplier – go to Stage Two

Stage Two – Incorporation of a new vehicle

Identify partners and decide the extent of the new vehicle

Agree the governance arrangements:
• Jointly agree on the balance of power on the membership council
• Decide the executive structure

Decide the corporate form:
Company Limited by Guarantee
or
Industrial & Provident Society

Stage Three – Start-up and transfer from GP Co-ops

Prepare to commence trading:

Organise arrangements with existing GP Co-ops

Complete transfer formalities:
• Staff, Premises, Assets, Systems

Complete formal Board and membership decisions

Put administrative systems in place:
• PAYE, VAT, Insurance, Financial and banking arrangements

6. where and how to get help

If you are considering taking the mutual option and establishing a new provider, further assistance and advice is available from:

Cobbetts Solicitors,
Ship Canal House,
King Street,
Manchester,
M2 4WB
UK

http://www.cobbetts.co.uk

Out-of-Hours Implementation Team
Room 4N34E,
Quarry House,
Quarry Hill,
Leeds LS2 7

0113 254 6341

http://www.out-of-hours.info

NAGPC
Regency House
90-92 Otley Road
Leeds
LS64BA

Tel: 0113 2782381 Fax: 0113 2783674
Email: manager@nagpc.org.uk

http://www.nagpc.org.uk

An overview of mutuality

Most people recognise the UK mutual sector through one of the following types of organisation:

- Building societies
- Co-operatives
- Friendly societies
- Mutual insurers

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.

Over the last few years, a growing number of new mutuals have also been established, including Football Supporter Trusts, child care co-operatives, and local government leisure service mutuals.

There is no single definition of a mutual, but there are a range of corporate forms that share a number of common features. Even though these organisations may appear very different at first, it is their adherence to these common features that defines their mutuality.

Mutual Features

Firstly, mutuals are all established for a shared community purpose. They might have been set up to serve a specific community or interest group.

Next, they are all 'owned' by their members. This ownership is vested in the membership community of each mutual and is expressed commonly – 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.

All mutuals operate democratic voting systems, with each member valued the same - one member one vote.

Mutuals have stakeholder council governance structures, and seek to ensure that different stakeholders have an appropriate role in running the organisation, proportional to their relative stake.

All mutuals share these features, to a greater or lesser degree, depending on their individual circumstances and the distinct purpose of the organisation.

Origins of Mutuality

Some mutuals have been around for nearly 200 years. The earliest mutuals were societies, often referred to as 'self-help organisations,' that provided a means of mutual insurance through regular member contributions. The Amicable Society for a Perpetual Assurance, established in 1706, was the UK's oldest mutual life insurer when it was taken over by The Life Society in 1866.

Members of friendly societies, as these early mutual societies were known, were bonded to each other by, for instance, locality or trade, and their regular contributions ensured both themselves and their families' benefits in the event of sickness or death. Their meetings took the form of social gatherings of friends.

The fact that these bodies are still going today suggests that they have robust corporate structures. From their beginnings, they have developed into a global phenomenon, with many millions of members throughout the world.

Professional Service Mutuals

A number of innovative and successful professional service businesses have established themselves as mutuals.

For example, consulting engineers and designers, Arup Group Ltd is trust-owned for the benefit of its employees and their dependents. The company is a global professional firm, currently operating out of 71 offices in 32 countries, and employing over 6,500 members of staff.

The trusts are represented by Trustee Companies whose directors are collectively responsible for ensuring that the terms of the Trust are met. Responsibility for the business operations of the Group are delegated to the Group Board, which comprises the Chairman, and twelve directors together with three advisory officers for Finance, Legal, and Human Resources matters.

Another example is St Luke's communications agency. It is a creative co-operative that was established when the staff of an independent agency bought themselves out of a proposed merger with a large corporate competitor in 1996.

It now has 130 co-owners, with offices in London, Paris, Stockholm and India, and the focus of the business remains the personal growth and development of these individuals.

Mutuality and Health

Before the NHS was created, many people paid into insurance funds held by their Friendly Societies. There is also a tradition of not for profit providers delivering healthcare.

In fact, when the NHS was formed in 1948 there were over three thousand independent hospitals, mostly operating in this way.

Today, there are about 200 GP Co-ops, providing out of hours care across the country, and a small number of residential care co-ops and home visiting co-operatives.

In recent months, the Government has legislated for NHS Foundation Trusts, which use mutual governance structures to establish strong partnerships between the Acute Trust Boards, PCTs, staff and local patient communities.

The mutual sector today

The UK mutual sector includes a wide range of organisations that share the above common features.

Mutuals are either established for the benefit of their members – usually financial – or for the benefit of a defined community. The spectrum diagram (fig.1) below includes many types of mutuals that are easily recognisable.

Those established for member benefit sit above the axis and community benefit mutuals sit beneath it. Each organisation is placed on the axis according to how active the individual member's role in their governance structure will actually be. Thus in a mutual insurer, the average member will only participate, if at all, through the democratic process – professional Boards are established to run the business. At the other end of the scale, a credit union member may be involved in some of the business decision making of that body and even become an officer of the mutual.

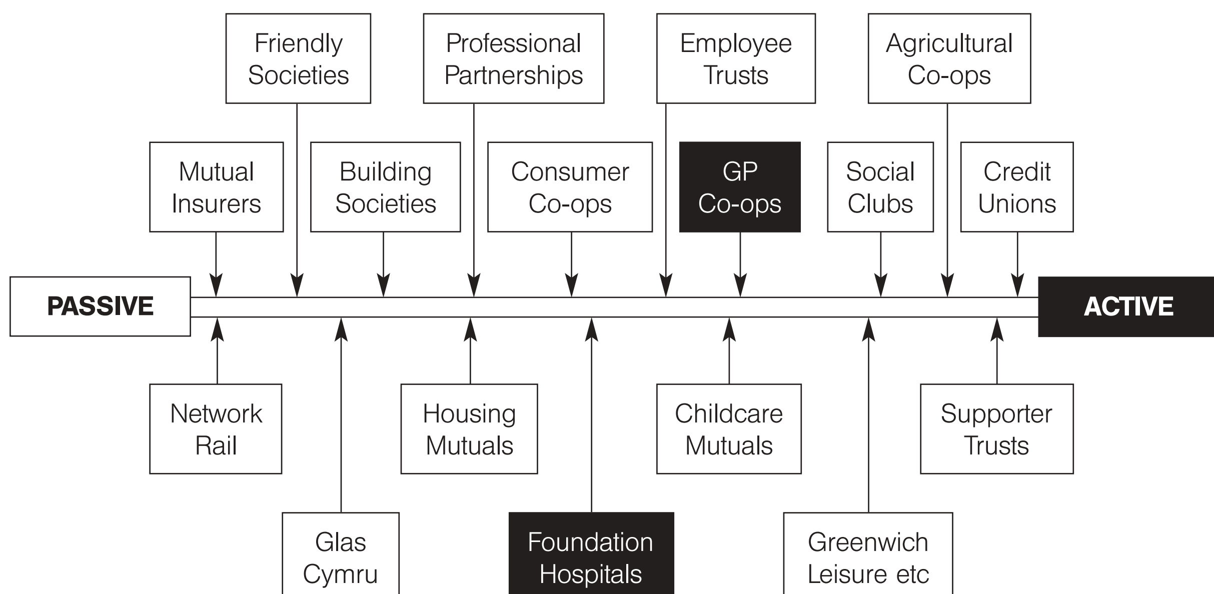
The level of an individual member's involvement in any mutual will depend on the governance structure in operation and the appropriate relationship between members and executive decision making, as decided by the mutual.

In the diagram, different sectors within the spectrum of mutuality have been placed roughly in relation to their relative position on the axis. Naturally, there will be exceptions within each group, but a view has been taken in order to give an overview of the whole mutual sector.

They will be established under a range of corporate forms – from societies to companies. It is the constitutional arrangements that they adopt, instead of a single corporate form that defines them as mutuals.

The spectrum of UK mutuality

Member benefit mutuals



Community benefit mutuals

What are the potential benefits of mutual structures?

As has already been explained, mutuals can take a variety of forms. They might be producer dominated, in the case of GP co-operatives, worker co-operatives or leisure trusts, or they may be consumer dominated in the case of consumer co-ops, building societies, foundation hospitals or football supporter trusts. In each case, the members will behave differently, and the culture of the organisation will reflect the relative balance of the different stakeholders, as well as its overall aims and objectives.

The starting point in assessing the benefits of mutual structures is to look at what advantages they have in not being proprietary businesses owned by investors. Compared to proprietary organisations such as companies, mutuals do not need to serve the cash hungry needs of shareholders, whose purpose in investing is to maximise their profits. Their lack of equity capital means that they do not need to distribute profits to investors, and can retain any surplus to improve the service they provide, or to reduce the price. This gives them a marginal financial advantage over proprietary businesses and enables them to take a longer term view of their business.

Compared to public corporations, mutuals do not suffer from political and government interference. In heavily regulated industries such as financial services and elsewhere, they are dealt with in the same way as other proprietary companies.

Mutual governance structures are designed to build stakeholder participation in the business, theoretically bringing a range of benefits. GP Co-operatives, which are producer dominated mutuals, identified four success factors that were related to their mutual governance arrangements:

- 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

Many mutuals go further by building in participation from and accountability to their customers and achieve the benefit of having an inclusive decision making structures. Traditional companies can benefit from ethical behaviour, and this should certainly be encouraged, but they are constrained by the overriding need to maintain shareholder value. They are accountable to investors, not customers. They are not able to prioritise customer interests in the way mutuals can; customers themselves increasingly recognise this difference.

Trust In Mutuals

According to their founding and guiding principles, mutuals should be more trustworthy and responsive to their stakeholders than companies with external shareholders whose sole goal is financial gain.

Indeed, customers of mutual businesses do in fact believe them to be inherently more trustworthy than their PLC counterparts, according to research published by Mutuo.

‘Trust Rewards,’ an independent report from Cambridge University and the University of London, surveyed members of mutual societies to establish how they rated various aspects of performance, and how these contributed to overall trust levels. The results give an overwhelming endorsement of mutuality as a business form.

Customers agreed that the organisational structure of mutuals – in which the members are also the owners – contributes to their performance:

- 75% of building society members said they liked the fact that building societies, unlike banks, have no shareholders

- 58% of members said that they felt a sense of ownership that they did not experience when dealing with a plc

- Mutual society members were four times more likely to trust their mutual than a plc

- 72% of co-operative society members felt that the Co-operative acts more in members' interests because it is not answerable to 'Big City' investors, with 90% agreeing with the statement 'The Co-op is trustworthy'.

These findings were supported in a parallel survey of the general public, which found that people were more likely to trust a building society than a bank and twice as likely to invest with one in the future. They build upon a raft of earlier research such as the Consumers' Association (2001) Mutual Advantage survey, which found that building societies consistently delivered better value to customers and enjoyed higher levels of customer satisfaction and loyalty.

Fig 2. From mutualism to trust

Corporate Forms Compared

This document proposes that the new providers should be established as Industrial & Provident Societies (IPS). This appendix compares the main features of an IPS with the Company Limited by Guarantee (CLG).

The Company Limited by Guarantee

A CLG is a commonly used vehicle in the charitable sector, where it is convenient for a charity to have a rather more sophisticated structure than a simple trust, perhaps because it needs employees and other officers.

The CLG is also used in situations where incorporation is required for some reason, where generating profits for investors are not the priority, and some kind of alternative purpose underlies the business. Social housing is an example of this, where local housing companies use the CLG form to own housing stock.

There are some interesting one off examples of this in some quite big businesses (Reuters Founders Share Company) where some special purpose is being protected (in Reuters case, editorial integrity). BUPA is another example.

The proposed solution of putting the business into a company limited by guarantee (CLG) acknowledges that (i) the business will not be funded by equity capital (a CLG does not have any), and (ii) it will therefore be controlled by a special group of people who have the opportunity to become members (a CLG has members just like a company with a share capital; the difference is that members have to give a guarantee rather than subscribing for shares).

One of the advantages of a CLG is that the company can make its own rules about who the members are. Commonly the board itself determines this, and it is also common for the members of the company to be the members of the board. This is entirely appropriate in the charitable context, where those who are effectively the trustees appoint their successors, thereby ensuring that appropriate individuals continue to have responsibility for the charitable objectives.

Big questions arise, however, when the CLG is owner of a substantial business, particularly in public services, where accountability is important. If there are no share-holding investors, or customer/community members with a right to remove the board if they are failing to perform, how will executives be held to account? Who should be responsible for choosing their replacements? What is the mechanism for driving efficiency and success in the organisation?

The CLG is often regarded as a convenient legal form to use in many situations, because it is easy to set up, and is reasonably well-known and understood.

It could be used in establishing new providers for OOH cover. However it is important that its weaknesses are understood at the outset. There is growing concern about the wide and indiscriminate use of the CLG, because of its inherent lack of accountability, and lack of transparency. These factors should be carefully considered by those intending to use this form.

The Industrial & Provident Society

These societies have different aims and objectives from Companies. They are either run for the benefit of their members ("bona fide co-operatives") or for the benefit of the wider community ("community benefit societies").

In a society or mutual model you can choose either workers, customers or members of the local community, or a combination of these as owners, and therefore the ones who drive the success and efficiency of the business. The society model is not prescriptive about who ownership is given to.

But it is more than just who the owners are that matters. It is the underlying purpose of the organisation which is inextricably linked to that ownership issue. The difference with a co-operative or community benefit organisation is that their reason for being is based upon the fulfilment of a need, and those who own and control such organisations have it within their power to ensure that the need is met. The organisation is therefore run according to guiding principles, and the owners/members are the custodians of those principles, whether they be co-operative or community-based ones.

A mutual structure which puts the interests of the community at the top of the agenda has clear advantages in public service delivery, and that is why the option we are suggesting is a community benefit society.

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