Rushcliffe Mutual - Who, What, Why and How

A proposal to establish a social enterprise Community Benefit Company to provide and commission an extended range of local health care services through practice based commissioning (PBC) is being taken forward in Rushcliffe, South Nottinghamshire. The proposal to establish a new not-for-profit mutual organisation to go live in Spring 2006 is in an advanced stage of development and is being led by Rushcliffe general practitioners, other independent contractors, directly employed PCT staff and the Rushcliffe Patients Forum. We believe that the work we are doing here in Rushcliffe is the most coherent (and possibly the most creative) response to the current NHS policy agenda.

The proposal is predicated and builds on our long held view that the current acute focused model of care is not sustainable. Year on year increases in emergency admissions, Emergency and Out Patient Department attendances have created enormous pressures within our local hospitals. Notwithstanding their magnificent response, the consequences have resulted in pressure on elective performance, unacceptable cancellation rates, and long waiting times; poorer patient centred care away from home, more prolonged and more expensive care. The inevitable response has been that in the last ten years we have seen huge real term increases in spending on hospital services while spending on community services has remained virtually constant. This has been deeply frustrating to both the public and the primary care clinical community.

This experience has been sufficient motivation in itself, but in looking forward we also anticipate a slowing down of the recent rapid rate of growth in investment in the NHS, a period of further organisational turbulence, a new, more distant commissioning PCT possibly distracted by other issues within its larger geographical coverage and with as yet unpredictable behaviours. We also acknowledge the increasing difficulties in maintaining and improving existing performance in the face of future demographic, epidemiological, consumer and technological pressures. Comprehensive clinical service redesign at scale, and with some urgency, is both the essential and only realistic response.

The Rushcliffe community response has to been to develop a new primary care organisational form which will have the aggregated practice based commissioning budget of its constituent practices and which would be accountable to the new PCT through an APMS contract. In the short term, but with the anticipation of eventually employing its own staff, it will also have a service level agreement and staff supply agreement with the PCT for the provision of community services. It will assist the PCT in its major strategic challenge of achieving recurrent balance between service requirements and available resource. The Mutual will also create the headroom to address the public health and long-term conditions agenda, and critically to expand the range of high quality, locally accessible services to our patients.

Using the dynamic created by financial flows, payment by results and practice based commissioning, and building on local entrepreneurialism and innovation, the Mutual aims to deliver better services for patients by managing demand and reducing our dependence on the hospital. It proposes to do this by managing elective and emergency demand; providing hospital care in alternative settings, developing clinical networks and care pathways, and developing the supporting infrastructure.

The Mutual has been conceived as a social enterprise which integrates three themes: the first a vehicle for a collaborative approach to the challenges of practice based commissioning; the second, an opportunity for a new relationship with directly

employed community staff; and third, an organisation which delivers greater accountability to, and involvement, of the local population.
The twenty-one practices involved in the development of the Mutual all trade independently. This model of primary care has served the local NHS and patients extremely well but it is clear to us that it cannot continue to be the only organisational model for the future. Thus, what is proposed here is a mutual model wherein individual practices continue to operate as autonomous business units within their existing contractual framework, while in addition coming together to realise the synergies of collaborative commissioning and share the provision of an extended range of services to achieve common objectives.

The PBC objective is to shift large volumes of currently hospital-based activity into primary and community care settings through managing demand reducing delays, duplication and inefficiencies and increasing productivity. In order to do this it is acknowledged that this cannot be dependent only on GPs but that it will be necessary to recruit the active involvement of other clinical professional groups in the broadest inter-practice and inter-professional coalition. This will need to amount to a level of clinical engagement not seen hereto in the local NHS. That engagement needs of course to extend to secondary care and look forward to a new relationship between specialists and generalists. We acknowledge that we operate in a 'whole system' and that we will need to operate within an agreed strategic framework and present coherent demands on local Trusts.

The second theme develops this understanding further and acknowledges the benefits of the involvement of other health professionals. We anticipate that the Mutual will provide the platform for community nurses, health visitors, allied health professionals, and others, to make an even greater contribution to achieving the objectives, planning and service development, governance, and best use of all available resources. Looking forward to the review of PCT provider functions this model provides a genuine opportunity for directly employed staff to reform and realise their professional aspirations and development.

Increase accountability to the local population is the third theme. Rushcliffe has an activated population, and the relationships with practices and the existing PCT are excellent. Developing this and building meaningful patient involvement through the Mutual governance structure will allow the local community to undertake a key partnership role in setting objectives and agreeing strategies and to hold management and provider services to account. The local community engagement will ensure patients are fully involved in developing a greater choice of services that are more directly responsive to patients needs. It will also act as a guarantor of probity and value for money in commissioning decisions.

A multi professional constitution, which also includes local patient and community membership, has been developed to reflect the three themes and the contribution and inter-relationships of those stakeholders who share the common objectives in improving the health of the population. All those registered with constituent practices will be members. Different classes of membership will allow the accommodation of all types of members with protection for certain types of decision. A Board of Governors responsible for company policy and strategy as well as a Management Executive, to manage the overall business, will be established.

We have judged that the financial, supply and service issues that face our local NHS require more than incremental fixes. This initiative has a unique opportunity to create a platform for delivering expanded and sustainable primary care services locally. Operating at scale, with urgency, and by aligning the objectives of general practice,

other independent contractors, PCT employed community staff and the local population, by focusing on improved services not just the money; we believe we can make the biggest contribution to transforming the experience for our population. We believe this initiative is transferable to other communities.

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