



UNIVERSITY OF
OXFORD



KELLOGG COLLEGE

A Mutual Health Service

Report of a Parliamentary Seminar
held on 18th December, 2009

Portcullis House
Palace of Westminster

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Contributors

Mr Matthew Ball is Head of Public Affairs with Mutuo where he provides advice and support to mutual sector trade associations and works with Government to seek to influence the public policy agenda to expand the mutual sector.

Mr John Coutts works as Governance Advisor with the Foundation Trust Network.

Mr Geraint Day is Gloucester and Swindon Branch Committee member at the Benenden Healthcare Society Ltd.

Mr Mo Girach is a member of the NHS Forward Thinking Group. Mo is also a special advisor to the NHS Alliance.

Professor Chris Ham is Professor of Health Policy and Management at the University of Birmingham. As a health policy analyst, Chris has been working with health service agencies in the UK and in other countries.

Mr Peter Hunt is founder and Chief Executive of Mutuo, the cross mutual sector body to promote mutual governance to opinion formers and decision makers.

Mr Andrew Love is a Member of Parliament.

Mr Nigel Mason is Policy Director with the Employee Ownership Association.

Professor Jonathan Michie is President of Kellogg College and Director of the Department for Continuing Education at the University of Oxford. Jonathan is also the Director of the Oxford Centre for Mutual and Employee-owned Business.

Mr Cliff Mills works as Principal Associate and constitutional expert with Mutuo. Cliff is also a consultant at Cobbetts, solicitors in Manchester, Leeds and Birmingham where he is a leading expert in corporate governance and the law of mutual and co-operative organisations.

Ms Deborah Rozansky is Principal Consultant at the Office for Public Management (OPM) where she advises public sector organisations seeking to improve the delivery of public services. Deborah's main focus is public health and healthcare.

Mr Tom Shirley works for the Cabinet Office within the Prime Minister's Strategy Unit.

Mr Nigel Wylie is Chief Executive of Urgent Care 24, a Social Enterprise provider of Primary Care Out-of-Hours and associated services to two Primary Care Trusts.

Foreword

Parliamentarians are committed to an ongoing process of modernisation and reform of health services. They aim to deliver customer-focused services that are increasingly personalised and offer more choices, while driving up standards and quality.

Encouraging mutuals in health and social care should be a key part of the patient-led reforms. They offer patients and users a greater choice from a wider selection of convenient, innovative and responsive services.

In the run up to the forthcoming General Election, this is an apt time to discuss how mutuals are currently working in health and how they might be helped to develop in the future. This seminar brought together experts so we could consider the current situation and how mutuals might help the political parties to deliver solutions in the health services.

Andrew Love, MP



1. Introduction

by Jonathan Michie

The National Health Service is Europe's biggest employer, with around 1.3 million members of staff.¹ Ensuring that it delivers the best possible health service for the population – and taxpayers – has been a major political issue for all governments since the foundation of the NHS following World War Two. For much of the forty years following its formation, there was a consensus across the political parties of the importance of the NHS and its funding and governance. However, it became a party political issue during the 1980s, when the Labour Party repeatedly claimed that the Thatcher governments were underfunding the NHS, and claimed in the general elections of the 1980s and 1990s that the NHS was not safe in Conservative hands. Various reforms were introduced by the Thatcher governments that were widely interpreted as introducing 'the market' into the NHS. This was in the context of a lack of trust, certainly from the Labour Party but also from the electorate as a whole, as to whether the Conservative Party were really committed to the NHS, or whether they would be quite content with a greater role for the private sector instead.

The reforms of the late 1980s and early 1990s introduced a purchaser/provider split. The intention was to reduce costs by introducing the requirement to compete for contracts. One criticism of the reforms was that increased resources – of time, people and money – went into managing this process, as against patient care.² The Labour Party was thus elected to Government in 1997 committed to doing away with what were characterised as management reforms. The successive Labour Governments from 1997 did, however, continue to reform the NHS. One of the major steps was the introduction of Foundation Trust status, whereby hospitals

could achieve what was in effect mutual status, owned and governed by their various stakeholders, most particularly patients, the local community, and employees. Governance structures were developed to allow this multi-stakeholder model to have oversight whilst allowing professional managers and clinicians to actually run the hospitals, albeit with the involvement of non-executive directors.

The big political question at the time of writing (March 2010), in the run-up to the 2010 general election, is what the incoming government will do with the health service, and in particular whether, how, and to what extent the mutual model will be further developed in order to better engage the vast NHS workforce in the delivery of the country's health services.

The Conservative Party have pledged to allow public sector employees to form member co-operatives to deliver public services. This begs a number of questions such as how the interests of the other stakeholders – in the case of health services, most obviously the patients – would be properly prioritised within such structures. Another is what would be done on the pension issue which Chris Ham (see this pamphlet, Section 4) identifies as a key stumbling block – indeed, a deal breaker – to the further development of mutual models for service delivery. The issue is that while those who might form a co-operative or mutual to deliver the health services which they are currently providing within the NHS structure would have their pension provisions protected, the same would not be true of new recruits. This is perceived by health workers to be a key obstacle, and unless it is removed by Government, it will remain a road-block to any further progress along this route.

The Labour Party is committed to promoting mutual and co-operative models across various sectors of the economy and society. The Labour Government supported the launch of the Commission on Ownership, chaired by Will Hutton, and running from March 2010 to September 2011 to consider the role of ownership in the governance and performance of different organisations, and the impact of this on the economy and society.³ By supporting the Commission on Ownership, the Government signalled that the considerations of such models should be ambitious and imaginative, including for those sectors currently served by shareholder-owned companies.

The Liberal Democrats have been supportive of the extension of mutual ownership into public services and have also voiced their intention to undertake a radical review of public sector pensions with the view to moving to higher employee contributions and later retirement ages. Such a review might open up this debate further.⁴

Two of the leading authorities on devising appropriate structures for employee engagement and public benefit are Professor Chris Ham, co-author of *NHS Mutual: engaging staff and aligning incentives to achieve higher levels of performance* (Ellins and Ham, 2009) and Cliff Mills, author of *From State to Community Ownership: transforming NHS Community Services* (Mills and Griffiths, 2009). The Oxford Centre for Mutual and Employee-owned Business therefore invited Chris and Cliff to lead a round-table discussion of sector experts to consider how these twin aims – of employee engagement on the one hand, and designing mutual structures to deliver public benefit on the other – can best be achieved within the NHS. On mutual structures, the consensus was

that new models need to be developed both to try to achieve greater involvement of the key stakeholders, and also to ensure that structures are fit for purpose, recognising that different models may be appropriate for different aspects of the health sector. On employee engagement, one issue debated was how to ensure that any financial pay-outs remained within the boundaries of rewarding performance without allowing the purpose of the organisation to become the creation of a financial surplus for the purpose of paying bonuses. Beyond these organisational issues, there are the political obstacles to overcome, most immediately the need to deal with the pensions issue, without which none of the disadvantaged options are really options at all.

There remains a need for financial and practical support to those wishing to take up the invitation to develop new mutual models for health service delivery. To create such ventures would take time and effort and would require considerable legal and other advice. Little headway would be possible without the provision of the necessary advice. The experience of NHS Foundation Trusts is that a set model can be quickly adopted with appropriate professional support. This could be provided by a dedicated business conversion unit, which would draw upon the experience of similar public sector conversions, such as NHS Foundation Trusts and co-operative trust schools. An example of such an agency might be Supporters Direct, which provides legal, financial and other advice to football supporters trusts wishing to take ownership and governance stakes in their clubs (on which, see Hamil et al., 2001). Some such vehicle is required for the health sector if the ambitions for stakeholder involvement and employee engagement are to be achieved.



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Hamil S, Michie J, Oughton C and Warby S (eds). *The Changing Face of the Football Business: Supporters Direct*, London: Frank Cass, 2001.

Notes

- 1 See for example www.nhscareers.nhs.uk
- 2 For a detailed analysis and discussion of the introduction of contracting into the NHS – and indeed more generally – see the various papers in Deakin and Michie (1997).
- 3 See for example http://www.ox.ac.uk/media/news_stories/2009/091215.html
- 4 See <http://www.timesonline.co.uk/tol/news/politics/article6835260.ece> and <http://www.reform.co.uk/Research/ResearchArticles/tabid/82/smld/378/ArticleID/950/reftab/56/Default.aspx>

2. From State to Community Ownership: Transforming NHS Community Services

by Cliff Mills

Currently, the future of NHS community services is uncertain. Various possible options were set out in the Department of Health's document *Transforming Community Services*. But that document gives no clear indication of a preferred option; nor did the Department of Health set out to identify a preferred option. Why not?

The reasons for this are fairly obvious:

- i. the state is generally moving away from the ownership of service-provision, and looking to concentrate on commissioning;
- ii. this raises a big question: who or what is to replace the state as the owner of service-provision? There is no single policy line on this important question;
- iii. the most common and best-known form of (non-state) ownership in western economies is investor-ownership; but in 2010 this looks an improbable option for core NHS services;
- iv. a different form of ownership is needed, which is a credible business model, and based upon public rather than private benefit.

There is no ready-made answer – no generic solution – which fully solves this problem for community services; so no clear guidance can be or is given. Instead a range of partial solutions is put forward, which are presented in the Department of Health's document as "organisational options" and each of which has some draw-back; and PCTs are left to make the choice themselves.

There is an obvious generic option to pursue as an answer to that big question, namely community ownership. This is founded upon the idea behind NHS Foundation Trusts – namely, membership based businesses that trade for the public good. The underlying concept for community ownership is that the entity is

"owned" by its grass-roots members who are its service-users, carers and staff; there is a representative body comprising elected individuals from the different membership constituencies and appointed individuals from bodies who are key to the success of the provision of community services; and it is managed by a professional board of directors, comprising executive directors who are selected for their skills and experience, and non-executive directors appointed by the representative body.

This approach draws unashamedly upon traditional co-operative and mutual heritage, in which the members "own" the organisation which exists to serve them, though it is not an ownership which they can sell. It seeks to draw upon the growing familiarity in the NHS with the NHS Foundation Trust model; to make use of the skills and experience gained by the wider health sector (including managers, professional advisors and civil servants) in the process of transition from state to NHS Foundation Trust ownership, and to describe a clear vision for the future which everyone can understand as a viable basis for the continuing provision of public services in the modern world.

Being realistic

It is appropriate, when seeking to promote an emerging and new approach to ownership and governance, to have a good grasp of reality and an awareness of how good service-delivery is achieved.

At the end of the day, it is people who solve problems, not structures. Whatever solutions academics, policy-makers and lawyers can dream up, those actually delivering the services – clinicians, support staff and their immediate managers – are the ones whose day-to-day input determines whether the service operates



well, or badly. There are plenty of examples of organisations which have been highly successful *in spite* of a poor or inappropriate ownership and governance structure; there are, equally, plenty of examples of organisations which have failed even though they appeared to have a robust and well-designed one.

An appropriate and well-designed ownership and governance structure can never guarantee success. The best it can do is to make success more likely and failure less likely. If it is well-designed, if it contains the in-built drivers of success such that those involved have the appropriate incentives to constantly drive improvement, it will make a useful contribution.

Why mutuality?

But why are co-operative and mutual ideas being put forward as an important ingredient of the future? Why has mutualism currently caught the imagination of journalists and commentators, and the main political parties? Is it just because it is not capitalism? That would be a hollow – and somewhat depressing – basis on which to promote an idea which many thought, and many may still think has had its day. The proper question is this: why do we believe that the idea would work today?

That it worked in the past is beyond doubt. The fact that there were 14 million members of friendly societies, that there was a building society in almost every town, and that more than 30 per cent of retail trade (equivalent to the market-share of Tesco today) was under co-operative ownership tells us something significant: mutuality worked. It was a highly successful way of running businesses. That strange-looking (to a modern

business eye) ownership and governance structure really worked. The businesses were not just sustainable; they grew, became very big, and in their heyday were a substantial part of the UK economy.

But that was a long time ago. The history of the second half of the twentieth century is one of sad decline. Mutuality faded. It did not implode, it did not suddenly fall apart; it gently subsided into decline, for a range of reasons which we can now look back and reflect upon. We can look back at the creation of the welfare state, and the introduction of universal provision to replace the previous patchwork of mutual and community-based provision; at the introduction of central taxation to fund services which people had previously supported locally through their weekly contributions; at the transformation of the financial services industry, such that we no longer needed local mutual organizations to look after our cash whilst we were out at work; we can reflect on an age of individualism and consumerism, in which *being a member of something*, and following *values and principles* in trading no longer seemed to make sense in a world driven largely by the pursuit of private gain.

With the benefit of hindsight, we can look back at big cultural changes that took place over a number of decades, and as a result of which mutuality no longer seemed to be relevant to ordinary people. Mutuality went into decline because it was no longer fulfilling a mainstream need; and few people missed it when it disappeared. We have to be aware of that because if we are getting excited about mutuality today we have to ask whether it would work today, and if so why.

Will mutuality work today?

Mutuality will only work today in any context if it is reinterpreted, represented and explained to a largely ignorant audience. The experience of those who work regularly now with mutual businesses is that such entities are commonly seen just as a slightly different, or rather odd way of owning and governing businesses. They are a different way of owning and governing businesses; but fundamentally, until they started to go into decline, they were also a different business model.

Outside the mutual sector, few professionals and managers are aware of this. Since few people have themselves experienced the mutual business model, they look at and interpret it through the perspective of the only business form they know and understand – namely investor ownership – and think it is just a different set of owners; you make a profit and you distribute it to different people. That is not what mutuality is. There is a big exercise of reinterpreting and representing mutuality today and re-educating those who wish to apply it.

The second point to make is that it will only work today if there is a gap to fill where other approaches have failed (a “gap in the market”, if such a phrase is not ironically inappropriate). Mutuality took off in the mid-19th century because there was a huge gap in the market – people could not get access to things which were essential – food at a fair price, protection against adversity, funds to buy their own home – and they found that if they worked together, they could meet their own needs. The genius of mutuality was that it captured self-interest and channeled it into collective action to deliver self-help.

This worked economically, and what emerged from it was an ownership and governance structure designed to deliver that economic model. Mutuality was a response to a need, and when people realized how it could help them, it grew. What is interesting about the current situation is that people (journalists, commentators, politicians) seem to be saying once again that we need something other than the traditional investor-owned business model.

Maybe these people are starting to see that there is a gap in the market today because they recognise that current ideas are not solving the problems; maybe people are starting to accept that if there really is a problem with the profit maximisation model, another business model is needed, as they implicitly recognised in the nineteenth century, but were conspicuously not admitting in the final decades of the twentieth century.

Whether mutuality works again today (in a whole range of businesses) either in its old historic guise, or as a newly recreated idea which takes on board the learning about corporate governance which has emerged over recent years, is largely a matter of choice by all of us – as users of the services, providers of the service, or members of the community which wants access to the service. A revival of mutuality in a modern form will happen if people want it to happen, and if there is a popular movement for change; it will not happen if people are largely apathetic, however enthusiastic policy-makers might be.



Can mutuality work in public services?

Perhaps the most significant problem that mutuality experienced in the 20th century was (ironically) the creation of the welfare state. At a stroke central taxation severed that link between the individual and the local organisation to which they were making their weekly contribution, or where they were depositing their cash. Many of these local community organisations, which people were entrusting with their cash, in which they had a voice and the chance to influence what they did, and which were providing them with the goods and services which they, their families and their local community needed, all of these were replaced by central taxation and, as it is commonly perceived, a centrally driven bureaucracy.

With hindsight, we can see that severing this link was a very significant factor. It was the point at which (crudely) engagement was replaced by disengagement. We have been trying to recover it ever since. If we are looking again today at the possibility of importing mutuality into public services, we have to find methods – as effective as the economic bonds between individuals and their local co-operatives a hundred years ago – to engage ordinary people in the delivery of their local services. Treating them like consumers will certainly not work, because the consumer simply goes to the competing provider.

Can that be achieved within health services? In a system based upon providing services which are free at the point of access, this looks difficult. However, much has happened in recent years and is happening now to help to re-create a meaningful and economic relationship between patients, service-users and carers and their healthcare providers. Payment by results, patient choice and personalised budgets are all helping

to recreate a meaningful and economic relationship. Slowly and gradually, economic engagement is being recreated. It is work in progress.

How will community services become community-owned?

The process of re-inventing mutuality in public services took a massive step forward with the introduction of NHS Foundation Trusts. Those involved in that process have experienced how changing structures is one thing (and hard enough), but changing culture is a different matter entirely. But it is the change of culture which is ultimately important – change to being an organisation closely linked into, responsive to and valued, supported and driven by the community – “community-owned” – which is ultimately important. The structure should help.

The NHS Foundation Trust model is a big step forwards from state ownership, but it is not the finished article. It is a stage in the process of development towards what we would argue is community ownership. The next step is the emergence of community ownership where staff, patients and communities are making it happen, not the state. For this, the Department of Health needs to be an enabler, but it is not the driver. It is good that *Transforming Community Services* does not dictate the solution. Staff, patients and communities must seek out that solution themselves.

This process has already started in some places. One of those is Kingston in south London, where the Community Services are currently in transition from state ownership to a form of community ownership along the lines described in Mills and Griffiths, *From State to Community Ownership* (see case study).

Conclusion

If we are not going to go down the route of universal state provision again, if the future of public services is not state provision, what is that future? State commissioning looks to be the future for some time; but the future ownership of provision currently remains undecided.

There would appear to be a gap in the market, which private ownership will probably not fill. Community ownership, based upon principles of traditional mutuality but recreated to incorporate the lessons of modern corporate governance, might do.

But it is only likely to do so if we as individuals – citizens, NHS staff, patients and carers – want it to.

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3. Case Study: Your Healthcare

by Cliff Mills

Your Healthcare is the new name for the Community Services of Kingston Primary Care Trust (PCT). It is currently on a pathway to separate and independent existence from its host PCT.

The new organisation will employ 550 staff, and will have an annual turn-over of approximately £25 million. It provides the full range of community based healthcare services for the general practice population of Kingston and for people with learning difficulties in the borough of Richmond.

Your Healthcare exists to provide services for the benefit of the community, rather than for the profit of its owners. It is expressly committed to:

- the Principles and Values of the NHS set out in the NHS Constitution;
- partnership working and staff involvement;
- retaining any surpluses to apply them for the benefit of the community.

Your Healthcare is a democratic membership-based organisation, with close links to its local community. It has two categories of members – Community Members (service-users, carers and volunteers) and Staff Members (employed staff). Membership provides the right to information, voice and representation within the governance. Membership is open to anyone who fulfils the relevant criteria, at no cost.

There is a Council of Governors, comprising nine Community Governors elected by Community Members, four Staff Governors elected by Staff Members, and four Appointed Governors, appointed by key local organisations which are important to the success of Your Healthcare.

The Council of Governors represents the local community within the Governance of Your Healthcare, works closely with the Board of Directors and supports them in a number of ways, in particular in the planning of future services. The Council of Governors provides a forum in which the views of patients, carers, volunteers, staff and key local bodies can be heard. It is a place where issues affecting the future of Your Healthcare can be debated and worked through with the benefit of direct input from all relevant sources.

There is a Board of Directors, comprising executive and non-executive Directors, which is responsible for managing the business, and carries full legal responsibility for delivering the services.

Through these arrangements which are based on the NHS Foundation Trust model, the local community, rather than the state, becomes the owner of Your Healthcare; and the community has an embedded role in the development of future plans for the services being provided. Although the Board of Directors remains (and must remain) responsible for delivering the service, the Directors will be discharging those responsibilities alongside and amongst the members of the community they are serving.

4. NHS Mutuals

by Chris Ham

The Government's modernisation agenda for the NHS intends to create a 'self-improving system' in which the drivers for improvement come from within the health service rather than being imposed from outside. As Lord Darzi's *NHS Next Stage Review* (Secretary of State for Health, 2008) set out, such a locally led approach to reform depends on the full engagement of NHS staff, especially clinicians. Engaging staff in the NHS and fostering partnership working at a local and national level has been an explicit priority in government for over a decade. However, experience in the NHS is variable and policy aspirations have yet to be translated into practice on a consistent basis. Surveys of NHS staff show that poor communication and a lack of involvement in decision-making appear to leave many staff feeling disempowered and demoralised. This raises questions about whether the current approach to staff engagement, important as this is, is sufficient to deliver the goal of a self-improving NHS. Rather, a re-thinking of the relationship between the NHS and its staff may now be necessary. One option is to explore the potential of employee ownership models and how these might be adapted within the NHS.

Employee ownership – when combined with opportunities for workplace participation – can deliver a range of benefits in terms of improved productivity and innovation, reduced absences and staff turnover, and higher levels of employee commitment and well-being. It achieves these outcomes by more closely aligning employee interests and goals with those of the broader organisation. The evidence suggests that employee ownership may help the NHS to engage staff and unlock their potential to drive service improvements.¹ There are at least five ways in which employee ownership in the NHS might be fostered.

- i Greater voice and participation: At a minimum, local NHS organisations could increase the extent and ways in which staff can play a role in shaping the services they deliver. This should be informed by evidence about the factors that promote effective staff participation, in particular the importance of leadership styles and managerial commitment.
- ii Employee-owned community health services: New models for community health services are being sought and appraised, and could include employee-owned social enterprises. Given the opportunity, participation structures could be built into the governance framework of an employee-owned social enterprise from the outset.
- iii Multi-professional partnerships in general practice: Employee ownership is well established in general practice and the new primary care contract made multi-professional partnerships possible for the first time. Ownership of GP services could be extended to other primary care professionals, non-clinical staff such as practice managers, and medical specialists whose work is increasingly community-orientated.
- iv A social enterprise model for primary care and community health services: A further possibility is for primary care and community health services to combine elements of options ii and iii above. General practices would continue to be run as partnerships but would collaborate with a wider range of community and stakeholder interests through a social enterprise approach.



- v Multi-professional chambers within NHS foundation trusts: In NHS foundation trusts, a multi-professional 'chambers-type' arrangement in which clinical staff within the same directorate or service unit take greater ownership would be possible. This is consistent with the development of service line management in these organisations.

These options are not mutually exclusive and the time is now right for government to support the testing out of different approaches to support the engagement of staff and to achieve a better alignment of incentives.

Staff surveys in the NHS

Many policy initiatives have been launched since 1998 to increase staff involvement and foster partnership working at a national and local level. These include the NHS Taskforce on Staff Involvement, the NHS Social Partnership Forum and the first comprehensive human resources strategy for the NHS. These initiatives have identified engaging and motivating staff as critical to the delivery of the NHS reform programme, and to achieving the goals of high-quality, responsive and efficient patient care.

The NHS Next Stage Review (The 'Darzi Review'; Secretary of State for Health, 2008) reiterated the need for NHS reforms to be locally led and clinically driven, and for there to be greater freedoms for front-line staff. The NHS Constitution (Department of Health, 2009) pledged that staff will be engaged in decisions that affect them and empowered to put forward ways of delivering better and safer services.

Notwithstanding the emphasis placed on staff engagement, experience in the NHS is variable and policy aspirations have yet to be translated into practice on a consistent basis. This suggests that more than exhortation and guidance are needed to convert policy into practice. The strongest driver of staff engagement in the NHS is a sense of being valued and involved. Annual surveys show that NHS staff are highly satisfied with the support they receive from colleagues, the amount of responsibility they are given and the opportunity they have to use their skills. However, relatively few staff report that they are involved in important decisions, consulted about changes that affect them, encouraged to suggest ideas for improving services, or feel that their organisation values their work.

NHS staff are motivated by the opportunity to deliver high-quality services that make a difference to patients. But they feel that their ability to do this is being threatened by the adoption of a more business-orientated approach within the health service.

Awareness among the NHS staff of involvement initiatives is much higher than actual levels of participation. Staff involvement is associated with a wide range of performance benefits including lowering levels of sickness absence, patient mortality and complaints, and higher levels of innovation, job satisfaction and co-operation with co-workers.

Comparisons of the findings from recent NHS surveys have found that there is a correlation between staff and patient experience. Patients are more satisfied with their care when this is provided by organisations that have satisfied staff.

Evidence of Impact

In theory, employee ownership provides employees with financial incentives that make them more committed to their organisation and more motivated at work. The benefits of employee ownership are likely to occur both directly by increasing productivity and indirectly by encouraging staff retention (see figure 1).

On average, companies experience a productivity boost of four to five per cent when employee ownership is introduced, which is sustained over subsequent years. There is also evidence that employee ownership can lead to lower levels of staff turnover and absenteeism, and to higher levels of innovation. Research has also shown that staff in employee-owned companies are more likely to confront a non-performing colleague. This finding is especially important in health care, given the importance of peer pressure as a driver of performance and the difficulty facing non-clinicians in challenging under-performance.

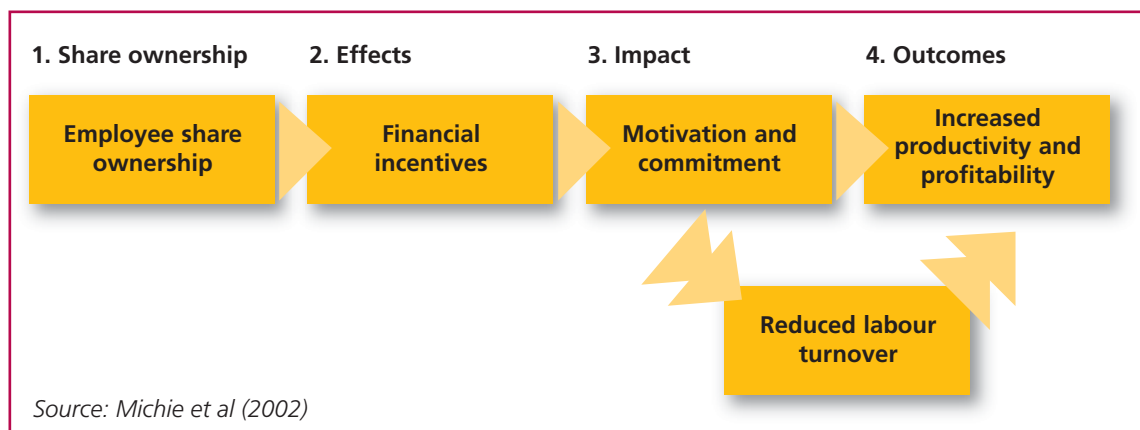
Few studies have assessed the impact of employee ownership on customer/service user outcomes. The best evidence is for mutuals, whose accountability to their customers (rather than external shareholders) has resulted in

higher levels of customer trust and loyalty. Research consistently demonstrates that employee ownership only produces (or only sustains) benefits when two further factors are present: human resource management practices that foster staff participation; and a culture of ownership that is associated with staff having a collective voice in the organisation.

This raises questions about whether staff participation and collective voice (in the absence of employee ownership) would achieve similar outcomes. Research shows that initiatives to increase staff participation in the workplace can improve financial performance, employee turnover and satisfaction. But these schemes are generally only effective when they grant staff higher levels of influence and autonomy, are introduced in bundles rather than as one-off initiatives and are actively supported by managers.

Neither employee ownership nor staff participation schemes by themselves produce the same level and sustainability of impact as they do in combination. The evidence suggests that employee ownership underpins and enhances the positive effect of staff participation schemes and increases employees' faith that such schemes are genuine and long-term.

Figure 1: Links from employee ownership to organisational effects





Within the health sector, the government is promoting new forms of ownership through the establishment of social enterprises and NHS foundation trusts. Evidence suggests that more needs to be done to promote the development of social enterprises and help them enter the market. Social enterprises may face particular barriers in competing for public sector contracts. In the UK there are currently only a handful of employee-owned organisations delivering public services. These include Central Surrey Health, which provides community nursing and therapy services and is owned by its 780 staff.

Employee ownership of public services may be expected to grow as the government challenges monopoly provision and encourages greater plurality of service provision. While there is political sensitivity around an increased role for commercial companies in public service provision, employee-owned organisations may be seen as a more acceptable alternative. Within the NHS, PCTs are being asked to develop plans for the future of their directly provided services and establish themselves as commissioning organisations. A number of options for provider services have been proposed, including the social enterprise model.

Challenges for the NHS

There are a number of challenges in the developing employee ownership in the NHS. These include whether there is sufficient political will and practical and financial support available to make this happen. The establishment of any new type of organisation within the NHS also requires support from leaders at a regional and local level, including strategic health authorities who will have a major role to play in approving local plans and business cases.

Trade unions are concerned about moves to introduce new types of provider organisation and create a mixed economy in health. However, employee-owned organisations may be seen as more closely aligned to core NHS values, and an acceptable alternative to commercial providers.

Employee-owned organisations in the NHS will be operating in an increasingly competitive market environment. While this poses a risk in terms of their long-term sustainability, choice and competition may prevent employee ownership leading to provider capture.

Access to NHS pensions remains a major barrier to Primary Care Trust (PCT) provider arms becoming social enterprises. Unless the rules on new staff employed by social enterprises not being entitled to join the NHS pension scheme are changed, then the number of provider arms choosing to go down this route is likely to be extremely limited.

Clarity about the migration path to employee ownership is also needed before this is seen as a viable option. Organisations will need to access business and legal support and other practical advice on organisational options, the transfer of staff and related issues.

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Note

- 1 This is argued in detail by Ellins and Ham (2009), which these remarks are summarising.



5. Discussion

Mr Andrew Love, MP: Under foundation trusts we had a standard model which is gradually being introduced across the whole of the Health Service. Do we see the two presentations from Cliff Mills and Chris Ham as competitive or co-operative? Do you think it would make more sense to have one or other of the models introduced?

Mr Cliff Mills, Principal Associate and constitutional expert with Mutuo: Working in a lot of sectors and then coming into the NHS, it is an extraordinarily schizophrenic context. There are those people who are passionate about doing what they absolutely believe is the right thing to do, and there is another group of people who want to get on with doing their job, they are in the NHS because they want to do care, but they actually want to be told what the rules are, what the framework is; they do not want to have to invent it because they want to get on being clinicians or carers or whatever it is. And so behind your question the issue is what do people in the NHS want?

I think the experience of foundation trusts has been that where you just drive something forwards and do it, people will sign up to it and get on board and make it work, and there are some good ones and there are some not such good ones. The advantage of having a clear model and promoting it is that a lot of people want that. It enables them to get on with the day job if they get some leadership and clarity about the direction of travel, as the NHS jargon goes. I think broadly my view is that we should be promoting a model, a way of doing it. I think there is scope for variation within that. I do not think we need to be as prescriptive as the foundation trust model. The foundation trust model is very prescriptive. The legislation is the most prescriptive corporate legislation we have

in this country, which is fine - it was a radical step forward and there were all sorts of issues that Parliament had to address in it. However, I think we can allow greater flexibility within the model of community ownership.

Mr Andrew Love: The NHS is known as very centralised. When I used to be a Parliamentary Private Secretary in the Department of Health, I was always amazed that the menus for a cafeteria in whichever hospital would come out from the Department of Health. It is very centralised. Do we have to be somewhat prescriptive?

Professor Chris Ham, Professor of Health Policy and Management at the University of Birmingham: I do not think we should be too prescriptive and say there is only one model. My view is that the way you apply these principles is likely to vary. If you are talking about community services currently provided directly by a PCT, there may be one or two approaches that could be best applied there. It is unlikely that these will always apply equally, say, in general practice. If there is an interest in going back to some of those partnership models in general practice with a big foundation trust or let us say a large mental health trust, it may well be there are other approaches too. There is a great variety out there. I sit on a foundation trust as a non-executive in the West Midlands. What is interesting is I do not think becoming a foundation trust has fundamentally changed the way that staff feel about working within that organisation. I know that because it is our experience at board level but also from talking to the chief executive of the trust who was very sceptical of these mutual approaches. Given some of our recent difficulties, he said, "I think you might have been right all along - I think there is something in this mutuality issue." That

“something” is around the lack of alignment between what the organisations are trying to do at the board level and how it feels to the front-line staff delivering the clinical services to patients and the struggle that the chief executive and the board have of really getting the energy and commitment of 10,000 staff, It feels a long way from where the board is sitting setting the direction and where those staff are actually delivering the service. So the chief executive’s view is if the learning from this work can help me in my leadership to feel the staff are with me and we are all moving in the same direction, then that is quite a radical step we may need to consider.

Mr John Coutts, Governance Advisor, Foundation Trust Network: Trying to get staff to move in the same direction as boards is a fundamental challenge, but I think foundation trusts are beginning to get there. I think that boards are becoming increasingly interested in the mutual model. I think support will grow in the future, so we could be getting to a stage where there will be a critical mass of people who are prepared to explore and look at going further, so the more discussion that takes place, the better, and it is very encouraging to see the political parties taking the issues seriously as well, so let us keep on talking about it because I think there will be scope to go further. It is certainly something that we will be looking at closely in the near future and encouraging our members to do so.

Mr Nigel Wylie, Chief Executive of Urgent Care 24: I think the issue is around investment and leadership. One of the challenges for me is getting the necessary skills and the calibre of the non-executives, and on the board of governors, to be able to drive mutual models along. A lot

of the good social enterprises that I know are driven by fairly passionate individuals and I think that passion needs to start to dissipate throughout the boards if this model is to have longevity.

Mr Mo Girach, special adviser to the NHS:

One of the reasons why mutual ownership has not been taken up by clinicians is because they are not aware of it. If mutuality is going to work, or any other forms, then clinicians will have to be there at the forefront. I think that is very, very important. Talking about community services - they are run by clinicians. Where does the patient turn up? In front of a GP in the first instance. Do not forget that GPs ran successful co-ops in this country. They owned them. So they are already aware of the model. Clinicians do not like fancy terminology like social enterprise - they are familiar with the co-operative terminology. When I talk to clinicians I do not talk about social enterprise, I talk about co-operatives, and instantly there is an engagement. There is an issue around how we engage with clinicians in terms of terminology. The other thing is to bring clinicians to the forefront of these discussions. Managers are one thing but clinicians are most important, and that does not often happen. I think that is one of the reasons why the social enterprise unit has failed to get clinicians engaged.

There are two issues around models. There is one around whether we put clinicians at the forefront; the other issue is around giving options of different models, to consider what fits best with the clinicians and the localities. We need to look at different models about how you give ownership. I know there is a lot of work involved in putting a whole hospital as a mutual but why can we not do a pilot?



Mr Geraint Day, member of a committee of the Benenden Healthcare Society:

The Benenden Healthcare Society is one of the two friendly societies that was not nationalised to create the NHS. It is a mutual organisation. Cliff Mills talked about the importance of explaining to the world at large, and the health sector in particular, the different possibilities. I think it is very important not for the sake of explanations but to actually get people to understand the language and understand what the real existing and possible structures are. We have heard about two different possibilities. You have got employee involvement models and when foundation trusts were created you got the multi-stakeholder involvement, of which one element could be employee involvement, but there is a whole taxonomy there which does actually need to be explained. I think this meeting seems to be a very good place to start and I know that other things are going on as well.

Mr Peter Hunt, Chief Executive of Mutuo:

I think what is missing from all of this is an understanding of the culture that we are trying to create. What is it that we are trying to achieve in all of this? When we talk about leadership I think that has got to start with the politicians. What I would absolutely like to see is some clarity from all the political parties about what it is we are trying to achieve here. If you talk about models, they mean different things to different people. You talk to GPs and they know about co-ops because to them co-ops are beneficial organisations for them. When you talk about different types of models it really depends on what people's personal experience is of them. My starting point would be to take a step back from all of this and look at what it is that we are trying to achieve. I think there are two things. The first thing is services that actually

work for the public. It seems a bit obvious to say it but that is what we are trying to achieve: services that work for the public and that the public feel work for them. At the same time we have got to have services where the staff feel empowered and engaged in delivering those services. The whole culture of the NHS has not been to look at either of those two as a desirable outcome in themselves. We are driven by a much more technocratic approach which you see all over the place. I can completely understand what Chris Ham has been saying about his chief executive and the penny dropping - the cultural change that is facilitated by the foundation trust structure is potentially very powerful in improving the performance of his business.

We need to be really clear about what we are trying to achieve in all of these things - we need understandable, useable, replicable models which people can take forward, but then they would know what each one is for because they are for different things. So a GP co-op is for a different thing, its purpose is different from a foundation trust. Where I would like to see the debate going next is to look at what the best places are to apply different approaches. There are risks of producer capture. We have seen it in GP co-ops. They are producer captured. The GP sector is producer captured completely, so what are the things that we would like to see and what does that mean for the application of employee-owned models? Are we satisfied that the contestability, the competitive contracts themselves are going to weed out the different interests? Are we satisfied with that? At the same time let us not throw out the desirability of employee engagement as well as employee ownership.

Mr Nigel Mason, Policy Director with the Employee Ownership Association: We work very closely with the Oxford Centre and with Mutuo. I think the three missing ingredients, as well as those mentioned, would include an absolute embrace of the profit motive; secondly, the existence of competition; and then thirdly the existence of a short list of structures that will temper those two rather strong forces that I mentioned. I think structures do matter. I know that one can get obsessed with them but I think they do matter.

On the profit motive point, I think that there are very few people like the Central Surrey example but because the career risks involved and the sheer grief involved in leading organisations through change of this magnitude is so great, a lot of people would much prefer to try and improve the status quo. Profit motives and incentives can help. They can also help in the right sort of market to create economically neat outcomes that would sometimes lead to mergers, acquisitions, assets being disposed of, other assets being acquired, businesses diversifying, businesses becoming national in scale to achieve economies.

Secondly competition - I think the absence of competition will lead to producer capture. The most grotesque example of that at the moment is obviously the investment banks which are *de facto* employee-owned but operate in a sector that does not have open and transparent competition. The people who claim the greatest share of the residual assets of some of the biggest banks in the world are the top bankers and traders because there is not sufficient competition, which is why steps are being taken to try and break that.

I think the third issue is structures. Having mentioned profit and mentioned competition, I do think that structures are needed to make sure there are the right checks and balances, and that when businesses get sold it is not for private gain if they were set up to be partly mutually owned, because that is a kind of theft really, so we need trust ownership and asset locks, even with profit motives and competition. I think we have to settle on a small number of acceptable structures that we should feel able to then promote very, very strongly and be quite clear about what the boundaries are.

Mr Andrew Love: Cliff, would you like to respond to the diversity of opinions we have had around the table?

Mr Cliff Mills: We deal with this partly in *From State to Community Ownership: Transforming NHS Community Services* by saying there is a lot of fog around this thing called social enterprise. When you stand back, there are organisations that exist for private benefit and that is the company, the for-profit market, and there are organisations that exist for public benefit. Until recently, the organisations that existed for public benefit - other than charities, which I put to one side for the purposes of this discussion - were the state bodies. What Parliament did in 2003 was to create a thing called a "public benefit corporation", which is the foundation trust, and which was an attempt to create a public benefit organisation which was not the state.

There are lots of models of private benefit, such as companies, GP partnerships, or employee-owned businesses. If the organisation exists to reward the owners and there is a restriction on the owners, it is for private benefit.



The question for us today is: who and what delivers public benefit? Historically, in our UK mind-set, it is the state and there are checks and balances on that called judicial review and statutory duties of ministers and all sorts. There is another way of delivering public benefit, which is where people themselves decide they want to get together and do something for public benefit. They want to benefit themselves because they need food at a fair price or medical care or whatever it is. What the mutual sector has not done - and we have completely failed in this sense - is to describe and get everybody to understand that there is a range of models or forms that we can use which are for public benefit and they only work if they preclude private benefit. Because if they do not preclude private benefit they become private; it is called capture. The public benefit models which are all under this woolly title "social enterprise" is really problematic because people are trying to use social enterprise to generate private benefit, and I do not think you can do it.

We need far greater clarity and we need the structures that expressly say this is a public benefit organisation. If you work hard for it you can earn more - no problem with that - but by owning a stake in it you are not going to get a lot of money. By owning a stake in it all you do is have membership rights. That is the mutual model. For me mutuality in its natural and historic form is a public benefit model. The challenge for us today is to explain that and to say you can go down 101 different routes of private benefit - no problem with that - and you are right, you need the structures.

Mr Nigel Mason: Like John Lewis.

Mr Cliff Mills: Like John Lewis, exactly. That is fine but we have got to be clear that that is not public benefit. What we have got to do - and we the lawyers are the worst to blame for this because we are totally mesmerised by all the private benefit models - is to design and promote the public benefit models. The lawyers have made it far worse by inventing something called a community interest company, which potentially causes even more confusion. What we need are absolutely clear models so that anybody who wants to work for it, who wants to trade with it, who wants to lend money to it knows that it exists as a public benefit model because that then introduces a whole different series of commercial issues, whether you are a worker, whether you are a lender, or a contracting partner, it is really helpful to know that it is a public benefit organisation and not a private benefit one.

Do not try and introduce private investment funding because you will kill it. It is perfectly possible for it to trade commercially, for income to exceed expenditure and for it to deliver a whole series of outcomes - which must include financial prudence and financial success but it does not exist in order to generate a profit or a surplus for investors, it exists to provide mutuality, and we have failed to explain that.

Professor Chris Ham: The way you present the argument, is one thing or the other. I am wondering whether that is the correct characterization. We want to find a way of maximising benefit to the public from investments in public services. It does not seem to me that precludes there being a way in which employee owners, if that is the direction we are going to go in, also achieve some benefit for themselves in the pursuit of public benefit.

Mr Cliff Mills: I think it is either/or. I think that the public benefit vehicle can pay people who work harder or deliver results. I think you can reward performance but what I do not think you can do in the public benefit model is have the delivery of a financial surplus as one of the outcomes. As lawyers we advise a board of directors that is facing Armageddon and they come to us and say, "We have got to make a very difficult decision; what are our duties? Literally, what can we do within the law without breaching our duty as directors?" If you are advising the directors of a PLC, as a lawyer you say to them your duties as a director are to maximise the return for your investors. That is the legal advice. If you are an entity which exists for a public purpose, you have got to survive financially so it does not make the economic problem go away but that is within the context of the public service obligation. I know that if I cannot go into a board room and give the directors clear advice, if I say, "You have got to take this into account and you have got to take that into account," they are going to say, "that is no good - what can we do? Have we got to prefer the interests of investors and the long-term financial viability of this entity because that is our duty, or can we take into account other things?" That is why the community interest company is such a difficult concept for me as a lawyer.

Professor Chris Ham: Does it not depend a bit on whether these organisations generate a financial surplus - what then happens to that financial surplus? I can see exactly your argument if it is a question of distributing that to investors who take it away as personal gain, but if, for example, a foundation trust generates a surplus which many of them have over the last five or six years, why not use some of that surplus to give their staff a bonus at the end of the year, which is a private benefit for the staff who work in the foundation trust?

Mr Cliff Mills: If you are writing a business plan a key thing you need to know is your selling price. How much am I going to charge for what I am producing? In fixing your selling price you need to know whether to build a profit element for investors or not.

Mr Nigel Mason: Or for the enterprise itself.

Mr Cliff Mills: Exactly. I have got to make provision for replacing assets, for expansion, et cetera. Every business has to do that, but do I also have to build into my selling price a reward for investors? If I am a private benefit enterprise, that is what I must do and I have got to operate in that competitive market-place. If I am a mutual organisation I do not have to build in a surplus for investors. I may make a surplus at the end of the year because I was being prudent, and I need to build up reserves and I need to replace the assets, but what else do I do with it? Yes, you have to have an answer to that. The co-operative answer is that our aim was, say, to provide people with food at a fair price, in which case they have paid too much. We had better give them some of it back as a dividend on what they bought to get back to a fair price. That is the co-operative approach. The difference in the business plan model about setting the prices is that the private benefit model is a profit maximisation vehicle and therefore sets its prices to deliver profit. The public benefit organisation sets its price to provide goods and services to customers without building in a profit element beyond what is needed to be prudent in operating as a business.

Mr Andrew Love: In the overall context of the Health Service, Parliament will want to be convinced about productivity. We know it is notoriously difficult to accurately estimate productivity gains but the view that has gone abroad in Parliament is that we are not getting



any productivity gains, so in that sense we are going backwards, not just in the Health Service but through a lot of our public services. I think you will need to convince Parliament that whichever model, or multiplicity of models, they will deliver real gains in terms of productivity.

A second issue is personalising services. This goes across the political spectrum. Everybody talks about it and nobody really knows how to deliver it but I do not think it is going to go away. Whichever model we introduce, or whatever the different advantages of different models, they need to be able to make a tangible difference to the experience of the person who comes into contact with the Health Service.

What I think Parliament will say is that South Surrey has happened because there is a particular individual, we know that there are not that many of these types of individuals up and down the country so the only way you can achieve substantial change in this direction is to put resources into achieving it. So you would be saying put resources into this at a time of real difficulty and we hope that we might be able to deliver a productivity improvement and a better service and experience for the patient. That is a lot to ask.

Mr Tom Shirley, Cabinet Office, Public Services Strategy:

Different models will be able to deliver different benefits and will have different risks. We need criteria by which to decide which model is appropriate in which area across public services. Clearly the health economy is diverse and there are lots of different things going on and different models are going to be appropriate on different occasions. We need to be clear on which model of mutualism, if any, will be able to help address different challenges - personalisation, productivity, the co-production agenda. I am very surprised that the co-production agenda

has not been mentioned today; we talked about employee ownership but we know the key challenges in health in particular are going to be addressed most successfully in years to come through co-production. Productivity gains of four to five per cent have been quoted by Philip Blond, and my understanding of that is that it is linked to shared ownership, which is a very different model. With other mutual models you do not see those sorts of productivity gains. We need to be very clear what we are talking about when we have these different pieces of evidence put before us.

Ms Deborah Rozansky, Office of Public Management:

The Office of Public Management is an employee-owned community interest company. I will not labour the point on how we operate but I do think that employee participation does focus on delivering better services. Fundamentally, I come back to something that Cliff mentioned which is understanding the core purpose of the organization. We have not talked about community services and what they are there for, what they encompass and, indeed, how they benefit patients. A lot of the community services fall into the category of what some people have called the "Cinderella" services. They are provided to people who have very serious, complex needs. They are the kinds of decisions that would have to be made clinically across health and social care which are very complex, which brings in of course the co-production argument. If we are talking about mutuals and the possibilities from more public participation, by focusing on providers we are missing half of the argument - not looking at the commissioners where the scope for influencing decision-making and accountability is much greater. With PCTs, why are we not talking about more public participation in decisions that are being made about an

enormous amount of resources covering the full spectrum of health services, from primary and community services, through acute services, to even the integration of services across health and social care? I would expect a number of models to emerge, but we must get the participation of the public in the commissioning decisions right.

Mr Nigel Wylie: It will be interesting to see what happens with mental health trusts and ambulance trusts as they become foundation trusts. Generally foundations trusts centre around an acute trust, which is bricks and mortar, somebody has been born there, somebody has died there, it has a natural community, there is an ownership issue, a bit like somebody volunteering to be a parent governor and then staying on, so there is something real. With an out-of-hours organization, nobody knows we exist. They phone their doctor and they get through to us and they say “who was that masked man?” Getting the public to engage and join us - and we have worked with Cliff through the summer – is an enormous task. We have gone no further than staff engagement at the moment and we desperately want care of the elderly or palliative care groups because that is where we really can make a difference, but trying to engage with the public when you are an amorphous organisation, such as many of the community services are, is really quite difficult. If you are a big foundation trust that is talking about closing a ward or a hospital then you do galvanise the public. That is a challenge for some of the smaller players in the sector such as my organisation which is less than £10 million – but that is still a significant amount of health spend.

Professor Chris Ham: It seems to me there is a narrative here that says there is market failure in many public services which leads to state/governmental intervention, but the evidence tells us that governments are not always very successful in running public services efficiently for the benefit of users and therefore there is an argument for exploring other approaches which takes us into this sort of territory. I do not think any of us is saying that mutual employee ownership models are the only ones that ought to be part of the future. It is back to how much diversity there might be, both within the mutual models and mutual models co-existing with other sorts of approaches. If you take that fairly pragmatic stance it seems to me the questions are largely empirical ones.

If there is going to be more emphasis in some places on testing out mutual models then it ought to be possible to answer many of the questions raised around the table - are they more effective in meeting user needs, do they deliver the productivity gains and efficiency gains which all of us desire to see? Unless we actually have some of those models up and running and evaluate their performance we will never know and we will be here in ten years' time having a conceptual argument for this and, frankly, we are likely to be a having a conceptual argument if they are still thin on the ground. I do not think there is an inconsistency there - and I would argue this really strongly in health care - but it is fundamentally important to get what we said in the sub-title to our research publication – an alignment of incentives for the staff delivering the care and what the organisation itself is trying to achieve. I do not think in many parts of the NHS that incentive alignment is there.



I always tell the story about my local John Lewis where you go and pick up your TV or whatever it is, having done your shopping, and there is a sign by the light switch saying "will the last person who leaves this office turn the light off because it is burning your bonus". Burning your bonus is about incentive alignment and I do not think we have got that cultural set of attitudes in many parts of the NHS because people working for hospitals and community services do not have that feeling that they are the owners and that there is a direct relationship between what they do and the success of the organisation. It does not have to be a financial incentive. It happens to be like that in the John Lewis Partnership. If you think about the Central Surrey example they would say we are not going to pay big bonuses to our staff. What we are going to do is reinvest in our staff, give them a voice in the organisation, that is the incentive - the ability to share in the direction and the management, in the way I am sure is the case in OPM and other employee-owned organisations. It is that set of issues which I think are really critical.

Mr Nigel Wylie: There is something that galvanises staff, and it is competition. We went to the market place. Our contract was up for renewal at the end of three years and 16 people came for us, from the big boys of Serco to other social enterprises, and that galvanises your staff to say, "We are going to win this because there is a pride issue." It is interesting because they would have been TUPE-ed across and everything like that, so it was not about employment; it is about 'this is us and we have built this.' So competition can be quite positive.

Professor Chris Ham: I think competition is one of the safeguards against the producer capture argument.

Mr Andrew Love: If I may say, the downside of competition we have heard earlier on in terms of foundation trusts - it takes some time to inculcate the changes that you are looking to achieve and you do not often have that time if you have to compete continuously. The Government has been convinced by the argument they are going to address some of the shortcomings in public services through competition. I am not entirely convinced that has been shown to be the case.

Mr Nigel Mason: Competition may not always work or may not always be possible. I do think Chris is spot on; it is about horses for courses. John Lewis has been mentioned a lot in the last fortnight but it works because it is in a fiercely competitive sector, it is wholly employee-owned and its structure is completely inviolable. It cannot be sold for private gain so there are things about John Lewis that are unique, it fits in that set of circumstances, and is not easily replicable. The other situation is where it is either economically stupid or just very difficult to introduce competition, where you have vulnerable users of a service who do not have an ability to shop around, and where consumer ownership and input is absolutely right. It is about fitness for purpose in a particular set of circumstance. The challenge is how do you create this kind of speed of change and vibrancy without ultimately in 20 years' time letting Capita and Serco and Tribal control the entire sector? It needs to be loosened up. I think lots of experimentation, lots of risk needs to be taken, but if that culminates in private monopolies at the end of the day, that will clearly be an abject failure.

Mr Cliff Mills: I want to return to the co-production and the commissioning points that Tom and Deborah have raised. The foundation trust experiment is interesting because, as Nigel says, you start with acutes which are bricks and mortar and the relationship that individuals have with their District General Hospital is one thing but moving into mental health trusts and specialist trusts is very different because a lot of people do not know of the existence of the mental health trust, and you are dealing with both service users and carers in a way that is different from the acute sector. Regarding how mutuality addresses these varying relationships, I think there is some learning emerging from the experience of the foundation trusts which is probably not there in the historic mutual sector because there is not that complexity of stakeholder groups that have had to be brought into the structure. For me trying to write constitutions it has been interesting to hear what those trusts are saying they want to do. It is rather constraining for a foundation trust because of the legislation, with people saying "We want to do this with the carers" and I have to say "Sorry, you can't because the legislation says this". I think there is scope to use the learning coming from the breadth of foundation trusts to address some of those points.

I think the commissioner issue is really difficult because if you engage with your users, and you are getting a lot of feedback from your community about what they want, if you then have somebody else who says we will spend the money, it is up to us, there is a tension built into what we are trying to do. There is a tension between going down the local ownership route and the separation of commissioner and providers. We have just got to work with that. We have just got to build it into the solutions that are being designed. It is no good just

assuming that you can have all this community ownership which will filter straight through into the services that are provided because there is a commissioner there, and it is one of the structural difficulties that we have to deal with. We have not decided to have PCTs with community members, probably a good thing (although it may happen). I think all we can do is recognise that we are pursuing two effectively competing policy ideas and we have just got to work within it.

Professor Chris Ham: I think all the issues have been covered from my point of view. Perhaps I could return to the multi-stakeholder theme that has been running through some of our discussion. Should this be just about employee ownership? What about the broader agenda of patients, users, citizens, the public? Precipia in Nottingham is interesting because although set up by a federation of GPs aligning with community services as a social enterprise, it emphasises, too, the role of patients and the public within its governance arrangements. I think it is a much more impressive example today of patient and public involvement in the governance of the running of NHS services than anything that has happened through Links or the other PPI initiatives (and I have lost track of what they are because they keep on changing so rapidly over the years) and it has not required the Department of Health to come out with a new institutional arrangement. It has come from the local staff and GPs saying we want to take more ownership here but we want to do it in association with the people we are serving, and they have developed their own membership model and the governance of that social enterprise has a majority of lay people sitting alongside the GPs and the nurses - developed in Rushcliffe for Rushcliffe, so it can be done.



Mr Andrew Love: I mentioned earlier that I was a Parliamentary Private Secretary in the Department of Health and I was there at the time foundation trusts were introduced and I sat through a very long dispute. One of the joys of being a PPS is you get to sit with Alan Milburn or Jacquie Smith, who were the two ministers I was working to, having conversations with recalcitrant Labour Members who are strong supporters of the centralised state model that has always existed in the Health Service, so I know the compromises that led to the introduction of foundation trusts. I have to say as a Co-operative member of fairly long-standing I remained to be convinced when they were first set up and thought that the ambition, to be honest with you, was too great. I think I have been proved to have been wrong and the cynicism about their creation has proven to be wrong as well. They have actually done much better than I think anyone expected and it seems to me that that is the building block, the foundation upon which we can build into the future.

Clearly, they have still got a long way to go and, in my view, we ought to be open and welcoming about whichever model people

want to take up locally. I think there is still a lot of work to go into refining what the choices will be, but it does seem to me that we have something here that really can address some of the serious challenges that we continue to face, not just in the Health Service, because there are attempts within education to create co-operative structures and I do think that this can be applicable much wider than just the Health Service, but of course the Health Service is, in a sense, the archetypal public service that is so close to the hearts of the public in this country, and if we can show through the adoption of some of these models, through changes in the way that both patients and employees respond to the challenges in the Health Service, then I think we can really do something to address those real challenges that we face.

Hopefully this is the start of it. I know there is a lot still to be done but I believe that we are setting out on a road that will lead to significant change, initially in the Health Service but hopefully wider in our public services, that will deliver real benefits to the people that we are there to deliver to, which is of course, the public.

About the Centre for Mutual and Employee-Owned Business (MEOB)

www.kellogg.ox.ac.uk/researchcentres/meob.php

Policy makers, academics, employees and citizens more generally are showing increasing interest in the participatory approach to stakeholder involvement created by co-owned and mutual enterprise. Sea changes in the UK and global economies have reinforced the importance of the mutual and co-owned business sectors, with their high standards of corporate ethics, community responsibility and long-term sustainable strategies.

The Oxford Centre for Mutual and Employee-owned Business is a response to this new environment. It aims to be a centre of new thinking, new ideas, new evidence and new education on these increasingly significant sectors of the UK economy.

The principal activities of the Oxford Centre for Mutual and Employee-owned Business will thus be research and professional development via tailored short courses and educational programmes focused on the business needs of the mutual and co-owned sectors.

With a commitment to applied knowledge and dissemination, the Centre will also run conferences, seminars and guest lectures and aims to promote networking and partnering within and beyond Oxford.

Aims

The aims of the Centre are to:

- Lead research into the performance of the mutual and co-owned sectors
- Offer professional development programmes closely matched to the needs of relevant businesses and the development of their current and future leaders
- Encourage debate and advance new thinking about mutuality and co-ownership
- Create a national and international network of academics, practitioners and policy makers

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The Employee Ownership Association www.employeeownership.co.uk.

Commission on Ownership

The Oxford Centre for Mutual and Employee-owned Business is hosting the Commission on Ownership, announced by Government in December 2009, chaired by Will Hutton and running from March 2010 to the autumn of 2011 – see www.ox.ac.uk/media/news_stories/2009/091215.html



Free downloads from
www.kellogg.ox.ac.uk/researchcentres/meob.php

Converting Failed Financial Institutions into Mutual Organisations

2009 Mutuals Yearbook

Copies of both the above and of this report on *A Mutual Health Service* are available for £10 (including postage and packaging) from:

The Oxford Centre for Mutual and Employee-owned Business
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Oxford OX2 6PN.

They are also downloadable free of charge from:

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Published by:

The Oxford Centre for Mutual and Employee-owned Business
Kellogg College
University of Oxford
62 Banbury Road
Oxford OX2 6PN

www.kellogg.ox.ac.uk/resarchcentres/meob.php

ISBN: 978-0-9565448-0-3

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