Their Health, Your Business:
The New Rôle of the District Health Authority
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Preface

The Audit Commission is responsible for the external audit of National Health Service (NHS) bodies in England and Wales, including district health authorities (DHAs) and family health service authorities (FHSAs). The Commission's auditors are required by law to examine the arrangements being made for securing economy, efficiency and effectiveness in these authorities.

The role of the district health authority was fundamentally altered by the NHS reforms introduced by the NHS and Community Care Act 1990. Many DHAs are no longer responsible for direct management of health service provision, and instead have to ensure that the population receives those services which best meet identified health needs. This report sets out the Commission's view of the DHA's new role (but not the relationship to any directly managed provider units, nor other duties such as communicable disease control and nursing home inspection).

The implementation of the reforms has been characterised by rapid change, which was observed during the fieldwork for this study over a year ago, and has continued since. Many and various working practices have evolved. This is in some ways a healthy sign, like the bio-diversity that is essential to the tropical rain forests. Yet it also suggests a lack of direction in all this activity - a gap which this report aims to help fill.

This report is being published at the same time as another Audit Commission report on the developing role of FHSAs. But the fact that the Commission is publishing separate reports on DHAs and FHSAs does not indicate a belief that they should remain as separate authorities. Indeed, in the Audit Commission's view, there is much to be gained from having a single authority to cover all the existing roles.

Over the next six months, the auditors of each DHA will be assessing how well it is meeting the challenge of the new rôle. They will make a confidential report to each authority.

The study on which this report is based was carried out by a team directed by Dr Jonathan Boyce and consisting of David Bird, Geoffrey Rendle and Ellie Scrivens, supported by Jonathan Sercombe and Netrapi Srisasi. The health authorities visited, and the members of the project advisory group, are listed in the appendix to the report; we are grateful to them all for their co-operation and support.
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Since April 1991 responsibility for hospitals and community health services has increasingly been devolved to their own unit management. District health authorities (DHAs) now have to focus their work on identifying the health needs of their resident populations, and how improvements in health may most effectively be secured. This requires that DHAs make progress in four areas:

— **Formulating strategy** for implementing their new role;

— **Preparing to purchase** hospital and community health services, by identifying the most effective patterns of care (preventative as well as remedial, rehabilitative and supportive);

— **Working with providers** to ensure that these services are delivered efficiently and to acceptable standards;

— ** Liaising** with the wide range of local organisations, statutory and otherwise, that also have an interest in people’s health.

**FORMULATING STRATEGY**

Implementing the new commissioning role demands radical change from all DHA staff. Some DHAs lack a clear vision of the future which is shared throughout the organisation. Others have made substantial progress.

Authorities should produce a concise document setting out a vision of health for the local population, and specifying the areas for priority action. This exercise should be co-ordinated with FHSAs and local authorities.

Chief executives have to ensure that the strategy is translated into objectives for each part of the DHA.

**PREPARING TO PURCHASE**

Identifying local needs is the first stage in a process that must continue with an assessment of which services will most effectively meet those needs, and conclude with an affordable purchasing plan which can be negotiated with providers. Progress is frequently hampered by a shortage of information and skills, and a lack of clarity about the process.

The director responsible for preparing the purchasing plan must identify and improve access to a wide range of ‘hard’ and ‘soft’ information sources, and ensure that the DHA has the skills and resources to analyse, digest and report on all this information.

The responsible director should:

— have a long-term programme of work, agreed with the chief executive and rooted in the DHA’s corporate strategy;

— concentrate in the short term on a few areas of work, to develop specific recommendations that can be negotiated and reviewed with providers.

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**Summary**

Since April 1991 responsibility for hospitals and community health services has increasingly been devolved to their own unit management. District health authorities (DHAs) now have to focus their work on identifying the health needs of their resident populations, and how improvements in health may most effectively be secured. This requires that DHAs make progress in four areas:

— **Formulating strategy** for implementing their new role;

— **Preparing to purchase** hospital and community health services, by identifying the most effective patterns of care (preventative as well as remedial, rehabilitative and supportive);

— **Working with providers** to ensure that these services are delivered efficiently and to acceptable standards;

— **Liaising** with the wide range of local organisations, statutory and otherwise, that also have an interest in people’s health.
The annual plan that each authority has to publish should make clear not only what it wishes to purchase but why those options were chosen as priorities.

**WORKING WITH PROVIDERS**

Having specified services needed by their population, DHAs have to obtain them from provider units. Three issues stand out: many purchasers have little real choice of providers; information on what is or could be provided is poor; and the process of contracting is both complex and unfamiliar.

Directors of purchasing should understand the capabilities and aspirations of current providers, and actively support development proposals that fit in with the DHA's own objectives – perhaps by providing pump-priming funds.

DHAs should improve their information about the price and quality of services offered by different providers. They should use it, working closely with GPs and neighbouring DHAs, to make best use of any opportunities for moving work to those providers that offer better value for money.

To improve the ability of contracts to influence service provision, DHAs need to:
- encourage the development of clinical guidelines, and auditing of compliance with them;
- define and monitor a limited number of realistic and measurable quality targets;
- develop pricing arrangements which influence providers to deliver the required quantity and quality of activity.

And all negotiating and monitoring meetings should be properly and efficiently conducted.

Extra-contractual referrals (ECRs) should be analysed to indicate needs that are not being met under current contracts.

**LIAISING WITH OTHERS**

DHAs need good communication with many sectors of the local community, particularly GPs and service users. Such communication must be two-way: informing them about current services and proposed directions for change, and seeking their knowledge and opinion of local provision. Whatever methods of communication are used, districts must ensure that:
- coverage is comprehensive or at least representative;
- communication is carried out jointly with the FHSA and local providers whenever appropriate;
- there is a firm intention to allow the feedback to influence commissioning decisions.

Better working with the FHSA and local authorities (LAs) is crucial to the success of commissioning. General practices offer an increasingly wide range of health care, and integrated community care planning is now a statutory requirement. Despite the great differences between the three bodies, all DHA directors should:
- pursue a clear agenda with FHSA and LA colleagues, with the chief executives setting a lead and meeting regularly;
- work rapidly towards joint appointments and projects.
MANAGING THE RESOURCES

Commissioning activity typically absorbs 1% to 2% of DHAs' revenues (depending on the size of the authority). Some authorities spend well above average on particular activities; they need to be able to demonstrate that this extra spending contributes to their strategic objectives.

Finance directors must ensure that the costs of commissioning are clearly identified separately from any remaining provider functions such as running the payroll for the local hospital. Some aspects of commissioning such as processing data from providers, may be carried out more efficiently by consortia of districts, or independent agencies.

All directors must identify the staff numbers and skills they require, and develop plans for individuals' career and professional development, in such a way as to meet the organisation's needs.

FINALLY...

The practice of health care is changing radically, with increasing emphasis on primary care and on patient involvement. In this environment, really effective commissioning depends on joint working by DHAs and FHSAs, and this is evolving steadily in a significant number of authorities. But it is voluntary at present, and some DHAs and FHSAs are not doing it. All need to be encouraged to do so, and legislation is needed to allow the formation of single, comprehensive commissioning authorities. A unified strategic commissioning authority would have to be clear how it related to GP fund-holders, and indeed a more flexible relationship with all general practices may be needed. But whatever developments occur in future, district health authorities already have a distinctive part to play in making services more effective and responsive to the needs of their population.
COMMISSIONING: A NEW FOCUS FOR DHAs

1. District health authorities (DHAs) will spend some £25bn in 1993/94 on hospital and community health services in England and Wales. In doing so, each must ensure that health needs of the local population are met and that people have access to a range of high quality, good value-for-money services. It must also seek to influence and work with other statutory and voluntary bodies whose activities affect local people's health.

2. All of this has been true of DHAs since they were instituted in 1982, and has not been altered by the reforms stemming from the NHS & Community Care Act 1990. So what has changed?

3. First, the relationship of DHAs to health service providers has been altered. DHAs are losing direct responsibility for running local hospital and community services which convert to NHS trust status. Instead, districts have to decide what activity and quality levels they require, and reach explicit agreements with service providers on these and on the appropriate funding levels. And they have to relate in this way to any providers of health services to the local population - not just to those that lie within their boundaries.

4. Second, in parallel with the reforms, there have been significant central policy initiatives, for example those embodied in Health of the Nation (Ref. 16) and the Patient's Charter (Ref. 17). To implement such initiatives, DHAs have to place greater emphasis than before on tasks such as: working with other bodies to develop community care, listening to the views of the local population about health needs and services, and establishing closer links with primary care. And above all, they now have to monitor local health status as the ultimate measure of their success. Together with the purchasing of health services, these wider responsibilities comprise the commissioning role 1.

5. Freed from responsibility for particular provider units, and held accountable for improving the population's health, DHAs have a great opportunity to alter the pattern of health care provision. They should be seeking to move to services which are not only more efficient, but also more effective in satisfying the local population's needs, and improving its health.

6. Grasping this opportunity will not be easy. Districts are having to make radical changes to their own objectives, cultures and working practices. Many DHAs have responded well to these challenges, and some of their initiatives have been publicised in NHS Management Executive papers (Refs. 1 to 5). There has however been concern that slower progress by some districts could result in an imbalance of influence between DHAs and providers, and limit the

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1 DHAs are now often referred to as purchasers. But the word purchaser, implying as it does an act of handing over money in return for services, fails to convey a DHA's wider responsibility for meeting the population's health needs. The term commissioning is often used to describe the whole process of assessing local service needs and meeting them, whether by purchasing health services, or by working alongside other organisations with similar objectives. This report generally uses the term commissioning, reserving purchasing for the narrower task of contracting for, monitoring and paying for health services.
overall gain from the reforms. This internal readjustment is made even harder by uncertainties in the external environment such as the future roles of regional health authorities (RHAs) and family health service authorities (FHSA)s, the possibility of mergers between DHAs, and future levels of funding.

7. This report aims to do three things:
— to clarify the framework within which DHAs must set their objectives;
— to set out key elements of the commissioning process, around which DHAs must reshape their structures and activities; and
— to identify problems in setting objectives and reshaping the organisations, and wherever possible to suggest solutions.

This introduction continues with overviews of the objectives of commissioning, the key tasks facing districts, and the importance of working closely with other organisations. The main part of the report (Chapters 1 to 6) then looks at each of the key elements in turn, highlighting problems and suggesting approaches to their solution.

THE OBJECTIVES OF COMMISSIONING

8. The ultimate aim of commissioning is to improve the health of the population while increasing users' satisfaction with health services. Put fashionably, it is to achieve 'health gain'.

9. Such a broad aim encompasses many specific outcomes, both for individuals and populations. Examples are: increased life expectancy for 70-year olds, reduction in avoidable deaths in those aged under 60, or improvement in the quality of life for sufferers from chronic diseases such as rheumatoid arthritis. Such objectives are unlikely to conflict with each other directly, but they will always be in competition for limited resources. It is therefore desirable that each DHA debate and clarify its underlying values so that its purchasing plans (Chapter 2) reflect agreed strategic priorities. This process will be contentious and difficult, and it is doubtful whether the NHS is professionally, managerially or politically ready for it. But in the long run such clarity will be essential if real headway is to be made with the broad aims.

10. But whether or not DHAs have succeeded in clarifying and prioritising the components of their broad aims, they should have operational objectives to guide their commissioning activities. There are four groups of operational objectives which will ensure that the DHA makes the best use of its resources for commissioning health services. These are:
— improving the quality and efficiency obtained from current service providers;
— transferring work to other providers whose services represent better value for money, but are just as acceptable to GPs and patients;
— substituting more effective services in place of existing forms of treatment, and actively supporting providers in developing these, as well as reducing commitment to services known to be ineffective;
— working with the local community and with other organisations to ensure that commissioning of health services is co-ordinated with other programmes (Exhibit 1).
Exhibit 1
A FRAMEWORK FOR OBJECTIVES IN COMMISSIONING

There are four groups of operational objectives for DHAs

Source: Audit Commission.

THE TASKS

11. Progress within this framework of objectives depends on success with several key, interlinked activities (Exhibit 2, overleaf). Of over-arching importance is the process of:

— **formulating strategy**, of determining the desired outcomes and the actions to be taken to achieve them.

These actions fall naturally into three categories:

— **preparing to purchase** by assessing needs and deciding on suitable services to commission;

— **working with providers** such as hospitals and community units, through contracts and extra-contractual referrals;

— **liaising** with statutory organisations and community-based groups.

And all four activities rely on a fifth one:

— the DHA's **management of its own resources**, especially its staff and its information and financial systems.

12. Although these five activities are discussed separately in subsequent chapters, in reality they are strongly interdependent. For example:

— Good **liaison** with the local community is vital if its needs are to be understood in preparation for purchasing.

— Effective **working with providers** is easier if the preparation for purchasing has clearly established why service changes are required locally.
COMMISSIONING ACTIVITY

There are several key, interlinked areas of commissioning activity:

- Above all, without a shared corporate strategy, there is a risk that individual DHA departments will follow their own priorities to the detriment of corporate objectives.

WORKING WITH OTHERS

13. The district health authority is not the only body concerned with the health needs of the local population. Many other stakeholders, including GPs, hospitals and community health providers, FHSAs, CHCs and voluntary organisations, share this concern. And others, not so directly involved with health services, can affect the DHA's ability to ensure that health needs are met; for example, local authority departments of social services and housing have objectives that make strategic and operational interaction with DHAs essential.

14. There are several reasons why a DHA needs to develop close working relationships with these other bodies or individuals whose objectives overlap its own. First, there is a need to clarify and understand what they are trying to achieve and then work with them to avoid duplication or omission in meeting needs. Second, joint working can increase the potential for achieving mutual objectives. For example, since DHAs cannot guarantee to fund all GP referrals, however many there are or however much they may cost, it is in everyone's interest that the available resources are matched to those most in need. But this matching can only be achieved if there is co-operation between the DHA, hospitals and local GPs.

15. Finally, and most importantly from the consumer's point of view, close collaboration is necessary to ensure good communication and co-operation at the operational level. Indeed, this
should be so good that the consumer of services is unaware that different bodies have been involved in making them available - the so-called 'seamless service'.

16. Various patterns of collaborative arrangements between DHAs and other bodies are evolving. In the case of local authority social services, the issues have been addressed in separate Audit Commission reports — Managing the Cascade of Change, and The Community Revolution (Refs. 6 and 7). Patterns of working with FHSAs are covered in chapters 5 and 7 of this report, and also in the Commission's report Practices Make Perfect (Ref. 12). Three others merit special consideration:

— GP fund-holders, as the main alternative commissioners of secondary health care;
— neighbouring DHAs, in view of the possibilities for consortium working or merger;
— RHAs, as being responsible for DHAs' performance as commissioners.

GP FUND-HOLDERS

17. Fund-holding GPs are responsible for purchasing some secondary care services for their own patients. They are well-placed to do so. Since they make most of the referrals of their patients to hospital and community health services (HCHS), they are aware of the needs of individuals. And early fund-holding practices have been quick to use their purchasing power to influence local hospitals to provide services and standards that meet their patients' needs. The number of fund-holding practices has increased substantially each year. Their influence would extend if - as many existing fund-holders would like - they were to be funded for purchasing a greater proportion of HCHS than the present 20%.

18. District health authorities are therefore in one sense 'in competition with' fund-holding GPs. If a DHA fails to assess needs accurately or to commission the right services, then it will increasingly be local fund-holders who set the agenda for change in hospitals and other health services. But the 'competition' is for the same prize, better health for local people, and they will be better served where DHAs and GP fund-holders work in partnership. Achieving such partnership may require structural changes, as discussed further in chapter 7.

NEIGHBOURING DHAs

19. The second special case of liaison with other bodies is that of neighbouring DHAs. Although they are responsible for different populations, there are good reasons for developing close working relationships. Benefits can include:

— joint liaison with third parties such as local authorities, often with a gain in coterminosity and simplicity;
— sharing scarce technical or professional skills;
— gaining some scale economies in the commissioning process;
— improving purchasing power and intelligence, and increasing the choice of providers;
— spreading the risk for some rare medical conditions with high treatment costs.

Many different models have evolved of joint working between neighbouring DHAs (Exhibit 3, overleaf), and in some cases there has been complete statutory and operational merger.
Exhibit 3

WORKING MORE CLOSELY TOGETHER

Many different models have evolved of joint working between DHAs

Source: Audit Commission.
20. There are disadvantages to any partnership (or 'consortium') arrangements or mergers. The larger and more diverse the population served, the more difficult it is for senior managers to be accessible to GPs and other key local figures, or to be in touch with a representative sample of the local community. (One solution, discussed in chapter 7, is to base commissioning around 'localities' within the larger population.) It can take many months for staff to work effectively together in large consortia, particularly where the 'partnership' has come about at the RHA's instigation, without the full commitment of all the participants. Finally, the run-up to the formation of consortia can create uncertainty for staff and for other organisations, and this uncertainty itself becomes an obstacle to progress.

REGIONAL HEALTH AUTHORITIES

21. RHAs have two major roles to play in relation to DHA commissioning: allocating resources equitably, and holding commissioners accountable to ensure the availability of a comprehensive range of effective health services in each locality.

22. RHAs must hold district health authorities accountable for their performance, both as purchasers of care and in their broader public health functions, reviewing them against objectives that reflect national initiatives such as Health of the Nation or the Patient's Charter. However, this must be done in a way which allows DHAs to balance such top-down objectives with local priorities.

23. Performance review will identify areas of weakness in individual districts. Regions therefore have to indicate where development is needed. Many RHAs go further by providing development programmes such as training and conferences, but districts should be able to choose alternatives.

24. Regional health authorities currently set objectives not only for DHAs, but also for FHSAs and (either directly or by delegation to FHSAs) for GP fund-holders. They are therefore responsible for the balance between primary and community services on the one hand and hospital services on the other, and should ensure that DHA and FHSA objectives and strategies are co-ordinated.

25. There is a need for some elements of supervision and regulation in the new market. For example:

— Provider units can be placed in financial difficulty if a few purchasers withdraw even a minor amount of business.

— Contract disputes and inconsistent information can cause the market to malfunction and require arbitration.

— The process by which a provider ceases to provide services may require careful management.

26. So far, market supervision and regulation have been shared between RHAs and zonal outposts. This has happened chiefly because these bodies have the powers necessary to carry out such regulation (e.g. the ability to top-slice funds, to force acceptance of contracts, and to intervene in the capital allocation process). It has not happened as part of a clearly specified policy framework. Yet it is by no means clear that the default solution of RHAs and zonal outposts carrying out these roles is necessarily the best one.
27. In this context, the Secretary of State's recently established review of the role of RHAs is particularly timely. The greater clarity and reduced uncertainty expected as a result of that review should greatly assist the development of health care commissioning.
1. Formulating Strategy

INTRODUCTION

28. A commissioning authority exists to bring about changes which will improve the health of local people. It must have a clear vision of how it will influence the nature, quality and efficiency of health services. It is also essential that the strategy is co-ordinated with other organisations whose products or services have an effect on health. The whole strategy should embody the authority's core objectives and values, demonstrating where the authority is going, and how it intends to get there (Box A).

Box A
THE COMPONENTS OF A COMMISSIONING STRATEGY

<table>
<thead>
<tr>
<th>Where are we going?</th>
<th>How do we get there?</th>
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</thead>
<tbody>
<tr>
<td>Broad objectives and values</td>
<td>Approaches to needs assessment</td>
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<td></td>
<td>Public communication</td>
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<td></td>
<td>Choice of services and providers</td>
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<td>Current pressures for change</td>
<td>Quality development in providers</td>
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<td>Efficiency gains in providers</td>
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<td>Information technology</td>
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<td>Finance (balancing expenditure with income)</td>
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<td>Staff development</td>
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<td>Influencing other organisations</td>
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29. This does not mean that a commissioning authority must produce a single document covering all aspects of its strategy in detail. Details of the strategy may be embodied in several separate documents. But there should at least be a brief document summarising all the main components. Whatever the format of the strategy, it is essential that the parts fit together, that all sections of the organisation base their activities on it, and that it is readily capable of being developed.

THE PROBLEMS

30. Problems in formulating and developing strategy include:

— the magnitude of the task;

— the failure of some staff to adjust fully to the commissioning role;

— the uncertainty surrounding changes such as DHA mergers and the growth in GP fund-holding;

— the persistence of traditional departmental boundaries.
31. The magnitude of the task of formulating strategy appears daunting. Not only do many different areas have to be addressed in a co-ordinated fashion, but some, particularly core objectives and values, will be contentious or difficult to express.

32. Strategic direction is hard to develop in those DHAs where key staff have not fully adjusted to the commissioning rôle. The new role represents a major challenge, which has been accepted enthusiastically by many managers. However, where large provider units are still directly managed, senior DHA staff remain ultimately responsible for their performance and finance, and some want to work for the provider side once an NHS trust is established. Such circumstances make it harder to develop the benefits of separate commissioning.

33. There is a disincentive to thinking strategically in districts where change (or proposals for change) involving consortia and mergers is superimposed on the substantial functional changes that all districts are experiencing. Many districts have tried to form consortia with neighbouring authorities, perhaps also involving the FHSA. Some such plans have been stable. Others however have suffered successive revisions; they have been imminent one month, and off the agenda a short time later. Such equivocation appeared to have affected the development of effective commissioning in 4 out of the 11 sites visited as part of this study.

34. In addition, there has been general uncertainty about the future role of RHAs, about the relationship of DHAs to FHSAs, and about the likely growth of GP fund-holding. Many managers and their organisations have taken the view that there is no point in developing a strategy in any detail until such issues are resolved.

35. Unless a district develops an overall strategy, it is hard to build working arrangements that cross traditional departmental boundaries. Yet many of the operational tasks essential to good commissioning need to cut across these boundaries if they are to be most effective. For example, optimal management of extra-contractual referrals (see Chapter 4) requires co-ordinated working by finance, information, and public health staff.

OVERCOMING THE PROBLEMS

36. Despite the magnitude of the task of formulating a strategy, many commissioning authorities have determined at least the basis of their approach. Although few districts attempted this when the reforms were first introduced, an increasing number are producing an overall health strategy, or at least defining an approach to doing so. Documentation in the early stages can be limited to concise statements about the key task (Case study 1). Each section can then be reviewed corporately and extended as much as necessary to guide operational activity towards the organisation’s goals.
There is no simple way to resolve complex or contentious issues such as core values. But they will be easier to address with conviction if there is effective consultation with the authority’s various stakeholders.

37. The problem of key staff not having fully adjusted to the commissioning role, and the uncertainty caused by continuing structural change, will both reduce the effectiveness of commissioning unless they are addressed. DHAs can develop their own staff in many ways, some of which are discussed in chapter 6. Structural stability, however, is an issue for the NHS Management Executive, and RHAs or their successors.

38. A strategy will have most effect if it has been developed and discussed by all senior staff. They should also be involved in any subsequent revision and updating. This process will help to strengthen corporate cohesion and address the problem of traditional departmental boundaries. Techniques such as one-off seminars or regular team meetings have been used (see Case studies 2, below and 3, overleaf).

Case study 1

The former North Mersey Consortium set out a three-year purchasing strategy, and presented it with a six-page summary for the benefit of DHA members. It outlined the major initiatives being undertaken to:

- assess health needs;
- address quality issues;
- agree contract volumes in the light of historic patterns of treatment and pressures for change;
- seek efficiency gains through contracts;
- relate to other agencies and consumers;
- manage the capitation-related loss of funding;
- monitor and review contracts.

Key components of the plan were updated the following year in order to set priorities for action.

In Bath DHA the public health director's annual report was used not just to make recommendations to address specific identified health needs, but also as a structure for discussing broader issues facing the authority, such as:

- the nature of health, and the effect of environmental factors and funding levels;
- contributions from statutory bodies, voluntary organisations, GPs, consultants and CHCs;
- challenges such as outcome-based purchasing, equity, priority setting and consumerism;
- the implications of surveys undertaken of professional and public opinion.

Following publication of the report, seminars were held for all senior employees and non-executive directors, at which these issues were debated.

Case study 2

In Bath DHA the public health director's annual report was used not just to make recommendations to address specific identified health needs, but also as a structure for discussing broader issues facing the authority, such as:

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- challenges such as outcome-based purchasing, equity, priority setting and consumerism;
- the implications of surveys undertaken of professional and public opinion.

Following publication of the report, seminars were held for all senior employees and non-executive directors, at which these issues were debated.
DHAs should:

- engage in widespread consultation about their strategy, especially with FHSAs and local authorities;
- produce a concise strategy document which:
  - sets out their health objectives;
  - specifies priorities for action;
  - states how the strategy will be updated and reviewed.

Chief executives should:

- stimulate discussion of the strategy throughout their organisation;
- translate it into specific objectives for each DHA directorate.

### Case study 3

Great Yarmouth & Waveney DHA places great importance on structured weekly meetings of senior staff responsible for finance, information and public health as well as contract managers, so that a common sense of direction can be developed. Papers are presented to successive meetings for full discussion before being taken at the formal health authority meeting. Topics being covered at the end of 1991/92 included:

- improving the quality of health care;
- consumer research with the CHC;
- mental health strategy;
- the purchasing intentions of a neighbouring district;
- public relations.

### SUMMARY OF RECOMMENDATIONS

DHAs should:

- engage in widespread consultation about their strategy, especially with FHSAs and local authorities;
- produce a concise strategy document which:
  - sets out their health objectives;
  - specifies priorities for action;
  - states how the strategy will be updated and reviewed.

Chief executives should:

- stimulate discussion of the strategy throughout their organisation;
- translate it into specific objectives for each DHA directorate.
2. Preparing to Purchase

BACKGROUND

39. District health authorities have the task of using available funds to commission services that best meet the needs of the local population. Identifying local health needs is only the first stage in a process that must continue with an assessment of which services can help to meet the needs, and end as an affordable purchasing plan which can be negotiated with providers. Each of these three stages in preparing to purchase requires information from several sources (Exhibit 4).

Exhibit 4

PREPARING TO PURCHASE
Each of the three stages in preparing to purchase requires information from several sources

Source: Audit Commission.

40. The first stage is to compile a list of local health needs, using a range of sources of data and information, including:

— the opinions of many individuals and groups, including consumers, carers, GPs, hospital and community health staff, patients, self-help groups, voluntary organisations, and the general population;

— epidemiological data on incidence and prevalence of disease, both locally and elsewhere;

— published research reports and ‘grey’ literature;
The last stage is to determine priorities, since almost inevitably the whole 'shopping list' will not be affordable. The choice of services needs to be based on the effectiveness, cost, and local support for each. The effects of not providing a particular service should also enter the equation. The final result is a purchasing plan, to be used as the basis for negotiating and working with local providers (Chapter 3). The current chapter considers problems and solutions relating to the information needed at each stage, and to the management of the processes involved.
THE PROBLEMS

PROBLEMS WITH INFORMATION

43. Information problems are not new to those working in the NHS. DHAs as commissioners need many types of information, ranging from informally gathered local opinion, to formal data on such things as service activity and cost. There are problems in all of these areas.

Local opinion

44. District health authorities need to obtain the views of many groups of people about local health needs and priorities for purchasing health services. But it is difficult to obtain views that are representative of a whole population. Self-selected groups are almost always a biased sample. Random samples from, for example, the electoral register, are more reliable provided the response rates are sufficiently high.

45. Perhaps the most serious difficulty is obtaining informed opinions, given after the issues have been properly communicated, understood and considered. Questions about health needs, for example, are often interpreted as if they were about the need for health services. Responses such as 'the people of this town need a scanner' are not uncommon.

Epidemiological data

46. Most routinely available epidemiological data relate to mortality, not to the incidence and prevalence of disease, although there are exceptions such as cancer registries and child health surveillance systems. Only for diseases which are usually rapidly fatal, such as some leukaemias, does mortality act as a reasonable proxy for incidence.

47. But for many common diseases such as rheumatoid arthritis, mortality is virtually useless as an indicator of need. The use of data from GP practices can help in such circumstances. Although such data are strictly speaking a measure of demand, and therefore probably underestimate true incidences and prevalences, they nevertheless provide some of the best available estimates of population need. But there are practical problems: systems are seldom compatible between practices, and practices with good data tend not to be typical. Moreover some FHSAs have taken the view that obligations of confidentiality prevent them from releasing such data to DHAs.

48. Finally, local surveys such as those of health status may be helpful. But they are relatively expensive, and it is seldom possible to make comparisons with other districts unless the surveys have been co-ordinated.

Current use of services

49. Information on use of services poses several difficulties as an index of need. The level of use will be influenced by expressed demand which may differ considerably from an authority's view of need. Furthermore, use of services is heavily reliant upon the amount available: for example, the more beds there are in a hospital, the higher the in-patient admission rate for local people. There are similar problems in using waiting lists and times as an index of need.

50. Although it is difficult to interpret, information on the current use of services is generally held to be some of the most reliable available, and cannot be ignored. Some problems do occur, because the coding of clinical information such as diagnosis or operation
is often poor (Exhibit 6) - in 28% of hospitals, at least 20% of in-patient episodes had poor or missing coding in 1990/91 - and because different providers hold the data in different forms. The quality of data is usually worse for out-patient and community health services.

Exhibit 6
QUALITY OF DIAGNOSTIC CODING
The coding of clinical information is often poor

Note 1: Hospitals are shown in order of size, with the smallest on the left.
Note 2: Episodes were classified as having poor or missing coding if the records generated DRGs 467-469 ('dubious') or 470 ('ungroupable').
Source: Audit Commission data from 12 regions, 1990/91.

51. Information on the use of services is not required just as an index of need. It is necessary to understand current usage in some detail if more effective patterns of service are to be commissioned. For example, if DMAs wish to move from purchasing services en bloc, to purchasing to meet the needs of specific care groups (Exhibit 7, overleaf), they will require information that identifies the current use of each service by each care group. Such detailed information is seldom available.

Effectiveness

52. Conclusive evidence of the effectiveness of most services currently provided by the NHS is scarce. And what there is, is often narrow in scope. As the Royal College of Physicians has recently observed, 'although outcomes of care used in randomised controlled trials may be biologically important and may be relevant to prolonging life, they may be insufficiently sensitive to the quality of life and fail adequately to reflect the patient's perspective' (Ref. 24).

PROBLEMS WITH THE PROCESS

53. Obtaining accurate and relevant information is not the only area of difficulty. Further problems arise in managing the way in which the purchasing plan is derived, and ensuring that
the tasks involved (outlined in Exhibit 4) are well integrated with the contracting process. Shortage of skilled staff is a major problem as in other areas of DHA activity; it is considered in chapter 6.

The size of the agenda

54. The range of health needs and health services is vast and complex, and the lack of relevant information is profound. Consequently those responsible for 'preparing to purchase' often have trouble deciding where to begin. Yet unless there is a strategy defining the overall approach to the task, the work programme may come to be driven by the interests and enthusiasms of individuals.

Limited use of data

55. Districts receive data from many sources, especially provider units. Yet often they are ill-equipped to handle the data, lacking appropriate technology and suitable analytical skills. This is compounded if the data lack a common format, or if the useful data have to be extracted from a large quantity of chaff.

Poor integration into the DHA

56. In some DHAs, preparation for purchasing does not appear to be well integrated into the rest of the organisation. There are various reasons for this:
— The advice being fed to the contract negotiators may be impractical. It may be couched in terms of needs rather than services or it may not be adequately prioritised.

— Those responsible for the tasks may lack influence with the rest of the organisation. This may have a historical foundation; prior to the reforms, public health views sometimes went unheeded when decisions were made. And particular directors of public health have had problems reconciling their independent role as guardian of the community’s health, with the requirement to participate in such unenviable corporate decisions as deciding which services are unaffordable. Whatever causes such lack of influence, the outcome is usually insufficient dialogue between those assessing needs and those responsible for implementing contracts with providers.

Unclear management of the process

57. The process by which identified health needs are turned into a purchasing plan is often obscure. Almost all districts document the start and end points using the public health report and the purchasing plan. But frequently the intermediate steps are unclear: for example how priorities were established or which criteria were used to evaluate effectiveness. It may consequently be harder to justify the purchasing plan and defend its proposals as an effective agenda for change.

58. Health authorities also face a problem knowing how much weight to give to information from different sources. The local perception of service priorities may conflict with central directives from the Department of Health or the RHA, and they then have the difficult task of deciding between them.

OVERCOMING THE PROBLEMS
GETTING BETTER INFORMATION

59. There is a growing number of sources of information which can support preparation for purchasing. Relevant staff need to be aware of the opportunities, and to establish links where appropriate. Action should be taken to improve access to information, both from routinely available national sources, and from local ones.

60. Information on effectiveness of services is becoming more common. The Leeds School of Public Health is co-ordinating a pilot series of effectiveness bulletins. The Cochrane Centre in Oxford is co-ordinating and facilitating systematic overviews of research into effectiveness. A ‘Needs Network’ clearing house for public health studies has been set up at the West Midlands Institute for Public Health, to supplement published sources by facilitating access to unpublished work from other districts.

61. Information on effectiveness of services traditionally tends to under-represent patients’ views. Health authorities need to establish patients’ views, perhaps locally, about different types of service, and use these, alongside information about medical outcomes, when prioritising services.

62. Epidemiological literature, and especially work on service usage rates in primary care, may provide a useful starting point (Box B). And the 1991 census will provide more up-to-date demographic information about age and sex distributions of residents, and about disability, and will make limited information on ethnic origin available for the first time.
Box B
A STUDY OF CURRENT USE OF OPHTHALMOLOGY SERVICES
Service usage rates in primary care may provide a useful starting point for reviewing needs and provision.

A recent study (Ref. 10) recorded the consultation rates for eye problems for a defined population of 36,000 people over a 12-month period. Consultations included were those with the 17 GPs covering the population, as well as with the eye casualty department of the local hospital. The authors comment that this represents an improvement on previously available data on ophthalmic disease. National data from general practice are of little value for following specific conditions, while purely hospital-based data do not refer to any defined populations.

The study analysed the conditions which make demands on local health services, and how the incidences of the more common ones vary with age. The reported results included analyses of:

- new consultations ('demand incidence rates') for chronic conditions such as cataract;
- total consultations, whether new or recurrent ('demand episode rates') for acute recurrent conditions such as infective conjunctivitis;

<table>
<thead>
<tr>
<th>Chronic conditions</th>
<th>Acute recurrent conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age related macular degeneration</td>
<td>Infective conjunctivitis</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Allergic conjunctivitis</td>
</tr>
<tr>
<td>Refractive problems</td>
<td>Corneal abrasion</td>
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<tr>
<td>Dry eyes</td>
<td>Corneal foreign body</td>
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<tr>
<td>Anterior uveitis</td>
<td>Subconjunctival haemorrhage</td>
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<td>Allergic blepharitis</td>
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<td>Blepharitis</td>
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<td>Chalazion</td>
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- and how the disease rates vary with age.
Demand for services undoubtedly underestimates the true population need. And such studies inevitably face methodological problems. But these errors are likely to be small; the demographic differences are likely to be far more significant since incidence of the common degenerative diseases is strongly age related. The authors conclude:

‘Our results indicate that demand incidence will alter as population demographics change. ... Our study therefore provides data to aid the planning of ... the minimum ophthalmic service for the 1990s.’

The data contained in the authors' simple four page report would probably improve on those being used in many DHAs to assess need for ophthalmology services.

63. DHAs should be developing systems to process the minimum data set (MDS) that accompanies providers’ invoices. For example, analysis by postcode may demonstrate differences in hospitalisation rates which could result from variation in health needs or differences in access.

64. Computer-based information from general practice is becoming available as more GP practices become computerised and keep data from clinics for particular conditions, or from health checks on patients over 75. Care needs to be exercised at present to ensure that the quality of such data is acceptable, but they should eventually provide an important source of information about morbidity in primary care and in some cases about health risk factors in the wider community. Commissioning authorities must be prepared to meet any extra costs that practices incur in providing them with such data.

65. Local people - both health professionals and lay - are important sources of information about health needs. A wider range of effective communication techniques is now being used, as described in chapter 5. One particular example is so-called 'community oriented primary care' in which a public health department works closely with selected GPs in order to understand the needs of the practice population.

66. The DHA is not the only body assessing health needs. Increasingly FHSAs and local authority departments collect data of value to DHAs. Staff from all three bodies should meet regularly and work towards open access to each other's information systems. It would be helpful if the Department of Health were to disseminate a clear statement on access by DHAs to data collected in GP practices.

IMPROVED MANAGEMENT OF THE PROCESS

The size of the agenda

67. This can be addressed by setting out a long-term programme of necessary work. It should explain how this is to be carried out, and show the order in which particular conditions or health needs will be studied. The Health of the Nation White Paper, and the Welsh Office's earlier Strategic Intent and Direction (Ref. 14), provide a focus for such a strategy. They list key areas of national concern in which districts must demonstrate progress. Districts are also required to identify local priorities for improvement. These should include chronic diseases, which are under-represented in the White Paper.
**Better use of data**

68. Districts must define their information needs and improve their ability to turn data into timely and palatable reports. They should pay particular attention to statistical technique when analysing survey results, especially where data are incomplete. For example, non-response rates and sampling errors are often ignored.

69. Some districts are setting up computerised population registers with encouragement from the NHS Management Executive. These enable information about different services received by one person to be linked. Although such registers are powerful tools for needs assessment, they are also expensive, and the experience of pilot sites should be carefully evaluated.

**Better integration into the rest of the organisation**

70. Integration will depend on the ability of the chief executive to develop and implement a corporate approach. He or she must provide leadership and hold individuals accountable for tasks that will ensure that this integration is maintained. Those responsible for needs assessment must see contract negotiators as their ‘internal customers’. Individuals’ personal interests must come second, if at all. However, in order not to compromise the public health director's independent role as guardian of the community's health, a limited amount of ‘research and development’ time should be agreed in which to follow up issues of concern. And integration will be helped if recommendations include practical points for service development (Case study 4).

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**Case study 4**


The public health department had noted that there was a high accident rate among children, particularly in more deprived parts of its area, and among elderly people. The cost to the authority of child accidents alone was estimated at £380,000 pa. Yet external evidence suggested that 95% of such accidents were preventable.

The DHA agreed to target a 25% reduction in deaths from accidents based on the recommendation of the World Health Organisation. (The *Health of the Nation* target of up to 33% reduction has since been adopted.)

The policy identified specific areas for action by the community services unit, including the provision of resources and training to enable primary health care workers to offer better advice on unsafe home environments. The district committed itself to involvement with national safety organisations, and close working with local statutory bodies and community groups.

The accident prevention policy and implementation programme has since been incorporated into the DHA's *Health of the Nation* programme.

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**Clarity of the decision-making process**

71. Clear decision making is especially important when an authority sets priorities within its ‘shopping list’ of desired health services. Although there is no one right way to compare the health needs of different groups (children and mentally ill adults, for example) or of balancing cost, quality, effectiveness and the strength of local opinion, an authority must be able to explain
how these factors were considered. Positive decisions about what to commission should be openly
set alongside any decisions about what is unaffordable.

72. The requirement to publish a purchasing plan (or 'health plan') provides a timely
opportunity to review and record all aspects of the decision-making process. The plan should
form the basis of consultation with the community about proposed changes, and then become the
starting point for contract negotiations (Exhibit 8). Most districts already make these plans
available for public consultation, and some have even published their plans in local newspapers,
and invited comment. Health authorities in Wales are required to publish both their detailed
plans and a one-page, popular summary.

73. Preparing to purchase merges into working with providers as recommendations begin to be
implemented. Working with providers is the subject of the next chapter.
Exhibit 8

THE PURCHASING PLAN

The plan should form the basis of consultation about proposed changes, and then become the starting point for contract negotiations.

Source: Audit Commission study sites.

Exhibit 8 (dha-x-8)
In liaison with FHSAs, local authorities and other outside bodies, chief executives should:

- ensure that there is a clear corporate process whereby the purchasing priorities are selected;
- agree with the director responsible for preparing the purchasing plan a long-term programme of work based on that review.

Directors of public health (or other directors responsible) should:

- carry out an initial wide-ranging review of local health needs;
- maintain access to up-to-date information on:
  - the effectiveness of health services, including patients' views of outcome wherever possible;
  - local people's current use of services, especially any information from GP practices;
- identify the special skills, such as statistical ability, required to carry out all these tasks;
- prepare specific recommendations as to the type and quantity of services which can be used in the contract negotiations;
- review (with the FHSA) the provision of health promotion and preventive services;
- make it clear in the purchasing plan not only *what* services are to be purchased but *why* these were selected.
3. Working with Providers

BACKGROUND

74. The commissioning role has been formally distinguished from that of providing health services since April 1991. During that time, the following issues have emerged:

— the style of the relationship between commissioner and provider;

— the form of the contracts (or service level agreements) between them.

75. Not surprisingly, the **style of working relationship** between purchasers and providers varies. Newly-formed hospital and community trusts have often been keen to assert their independence from the DHAs that used to manage them, and reluctant to disclose financial information, especially cost structures, to purchasers in general.

76. In many parts of the country, purchasers are closely linked to the local hospitals and community services as their main providers (Exhibit 9) - leaving them little freedom to alter the services...

**Exhibit 9**

**INTERDEPENDENCE OF PURCHASERS AND PROVIDERS**

Some purchasers are closely linked to the local hospital, leaving them little freedom to alter the services...

...whereas others have a choice, and more room to negotiate change

*Source: Two study sites, acute service contracts.*
pattern of services except in the most marginal ways. In such circumstances they have usually concentrated on developing a collaborative relationship. In some areas, however, especially metropolitan ones, purchasers have a choice between several local provider units and have more room to negotiate change.

77. The style of the purchaser-provider relationship is also influenced by the effect of capitation funding. Many districts expect eventually to gain or lose more than 5% of their 1991/92 income (Exhibit 10). Such expectations are affecting their relationships with their providers. Those due to lose income are having to focus negotiations on price in order to minimise the effect on service levels. Those that are due to gain revenue in the next few years are able to sweeten the negotiation process by funding specific developments.

Exhibit 10
THE LONG TERM EFFECT OF CAPITATION FUNDING
Many districts expect eventually to gain or lose more than 5% of their 1991/92 income

78. There is no one standard form of contract, although many districts have used models developed by RHAs. Documents have taken shape differently, but all serve four chief purposes, namely to:

— define the work to be done, especially the details of any agreed changes to current service-delivery;

— set out a basis of payment that reflects the costs reasonably incurred, and establish how the parties will share financial risks such as higher than expected inflation or referral rates;

— outline the process for reviewing performance and quality, including some agreed standards for improvement;

— define how disputes are to be resolved.
THE PROBLEMS
DIFFICULTY IN INFLUENCING PROVIDERS

79. Purchasers no longer have direct authority over service providers. Those DHAs that remain statutorily responsible for directly managed units (DMUs) should be delegating responsibility as much as possible to those units. Their residual responsibility should be exercised only at the highest level – normally directly between the district and unit general managers – and it should not interfere with the proper execution of the commissioning role for the maximum benefit of local people. Once formal, direct authority is removed, purchasers are left to develop influence within the market.

80. The power of purchasers depends in large measure on the local market situation. Many providers, particularly in rural areas, have a monopoly for at least some of their services. Purchasers in such areas may be able to show that treatment is unacceptably costly or inferior in quality, but do not have purchasing power that they can use to improve the situation. And in any case, for many emergency services patients cannot be readily 'switched' to alternative providers.

81. Even where alternative providers are available and the service is suitable for 'switching', the purchaser may still be constrained. GPs are unlikely to share a district's concern over the high cost of a local hospital and may want to continue to refer to the original provider, especially if this matches patients' preferences. A district which gives the contract to a different provider against the wishes of GPs will come under pressure from a rising volume of extra-contractual referrals (ECRs).

82. Where purchasers are unable or unwilling to influence providers by using market leverage, they can try to bring about change by proposing to work in collaboration with them. But providers sometimes resist such proposals, particularly if, as newly established NHS trusts, they are trying to assert their autonomy.

PROBLEMS WITH PROVIDER INFORMATION

83. Purchasers require a wide variety of information from providers about the price, quality, and quantity of services to ensure that they are obtaining value for money (as well as for formulating their purchasing plans, as discussed in Chapter 2). Problems of two types occur:

— data being of poor quality or even unavailable;
— purchasers' difficulties in making use of what they do receive.

Poor quality and availability of data

84. Accurate prices are essential for placing contracts in the new internal market. But providers' prices vary widely, costing systems are still relatively crude, and the figures quoted seem unlikely to be a true reflection of providers' costs in many cases. Purchasers have so far judged that prices are not a good basis on which to consider switching between providers.

85. Good comparison of prices between providers involves detailed analysis of factors such as case-mix, clinical practice, and asset utilisation. But prices are quoted to purchasers on differing bases. For example, some providers quote prices for a total workload in surgical specialties, whereas others offer banded prices for minor, intermediate, and major operations. Prices may or
may not include community services, follow-up visits, cost of prostheses and a host of other variables.

86. Information about activity is essential to specifying and monitoring contracted work. But this too is a source of problems. Each invoice has to be accompanied by a 'contract minimum dataset' (MDS) giving data about each episode of care. In-patient MDSs are now common but of variable quality. Few providers generate the MDS to support invoices for out-patients, or accident and emergency work, while the MDS for community health invoices has yet to be defined. Total clinical activity measured in ‘finished consultant episodes’ (FCEs) has increased in many places. But some purchasers believe that this increase may largely reflect changes in recording practice.

87. Diagnostic data are particularly poor. Attempts to place over 5 million in-patient episodes into ‘diagnostic-related groups’ (DRGs) show that in many hospitals there are large proportions of ‘dubious’ or ‘ungroupable’ cases (Exhibit 6).

88. Districts need information about residents who are waiting for hospital treatment. Yet operational waiting lists are held by providers. To compile a complete residence-based list, districts must obtain, and then collate, details from all the relevant providers. But providers’ lists are often held in different formats and systems, and in some cases even the postcoding is inadequate.

89. Purchasers also have a responsibility to monitor quality of services under contract. This constitutes a further huge information problem, extending from Patient’s Charter standards to measurements of clinical outcomes and the effectiveness of care.

Purchasers’ problems using data

90. The problem lies not only with acquiring good data, but with using and interpreting them. Much management time is being expended on attempts to make the best of inaccurate or incomplete data, or to reconcile reports from incompatible provider systems. As a result, some analyses that could be carried out, get missed (Case study 5).

Case study 5.

One district let a contract aimed at reducing a waiting list, and was happy when the activity reports showed that this had been achieved. In fact the reduction had largely been achieved by the provider treating more minor cases; but the contract had not specified the case-mix, and payment was made as for an average case-mix.

This failure by the purchaser to obtain value for money came to light only when a local GP fund-holder scrutinised the provider’s performance in more detail, noticed the change in case-mix, and compared notes with the district. The district had had the information on case-mix available but had not analysed it.

LACK OF EXPERIENCE WITH CONTRACTING

91. The process of contracting is still relatively new to the NHS. Major contracts, often worth many millions of pounds and covering thousands of episodes of patient care, have to define in advance:
— the amount of service required;
— the contract price structure;
— the quality standards to be observed.

Because the tasks are new, drawing up contracts has proved difficult in each of these areas. There have also been problems in negotiating and monitoring the contracts.

The amount of service required

92. One major problem has been that contracts have dealt with aggregate activity and been too blunt to obtain the changes that were really needed. The contracted level of activity has often simply rolled forward previous years’ figures, and not taken account of any perceived need for change. The volume of acute work is typically defined as total in-patient finished consultant episodes (FCEs) and out-patient attendances for each major specialty. Contracts that specify services for particular groups of patients are rare, one of the main obstacles being the lack of detailed information (see paragraph 52 and exhibit 7).

93. A second problem relates to using contracts to co-ordinate change in more than one provider. For example, in many places some children are being inappropriately admitted to hospital. But reducing paediatric in-patient rates is likely to depend on improved home- and clinic-based treatment and on better communication between hospitals and providers of community care (as described in the Audit Commission's report *Children First*, Ref. 9). Again, for much chronic illness, effective services are characterised not by a number of FCEs of hospital care, nor even by a number of community nursing contacts, but by the pattern of care delivered jointly by the various agencies.

The contract price

94. The pricing arrangement within some contracts has been a single block payment which fails to reflect the wide range and unpredictable nature of the work to be carried out. Such arrangements are convenient for (cash-limited) purchasers, but do not reflect the relationship between costs and activity levels within providers, which results from a complex mix of fixed, semi-fixed and marginal costs. Yet providers are meant to charge prices that equate to costs, and so the ideal contract pricing arrangement would replicate the actual cost-activity relationship. In practice this relationship is only vaguely known by providers, and they may in any case be reluctant to share it with purchasers. So contract prices typically fail to match providers’ true costs (Exhibit 11, overleaf) and there are incentives for providers to achieve just the activity levels that give them the greatest financial returns.

95. Finally, those contracts which merely specify a single price across all the different specialties and types of work, do not assist providers in focusing market pressures on under-performing areas of their organisations.

Quality standards

96. To be effective contracts have to specify the *quality* as well as the volume and cost of services. But quality is notoriously difficult to define, let alone measure. For each aspect of every
service it is necessary to determine criteria of quality from the point of view of consumers and professionals. For each criterion, measures have to be devised and standards set. Some purchasers have attempted to include comprehensive quality sections in their contracts. These have consequently been much too long and detailed to be of any practical use.

97. A further problem for purchasers is how to set realistic standards when they do not have direct or detailed experience of providing services. Their credibility in this respect is sometimes undermined when national objectives and guarantees are imposed on contracts without discussion of the local implications, resulting in standards being demanded which are probably unattainable.

**Poor contract processes**

98. Purchasers vary considerably in how much attention they pay to the processes of negotiating and monitoring contracts. Some have failed to set clear agendas for meetings or to document their outcome. The number of staff attending varies widely, with no apparent regard to the size or complexity of the contracts. Site visits, which ought to allow purchasers to appreciate providers’ problems, have sometimes lacked impact because the purpose has been unclear, or those involved have not been trained in what to look for or ask about.

99. Timing has been a particular problem in reaching agreement on contracts. Purchasers have not known final details of their cash limits until January, but NHS trusts have to submit their business plans by March.

100. A vicious circle of uncertainty can sometimes develop, with providers unwilling to quote prices until they know precisely what level of work to expect, and purchasers unable to commit themselves to a level of activity until they have prices from each provider to set against their available cash limit. As a result contracts have remained unsigned well into the financial year.
OVERCOMING THE PROBLEMS
BECOMING MORE INFLUENTIAL

101. Three problems which have left purchasers poorly placed to influence providers were identified above:

— Some purchasers may be geographically tied to a single provider for particular services.

— Even when they can place contracts elsewhere, purchasers may not succeed in persuading GPs to follow with their referrals.

— Hospital and community trusts may resist purchasers’ overtures to collaborate.

But the market is still evolving, and there are many actions that purchasers can take in relation to each of these problems.

Making the most of the market

102. Purchasers have some scope to widen their choice by encouraging new providers or new methods of provision. But before doing so, they should make sure that they are familiar with all the existing possibilities. There will seldom be any large institutional services of which they are unaware (although they may know less than they could about local private hospitals). But there may well be services in the voluntary and community sectors, such as domiciliary continuing care for the dying, which purchasers have not fully considered. Purchasers should maintain a dossier of all existing and potential providers which sets out details of their capacities, prices, and service standards.

103. Purchasers can broaden their choices by encouraging providers to invest against the expectation of receiving contracts. Known examples include:

— an urban district negotiating with an independent sector agency to provide a mental illness service;

— a rural district considering a transportable private sector service for varicose vein surgery.

104. Districts can also widen their choice by looking further afield. Clearly this will depend on the willingness of patients to travel, as well as on support from GPs, and districts should determine their views as robustly as possible.

105. A second approach to changing the market structure is through purchaser consolidation. Many districts have joined together in formal consortia as a means of improving their purchasing power. In a commercial market, the strongest purchasers are those who are major customers of each of several providers (Exhibit 12, overleaf). In that situation the purchaser has the opportunity to move its business around – and can exert significant influence even by threatening to do so.
Working with GPs

106. Purchasers should therefore discuss their purchasing plans with GPs. They must avoid placing contracts which GPs subsequently ignore when making referrals. And they should monitor ECRs (see next chapter) for evidence that any contracts are under-used, and find out why they are considered unsuitable.

107. A more radical solution is to involve GPs directly in the purchasing decisions. Some districts are working towards devolving budgets to localities (30,000 to 40,000 population) within their area - a level at which individual practices can easily exert influence on the purchasing decisions. Others have given practices themselves an 'indicative' budget against which to set the costs of their referrals.

Obtaining provider collaboration

108. Joint work by purchasers and providers is often an effective way to deal with recognised problems (Case study 6). But even where providers are reluctant to work in collaboration, purchasers may be able to influence them. Many districts have some real growth in income, and even those that do not may be able to create contingency funds by negotiating efficiency gains or reducing contractual activity. Such funds can then be directed at improving the efficiency or quality of particular services, and if the purchaser makes this help contingent on collaborative working, an opportunity to influence the provider has been created.
Case study 6

In Wandsworth DHA the public health director took the lead in organising development of a protocol for acute myocardial infarction with the main acute hospital provider. Clinicians were willing to work on implementing the protocol because the need for better communication between specialties was already acknowledged.

BRIDGING THE INFORMATION GAP

109. Resolving the difficulties with information on prices, activity and quality should be a high priority for both purchasers and providers.

110. Purchasers should negotiate access to providers’ information systems in order to audit data quality. Alternatively, the audit of data can be carried out by an independent third party; for example, one accountancy firm that acts as internal auditor to a provider verifies that a sample of the invoices correspond to its actual workload.

111. The NHS Management Executive has set up various projects to improve information for purchasers:

— Under the ‘data quality initiative’, RHAs arranged ‘third-party’ studies of data quality, including the completeness of in-patient data, early in 1993. Particular attention was paid to postcoding, GP codes and clinical codes. Site visits to providers examined the procedures for data collection and processing, and the responsibility and incentives for ensuring high quality of data. Action plans are to be agreed on the basis of the reports.

— In a separate project, the national steering group on costing aims to establish standards both for costing methodology, and for contract categories at sub-specialty level, so that meaningful comparisons can be made between providers (Ref. 25). Comprehensive guidance is to be published to inform the 1994/95 contracting round. It will be important to ensure that the lessons learnt from the pilot sites are spread rapidly around the health service.

112. Purchasers must ensure they are making the best use of the information currently available. The MDS that supports invoices should be used to monitor key aspects of performance (Exhibit 13, overleaf). Purchasers should particularly monitor:

— the average length of stay by specialty in each of their acute providers;

— the ratio of FCEs to discharges (an index of internal referral rates);

— the use of day-case treatment for some surgical procedures.

Purchasers should also be analysing data on case-mix now, with a view to requiring acute providers to price by type of case as soon as their costing technology allows.

113. Purchasers will need to develop their understanding of providers’ contract prices. The effects of switching contracts between providers is a particularly sensitive area. The consequences for an established provider of removing work, even small amounts, must be considered carefully; they may include under-utilised assets and staff skills, as well as wider issues such as reduced ability to support medical education.
USING CONTRACTS MORE EFFECTIVELY

Specifying activity

114. If purchasers wish to contract for particular types of activity rather than gross levels of provision they will have to specify their requirements clearly. This will entail understanding the detail of clinical decision making, and key to this is the development of clinical guidelines. Guidelines set out which decisions are appropriate under which circumstances. Some guidelines deal with the interface between GPs and hospitals, particularly the referral and admission decisions. They aim to ensure that appropriate and consistent use is made of both out-patient and in-patient services. Other guidelines deal with treatment once in hospital. They aim to ensure that care is not only efficient, but of consistent quality.

115. Many guidelines are currently being developed, both by local groups of clinicians and nationally by professional bodies such as the medical Royal Colleges. It is of course essential that guidelines are based on sound evidence rather than personal opinion, and there are numerous questions yet to be answered about the best ways of using such guidelines so as to maximise progress towards rational decision making. But there is no doubt that guidelines will have a major impact on the ability of purchasers not only to specify and influence activity levels, but equally to ensure that consistent levels of quality are being achieved.
116. There is increasing evidence that the threshold for intervention alters if patients become more involved in making decisions about their own care. Giving patients more information and greater choice can reduce anxiety and depression. Many purchasers may consider that it is an important aspect of the quality of care, and will wish to specify that patients are empowered in this way. In some situations, such as consent for elective benign prostatectomy (Ref. 21), it is likely that levels of activity will fall.

117. In order to improve the co-ordination between different providers of related services, purchasers have adopted two approaches. One is to contract with a single provider for the whole package of health care, requiring that provider to sub-contract as necessary (e.g. a main acute hospital sub-contracting for community follow-up support). In such an arrangement, it is important to be clear about responsibility for monitoring both the amount and the quality of sub-contracted care. The other approach is to ensure that all the providers of linked services separately sign co-ordinated contracts which clearly set out their individual and joint responsibilities.

Pricing the contract
118. Districts are increasingly negotiating contracts with pricing arrangements that reflect the true cost of services at different activity levels. Such contracts should become widespread.

119. Contracts can help make clear what is required from each separately-managed part of the provider's organisation. With a hospital whose management is already structured into clinical directorates, the contract might usefully specify the payment and activity for each. A community unit may be managed through geographically defined 'patches', and again this structure could be reflected in the contracts.

Improving quality
120. It is not possible to define and measure all aspects of quality for all services at present. Any attempt to do so will spread the limited resources too thinly and should be seen as bad practice. It is better by far for purchasers to agree a few key measures in each clinical area and then ensure that standards are set and monitoring is carried out properly against them.

121. In order to make criteria and standards more realistic and compensate for their relative lack of in-house expertise in many clinical areas, purchasers should work with providers wherever possible. Most providers have made some progress in developing quality assurance systems. Examples include: patient satisfaction measurement, clinical audit, infectious disease monitoring, and risk management.

122. Hospital boards should be receiving regular reports summarising such aspects of quality, and purchasers should simply ask to be furnished with copies of these. Purchasers can then confine their own monitoring to periodic checks on the monitoring processes themselves. For example with patient satisfaction surveys, purchasers may wish from time to time to carry out an audit trail of the data. Purchasers should be involved in the development of new criteria, standards and systems in other key areas and should ensure that such development has the full commitment and involvement of clinical staff (Case study 7, overleaf). Ideally development will be done jointly by purchasers and providers, but there must be clear agreements on who does what, and where the costs will fall.
Leicestershire DHA has purchased a medical audit system for three of its major providers on the basis that they will provide the DHA with regular output. The system uses medical records to review decisions about individual patients against agreed good practice guidelines.

Two types of report are produced by the system. First, some cases are referred to the medical audit machinery for peer review. The system also produces summary reports showing for each specialty the proportion of cases highlighted, and the reasons why. It is these reports, which do not identify individual patients or clinicians, that are fed back to the purchasing authority.

123. In addition to working with providers, purchasers may be able to tap expertise in third parties. The King's Fund organisational audit programme sets detailed standards for acute hospitals and is now being applied in over 100 of them in the UK. This could provide an alternative form of reassurance for purchasers, particularly if they contract for only a small volume of services from a given provider. GPs are especially well placed to judge the quality of hospital and community services, and purchasers should be making plans to tap this valuable source of quality monitoring.

Better negotiation and monitoring procedures

124. Even the best-designed contracts will fail to achieve their purpose unless there are good processes for negotiating and monitoring. Purchasers should observe the simple rules in boxes C and D.

Box C
GOOD PRACTICE IN NEGOTIATION

— Set a clear agenda for each meeting.
— Send to meetings only those individuals who have a clear contribution to make.
— Record what has been agreed and what is outstanding at the end of each meeting.
— Establish that clinicians are aware of, and agree with, the contents of the contracts. If necessary, ask to speak to them, but do not by-pass provider management.
— Avoid springing surprises by giving good notice of purchasing intentions.
— Agree as much of the contract as early as possible in the previous financial year; there is a lot to do at the end of the financial year, negotiating detailed prices and volumes.
BoxD
GOOD PRACTICE IN CONTRACT MONITORING

- See that purchaser staff undertaking a site visit are trained appropriately.
- Share the work where possible (e.g. quality monitoring), with other purchasers of the same provider’s services.
- Set a clear agenda for each site visit.
- Record what was agreed and what was outstanding at the end of each site visit.
- See that purchaser staff undertaking site visits are appropriately trained.
- Keep informed through communication with GPs, the Community Health Council, and other agencies which are in close touch with users of the services.

125. It has to be expected that the relationship between purchaser and provider will be strongly influenced by the structure of market forces, as described in the introduction to this chapter (paragraphs 75 to 77). But as a general rule, the public interest will be best served if both parties strive to maintain an open and co-operative style when they negotiate contracts and review performance.
Directors of purchasing should:

• try to understand the strategies and capabilities of all providers accessible to local people;

• wherever possible, compare the contract prices and standards of care — including outcomes - that these providers offer;

• try to create pockets of funds as incentives for providers to develop services which the DHA supports;

• work with GPs and neighbouring DHAs to identify how contracts can be re-arranged to improve value-for-money;

• use contracts to reinforce the application of clinical guidelines agreed with FHSAs, hospital clinicians and GPs;

• define and monitor a limited number of realistic and measurable quality targets;

• influence the development and use of provider-based quality systems such as patient satisfaction surveys and medical audit;

• ensure contract monitoring data are audited;

• develop pricing arrangements which influence providers to deliver the required workload;

• document the course of contract negotiations and reviews.
4. Extra-contractual Referrals

BACKGROUND

126. While most patients receive health services under contract, 1% of episodes are extra-contractual, resulting either from GP or inter-consultant referral, or from emergency admission. Such referrals are usually known as 'ECRs'.

127. Elective ECRs can arise for several reasons. For example:
— A GP decides that a patient might benefit from highly specialised advice or treatment not available locally, such as paediatric nephrology or oncology.
— An elderly patient wants to be admitted to a hospital close to other family members who live some distance from the patient's home.

128. Purchasers require prior notification of these elective ECRs, and are allowed to refuse payment if authorisation was not given. On the other hand legitimate invoices relating to emergency ECRs have to be settled unconditionally (Ref. 11), as do those for tertiary ECRs initiated by consultants (Ref. 20).

129. In the first year of the internal market some districts had many more ECRs than others (Exhibit 14), especially elective ones. This is partly because some populations are more closely tied to a few local hospitals than others and are thus able to cover more of their referrals by contracts. It is also because of differing policies on the volume of work it is worthwhile contracting for.

Exhibit 14
ECR RATES FOR 6 DISTRICTS
The use of ECRs varies greatly, especially for elective cases

Source: Audit Commission study 1991/92.
130. ECRs have been criticised on various grounds, particularly the costs of processing them, and their potential threat to freedom of choice for clinicians and patients if DHAs have any power to refuse to pay. But it is hard to see how a system in which 'money follows the patients' could be compatible with cash limits unless DHAs have some such power. For this reason alone the ECR system must remain, including the rights of health authorities to question elective referrals. But efforts must be made to minimise some of the existing problems and resulting concerns.

THE PROBLEMS

BUDGET UNCERTAINTY

131. ECRs are largely unpredictable, and consequently districts have difficulty in budgeting for them. In some cases an individual has need of special treatment, not widely available, which costs many thousands of pounds (bone-marrow transplantation for example). During 1991/92 many districts had to add to their original ECR budget, and even so some overspent. Financial control remained a problem in 1992/93 (Ref. 22).

CONFLICT WITH FREEDOM OF CHOICE

132. Many purchasers have been reluctant to challenge the decisions of GPs. Public health directors (often the only source of clinical advice available within the purchaser authority) are frequently unwilling to take on such a role. And the NHS Management Executive advised health authorities in September 1992 (Ref. 11) to refuse payment only:

— when the referral is not justified on clinical grounds (appropriate clinical advice to support this judgement would include breach of an agreed referral protocol), or

— where an alternative referral would be equally efficacious for the patient, taking account of the patient's wishes.

The advice is that it is unacceptable for a purchaser to refuse authorisation solely on the grounds of the proposed cost.

133. Similarly, patients may have cogent reasons for seeking referral by their GP to another hospital, but be deterred from doing so because of their belief that such requests will not be considered.

134. The ECR system therefore creates a dilemma for health authorities. On the one hand they need to respect GPs' freedom of referral and choice for patients as far as possible. On the other, they must make adequate budgetary arrangements to keep expenditure within cash limits. Finding a balance is not easy.

LOGISTICAL DIFFICULTIES

135. The average district currently receives about seven new ECRs per working day on average. Though this may not appear many at first sight, each has to be checked for eligibility, recorded, approved, and paid for once treatment has been completed. In addition, the medical appropriateness of the referral may need to be discussed. Each district has had to set up its own administrative arrangements for carrying out these tasks.

136. In practice there is no common pattern of responsibility or staffing. Lead responsibility usually lies with the contracting team or with the finance department, but the number of staff involved, their designations and estimated time input, all vary considerably. As a result, the
average staff cost of handling ECRs in some districts is significantly lower than in the majority (Exhibit 15). In most, the average administrative cost is significant compared to the amount being invoiced for some of the cheaper ECRs such as single out-patient consultations (typically around £50 in 1991/92).

OVERCOMING THE PROBLEMS
KEEPING WITHIN BUDGET

137. Although individual ECRs are unpredictable, increasing experience should enable better estimation of the likely range of total demand, and better budget setting. But there will still be occasions when such estimations (and hence budgets) are too low.

138. There are three options immediately open to a district which is heading for an overspend on its ECR budget:
— to defer more non-urgent treatment until the following financial year;
— to persuade the GP or hospital consultant to redirect the referral to a contracted provider;
— to be more stringent about refusing authorisation altogether where the NHS Management Executive guidance (Ref. 11) allows.

None of these is an attractive option. Deferrals lengthen waiting lists, while redirections and refusals represent a challenge to clinical freedom and patient choice. And all three are likely to cause the patient inconvenience and distress and possibly make their condition deteriorate.

139. In the first year of the reforms DHAs rarely refused ECR requests outright provided that the patient was a resident, and that payment was not a GP fund-holder's responsibility. Only a few instances of refusal on clinical grounds occurred with treatments such as in-vitro fertilisation (IVF) which had not in any case been universally available prior to the reforms. But many districts succeeded in persuading GPs to redirect ECRs to contracted providers. Deferral of treatment to the following year was used by only 2 of the 6 districts in exhibit 14.

140. These options will continue to be available as short-term expedients. But because of their adverse side-effects, longer-term solutions must be found. Difficulty in keeping ECRs within budget is a symptom of problems with contract planning and financial management, and it is in these areas that long-term solutions should be sought.
MAXIMISING CHOICE

141. Districts should have an explicit policy on ECRs, explaining the circumstances in which requests may be redirected, delayed or deferred. This policy will need to be adjusted in the light of financial forecasts. Districts should determine whether they wish to adopt a laissez-faire approach (which aims to pay for all valid referrals) or make more effort to persuade GPs to use contracted providers. In practice, many authorities will probably choose to occupy a midway position, accommodating GPs’ referrals except where there are good grounds for questioning them, such as a high price¹ or doubtful effectiveness of the treatment.

142. GPs should be consulted about the basis of the ECR policy and any major changes proposed to it, just as they should about the pattern of contracts. The policy must then be widely communicated to both GPs and providers.

IMPROVED LOGISTICS

143. Districts should review their management arrangements for processing ECRs in order to minimise cost while achieving their planned objectives. It must be clear who has the overall responsibility for ECRs. Arrangements must be efficient in the use of scarce skills, while at the same time minimising the delay and uncertainty for patients, GPs and providers. It is particularly important that the person carrying out the initial scrutiny of ECRs is not over-qualified. Skills such as those of the public health specialist should be enlisted only once an initial screen has identified a ‘questionable’ referral, on the basis of criteria such as price or nature of the procedure.

144. ECR information systems should have the analytical capability to answer such questions as:
   — Have certain GP practices generated significantly more ECRs than average, and if so, why?
     (Practices near the boundary of a district may have different referral preferences from most others.)

   — Which specialties have generated the most ECRs? For which conditions and procedures?
Managers should be following up trends and investigating their causes - such as inadequate contracts, or GPs' dissatisfaction with contracted services.

SUMMARY OF RECOMMENDATIONS

DHAs should:

• determine a policy on approval of ECRs;
• communicate the policy to GPs and aim to obtain their support;
• ensure that the arrangements for approving elective ECRs are efficient and effective in delivering the DHA's policy;
• analyse ECRs in order to identify needs not being met by current contracts.

¹ Although DHAs must not refuse payment solely on the grounds of high cost, they have every reason to question and discuss such ECRs with the referring GP.
5. Liaising with Others

BACKGROUND

145. There is a wide variety of groups with which districts have to liaise in order to carry out their commissioning role. With some, like local GPs and patient groups, the need is for better dialogue and communication. With bodies such as FHSAs and local authority social services departments (SSDs) the main requirement is for joint decision-making.

146. Local general practices. Good communications are vital so that districts:
— learn about (and perhaps seek to influence) future referral intentions;
— obtain better feedback on the quality of care (since patients will often relate their experiences to their GP rather than make complaints or fill out questionnaires);
— obtain GPs’ views (and perhaps data) on local needs and priorities, and their preferred balance of primary and secondary care.

147. Patients and the public must be:
— informed about local services;
— given the opportunity to feed back their experiences of services;
— asked to express preferences about where they are treated;
— consulted on local health needs, priorities, and purchasing plans.

148. FHSAs and local authorities. There is a need for a consistent, if not a joint, approach to:
— needs assessment;
— developing community care;
— communicating with clients and the general population.

149. With regard to local authorities, this report concentrates on relationships with social services departments, since community care is likely to be the highest priority for joint working in the near future. However, there are many other reasons why DHAs will find it worthwhile developing links more widely within local authorities:
— Many local authority functions affect the health of the population: environmental health, housing and action on homelessness, education including adult education, provision for sport, transport planning and the environment. Authorities are increasingly doing so in a strategic fashion, as their role becomes one of commissioning rather than providing services.
— Many local authorities are also large local employers, and thus well-placed to lead the way in initiatives aimed at better health in the workplace.
— They can be useful channels of communication with local people - for example, by distributing literature through their many service points.
— As elected bodies they are able formally to represent the needs, aspirations and interests of local people.

THE PROBLEMS

COMMUNICATING WITH GENERAL PRACTITIONERS

150. An average district has some 150 GPs in about 50 practices and this will increase with mergers and consortia. Communication involving individual GPs is therefore bound to be a time-consuming process, particularly in areas with more small or single-handed practices than average. While commissioning staff may feel that they have devoted a good deal of time to the process, individual GPs may feel that the contact was inadequate.

151. GPs are a disparate group of independent contractors, with varying opinions on health care. Although Local Medical Committees are the established mechanism for representing GPs, they are unlikely to be able to reflect all their views. And a minority of GPs see the commissioning DHA as irrelevant or even interfering.

152. DHAs are not the only NHS organisations with an interest in GPs' decisions and local knowledge. FHSAs are now increasingly reviewing practices, and items for review may include referrals to hospital and community services, as well as the development of primary care services generally. Local providers, especially NHS trusts, are also asking GPs for their views on service developments and local needs. These different approaches to GPs are often not co-ordinated, which at best wastes time on all sides, and at worst results in GPs being given conflicting advice.

153. Districts need a great deal of information from GPs, but have relatively little to offer in return other than well-placed contracts which reflect GPs' concerns. Districts will need to demonstrate to GPs that they take account of their views and that contracts are an effective way of influencing providers.

COMMUNICATING WITH PATIENTS AND THE PUBLIC

154. Community contacts can be classified into three categories, each of which will require different techniques of communication. The most vocal category comprises the wide variety of voluntary organisations and pressure groups, some formed specifically to lobby on one issue or for patients with one condition. It is possible to identify large numbers of such groups in a district - in one case as many as 300. The second category comprises individual patients and carers who do not belong to such organisations and are often reluctant to express criticism. Lastly, there is the healthy majority of the population, who commonly hold strong opinions about the local health service, but with whom the service has no natural point of contact.

155. The DHA's communications task is made harder because the public is often unclear about the distinction between commissioner and provider. Most people still see the local hospital as the focus for health issues and do not understand the DHA's role. This confusion is reinforced where NHS trusts engage in their own separate public consultation or communication.

156. The complexity of health issues makes communication difficult, especially with the general population, few of whom will have had recent contact with health services. Professionals can forget that not everyone understands their language. For example, one recent public health
report highlights ‘ischaemic heart disease’ as a major local problem, without any explanation of what it is.

157. In many districts, public consultation exercises have been carried out with little professional expertise. Public meetings have been ‘fitted in’ to the work of officers whose main responsibilities lie elsewhere.

CO-ORDINATING WITH OTHER STATUTORY BODIES

158. DHAs, FHSAs and local authorities affect each others' ability to achieve many of their objectives. For example, a local authority’s capacity to maintain very dependent people at home requires significant community health and primary care support. Agreement on who does what and who bears the cost is crucial, and so too is liaison between these organisations.

159. Yet in practice these bodies may fail to talk effectively to one another, to share information, or to co-ordinate their public communication or the services they provide to shared clients. These shortcomings are due to key differences between the organisations, notably:

— their powers, cultures and structures;
— the different populations and areas they serve;
— their different funding mechanisms.

The different powers, cultures and structures of the three bodies

160. Structures and cultures within each of the three bodies can be very different. Shared decision-making requires local councils to give up power to joint groups of officers, yet some councillors already regret losing their ability to appoint DHA members. Some FHSAs and SSDs claim that DHAs underestimate - or fail to understand - the services they are responsible for. Managers’ and members’ first commitment tends to be the promotion and development of the services for which they are primarily responsible. And even the concept of the purchaser or commissioner role tends to be understood differently within the three organisations.

161. In some FHSAs and SSDs the commissioning of services has related to much smaller areas ('localities' or 'patches') than the DHA's population. Some community health providers have participated in this process. Needs assessment for community care is often built up at this small area level. However, many DHAs are not used to working with such small units of population, dealing as they do with average populations of 250,000.

The different populations and areas served

162. Some DHAs serve a population covered by more than one FHSA or local authority; and many more serve only a part of one such authority's area. Problems arise, for example, because information on local needs and services is not readily comparable, and managers are overburdened with large numbers of meetings to attend.

1 For the record, ischaemic heart disease is damage to the heart muscle due to its not receiving sufficient oxygen, usually because the arteries that carry blood to the muscle have become narrowed. It causes angina (chest pain) and myocardial infarction (heart attack).
Different funding mechanisms

163. Even where there is a willingness to work together, funding mechanisms cause problems. The organisations differ in the extent of their fiscal freedom - FHSAs in particular have the bulk of their funds committed by national rules.

164. A possible solution to the problem of different funding mechanisms is for each of the three authorities to identify the money currently spent on community-based services for a care-group such as the elderly, and place this money into a single joint budget controlled by a joint working group. But adequate financial information is seldom available. It is not easy to apportion the cost of domiciliary nursing, for example, into broad client groups such as the elderly. And there is uncertainty about the legality of re-allocating money between the different authorities in this way, because it is unclear which authority is accountable for the spending.

OVERCOMING THE PROBLEMS

BETTER COMMUNICATION WITH GPs

165. The large number of GPs makes individual communication time-consuming. Although personal contact is desirable, it is advisable to use it to supplement some systematic method of tapping their views and keeping them informed. It is also important to have formal consultation machinery, agreed with the Local Medical Committee. But such formal machinery is not sufficient, and districts have also used a variety of other approaches: regular visits to practices (once a year is probably adequate), newsletters, telephone surveys and postal questionnaires. At least 15 districts have used or adapted a questionnaire for GPs, developed by Bristol DHA, on their views of the quantity and quality of local services (Ref. 26).

166. It is not possible to define ‘best buys’ out of this range of methods. But whatever methods are adopted, districts must ensure that they address the problems identified in this chapter by keeping some simple questions under review:

— To meet the problem that GPs are a large, disparate, independent workforce, districts should ask: Is the coverage of GPs comprehensive? Are fund-holding practices adequately represented? Is there a minority who are being missed out on every occasion? Are we integrating their views fairly, or just listening to the most vociferous?

— To deal with the problems of wasted time and possibly conflicting messages, districts should ask: How well are we co-ordinating our communications with those of the FHSA(s), local hospitals and community services?

167. This section has concentrated on communications with GPs. Communication with other health professionals has been slower to develop. Few districts have devoted as much effort to tapping the experience of community nursing staff for example. Community nurses are experienced in assessing clients' needs; working with them would provide insights into the balance and effectiveness of local services, as well as health needs and priorities in the community.

BETTER COMMUNICATION WITH PATIENTS AND THE PUBLIC

168. Communicating with patients should now be regarded as a core activity of DHAs. It is the basis of one of the main measures of their success. So not surprisingly the reforms have encouraged a growth of activity in this area, with many new ideas being tried out. Some of these
have been gathered together by the NHS Management Executive and published in the excellent report, *Local Voices* (Ref. 5).

169. The number and diversity of groups means that there is no single solution, and districts are right to develop a variety of approaches. These must however be underpinned by a communications strategy which clarifies how each of the initiatives contributes to the organisation's objectives. It should also make clear the purpose of public communication. This strategy should be agreed with the local CHC as the formal representative of consumer interests. Possible objectives include:

— eliciting information about experiences of and preferences for services;

— obtaining reactions to the authority's proposals;

— involving people in setting out options for the future;

— giving people more power and ability to influence their own health, and that of the community.

170. Districts' objectives should include at least the first two of these. They should take particular care to assess reactions to proposed major changes such as 'switching' a contract to a different hospital. These reactions should be sought in a spirit of genuine enquiry and as a real opportunity to influence policy. CHCs should be seen as an important but not exclusive channel for such consultation.

171. To overcome the confusion with communications from other NHS bodies, districts should work with local hospitals and FHSAs to develop joint communication strategies and possibly implement them together.

172. Approaches to communication vary. While some allow the district simply to give out information, others enable it to listen or develop a dialogue. Districts should aim to use a wide spectrum of approaches (Exhibit 16, overleaf).

173. Communication with the public is an area in which innovation is widespread. One district organised a series of adult education classes around *Health of the Nation* and the reforms, with a view to establishing a better-informed consumer panel. Others have opened high-street shops to make themselves available to the public. Diversity and experimentation are valuable; but districts need to be sure that they are evaluating their experience in order to build an understanding of good practice and value for money.

174. Problems with communication activities can also be addressed by obtaining expert advice, and possibly by external review. Such a review could for example be used to check that:

— good value is being obtained from money spent on advertising, phone-lines, and leafleting;

— the language used in written material can be understood by ordinary people;

— questions are not loaded so as to obtain the responses that staff want to hear.
Communicating with Service Users

Districts should aim to use a wide spectrum of approaches.

Source: Audit Commission.
BETTER CO-ORDINATION WITH OTHER STATUTORY BODIES

175. Three problems were identified above: their different cultures, structures and powers, the lack of coterminosity, and the different funding mechanisms.

176. Differences in culture, structure and power are great. There is no hope of addressing them at all without leadership from the top, aimed at unifying objectives, increasing mutual understanding, and creating operational links. Although in some places the existing Joint Consultative Committee (JCC) machinery will be an appropriate framework for achieving these aims, elsewhere a fresh start may be more productive. The practical steps that can then be taken will differ for FHSAs and local authorities.

Working with FHSAs

177. One step is to involve the FHSA in DHAs’ own internal work programmes. For example districts should:
— ask the FHSA for advice on how to approach GPs;
— organise approaches to the CHC, or the wider population, jointly with the FHSA; this may save respondents’ time and achieve joint ownership of the results;
— seek access to FHSA and GP practice data as they become available.

178. A second step is for DHAs to understand FHSAs’ activities. A district might for example benefit from working with the FHSA’s Medical Advisor in examining referral rates to hospitals as part of their annual review of GP practices.

179. A third step is to share development of new activities. Regional health authorities can help by setting ‘corporate contracts’ with co-ordinated objectives. Within such a framework, the DHA and FHSA can work together, for example on common specification of services, where each determines how it can most effectively contribute to meeting local needs. Family planning, and health promotion, are two areas where such common shared specifications would be particularly valuable.

180. None of the problems can be completely solved by merely exhorting the authorities to work together. There will be strain so long as they remain separate bodies with separate funding mechanisms. Joint appointments to key posts and to the health authorities themselves will help. But the eventual merger of DHAs and FHSAs into combined health authorities must be considered as the ideal solution.

Working with local authorities

181. For many DHAs, work with local authorities is likely to be dominated by implementation of community care plans. However, DHAs need to look beyond the agenda of Caring for People (Ref. 19), important though that is, to the wider range of issues on which effective collaboration with local authorities is essential. For example, economic development, housing, education and environmental health will all require strong DHA input to promote inter-agency collaboration in a form which should include voluntary organisations and the business community. Major initiatives such as Health of the Nation will be delivered only through such a process. Whilst Caring for People gives the lead role to local authorities, the close involvement of DHAs,
FHSAs, and local providers is essential. The DHA as commissioner has to consider what its particular input is, as distinct from that of providers. Two areas will be important:

— how the machinery for health needs assessment and consumer input can inform decisions made at the boundary between health and social care;

— how funds should be allocated between existing and alternative providers; this is an important role since the Government now requires that community care plans make substantial use of the voluntary and particularly the private sectors.

DHAs that successfully move from providing to commissioning community health services, will be well placed to stimulate imaginative and innovative working with FHSAs and local authorities as well as their own providers.

182. Lack of coterminosity is also a problem. Regional health authorities can help reduce boundary problems by encouraging consortium working and mergers which increase coterminosity. But their decisions should take account of the Local Government Commission's review of the structure and boundaries of local authorities (outside Metropolitan areas). And indeed they might wish to submit evidence to the Local Government Commission since one of the considerations in its deliberations should be reconciling health and local government boundaries.

183. 'Liaising with other bodies' is the last of our four key activities for DHAs in commissioning health care. All four need to be supported by effective management and development of the district's own resources. It is to these internal management issues that we now turn.

### SUMMARY OF RECOMMENDATIONS

DHA staff responsible for communications with GPs and patients' groups should ensure that:

- coverage is either comprehensive or else widely representative;

- communication is carried out jointly with the FHSA and local providers whenever appropriate;

- there is a firm intention that the feedback shall influence the commissioning of services.

Chief executives and senior officers should:

- hold regular purposeful meetings with their counterparts in the FHSA and local authority;

- work rapidly towards joint projects and appointments.
6. Managing Resources for Commissioning

THE PROBLEMS

184. Commissioning authorities have three types of resource which they must manage effectively in pursuing their objectives: staff, finance, and information. They inherited many of their resources from the pre-reform district headquarters. These were of variable quality and there was no model practice to be followed. So, not surprisingly, new commissioner-side staffing structures, capabilities and information systems have evolved faster in some districts than others. Certain problems are discernible in most authorities:

— uncertainty as to appropriate spending levels;
— shortages of some of the skills and capabilities now needed for commissioning;
— slow development of a commissioning outlook within the finance department;
— patchy establishment of necessary information resources, systems and technology.

UNCERTAINTY AS TO APPROPRIATE SPENDING LEVELS

185. When districts were set up as commissioners of health services, there was no model for the required structure or staffing levels, and they were largely determined by the availability of staff at that time. And in most districts the associated costs were not clearly identified, due to the difficulty of separating commissioning activities from provider-side support and statutory functions (such as nursing home registration, and communicable disease control). The Audit Commission intends to study costs in greater detail during the course of the audits linked to this report, and to publish the results of that analysis. Such data as have been obtained from a sample of districts show that in 1991/92, the cost of commissioning - largely represented by staff costs - varied widely, from 0.5% to 2.0% of the total cash limit, with a mean of 1.3% (Exhibit 17, overleaf).

186. Some of the variation in the percentage of cash limits spent on commissioning results from economies of scale: although large districts employ more staff than small ones, staffing does not increase in direct proportion to size (Exhibit 18, overleaf). So for example a district of 400,000 population would usually have less than twice the staffing of one of 200,000.

187. But a district’s size does not account for all of the variation, and there are considerable differences even between similar-sized districts (Exhibit 18, overleaf). There are many legitimate reasons why staffing levels might be high. For example, there may be more providers to negotiate with, or the district may have taken a decision to move ahead quickly in a particular area.

188. The existence of economies of scale means that there will be possibilities for savings when districts form consortia, or merge. Although the implication of Exhibit 18 is that the ‘fixed costs’ of 10 to 15 staff might be saved per district merged, this should not be the major driving
Exhibit 17
COSTS OF COMMISSIONING
The cost of commissioning varied widely in 1991/92

Source: site visits and RHA returns.

force behind mergers. There are risks that beyond some size, commissioning bodies will become unwieldy as well as remote.

SHORTAGE OF COMMISSIONING SKILLS
189. Value for money in commissioning authorities does not of course depend only on the numbers of people employed. Identifying and developing the requisite skills are also important. The introduction of commissioning has increased the need for certain activities, such as health

Exhibit 18
STAFF EMPLOYED IN COMMISSIONING
Staffing does not increase in direct proportion to size; and staff numbers vary considerably even in similar-sized districts

Note: The graph shows the number of management staff employed on commissioning work, excluding those with responsibilities for communicable diseases and nursing homes.

Source: Site visits.
economics and external communications. Supply of many of the relevant skills is inadequate to meet the increased demand and many districts are having to make do with people with general skills only.

190. Recruiting for new skills is not the only problem area for personnel staff in commissioning organisations. Existing staff in all departments need to develop new functions and abilities to support commissioning, even where - as with finance and information - many of the basic skills have not changed. But some staff are having difficulty in adapting. And in districts that still have DMUs, where staff continue to have both purchaser and provider responsibilities, the new commissioning activities may still be taking second place to the old direct management responsibilities.

191. It is not just employees that may have an underdeveloped sense of commissioning. Many non-executive members have been appointed to health authorities for their links with the community or their business experience, rather than for their understanding of commissioning services. Often, like the public, they still perceive the local health service as consisting of hospitals, and the DHA as an administrative support.

THE RÔLE OF FINANCE DEPARTMENTS - THE NEED FOR A NEW OUTLOOK

192. The degree of change is especially great for finance staff. In the past, the task of DHA finance departments was to maintain financial control in large complex service organisations. Provider-based finance departments are now taking on most or all of this responsibility. Accounting for residual DHA income and expenditure once provider units are completely independent is relatively simple. But crucial new tasks have emerged for finance departments in support of effective commissioning: these include risk management, market analysis, and support for negotiations.

193. Keeping within the cash limit remains a vital objective for DHAs. Typically over 95% of the cash limit is committed in advance in contracts, with the remainder split roughly equally between ECRs and the costs of running the DHA itself. Risks attach to all these elements. The number and costs of ECRs may exceed budget, as described in chapter 4. And contracted providers may request extra funding:

— for extra workload (either ex gratia under a block contract, or - increasingly - because the contract links payment to workload);

— for higher than expected inflation;

— to introduce a more costly form of treatment mid-year;

— to cover higher than expected medical negligence claims.

Many districts have not earmarked sufficient contingency funds to cover these risks; yet the alternatives of delaying payment, or deferring non-emergency ECRs, are undesirable. Thus although districts have to some extent passed on cash limit responsibility to providers within contracts, they do still face significant risks and have fewer means of offsetting them.

194. Throughout the organisation there is a need for financial advice which some finance staff are only beginning to address:
— Market analysis involves comparing providers' prices and trying to understand how the organisation of different services makes them more or less expensive, as a basis for advising on the likely effects on prices if contract patterns were altered.

— Negotiation with providers requires some evaluation of what price changes are reasonable, bearing in mind changes in quality standards and treatment methods as well as activity levels.

POOR INFORMATION SYSTEMS AND SUPPORT

195. As the objectives of the DHA have changed, so has the information required to support decision-making and monitor progress. With the health of the population as its primary objective, information on health status, treatment outcomes, and effectiveness has become fundamental. Yet information in these areas has traditionally been poorly developed in the NHS.

196. It is not surprising that information problems have pervaded the commissioning role, as reflected throughout this report. Some of the problems are about the poor quality, or non-availability, of data, especially from other parts of the NHS. But the commissioner's ability to handle data is also relevant, and will become more significant as the range of usable data expands.

197. The information requirements of commissioning were not defined on day one; district staff have learnt them through experience. Commissioners inherited computer systems, and strategies for developing them, that were designed around hospitals' needs before the reforms. The NHS Management Executive's DISP (District Information in Support of Purchasing) project worked with some districts to define a specification for the requirements. But the commercial packages meeting this specification have only gradually become available module by module, and full implementation of the DISP specification has largely been confined to pilot sites.

198. Other districts have adopted their own information technology (IT) solutions, which have often resulted in a variety of different systems rather than an integrated package. Their solutions have been greatly influenced by the nature of existing systems. For example, districts with access to a regional patient administration system have the task of analysing hospital activity for residents greatly simplified.

199. Substantial sums were made available for commissioning systems (£100,000 capital and £40,000 revenue per district) in 1991/92 under a special initiative. There was a diversity of systems purchased, yet the choices were not effectively managed, and few districts have formulated a strategy to guide their investment. Many districts appear to be unable even to define the total cost of their existing computer systems.

OVERCOMING THE PROBLEMS
CONTROLLING THE COSTS OF COMMISSIONING

200. First, districts must ensure that the costs of commissioning are clearly identified and budgeted for. The NHS Manual for Accounts (Ref. 18) sets out a framework within which this should be done. There should be service level agreements covering the basic support services bought in from provider units or sold to them (such as personnel or building maintenance), and the costs of these should be added into (or subtracted from) the costs of commissioning as appropriate.
201. Identifying the full costs of commissioning is not merely a matter of administrative tidiness. Districts should make a calculated decision whether to provide 'in-house' or 'buy-in' the support they need. Eventually even some of the main commissioning functions could be bought in. Having clear budgets and expenditure statements is a first step to making these decisions.

202. There is no simple way of judging the cost-effectiveness of the commissioning function. The best approach is to investigate the build-up of costs, which varies markedly between districts (Exhibit 19). The activities which are costly in comparison with other districts should be justified either by local circumstances (such as a large number of contracts to be managed) or by the exceptional rate of progress being made.

Exhibit 19
THE COMPONENT COSTS OF COMMISSIONING
The build-up of commissioning costs varies markedly between districts
DEVELOPING COMMISSIONING SKILLS

203. Districts will not be able to develop 'in-house' all the scarce skills that they need. This applies particularly to clinical skills. Districts must therefore develop links with professional advisers both in local provider units and (to ensure a balanced view) through national networks and associations.

204. Some skill shortages can be addressed by buying-in consultancy as specific needs are identified, for example in health economics. However there may be more opportunities in future to buy main areas of work from external agencies. Some fund-holders are already joining together to purchase support for finance and contract monitoring in this way; and the States of Guernsey (where health care provision is not part of the NHS) have discussed giving a health insurance company the task of managing the cost of local health services.

205. Where a district has decided to develop skills itself, a training budget should be identified. This need not be restricted to training in specialist skills; it can also be used to develop commissioning capabilities generally, for example by allowing staff to meet colleagues from other districts in learning networks.

206. Non-executive members of DHAs should be included in the training programme where appropriate to ensure that they all understand the principles of commissioning.

207. Commissioning is probably best done by staff with a variety of skills and experience. Districts should try to develop these by allowing staff to rotate between jobs on the commissioning side, and if possible encouraging moves into and out of other areas of health and social care (particularly provider organisations). But simultaneous commitment to commissioning and provision should be avoided.

FINANCE RÔLES IN SUPPORT OF COMMISSIONING

208. New approaches to the finance role are beginning to develop, especially in districts and consortia which have no DMU responsibility, or where market pressures are intense. One district's proposal for its finance structure and accountabilities is shown in part in box E.

Box E
A STRUCTURE FOR A COMMISSIONING FINANCE DEPARTMENT
INFORMATION RÔLES IN SUPPORT OF COMMISSIONING

209. The information support required by a commissioning authority depends on more than good IT. A range of expertise is needed, including knowledge of sources, access, assembly and analysis. It is essential to have access to literature so that staff can keep informed about the effectiveness of treatments, the health of local people, and the methods for identifying areas of health improvement.

210. Good IT is also important. Some districts have now begun to produce the written IT strategies which are needed as a basis for investment. These strategies should include the following features:
— They should start from the authority's strategic objectives for health, and discuss what information is most important to support these. Costly activities such as maintaining and analysing a population register should not be undertaken unless they clearly support initiatives for health which the authority has agreed.
— They should review what IT systems will continue to be available to the commissioning side, and consider how useful and adaptable they are likely to be.
— They should set out the benefits and requirements of a variety of options, including very simple PC-based ones. They should explain what the priorities are, in the short, medium and long-term.
— They should list what finance, staffing and training will be needed in order to implement the preferred solution successfully, and identify any likely shortfalls.

211. A document of this sort takes time and thought to develop. It must continue to be seen as a working document since requirements and capabilities are changing rapidly. It is vital that district's top management should understand the issues, and be actively involved in reviewing progress.
SUMMARY OF RECOMMENDATIONS

Chief executives should:

• separate any residual DMU responsibilities clearly from commissioning activity;

• identify any high-spending sections of their organisations and ensure that they are contributing proportionately to the advancement of commissioning;

• identify the skills needed throughout the organisation, and develop staff in the commissioning role, except where work is better bought in.

Directors of finance should support the commissioning and contracting processes by:

• identifying and managing financial risks;

• understanding providers’ price structures and how contract movements might affect them;

• advising and informing contract negotiators.

Those responsible for information services should:

• ensure that information needs have been identified throughout the organisation;

• establish information and IT strategies for meeting such needs.
7. The Way Forward

212. Commissioning authorities have great potential to influence the development of health services in the future. But, as this report has made clear, there are many obstacles still to be overcome if good intentions are to be converted into better services and healthier populations. Three things are needed:

— the capability (skills, resources and information) to carry out commissioning tasks;

— a clear sense of direction;

— a conducive environment.

There is room for improvement in all three areas. While DHAs should be able to make some progress on their own, action will also be required from other NHS bodies - fund-holders, FHSAs, RHAs and the Management Executive. The actions that each could usefully take are set out separately under each heading. Finally, the report describes the part that the Audit Commission will play in securing further progress.

DEVELOPING MORE CAPABLE COMMISSIONING AUTHORITIES

STAFF

213. The first two years of the reforms have demanded massive changes from staff in district health authorities. Although many have responded well and put imaginative ideas into practice, elsewhere commissioning has been seen as a 'second-best' option for managers, and progress has been slow as a result. However, the Secretary of State has recently spoken of 'purchasers calling the tune' and made it clear that the development of health care in the NHS is to be purchaser-led. DHA chairmen, members, and most crucially chief executives must follow this lead. Recruitment and reward practices must recognise the significance of health commissioning. Thus in making future appointments to any of these posts, authorities must look first for understanding of commissioning and commitment to it; knowledge of hospitals and service management should be of secondary importance.

214. The need for functional continuity between various aspects of the commissioning role means that team working is essential. Regardless of their personal background, which may be in finance, public health or information, those working in commissioning must be able to perform well in multi-disciplinary groups and contribute to each other's objectives within the district's strategy. Districts must therefore make time and opportunity for objectives to be discussed and disseminated through the organisation.

215. Staff development to meet the DHA's needs is now a priority. DHAs must allow time and funds for staff training, for participation in external seminars and learning networks, and, where more appropriate, for buying in specialist expertise for specific tasks.
INFORMATION

216. The amount of ‘hard’ information relevant to commissioning will continue to expand. Topics to be covered will include: population health status, details of services being purchased, the effectiveness of treatments, and the costs of available alternative services. Increasing emphasis on purchasing for specific care groups and localities will make new demands on staff who analyse and interpret data. District information departments must be alert to new sources of information, and to methods of obtaining it locally.

217. A thirst for knowledge must permeate the organisation. Districts must make information more accessible by:

— investing in information technology within a strategy that allows appropriate management of data with the local FHSA(s) and other interested parties;

— developing expertise in literature review as well as quantitative information sources;

— sharing programmes of work with other health authorities and outside bodies such as university departments.

218. But ‘hard’ information sources are insufficient for addressing local needs. Districts will have to supplement them by drawing on local opinions and experience. Dialogue with local communities is vital to the success of commissioning. Groups such as GPs, CHCs, and voluntary organisations will now expect to see results from the wide range of activities that have been initiated. Districts must therefore concentrate on getting some key messages from local communities; they must show that policy documents reflect the messages and that service delivery has changed as a result.

219. While much of this is down to individual district health authorities, their staff sometimes lack the necessary skills and experience. RHAs and the NHS Management Executive therefore have an important role to play in facilitating the exchange of information and experience. They should continue to arrange conferences and workshops, whether these are to discuss the implications of major national policy objectives, or to give an early opportunity for purchasers and providers to resolve problems identified through regional or national monitoring. They should also continue to co-ordinate programmes of work in individual districts and ensure that other districts can share the results. However the most important single step for RHAs to take is that of setting up a framework that integrates the commissioning activities of DHAs and FHSAs. This will have three benefits: it will bring together staff with scarce skills, remove organisational uncertainty, and eliminate rivalry between the two organisations.

220. RHAs and the NHS Management Executive should also continue to establish or act as clearing-houses for information. This will be especially appropriate in areas where individual districts might lack the necessary professional knowledge (as with advice on the effectiveness of current clinical practice, or evaluation of technical innovations), or where economies of scale apply (as with analysis of census data).

SETTING A STRATEGIC DIRECTION

221. The reforms have introduced great structural changes to the NHS, which must be a springboard for change and improvement to services in the future. Health authority leadership
needs to have a clear vision of what should be achieved during the next five years and the steps to start taking now in order to make it a reality. A pre-requisite is thorough-going devolution of management responsibility to any remaining DMUs.

222. There must be an underlying emphasis on improving the health of the population. Districts must equip themselves to analyse the outcome of the services they currently purchase, and use the results, along with review of literature and experience elsewhere, to identify those that are most effective.

223. But districts must not develop commissioning strategies in isolation. They must incorporate the views of GPs (including fund-holders) and community groups, and work with them to ensure that the direction chosen has local support. They will also need to reach agreement with FHSAs, local authorities, and health service provider units, on strategic aims and planned service developments. Each of these bodies will have its own aspirations, but the interests of patients are unlikely to be best served if the different bodies develop separate and independent strategies.

224. RHAs, with the support of the NHS Management Executive, must ensure that the various bodies co-ordinate strategies. It is particularly their responsibility to see that DHAs and FHSAs jointly develop strategies that are good enough to attract the support of all GPs, particularly fund-holders. But the objectives set centrally for health authorities should not be too detailed; there must be space for local health authorities to respond to local as well as national priorities.

CREATING AN ENVIRONMENT FOR EFFECTIVE COMMISSIONING

225. Even if all districts are capable of effective commissioning and have a good sense of direction, a third ingredient will be needed before the full benefits of the reforms can be reaped: the health service itself must be structured appropriately, providing all the component bodies with clear lines of accountability and remits, and the ability to act on them. Currently, commissioning of health services is chiefly the responsibility of two separate authorities, the DHA and the FHSA. Although joint working between these authorities is increasing, their separate existence and distinct lines of accountability are illogical, and there is increasing pressure to create one commissioning body. But any solutions of this sort must be viewed in the context of the health service as a whole, in particular:

— the management of primary care;

— the future and accountability of GP fund-holding;

— the structure of the market for secondary care.

The next few paragraphs accordingly suggest one direction in which it would be appropriate for the NHS to evolve.

THE FUTURE MANAGEMENT OF PRIMARY CARE

226. Any future model of NHS services must have general practice at its centre, for two reasons.

— Good general practice will increasingly determine what DHAs should purchase from secondary providers. More patients who would currently be referred to hospitals will be
appropriately treated in the community, a change that patients will increasingly value and expect as the range of services and supporting technology expands.

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Fund-holding practices commission some secondary care. These practices have achieved a head-start in the purchase of more efficient, higher quality care now that they are able to control the funds, and the number of fund-holding practices looks set to increase.

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227. DHAs should therefore commission in conjunction with FHSAs, the bodies that manage general practice. But there are two problems: the separation of the two bodies, and a lack of effective power on the part of the FHSAs.

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The separate bodies should be replaced by a single authority that would be responsible for the current DHA and FHSA service development functions and also be capable of developing general practice as an integral part of the health service. This is already happening in some parts of the country.

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FHSAs have little power to influence and reshape primary care. Currently most of their money is committed through inflexible, nationally-determined contracts with individual GPs. The Commission's report on FHSAs (Ref. 12) argues that this contract impedes local development of primary care. A more flexible contract might allow health authorities to contract with practices for a range of health services; it could be tailored to the strengths of individual practices and the needs of their patients. Part of the contract sum could be spent by practices on their own contracts with local hospitals and community units.

DEVELOPMENT AND ACCOUNTABILITY OF FUND-HOLDING

228. However primary care is managed in future, a dual economy is likely to persist, in which some hospital and community care is commissioned centrally by health authorities on behalf of their residents, and some by GPs on behalf of their patients. Current experience of the fund-holding scheme suggests that there is benefit from this dual commissioning arrangement. GP fund-holders have shown their ability to use funds imaginatively for certain services such as routine elective admissions, and to stimulate change in providers. However, DHAs will continue to have a role in commissioning services centrally if there is no clear client group or the numbers are unpredictable. And DHAs will continue to commission all services centrally for those practices that have not taken on fund-holding responsibilities.

229. However, there is a need to monitor whether fund-holding practices and health authorities are working in co-operation. They should therefore be required to agree on a strategy for addressing the health needs of local people. The contracts set by both would have to conform to the strategy. These requirements should be overseen by RHAs.

230. Commissioning authorities will naturally need to be aware of the details of GPs' wishes and purchasing decisions, in order to tailor their own contracts and any recommendations to other local bodies. But links with GPs are not easy to build, especially in large authorities. 'Locality purchasing' is one approach to dealing with this. Some DHAs and FHSAs have divided their population into smaller geographical areas ('localities') and are developing links with GPs and local people in each. The aim is to gain an improved understanding of local needs, and to develop contracts that allow GPs to respond appropriately; for example, extra funds could be targeted towards the needier areas within their resident population. Furthermore, funds could be more
easily directed at the total need of people from a particular care-group, because the GP is the first and continuing point of contact for most patients and can therefore determine the best overall packages of health care.

231. A more flexible contract for GP practices and primary health services would allow the balance between centralised commissioning by DHAs and local, practice-based commissioning to be negotiated locally. The presumption should probably be in favour of practice-based commissioning (i.e. GPs selecting the best package of health care for each patient within an overall practice budget) provided the practice wished to exercise that responsibility and was judged managerially competent to do so.

232. Such arrangements would make many demands on information systems and management structures which currently support DHA-based commissioning. Yet there is a compelling logic about more local involvement which is missing from the present arrangements for commissioning.

CREATING A MORE EFFECTIVE 'INTERNAL MARKET' FOR SECONDARY CARE

233. An effective market requires purchasers who are knowledgeable about the services on offer and who are free to choose between providers. Neither of these conditions has applied fully in the first two years of the reforms.

234. Districts must become more knowledgeable about the services they commission, and how those services affect people's health. They should be agreeing clinical guidelines and other quality standards with GPs, providers and FHSAs, defining the pattern of treatment that patients should normally expect to receive both in hospitals and in general practice.

235. Districts and their main providers should expect to work collaboratively where problems have been identified. They must not treat the contract as the 'be-all-and-end-all' of their relationship. This might mean purchasers providing pump-priming money - from the limited funds available - for training provider staff or upgrading their information capabilities where this is necessary to achieve agreed improvements. Alternatively it might mean district staff participating in a joint working party, for example to monitor and reshape the service being given to a particular care-group. But regardless of such desirable initiatives, it must mean senior district managers keeping in close contact with their provider counterparts, so that they are not taken by surprise by major provider problems or by innovative proposals altering the contracted service. It is the responsibility of both districts and provider units to work as partners in the interests of the service to patients.

236. Although the immediate relationship with providers should be a collaborative one, districts must have freedom to alter their purchasing patterns if they are to be fully effective. The NHS Management Executive imposed 'steady-state' requirements at the start of the reforms, but RHAs should now support districts who move contracts to different providers where such moves would clearly benefit the population.

THE RÔLE OF THE AUDIT COMMISSION

237. As part of the 1992/93 statutory audit of all health authorities in England and Wales, the Commission's auditors will be assessing the development of all aspects of the commissioning
process. They will report to each DHA on the effectiveness of its strategy and arrangements for assessing needs, translating them into contracts, and working with outside professionals and local people. They will comment on whether these activities appear to be well integrated, and whether some would benefit from more detailed attention. Significant matters will be brought formally to the attention of the authority through its management letter.

238. Auditors will continue to examine specific parts of the commissioning process in the future. Most, if not all, Audit Commission studies dealing with hospital and community health services will examine the role of commissioning in securing change. Examples of studies already published include those on community care, care of sick children, and community health services (Refs. 6, 7, 9 and 13). Future relevant topics will include the well-being of children, and communicating with patients.
Appendix

The following district health authorities were visited by the study team during 1991/92:

— Bath
— Bromsgrove and Redditch
— Croydon
— Gloucester
— Great Yarmouth and Waveney
— Haringey
— Harrow
— Leicestershire
— Wakefield.

A study of extra-contractual referrals was carried out with the King's Fund Institute/King's Fund College, whose staff visited a further six health authorities, namely:

— Barnet
— Herefordshire
— North Derbyshire
— Parkside
— Solihull
— South Bedfordshire.

The study team was supported by an advisory group consisting of:

Josephine Barry-Hicks, Chief Officer, Ealing CHC
Roger Cannon, Director of Business Development, St James’ NHS Hospital Trust
Peter Coe, District General Manager, Tower Hamlets DHA
Dr Bernard Crump, Director of Public Health, South Birmingham DHA
Mike Dunning, NHS Management Executive (until March 1992)
Dr Howard Freeman, GP Fund - holder
Professor Chris Ham, University of Birmingham, Health Services Management Centre
Dick Stockford, NHS Management Executive (from April 1992)
Dr Barry Tennison, Director of Information, Cambridge DHA.
References

8. A Lakhani, Department of Health, private communication.
18. NHS Management Executive, Health Authority Manual for Accounts, (Chapter 9).
19. Caring for People: Community Care in the Next Decade and Beyond. HMSO (Cm 849).
21. A Darkins, Kings Fund Centre, private communication.


