Purchasing with Authority:

The New Role of DHAs

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and
Tim Matthews

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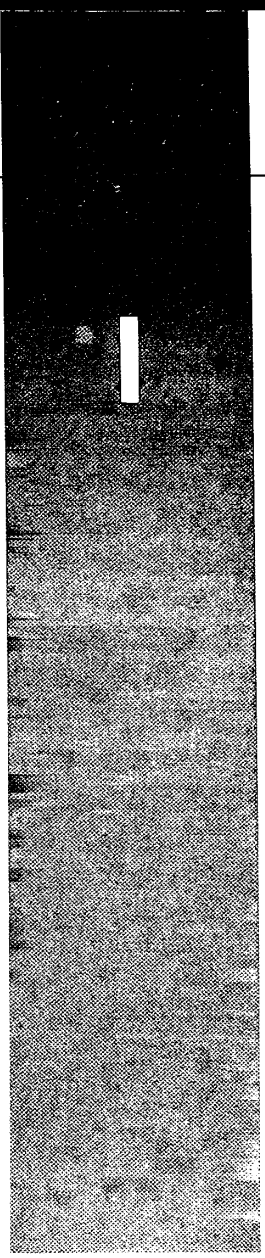

Purchasing with Authority:

The New Role of DHAs

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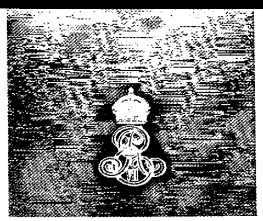

Acknowledgements

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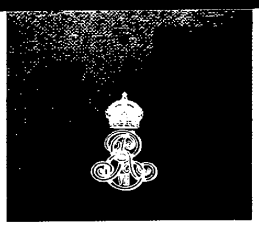
Chris Ham and Tim Matthews
May 1991



1. Introduction

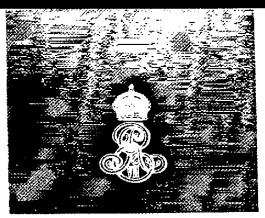
Much of the debate about the NHS reforms has centred on the most visible changes in the management of services, particularly the introduction of NHS trusts and GP fund holding. Far less attention has been given to the new role of district health authorities (DHAs) as purchasers of services for their residents. There has also been little debate about the impact of the new membership of health authorities on the implementation of the reforms. The move away from a local authority style member/officer model to a more corporate executive/non-executive approach is an integral part of the attempt to make the NHS more 'businesslike'. The new-style DHAs came into being in September 1990 and it is therefore an opportune time to review their experience so far.

In order to assess progress in the first six months, representatives of seven DHAs attended a workshop at the King's Fund College in March 1991. The aim of the workshop was to review the work of the seven authorities in relation to:

- the establishment of the purchaser role
- the contribution of chairmen, executive and non-executive members.

This report summarises discussions at the workshop. It both reviews progress to date and highlights challenges for the future.

The report has been prepared with the support of the DHA Project in the NHS Management Executive. The DHA Project was particularly concerned to explore the contribution of non-executive members of authorities and this aspect is therefore given special emphasis. As our report shows, non-executive members have the following contributions to make to the work of their authorities:



- bringing a wider range of experience than is available among the executive members. This involves both specialist experience (for example, contracting) and generalist knowledge. By asking simple, direct questions, non-executives can make a useful contribution to the development of policies and priorities

- ensuring that the time and attention of authorities is focused on 'board-level' issues. These issues include matters of overall strategy, policy and direction such as the purchasing plan and the Director of Public Health's annual report

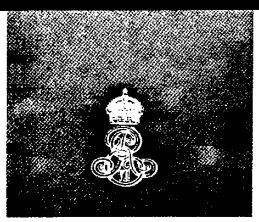
- appointing the right people to top management positions and appraising their performance systematically. Non-executives will work closely with the chairman in this process

- building the authority's links with other agencies. These agencies include community and voluntary organisations, statutory bodies, trade unions and employers. Non-executives can help to develop healthy alliances through their personal networks and contacts

- helping to strengthen management at unit level and enabling DMUs to make the transition to NHS trust status.

The recruitment of non-executive members in future needs to reflect the responsibilities of DHAs as purchasers. This means appointing people whose skills and experience are relevant to the role of authorities in assessing the population's need for health care, establishing priorities for the use of resources, and negotiating contracts with service providers.

In focusing on the contribution of non-executives, we do not intend to imply that non-executives are more important than the chairmen and executive members of DHAs. As our report highlights, it is the



combination of people sitting around the authority table that is vital to the effective working of DHAs. The appointment of managers as members has helped in the development of a corporate way of working and this must continue to be emphasised.

We hope our report will be a useful contribution to continuing debate and discussion of the future role of DHAs.

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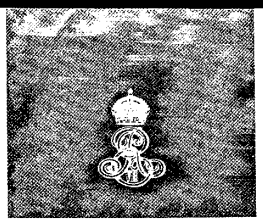


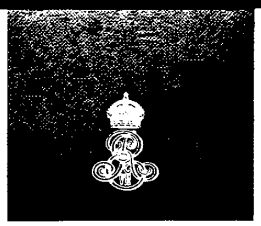
2. The Purchaser Role

Experience in the seven authorities indicates that the amount of time and attention devoted to purchaser issues has varied considerably. One authority reported that almost all of its work had been taken up with purchaser issues. This had been possible because all of the services in this authority became an NHS Trust on 1 April. In contrast, some authorities had allocated a majority of their time to provider issues.

Perhaps not surprisingly, most authorities indicated that they had considered both purchaser and provider issues. The proportion of time spent on purchaser issues ranged from an estimated 40 per cent to 75 per cent. As some of the authorities pointed out, there was often an overlap between purchaser and provider issues, and it was therefore not easy to give a precise indication of the balance of work to date. With authorities responsible for managing the transition to the new arrangements over the next 2-3 years, provider issues will continue to claim attention until NHS trusts become the norm for service provision.

Authorities were asked to give examples of the sorts of purchaser issues they had discussed. All districts reported that they had considered the Director of Public Health's annual report and the purchasing plan for 1991/2. In addition, the following issues were mentioned:

- DHA mission statement, values and objectives
- professional advice
- GP links
- quality of care and contracts
- public relations strategy and community involvement
- setting priorities
- joint purchasing with other agencies
- contribution of health economics to purchasing
- the operation of 'shadow' contracts in 1990/91.



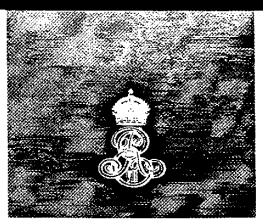
An issue taking up an increasing amount of time in many districts is the future configuration of authorities themselves. With the development of NHS trusts gathering pace, RHAs are actively considering district mergers. There are also moves to establish joint purchasing arrangements between DHAs, often as a prelude to formal mergers. As we discuss below, these issues are likely to become more important in the future.

The DHA as Champion of the People

In their purchasing role, DHAs are expected to act as champions of the people, buying services which reflect the community's needs and wants. The authorities that attended the workshop reported that they were pursuing a number of initiatives to get closer to their communities. These included:

- giving priority to public relations
- commissioning market research
- carrying out surveys of patients' views
- organising meetings with local voluntary organisations
- arranging public meetings to explain the DHA's new role and responsibilities
- undertaking life-style surveys of local residents
- working closely with the CHC.

As well as these specific initiatives, a number of authorities reported that they were exploring the idea of locality purchasing. This was seen as particularly important in the context of proposals to create larger authorities (see above). Participants at the workshop argued that organising purchasing on a locality basis was one way of making DHA decisions sensitive to community views. Authorities also argued that GPs were an important source of information and ideas on patients' needs: an issue to which we now turn.



Links with GPs

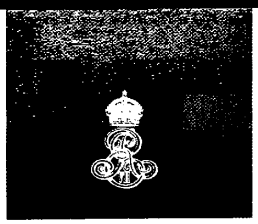
All authorities noted that, as part of the purchasing role, they had started developing a dialogue with GPs. This had been done in various ways including:

- questionnaire surveys of GPs seeking their views as part of the development of contracts for 1991/2
- face-to-face meetings with GPs to follow up questionnaire surveys and to find out directly what GPs feel about local services
- the use of established mechanisms such as the local medical committee and the FHSA.

In a number of districts, steps have been taken to refashion professional advisory committees. This is often motivated, at least in part, by concern to ensure that GPs have adequate representation on the medical committees that advise the DHA on its purchasing plan. In this context, some authorities have found it useful to establish advisory committees in which both GPs and consultants are involved, and to arrange meetings between the full authority and these committees.

Healthy Alliances

Most authorities have attached priority to developing links and alliances with other agencies. The main agencies concerned are FHSAs, local authorities, and voluntary organisations. Alliances include contacts between chairmen, between chief executives and between members. In addition, established collaborative arrangements, for example those involving joint planning between NHS authorities and local authorities, have been revised in the light of changes to the NHS and community care.



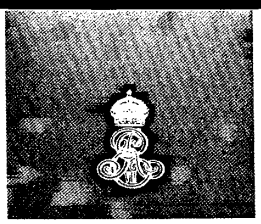
Specific initiatives pursued by the seven authorities included:

- a county-wide project on Caring For People involving the DHA, FHSA and local authority
- joint appointments and secondments involving DHAs and FHSAs. These appointments cover public health, planning, information, and professional advice
- joint working between a DHA and FHSA to establish a common information base and agreed service strategies
- the establishment of a joint group of managers drawn from the DHA, FHSA and local authority
- the involvement of non-executive members of the DHA in locality groups established by a social services authority
- a joint approach by a DHA, FHSA and local authority to the development of community care plans
- the involvement of FHSA and local authority executives in a DHA purchasing group
- a joint approach by a DHA and FHSA on pharmaceutical policy.

Initiatives involving voluntary organisations included representation on joint care planning teams and joint planning groups.

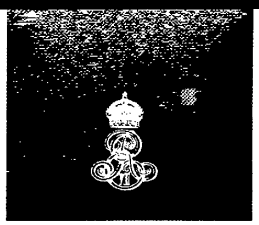
Provider Issues

As already indicated, authorities vary considerably in the extent to which they have devoted time and attention to provider issues. All have played a part in monitoring performance in their units and in ensuring that financial control was maintained during a year of tightly constrained budgets. Some had gone a good deal further and had found that much of the time of the authority had been taken up with provider concerns. This was often in those districts where units were overspending their budgets and authorities decided to work closely with unit managers in bringing expenditure back into line.



In one of these districts, a provider services committee had been set up, chaired by a non-executive member, to review financial and managerial performance in the unit. In another, unit review groups were established to perform a similar function, chaired by the chief executive and again involving non-executive members. In other districts, authorities had decided as a matter of policy not to become too closely involved in provider issues and to concentrate instead on the purchaser agenda.

Where non-executive members were closely involved in the affairs of their units, an increasingly important part of their role was perceived to be helping units make the transition to NHS trust status. More generally, in most districts authorities have spent some time discussing and reviewing the unit business plan. The plan was seen as a key document in the development of the work of units and as such requiring careful scrutiny by the DHA.



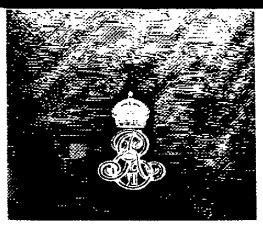
3. The Contribution of Chairmen, Executive and Non-Executive Members

Participants at the workshop reported that the new-style DHAs feel different from their predecessors. The smaller membership, the appointment of managers as members, and the introduction of non-executives from a variety of backgrounds means that they are already working in a new way. Debate is more intense than in the past, the level of questioning by non-executives more searching, and the quality of discussion often considerably higher. Non-executives appear less concerned to act as representatives than former authority members. The composition of authorities is leading to a more businesslike approach and it has been easier to develop a corporate way of working.

Set against these benefits are a number of teething problems. To begin with, managers have not always found it easy to take on the role of executive members. In addition, non-executives new to the NHS bring a range of experience and knowledge but sometimes lack understanding of health services.

Some non-executives have experienced problems in playing a full role in a public arena. This has caused authorities in a number of districts to do more of their business in private sessions. These sessions enable authorities to explore sensitive issues in an informal way.

Although helpful in enabling authorities to engage in constructive debate and discussion, the increasing use of private meetings reinforces the perception among some sections of the press and the public that the NHS has become more secretive. This creates a difficulty, particularly at a time when authorities are seeking to establish legitimacy and credibility for their role as champions of the people. Recognising this dilemma, some authorities are using methods other than public meetings to seek views from their communities and to explain their policies to the public. As we noted



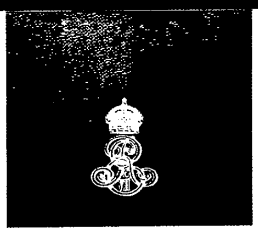
above, these methods include arranging special meetings to discuss the DHA's new role and responsibilities, organising meetings with local voluntary organisations, and working with CHCs.

Much of the time of authorities so far has been taken up understanding the issues that need to be tackled in the future. As a consequence, the emphasis has been placed on briefing and training new non-executives and helping executive and non-executive members get to know each other. Most authorities found it useful early on to organise time-out sessions at which the authority as a whole discussed its new responsibilities and the contribution of different members. This was especially helpful in the development of a corporate approach and a common understanding of the issues to be tackled.

With the passage of time, non-executives have begun contributing more directly to the work of their authorities. In part this has involved drawing on their specialised knowledge and in part it has entailed using non-executives as a sounding board to test out the ideas and recommendations of executives. Authorities have focused their attention increasingly on policy and strategic issues such as the purchasing plan, unit business plan, monitoring performance in directly managed units, and progress made in implementing the NHS reforms. Non-executives have also made a contribution outside meetings both in forging links with other interests and agencies, and in working informally with executive members.

Authority Meetings

Of the seven DHAs who attended the workshop, two have been meeting in public once a quarter, three have been meeting in public once every two months, and two have been meeting in public every month. One of the authorities meeting in public once a quarter has



also arranged a special meeting open to members of the public to discuss the authority's new role and responsibilities.

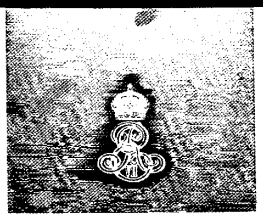
Alongside formal, public meetings, all authorities reported that they had made use of informal meetings, often referred to as seminars or briefing meetings. These are usually held on a monthly or bi-monthly basis. The purpose of these informal meetings has included briefing authority members on the issues with which they have to deal and providing an opportunity for in-depth examination of particular matters of concern.

Committees and Panels

The smaller size of DHAs has enabled much of the business to be done corporately by the full authority. As a consequence, relatively little use has been made of committees and ad hoc panels or working parties. Of those authorities that are using committees and panels, one has involved non-executives in health care panels organised on a care group basis. Another has established a provider services committee, an audit committee and a chairman's committee of non-executives. The role of the chairman's committee is to handle performance review and performance related pay of executives, with the participation of the chief executive as appropriate. A third has involved non-executives in committees on audit, trust funds, ethics and medical advice. One of the other districts has appointed some non-executives to unit review groups whose role is to monitor unit performance.

Special Interests

A further way of organising the work is to ask individual non-executive members to take on special interests. Some authorities have deliberately avoided doing this so far, preferring to work in a more corporate way. In other authorities, a number of special



interests have been identified. In some cases these interests are concerned with the development of provider units, in others they are based on particular care group services.

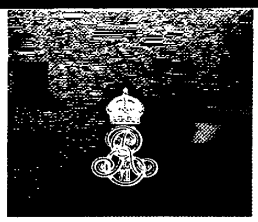
In two of the seven districts non-executives have been actively encouraged to take on special interests. In one authority this involved non-executives shadowing executive members in relation to needs assessment, contracting, quality and other responsibilities. In another authority it involved issues such as trust funds, health promotion and quality assurance.

The special interests of non-executives are often related to the experience and knowledge they bring with them into the NHS. Authorities reported that non-executives contributed a range of experience in fields such as: finance, personnel, law, business, contracting, education, quality, local government, voluntary sector, nursing, primary care, and trade unions. As this list indicates, business experience is important but not predominant. Non-executives bring a variety of knowledge with them and it is the combination of skills sitting around the authority table that is seen as important.

Associates

In a number of districts, the time pressures on non-executives are considerable. Many non-executives have significant professional and personal commitments outside the NHS and are constrained in the contribution they are able to make. This has led all but one authority to make use of associates.

Associates have usually been asked to undertake Mental Health Act duties and personnel appeals. Other functions mentioned included appointments panels, sitting on ethics committees and chaplaincy committees, and participating in a health promotion forum. Where



associates are used, it is important that they carry out their responsibilities in a way that is consistent with DHA policies. In this context, one authority had found it useful to ask its vice chairman to convene meetings of associates on a regular basis to keep them informed of the authority's thinking.

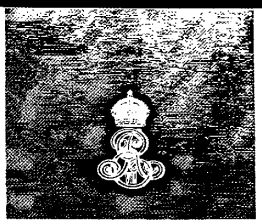
Managers as Members

Four of the seven authorities had filled all five executive member posts while the other three had filled four posts. The most common appointments were chief executive, finance director, director of public health, and director of planning (and/or contracting). One authority had appointed a director of policy and business management, another a director of administration and personnel, and a third a director of quality and consumer affairs.

Some managers have experienced no difficulty in becoming authority members, others have taken time to make the adjustment. One problem has been enabling executives to play a part as full members rather than just contributing in their functional capacity. Another issue of concern has been to develop the right relationship between the chief executive and the other executive members.

On the one hand, it is important to preserve the position of the chief executive as the 'managing director'. On the other, executive members are expected to contribute across the range of the authority's work and this may mean that on some issues they take a different view from that of their colleagues. A delicate balance has to be struck between the need to maintain cohesion in the executive team and the importance of encouraging open and critical debate of major issues of policy.

One of the challenges facing authorities in the first few months has been to ensure that executive and non-executive members are



treated equally. Insisting that different types of members are intermingled around the authority table is one simple approach that has proved useful in some places. There is also value in avoiding a style of doing business in which executives always present papers and non-executives respond.

To some extent this is an inevitable part of the way in which business is conducted, but it can be tempered if non-executives take the lead on some issues, and also if managers other than those who are executive members are encouraged to initiate discussion at authority meetings. Above all, chairmen have a key responsibility in leading the authority and in making the most of the experience of both executive and non-executive members.

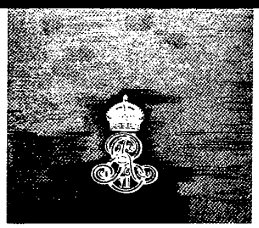
The Chairman's Role

Chairmen have always had an important part to play in the work of DHAs but arguably their contribution is even more significant in the new-style authorities. In particular, it is the chairman's job to lead the authority, to ensure that its work is organised effectively, and to help all members work together as a team. The chairman will collaborate closely with the chief executive in carrying out these functions but he or she has a personal responsibility to bring the activities of authorities together in a coherent way.

Beyond this responsibility, the chairman's role includes:

- managing upwards to the RHA
- managing outwards to other agencies
- communicating the authority's policies to staff and to the public
- providing a sense of vision to guide the authority's work
- insisting that there is a clear sense of direction in all the authority's business.

Some authorities have found that vice chairmen have an important job to do in supporting the chairman in carrying out these functions.



4. The Future Agenda

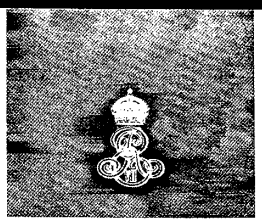
Looking to the future, DHAs face a number of challenges in taking the reforms forward. In this part of our report we set out the nature of these challenges, building on the discussions at the workshop and our contacts with other DHAs. We begin by outlining the future development of the purchaser role and go on to review the contribution of non-executive members.

The Purchaser Role

Many of the challenges in this area involve consolidating and extending what has been achieved so far. This includes ensuring that purchasing teams with the requisite skills are in place, developing further links with GPs, and continuing to forge healthy alliances with FHSAs, local authorities and other agencies.

The development of the purchaser role needs to be given higher priority because the existence of effective purchasers is essential to the success of the NHS reforms. The NHS has always been a provider dominated service and it will not become more responsive to the needs of patients and the public unless DHAs are established as an effective countervailing force to the power of providers.

Of particular importance is the role of DHAs in acting as champions of the people. Much remains to be done to make a reality of this role. Some of the initiatives already taken by the DHAs have been described earlier in this report and there is an urgent need to explore which of these initiatives offers most promise for the future. It is unlikely that any single approach will be sufficient and authorities will have to put effort both into communicating their policies to the public (through public relations strategies, public meetings and other methods) and to seeking the public's views on purchasing priorities.

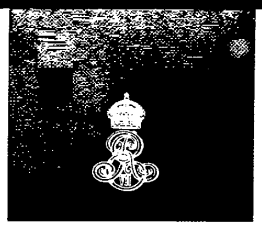


A second challenge is to explore the role of DHAs in setting priorities. As many observers have noted, the NHS reforms will make priority setting more explicit. Authorities will have to defend the choices they make on which services to purchase (and which not to purchase). This must involve open debate and discussion about priorities and a more systematic assessment of the costs and benefits of different services.

As experience in the state of Oregon has shown, there are a number of ways of approaching priority setting. This includes public consultation, the use of quality adjusted life years (QALYs) and a review of the evidence on service effectiveness. DHAs will need to explore the relevance of these approaches and to establish the process by which they should choose between competing options.

A third issue for the future is the configuration of authorities. Experience so far suggests that there may be advantages in moving towards fewer, bigger DHAs for purchasing purposes. These advantages include economies of scale, the greater financial leverage that will be available to bigger authorities, and the opportunity to make better use of the limited number of people and skills available to support purchasing. It may also be easier to establish healthy alliances if DHA boundaries are coterminous with those of FHSAs and social services authorities.

Set against these advantages are a number of potential drawbacks. These include the organisational disruption that would result, the difficulty of making purchasing decisions sensitive to the needs of the local community, and the challenge of maintaining links with a larger number of GPs. Given these arguments, it may be more productive in the immediate future to explore ways of developing joint purchasing arrangements based on existing boundaries.



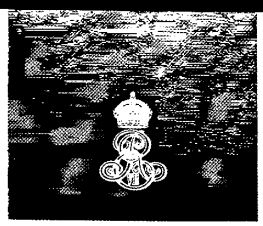
This is already happening in many parts of the NHS. DHAs as well as FHSAs are collaborating in these developments and are undertaking a range of initiatives including:

- the establishment of purchasing consortia in areas such as South East London, North Yorkshire and the Mersey region
- joint approaches to the development of service specifications and quality standards in contracts
- shared appointments in public health, planning and other functions
- the division of responsibility between districts in a region for the purchasing of regional specialties.

The variety of approaches emerging in different parts of the country is being mapped by one of us (CH) in a separate piece of work supported by the Management Executive. This will help to illustrate the contribution which joint purchasing arrangements can make as the NHS reforms proceed. As part of its programme of work to develop purchasing, the Management Executive has also commissioned studies of the role of authorities as champions of the people and in priority setting.

Taken together, these challenges represent a formidable agenda for DHAs. It is clear that the main effort so far has been concentrated on the negotiation of contracts which reflect established patterns of service provision. These contracts provide a baseline on which to build in the future.

The main priority in 1991/2 is to move from contracting to *real* purchasing in which assessing needs, evaluating service effectiveness, establishing priorities, and achieving greater sensitivity to the community's views figure more prominently in the work of authorities.



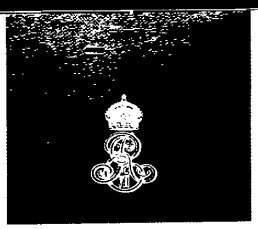
The Contribution of Non-Executives

As we have argued, non-executive members have focused mainly on learning about their districts and assessing the implications of the NHS reforms for their own role and that of DHAs as corporate bodies. More recently, they have started contributing more directly to the work of their authorities, and this will become an increasingly important part of their role with the passage of time. On the basis of what has been achieved so far, it can be suggested that non-executives have a number of functions to perform.

First, they can contribute a wider range of experience than is available among the executive members. This experience encompasses a variety of areas, some of which (for example, contracting) are central to the new role of DHAs and are in short supply in the NHS. As well as specialist experience, non-executives bring generalist knowledge to the work of authorities. By asking simple, direct questions, they can make a useful contribution to the development of policies and priorities, acting as a stimulus to higher performance on the part of executive members.

Second, non-executives can help to ensure that the time and attention of authorities is focused on 'board-level' issues. These issues include, first and foremost, matters of overall strategy, policy and direction. Examples include the purchasing plan, the director of public health's annual report, and unit business plans and performance. It is at this level that authorities should be working as corporate bodies, avoiding detailed operational issues which are properly the concern of executive members. In focusing on strategic issues, authorities need also to work in a way which is consistent with the district's mission and values.

Third, non-executives have a particular responsibility to ensure that the right people are appointed to top management positions and that their performance is appraised systematically. The chairman

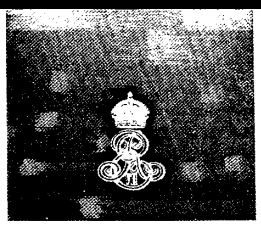


will take the lead in this process as far as the chief executive is concerned and will work with the non-executives to assess the performance of the chief executive. The chairman and non-executives will then work with the chief executive to assess the performance of the executive members. One authority has found it useful to establish a chairman's committee for this purpose.

Fourth, non-executives have an important job to do in building the authority's links with other local agencies. These agencies include community and voluntary organisations, statutory bodies, trade unions and employers. As the purchasing role develops, DHAs will need to put more effort into establishing healthy alliances and getting close to their communities, and non-executives can assist in this process through their personal networks and contacts.

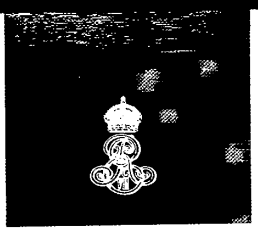
Fifth, while the purchaser role will take up more time and attention in future, DHAs will remain responsible for overseeing the performance of units and helping them to move towards trust status. In most authorities it is likely that one or two non-executives will take a particular interest in the affairs of their units and will work with the UGM in strengthening management at unit level. This could well lead some non-executives to join the boards of trusts, although it will be important to ensure that the involvement of non-executives in this area does not overshadow or retard the development of the purchasing agenda.

A more general issue follows from this, namely the skills and background required of non-executive members of authorities. Experience so far indicates that some non-executives are more suited to membership of a trust board than to membership of a DHA. This applies mainly but not solely to non-executives who come from business backgrounds.



In many cases, these non-executives appear to be more interested in contributing to the establishment of strong provider 'businesses' than to developing purchasing plans and priorities. The latter function needs skills that are often different from those brought by some managers with a successful track record in a commercial environment. More specifically, non-executive members of DHAs require links with their local communities, an ability to analyse options at a strategic level, and an interest in resolving some of the complex ethical issues that setting priorities in a purchasing organisation inevitably involves. They must also be sensitive to the political context in which purchasing takes place and the importance of making decisions that are relevant to local needs.

The recruitment of non-executive members must reflect these requirements. People with business and management experience from outside the NHS often have a good deal to contribute to the work of DHAs. But they and other potential members need to be chosen carefully if an operational management focus is to be avoided.



5. Conclusion

The findings discussed in this report are very much first impressions from a small number of DHAs. We make no claim that the authorities are representative of the NHS as a whole, although our contacts with other districts suggest that they are not untypical. The NHS is developing so quickly in response to the reforms that some of the findings may well be out of date even by the time this report is published. Health authorities are having to learn about their new role in the process of implementing the reforms and this inevitably means that management arrangements are adapting in the face of changing circumstances. Given the importance of 'learning by doing', we hope that this report will be useful to chairmen and members in thinking through their working practices and in organising their business to make purchasing work for patients and the public.

The King's Fund College

The College has played a major part in leading thinking on the role of the new-style DHAs. The College produced Managing With Authority for NAHAT in 1990 setting out a range of ideas on the way in which authorities might undertake their responsibilities.

Following this report, the College was asked by the Department of Health to conduct an assessment of the training and development needs of DHAs. This was carried out jointly with NAHAT and the results were published in a report entitled: The New DHAs: Preparing For Business.

In parallel, Chris Ham was commissioned by the NHS Management Executive to examine the way in which management thinking and practice on the relationship between DHAs and DMUs was developing. The findings were reported in a King's Find Project Paper, Holding On While Letting Go.

The College's 1991 programme has built on these foundations in a number of ways. To begin with, College Faculty have provided support in the field to RHAs and DHAs. This has included organising time-out sessions and assisting in the development of the new purchasing arrangements.

Another major area of activity has been College-based seminars. These seminars have been designed with the particular needs of chairmen, executive and non-executive members in mind. The College believes strongly in the importance of developing a corporate approach to the work of authorities. One of the ways in which this can be encouraged is through participation by different kinds of members in educational programmes.

Chris Ham leads the College's work with DHAs and would be pleased to provide further information. He can be contacted on (071) 727-0581 ext 2112/2120.

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