KINGS FUND COLLEGE

KINGS FUND COLLEGE PAPERS 6

THE COMMISSIONING EXPERIENCE

Learning the Art of Purchasing

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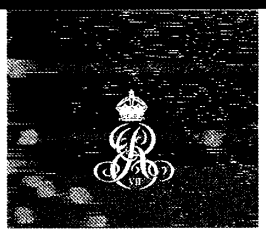


1. 'What the Future Holds'

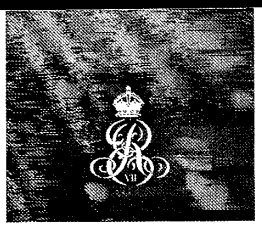
"It has been the most stimulating three years of my thirty years in the Health Service giving me a new focus to my real agenda. The particular configuration of the Health Service has created inequity and injustice which mirrors the values of our class ridden establishment conscious society - the power of purchasing is to change that, albeit on the margins".

The experience of purchasing over the last two and a half years has demonstrated what might be possible. What seems clear is that the future agenda is massive, complicated and feels different both quantitatively and qualitatively. It is not just that people are busy - a permanent pattern - but they are addressing new dilemmas which are stretching and extending their capacity. The agenda might be 'challenging'- the over-used euphemism - but it is also unpredictable and ambiguous.

The likely policy initiatives are well known; Care in the Community; Health of the Nation; Patients Charter; London (not just a parochial issue); the consequences of changing patterns of care leading to the continual run down of institutions - acute hospitals, residential institutions for those people with learning disability and mental health problems and the similar effect of prison contraction will impact throughout the country.

Concurrently, we can predict a range of managerial and organisational 'imperatives'. The move of the NHSME to Leeds, the changing role of Regions - the development of the intermediate tier, the potential mergers of purchasing authorities with FHSAs and the possibility of Trusts forming partnerships or cartels to reduce their vulnerability will be coupled by a drive to 'improve' performance. Monitoring contracts, emphasizing quality and developing outcome measures will be supplemented by accreditation initiatives, measures of comparable performance and a persistent pressure on individual performance and personal survival.

And, if this is not enough, the context is likely to be less than empathetic. The recession and a political desire to contain the public sector borrowing requirement will squeeze the health and welfare budget; purchasers will find their budgets curtailed by GP fundholders and capitation will induce



anomalies. Health related programmes, impacting both on health care and poverty, such as housing and leisure will not be priorities. Galbraith's underclass will be a reality.

Purchasers are pivotal in the management of these disparate dilemmas and tensions. They have to establish a productive (not necessarily harmonious) interrelationship with GPs (including fundholders) and develop continually their relationships with people, locally and in their communities.

It seems therefore the appropriate time to provide this collection of essays, thoughts and ideas. These have emerged from a group of purchasers who have been meeting, reflecting, working and learning since January 1990.

The essays attempt to describe what has been learnt, to be honest about the difficulties and blocks, and do not purport to provide any 'quick-fix' solutions. They do not attempt to be comprehensive, but the ideas generated point to some important messages for managers taking on the purchasing role:

- purchasing is about *managing* and making things happen; the expert process of qualifying need, measuring outcome and effectiveness and assessing the differences which should inform and support the managerial intention, not divert from it;

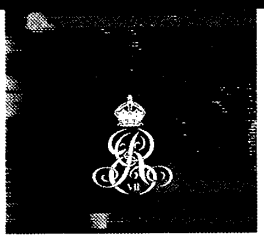
- having explicit values is fundamental;

- there are no simple answers, only better ways of purchasing;

- a learning network is an alternative model to help notice and review what is happening and tackle intractable problems in a setting of trust and mutual support.

How it began

During 1989, as the implications of the NHS reforms were thought through, the potential of purchasing (as opposed to provision) become apparent.



The King's Fund College responded by setting up a workshop- 'Planning for Purchasing'- which was attended by many managers from the Districts which would go on to form the Demonstration Sites and participated in 'Project 26'. This was one of the key projects teams set up by the NHS Management Executive in November 1989 to explore the purchasing role. To support this initiative five of the 'demonstration sites' - Parkside, East Hertfordshire, Wandsworth, West Dorset and North West Thames RHA joined Bristol & Weston to form the Project 26 Learning Network. The following participated:- Sheila Adam, Ian Baker, Olive Boles, Ian Carruthers, Peter Coe, Mike Dunning, Debbie Evans, Patricia Frost, Sue Gallagher, George Gibson, Ian Gregory, Lynda Hamlyn, Jac Kelly, David Knowles, Lelia Lessof, Kate Money, Bob Nessling and David Panter. (See Appendix 1). John Mitchell, Fellow at the King's Fund College directed the network.

The contributions in this publication have co-ownership and reflect the views of the group. There has been no attempt to be comprehensive and much of the background deliberations are not included. For example, issues such as professional advice, working with chairmen and non-executive members, and the legitimacy of authorities have exercised the group. What is included here reflects the agenda of 1992. The document is interspersed with quotes which are drawn from the personalised statements of the participants response to the question: why they became a purchaser.

2. Purchasing and Good Management

"At least I could be more responsive to the diverse needs of local people, empower users, question professional hegemony and breakdown the stultifying bureaucracy".

Two years on from those early days of choosing to be purchasers and being highly motivated by the opportunity to focus on how to improve health without the responsibilities of provider management, we reflected on "what is purchasing and what makes a good purchaser?"

The consensus was, that:-

- A good purchaser needs the same leadership qualities, management skills and strong value base as is found in a good general manager of a health provider.

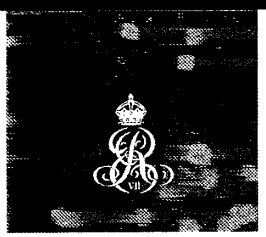
- Purchasing is about good management and the effective management of change.

These are important conclusions for NHS managers uncertain about purchasing roles and for the career development of NHS managers. It was also important to us because it said something significant about our learning from purchasing. Reflecting on what and how we reached these conclusions helped us explore some of what we had learned about purchasing over the two year period. We use the six key success criteria for general management contained in Duncan Nichol's message to NHS managers in the mid-1980s, as a framework for reflection.

1. Spotting the Issues

1.1 Spotting the concept of health gain from the plethora of writing and debate on health needs assessment took many months of agonising. Looking back it is hard to understand why we drowned in the process before seeing what we were talking about - adding years to life and life to years, and the conjunction of needs and resources to give health gain.

1.2 Leading up to the 1991/1992 contracting year, inevitably given the



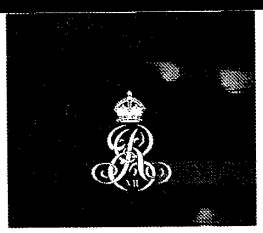
exhortations about the importance of being very specific, we (the purchasers) attempted to write every detail of the health care in our specification documents. If we were lucky the paper may have been read by providers but the approach made little difference to their intentions. We now know that spending time understanding what we are actually purchasing and then achieving commitment to significant but small changes is much more important than a highly detailed specification.

1.3 In the early days of debate about the internal market there was much talk and some evidence of 'macho' behaviour, in both purchasers and providers. It was not difficult for that to lead to talk of management incompetence or the need for sophisticated negotiating skills and high profile successes. Maturer and wiser, we now know that if we are to be influential in changing the nature of the health care business, we need to focus on earning respect, using highly developed enabling and facilitating skills to help achieve behavioural and cultural change, and building strong strategic alliances with a win/win aim.

2. Finding the People Who Can Resolve the Issues

2.1 A discussion about the purchasing role led to an early focus on the public health function and how to ensure sufficient public health expertise. Two years on, we have learned that defining the potential for health gain and translating this potential into a feasible purchasing strategy requires a combination of skills of a team of people who bring about different experiences, perspectives and competencies; and that an effective team-building leadership style is crucial to ensuring that all these skills are used to optimum effect. Developing productive matrix working is part of the challenge.

2.2 It was easy to delude ourselves in the early stages of contract negotiation that the crucial people to get "signed up" were the provider managers. Being arms length from providers, and purist, purchasers may have moved some of us too far from the reality of the provider. Provider managers had very real problems of achieving a massive organisational and cultural change, almost over night, and could not sign up to anything on behalf of all their clinicians. We are making better judge-



ments now and have gained considerably from talking to provider managers with their senior clinicians on a specialty by specialty basis. This sharing of different perspectives and meeting of minds about what is possible enables the signatures to be meaningful. Feedback suggests that the providers have gained much from this process of engaging clinicians in partnership with them.

3. Mapping What We Already Know

3.1 We had a number of round table discussions about how to develop an intelligence function, how to access epidemiological information, how to ensure that we had independent advice and how to obtain more specific information. At times these debates made the development of purchasing seem fraught with logistical and expensive problems before we could make a decision. It soon became clear to us all that we should use all the information we already had. The discipline of starting from what we knew, and mapping it carefully, brought us back to reality. Rather then seeking new data we appreciate we had plenty and set about thinking how it should be utilised to inform the management process.

3.2 Some of us had great aspirations of locality purchasing and ventured down that path - only to be bought face to face with two problems and a multitude of issues that needed much more careful thought. The first problem was that we had not sorted out how to address the numerous public concerns about the NHS of which we were already well aware, before going to collect another portfolio of expectations. The second problem was that the public's health agenda included all those health issues that the DHA had little direct control over, and that careful mapping of how we were to engage other agencies in health gain and locality based work was a critical early exercise.

4. Structuring the environment so that change is enabled

4.1 Networking and influencing are crucial functions of general management. The 'drip feed' approach may work well but it is likely to work substantially better if it is accompanied by an excitement for change. We have learnt that expecting purchasers and providers separately to effect change successfully has to be built from inspiring trust between the

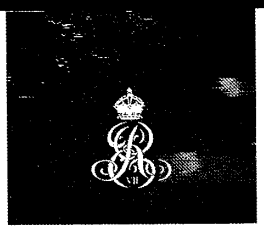
providers and ourselves. This is dependent on all parties being able to identify with the objectives of the change agenda. Early work in Project 26 DHAs on drafting mission statements, in one case going through fourteen drafts before being satisfied, proved a highly beneficial first step in gaining a corporately owned value base. The discipline of ensuring that subsequent plans, priorities and actions were demonstrably in accord with this statement has been important in gaining credibility and respect from providers.

4.2 Two other examples of structuring the environment to enable change are Parkside DHA's establishment of a purchaser to work as a bridge between purchasers, providers and the racial minority communities; and Dorset's use of health visitors to help implement their waiting list initiative.

5. Not seeing issues as difficulties

5.1 The learning network has spent many sessions falling into the trap of dwelling on the difficulties of implementing the White Paper `Caring for People' and the problems of developing joint purchasing with local authorities and FHSAs. One of the most important lessons we learned is the time honoured one of not seeing issues as difficulties, but as opportunities. With patience, creativity and flexibility, difficult problems can be moved forward. Building a shared understanding and trust with officers from other authorities and using a joint problem solving approach does create platforms of opportunities. The recognitions of what we have achieved, how far, jointly, we have come on the journey, rather than dwelling on the danger of the 'minefield' we had to cross, is an important management discipline and is crucial to maintaining morale and motivation in agencies overwhelmed with competing priorities.

5.2 At a much simpler level, we have all suffered from the difficulties of 'not seeing the wood for the trees' and have gone through periods of being daunted by the magnitude and complexity of simply stated objectives. In reality, each DHA has made successful progress in developing purchasing and has had successes and failures. The network has helped us recognise and be motivated by the successes. It has also helped to force us to



identify a few key priority areas for moving forward. Thus is has given give us a more realistic perspective of 'what is possible' so that we can rise above the constant demands and pressures which can so easily lead to burn out and demoralisation.

6. Knowing what we don't know and getting someone else to do it.

6.1 The fear of many professionals about purchasers was that we would sit in our 'ivory towers' and pronounce, and that we would become distant bureaucrats who made decisions on things about which we knew very little. Maybe there was, or is, a danger of this, but one of the most enriching and satisfying aspects of being a purchaser has been the dialogue that we are developing with provider clinicians. At last we can engage in a discussion of their business, health gain, in a way which is meaningful to them, motivating to all of us, as well as a highly enjoyable learning experience. Such dialogues have produced exciting ways of improving the clinical services.

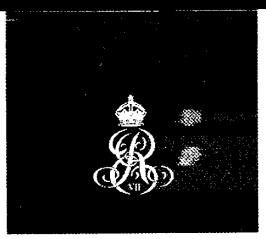
6.2 In a similar way we have spent a great deal of time seeking the direct experience, views and perceptions of GPs, generally, and specifically in relation to extra contractual referrals. Almost without exception the latter discussions have greatly enhanced our knowledge base and resulted in constructive agreed patient management plans.

6.3 Finally, dialogue with users, and carer and consumer representatives, has been a motivating and enriching experience. It has demonstrated that we don't know what the users experiences are until we actually go and talk to them - second guessing or basing our actions on assumptions can be dangerous and foolhardy.

7. Conclusions

We concluded that some of the characteristics of what we believe a successful purchaser will demonstrate are:

- An ability to manage change by addressing complexity and uncertainty from a clear value base and with considerable integrity and honesty.



- An ability to challenge the paradigms and be innovative whilst sustaining a high degree of credibility, efficiency and effectiveness.

- Having a vision and using perseverance, determination, courage, patience and adaptability to pursue objectives in the face of constant uncertainty and constant change.

- An ability to excite people to the belief (and convince them of it) that purchasing is the closest structural manifestation of "form following function" in the NHS this century. That is, it provides one of the most exciting means of marrying the fundamental values and sense of purpose of most NHS managers within their work focus and content.

3. Developing the Market

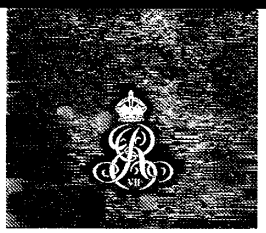
"Purchasing forced me to ask why does it take so long to ensure that proven effective approaches to care are available to everybody?"

Framing the Right Questions

We began to meet as a learning set in January 1990 and throughout the next 15 months our debates centred around 'purchasing', 'providing' and the 'NHS internal market'. In reality, most of our discussions returned time and again to the organisational and relationship issues that had been generated by the separation of purchasing and providing. This has led to the simultaneous pursuit of both NHS Trust status and the creation of the new Health Authorities. Our thoughts on the internal market were mostly expressed in frustrations about contracting on a 'steady state' basis or in posing questions to which none of us had the answers.

In May 1990 (as the internal market began to operate) we engaged in a more structured discussion on the market, and identified a continuing uncertainty about the extent to which regulation would be needed as the internal market began to operate. Two examples discussed were the development of lithotripter service facilities and plastic surgery services. Should the distribution of these two services be left to market forces or should regions continue to have a role in planning their equitable provision? One view was that the availability of purchasing resources and a demand for these services would ensure their availability where they are needed. A counter view was that this would not happen effectively and that regions should continue to perform a planning function for these specialised areas.

At the end of 1990 a certain nervousness became detectible - most noticeably around the high profile of the last stages of the Department's 'fifty two weeks and counting' exercise - but also with the production of 'market rules'. These had been induced by a a number of Regions who feared chaos, confusion and the eradication of NHS values as the market economy was established. To us, these were not 'market' rules as were commonly understood but rather a way of operating characterised by:-



- groundrules about contracting

- a synthesis of locally owned value systems produced in a 'mission statement' type format

- a renamed and re-presented Regional strategic planning framework about service provision.

We understood 'market rules' to be about the rules of the game. They are *not* the same as the *purpose* of the game - which is to win. (Winning in this instance means to achieve objectives which year on year deliver our longterm goals, these goals having been tested against and sustained by our long-term concerns and by clearly agreed value systems). So the rules had to help both sides (purchasers and providers) compete fairly (using 'level playing fields') and had to be able to identify 'foul play' or circumvention of the rules. There were two different and potentially conflicting roles for these rules to perform. These were either:

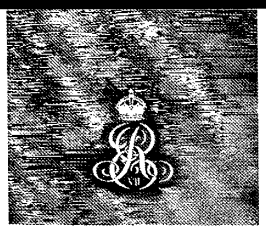
- to focus attention on achievement of national and local goals and design the rules to have the best chance of delivery on these

or

- to assess what were likely to be the most high risk scenarios, and abuses, arising from the introduction of the new systems and to prevent or ameliorate those risks and abuses.

The two options offer both different ends and differing means:

(i) Taking the first option leads us quickly to an outcome driven system dependent upon DHAs' corporate objectives and a clear monitoring mechanism. More specifically it may result, for example, in targeting psychiatric services and tracking targets through, ensuring that the contracting mechanisms and funding allocations deliver enhanced care through the market system.



(ii) Alternatively, the second option might result in a diagnostic tool similar to the risk analysis work developed elsewhere. This would lead to evaluation of risk using a points scale with objective criteria to judge risks inherent in the market system. Having identified risks, or threats of high impact and high likelihood, it would be necessary to reprioritize any action arising having considered (a) timescale and (b) cost. Cost would often be financial but would include consideration of opportunity cost; for example: what happens if we allow stability to break down?

In January 1991, the Management Executive discussed 'Market Rules' with the Regional General Managers which they largely interpreted to be rules and principles for the operation of contracts and these wider questions remained unanswered.

Purchasers and the market

Our real experience of the 'market', as planning gave way to reality in 1991/92, was in relation to waiting lists (which we rarely referred to) and ECRs (which we probably referred to at least once every time we met). It was, nevertheless, the period in which we began to refocus away from 'contracting' to the real challenge of 'purchasing' and the task of how to create space and exercise leverage in order to begin to define and achieve our change agenda for health and health services.

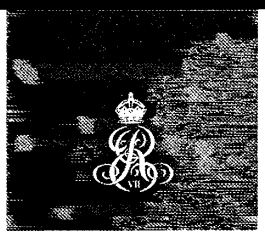
During the second half of 1991 we began to discuss more frequently the issues of change and leverage in preparation for agreeing service contracts in April 1992. Our debates focused around three areas:

1. The Shape of Provision

- How to disinvest in certain types of in-patient care or treatment patterns and the levers which were appropriate to assist in this?

- What impact this would have on the overall shape, size and configuration of provider units and how could this be managed?

- How to promote change by the credible threat of provider competition and how this could be managed?



2. Market Rules

- The need to reduce regulation across the NHS, which inhibits or substitutes for competition.

- The creation of simple and explicit tasks, data definitions, vocabulary and timetables which allow change to be defined, managed and planned.

- The establishment of clear roles and responsibilities between each tier of the NHS.

- The need for arbitration procedures.

- The allocation of capital in the market place.

3. The Responsibilities of Commissioners/Health Assurers

- Purchasing competitively against other Health Authorities and Fundholding practices.

- How far "healthy alliances" could work without organisational integration.

- How could DHAs best achieve changes in health status for their residents given the existence of fundholders?

Issues of about the pace of change in 1992/93, and debates over whether intervention was necessary to prevent unmanageable change, became almost as theoretical as the basic framework for contracting threatened to become dysfunctional. A clear timetable, which had been set out both for purchasers to make public their future commissioning intentions, and for providers to declare their service developments responses (as well as for indicative prices/service definitions for the following year), was not adhered to by most providers.

We need to establish further ways in which providers can be held to account for performance against basic 'market management' processes. Learning

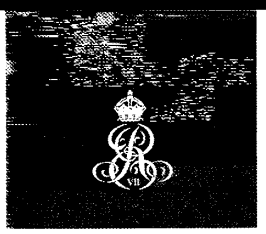
network members have frequently discussed behavioural issues and the need to influence managerial and professional cultures - together with the levers available.

We have also been aware of the increasingly explicit expectations around shifting activity - either in location between 'like' providers or between sectors of care (acute, community and GPs) in order to increase patient satisfaction (more local, user friendly, appropriate) and/or for efficiency reasons. Contracts for non-acute services remain crude instruments and are currently ill-equipped either to prove that the delivery of value for money services has taken place, or to promote shifts in the location or management of local care arrangements. We realised the importance of treating primary care as an integral part of the proper debate on the market - despite the difficulties and incongruities which this gave rise to - and we were concerned about the lack of congruence sometimes apparent between policy makers at the DoH and managers within the NHS.

There is no agreement of how the allocation of capital should be used to reinforce the legitimate commissioning intentions of purchasers and any resolution needs to address not only the issue of capital required for new service development but capital for service reconfiguration, rationalisation and reduction (where purchasers are likely to feel less ownership to agreeing monies for downsizing rather than the more seductive areas of growth and newbuild). This will prove a highly charged issue - not only in the decision-making process about who gains access to restricted resources, but in what role Regions play in attempting to arbitrate or intervene in size, capacity and location issues.

Conclusion

We have reached the stage of recognising what the 'intermediate tier' between NHSME and the service must regulate or 'steer'. This must include purchaser/provider behaviour in the public interest, and should use the revenue and capital resource allocation processes to underpin and support its objectives, intervening only in extremes. In the interim the 'market' will operate through a combination of old and new style activities including the deployment of a significant regional fund for transitional support purposes.



4. Purchasing with Local People

"The combination of intellectual endeavour and the production of an action programme for a tangible audience - the local residents".

Why Involve Local People?

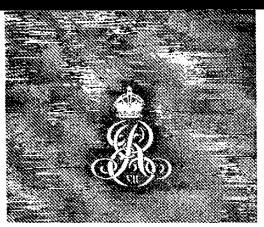
A key consequence of the purchaser-provider split was to make the service more responsive to local people through purchasers listening and taking account of the expectations of the public, and providers delivering services geared to people's expressed needs. During the last two years the learning network has returned frequently to explore the complex issue of involving people effectively without raising expectations which are undeliverable.

From the purchasing perspective, we frequently asked: "Whose NHS is it?". There are several would-be stakeholders who would lay sole claim. If the DHA is to have influence, legitimacy and credibility and wishes to involve local people, perhaps a starting point is to ask why it wishes to do so, and how to weigh potential reasons. (Figure 1)

FIGURE 1

A Task Analysis for the DHA

- inform purchasing strategy/priorities
- feedback on quality/involvement in quality assurance
- user empowerment, citizen advocacy/mobilisation
- public relations/DHA image/corporate identity
- build healthy alliances
- assist health needs assessment/health gain
- promote informed choices
- inform debate on models of service/restructuring the health care business
- mobilise community self help
- inform values of DHA
- promote health, prevent illness



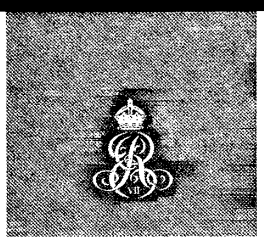
Who Are Local People?

A second dilemma, as yet still requiring resolution, is to ask who local people are and in what role should they be involved. Figure 2 sets out some of the possible parties:-

FIGURE 2

LOCAL PEOPLE?	WHO THEY MIGHT BE!
Actual users and carers of users	- short term contacts - continuous users - chronically ill/disabled - minority group users/special needs
Ordinary citizens - potential users	children young people adults the elderly affluent disadvantaged with time without time with dependents without dependents
Co-workers in health	GPs GPFHs NHS staff CHCs PHCT Professions
Partners in health and social well being	Local authorities (many depts./committees), voluntary organis., private sector, police
Advice agencies/workers	CABx, voluntary group (client group specific)
Opinion leaders	Religious leaders, politicians (MPs, councillors, members) chairmen, trades councils, rotary clubs, teachers, mediabriefs
Potential investors in health	Suppliers, e.g. shops, manufacturers,distributors, e.g. libraries, launderettes, educators, e.g. schools, colleges, community groups, e.g. residents associations, scout troop leaders, environment lobbying groups, NCT

We noted there would be many different views about the appropriate nature, focus, desirability and benefits of being involved.



What Do We Mean By Involvement?

Involvement is a term used very loosely. A shared understanding of what it means, how 'purist' we want to strive to be and some key issues is essential. Attaining real involvement means obtaining feedback or undertaking surveys which can take some time. It is a dynamic process, characterised by and requiring some or all of the following:

- a process for continuing dialogue in a working partnership
- discussion and debate before decisions are made and/or participation in decision making
- sufficient information to enable people to offer informed opinions
- a willingness to listen to views and advice and allow participation in agenda setting
- provision of various and regular opportunities for people to give views
- a rigorous discipline about feeding back progress on issues raised/discussed, the outcome of consultation and, the rationale for decisions/strategies/changes
- investment in user empowerment/citizen mobilisation
- addressing how to involve minority/disadvantaged groups
- investment in staff training and the culture of the purchasing organisation (and providers).

Involvement should be built on values which emerge from a debate on the shared values of DHA members and reflected in the mission of the DHA. It must involve all staff of the purchasing organisation. It will require a diversity of approaches, which must be attuned to local communities.

It should raise the question of who is the patients' advocate. The DHA's role is about making the health strategy and policy a citizen's issue, not just an issue for users and their carers. The approach must be incremental and recognise that however small and pragmatic the first phase of the strategy, it will be very demanding on the purchasing organisation. The expertise cannot be bought, it has to be learnt from experiential approaches, incremental building and refinement. Some approaches will

fail, but this should not be construed as failure of the process of involvement process but as part of the learning process.

We are reaching conclusions that time must be spent on deciding clear priorities for involving the consumer, balancing how many of the interrelated activities fit into the whole. Dabbling in too many areas at once can be dangerous. What is attempted must be done well, with good preparation and clear success criteria.

Finally, in deciding what we mean by involvement, the use of the terminology is critical. Failure to follow this rule may result in criticism from consumer groups. The terms 'involving' and 'involvement' should only be used when a real attempt is being taken to involve people in a dynamic process.

Options For Involving Local People

The incremental approach to developing a strategy for involving people requires strong building blocks, with their foundation in the overall purchasing function. Figure 3 identifies some of these issues:

FIGURE 3

Basic purchasing support for involvement

- information and advice helplines (accessible and well publicised)
- written and other factual aids (on all services, conditions, procedures)
- database of stakeholders
- careful use of terminology, e.g. surveyor sampling
- simple language - simple questions
- some words and concepts banned from discussion, e.g. rationing
- good knowledge about access and access criteria to services, assessment process and methodologies, apparent service deficiencies and corrective plan
- clear complaints policies and procedures which are accessible
- public relations expertise - good media links
- visible high quality health promotion with strong reinforcement through providers
- users of health service facilities promoting DHA health messages.

Having established the base from which to launch the strategy for involving local people there are a number of options for processes to be tried to see their effectiveness. These are set out in Figure 4:

FIGURE 4

Condition specific/client group specific work

- stakeholder/consensus conference involving GPs, voluntary organisations, providers, users, carers, consuming organisations
- user focus groups
- user dimension to health gains/needs
- carer focus groups
- surveys of users/carers/GPs, etc
- specific 'cohort' concentrated work, e.g. with racial minority communities
- community care alliance and interest group
- patients' councils, user advocacy services
- user quality assurance and monitoring group
- use of DHA outreach services
- involvement of users in training/sessions
- use of health visitors, GP practice staff, locality workers, community nursing and other staff
- GP practice user/carer groups
- assessment and care management for care in the community
- community care plans

Where Now?

The complex interactions identified so far, linked to our reluctance to embark on a process which could not match delivery to expectation, have meant a cautious approach to local people. Our detailed exploration of the issues has resulted in some very positive learning, and the intention to test the methodologies during 1992.

Involvement of local people should inform the development of an already established health and purchasing strategy. Health targets should be clear before opening up debate, and local people's views, priorities and

preferences should be used to shape and refine the health strategy. The World Health Organisation targets are a good basis for commencing dialogue on issues of equity and health but must be related to the local population. Local authorities have been found to engage positively when these have been used. Equally, the 'Health of the Nation' White Paper will serve to concentrate on specific targets.

An investment in providing a considerably higher standard of information about local health status, local health and related provision, local standards, local sources of advice, and information about health issues etc., is a crucial first and ongoing task. This work must represent a fundamentally important and ongoing commitment of the DHA in developing an informed public. It will require concentration on content coverage, language, presentation options, access sources, publicity etc.

Clarity about how open the debate can be is important. In Dorset, when local people in market towns were asked what the DHA could do to improve health locally, the response was build a swimming pool! The recognition that there is a distinction between purchasing for localities and purchasing by localities is an important check. Involvement may mean no participation in decision making, except about the horizontal slices of the cake or the balance of resources across client groups. It may be preferable to take small steps in this area, initially, and to start discussion within 'envelopes of the portfolio'. In contrast, it is much easier to involve client groups,in condition or client group specific work, on models of care and resource utilisation. Our experience indicates that, not surprisingly, only a few GPs or other people want to be involved in 'explicit decision making' when it is perceived as 'rationing'.

Any involvement with local people reinforces the importance of healthy alliances with partner agencies (LA, FHSA). Many of the issues and concern raised by local people are about matters over which health professionals have no direct control. It is worth investing time in building healthy alliances amongst members and officers of these other agencies and attempting to have a joint approach. Health providers will increasingly want to involve users and carers. GPs/GPFHs have a captive audi-

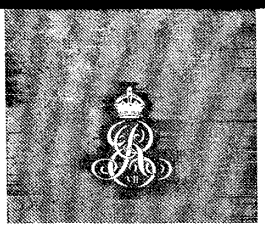
ence in their patients. Inconsistent messages from the DHA and these other players will confuse people. They will have more contact with the clinicians who are delivering services and are likely to be strongly influenced by them. The DHA needs to consider how to work compatibly, jointly, or through these people and how to build relationships and agreed objectives with them.

Much is known about the public's perceptions of the deficiencies of services. Priority must be given to addressing these deficiencies and being seen to do so successfully. If this is not taken seriously at the outset and as further quality issues emerge, the DHA will have little credibility and people will not be motivated to be involved. In a political sense, the DHA can never be truly accountable to the local population as it has no elected members. The DHA can, however, increase the legitimacy of its role by promoting informed choices, conveying informed decisions and helping the public cope with the reality of there being no right answers.

Building an appropriate and helpful culture in the purchasing organisation requires an investment of time and an associated organisation development strategy. Many DHAs are not consumer friendly and do not have priorities for the simple things that would 'rate' their performance in this respect. Most staff have little knowledge about 'the community' and have not received basic consumer, racial or disability awareness training. The DHAs health and purchasing strategy may not be well understood by many staff and there will need to be work on communications internally and externally.

Each member of staff must become an ambassador for the DHA and the credibility of the organisation must not rely on a few key people or it will 'crumble' or at least suffer severe setbacks if they leave. The relationship of work with local people and the purchasing and contracting cycle needs careful consideration so that the 'feed ins' are timely and can be used.

A key element of the work is based on the recognition that localities within DHA boundaries may have different views and priorities. Early



work will attempt to recognise and explore whether these differences are real or imagined. We believe the involvement of local people in their health care is fundamental to the success of purchasing and must continue.

5. Purchasing with General Practitioners

"Purchasing is the opportunity for a reappraisal of an approach which is citizen driven; linked to primary care professional advice and delivered in effective, affordable, and, if necessary, innovative ways".

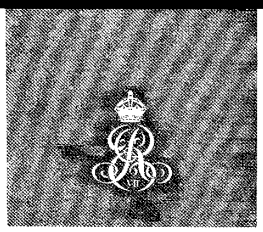
In the beginning

With the publication of the White Paper on the NHS Reforms we developed a gradual realisation that General Practitioners (GPs) were of prime importance to us. Our understanding of this need was but a glimmer of where we are now and where we might be in another two years. We had realised that they were the gate-keepers to secondary care and that the brave new world of purchasing could not be achieved without their co-operation - whether or not they were fundholders. If we wanted to change patterns of referrals then we had to listen to and influence GPs first.

What did we do

We tried to consult with GPs but we were soon reminded of the fact that they were all individual practitioners, even if some were grouped in practices. So we variously:

- carried out postal surveys (and had a very poor response)
- carried out surveys by interview (better response but were we asking the right questions?)
- invited GPs to meetings on a locality basis (not many turned up)
- invited GPs to meetings with a promise of a post graduate fee and lunch (slightly better attendance)
- established GP Advisory Committees to include representatives of localities, single-handed GPs and GP fundholders (of some help but still unrepresentative)
- arranged for each member of the Purchasing Team to adopt a num-



ber of GP practices and build up a broad relationship and knowledge base (the most productive use of time but difficult if there are too many practices).

These stages were explored with some rapidity by many purchasers.

How did GPs react?

GPs were still recovering from negotiations on their contracts, so the word 'contract' from a purchaser conjured up many horrible visions for them. However, many GPs were pleased to note the sudden interest shown in them by not only the FHSA but also the Health Authority purchasers and providers! It is not surprising that they became quite confused and cynical about who was doing what and some were resistant in the initial stages to talking to anyone.

What did we do wrong?

There are exceptions but many purchasers developed their links with GPs, immediately. Not surprising the FHSAs feel threatened by this sudden interest in GPs by Health Authorities and LMCs reacted predictably. There have also been service problems. For example, many of us have failed to solve the real difficulties GPs have in getting patients admitted as emergencies to acute hospitals in the winter months.

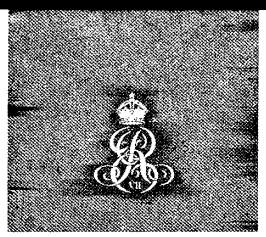
What do we need to do?

If we are to achieve health gain and reduce morbidity, and achieve more cost effective purchasing for our resident population, then we have to:

- learn with FHSA colleagues about our joint vision of primary health care and how it interacts with secondary and tertiary care.

- learn the business and motivations of General Practitioners and how we can jointly help them to help us create our vision. It is important to recognise these, for example:

    - they want to be in control and to orchestrate the management of policies valued and respected



- some understand the language of health gain
- as a group they have a health regard to their life outside medicine

- recognise that the focus of health care should be based in GP practices, where a holistic philosophy is practiced.

- the majority of the population look to GPs as a first port of call but this necessitates the abolition of the health care/social care divide.

- recognise and promote other primary health care agents.

- recognise that the general practitioners network is extended and they relate to a whole range of people other than purchasers, ie. patients, other GPs, Social Service Departments, other GPs, SSD, social workers, community units, hospitals, consultants, FHSAs, voluntary organisations, Public Health doctors, housing, education, and so on. Purchasers should recognise the difficulty of this and use their influence to simplify it.

- understand them there are three tiers of primary care provided to users; those that have GPs, those who get minimal service, those who get access by status and privatisation.

- recognise that GPs have different concepts of their role vis a vis 'individuals', 'communities' and 'health'.

We need to:

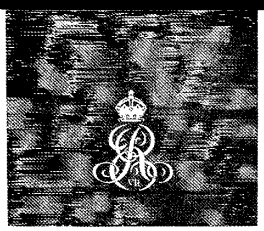
- facilitate interaction between GPs and Consultants;

- utilise audit, monitoring and outcome measures;

- make purchasing locality focused, jointly with FHSAs and social services;

- involve GPs in case management at every stage;

- resource projects with GPs, jointly with the FHSA



What are the separate issues for GP fundholders?

We have to develop partnerships with GP fundholders so that the purchase of health care for a resident population is co-ordinated whilst at the same time:

- not restricting GP fundholders
- learning from the greater flexibility available to GP fundholders.

If purchasing is good management how can we apply this to our relationship with General Practitioners?

- We need to listen as well as talk, and we need to be prepared to do deals with GPs so that they can see some advantage for themselves in helping us with our objectives.
- We need to identify difficulties which GPs are having which we can solve to give us credibility in getting their support to help us.
- We need to be honest and base honesty on our health goals, in language which GPs can relate to.
- We need to recognise that achievement is through influencing and not only from command.
- We need to map all the aspects of primary care with FHSAs so we can understand the role of GPs.

How might purchasing of primary care develop?

Primary care must be inclusive of all the supporting facilities including those services currently purchased by Health Authorities under the heading of 'community health services'. Perhaps in the future we may be purchasing from GPs in the same way that we purchase from hospital providers, and allow GPs to either engage staff or sub-contract work to other providers, e.g. district nurses. This would be in line with the further development of the GP fundholder's role in being able to purchase these services from those providers which they select.

6. Purchasing with Local Authorities

"Purchasing gave me a commitment to working for social justice and the final recognition that a 'conventional' career in medicine would not achieve this".

Introduction

If good purchasing is good general management then one key aspect of this is managing relationships with external agencies. Since 1974, health authorities and local authorities (and in particular social service departments) have been struggling to get the right level of relationship and to work together successfully at all management levels: some have succeeded better than others. Now the pressures to meet the deadline of 1st April 1993 have given a new impetus as the community care element of the 1989 Act starts to be implemented.

For us, and for many other health and social services managers, it really feels as if we have been plugging away at the same end point for the last 20 years. The focus on assessing community needs, on the user and carers, and no choice, is nothing new. So why is it that the changes being proposed 1st April 1993 are perceived so negatively? A senior and successful NHS manager was seeking advice as late as May 1992 as to where to go to see successful care in the community (as envisaged in the Act): "Where can I go to touch it?" It is clear that NHS managers felt that the implementation process for 'Caring for People' did not possess the dynamism of the introduction of the NHS reforms, and for many there was a sense of frustration that the agenda was lacking direction. But for others, it all felt rather familiar and the message from them was that this is a long process and we would have to be patient and persistent to achieve our goals.

We perceive the changes being proposed as more radical than many, in changing the nature of joint working with the social services and other local authorities. The reforms mean that the two agencies have to work together in particular on the allocation of resources and this concentrates the mind wonderfully. In this we saw the changing nature of the relationship as a sort of rites of passage during which we would pass from the old to the new rela-

tionship. The 'old agenda' was typified by tribalism, marginalised decision making, rhetoric and diplomacy. Thus, the focus was (or should be) on renegotiating these relationships and trying to share our development as the policy culture and environment changes.

But having said this, the overwhelming opinion of the people in the learning network was that we were dealing with a nebulous area, where leadership was unclear, where it was difficult to make things happen and unclear how purchasers could influence an agenda from a position of little control. How can we apply the good management principles we have developed?

Open and honest talking and listening

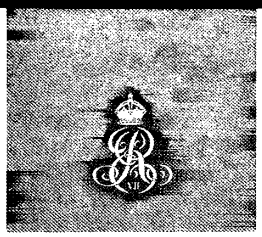
We should understand that the changes demanded in the Health Service are exceeded by different pressures on local government. Those pressures will lead to undermine their 'sense of purpose' and morale affecting the capacity to deliver. Simply criticising them will achieve little; instead we need to be prepared to enter into a sustained process of building links, being supportive and ensuring that we have got our act together. For example, are we clear who is responsible for working with social services departments - the providers or us, the purchasers - on any given issue? Health is only a part of the local government's agenda - arranging meetings with no possible outcome will not help us building partnerships.

Taking advantage of local accountability

We should not underestimate local accountability and in many ways should want to nurture it. They should understand that relationships between local authorities and central government are significantly different from those between the Health Service Management Executive and the Health Service. We should look to this as an opportunity to legitamise our role with the local community rather than become frustrated by what we see as interference of councillors. A powerful initiative we have used has been the joint agreement of health targets and social care targets which builds a joint purpose and encourages 'win-win' arrangements.

Not seeing issues as problems

In our experience, it is only too easy to see the introduction of the



community care changes from April 1995 as a problem. Alternatively, we can use it to take hold of the agenda with social services departments and use it as a catalyst to attain our longer term vision and policy objectives:

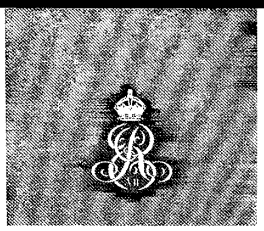
- seeing new information is coming into the system about a whole area of social care hitherto unknown to us, i.e. independent residential and nursing home care;

- the spirit of the Act is the shift from the 'perverse incentive' of residential care towards care in the home. This is the policy objective - and 1993 represents a milestone on the way to achieving this policy;

- the nature of the funding changes must be exploited to ensure joint commissioning and the development of the mixed economy. This also means that goals can be clarified jointly and that space has to be created to pump prime community developments and ensure the shift in resources from residential care.

- The introduction of the social care grant changes the responsibilities of local authorities in ways which will affect directly their relationships with health authorities. This change needs to be mapped out on both sides. For example, it is estimated that 40% of the new admissions to nursing homes and residential care are discharges from hospitals. Health authorities need to validate this figure locally by finding out how many of their residents are being discharged into residential care. They need to share this information with their local authority counterparts so that discussions about future arrangements can proceed on the basis of facts. The April 1993 changes need to be managed positively; if they are not then the choices available to people in need of care will be reduced and the likelihood of people residing inappropriately in hospitals will result.

These consequences are too dramatic to warrant a half hearted attitude to the management of relationships between health and local authorities. Addressed in a positive fashion the reforms provide an opportunity for health and local authorities to plan together and to build and develop more positive relationships so as to enhance rather than diminish choice.



7. Purchasing with Public Health Doctors

"It suddenly became a real possibility that we would shift resources from 'cure' to 'prevention' or from acute to community - something we had been trying to do for twenty years".

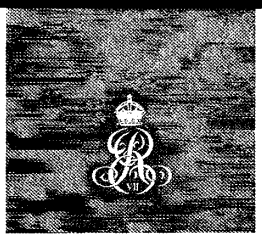
Spotting the issues

Public health physicians and managers share the challenges of working for a district health authority. Both are interested in determining how public finances available for health care are best invested, and both enjoy declaring successes in improving health status and have responsibilities for reporting partial gains and unresolved problems. Public health physicians report to the DHA publicly through their Annual Health Reports and managers are accountable continuously in the District Health Authority as well as the NHSME via Regional Health Authorities.

Public Health physicians appreciate the difficulties of generating health concepts alongside the traditional response of health services to disease. Public health physicians are well aware of determinants of health status which are quite unrelated to the activities of medical and other health services. Health services which do influence health status are often not secured in sufficient volume whilst resources are spent inefficiently on services of uncertain and, in some cases, unproven care. Effective services purchased may also be less than equitably available to the District's population.

Public health physicians can gauge the relative effects of investments in the NHS as compared to gains to health status that may be acquired through collaboration with other bodies. This approach was recognised clearly in the 'Health of the Nation' which described the need for central collaboration of Governmental departments and similar practice between different fields of influence locally. Public health physicians can translate the potential for collaborative ventures to management in the DHA and to officers of local statutory and voluntary agencies.

Managers may feel that even with the knowledge that health status is only partially influenced by health services, the complexity of resource allocation



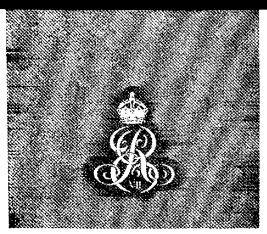
and purchasing of better health services is sufficiently challenging. Managers work in the context of overwhelming demands for more treatment and care, limited resource flexibility and increasingly well-organised lobbying from professional, patient and public groups.

Gaining insights

Both managers and public health physicians find common ground when it is recognised that all who work with the DHA need to demonstrate change in health and health care in the population. Finding this common ground is often a difficult but illuminating debate as many different perceptions will be involved. However, no single individual agenda can be satisfied. Public health physicians cannot expect to be too theoretical and expect managers to be insensitive to real resource and political pressures which they face. Public health physicians may take their major concerns to a national level through their own professional network. Managers equally will not gain a close relationship with public health physicians if it is not clear what aspect of health/disease is being addressed through change of contracts and resource investment or if there are too many expedient resolutions of short terms problems.

Making it happen

With common aims or endeavours identified, the intelligence and information systems used by public health physicians will help to develop strategies and options whereby change can be taken forward. Public health physicians have access to medical and other scientific literature which managers may have insufficient time and expertise to interpret. Public health physicians should generate ideas and innovations from such technical appraisals and determine applicability to local issues and resource limitations. Such ideas and innovations will be debated with general practitioners and other professionals in order to build up relevant expectations and support for change. Similar advice will be required by GP fund holders who, whilst understanding fully the demands of their own patients and having budgetary control for elective procedures, may value and epidemiological perspective on aspects of disease change and a measured view of the benefits to be derived from the use of secondary clinical services. GPs both fund holders and non-fund holders will have advice from their own practices and innovations to convey to public



health physicians.

Increasingly, rationing of health care is becoming explicit and of greater concern to public and professional representatives. The starkness of rationing will be more acceptable if decisions are seen to be based on rational enquiry and addressed honestly and equitably. For a general manager to carry this responsibility, he/she must be in a position to have confidence in the advice received from public health physicians who must generate trust and understanding through high standards of practice. Indeed, in giving such advice, public health physicians are rightly sharing the risk that the rationed allocation may be less than optimal even though the most critical analysis of current knowledge has been undertaken. Public health physicians cannot expect to provide advice and back away from the sharing of this risk. Indeed they are rewarded appropriately for accepting the responsibility. Public health physicians must be prepared to support managers with advice for relevant change, even if this places them in a position of challenging vested interests and entrenched positions of other medical staff.

Public health physicians need to maintain their own professional standards and organisation no different to that which will be sought by those from managerial or accounting backgrounds. Public health physicians must be open to constructive criticism and be prepared to demonstrate ways in which their methods and practice are subject to review and improvement. In turn managers will support access to continuing education and training.

With the NHS Reforms, managers often have an appreciation of local needs for health services and options for resource allocation,and face conflicting guidance determined at a distance by the RHA and NHSME. This tension can be a healthy test of central imperatives and local flexibility with refines efficiency, quality and choice. If general managers are to defend successfully their local decisions, then timely and substantial support of public health physicians is critical along side that of financial and contracting colleagues within the same health authority. In a similar manner, directors of contract management will need support from public health physicians when tackling service change with clinical directors.

Managers will want to manage the public health resource of their authorities. Public health physicians will wish to influence managers in making their decisions. The more that managers understand the minds of public health physicians and the more public health physicians appreciate the stresses of management, the more there will be for the public good.

What managers want:

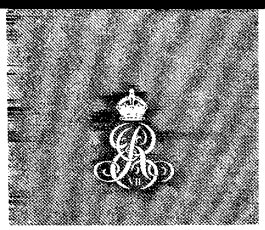
- advice based on knowledge, experience and interpretation
- options for better benefits at lower costs
- interpretation of professional behaviour and lobbies
- support for managerial endeavour especially if challenged vested interests

What public health physicians want:

- appreciation of their health perspectives
- support for efficient methods of working
- recognition of liaison role
- time for explanations

What managers and public health physicians need to do:

- understand each other's perceptions
- understand limitations and stresses of roles
- develop a joint commitment
- use each other's abilities
- support decisions taken and share risk
- accept criticism and guidance
- improve standards of performance



8. Purchasing with Providers

"Purchasing was an opportunity to align professional practice with service need and to separate the day to day work of operational management problems from achieving improved health status".

Key factors for successful purchasing

1. It is vital that both the purchasers and providers in any transaction have good knowledge about each other's corporate histories, corporate values, internal key issues and key targets. This sort of research is increasingly important as purchasers trade with more distant providers. There may not be sufficient knowledge within the purchasing organisation, and equally providers need to know more about all of the major partners with whom they are trading. The level of knowledge required is variable with either the size of the contract or its strategic importance.

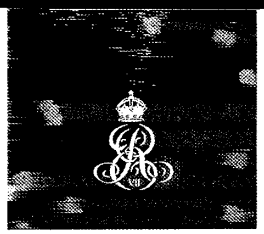
2. It is essential that open statements of strategy, (including clarity about funding), explicitness about priorities, are exchanged between parties. Strategy documents must be published by each party and should not just be exchanged but discussed so that a common understanding of meaning is reached explicitly.

3. There must to be a clear and crisp understanding of each party's role, and an explicit agreement to the nature of the relationship. This may well vary depending on the size of the contract portfolio, or on past histories.

4. There needs to be an agreement on the 'modus operandi', on who will decide what, on who will minute what, on who should contact whom in each organisation on the different aspects of contracting, strategy formation, planning and so on.

5. Each 'party' needs to understand his/her relative position in the network of alliances that each other operates. This will depend on a number of factors:

    - the relative importance to each other in long term strategy;

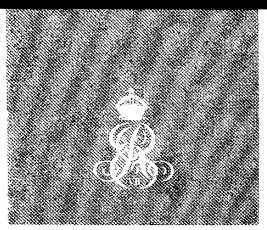


- the percentage value of the total contract portfolio represented by the particular contract;
- the value of the contract in meeting 'fixed costs'
- that a percentage value of specific services within the contract portfolio;
- the importance of the particular contracts to the critical viable size of a department or full unit;
- the logistical or political problems that there would be in securing alternative providers;
- the possibility of creation of financial space for mutual agenda problem solving.

6. Explicitness on the extent of risk sharing between partners and in consequence the extent of openness of information exchange and extent of frequent dialogue between the parties. As an example, a purchaser may be happy for a provider to use the purchaser or the purchaser's possible actions as leverage within the provider organisation to help achieve specific change objectives.

7. Clarity on what is required, the baseline position and what is the targets required in respect of:

- quality
- activity
- price (relative to the rest of the market)
- monitoring dilemmas
  - purchasers must be explicit about what they want to buy;



providers must be open about what they want to supply; the difference must be clear and the purchaser must decide what action they will take with each provider where there is a difference.

- providers should not undertake developments without confidence that there will be purchasers agreeing to the new services

8. It is vital that providers and purchasers pay regard to how they speak of each other externally and internally, as corporate values are easily created and distorted and this will eventually come back to the other parties:

- clarity on planning and decision timetables with funding frameworks are essential for purchaser and provider;

- feedback of GP and consumer views obtained by both parties should be shared. Clarity is required on which parts of the organisations will influence each other's objectives for change;

- careful monitoring, with visible action on any supply failures detected within an agreed time framework, is an essential reinforcement to the process both for purchasers and providers both at the top levels as well as throughout their organisations;

- behaviour patterns of both organisations are important and should be mutually audited. Purchasers and providers should have standards with internal and interface/external protocols requiring responses within certain times, and clarity on decisions. Promises should all be honoured so that purchaser can and retain credibility in requiring providers to work to certain standards;

- access to professional staff in providers should be created within a framework that the purchaser and provider agree jointly. Purchasers should therefore facilitate the good provider management.

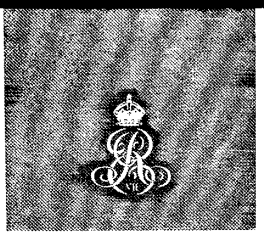
9. Purchasing: The Stimulus for Creating Learning Networks

This publication has been created by a group of busy managers. It is important to remember that through this period they invested time to review, reflect and notice; and they developed an alternative way of doing it. In the mid-eighties, in response to the challenge of general management, Learning Sets were established as a valuable asset. It is not surprising that the reform,s and especially purchasing should require an alternative method. Learning networks are operating up and down the country, not just with purchasers, but increasingly with other groups who are responding to new roles and responsibilities.

What is a learning network?

The concept of a 'learning set' is now well established. Revans has been responsible for popularising 'action learning' in the UK and much of that thinking has led to the investment by senior NHS managers and, senior professionals in learning sets. In essence, a learning set provides a secure setting in which the participants can engage in a process of peer review, support and criticism; where doubts and feelings can be expressed openly about needs, failings, frustrations, anxieties and a sense of organisational loneliness and isolation. Learning sets provide a setting where the general manager lives - both professional and personal issues can be addressed. The experience is usually fulfilling but it does require time, commitment and the development of trust.

In working with six authorities involved in Project 26 work and using many of the principles of the learning set method, we have evolved an alternative way of working which we have called a 'learning network'. This involved up to three people from each authority. It is important to have a regular core of members but this composition can change without harming the group's dynamics. The principles on which the group works are similar to a learning set but instead of meeting in two or three day modules every couple of months, the learning network meets monthly, if possible. The agenda is determined by the participating authorities who take responsibility for introducing the issues and setting the scene. There is agreement on confidentiali-

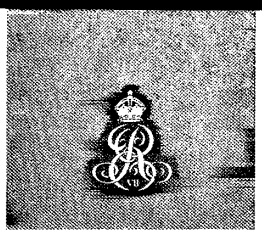


ty around specifics (Chatham House rules), and the facilitator's role is to draw out themes and make some brief notes of the conclusions the group comes to. In this way, we incorporated a range of individuals from different backgrounds - general managers, public health doctors, planners, health education officers - who take on new, ill-defined roles in an organisation whose functions and responsibilities were being continually reshaped.

In the early days of the group, this work was, of necessity, both speculative and 'cerebral'. We tended to look for formulae or the right arrangements. Often we invited outside people - Health Authority Chairs, General Managers of FHSAs, Directors of Social Service Departments and engaged in interesting but somewhat sterile debates. After the announcement of the new chairs and non-executive members in September 1990, the atmosphere of the group changed. The participants now had real issues and challenges with which they were dealing. The meetings of the network dealt increasingly with these issues; the agenda was generated more spontaneously, led by a member of the group; and the discussion was grounded in people's experiences. As the challenges became real, the feelings being expressed were stronger, the importance of values became more explicit and the benefits to the learning process were more profound and helpful.

1 Characteristics of the Project 26 learning network

- Multi-disciplinary
  - Public Health
  - Purchaser/Commissioner (with backgrounds in planning, nursing, general management and the voluntary sector)
  - Occasional finance representation
- Organisational
  - 5 from DHAs, 1 from RHA (but no FHSA) and later 1 from NHSME
- Geographical
  - Urban/rural : Bristol, Dorset, Hertfordshire and London.
- Team Based
  - Core membership but always more than 1 representative from each DHA/RHA - who



were at different levels in the organisation. Maximum attendance of three per organisation.

- Same starting point
  - Very unusual. Possible because purchasing was new to everyone.
  - Enthusiasm and commitment (we had all opted in).

- Self discipline
  - Kept us orientated towards analysis and away from anecdotes.

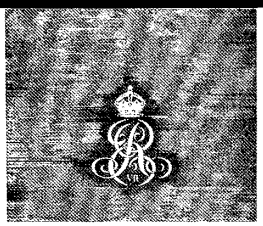
2 The way we worked

- Consistency of Membership
  - Some members changed jobs/Districts during the 2 + years but stayed in a pur chasing role. This ultimately changed the 'team representation' potential, and it has now become more based on the continuity of individual membership.

- Consistency of
  - Core members of the learning set. Commitment missed very few meetings. Dates booked into diaries well in advance and peer group pressure was used on any 'flaggers' to maintain attendance.

- Established Group style
  - Honesty/truth and openness 'Chatham House Rules'. Felt comfortable with inviting visitors/new members but eventually agreed limit to numbers in order to preserve coherence.

- Established Group format
  - overtime evolved through various stages:-
    - loose/unstructured
    - structured/some formal invitations to speakers



- informal/supportive
- informal/structured

- problem/issue based meetings with time for 'networking'

- added value to group learning and group dynamics through arranged trips (Holland and Italy)

- formed a "corporate memory bank of learning curves".

3 Lessons learnt

How do we actually do purchasing?

- it is necessary to be very practical sometimes. For example, Dorset focus on the user by using the "would it benefit Mrs Snooks"? method, Wandsworth produced fourteen draft mission statements without reaching agreement; and Bristol developed an elegant but simple approach to contract monitoring;

- recognise the successes, however small, understand why it works, and apply to other situations.

How we are as purchasers?

- better multidisciplinary working on issues

- informal

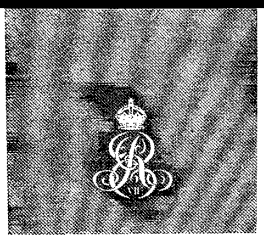
- identify successful behaviours in others in group and then transfer learning to team working back at DHA/RHA

- prevent alienating others in group and then transfer learning back to team working at DHA/RHA level

- getting the 'basics' right, i.e. good people, good management, team building

- remember these lessons when we return to work

- remind ourselves that we don't know everything, acknowledge this fact back at work as we do in the group : we need joint ways forward.



Appendix

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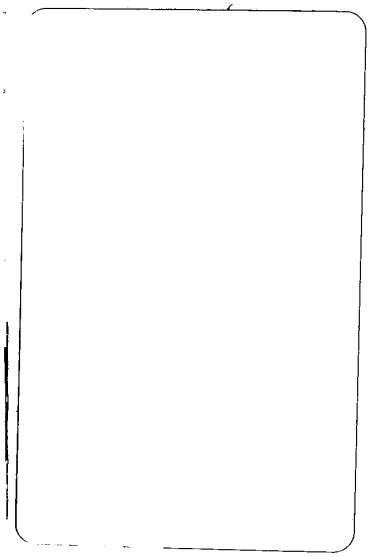

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