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District health authorities: the next steps

A discussion paper by the Policy Set
at the King's Fund College

District Health Authorities: The Next Steps

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Preface

This working paper sets out some new thinking about the future role of district health authorities. It is intended to introduce into the wider discussion about the future of the NHS some specific ideas about the business of meeting health needs of the local population.

The ideas on which this working paper is based have been developed, discussed and refined by a group of eight managers, practitioners and leaders from the NHS. It is not an official document in any governmental sense. What distinguishes this paper from other official ones that have emerged following the Government's White Paper is that it is influenced principally by the group's collective experience in the field. It is positive and it is practical.

As a set of proposals for change, the paper is also intended to help open further the official formulation of health service policy and organisation to the broader participation of NHS managers and practitioners. This group of top managers and practitioners began working together in September 1988 at the King's Fund College with the specific purpose of learning more about how to exercise effectively their senior managerial roles in public policy-making. The Government's proposals for change in the NHS provide a fortuitous opportunity for them and for others involved in public management to play a more active part in that process.

The authors intend to host an action workshop in the autumn to discuss the future role of district health authorities. In the meantime, any comments or suggestions may be addressed to me at the King's Fund College or to anyone else on the the policy set.

Greg Parston
July 1989

DISTRICT HEALTH AUTHORITIES - THE NEXT STEPS

Introduction

Debate following publication of the White Paper has tended to concentrate on Self-Governing Trusts, change to per-capita funding of DHAs and the introduction of contracts as the instruments by which services are specified. The debate has understated the role of District Health Authorities.

This Discussion Paper defines that role more clearly and, by describing some of the dynamics within which District Health Authorities will operate, may help Authorities and others to function effectively in their new environment.

The analysis is equally relevant to Districts where there are no Self-Governing Trusts. The introduction of "management budgets" (quasi-contracts) will require an almost identical approach on the part of the DHA.

1. The Role Described

1.1 The White Paper envisaged that DHAs would "concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health, that their population has access to a comprehensive range of high quality, value for money services; and on setting targets for and monitoring the performance of those management units for which they continue to have responsibility".

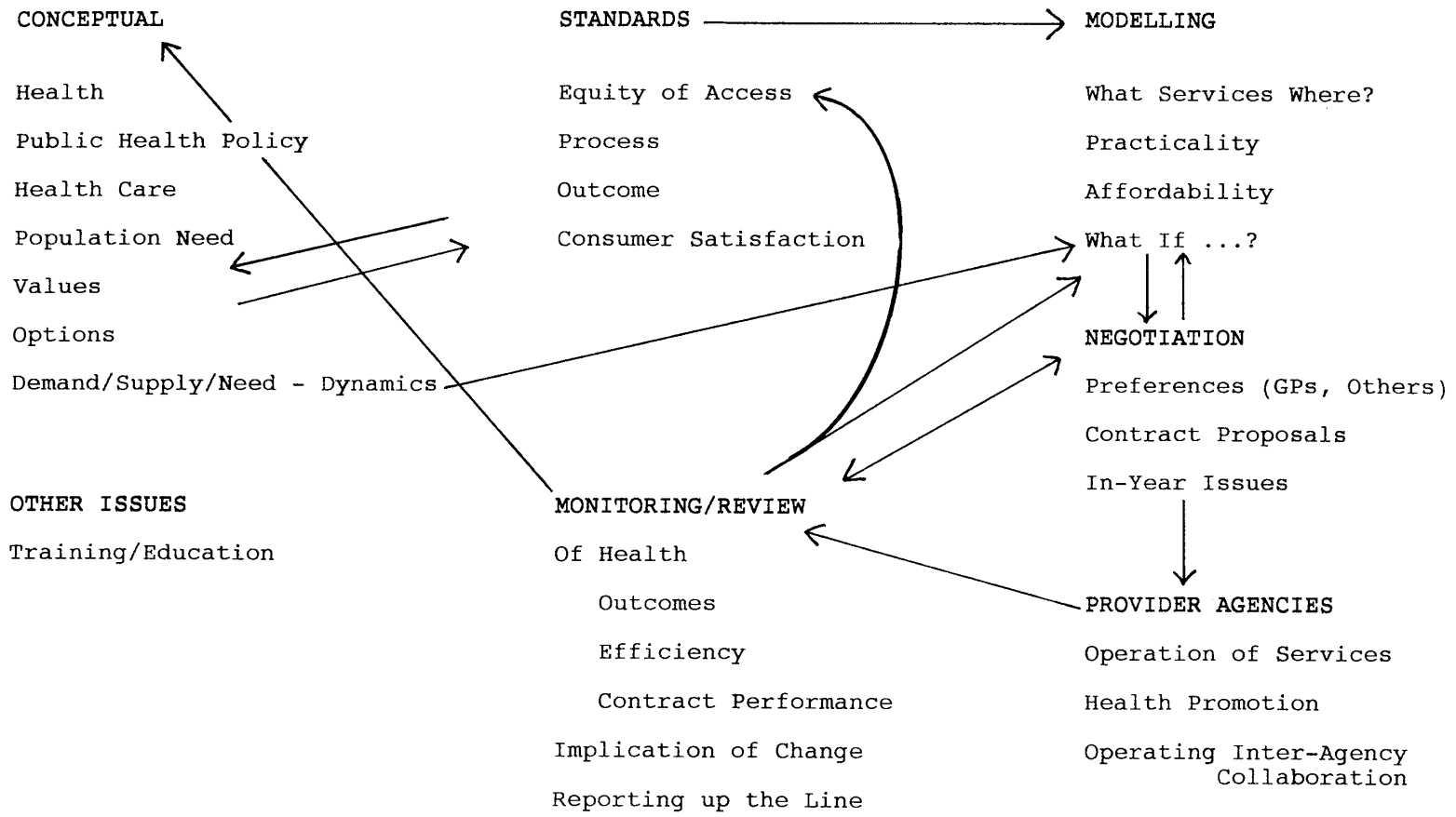
1.2 The processes by which this role is fulfilled can be described by reference to Figure 1. The way in which the different elements influence each other is illustrated by arrows in the diagram.

1.3 The conceptual stage entails the DHA forming an understanding on a number of questions such as:

- what is health?
- how can it be measured?
- how can it be promoted?
- what are the overarching policies for public health that we wish to see?
- how does health care promote health?

Figure 1

CONTEXT FOR DHA ROLE



- what are the boundaries of health care
  - overall
  - between it and other agencies
  - within different sectors of health care?
- how can the health care needs of the population be defined?
- what are the different options for patterns of health care (and related provision)?
- how adequately do those different options meet the defined pattern of health care need?
- what values should imbue delivery?
- what are the dynamics of the inter-relationship between supply, demand and need?

Addressing such conceptual questions is difficult. Nor are they questions which DHAs can or should address in isolation. RHAs also have a role in exploring such questions across a Region. Since the necessary skills are scarce, some collective endeavour between RHA and DHAs will be necessary. The way in which this occurs will vary from one Region to another. The process will draw upon factual information, research hypotheses, comparative databases, and a range of different expertise such as epidemiology, statistics, clinical medicine, education, health economics and sociology. Some of this knowledge will be available in the form of government and academic publications. In addition to the available expertise of RHAs, FPCs and DHAs, universities, health care providers and local authorities will also be sources for some of the necessary specialist expertise. Nevertheless the DHA will require its own capability in translating this range of available intelligence into interpretations of unique local circumstances and the local networks of voluntary, statutory and private providers. In doing so the DHA will clearly need to have regard to the perspectives offered by the Community Health Council, but it will also commission its own local surveys to elucidate useful insights on the issues.

1.4 These conceptual processes need to be augmented by the formulation of standards. Standards do not emerge from a vacuum. They spring from the exercise of judgement about the distinction between what is acceptable and what is not (hence "minimum standards") and about reasonable levels of aspiration ("targets"). Such judgements are informed by comparative data, the publication of good practice, the reporting of research findings, surveys of opinion, and the political processes of a democratic society.

Standards need to be articulated throughout the continuum of health care, involving:

- equity of access
- the many contributing processes of health care delivery
- outcomes.

Standards can be defined and measured by reference to "hard" objective data but also need to reflect messages from the "softer" but no less significant data yielded by consumer satisfaction surveys, Community Health Councils and other organised consumer groups.

The task for the DHA is to distil locally meaningful statements about standards from the plethora of guidance; advice; political, professional and public pressure; and factual data that is available. The potential for defining standards is almost limitless. The experience of the US Joint Commission on Accreditation of Healthcare Organisations is instructive. The JCAHO is currently retreating from its former approach of comprehensive stipulation of thousands of standards ranging across clinical, environmental and support services since the resultant "telephone directory" of standards became difficult to use in practice, could not cater for local variations and lost credibility among those intended to use it. A careful balance must be struck in deciding:

- what issues need governing standards;
- at what level to pitch those standards;
- how to publish them in an accessible and credible form.

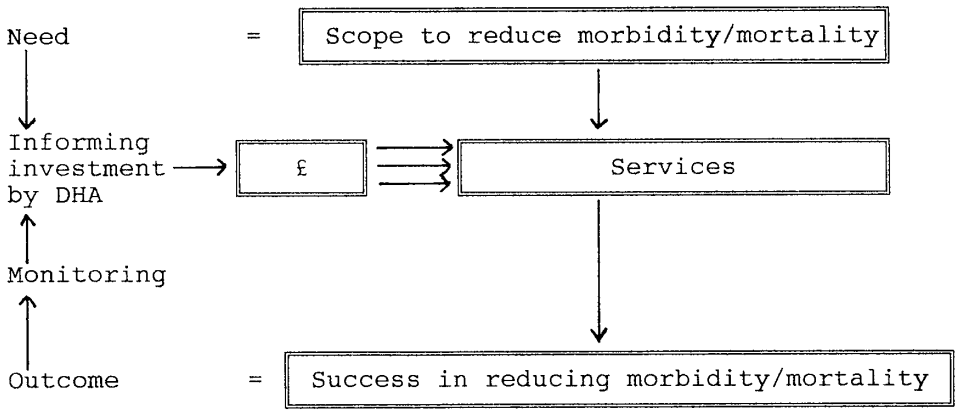
Such judgements cannot and should not be made purely at a national or regional level. The way in which a DHA might approach this difficult area is discussed in more detail in section 3 below.

1.5 Modelling is the process of turning a set of health care objectives with measurable standards into a range of options for delivery and of assessing those options to determine a 'basket' of health services which are judged to be the services required over the next 1-3 years and which will be the basis of specifications for contracts. Although modelling is shown as a separate function in Figure 1, in practice it will be an integral part of the interplays which occur within the conceptual and standard-setting processes. However, the modelling process highlights a major distinction between present and future role for the DHA.

Whereas hitherto DHAs should have been engaged in the conceptual and standard-setting task (but probably have been too diverted by short-term operational distractions to do it as well as they would like), in future they cannot avoid articulating their vision of affordable health services in a form amenable to the letting of contracts with providers. The separation of the DHAs primary role as purchaser from the very different role of provider lies at the very heart of the DHA's mission in the NHS.

Since aspirations will always outstrip available resource it is necessary to test the affordability of different permutations of health care programmes and provision. It will be necessary to make judgements about relative priorities. This process is iterative but can be displayed two-dimensionally in Figure 2.

Figure 2



In practice the DHAs' assessment must take account of the multitude of care groups within its population, the different levels of care that can be available (preventive, primary, secondary, tertiary, rehabilitative and continuing care) and the settings (residential, domiciliary, ambulatory, day treatment/day care, short in-patient stay, long in-patient stay). Modelling the many possible permutations within and between different programmes of care is complex. Moreover the DHA needs to make allowance for the requirements, implications and costs of teaching and research.

Such analyses need a multi-sectoral view as to the contributions that can be made by the different health care providers, by the private and voluntary sectors, by informal carers and by the local authority. The implications of FPC activity, GP practice budgets and the interface between different elements of the total portfolio of potential contracts (eg the discharge of hospital patients then requiring community or primary care) need to be considered.

Although this is a challenging task, its complexity does not diminish its importance. Sir Roy Griffiths, in his review of care in the community, highlighted the disadvantages and costs resulting from a lack of coherence in taking an overall view of need and how best to meet it. Achieving success in this task requires local knowledge of circumstances and available networks and it cannot, for that reason, be undertaken at a distance by RHAs. The fluidity of policy and practice in community care and in the interface between DHAs, local authorities and FPCs make this a tantalising area for future debate. In particular will the White Paper's distinction between purchaser and provider remain as sharply differentiated in an environment in which primary care teams might be both purchaser and provider?

Modelling needs to be seen on two timescales; firstly how to purchase services in the short-term to provide the best possible care, but secondly, a longer term issue of what change in patterns should be promoted either to improve quality or else to provide an effective response to unmet need. In both timescales there is a question of what research and development the DHAs should promote in order to identify options or to facilitate change.

1.6 At this point in the analysis it is worth dwelling in more detail on what the practical steps might be in moving from the conceptual, standard-setting and modelling modes towards the process of negotiating service contracts.

2. The First Steps - From Implicit Understanding Towards Explicit Contract

2.1 In devising service contracts a DHA needs to reconcile the underlying competitive instincts which the Government is seeking to introduce into NHS thinking with the conclusions of the conceptual and related processes concerned with need, equity and

value. It moreover needs to be done in a way which never loses sight of the fact that the DHA is accountable for ensuring that its local population gets the best possible service from the public money allocated to it.

2.2 The overall process is so large and complex that it is not practicable for a DHA to pursue it comprehensively in the early years of the 1990s. Judgements will need to be made as to which areas of service require early detailed attention. Some services may be intrinsically costly or volatile in their potential to destabilise financial projections. Others may be highly significant for a population or have an obvious potential to act as a vehicle for successful and desirable change. Those services which are more stable and predictable or in which early change is unlikely will require less rigorous attention.

Making this particular judgement will depend on three different types of analysis:

a) a factual analysis of existing service patterns;

b) an understanding of the scope and implications of competitive position;

c) an appreciation of what changes in service are likely or desirable.

What follows is not intended to be a comprehensive exposition of this analysis since other groups have been engaged on thinking through the detail on contracting. It may however give a taste of the issues involved and contributes some contextual background.

2.3 Factual Analysis of Existing Service

a) Demand and usage by the DHA's resident population

The DHA will need to obtain information about the use made by its resident population of health care services provided both within the District and of services located outside the District. There are several levels of analysis necessary here:

i) Firstly, data about the population's access to care (such as the hospitalisation rate, the levels of day care and out-patient attendances) segmented by specialties and services.

ii) Secondly, data about the processes by which the resident population is able to access care. This will include information about waiting times and waiting lists and, where available, the sources of referral to hospital (eg individual GP practices, unheralded admissions via the Accident and Emergency Department, tertiary referrals etc).

iii) Thirdly, data about the morbidity being dealt with. This will probably require a process of aggregating existing HA (or, where available, Resource Management) data into DRGs or some other useful categorisation. This process of analysis will need to be tempered by an appreciation of the adequacy of local processes for ICD/OPCS coding and of the still experimental status of DRGs in United Kingdom experience. The possible significance of any morbidity <u>not</u> being dealt with or remaining 'undisclosed' must be borne in mind and may be suggested from perusal of hospitalisation rates or other epidemiological data.

iv) Finally, analysis of available data of consumer opinion about the range, adequacy and accessibility of services.

Insights into the definitions for the various data elements and their meaning can be gained conveniently from the "Report on Korner Indicators' published by the Health Service Indicators Group under the cover of EL(88)MB 219 dated December 1988.

There are limitations and a relative lack of sophistication in such data, but they are probably the best that is generally available at this time. Given the gradualist approach to contracting which practicality will dictate, these shortcomings are unlikely to be too serious. They will tend to result in broad-based approaches to contracting which, given the inexperience of the NHS in this field, are likely to be the best guarantor of avoiding the creation of new and undesirable barriers of patient access to care.

b) <u>An analysis of process costs</u>

The DHA will wish to know the costs of the various health care processes. The data available will be relatively coarse. Even where Districts or units have introduced Resource

Management the state of the art will not yet readily yield immediately accessible understandings of marginal costs as opposed to average costs. It is, of course, possible that an environment of contract negotiation will make such data inaccessible to some DHAs. In that event the DHA may have to use price as a proxy, with historical data on cost (adjusted to current money values) as a yardstick for testing 'reasonableness'.

In making judgements about what to concentrate on first the DHA will need to form some view about expenditure: volume: unit cost ratios service by service (or specialty). Some ratios will have a significance that demands the DHA's attention, but there will also be some services where volatility in cost or demand may be significant. Spotting the latter will require the exercise of some judgement.

These analyses will be put in the context of what the "expected" figures might be if national average experience were to exist locally. This might suggest that some services are more costly than might be expected or alternatively that some with lower costs need careful consideration in terms of skewed case mix or unsatisfactory aspects of quality care.

2.4 The Scope and Implications of Competitive Position

So far, the analyses described have a familiar ring. However, the White Paper's introduction of a competitive element and its separation of purchaser and provider roles give rise to a new perspective that must inform the DHA's thinking. The DHA needs to understand:

- the degree of its mutual interdependence with various Self-Governing Trusts (and directly managed services)

- the mutual inter-dependence of Self-Governing Trusts with other DHAs.

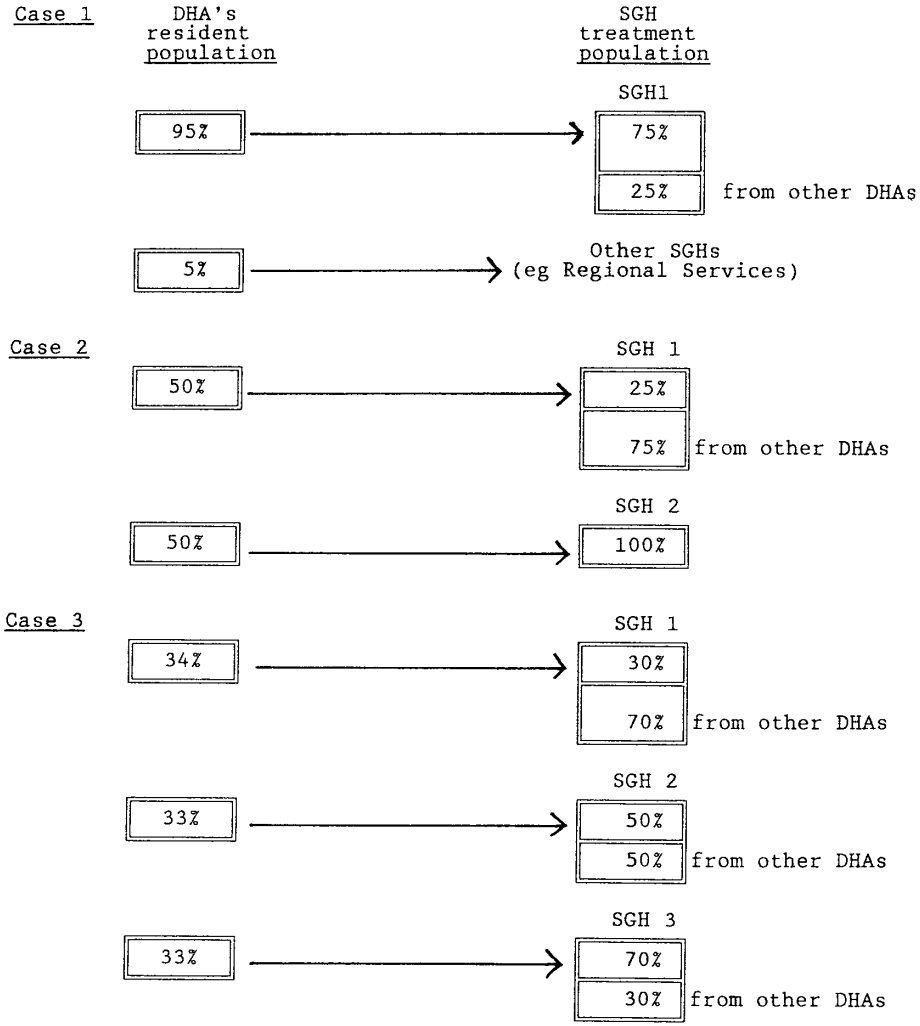
This understanding will need to be informed by the analysis described in 2.3 above since interdependence between providers and purchasers will vary from one service/specialty to another.

Figure 3 illustrates the different scenarios that might arise in connection with such a diagnosis of interdependence and its implications. It is important to note that the implications of any one scenario depend on whether they are being viewed through the eyes of a purchaser or a provider.

BALANCE OF INTERDEPENDENCE BETWEEN DHA/SGHs

Figure 3

Range of permutation might apply. Which applies to you?



In this case DHA and SGH 1 are highly interdependent, but DHA is vulnerable to SGH enlarging its business with other DHAs (although this depends on specialty mix of the business). DHA is vulnerable to aggressive pricing by other SGHs (low volume: high cost services) without necessarily having much influence over those SGHs. If any of those SGHs are geographically close, they might provide a further option for DHA to resist price leverage by SGH 1.

In this case, SGH 2 is heavily dependent on DHA, but DHA's leverage on SGH 2 depends on scope of SGH 1 to take on more business. SGH 1's power position depends on how many DHAs are in contract providing the other 75% of its business.

In this case, the DHA has room for manoeuvre (depending on the specialty issue of the SGH's) with SGH3 in particular appearing highly dependent on the DHA. SGH 1 on the other hand, may be in a stronger position vis-a-vis DHA but this does depend on the specialty.

2.5 Should Services Change?

The next step is to consider how the pattern of service might or should change. There are four ways of addressing this. In each case the DHA must have in mind values and priorities emerging from the processes described in paragraphs 1.3 to 1.5 of this paper and the behavioural implications beginning to emerge from the analyses described in 2.3 and 2.4. The exploration of the questions arising is likely to be an interactive and inter-connecting process which progresses through several cycles before a conclusion is reached.

a) Will the pattern change anyway, even if the DHA does nothing? For each of the following eventualities the DHA must consider the likelihood of change and the impact of change.

- Likelihood of change in GP referral patterns and GP practice budgets
- " " " " Consultant patterns (sessions, special interests etc)
- " " " " other DHAs' contracts
- " " " " SGT marketing strategy
- " " " " technology/treatment patterns
- " " " " demographic factors which impel a service response (eg birthrate).

b) Does the DHA want the pattern to change? Factors influencing this might include:

- national/regional/district priorities which affect desired health outcomes
- local consumer/political pressure
- demographic change over which there is choice regarding service response
- desire to improve service philosophy, style, performance, access rates, location site
- desire to change the level of expenditure or the cost profile
- the possibilities offered by competing service providers.

Assessment of these factors is likely to be influenced by the need for the DHA to work closely with GPs in identifying and seeking to resolve dissatisfactions which GPs might feel regarding hospital or community services.

c) Is there any reason why the DHA should want to change GP (or inter-hospital) referral patterns? This might be on the grounds of concern about the quality of provision of a local SGT, or its ability to sustain its clinical viability or of financial pressures or conflicts in competing priorities. In any event a process of communication with GPs is essential before detailed negotiation with SGTs begins.

d) What can the DHA afford? This will need to take account of:

- resource allocation projections
- the differential impact of inflation on different segments of the service
- the amount needed to be held as a contingency reserve
- prevailing policy on the seeking of declared cost improvements
- the extent to which GP practice budgets have reduced (by "side-slicing"!) the net allocation available to the DHA. The more this has occurred the greater the incentive for the DHA to liaise with GPs in a joint quest to secure value for money in their contracts with providers.

2.6 The Agenda for Contract Negotiation

The result of these various analyses and questions will lead to the DHA forming a view on the likely overall shape of its portfolio of contracts, its agenda for change and a differentiation between those contracts which are "simple" or "steady state" on the one hand, and those which are "complex", "cost or volume volatile" or where specific change is being sought. The DHA should also have some view about the competitive position of the providers with which it will be negotiating and how that is likely to influence the providers' negotiating strategies. It also needs to bear in mind the extent to which GPs, as primary care providers and as influencers of secondary care, constitute a variable outside the direct control of the DHA. Finally, the DHA needs to explore the extent to which collaboration with other DHAs and GP budget holders might empower them in achieving better value for money in their contract negotiations with providers (without precipitating a counter-productive defensive reaction from providers).

3. Standards and Quality Assurance

3.1 Before a DHA can embark on the process of contract negotiation it must revisit the question of standard-setting (and hence quality assurance). This was discussed in 1.4 above, where it was suggested that the pursuit for total comprehensiveness may so overwhelm those involved that they retreat and hence settle for a definition of standards and quality assurance which are less than satisfactory.

3.2 There is no magic way of achieving the right balance. However, a systematic way of viewing the issues will help DHAs at the outset. There are several ways in which this might be done. What follows is based on a concern to focus on the main blocks of consumption of hospital and community service resources, a desire to be 'stipulative of results (or outcome) rather than about inputs or operational processes and pragmatism'.

a) The largest component of NHS expenditure is nursing. The existence of a quality assessment tool such as MONITOR enables a DHA to achieve three positions of strength:

   i in the first place to require providers to operate a quality assessment tool which is comprehensive, quantitative, and capable of being used comparatively between locations and over time;

   ii subsequently to set minimum standards of achievement and to require, under contracts, remedial action to improve nursing performance being delivered below standard;

   iii to be able to compare the quality of nursing care in different organisations and to use that insight in deciding how to locate its contracts for services.

b) The delivery of medical care is of course the primary purpose of much of health service provision. The DHA can specify quality assurance procedures and standards at several levels:

   i Firstly, it must require providers to demonstrate that acceptable arrangements for medical audit are in operation.

ii Secondly, it will need to compare the outcomes of the services it has commissioned with the estimates of their potential effectiveness that will have formed part of the decision process leading to the placement of contracts described earlier. Information for this will come from a variety of sources, including reports of the "general results" of medical audit. In the current state of the art this approach cannot be comprehensive.

iii Thirdly, the DHA must insist on having the right to require providers to "zoom in" on areas of concern and to produce audit-based responses to queries or anxieties being felt in the public or professional domain.

iv Finally, the DHA can require participation by providers in programmes such as CEPOD, regional neonatal mortality surveys and the like.

c) Waiting times constitute a major public concern and are very amenable to monitoring and to the setting of both minimum standards and targets. DHAs will however need to judge whether the standards and targets they set are achievable and affordable. They also need to remember that waiting times have an unpredictable relationship with demand at different levels of volume.

d) Patients' opinions (and public opinions) about their experience of the health service can be assessed (for example by questionnaires of the types devised by Bloomsbury HA/CASPE and UMIST/UWIST). Aspects of unsatisfactory experience can be identified and can be made amenable to standard setting in service contracts. Commentaries from CHCs and other consumer groups may also be significant, depending on their methodological credentials.

These four basic approaches provide a wide-ranging and effective framework and are largely within the capability of present NHS experience.

3.3 Beyond the first order framework described in 3.2 there is also a range of second order mechanisms that can also be seen to be underpinning a standards-based approach to the delivery of services. These include:

a) the setting of operational performance standards by individual departments or services;

b) the national quality assurance scheme in Pathology;

c) the specification of standards in contracts entered into by hospitals made for support services (ranging across the various hotel, maintenance and other support services);

d) the observance of legal requirements in matters of health and safety, hygiene, environmental pollution and so on.

Although specific standards in these areas should not normally need to be prescribed by DHAs in their contracts there can be a general statement about the need for such standards to be defined and observed within the provider institution. If, subsequently, experience reveals unacceptable lapses by a provider a DHA might choose to exert more specific influence through its contract negotiation. This approach, combining a general requirement of "merchantable quality" with specific focus on remedying known shortcomings constitutes a more manageable, less overwhelmingly legalistic approach than the alternative of (over-zealously) specifying everything.

4. Conclusion

4.1 The processes of contract negotiation and monitoring contract performance are, obviously, the remaining significant DHA responsibilities described in Figure 1. This Discussion Paper does not explore these since, at the time of writing, more needs to be known about the ground rules for contracting. It must, however, be clear that contract negotiation and monitoring will require considerable skill on the part of DHAs.

4.2 This Discussion Paper can be seen to serve three important purposes.

a) to demonstrate the importance of the DHA in assessing health care needs and converting that assessment into an explicit portfolio of contract requirements; this is the "sheet anchor" of the NHS;

b) to emphasise that the DHA role is neither intellectually sterile or legalistic. On the contrary it is challenging, and it concerns human needs rather than dry bureaucratic process.

c) to begin to suggest the type of skills that DHAs will need to recruit.

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