Purchasing Together

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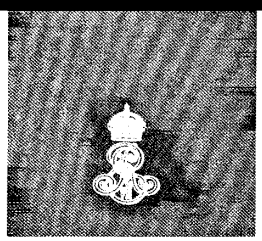

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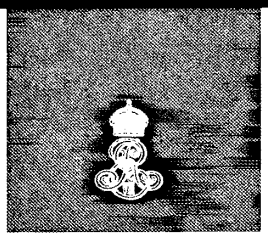
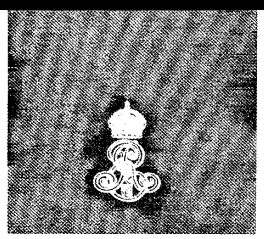


Acknowledgements

Thanks are due to Mike Dunning and his colleagues of the DHA Project in the NHS Management Executive for their support and assistance. Considerable help was also provided by the managers involved in the areas included in this study. Particular mention should be made of John Sully, Julian Pedley, Roger Brown, Keith Osborne, Geoff Greenwood, Stephen Duns, and Mark Rees. We would also like to acknowledge Marie Langseth's contribution in word processing this report.

Chris Ham and Chris Heginbotham August 1991



1. Executive Summary

Joint purchasing

This report describes the development of joint purchasing in some parts of the NHS. It is principally concerned with joint purchasing between DHAs. The main aim of the report is to review progress made in the establishment of joint purchasing and to identify the lessons that emerge.

Variety of approaches

The report emphasises that joint purchasing covers a variety of approaches. These include informal joint purchasing, formal joint purchasing and consortia or agencies. Early indications suggest that there is unlikely to be a single approach to suit all areas and the variety that exists may well be appropriate.

Collaboration

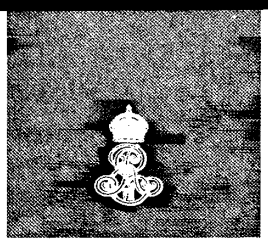
Experience indicates that it often takes considerable time to develop trust and understanding between DHAs and FHSAs to enable effective collaboration to be established. A top-down directive approach to purchasing carries high risks. Much more productive are those arrangements in which authorities start working collaboratively on their own initiative and proceed gradually towards more comprehensive joint purchasing.

Key players

Effective joint purchasing depends on identifying the key players at an early stage and agreeing with them their contribution. This applies particularly to general managers and their senior colleagues but it also concerns chairmen and non-executives. RHAs will often have a significant contribution to make to this process.

Flexibility

There is a need for flexibility in the approach that is pursued to joint purchasing. The experience reported here indicates that plans and ideas changed and developed in the light of experience. It is important that space is created for modifications to be made in response to changing circumstances and increasing understanding of what is involved.



Project management

Project management is a key ingredient of success. At one level, this means identifying a lead general manager and a lead chairman. At another, it involves appointing staff as overall project managers or as lead officers in particular areas of responsibility.

Direction

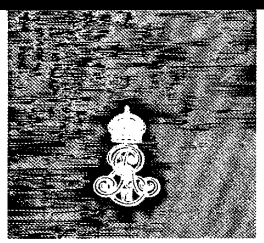
Steering groups including representatives of constituent authorities will often have a significant contribution to make. Such groups can help to avoid the impression that any one authority is taking over the work of others. They can also help to ensure that the work that is done is guided by the authorities themselves.

Organisation Development

As joint purchasing moves from being an informal, ad hoc activity to a more formal and systematic approach, there is a need to invest in organisation development. This is essential in building a corporate approach to purchasing, defining the mission and values which will guide purchasing, and agreeing aims and objectives.

Locality focus

Those involved in joint purchasing perceive it to be important to incorporate a locality focus to their work. This means balancing the advantages of working across existing boundaries with a sensitivity to local views and issues.



2. Introduction

Effective purchasing

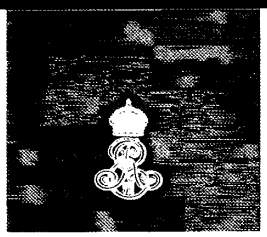
The successful implementation of the NHS reforms hinges on the development of DHAs as effective purchasers of health care for their residents. The NHS has always been provider driven and if services are to be delivered more efficiently and responsively then it is essential that health authorities are established as agencies which can challenge providers and hold them accountable for their performance. Whether this can be achieved depends on the ability of health authorities to recruit the staff they need to take on the purchasing role. It also rests on the financial leverage authorities are able to exert in negotiating contracts with providers, and on the availability of information and intelligence to support purchasing.

Joint arrangements

In recognition of this, health authorities in various parts of the country have been exploring ways in which they can co-operate in joint purchasing arrangements. In a few cases, districts have merged formally to create larger authorities, but more commonly effort has been put into co-operation across existing boundaries. A wide variety of initiatives have emerged ranging from joint appointments of staff, through shared work on service specifications and quality, to more formal agency or consortium arrangements. Some of these initiatives have been ad hoc and opportunistic, others have formed part of an explicit strategy to strengthen and develop the purchasing function.

This report describes some of the joint purchasing arrangements which have been undertaken so far. The report was commissioned by the DHA Project in the NHS Management Executive as part of its programme of work on purchasing. The experience summarised here draws mainly on initiatives pursued in six areas: Chester/ Wirral, Buckinghamshire, East Sussex, North Yorkshire, Manchester and Ealing.

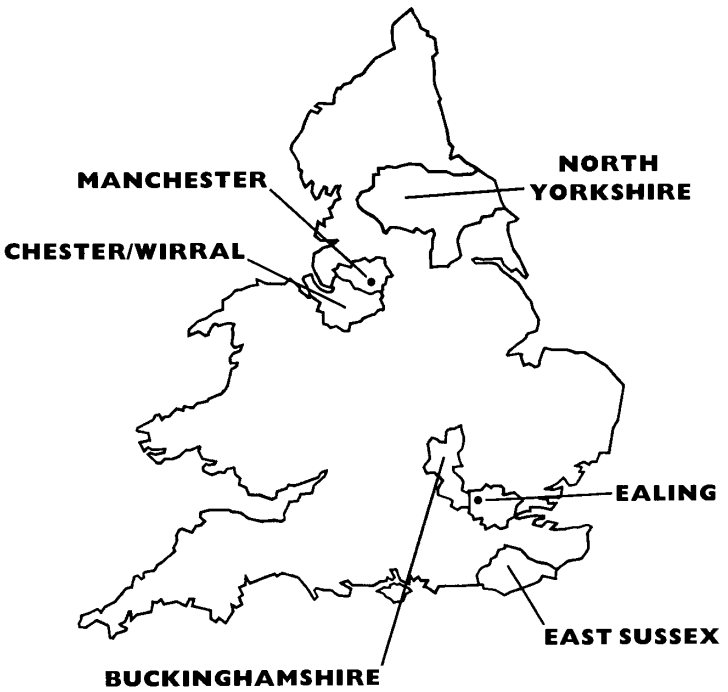
These areas were selected because they were known to have demonstrated interest in joint purchasing and therefore had

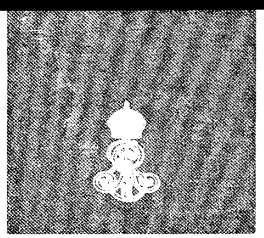


Areas selected

experience likely to be relevant to health authorities in other parts of the country. The principal focus is on collaboration between DHAs, although Ealing was chosen for inclusion to illustrate some of the issues involved in collaboration between a DHA and a FHSA. There are many other examples of joint purchasing in the rest of the country and brief summaries of what is happening in different regions are presented in an appendix.

The main aim of the report is to review progress made in these areas and to identify the lessons which emerge. It is intended to be of use to health authorities in taking purchasing forward.





3. Joint Purchasing in Practice

Origins

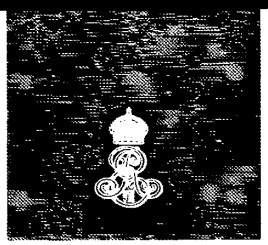
Joint purchasing is being explored by DHAs as a means of fulfilling their new responsibilities more effectively. There are various reasons for this (see Box 1). In some parts of the NHS, DHAs are relatively small and it has proved difficult for them to acquire the expertise they need in purchasing. This has been particularly evident where hospitals and other services have shown interest in becoming NHS trusts. Key managers have often chosen to work in trusts and this has left too few staff at district headquarters to form a viable purchasing organisation.

Staffing

These problems have been compounded by the paucity of people with skills in purchasing across the NHS. Staff with expertise in public health medicine, finance, contracting, health services evaluation, information technology, communications and public relations are in short supply. In view of this, health authorities have often found it helpful to make joint appointments and pursue other collaborative arrangements in order to make the best use of the skills which are available.

BOX 1 Reasons for Joint Purchasing

- Some DHAs too small to form viable purchasing organisations
- Shortage of people with skills in purchasing
- Achieves economies of scale
- Greater financial leverage will be available
- Increases the potential of competition among providers
- Makes it easier to form healthy alliances with FHSAs and local authorities
- Assists in the integrated purchasing and provision of primary care, community care and secondary care.



Economies of scale

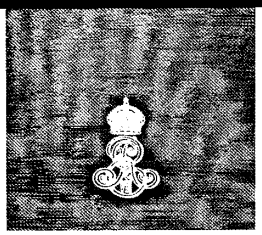
Another factor behind the development of joint purchasing is the prospect of achieving economies of scale. These economies include possible savings in staff costs, support systems such as information technology, and, in the long term, expenditure on office accommodation. As an illustration, in one of the areas included in the study it has been estimated that the savings on information systems alone are of the order of £750,000 capital and £200,000 revenue. More immediately, DHAs have been able to avoid duplication in the contracting process by pooling effort and resources to produce common service specifications and to collaborate in specific fields, such as the registration and inspection of nursing homes.

Leverage

A further consideration is that purchasers require significant financial leverage if they are to make the reforms work for patients. It is argued that leverage is more likely to be developed where authorities use their purchasing power in a concerted manner. Not only will this simplify the contracting process, in that a more consistent approach to contracts will emerge, but also it should enable DHAs to negotiate with providers from a position of strength. With GP fundholders taking responsibility for an increasing share of the NHS budget, many DHAs have perceived a need to consolidate their own position by working in collaboration with each other and not in competition.

Purchaser/provider relations

A related point is that joint purchasing helps to avoid the danger of DHAs developing relationships with their providers which are too cosy. In particular, by linking purchasers with a range of providers across an area, it opens up the possibility of greater competition between hospitals. This is consistent with the purpose of the NHS reforms and it should enable services to be delivered more efficiently and responsively.



Healthy alliances

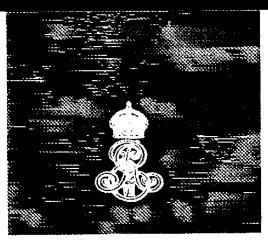
In addition to these arguments, it is increasingly recognised that DHAs should seek to form healthy alliances with other agencies. Among these agencies, FHSAs and local authorities are particularly important. In many parts of the country, the boundaries of the different kinds of authorities are not co-terminous. The interest shown in joint purchasing has been motivated in part by concern to develop healthy alliances through DHAs collaborating with each other in areas whose boundaries match those of FHSAs and local authorities. It is argued that this will help in giving greater priority to primary care and in developing co-ordinated strategies and services for the priority care groups.

Formal mergers

Many of the arguments used to support joint purchasing can also be invoked to advance the case for formal mergers of DHAs. Although the Secretary of State for Health has indicated that he will approve merger proposals where they have the backing of local people, only a small number have come forward at this stage. Instead, DHAs have often preferred to concentrate effort on working together across existing boundaries, seeing mergers as an issue for consideration in the longer term. In some areas there is a clear expectation that mergers will take place in due course, in others there is as yet no specific intention of moving in this direction. Many DHAs feel that the management agenda is already overcrowded and that to initiate merger discussions would add an unnecessary and unhelpful complication.

Boundaries

It is also recognised that the areas covered by existing authorities may not be the most appropriate basis on which to organise services in the future. In other words, some DHAs or FHSAs may have to be divided to create purchasing frameworks more suited to the new NHS. This suggests the need for caution in taking joint purchasing forward to allow time for the configuration of authorities to be thought through properly and to reflect natural



communities. Uncertainty over the future structure of local government adds to the argument for change to be gradual rather than immediate.

A Continuum of Purchasing

Box 2 illustrates the variety of approaches to joint purchasing that have emerged in the six areas involved in this study. As the box indicates, it is possible to identify a continuum of purchasing ranging from purchasing by individual DHAs to formal mergers.

Box 2: A Continuum of Purchasing

Individual DHA Purchasing	→	Informal Joint Purchasing	→	Formal Joint Purchasing	→	Consortia or Agencies	→	Mergers

Between these positions are the three main types of joint purchasing that have been developed. These are

- informal joint purchasing
- formal joint purchasing and
- consortia or agencies.

Each will be discussed in turn.

Informal joint purchasing involves DHAs coming together to share some of the work that needs to be done. Examples include developing common service specifications, undertaking joint work on quality and contracts and making joint staff appointments. This approach involves authorities taking opportunities for collaboration as they arise and is sustained as long as proves useful to the participating districts.

Formal joint purchasing includes many of the same activities as informal joint purchasing but is based on a more explicit commit-

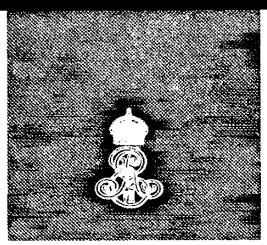
ment on the part of the constituent authorities to working together. As such, it is more strategic than opportunistic. Arrangements vary from place to place, but usually include not only sharing work on purchasing but also the appointment of staff to take on lead roles in particular areas of responsibility on behalf of the authorities concerned. Reflecting the more formal approach, the work that is done is usually steered and co-ordinated by joint groups of chairmen and senior managers.

The consortium or agency approach goes a stage further in terms of the degree of formality adopted and the relationship between consortia and constituent authorities. In effect, consortia take on all or most of the purchasing work for DHAs and in this respect are rather like common services agencies. Furthermore, they employ some of their own staff, including staff who hold joint appointments with the participating authorities. They also operate from their own buildings. Like formal joint purchasing, consortia are steered by joint groups of chairmen and senior managers. This is the strongest form of joint purchasing and is as close as DHAs can become without formally merging.

Joint purchasing

Of the areas included in this study, three concentrated their efforts initially on informal joint purchasing. These were Buckinghamshire, East Sussex and Ealing. After a period of working together informally and exploring alternative approaches, all of these areas have now begun to develop more formal joint purchasing arrangements. In one case (Buckinghamshire) this shift from an informal to a formal arrangement has coincided with a proposal to merge the three district health authorities involved into a single Buckinghamshire Health Authority from 1st April 1992.

Two of the other areas exemplify the consortium or agency approach. These are Manchester and Chester/Wirral. In each case,



the constituent authorities came together during 1990 to set up agencies to act on their behalf. In Chester/Wirral, moves have been made more recently to include three other DHAs in the consortium.

Agency

The remaining area, North Yorkshire, is somewhat different in that it is a regional project, established in conjunction with the five existing DHAs and the FHSA. The aim of the project is to explore and develop the purchasing role of DHAs and to assist them in purchasing. A chief executive was appointed to lead the project during 1990 and three other senior staff were recruited early in 1991. While DHAs in the area covered by the project continue to have overall responsibility for purchasing, clear definitions of 'who does what' have been agreed. The project will work in collaboration with DHAs in 1991 and beyond.

The participants in joint purchasing have principally been DHAs. The main exception is Ealing, an area chosen for inclusion as an example of collaboration between a DHA and FHSA. In the other areas, FHSAs have participated to varying degrees (see below). Box 3 illustrates the main agencies involved in different areas.

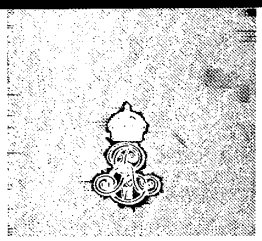
BOX 3 Agencies Involved in Joint Purchasing

Chester/Wirral	2 DHAs
Manchester	3 DHAs & FHSA
North Yorkshire	5 DHAs & FHSA
East Sussex	3 DHAs & FHSA
Buckinghamshire	3 DHAs & FHSA
Ealing	1 DHA & FHSA

Top Down or Bottom Up?

RHA involvement

One of the ways in which the six areas differ is in the extent of RHA involvement. In both North Yorkshire and Chester/Wirral, the



respective RHAs took the initiative in developing joint purchasing and guiding its development. In contrast, the arrangements which have been established in Buckinghamshire and Ealing arose principally out of the interest shown by the constituent authorities. RHAs gave their support and encouragement to what was happening in these areas but to a large extent it was left to the authorities themselves to determine how to proceed. In Manchester and East Sussex, joint purchasing was the product of both regional and local interest and initiative.

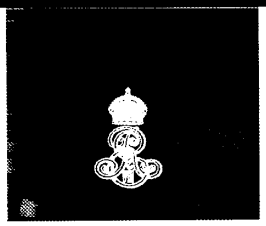
There are risks in RHAs adopting too directive an approach. As experience has demonstrated, DHAs cannot be instructed to work together. Like arranged marriages, a great deal hinges on the willingness of the partners to get to know each other quickly and to overcome incompatabilities. In some cases this has proved impossible.

'Bottom up'

Much more productive is the bottom-up style adopted in East Sussex and other areas. The three DHAs in East Sussex spent eighteen months exploring possibilities for collaboration through informal joint purchasing. On this basis, a proposal was prepared in April 1991 to extend the work into a formal joint purchasing approach. The time spent working together and generating a shared understanding of what was involved was seen as essential to the long term success of the initiative.

Regional project

The North Yorkshire project occupies a mid-point between the top down and bottom up approaches. Although it is an RHA project, a great deal of effort has been put into working with existing DHAs. As a consequence, all public health staff from the constituent districts will work under the aegis of the project from August 1991 and the authorities are also contributing money and/or staff to enable the project to develop its role. The authorities involved have



not always supported the project wholeheartedly, but it has gained increasing commitment among DHAs with the passage of time.

Steering groups

In a number of areas the development of joint purchasing has been supervised by steering groups whose members have been drawn from constituent authorities. These groups have usually included one or more chairmen and senior managers. The value of such an arrangement is in demonstrating that joint purchasing is clearly under the control of the authorities concerned and subject to their supervision and guidance. This helps in avoiding the impression that any one authority is taking over the work of others and in ensuring that the work that is done is steered and guided by the authorities themselves.

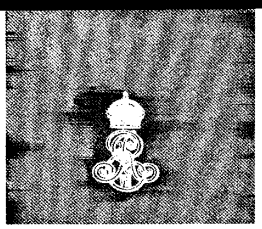
Chairmen

While much of the work that has gone into joint purchasing has been led by senior managers, authority chairmen have been actively involved in most areas. Experience indicates that there are clear advantages in identifying a lead chairman to work with managers in taking joint purchasing forward. Not least, chairmen can help in carrying non-executive members along and in relating to the RHA. The other side of the coin is that the exclusion of chairmen makes the process of change that much more difficult.

What is Joint Purchasing?

Informal joint purchasing

The nature of joint purchasing work varies according to where authorities are placed on the continuum of purchasing (see Box 2). In those areas where informal joint purchasing exists, effort has been concentrated on shared work on particular projects. This includes the development of service specifications, information systems, the inspection and registration of nursing homes, health needs assessment, and quality in contracts. In a number of cases, this work has been undertaken by staff who hold joint appointments, for example in public health. Constituent authorities make use of the



shared work for their own purposes, adapting it as appropriate to suit their own circumstances. In addition, they continue to carry out other purchasing functions on a district basis, as well as overseeing the work of directly managed units.

Consortia and agencies

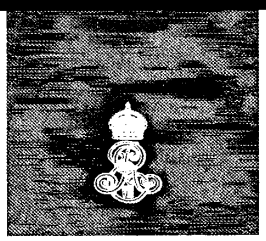
Joint purchasing means something different in those areas where consortia or agencies exist. As already indicated, in both Chester/ Wirral and Manchester, the consortia play a much bigger part in supporting DHAs in their purchasing role. The authorities can accept, amend or reject the work that is done, but to a large extent they are dependent on the consortia for advice and support in carrying out their purchasing function. In these areas, there is a strong element of overlapping executive membership between the consortia and the authorities (see below), and this helps in ensuring that purchasing is relevant to the needs of the authorities.

Formal joint purchasing

The formal joint purchasing arrangements that are developing come midway between the two approaches described above. As an example, in East Sussex the three DHAs have agreed to develop common systems for purchasing across a range of areas including finance, service specifications, information, contracts, quality standards, monitoring and professional advice. Lead managers have been identified from the authorities to take responsibility for particular areas and to work on behalf of all three authorities. Similarly, Ealing DHA and Ealing, Hammersmith and Hounslow FHSA are developing shared public health profiles, quality assurance and information systems.

Complementary approach

North Yorkshire differs from these approaches in that the project team and constituent DHAs have different, complementary, purchasing tasks. The approach was deliberately designed to create time and space to think and work through what the wider purchasing role means. DHAs are continuing to contract for



services in 1991 (with some assistance from project staff) and the project will take on this responsibility for the constituent districts in 1992. In contracting terms it will then be working in a similar way to the consortia that exist in Chester/Wirral and Manchester, but will still have the development of a strategic purchasing approach as its main aim.

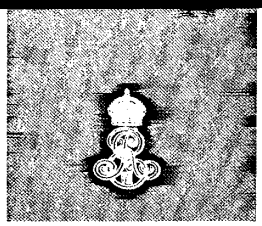
Sovereignty

It should be emphasised that in all areas the constituent authorities remain sovereign bodies. DHAs continue to take decisions on the content of contracts and where these contracts should be placed. They are also responsible for ensuring that financial control is maintained, including handling ECRs.

Granted this, a clear distinction emerges between those areas where a strong agency function has emerged, and those areas where no agency exists and purchasing is firmly located in the authorities themselves. The establishment of separate offices for the consortia in Chester/Wirral and Manchester and the appointment of staff to work for these consortia symbolises this difference. North Yorkshire is moving in a similar direction to Chester/Wirral and Manchester.

NHS trusts

Part of the reason for these differences is the more rapid development of NHS trusts in those areas where agencies exist. This has had the effect of leaving some districts (eg Central Manchester and Wirral) with reduced management responsibilities. Where this has happened, the impetus to develop agency arrangements has been stronger. In part, this has been because of the difficulty of recruiting sufficient staff of the appropriate calibre to undertake purchasing, and in part because of a perception that individual districts should not seek to establish separate purchasing organisations.



This is also a major factor behind the development of the North Yorkshire project. It is anticipated that the five DHAs in North Yorkshire will become whole district trusts in April 1992. The establishment of trusts will mean that from April 1992, DHAs, with minimum staffing of their own, will be able to look to the project for support on purchasing, including the preparation of contracts. In North Yorkshire, it is perceived to be unrealistic and uneconomical for each district to retain an independent purchasing capacity. It follows that the pace at which trusts are established has an important bearing on the viability of DHAs and the development of joint purchasing arrangements.

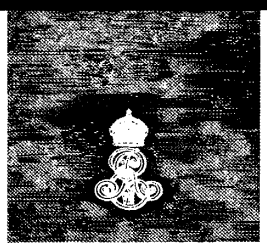
Staffing Issues

Position of managers

Joint purchasing raises important and sometimes difficult issues in relation to staff. In all cases, lead general managers have emerged, and this has been made possible by an understanding that the general managers of the other authorities involved are likely to become chief executives of NHS trusts or take on other roles. As an example, in Ealing the FHSA general manager was prepared to become deputy chief officer of a combined executive working to both the DHA and FHSA to assist in the development of joint purchasing. However, in some places this understanding does not exist, and It remains unclear how the aspirations of general managers will be accommodated in the longer term. Similar considerations apply to other executive members, particularly those involved in public health, finance and contracting.

Role of RHAs

RHAs have been actively involved in some places in working with DHAs to clarify staffing issues. In North Yorkshire, for example, the RGM reached an agreement with DGMs on their role under the reforms, and this paved the way for a chief executive to be appointed to lead the project. Similarly, in Chester/Wirral the RHA designated one DGM to take on lead management responsibility for



the consortium and asked the chairman of the other district to be the lead chairman. Subsequent movements among senior staff created opportunities for interlocking appointments between the DHAs and the consortium. As a consequence, the directors of public health, finance, contracting and quality sit on both authorities, and, together with the lead DGM, comprise the executive team of the consortia.

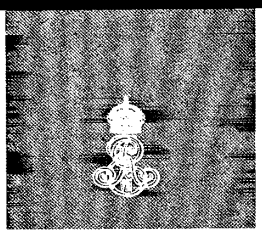
In Manchester, the RHA was involved in working with the DHAs to appoint a chief executive for the consortium. In this case, one of the finance directors became the chief executive. As in Chester/Wirral, two of the other senior management appointments in the consortium involve interlocking membership with DHAs.

Local decision

In other areas, it has been left to authorities themselves to clarify the position of managers. In Buckinghamshire and East Sussex this has been achieved through a process of local discussion and negotiation. RHAs have become involved in this process largely to sanction decisions and approve arrangements reached locally. In some cases they have also helped in identifying lead chairmen and general managers. Difficult issues have arisen along the way, but it has been possible to resolve these issues by taking opportunities that have occurred when staff have left post, and by a willingness on the part of the constituent authorities to make joint purchasing work.

Staff recruitment

A particular concern in a number of districts has been how to attract and retain high calibre staff to support purchasing. In some cases, providers, whether trusts or potential trusts, have taken senior staff with them, leaving purchasers with gaps and shortages to fill. The greater certainty seen to be associated with employment in trusts is one of the factors at work here, as is the opportunity to offer higher salaries. Also important is the fact that many managers



have pursued a career in provider organisations and remain to be convinced that purchasing will offer them job satisfaction. Joint purchasing arrangements are perceived to be relatively fragile by some staff and this has not helped in the process of recruiting able and skilled people.

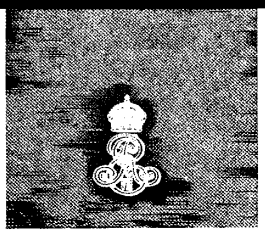
Size

Ideas continue to evolve about the appropriate size of purchasing organisations. The areas included in this study include populations which range from 300,000 to 720,000 and purchasing budgets which range from £130 million to £240 million. As Box 4 illustrates, the number of people likely to be employed in the longer term varies from 35 to 60. In broad terms, it is estimated that the essential costs of purchasing will be in the range of 1-1.5 per cent of the total purchasing expenditure.

BOX 4 The Size of Purchasing Organisations

Population		*Purchasing Budget*	*Establishment*
Chester/ Wirral	500,000	£160 million	35-40
Manchester	450,000	£180 million	35
North Yorkshire	720,000	£220 million	N/A
East Sussex	720,000	£240 million	60
Bucks	700,000	£200 million	50
Ealing	300,000	£130 million	45

NOTE:
Establisment figures are all provisional at this stage. Purchasing and establishment data relate to DHAs only, except in the case of Ealing which includes the Ealing component of the FHSA budget.



Clearly, the organisations envisaged are considerably smaller than many DHA headquarters have been in the past. One of the reasons for this is that a significant number of headquarters staff are likely to be employed in trusts or DMUs.

Purchasing skills

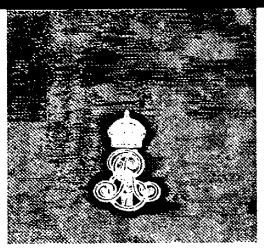
Another factor is that purchasing is in many ways quite different from the functions previously undertaken by DHAs. The skills needed by purchasers are concerned mainly with public health medicine, finance, contracting, planning, information, quality, communications and public relations. A number of areas have also expressed an interest in recruiting staff with expertise in health economics. In North Yorkshire, this may be achieved through a link with the Centre for Health Economics at York University.

Organisation development

Those involved in joint purchasing have increasingly recognised the importance of investing in organisation development. This is seen as essential in building a corporate approach to purchasing, defining the mission and values which will guide purchasing, and agreeing aims and objectives. Organisation development also enables team relationships to be established and it allows top managers to develop a vision of where their organisations are going. A number of areas included in this study have found it useful to take time out and to use outside facilitators in the process of growing and developing new organisations for purchasing.

Project management

The experience of the areas included in the study also points to the need for joint purchasing to be supported by project management. This has been recognised explicitly in Chester/Wirral, Manchester and North Yorkshire where staff have been appointed specifically to take joint purchasing forward. It has also emerged as an issue of concern in the other areas. For as long as joint purchasing remains informal then it has been possible for managers to combine their existing responsibilities with the development of collaboration with



other authorities. The shift to more formal joint purchasing makes this more difficult and has resulted in the appointment of senior managers both as overall project leaders and as lead officers for issues such as public health, quality and information systems.

Chairmen and Non-Executives

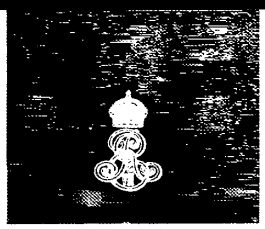
Chairmen

In most areas, chairmen have been fully involved in the establishment and development of joint purchasing. As with general managers, it has been necessary to agree the future role that chairmen will play. In some areas they have been designated as lead chairmen for purchasing, in others they have been identified as potential chairmen of trusts. Where chairmen have not been involved, difficulties have arisen and districts have been less willing to support collaboration. As noted above, the establishment of a steering group involving chairmen as well as other key players has often proved a useful device.

Non-executive members

The non-executive members of DHAs have usually been much less involved than chairmen. This creates a problem in that, having been appointed as recently as September 1990, non-executives have found their own role increasingly under question. Although DHAs remain sovereign bodies, the establishment of trusts and the emergence of purchasing arrangements spanning more than one authority has left non-executives in something of a vacuum.

In recognition of this, attempts have been made in a number of areas to involve non-executives more fully in joint purchasing. At one level these attempts include arranging seminars and briefing sessions for non-executives to increase understanding of the new role of authorities and the contribution of joint purchasing. At another level, they entail lead managers attending meetings of DHAs to report to the authorities directly on the work that is taking place, to seek the guidance and support of authorities, and to



make proposals and recommendations directly to the DHAs for their decisions. Some DHAs have found it useful to divide their agendas into purchaser and provider sections in order to recognise explicitly the dual nature of their responsibilities.

FHSAs

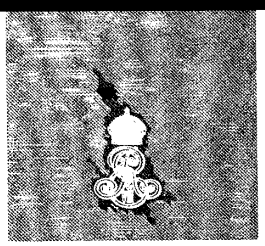
In the case of FHSAs, there is particular concern at the potential loss of newly acquired management responsibilities. In addition there is continuing uncertainty about the future role of FHSAs. Although there is increasing interest in including FHSAs in joint purchasing initiatives, this has not always proved easy to achieve (see below).

Localities

Although joint purchasing arrangements may offer advantages in terms of economies of scale, financial leverage and the ability to recruit scarce staff, there is a risk that purchasers will become remote from the people they serve. To counteract this risk, there is growing interest in the development of locality purchasing.

Locality offices

As an example, in North Yorkshire it is anticipated that there will be a central purchasing capability and a number of locality offices. The locality team will liaise with those staff identified by the FHSA and social services to work in the same areas. Each locality team will have its own office with around six staff. The locality offices will be the eyes and ears of the agency and will be involved in needs assessment, making contact with GPs and community organisations, and relating to other agencies. The central purchasing capability will comprise staff who will concentrate on public health, contract negotiation, financial control, information systems, statistical analysis, communications and public relations. They will also provide overall leadership, develop strategies and policies, and liaise with other agencies (see box 5).



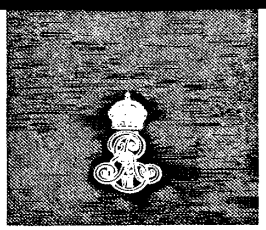
Box 5: Consortia/Agency Functions

CENTRE		LOCALITY
Strategy and Policy Public Health Finance Information and Statistics Contracting Quality Communications Public Relations	Monitoring	Joint Planning Needs Assessment Links with GPs Consumer Involvement

Locality commissioning

Similar ideas are emerging in the other areas included in this study, although they are less developed. As an example, in East Sussex it is anticipated that each locality will have a health commissioner responsible for:

- dealing with any commissioning matters with individual GPs;
- working closely with the GPs and purchasing health services accordingly;
- working closely with local voluntary organisations and the district council;
- possibly sharing a local office base with, for example, social services and playing a role in commissioning care in the community;
- managing budgets either for the whole of the locality or for more discreet areas;
- drawing on headquarters expertise and information in support of these activities;
- working with and influencing health authority policies;
- maintaining effective relationships on behalf of the population and GPs with providers of care and seeking out new providers as appropriate.



Both North Yorkshire and East Sussex cover relatively large geographical areas and this is one of the reasons why the need to retain sensitivity to local communities is felt strongly.

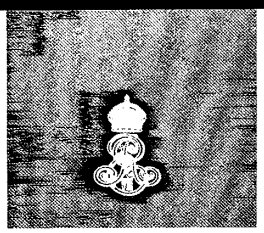
Nevertheless, even in Manchester, which is a much more compact geographical area, there is interest in the locality dimension. In this area and elsewhere it is not yet clear whether this will involve the establishment of locality offices or alternatively building a locality focus into the work of the purchasing team. One line of argument is that the development of joint purchasing needs to avoid repeating the mistake of the former multi-district area health authorities and the additional layers of bureaucracy that they entailed. This suggests that locality offices may be less appropriate in some areas than other arrangements which ensure that the views of different communities feed into the purchasing process.

Involvement of CHCs

One approach is for purchasers to work closely with CHCs. There is no reason why CHCs should not be retained on a district basis even if health authorities merge. As champions of the people, purchasers have an obvious interest in collaborating with CHCs to ensure that services match the population's needs. CHCs are likely to be an increasingly important channel for local involvement in the NHS if, as authorities merge, five non-executive members are expected to contribute a lay perspective across a much bigger area and population.

Involvement of GPs

Another approach is for purchasers to work closely with GPs. This has already started to happen in many areas and the developing dialogue between purchasers and GPs opens up the possibility of shifting the boundary between primary and secondary care and making services more responsive to the needs and demands of patients. GPs are often much closer to their communities than DHAs and they have a vital contribution to make in overcoming the dangers of remoteness inherent in larger purchasing organisations.



Neighbourhood forums

A further possibility is to encourage the development of neighbourhood forums. These would be a channel for community and voluntary organisations to feed their views into purchasing. Neighbourhood forums have been established in a number of districts, and they can be used by DHAs, perhaps in collaboration with FHSAs and local authorities, to engage in a dialogue with community representatives. It may also be possible to encourage non-executive members to take on a role in relation to neighbourhoods or localities.

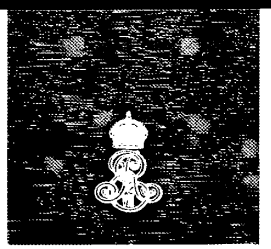
These suggestions do not exhaust the list of possibilities. It is unlikely that any single approach will be sufficient and purchasers will have to put effort both into communicating their policies to the public and to seeking the public's views on purchasing priorities. The DHA Project in the NHS Management Executive is currently working with a number of districts to explore different approaches.

FHSAs and Local Authorities

This study was undertaken principally to examine the experience of collaboration between DHAs. As the work progressed, it became increasingly apparent that there were strong arguments for also involving FHSAs in joint purchasing. The rationale behind FHSA involvement is the need to link the breath of DHA alliances with the greater depth that will be achieved through integrated primary and secondary care purchasing.

Joint appointments

This was recognised at an early stage in Manchester, Buckinghamshire and North Yorkshire and considerable progress has been made in these areas in involving FHSAs as well as DHAs. The initiatives that have been pursued include joint appointments in public health and planning, and collaborative work in areas such as health promotion and the development of a common information base. East Sussex and Chester/Wirral are moving in a similar



direction. Indeed, it is relevant to note that the lead general manager in Chester/Wirral held an appointment as joint general manager for the Wirral DHA and FHSA during 1990 and this has now been followed by similar appointments in other areas.

The area in this study in which most progress has been made is Ealing. Collaboration between the DHA and FHSA in Ealing began with the appointment of a Director of Public Health to serve both authorities. This led into discussion of shared work on information, health promotion and quality and standards.

Single executive body

Subsequently, a proposal was developed to create a single chief executive responsible to both authorities. This is likely to involve the DGM becoming joint chief executive. The FHSA general manager will serve as the deputy chief executive and will remain the executive member of the FHSA until such time as the two authorities decide that the joint chief executive should take on this role. These developments are proceeding with active support and encouragement of the the two general managers, chairmen and respective boards.

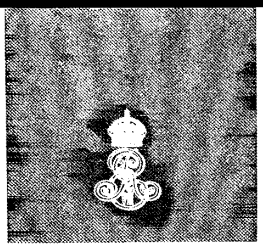
Advantages

The perceived advantages of this development are:

- to create a single focus for needs assessment and public health;
- to integrate the purchasing of primary care and secondary care;
- to enhance the role of primary care;
- to improve the quality of management through sharing scarce resources and skills;
- to simplify and unify the process of consulting with the community and involving GPs in purchasing.

Disadvantages

Potential disadvantages include lack of coterminosity (the FHSA covers three district health authorities) and uncertainty about the configuration of health authorities in the area in the longer term. In



particular, the FHSA has to maintain effective relationships with the other two DHAs at the same time as developing an alliance with Ealing DHA.

Four models

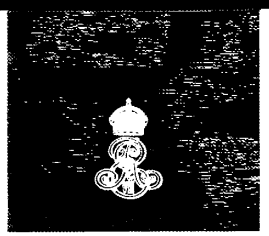
In the broader context, all of the areas included in the study have been reviewing the role of FHSAs in the light of the report prepared by Andrew Foster entitled **FHSAs — Today's and Tomorrow's Priorities**. This identifies four models:

- the dynamic status quo
- the FHSA as provider
- unified purchasing between FHSAs and DHAs
- the development of primary health care authorities.

Different views have emerged in different areas about these models, although developments in Ealing and elsewhere point clearly to the merits of unified purchasing between FHSAs and DHAs.

Local authorities

Local authorities have also played a part in joint purchasing, although they have been much less involved so far than DHAs and FHSAs. As noted above, a key factor behind the development of joint purchasing has been the wish to achieve co-terminosity between DHAs and local authorities. The joint planning machinery continues to play an important part in enabling collaboration between health authorities and local authorities to occur, and this is increasingly linked to joint working on a locality basis (see above). In East Sussex, joint contracting by DHAs and the social service authority is being explored, building on a history of collaborative projects.



4. Lessons

What are the main lessons and conclusions to emerge from this study? A summary of key implications is presented in Box 6.

Variety of approaches

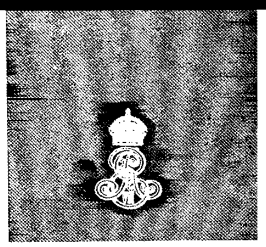
The first point to reiterate is that joint purchasing covers a variety of approaches. These range from informal, ad hoc arrangements to more systematic agency and consortium approaches. Early indications suggest that the variety that exists may well be appropriate and that there is unlikely to be a single approach to suit all areas.

BOX 6 Lessons

- Joint purchasing covers a variety of approaches
- Time is needed to develop trust and understanding
- It is essential to win local ownership and commitment
- Key players must be identified and their contribution agreed
- Flexibility is important — learning by doing
- Project management is a key ingredient of success
- Steering groups involving representatives of constituent authorities can make an important contribution
- An investment in organisation development is needed to build new purchasing organisations
- A locality focus has an important contribution to make

Collaboration and trust

Second, the evidence suggests that it often takes considerable time to develop trust and understanding between authorities to enable effective collaboration to be established. It is, of course, possible to direct authorities to work together, but the experience reported here indicates that this is a high risk approach. Much more productive are those arrangements in which authorities start working collaboratively on their own initiative and proceed gradually towards more comprehensive joint purchasing.



Local commitment

A third point linked to this is the need to win local commitment and ownership. Organisational change on this scale is frequently threatening to those affected. Unless managers and others are prepared to make joint purchasing work and feel that they have control over what is happening, then change is likely to be superficial rather than real.

Key players

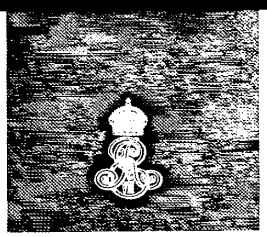
Fourth, it is important to identify the key players at an early stage and agree with them their contribution. This applies particularly to general managers and their senior colleagues but it also concerns chairmen and non-executives. RHAs will often have a vital contribution to make to this process. Not least, RHAs have responsibility to discuss with general managers and chairmen their future role as purchasers or providers. By establishing clarity at the top, other managers can then work through their position.

Flexibility

Fifth, there is a need for flexibility in the approach that is pursued. All the areas included in this study found that their plans and ideas changed and developed in the light of experience. Innovations of this kind are rarely born perfectly formed and it is important that space is created for modifications to be made in response to changing circumstances and increasing understanding of what is involved. It is also vital to recognise the considerable difficulties that are likely to emerge in establishing a new function such as purchasing and developing new organisational arrangements.

Project management

Sixth, project management is a key ingredient of success. At one level, this means identifying a lead general manager and a lead chairman. At another level, it involves appointing second in line staff either as overall project managers for joint purchasing or as lead officers in particular areas of responsibility.



Steering groups

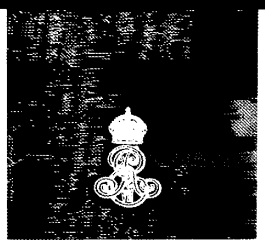
Seventh, the importance of establishing steering groups including representatives of constituent authorities emerges as a key conclusion. This is significant in avoiding the impression that any one authority is taking over the work of others and ensuring that the work that is done is guided by the authorities themselves.

Organisation development

Eighth, as joint purchasing moves from being an informal, ad hoc activity to a more formal and systematic approach, there is a need to invest in organisation development. This is essential in building a corporate approach to purchasing, defining the mission and values which will guide purchasing, and agreeing aims and objectives. Organisation development also enables team relationships to be established and it allows top managers to develop a shared view of where their organisation is going.

Locality focus

Finally, it is worth reiterating that a locality focus is seen as increasingly significant by those involved in joint purchasing. The thinking developing in North Yorkshire and East Sussex indicates the direction in which managers are beginning to move. This issue needs to be given higher priority to ensure that the advantages of joint purchasing are not outweighed by remoteness and insensitivity on the part of those now charged with acting as champions of the people.



5. Issues for the Future

Role of RHAs

As this study progressed, a number of the issues involved in purchasing emerged with greater clarity. To begin with, it is evident that RHAs have a key role to play in guiding the development of purchasing and establishing an agreed view on the framework within which purchasing will continue to evolve. The issues are too complex to be handled by DHAs and FHSAs alone and it is essential that RHAs work closely with authorities in taking this aspect of reforms forward, and in rolling out joint purchasing to other areas.

Sovereignty of health authorities

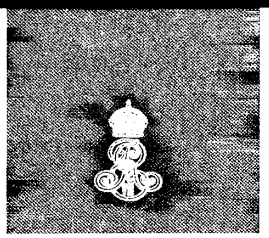
It is also apparent that joint purchasing, whatever form it takes, has to respect the sovereignty of health authorities. Purchasing remains the responsibility of DHAs even though some of the work concerned may be done by consortia or others on their behalf. It is vital that those involved in joint purchasing act as the servants of health authorities to enable accountability for decision making and financial control to be maintained.

Collaboration between agencies

Although the principal focus of this report has been collaboration between DHAs, it is clear that purchasing involves a range of other agencies. These include FHSAs, local authorities, GP fund holders, and RHAs (in some regions purchasing regional services and everywhere purchasing education and training). Purchaser pluralism has some advantages (for example, in encouraging DHAs to talk to GPs who might otherwise opt to become fund holders) but it also carries the risk of fragmentation. This underlines the need for collaboration and joint working involving all relevant agencies and interests. In the absence of collaboration, it will be more difficult to develop a seamless services for patients, and it will also create problems in making progress towards the national health goals and targets identified by ministers.

Role of FHSAs

As our review has indicated, it is likely that FHSAs will become increasingly involved in purchasing in the future. Uncertainties



remain, however, about the purchasing scope of FHSAs and the extent to which they will develop informal or formal alliances. A number of key questions were raised by participants in the study (see Box 7). Many of these require further resolution and policy direction, as well as providing room for local initiatives. Most authorities favoured model C in Andrew Foster's paper **FHSAs: Today's and Tomorrow's Priorities** (unified purchasing of primary and secondary care). However, there is still reluctance from some FHSAs to recognise the trend to joint purchasing initiatives, and a number favour primary care authorities or the role of FHSAs as providers rather than purchasers. Continued emphasis will be needed to ensure that authorities explore fully the most effective organisational structure for joint purchasing for the future.

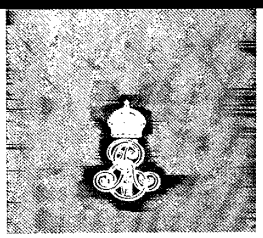
BOX 7 Involvement of FHSAs

Key Questions:

- What will FHSAs purchase?
- What relationships will emerge between FHSAs and FHGPs?
- Are FHSA values different from those of DHAs?
- How can reluctant FHSAs be involved?
- Which model(s) (of Andrew Foster's four models) of FHSA collaboration will emerge?
- Who will be responsible for primary prevention/ health promotion?

Strategic role

In the light of the experience reported here, two other issues merit consideration. First, it is clear that purchasing involves a range of functions and should not be equated with contracting. These functions include health needs assessment, service evaluation, priority setting, resource allocation and developing sensitivity to the community's views. DHAs have a strategic role to perform as



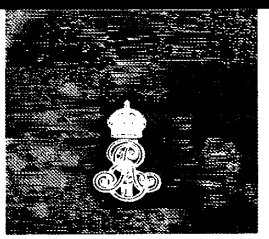
purchasers and they require staff with a variety of skills to carry out this role.

Local consultation

Second, more thought and work needs to go into ensuring that purchasing is based on effective consultation with local communities. As this report has demonstrated, building in a locality dimension to purchasing is seen as important in a number of areas. To date, however, relatively little progress has been made in establishing such a focus. The ideas emerging in North Yorkshire, East Sussex and other areas (eg Stockport) contain interesting pointers, but this aspect of purchasing remains underdeveloped.

Mergers?

Finally, it is worth asking whether joint purchasing inevitably leads to authority mergers. While this is the assumption that lies behind a number of the initiatives that have been taken, it is not a necessary outcome. Indeed, it may be that in some cases the experience of 'purchasing together' demonstrates the impossibility, or at least undesirability, of mergers taking place. As noted above, a complicating factor in some parts of the NHS is the existence of health authority boundaries which themselves may need to change to fit more appropriately with local communities and purchasing requirements. In view of these factors, there are good grounds for proceeding cautiously, exploring the potential of purchasing beyond individual authorities, without assuming that larger authorities will always be the ultimate destination.



Appendix

RHAs have provided the following information on the development of joint purchasing:

Northern Region

Hartlepool and North Tees health authorities have formed a combined purchasing executive. One of the DGMs has been appointed as chief executive and is accountable to both health authorities for purchasing and for managing the work of DMUs.

Darlington and South West Durham health authorities are working together on purchasing and a director of purchasing serves both authorities.

Durham and North West Durham: a merger proposal is being considered following consultation.

Yorkshire Region

North Yorkshire Commissioning Project covering five DHAs has been established (see the text of this report).

Leeds Eastern and Western DHAs merged in April 1991.

Trent Region

Doncaster DHA and FHSA have appointed a joint chief executive.

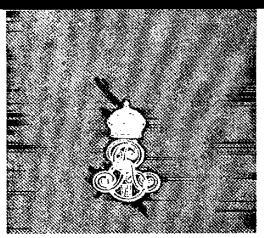
Bassetlaw and Central Nottinghamshire health authorities: a merger proposal is being considered following consultation.

East Anglian Region

Peterborough and West Norfolk and Wisbech health authorities: a merger proposal is under consideration.

Cambridge FHSA is collaborating with a number of DHAs on joint purchasing.

Great Yarmouth and Waveney DHA is collaborating with Norfolk FHSA and Suffolk FHSA as part of a broadly based purchasing strategy.



North West Thames Region

North Bedfordshire DHA and Bedfordshire FHSA are collaborating on a joint purchasing project concerning services for elderly people.

North Hertfordshire and East Hertfordshire health authorities have a joint DGM and a purchasing team.

Hillingdon and Hounslow and Spelthorne health authorities have a joint DGM and a merger proposal is under consideration.

Hillingdon DHA and Hillingdon FHSA have made a number of joint appointments.

Ealing DHA and Ealing, Hammersmith and Hounslow FHSA are collaborating in joint purchasing arrangements (see text of this report).

Harrow and Parkside health authorities have a joint DGM.

Groups of DHAs are collaborating in consortia to purchase regional specialties.

North East Thames Region

Barking, Havering and Brentwood health authority and Barking and Havering FHSA are undertaking joint purchasing of primary care services.

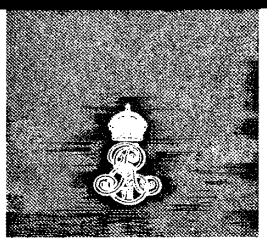
The Essex FHSA and DHAs have formed two purchasing consortia covering the north and the south of the county.

London health authorities in the Region are working on similar collaborative arrangements to strengthen purchasing and plans are likely to be developed over the next 6-18 months.

South East Thames Region

A commissioning agency has been established covering Camberwell, Lewisham and North Southwark and West Lambeth. This is known as the South East London Commissioning Agency.

Three DHAs in East Sussex are collaborating in joint purchasing arrangements (see the text of this report).



Four DHAs in West Kent are working together in the West Kent commissioning agency.

Elsewhere, there are plans to establish similar agencies in East Kent and Outer London.

South West Thames Region

Wandsworth and Merton and Sutton health authorities have collaborated informally on joint purchasing.

Three DHAs in West Sussex have shared scarce skills, particularly in public health.

Wessex Region

West Dorset and East Dorset health authorities: a merger proposal is being considered following consultation.

Isle of Wight DHA and FHSA are working together closely on joint purchasing.

Health authorities in Hampshire and Wiltshire are exploring opportunities for joint purchasing.

Oxford Region

Three DHAs in Buckinghamshire are collaborating in joint purchasing (see the text of this report).

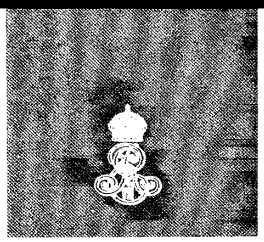
South Western Region

Three DHAs in Avon are likely to merge to form a Bristol and District purchasing authority.

Merger proposals are also out for consultation in Devon (covering four DHAs) and Gloucestershire (covering two DHAs).

West Midlands Region

Coventry, North East Warwickshire and South Warwickshire DHAs are collaborating in informal joint purchasing arrangements.



Bromsgrove and Redditch and Kidderminster health authorities have a joint purchasing executive and one of the DGMs has been appointed to take responsibility for purchasing for the two authorities.

Central and South Birmingham health authorities merged in April 1991.

Rugby and North Warwickshire health authorities merged in April 1991.

Mersey Region

The Region was originally organised into four purchasing consortia. One of these did not come together effectively and so purchasing was organised around five organisations. The Chester/Wirral consortium is described in the text of this report.

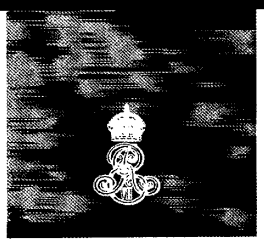
The RHA has now agreed to combine some of the consortia to create a North Mersey consortium (covering four DHAs) and a Cheshire/Wirral consortium (covering five DHAs). The position of Macclesfield DHA has yet to be determined.

North Western Region

Three DHAs in Manchester are collaborating in a purchasing consortium (see the text of this report).

Stockport DHA and FHSA are working jointly on purchasing (as the 'Stockport NHS authorities').

Elsewhere in the Region, purchasing consortia are under consideration in Oldham/Rochdale/Tameside; Blackburn and Burnley; and Lancaster and South Cumbria. Some of these are further developed than others.



Health Se
Purchasing at the King's Fund College

The successful implementation of the NHS reforms hinges on the development of effective purchasing of health care. District Health Authorities and Family Health service Authorities often in partnership with local authorities are now actively considering how to tackle health needs assessment including the involvement of and consultation with the local community, the establishment of priorities for commissioning, the use of purchasing power to lever service improvements, systems of care for patients and the development of effective contractual mechanisms.

The College has developed a range of programmes to assist non-executive and executive members and other staff of DHAs, FHSAs and social services leaders in local authorities to tackle their purchasing role effectively. A range of options are offered. These include short organisational development programmes such as the "Purchasing Dilemmas" programme (which will enable health authority teams to consider needs assessment and priority setting mechanisms) and extended classroom/learning set programmes for Directors of Public Health.

In addition the College offers an important new opportunity through the establishment of learning sets for fundholding GPs. The "community focus" of DHAs (in association with FHSAs and Social Service departments) is dealt with in a special programme entitled "Health Authorities: Peoples Champions", whilst a further programme has been developed on organisational development for leading edge purchasers.

This range of activity complements the provider focused programmes. "Managing through Contracts" considers the interface between purchasers and providers. Further programmes are being developed to enable purchasers and providers to work together on utilisation review and contract management.

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ISBN 1 873883 05 6