Expanding on contracting

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Health board commissioning: contracts & contracting

BULLETIN

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Managing and informing contracting: Health board approaches

The government has announced that it plans to abolish the internal market, and a White Paper is expected soon. Whatever replaces the internal market, there are lessons to be learned from the way in which it has developed in Scotland over the last five years.

The Accounts Commission is studying the way in which health boards carry out their contracting role. The study was informed by local audits of the 15 health boards, and a survey of the 47 trusts. Its aim is to provide a useful background against which to develop new mechanisms for planning and delivering health services. This is the second in a series of bulletins reporting the study. It suggests that:

- Boards and trusts support the continued separation between lead planners and providers. The mechanism to link them, if it is no longer to be contracting, should address the geographical, historical and political barriers which limit their efforts to improve health services.
- All those involved recognise the value of collaboration, but in practice it is made more difficult by a lack of co-ordination and consistency. There is little evidence of boards learning from one another by sharing good practice or innovations.
- Boards and trusts identify two main factors which have increased bureaucracy and costs: fruitless negotiations, often caused by a lack of the appropriate skills and authority and limited meaningful data; and the need to contract separately with increasing numbers of purchasers and providers, especially individual GP Fundholders (GPFHs).
- Successful contracting requires two sets of skills: technical skills (how to contract); and medical skills (what to contract for). However, no board has formally reviewed the mix of skills they require, and matched them to the skills available. Medical involvement in contracting is increasing, with different approaches seen across Scotland. The effectiveness and efficiency of these approaches has not being evaluated.
- The annual contracting cycle poses particular problems. To overcome some of these, boards should consider formalising the common practice of 'rolling forward' the bulk of agreements to free up time to concentrate on service development and change in specific areas. In addition, the balance between the tasks of preparing and monitoring needs to shift in favour of preparation.
- Overall, the NHS in Scotland suffers from a serious lack of information to support planning and contracting. As a result, plans are often too vague to provide an effective base for action, and performance measures are inadequate to demonstrate value for money. The move towards service specifications is positive, and offers a basis for development. However, the serious information gaps need to be addressed at a national level.

These messages are not new, but this bulletin provides evidence of how widespread these difficulties are, and the seriousness of their impact. The abolition of the internal market provides an opportunity to take concerted action to resolve them.

Introduction

In 1996/97, Scottish health boards were allocated some £4 billion to improve the health of their populations. About £2.8 billion (70%) of this money was used to purchase health care by means of contracts under the internal market. Contracting has been a key means by which health boards meet many of their statutory obligations. Drawing up, agreeing and monitoring contracts has been a major area of work for both boards and trusts during the 1990s.

The new government will shortly be publishing its White Paper, with proposals for the replacement of the internal market. It is widely anticipated that a separation will continue between boards, responsible for planning health care, and trusts, responsible for providing care in line with these plans. It is therefore essential that the contracting process, or whatever replaces it, is managed and informed efficiently and effectively, to both ensure that desired health outcomes are achieved and to avoid tying up resources which could otherwise be used to improve patient care.

The Accounts Commission for Scotland is studying the way in which health boards are carrying out their role as commissioners of health services. The first phase of this study focuses solely upon the contracting aspects of the 'commissioning cycle'. The study was developed by the Commission and undertaken by local auditors at all Scottish health boards in 1997.

A report detailing local audit findings has been produced for each board. These local reports contain an action plan to address areas for improvement and development. Complementary research was carried out by the Commission's national study team and included interviews with key staff at health boards and a postal questionnaire to NHS trusts. Forty three trusts (91%) returned a questionnaire. This high response rate reflects the desire of NHS bodies to participate in the debate on the best system to replace the internal market.

The findings of this study are being disseminated through a series of bulletins, Expanding on Contracting. We believe that our review of how contracting has worked in practice provides a useful background against which to develop a new mechanism for planning and delivering health services in Scotland. We also believe that the good practice identified will remain relevant to boards both during and after the abolition of the internal market.

The first bulletin, published in August 1997, provided information on the changing use of contracts between 1994 and 1997 and highlighted important national trends. This second bulletin provides details on how contracting is managed and evaluated by boards, problems of managing within an internal market and planning shortcomings in the NHS in Scotland.

The context for contracting

The commissioning role of health boards, introduced by the NHS and Community Care Act 1990, has developed throughout Scotland in different ways, at different paces. However, the Commission's review highlighted a lot of common ground in how boards see the contracting process.

Boards, in the main, consider contracting to have the potential to improve the quality of patient services, especially local access, whilst enabling boards to procure more efficient, effective and economic services. A smaller number of boards believe that contracting can enable the NHS in Scotland to better define the services provided, thus enabling them to measure change and improvement. The most rural boards add improved equity to this list, and two boards feel that contracting for services can lead to increased patient satisfaction.

In reality however, a significant number of boards consider the contracting function faces many barriers, some built-in. Overall these barriers are financial, political, geographical and historical, resulting in contracting being described by two boards as a "blunt tool".

Box 1: Barriers to effective contracting - boards' views

- Limited cost and activity data
- Twelve month cycle for contracting
- Small board
- Geography
- Trust mentality
- Locked into historical provision
- Political and public barriers to change
- Clinicians' rights undermining contract
- Funding restrictions
- Contracting conflicts with collaboration
- Bureaucracy /onerous processes
- A lot of external providers
- Lack of clinical involvement
- Fragmentation of purchasing

The Shield's report [1] was published in June 1996 and contained proposals intended to refine the contracting function, in the context of boards as 'commissioning' bodies. This report required both a cultural and financial response from boards. All were required to review their purchasing arrangements to focus upon the key role of commissioning services based on patient outcomes, and mainland boards were also required to limit total management costs to £10 per head of weighted population.

It is widely expected that the imminent White Paper will require further refinement of health boards' roles. The government has already announced its plans to consult on the boundaries and relationships between health and social work, and the Priorities and Planning Guidance for 1998/99 [2] stressed the need for purchasers and providers to *collaborate* more.

After the abolition of the internal market, health boards will continue to have a key role in the strategic planning and development of health services in Scotland. In order to achieve this, boards will need to ensure that their approaches are effective and efficient, avoiding and reducing bureaucracy wherever possible. Most importantly, they need robust information on which to determine their priorities and base their plans, which should be drawn up and implemented in collaboration with all key players.

Organisation

Management structures

The local audits confirmed the impact of the Shield's report on Scottish health boards. All mainland boards have changed the position and composition of contracting and purchasing within their management structures since 1996. The extent of restructuring varied immensely. Some merely fine tuned, while others were far more radical, for example shedding a significant number of posts and increasing the number of 'commissioning teams' from three to over a dozen.

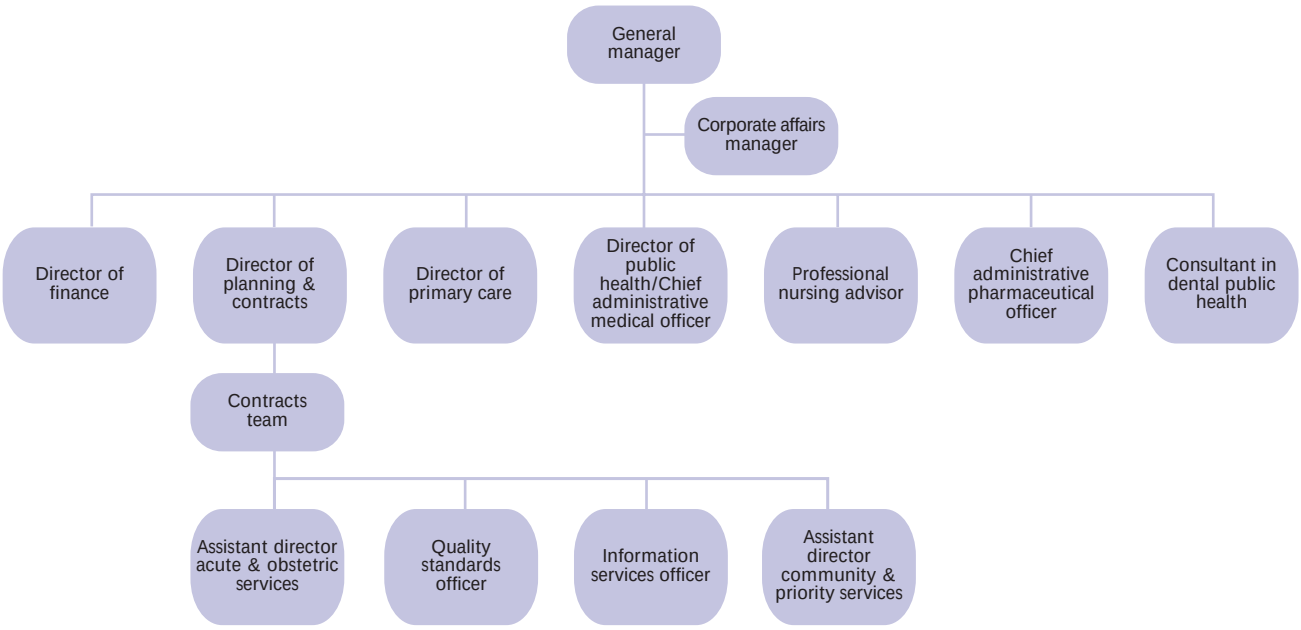
One board was found to have had three different structures since 1995-96.

Management structures now vary considerably. Exhibits 1, 2 and 4 illustrate this diversity. No two management structures for contracting were found to be the same. However the most noticeable similarity across Scotland is that ten boards now incorporate their contracting function within an integrated directorate of finance and contracting. Two also include information in this directorate's remit.

We found four broad approaches to the management of contracting in Scotland. The fifteen health boards can be categorised as having set up structures which are organised along one (or sometimes more) of the following lines:

- service areas
- NHS trusts
- geographic areas/localities
- traditional/functional lines.

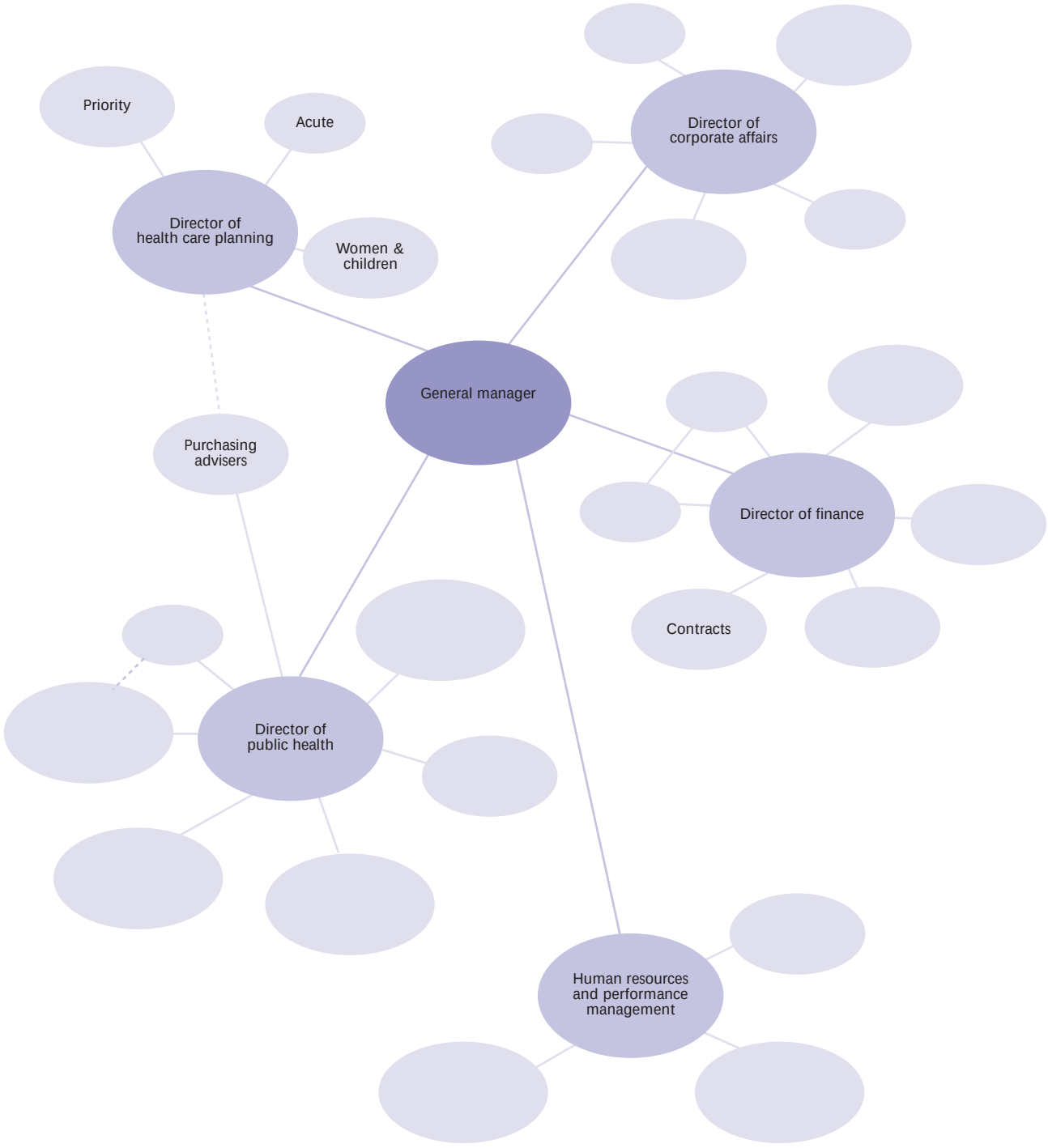
Exhibit 1: Example of a current board structure



However, within these broad categories there is little homogeneity. Three of the boards which are structured along service area lines have much broader categories (eg acute services, priority services) than the fourth board, whose service areas are more specific (eg mental health, care of the elderly). One board structured to reflect NHS trust lines also has a commissioning team which is responsible for a broad service area. There is some evidence that trusts are less critical of host boards which operate along locality lines. Their reasons are diverse however, and include improved communication, better focus on the area's health care needs and improved knowledge of the trust.

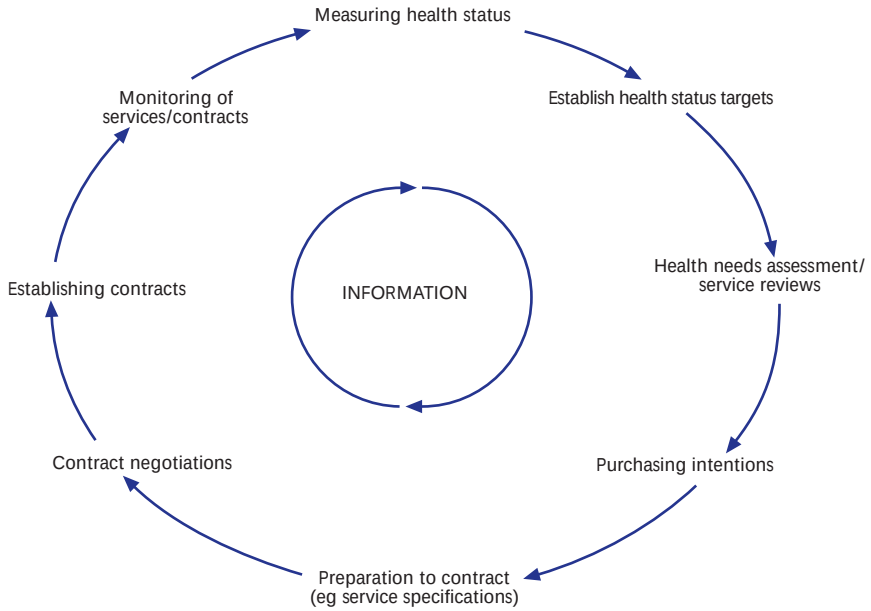
Another aspect of diversity can be found in the names given to the directorates responsible for commissioning (planning) and contracting (implementing plans). A noticeable trend is for the term 'contracting' to be removed (or linked directly with finance) and replaced by the terms 'commissioning', 'development' and 'planning'. Terminology is an important aspect of the NHS [3]. A lot can be conveyed to planning partners and the public through terms and titles. It is encouraging to note that boards are ensuring that their approaches or ideal structures are reflected in this way.

Exhibit 2: Example of a current board structure



Some boards consider contracting to be an integral part of the commissioning process, whilst others have a structure that firmly separates commissioning from contracting. It may be that as the majority of boards 'roll forward' the bulk of their purchases, making minimal changes to services or providers, the separation of broad mechanism from the implementation of specific plans is sensible. However, in light of imminent change to the contracting function boards may have to re-assess this separation to ensure they have systems geared up not only to plan, but to implement developments and improvements in collaboration with providers. Overall, we do not believe that it is effective to separate the two. They are integral parts of what is best visualised as a cyclical process (see exhibit 3).The need for contracting to be an integral part of planning was identified by the joint review of the contracting process conducted by board general managers and trust chief executives in 1996.

Exhibit 3: The health board commissioning cycle

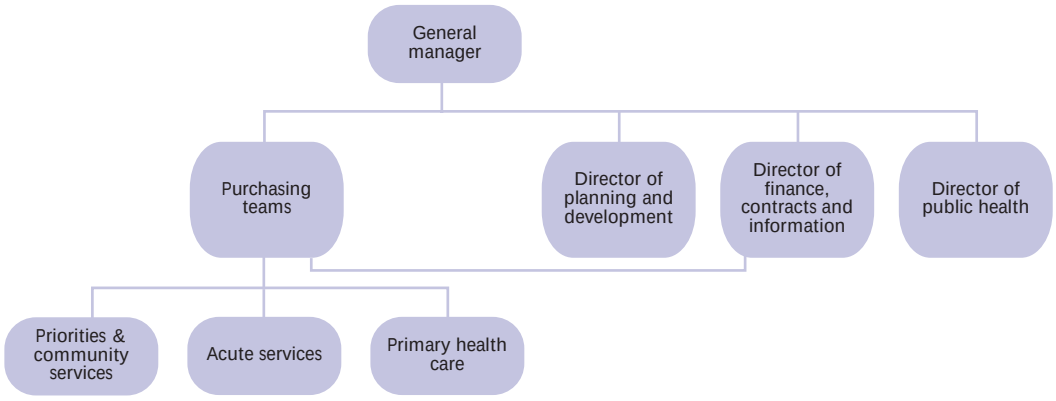


There is no single recommended or ideal management structure. However, the review findings clearly illustrated that some work better than others. In seven boards better or greater financial control had resulted from strengthening the link between contracting and financial management. Four boards were reported as having flexibility (identified as the ability to re-focus quickly and to respond to changing situations) as a strength.

Size posed varying problems for boards. Small boards were more likely to suffer from time pressures and are dependent upon one or two key staff members. A number of the larger boards have the opposite disadvantage in that their structures demand more extensive and formal communication channels. Four boards were recommended by their local auditor to ensure such channels were put in place. In three boards, co-ordinating the work of teams was reported as a potential obstacle to efficient practices. In these boards the level of complexity or 'sophistication' required by their commissioning structure has resulted in less effective working practices. It is interesting to note that the strength of flexibility comes hand in hand with weaknesses in communication and co-ordination.

A key issue for all boards, however structured, is comprehensive coverage of all aspects of health and health services. Some board structures were reported to leave gaps, most commonly in the grey area between community and primary care services. In addition to being reported by local auditors, this type of gap was mentioned by three trusts. Other boards display aspects of duplication and overlap in areas of responsibility. The potential for structural duplication and omission will be a key issue for boards in the future as their roles and responsibilities in relation to social work departments are reviewed.

Exhibit 4: Example of a current board structure



Skills and experience

Within all health board structures the way in which appropriate skills and expertise are accommodated is important. Boards require people who know *how* to 'contract well' and have the appropriate authority to do so on behalf of the board. More importantly health commissioners need staff who know *what* to 'contract for'.

a) Contracting skills

A lack of specialist knowledge and specific training was most apparent in islands boards. Medium sized boards had good skills mix, but are also dependent upon a limited number of experienced staff. In all boards training opportunities for contracting were very limited. Most contracting skills had been gained 'on the job'. Only one example of a formal skills audit for this function was found.

However, it is not enough to employ technically competent 'contract managers'. Within the contracting function of boards responsibility needs to be coupled with adequate authority. The local audit reports present a mixed picture of the ability of contracting staff to commit the board to agreements (especially financial agreements) during negotiations. In three boards it was found that to-ing and fro-ing was common during negotiations.

Appropriate delegation helps to speed up the contracting process and also contributes to a reduction in bureaucracy. It is obviously time consuming and costly to have to refer decisions up the structure and then convene another meeting. One trust commended their host board's new structure specifically because it now "involved the decision makers". However, five others expressed concern about the level of delegated authority held by negotiators.

A lack of authority can also result in over-attendance at meetings. Up to 16 staff from one board attend some negotiation meetings. This excessive level of representation is only necessary if negotiators are poorly briefed or lack empowerment.

Whatever mechanism replaces contracting, the key gaps in the current structures - limited delegation of authority, a dependence upon on the job training, and no formal audit of skill requirements - will remain and need to be addressed.

b) Medical involvement

Boards need to ensure that their strategic and operational plans are informed by appropriate clinical information. Health board staff also need medical knowledge upon which to base the contracts they negotiate and agree.

Those who negotiate and agree service delivery must either have this knowledge themselves, or be sufficiently briefed by others about the potential and problems of service developments. This is widely accepted as good practice, and is underpinned by ME guidance which states "purchasers must ensure that they have access to informed clinical advice and the necessary understanding of issues around the delivery of health care"[4]. Within Scottish health boards doctors (GPs and/or Consultants in Public Health Medicine (CPHM)) are involved in a range of ways and to varying degrees. A recent study conducted by the BMA also found that health authorities in England elicit clinical advice and information from GPs in many different ways.[5]

All boards employ doctors, mostly CPHMs, and practising GPs on a sessional basis. In only one Scottish health board were medically qualified staff found to be *leading* the contracting process. All of Forth Valley Health Board's commissioning teams are chaired by a public health doctor. Three of the six trusts who identified medically led contracting as good practice specifically named Forth Valley Health Board.

The mechanisms for involving greater numbers of doctors from outwith the boards' formal structures are newer in Scotland. Those boards who contract and commission along locality or NHS trust lines have groups of GPs who feed into the planning and contracting cycle at various stages. Many boards reimburse GPs for their part time work as group co-ordinators. There was little evidence of boards setting up similar structures to meet with hospital clinicians. At present the Area Medical Advisory Committees may provide some input. However, boards should be seeking the advice of both local hospital clinicians and others. Moreover, this should be sought in a structured and evaluated manner. At present, if hospital clinicians are involved, it is most likely to be at the latter stages of contract negotiations.

Nineteen trusts noted the importance of medical involvement in contracting in their reply to the Commission's survey. At least half of those stated that it was a key way to improve the commissioning cycle. Three trusts (each with a different host board) reported that commissioning was undermined by a lack of medical expertise within boards and seven consider this to result in limited and activity-focused negotiations and contracts.

Our findings indicate that as boards increase in size, the number of medically qualified staff involved in commissioning also increases. However, they must be involved in productive ways. The lack of medical involvement in some areas has to be addressed, the different methods of involvement evaluated and the potential contribution of trust clinicians has to be harnessed.

Boards' new planning tools, Health Improvement Programmes (HIPs) have to detail a rolling programme for the implementation of evidence based clinical guidelines. It is perhaps here, more than anywhere else, that the benefit of effective medical involvement, will be gained.

Managing 'within' the market

Costs and bureaucracy

Over the last seven years the main criticism levelled at the process of contracting is the perceived level of bureaucracy. The Commission sought the views of both boards and trusts about the main problems. These are summarised in box 2.

Box 2: Factors increasing costs and bureaucracy

Boards' views	Trusts' views
Deadlocked negotiations	Numerous purchasers
Numerous external providers	Short term contracts/annual process
GPFH administration	GPFH administration
Poor costing data	Cost per case contracts
Involving stakeholders	Gathering detailed montoring data
Providing data to ME	Tendering for contracts
Being innovative	

Both purchasers and providers highlighted the administration of GPFH as costly and potentially bureaucratic. The issues surrounding GPFH in relation to transaction costs are well documented elsewhere.[6] A number of trusts specifically mentioned that the cost of dealing with GPFH is disproportionate to the income received. Two estimated that 80% of their transaction costs are related to at most 20% of their income.

Box 3: Main problems contracting with more than one purchaser

- Increased workload
- Co-ordinating different strategies and approaches
- Inconsistent purchaser demands
- Unnecessary bureaucracy
- Poor purchaser-to-purchaser relationships
- Some GPFHs trying to maximise their own savings
- Transaction costs disproportionate to income

Nine trusts believe that the biggest problem in contracting with more than one board is the amount of management time it requires. A similar number of trusts consider co-ordinating different board approaches (and structures) and dealing with inconsistent purchaser demands (eg requests for different provision) to be the most problematic in this context. Three boards reported that contracting separately with each individual trust is time consuming and not wholly efficient. A small number of boards and trusts promoted the benefits of commissioning via consortia arrangements. It may be that boards could combine efficient planning and negotiations of specific local service developments with appropriate consortia arrangements. Our study found scant evidence of boards sharing good practice. Reinventing the

wheel was more common than collaboration.

Most boards consider that negotiating contracts is prone to bureaucracy and inefficiency. Eight boards identified the lack of detailed and meaningful activity and cost information as the main reason for prolonged or unproductive negotiations. Other complicating factors included: mismatch between board offer and provider expectations; the need to extract efficiency savings through the contracting process; and problems with cost/price data that may be inconsistent, manipulated or affected by external aspects such as the re-evaluation of provider estates.

Although the White Paper may remove the need to negotiate formally with providers, boards will still have to reach agreement with trusts on how the HIPs should be structured and implemented. This will require 'negotiations'. It is therefore disappointing to report that no board was found to be tackling the main cause of unproductive negotiations - inadequate data. As reported in Bulletin One, many were in fact ignoring data inadequacies, by using block contracts.

The majority of boards regard their central contract monitoring responsibilities to the NHS ME as bureacratic. There is not a great deal of understanding amongst boards as to the purpose of the national contract monitoring template. This template was designed to inform the ME about changing pattern of spending and patient activity. Although boards accept the need for national data returns, they suggested that national monitoring should relate to the information they actually use and, more importantly, be linked to financial returns. Only one board uses the template as their main monitoring tool, specifically to avoid reworking information. In addition to the extra work required, the template may work against board innovation in contract currencies. This template is seen as adding little to boards' contracting processes, by reinforcing the use of inadequate and inappropriate data. Moreover the template continues the gap between activity and resources. The current approach to monitoring contracted activity nationally is burdensome and does not address the fundamental data gaps in the NHS in Scotland.

The Commission identified similar problems in its review of local authority commissioning of community care services. There is obviously a need for a degree of national monitoring, but these systems should add value and not just add cost.

Managing the contracting cycle

The production of five year HIPs extends the three year coverage of the purchasing intention documents, but boards are still required to plan each twelve months in detail. The ME have requested "firm plans for the first year and provisional plans for later years" [7]. Bulletin One in this series pointed out the way in which annual funding of boards curtailed the implementation of longer term contracts. Our study has revealed further issues relevant to the twelve month contracting cycle.

A number of boards reported that they consider the timing of the Public Expenditure Survey to disrupt their planning cycles. The production of intentions in September, a few months before financial allocations are announced, squeezes their contracting and negotiation work into the first three months of the year. Many believe that trusts also delay publishing their tariffs until allocations are announced, sometimes revised to reflect the size of the board's allocation.

A significant number of boards continue to negotiate with trusts well into the next financial year, because they have been unable to agree the terms of the contract before 31 March . At times boards have signed contracts retrospectively, casting doubt on the value of the whole process. We recommend that boards should consider formalising the common practice of 'rolling forward' the majority of agreements to free up time to concentrate on service development and change in specific areas. The Commission has previously commended a *'service by service'* approach to service improvement, linked with increased collaboration and sharing between boards [8,9]. To do this well, boards will have to devote more time to preparing to commission services than they currently do. The estimated management costs for contracting, provided by boards, showed that on average, boards spend only a quarter of their time preparing to implement their plans and half their time monitoring service delivery. The Accounts Commission acknowledges the very real difficulties the annual cycle poses to boards, but the balance between the tasks of preparing and monitoring needs to shift in favour of preparation.

Planning

Information to support planning and contracting

There are significant information gaps relating to the quantity, cost and outcome of health service provision. The lack of detailed information about what is delivered is reflected in key planning documents, contractual agreements and service monitoring reports. These data shortcomings have major implications for boards' ability to set out precisely the services required and to ensure they are delivered.

A key first step on the way to reducing information shortcomings is to expose what is not known, rather than relying on the limited information available at present. Our first bulletin highlighted the considered return by boards to block contracts which do not require detailed data. A survey of health authorities in England found these commissioners also taking actions which temporarily reduced the need to address the implications of the severe lack of data on the NHS inputs and outcomes [10].

A key issue raised by the need to either contract or plan for health services is how to measure or count the use of health services - what unit of measurement to use. Related to this is how to set a price for these units. The most useful approach to this is the development of measurements (contract currencies) that are linked to actual resource use.

Eight trusts suggested that developing contract currencies could be a way of improving the current commissioning/contracting process. However, they proposed six different currencies, including average specialty costs; community services currencies; healthcare resource groups; whole packages of care and outcome measures.

There is however a debate about the need to specify services at highly dis-aggregated levels. For example, seven trusts highlighted the need to produce detailed monitoring reports, adhere to cost per case contracts, administer ECRs and prolonged discussions about detailed activity as unnecessarily bureaucratic.

The National Costing Project promotes consistent costing methodologies within providers. This is an approach which will continue to be relevant after the internal market, since it allows a comparable assessment of resource consumption and value for money. However, although the NHS in Scotland has operated a number of initiatives designed to improve provider information on activity and price there has been no requirement for boards to use the resulting data.

Nevertheless proper planning of health services requires information that identifies the resources used at a highly disaggregated level. In the absence of dissaggregated information on activity and resource use it is impossible to plan services and execute improvements effectively. The abolition of the internal market may diminish some of the disincentives to dissagregation experienced by both purchasers and providers.

The Commission is supportive of initiatives designed to improve our knowledge of the ways in which resources are used in the health service. It is only through the development and use of transparent and agreed measures that the NHS in Scotland will ever be able to demonstrate real savings, improvements or justify the need for radical change. This applies to all public bodies and is not just a feature of the internal market.

The Commission is not alone in its belief that the lack of robust data in the NHS is a serious weakness, with the potential to undermine any new structures which replace the internal market.[11] Accurate and timely knowledge of where public resources are being spent and to what effect is of prime importance.

Planning documents

Health boards are public bodies, responsible for planning health services to meet the needs of their populations. They should set out, as clearly and explicitly as data limitations will currently allow, how they are going to spend the money made available to them. Over the past few years, this has been done through the production of purchasing intentions and, more recently, through the use of service specifications.

A main part of this project involved a review of all Scottish boards' purchasing intentions. The Priorities and Planning Guidance for 1998/99 replaced purchasing intentions with Health Improvement Programmes (HIPs). These new planning documents still require health boards to make explicit their resources, priorities, development and implementation approaches. The main components of HIPs are compared with purchasing intention documents in box 4. The shortcomings identified within purchasing intentions by this review, will therefore still have to be addressed if HIPs are to be useful planning tools.

Box 4: Planning documents in the NHS in Scotland

Purchashing intentions	Health improvement programmes
Clear statements about assumptions made	Resource assumptions, including locally generated efficiencies
Clear statement of priorities	Rolling programme for implementation of evidence based clinical guidelines
Workload level for first year	Firm plans for first year and provisional plans for later years
Covers 3 year period	Covers 5 year period
Major changes indentified	Service changes and developments, including primary care
Produced by board	Production led by board in collaboration with trusts and GPs
Trust business plans required	Trust implementation plan required
Subject to public consultation period	Be open to public scrutiny, recognising the role of the local health council.

Purchasing intentions

There was no central formal guidance to boards on the content of this key planning document. However, purchasing intentions should have formed the basis for contracting work and contained a detailed record of contracting approach and plans. They therefore needed to be explicit about service profiles, service activity, purchasing priorities and about the resources assumed by the board to be available. All health service plans should cover these aspects if they are to provide an effective basis for contracting between boards and trusts.

The content and utility of purchasing intentions has improved in Scotland since 1994. They are better structured and easier to read. However, as planning documents for an accountable public service there were a number of common problems. These shortcomings will reduce the value of HIPs if not addressed.

A number of purchasing intentions contained very broad statements of intent. One board acknowledged that they were useful only as initial guidance, whilst two others stated that they had deliberately written them as strategic documents. Few contained adequate detail on the resource assumptions boards had made and the service priorities were not clear from the documents of three boards. A number of boards pointed to other documents, such as their corporate contract, for the identification of priorities.

This degree of vagueness will soon be exposed as trusts are required to produce detailed implementation plans, which relate to the HIPs. If boards, as the lead body in the production of these planning documents, are unable to be explicit about their priorities with robust supporting evidence, the task of trusts will not be easy. It will also not be possible to subject these plans to public scrutiny. In order to adequately plan health services and ensure an appropriate level of public accountability, the key gaps in information which currently hinder effective planning will have to be addressed at a national level.

Service specifications

As contracting has developed in Scotland, boards have become more specific in defining the services they purchase. Despite their lack of detailed knowledge of inputs and patient outcomes, boards are increasingly working with providers to make their expectations explicit. This is being done through the production of service specifications or service profiles.

There is of course a balance to be drawn between purchasers dictating services and providers offering services. The best specifications are written by boards and trusts working together to set the nature of services.

All but two Scottish boards use service specifications within the contracts they let. One of these boards considers that its strategic documents contain sufficient information. The other uses only those developed for services such as breast screening and artificial limbs, developed when these services were purchased nationally. The other 13 boards use specifications to varying degrees and for very different services.

There is little overlap between the boards in terms of the services currently formally specified. For example, two boards with over 15 specifications each only had two which covered the same services. The national priority areas of mental health and coronary heart disease/stroke featured only once each at two separate boards. The range of services covered was very diverse, ranging from domicilary physiotherapy to accident and emergency services. Just over half the specifications identified cover acute services, with the remainder defining community based services.

The style and content of the specifications also differs. Some are very detailed descriptions of quite specific services such as the provision of infertility services, whilst others are broader statements of intent covering a collection of related services, under titles such as 'mental health services' and 'care of the elderly'. A third category of 'specification in use' was found to be more a list of main standards, most of them process measures.

The Commission's detailed review of contracts for the last three years found no contracts which used 'patient outcome' as a contract currency. This lack of information on the impact of services was also found within the specifications. However, most boards make some, limited, use of proxy patient outcome measures within service specifications.

Fife Health Board is currently working towards the production of care specifications. One specification will cover the separate services used by a patient with a defined disease or illness, eg GP services, hospital discharge arrangements, and any out-patient appointments. This approach focuses board's resources on a specific area (perhaps a local priority or problem), and acknowledges the way in which individual patients move through the NHS in Scotland, unaware of the boundaries between primary, acute and community care. It is a useful step towards improving seamless patient care.

There is significant variation between boards in their approach to specification and limited evidence of boards sharing experience and knowledge. Shetland Health Board is commended for adapting specifications drawn up by Grampian Health Board.

Although outwith the scope of this bulletin, evidence based health care will increasingly be of importance to the NHS in Scotland. Service specifications should be making use of national work such as that conducted and disseminated by the Resource and Clinical Audit Group (CRAG) and the Scottish Health Purchasing Information Centre (SHPIC). More detail on this aspect of health service commissioning will be given in Bulletin Three.

Evaluation and review

Boards should regularly review their structures against set criteria to ensure they remain relevant and effective. This is an important indicator of good practice for health boards as the emphasis on elements of their statutory roles has changed over the last five years. An Audit Commission Management Paper, 'Form Follows Function'(1994)[12], recommended that "measures ought to be set up before any restructuring takes place to provide a baseline from which the outcome changes can be judged". However, few boards had set clear measurable criteria for the success of their new structures. Neither did we find evidence that boards have cost information to inform structural change.

Bulletin One in this series detailed the costs identified by boards as attributable to their contracting function. Overall, the total cost of managing contracts by Scottish health boards was £5.7 million in 1996/97, around £1.1 million less than that reported for 1995/96. This figure represents less than 0.2% of all contracted expenditure. Spend on managing contracts ranged from under £1 to over £3 per head of weighted population .

The exhibit below shows contracting staff costs in ten boards falling between 1995/96 and 1996/97. The overall reduction totalled 11% of all contracting costs. The most common factor resulting in reduced management costs for boards was the requirements of the Shield's report. It was described by one board as a "real catalyst for change".

Exhibit 5: Percentage change in contracting staff costs, 1995/96 to 1996/97

However, these reductions (albeit estimates) may reflect arbitrary cost reduction strategies by boards and not considered moves to proportionally reduce this aspect of a board's role. It is not possible to prove this either way as no board had adequate details on staff functions to inform restructuring.

There was also no evidence of any formal programme of review within boards, although a number of boards were reviewing or planning to review the structures during 1997. One board reported that they would review their structure in response to any changes in approach signalled by the ME.

The lack of criteria, cost information and a formal approach to evaluating commissioning processes and outcomes has serious implications for boards' ability to demonstrate efficiency and effectiveness.

The Commission's auditors have recommended eleven boards to establish formal mechanisms to ensure their structures are reviewed. Three years ago the Audit Commission also found little evidence of the evaluation of structural change within public bodies [13]. Given the complex and dynamic environment of the NHS we believe that formal evaluation of management structures and processes is essential.

Boards need to be aware of how individuals and groups of staff spend their time, how this affects other functions and what the costs of the processes are. The real waste may be the opportunity cost of staff time. The Commission recognises the difficulties in recording staff time spent on each function (a task arguably made more complex by the more common matrix structures). However, it is important that management structure and process are reviewed. The role of boards changed after the Shield's report and may shift again in light of the content of the White Paper.

In addition to investigating the extent to which boards reviewed management practices and structures as a whole, this study looked at how the function of contracting was evaluated by boards. The end result of contracts let is more likely to be reviewed by boards against set criteria or objectives than the means. In the main, boards use six key means to monitor the effectiveness of contracting. These are:

- objectives in corporate contracts
- waiting list targets
- patient charter guarantees
- contract monitoring
- financial objectives
- patient feedback.

The effectiveness of local contracting is measured mostly against national standards, such as waiting lists and efficiency saving targets. It was rare to see evidence of boards evaluating their performance against patient outcomes, although all have long term health promotion targets within their corporate contracts. Boards are charged overall with the statutory duty to improve the health of their populations, by using the resources available to them as effectively and efficiently as possible. This is done through a range of interrelated tasks. We therefore need to know how each task will be judged, and what information is required in order to make an assessment. Many of these issues will be considered within the Benchmarking and Performance Monitoring Group, established by the Management Executive and on which is the Accounts Commission is represented.

References

1 'Commissioning Better Health', The report of the working group on the roles and responsibilities ofhealth boards (Chairman, Professor Sir Robert Shields), Appendix to NHS MEL (1996)45.

2 Priorities and Planning Guidance for the NHS in Scotland: 1998/99, NHS MEL (1997) 44

3 Butler, J. 'Patients, Policies and Politics: before and after working for patients.' Open University Press, Buckingham (1992)

4 Clinical Involvement in Contracting, NHS MEL (1996) 4

5 Medical involvement in the commissioning process. A report of a national study of HAs and LMCs in England, BMA July 1997

6 refs re transaction costs of GPFH

7 Priorities and Planning Guidance for the NHS in Scotland: 1998/99, NHS MEL (1997) 44

8 The Commissioning Maze, Accounts Commission, November 1997

9 Expanding on contracting, Health board contracting in Scotland, Accounts Commission, August 1997

10 Simpson, C. Paper Chase, Health Service Journal, 13 February 1997

11 Maynard, A & Sheldon, T. 'Time to turn the tide', Heath Service Journal, 25 September 1997

12 Audit Commission, 'Form follows function', (October, 1996)

13 Ibid

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The Accounts Commission for Scotland

The Accounts Commission is a statutory independent body which through the audit process assists the NHS and local authorities in Scotland achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The commission has five main responsibilities:

- securing the statutory external audit
- following up issues of concern identified through the audit to ensure a satisfactory resolution
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in the NHS and local authorities
- issuing an annual direction to local authorities setting out the range of performance information which they have to publish.

The Commission assists the NHS in achieving value for money by highlighting good practice, providing comparative information, and supporting auditors in reviewing performance locally. Its Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies.

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