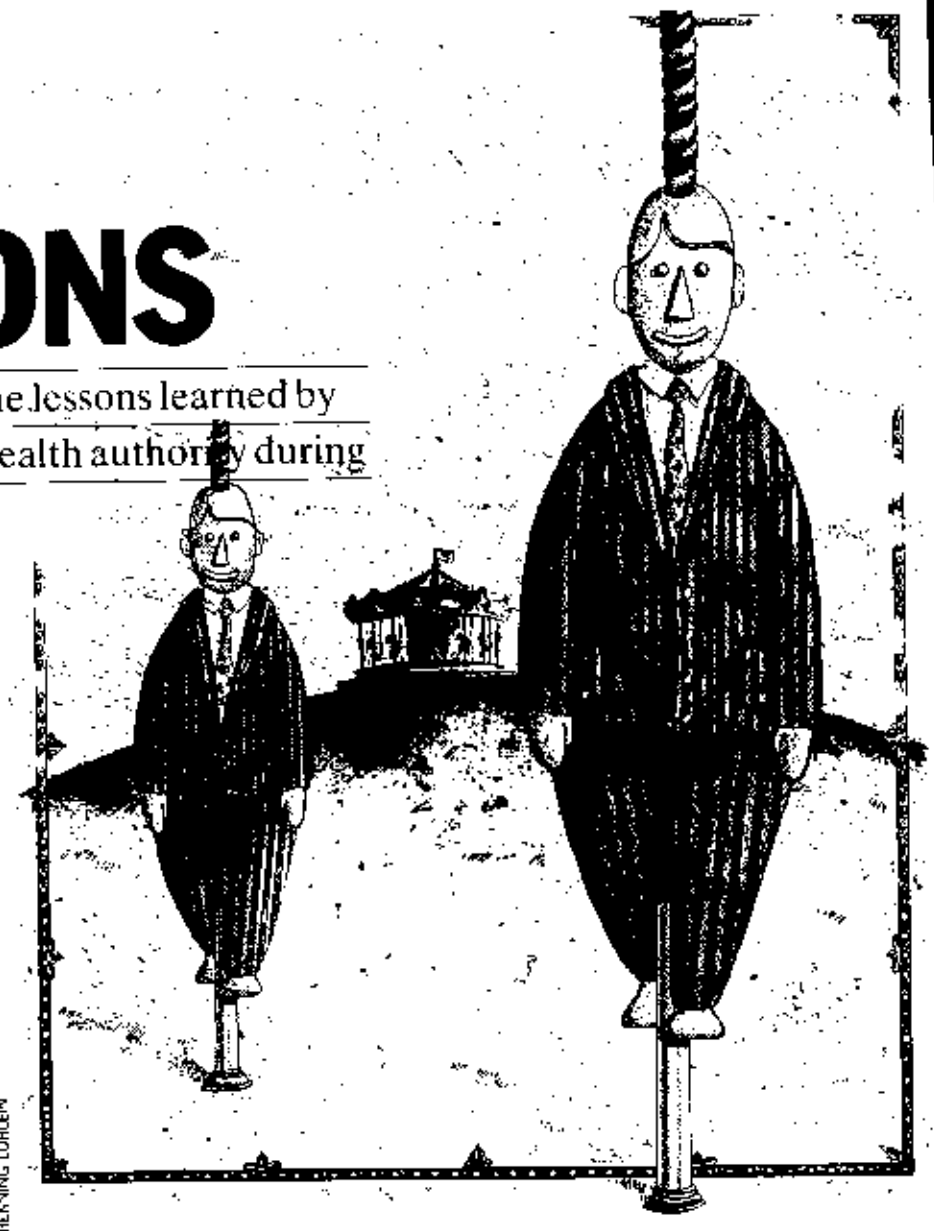
FEATURE

SPLIT DECISIONS

Allyson Pollock describes the lessons learned by Bloomsbury and Islington health authority during the first year of contracting



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With the end of the steady state in April, contracting became market led. Health authorities now buy services according to the healthcare needs of the population rather than following service-led provision, and they have the option to place their contracts with different providers. This radical change in emphasis has been difficult, partly because the Department of Health gave little guidance about how health needs should be assessed, and because organisations take time to absorb such a radical change in thinking, philosophy and service direction.

There are anecdotal accounts of how HAs around the country have evolved a range of commissioning structures, mechanisms and terminology for contracting. In most districts these are complicated and still changing rapidly. This article concentrates on how commissioning worked in one central London health authority between 1991-92.

The commissioning structure

Bloomsbury and Islington HA serves around 240,000 people. Its directly managed units include three large teaching hospitals, a community directorate and one specialist postgraduate centre. The HA may merge in 1993 with neighbouring Hampstead HA, whose main provider, the Royal Free teaching hospital, is already a trust. The new HA will be coterminous with the family health services authority.

A commissioning executive group was established in January 1992 to coordinate commissioning between the two HAs and the FHSA, with members drawn from departments of planning and contracting, public health, quality assurance and finance. Both HAs also have a local commissioning group with similar membership, but without an FHSA representative. The commissioning groups have agreed joint objectives for 1992-93 with the regional health authority which include ensuring that contracts are completed in time for each contracting cycle.

Needs assessment

Needs assessment is led by the department of public health and will feed into the contracting cycle for 1993-94. Epidemiological, health service and some consumer information is being collated. The process is purchaser-led although some providers have been extensively consulted and the community health councils have been consulted.

Population needs assessment in all districts is at a very early stage and is mainly an information gathering process. The department of public health decided to adopt a care group approach, instead of focusing on specific conditions, as a means of adopting a population overview and to point to service overprovision as well as underprovision.

Contract planning

When contract negotiations began for 1992-93, instead of an annual service specification which sets out in detail the services to be provided, Bloomsbury and Islington commissioners decided to issue providers with an annual service requirement. The ASR sets out the principles for service provision but leaves it to providers to state how they would provide services, so that providers in effect write the annual service specification.

Contracts are along care group lines, with separate contracts for acute services, accident and emergency, and health promotion. Each care group may include several contracts with different providers.

Before the ASRs were drawn up, care group conferences were proposed by the director of planning and contracting in response to the CHCs' call for greater public participation, and as a way of involving the local community in decisions about the 1992-93 contract. The HA invited providers, CHCs, charities and local people to a series of one-off commissioning conferences.

Six conferences were held from late October to early December, run along care group lines: children, elderly people, people with disabilities, people with

learning disabilities, mental health and alcohol and drug abuse. The mental health commissioning conference had some of the strongest public participation. It resulted in a statement of direction and philosophy for care as well as different types of service delivery. In others, such as the children's conference, the emphasis was more on hospital services. But, throughout the conferences, key issues such as information, training and quality kept re-appearing.

All the conferences highlighted the need for local authority input and intersectoral collaboration. For example, the conference for people with learning disablities concentrated on respite care and the absence of leisure services, the difficulties of getting access to dental care and a named and interested GP. This could have been a marvellous opportunity to build on *Caring for People* and to assess needs across the sectors but it was lost partly because of the absence of effective structures in the HA and the absence of local authority input.

The idea of commissioning conferences was novel and innovative. But there were problems which included poor organisation and poor consultation internally and externally about the nature and purpose of the conferences. There was no discussion with CHCs or other groups about how they or the public should be involved nor was a democratic process established.

In January, the first ASRs were sent out by the commissioners. These were statements of principle, but the ideas from the commissioning conferences and the information required to make decisions were strangely absent. Fortunately, purchasers and community representatives had an opportunity to participate again in late January, but the contribution of care group representatives varied.

Following the distribution of the mental health ASR there was an acrimonious exchange between purchasers, CHCs and local people which resulted in rewriting the ASR to include many of the issues raised in the commissioning conferences and requests for more detailed information from providers. The ASR for people with disabilities was hampered by the fact that there was no specifically identified budget for this care group; the budget was incorporated in other contracts. Providers recognised this early on and did not send a representative to any of the discussions.

When the shape of the ASRs were finally agreed in February, the providers had barely a month to respond. They responded with a service specification much like last year's with the inclusion of a development plan based on the providers' perception of need. Sometimes this coincided with the ASR and the views of

the commissioning conference, but on other occasions, most notably in the meetings on the mental health contract, there was conflict. The providers for the mental health contract submitted an annual service requirement and development plan which was hospital dominated and based on the medical model of care. One reason for this was the current crisis in mental health beds. At the same time, demands were being made for a community-based crisis intervention service from the voluntary sector.

The problems

A major problem still facing the district is how best to feed work in from this year's needs assessment and contract review meetings between purchasers and providers into the next contracting round. There is a further issue about how to take forward the work from the commissioning conferences and ensure that local people are heard. The absence of democratic structures compounds the problem.

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There is considerable inertia to overcome in moving towards the new way of thinking, partly because it is such a radical departure from the traditional emphasis on service delivery and because managers are stretched, having to handle vast amounts of paperwork generated by many contracts.

A shortage of resources, skills, expertise and good information to develop a good population needs assessment impedes service development and is compounded by a crisis in funding in many provider units, and will inevitably rebound on purchasers. The example of the mental health contract illustrates the conflict between crisis funding, to keep the service going, and development funding.

Clearly the current situation is far from that envisaged for a market. In our inner city district problems include difficulty formalising agreements for acute services – partly because of resource constraints and partly as a result of the drift away from some London providers, which may add to the cost of maintaining the local service. This may mean poorer services for local residents and reduced choice for others. It places London purchasers in the invidious position of having to protect providers in order to protect services for local residents. There is a real risk that protection of current service provision will be at the expense of new service development and good practice.

But there are some positive things to say. The split has focused the minds of both commissioners and providers on the problems of maintaining the population's health and providing care. It has also shown that we do have common final goals, and that there is a wish to provide high-quality, effective and appropriate services. There is also a growing realisation from within the NHS that health requires intersectoral input from housing, social services and environment departments. This is becoming a more political issue as the NHS tries to cope with the effects of social problems of homeless people, refugees, mental health and so on.

Information, too, is becoming critical as we realise how little we know about our population, its needs and the effectiveness of services. The split illustrates how weak current NHS information systems are, geared as they are to activity and finance which in turn are poor. The next steps will have to progress beyond passive consumer surveys of patient satisfaction, to develop mechanisms which will ensure that local people have an active voice in decision-making. This will mean designing a process for democracy and in the absence of national guidance and support may prove an insurmountable obstacle. ■

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