Contracting for acute health care in England : report / by the Comptroller and Auditor General.

NATIONAL AUDIT OFFICE

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

Contracting for Acute Health Care in England

HC 261 Session 1994–95
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John Bourn
Comptroller and Auditor General

National Audit Office
24 February 1995

The Comptroller and Auditor General is the head of the National Audit Office employing some 800 staff. He, and the NAO, are totally independent of Government. He certifies the accounts of all Government departments and a wide range of other public sector bodies; and he has statutory authority to report to Parliament on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

Contents

Summary and conclusions

1 The most fundamental change introduced by the National Health Service and Community Care Act 1990 was to separate the job of purchasing health care services from that of providing them. Since April 1991, health authorities and general practitioner fundholders (purchasers) have had to identify the health care needs of the people living in their area and negotiate contracts to purchase from hospitals and community health services (providers), services which will improve peoples' health, and ensure that as many as possible receive high quality care within available resources.

2 The NHS Management Executive* sought to introduce these fundamental changes in such a way so as to minimise disruption of patient care. This meant that in the first year contracts were required to continue existing patterns of services as set out in guidance to the service.

3 Hospitals are expected to compete to provide services at a price and quality standard that health authorities and general practitioner fundholders are prepared to pay. The link between health authorities and hospitals is the contract. This is not a legally enforceable document (unless the contract is with a non-NHS provider) but has more of the characteristics of a service agreement. Contracting is one means by which health authorities change the way hospitals deliver services. The aim is to improve efficiency, the quality of services and the health of the people on whose behalf they are buying services.

4 Implementing this new system is an immense task. Purchasing acute care, at the time of the study involved 141 health authorities and 1,244 general practitioner fundholder practices arranging, in 1992-93, for 9.3 million finished consultant episodes of in-patient treatment which includes day cases, in 1,000 hospitals at a cost of about £9.9 billion. Data about these episodes need to flow between the various contracting participants. These new flows are complex and have proved difficult to implement. Acute care may be required

* The NHS Management Executive became known as the NHS Executive on 1 April 1994

for acute disease or a condition requiring surgery. The classification used in England for hospital discharges includes 13,000 different disease and procedure codes.

5 A strong influence on the development of the purchasing role has been the extent to which health authorities have been able to transfer provider responsibilities to NHS trusts, and so concentrate on developing purchasing. The NHS are leading the development of internal markets in nationally managed health care systems.

6 The National Audit Office focused on three aspects of health authorities contracting; contracting information; the types of contracts; and the contracting process. This report is an assessment of progress, recognising that contracting is still developing and that the NHS are learning from their own experience.

Contracting information

Paragraphs 2.1-2.5, 2.13-2.16

7 Reliable information is a basic requirement for an effective contract and is critical to the delivery of better managed services. Hospitals are developing their information systems to overcome the difficulties they are still having in providing timely and accurate information on patient treatments and prices from their existing systems. The limited availability of data is the weak link in contracting for health care. Continued developments in the use of comparative data by, for example, the National Steering Group on Costing and the National Casemix Office, are intended to improve both the quality of data and effectiveness of contracting. However, the benefits of investment in better information need to be weighed against the cost.

Paragraphs 2.6-2.13

8 Health authorities will be able to purchase more effectively when they are able to compare prices for similar treatments with confidence. There is, as yet, no accepted consistent way of grouping diagnoses for treatment into useful categories for contracting, although one is currently being developed by the National Casemix Office in consultation with the Royal Colleges. While hospitals are required to set their prices based on full costs and with no planned cross subsidisation between specialties and customers, there is no consistent costing methodology in use on which to base prices although one is being developed by the National Steering Group on Costing. Consequently it is difficult for health authorities to judge whether they are achieving value for money when buying services for their residents. The action being taken by the NHS Management Executive is intended to lead to measures being fully in place by Summer 1996 in order to influence the 1997-98 contracting round.

Contract types

Paragraphs 3.1-3.7

9 All health authorities visited have made progress. But progress has been constrained by the limited information available. Health authorities have been reluctant to use longer term contracts because of an uncertain external environment and concerns about inflexibility. Some health authorities need to make quicker progress in developing a wider range of contracts which are more appropriate to the characteristics of the services they are purchasing and consistent with the information available.

The contracting process

Paragraphs 4.1-4.3

10 Managers considered there to be an acceptable level of tension in relationships. The National Audit Office survey of NHS regions and trust monitoring outposts showed that they both felt that forming joint long term strategies, providing comprehensive and timely information as well as maintaining regular communications between chief executives, were most important in achieving constructive relationships.

Paragraphs 4.4-4.7

11 Contracts for acute health care are largely based on those arrangements that were in place prior to the reforms. Health authorities' ability to manage change through contracts was constrained by the limited information available. The support of general practitioners is important if changes are to be managed successfully.

Paragraphs 4.8-4.9, 4.11-4.12

12 Hospitals are making progress in involving hospital doctors in contracting and all community health councils respondents in the areas visited were generally satisfied with the level of consultation from the local health authority on their purchasing intentions.

Paragraphs 4.13-4.14

13 The National Audit Office surveyed 360 out of 797 general practices in the six family health services authorities covering the health authorities visited, 60 in each of the six family health services authorities. The six areas used for the survey were City and East London, Enfield and Haringey, Leeds, Humberside, Buckinghamshire and Berkshire. The results are representative of the six areas. The National Audit Office survey showed that, whilst there was a marked variation across the six family health services authorities surveyed, 39 per cent of respondents stated that their local health authority never consulted them. In the family health services authority with the highest proportion of general practices stating that they had been consulted, their local health authority had established local purchasing teams which visited each practice every six months to discuss contracts and purchasing intentions. The

National Audit Office consider, that as contracting develops and health authorities attempt to manage change through contracts, it is important that they give priority to including general practices in the contracting process and obtaining information from general practices on their patients' needs.

Paragraphs 4.13, 4.15

14 Over 40 per cent of the general practice respondents felt that some or all of their comments on their health authority's purchasing intentions had been taken into account by their health authority. In response to a different question, over a quarter of respondents considered that the contracts their health authorities had made with acute hospitals were always appropriate for their patients needs. A further 61 per cent of the respondents considered that the contracts were sometimes appropriate for their patients' needs.

Paragraphs 4.16-4.17

15 General practitioners are much less involved in monitoring the performance of hospitals than community health councils. Only two of the six health authorities examined were making efforts to obtain any information from general practitioners which would help them monitor the hospitals' performance.

Paragraph 4.18

16 The survey of 360 general practices asked for views on whether their patients had benefited from the new contracting arrangements for acute health care services. The survey revealed that whilst about half of the respondents considered that the new contract arrangements had brought benefit to some of their patients, many are not convinced of the benefit to patients.

Conclusion

17 At the time of the study, contracting was at an early stage in its development. At the introduction of the NHS reforms, the development of the provider role was given a higher priority than developing the purchasing role of health authorities. The NHS Management Executive considered that health authorities could not concentrate on realising the potential of purchasing if they were also responsible for running local hospitals. The NHS Management Executive considered that the first two years were essential for establishing this separation of purchasing from providing. In 1993, they gave the development of purchasing the top position on the agenda for the health service and stated that it was the most crucial stage of the health reforms. In view of these circumstances contracting for acute health care is still undergoing change. Developing information, effective links with general practitioners, and nationally agreed definitions are key to ensuring effectiveness in the future.

18 The NHS Management Executive are continuing to strengthen contracting. They have identified targets and intermediate stages so that progress can be monitored, but time is required to build up the necessary skills and experience. The introduction of contracting has helped to draw attention to the need to focus on patients' requirements and to improving information. Health authorities and hospitals are taking steps to improve information, select more appropriate contract types and build up a constructive relationship to ensure that patients' needs are met in the most efficient and effective manner. When these further developments in contracting have been introduced the effectiveness of health authorities should be enhanced.

1. Introduction

Health care contracting

1.1 The most fundamental change introduced by the NHS and Community Care Act 1990 was to separate the job of purchasing health care services from that of providing them. Since April 1991 health authorities and general practitioner fundholders (purchasers) have had to identify the health care needs of the people living in their area and negotiate contracts to purchase from hospitals' and community health services (providers) services which will improve peoples' health, and ensure that as many as possible receive high quality care within the resources available.

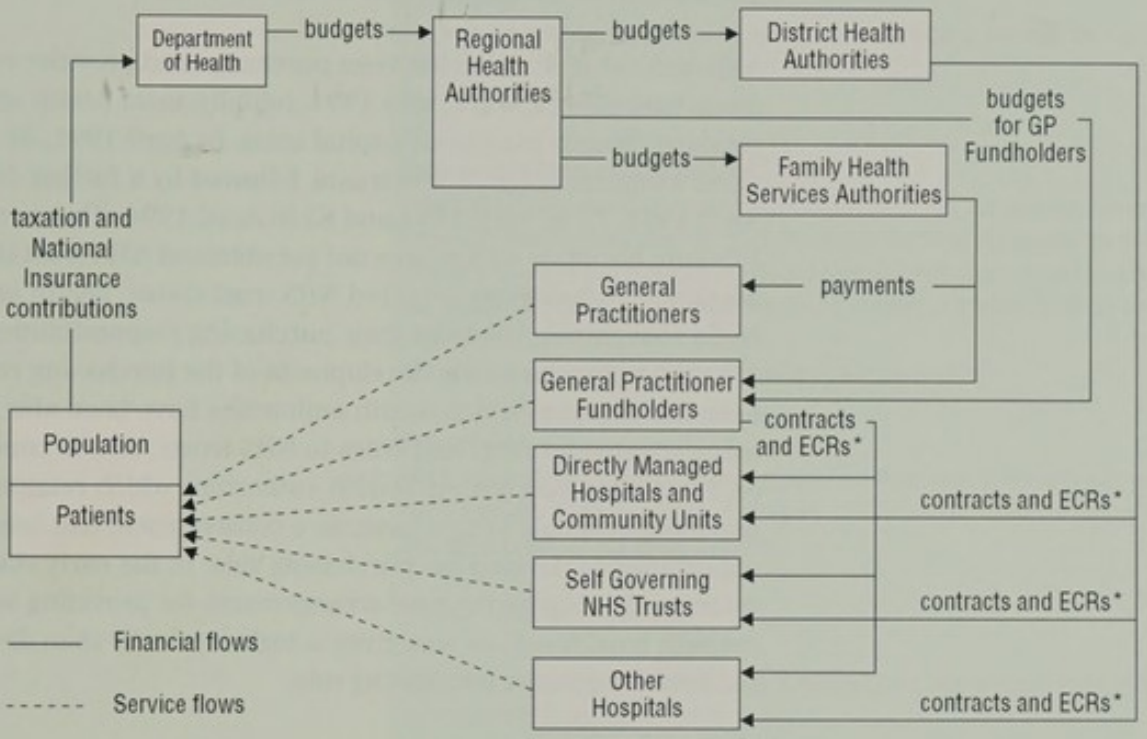
1.2 Hospitals are expected to compete to provide services at a price and quality standard that health authorities and general practitioner fundholders are prepared to pay. The link between health authorities and hospitals is an agreement for the provision of specified services known as the contract. This is not a legally enforceable document, (unless the contract is with a private hospital). Contracting is the means by which health authorities change the way hospitals deliver services. The aim is to improve efficiency, the quality of services and the health of the people on whose behalf they are buying services.

1.3 Implementing this new system is an immense task as illustrated by Figure 1 opposite. Purchasing acute care, at the time of the study involved 141 health authorities and 1,244 general practitioner fundholder practices arranging, in 1992-93, for 9.3 million (including day cases) episodes of treatment each year in 1,000 hospitals at a cost of about £9.9 billion. Data about these episodes need to flow between the various contracting participants. These new flows are complex and have proved difficult to implement. Acute care may be required for acute disease in which the attack is sudden, severe or of short duration or a condition requiring planned surgery. The classification used in England for hospital discharges includes 13,000 different disease and procedure codes.

The development of contracting

1.4 Prior to the NHS reforms, hospitals were managed directly by health authorities and received resource allocations which were largely historically based. This money was used to treat patients whom general practitioners referred to hospitals, irrespective of where the patients lived. There was no direct link between allocations to

Figure 1: Flow of funds and services for acute health care in the National Health Service



Source: *Based on a chart contained in "The reform of Health care: a comparative analysis of seven OECD countries: Organisation for Economic Co-operation and Development 1992."*

Note: *ECRs*: Extra-contractual referral: referral of a patient to a hospital which does not have a pre-existing formal agreement with the patient's health authority.*

Figure 1 shows the flow of funds and services for acute health care in the National Health Service after the implementation of the National Health Service and Community Care Act (1990).

hospitals and the number of patients they treated. If hospitals improved services and became more popular, their allocation often did not increase. This put pressure on their budgets, or the waiting lists went up. The reforms were designed to change this by enabling money to follow patients so that hospitals which offered improved health services could obtain additional money to treat the additional patients referred to them. Conversely hospitals which attracted fewer patients would receive less money.

1.5 To effect this change, and improve the internal management of their organisation, hospitals now need detailed information so that they can identify separately individual patients, the treatment they receive, their general practitioner and their area of residence, and in certain cases raise invoices for their treatment. If hospitals are

unable to do this they may not be paid for all the patients they treat, and health authorities will only know in very broad terms if the health services they have agreed to buy on behalf of their residents are being delivered to the right level and standard.

1.6 Although the distinction between purchaser and provider roles was made with effect from 1 April 1991, initially, most health authorities retained directly managed hospital units. In April 1991, 37 groups of acute hospitals became NHS trusts, followed by a further 50 in April 1992, 75 in April 1993 and 83 in April 1994. There remain 17 acute hospitals which have not yet obtained NHS trust status. As hospitals progressively achieved NHS trust status, health authorities could concentrate solely on their purchasing responsibilities.
A strong influence on the development of the purchasing role has been the extent to which health authorities have been able to transfer provider responsibilities to NHS trusts, and so concentrate on developing purchasing. Health authorities which retained directly managed hospitals longer have, as a consequence, had less opportunity to develop the purchasing role. In the early stages of the reforms, developing the new arrangements for providing services through trust hospitals was given a higher priority than developing the health authority purchasing role.

1.7 The NHS are leading the development of internal markets in nationally managed health care systems. Much of this development has been based on reviewing the experience gained and then refining objectives and guidance.

Figure 2: The seven imperatives for contracting

- Better working between purchasers and providers
- Involvement of doctors in the contracting process
- Involvement of nurses in the contracting process
- Realism about activity and the impact of change
- Ensuring contracts are appropriate
- Robust information on activity and prices
- Effective monitoring arrangements

Source: Department of Health, May 1993.

1.8 In the first two years of the reforms the priority was to protect health services for patients while the enormous organisational changes of separating hospitals from health authorities' direct management and establishing them as trusts took place. During this time, contracts between health authorities and hospitals were largely simple block contracts. A simple block contract is one where a fixed sum is paid for access to a service for every patient. The NHS Management Executive said that for health authorities to be fully effective, they need to develop their contracting to meet the criteria set out in Figure 2. This includes developing a wider range of contract types which are appropriate to the characteristics of the service being purchased - as discussed in Part 3. Health authorities progress in developing different contract types is constrained by the level of information available from hospitals, and their own capacity to use that information. An explanation of each contract type is shown in Figure 3 opposite.

Figure 3: The characteristics of each contract type

Contract Type
Simple Block
Hospitals are paid a fixed sum for access to a defined range of services with uncertain volume.
The risk is largely on the hospital.

Sophisticated Block and Cost/Volume
Contracts for service which specify minimum and maximum number of patients treated for the overall contract price. They include intermediate performance targets which if not met, prompt a review of the contract or additional payment. Hospitals are paid for a defined range and volume of treatments. An extra, or reduced, number of treatments attract extra or lesser payment.
The risk is shared between the health authority and the hospital.

Cost per case
The hospital agrees to provide a range of specified treatments in line with a given price list. There is usually a defined volume of services.
The risk is largely on the health authority.

Source: National Audit Office.

Figure 3 shows the main characteristics of simple block, sophisticated block and cost and volume, and cost per case types of contract.

National Audit Office examination

1.9 This study examines the following aspects of contracting by health authorities for acute health care in England:

- Contracting information: how acute hospitals identify the patients they treat and cost and price these treatments (Part 2);
- Contract types: how health authorities and acute hospitals identify the most appropriate type of contract for the service being purchased (Part 3);
- Contracting process: how health authorities and acute hospitals work together, and involve medical staff, general practitioners and community health councils in managing the contracting process (Part 4).

1.10 The National Audit Office examination carried out in the summer of 1993, covered the NHS Management Executive, a selection of three regional health authorities and two district health authorities within each region. The National Audit Office also examined a number of acute hospitals, mainly trusts, within each of the three regions. They also examined the relevant trust monitoring outpost of the NHS Management Executive (Appendix 1, Table 1).

1.11 In order to seek the views of general practitioner practices in the areas visited on aspects of the contracting process, the National Audit Office conducted a postal survey (Appendix 4). They also carried out a full postal survey of the community health councils in each area visited in order to seek their views (Appendix 5). They also gathered information by a postal survey from the 11 regional health authorities and the three trust monitoring outposts they did not visit (Appendix 5). They consulted a wide range of bodies and took advice from experts in the field of contracting for health services in the NHS, the private sector, and in the Netherlands and New Zealand (Appendix 1, Table 2 and Table 3).

2. Contracting information

Introduction

2.1 One of the basic requirements for an effective contract is reliable information on patients, their treatment and the cost of that treatment. This is critical to the delivery of better managed services, though the benefits of increasing investment in better information need to be weighed against the costs. This part of the report considers the extent to which the NHS have gathered such information on patients treated, prices and information for monitoring contracts.

Patients treated

2.2 The requirements of contracting create a new set of information needs concerning patients treated, treatments received and cost.

2.3 Three of the hospitals visited have experienced difficulties in producing timely information with their present systems, but were planning investments in improved information systems to enable them to respond to the additional information requirements. This would help overcome the problem facing health authorities who were paying hospitals on the basis of a judgement on whether contract terms broadly were being met, supported by limited data.

2.4 Two of these hospitals, the North Middlesex Trust and Newham Health Care, did not obtain adequate and timely information for contract management purposes from their patient administration systems. The North Middlesex Trust now have plans to overcome this problem by introducing a casemix management system which shows the complexity of treatment given to patients, and by replacing the patient administration system. Newham Health Care plan to introduce a new casemix management system also, to allow them to obtain information directly from the patient administration system on the number of patients being treated under each contract and to help manage performance on their contracts. The Royal Hull Hospitals Trust and the Royal Berkshire and Battle Trust are also investing in information systems for 1994-95 contracts.

2.5 One hospital visited had lost data through a failure of a patient administration system. At the North Middlesex Trust staff had to revert to manual record keeping for six weeks between April to June 1993 after data were corrupted following a back-up failure.

Restoration of the data lost was a major exercise and one million corrupted records had to be reentered onto the system. The problem highlighted the need for hospitals to have good back-up and stand-by arrangements.

2.6 Three of the seven hospitals visited had difficulties allocating the correct codes or completing all codes which describe the treatment each patient has received. This reduces the accuracy of the data supplied to health authorities which in turn limits the health authorities' ability to build up a clear picture of the services their residents are receiving and then assess if changes are needed. The NHS Management Executive established in 1991 a national network of coding tutors who work on a coordinated programme to improve the standards of clinical coding.

2.7 Two of the hospitals visited are doing specific work to improve diagnostic coding. The St James's Trust had carried out a detailed examination of the workload of the hospital. The third largest category was uncoded items. They considered that slow and inaccurate coding was a general weakness. Both St James's Trust and the Royal Hull Trust are now giving a higher priority to improving the accuracy and completeness of coding.

2.8 Since hospitals cannot contract separately for services to treat each of the 13,000 different diseases and procedures coded in the classifications used in England for hospital discharges, they need to be able to group them together in a consistent way. While there has been some progress since 1991, there is not, as yet, an accepted consistent way of grouping diagnoses for treatment into useful categories for contracting. This means that for example, removal of the prostate could be grouped with procedures on the male reproductive system in one hospital and into procedures on the urinary tract in another. Unless health authorities specifically investigate how each group is made up, they run the risk of failing to compare like with like when making value for money judgements between competing hospitals.

2.9 The NHS Management Executive were aware of these limitations and in 1990 established a National Casemix Office to develop a way of grouping diagnoses for treatment consistently into categories which have similar resource requirements and which can be used for costing. With 13,000 different treatments and to ensure ownership by the medical profession, the NHS Management Executive recognised that this was going to be a time-consuming and iterative process. The NHS Management Executive aim for these

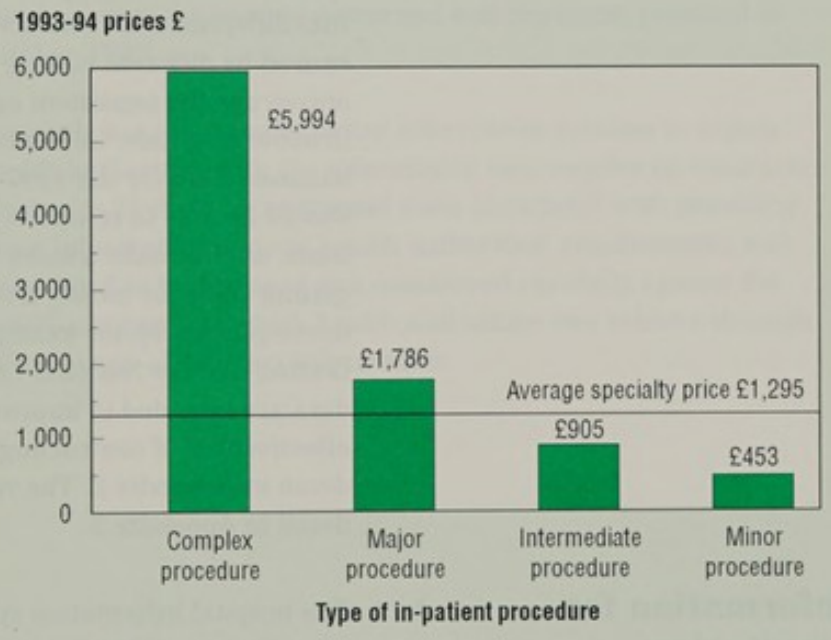
to be in general use for 1997-98 contracts. The key stages are shown in more detail in Appendix 2. The Healthcare Resource Groups are described in more detail in Appendix 3.

Prices

2.10 In view of information availability at the time and the need to minimise disruption to patient care, the NHS Management Executive issued guidance to hospitals that they should charge health authorities average specialty costs. This standard is being met by all seven hospitals visited. Two of the seven had gone beyond this and were able to analyse their costs in more detail and divide the total costs for some of their specialties into different price bands. Each price covered a band of treatments. Bands were categorised into complex, major, intermediate and minor. Separate prices were given for outpatients and day cases.

2.11 The Royal London Trust have quoted bands of prices for certain specialties. An example is shown in Figure 4.

Figure 4: Royal London Trust 1993-94 plastic surgery price bands for an episode of in-patient stay



Source: National Audit Office.

Figure 4 shows that there is a marked difference between minor and complex procedure prices.

2.12 Hospitals are required to set their prices based on full costs and there should be no planned cross subsidisation between specialties and customers. Health authorities can only make valid comparisons

of hospitals' prices if they are derived from a consistent costing methodology. The incomplete development of a consistent costing methodology on which to base prices at the time of the study, made it difficult for health authorities to be sure they were achieving the best value for money on behalf of their residents. In response to a funding problem affecting their major purchaser, the Royal London Trust altered their pricing structure in 1992-93 to load overheads onto services provided to patients living outside the immediate locality. When the trust removed all cross subsidisation between services in the following year in line with NHS Management Executive guidance, some of the trust's procedure prices rose markedly. As a result, there was a gap of £9 million on the initial negotiating position between the trust and the purchaser on a contract of £66 million. In an example of the positive effect of good purchasing practice, New River Health Authority successfully reduced the initial contract price quoted to them by one hospital by over £300,000 when they queried the costing methodology used by the hospital.

2.13 The National Steering Group on Costing was set up in response to concerns of the Audit Commission about weaknesses in information systems and costing systems. The remit of the group was to ensure that differences in contract prices between hospitals were not caused by different costing approaches. To this end, they aim to encourage the consistent application of minimum costing standards in acute hospitals. Guidance from the group will mean that by summer 1996 for the 1997-98 contracting round, health authorities should be able to compare prices for all specialties on the same basis, and so make a more informed judgement on whether they are getting value for money from their contracts. Continued developments by, for example, the National Steering Group on Costing and the National Casemix Office, in the use of comparative data are intended to improve both the quality of data and effectiveness of contracting. The key stages are shown in more detail in Appendix 2. The work of the group is described in more detail in Appendix 3.

Information for monitoring contracts

2.14 The hospital information systems before April 1991 concentrated on providing operational support for local managers and detailed data on patients were not transferred from these systems. The introduction of contracting placed new demands on the existing generation of hospital information systems. Due to their ageing technology and the complexity of the data flow arrangements required to support contracting, many of these systems need to be

replaced. Many hospitals are engaged in the task of developing or replacing their systems but the pace of implementation is constrained by the size and cost of modifications.

2.15 The present state of development in hospital information limits health authorities' ability to monitor contracts. Four of the six health authorities visited identified this as a major constraint. For example, in August 1993 Buckinghamshire Health Authority had received no information at all since March 1993 from nine of the 29 hospitals with which they had contracts, representing 1.5 per cent of the value of their acute contracts. Leeds Health Authority found that the provision of poor and late information was a major monitoring problem. Berkshire Health Purchasing Consortium said that when they questioned hospitals' claims to be treating more patients than were specified in the contract, typically they reduced the claim by 20 per cent. In line with NHS Management Executive guidance on the use of incentives and sanctions some health authorities have refused payment if adequate information has not been provided by hospitals. For example, Berkshire Health Purchasing Consortium stopped payments to St Mary's Hospital, Paddington in August 1993 after the hospital had failed to provide reliable data on patients treated in 1993-94. The matter has since been resolved to the satisfaction of the parties concerned and payments resumed in October 1993.

2.16 Hospitals are investing in better information systems to supply health authorities with the information they require on contracts. There are likely to be additional costs associated with providing more information to meet health authorities' requirements and these need to be assessed and considered carefully against the benefits to patients which health authorities can achieve through effective use of contract information.

3. Contract types

3.1 The requirements for effective health care contracting (see Figure 2) include selecting the most appropriate type of contract for the characteristics of the service being purchased. These characteristics would include the number of patients treated, the cost per episode of patient treatment and the sophistication of the costing information. This part of the report examines the extent to which health authorities and hospitals are meeting this requirement.

Appropriateness of contracts

3.2 In November 1992 the NHS Management Executive encouraged health authorities to continue to move away from simple block contracts into more sophisticated types of contract (see Figure 3). The guidance also encouraged health authorities to make greater use of incentives and sanctions. This gives health authorities more opportunities to influence changes in hospital services provided, in order to bring them more in line with patients' needs and general practitioners' preferences.

3.3 Subsequent guidance issued by the NHS Management Executive in mid February 1993 was intended to disseminate good practice in managing activity and change through contracting. This was based on pre-existing guidance and known good practice. Some of the guidance was to be implemented before 31 March 1993 and other guidance during 1993-94. One item to be implemented for 1993-94 contracts was that contracts should be appropriate for the service being purchased and consistent with the information available. Whilst many of the hospitals and health authorities visited welcomed the guidance they would have appreciated it more had it been issued earlier in 1992-93.

3.4 All health authorities visited had made progress towards developing more sophisticated contracts which specified the minimum and maximum number of patients that could be treated for the overall contract price. They were also specifying intermediate targets for performance during the year which, if these were not met, prompted a review of the contract or revised payment. But progress had been constrained by the limited information available. Some health authorities need to make quicker progress in developing a wider range of contracts which are more appropriate to the characteristics of the services they are purchasing and consistent with the information available.

3.5 Three of the health authorities visited included sanctions in their 1993-94 contracts, for example, withholding a percentage of the monthly contract payment until the relevant activity data are provided. Of the remaining three health authorities visited, two said that while they had not included sanctions in their contracts they would withhold payments where appropriate, for example where data received were unvalidated. All three health authorities which had included sanctions said that these were not particularly effective. They considered that their use could adversely affect relationships, also that reducing payments to a hospital for failing to provide information could result in that hospital having to reduce the service they offer to their patients.

3.6 There had been little use of incentives in contracts in the health authorities visited, who were concerned about the effect on hospitals of withholding, until the year end, funds which would otherwise be paid earlier. They preferred to attempt to improve their provider hospitals' performance through persuasion and maintaining close contact throughout the year.

3.7 The NHS Management Executive have encouraged health authorities and hospitals to increase the use of rolling contracts covering more than one year; or longer fixed term contracts to bring more stability and ensure that change is handled at the right pace. They also recommend that consideration be given, where appropriate, to short term contracts of less than one year in order, for example, to reduce waiting lists. In the health authorities visited most contracts had been let on an annual basis even though the benefits of contracting for longer periods were widely recognised. While longer term contracts were seen as a means of providing stability, improved security and avoidance of repetitive contract negotiations, thus reducing contract management costs, health authorities have been reluctant to use them because of an uncertain external environment and concerns about inflexibility.

New River Health Authority advised the National Audit Office that all their major hospital contracts are three year rolling contracts with nine months notice of termination; Leeds Healthcare have a few contracts in excess of one year; and the Berkshire Health Purchasing Consortium have a contract with one of their acute trusts which spans two years.

Reasons given for using longer term contracts include:

- reducing bureaucracy by allowing annual negotiations to be more tightly focused;

- enabling capital investment to be made;
- facilitating achievement of planned service changes over time;
- promoting better working relationships.

Services provided outside contracts

3.8 There are some circumstances where patients wish to have treatment at a hospital which does not have a contract with their own health authority. In emergencies patients are treated and, if they have had in-patient treatment outside an existing contract, an invoice is sent for that treatment to the health authority where the patient lives. For non-emergencies a general practitioner can refer a patient to a hospital which does not have a contract with a patient's district health authority. Such a referral however has to be approved by the patient's district health authority. This is known as an extra-contractual referral.

3.9 Patients and general practitioners need access to a reasonable choice of hospitals. Health authorities need to negotiate a range of contracts in line with NHS Management Executive guidance which include patients' and general practitioners' preferences. This will keep the proportion of extra-contractual referrals as small as possible and minimise the extra administrative costs of approving and invoicing each one. At present, extra-contractual referrals represent only one to two per cent of all referrals. Two of the health authorities visited had revised their systems for approving extra-contractual referrals in order to reduce administrative costs without unduly restricting general practitioners' freedom to refer patients to the hospital they consider most appropriate. For example, Buckinghamshire Health Authority have established categories of treatment with low clinical priority which will only be approved if the need for treatment can be justified by the general practitioner in discussion with the public health physician. This has reduced the workload associated with extra-contractual referral approval.

4. The contracting process

4.1 The NHS Management Executive have made it clear that developing mature relations between hospitals and health authorities is important to effective contracting. This helps ensure that contracts are realistic and changes in services can be managed smoothly. They have also stressed the importance of involving people with more clinical knowledge of the services, hospital medical staff, nurses, other clinical professionals and general practitioners. This part of the report examines how health authorities and hospitals are meeting these requirements.

Relationships between health authorities and hospitals

4.2 Health authorities and hospitals have been encouraged by the NHS Management Executive to develop a continuous dialogue which encourages a high level of mutual understanding, in an atmosphere of creative tension rather than a cosy relationship which inhibits change.

4.3 Most of the health authorities and hospitals visited felt they had good relationships with the parties to their major contracts. Managers considered there to be an acceptable level of tension in relationships. Managers agreed that where communications are good, contract negotiations go more smoothly and problems which arise during the year are more easily resolved. The National Audit Office surveys of regions and trust monitoring outposts (Appendix 5) showed that they both felt that health authorities and hospitals were still mainly concerned with achieving their own distinct objectives rather than coming to a jointly beneficial agreement. Both groups surveyed considered that forming joint long term strategies and providing comprehensive and timely information as well as maintaining regular communications between chief executives, were most important in achieving good relationships.

Managing change through contracts

4.4 The NHS Management Executive expect health authorities and hospitals to set contracts at a realistic level for the number of patients requiring treatment and resources available and to manage changes in services smoothly and effectively. It is also important that the local community, on whose behalf health authorities are buying services, understand the reasons for change and can comment on proposals.

4.5 Health authorities were advised by the NHS Management Executive to continue existing patterns of service during the first year of contracting in order to minimise disruption to patient care. The pattern of contracting in the health authorities visited in Summer 1993 was largely historical, with health authorities having moved few contracts to alternative hospitals since 1991. In most health authorities visited their ability to manage change through contracts was constrained by the limited information available. Contract negotiations tended to focus on changes to the total price of the contract, and the preferred number of patient treatments which this should buy. There was little negotiation on other areas such as priorities for purchasing services, or the proportions of a service which should be day case rather than in-patient treatments.

4.6 Although the information received by the health authorities was limited, they were required to assess the performance of the hospitals with which they have contracts. The ultimate sanction open to a health authority where performance on a particular contract has not been satisfactory is the removal of that contract from that hospital.

4.7 Health authorities may also want to move contracts from one hospital to another for reasons such as, achieving better value for money, improving access for patients, responding to general practitioners referral patterns, or to support their local hospital. New River Health Authority moved contracts out of London in an attempt to support their local hospital but this met with resistance in some cases from patients and their general practitioners and led to an increase in extra-contractual referrals. Berkshire Health Purchasing Consortium have successfully moved several of their contracts to purchase more appropriate services, and decrease the price of the work. They considered that this was achieved by the willingness of local hospitals to co-operate and by having the support of general practitioners.

Involving hospital doctors and nurses

4.8 Hospital doctors and nurses need to be involved in contracting to make sure that the contract documents which managers sign are realistic from a clinical point of view. All hospitals visited were including doctors in planning and monitoring contracts. In most cases this was limited to the clinical directors. Only one hospital had included a doctor as a full member of the negotiating team. One limitation to progress is the need to train doctors in this new area of activity. The value of their involvement needs to be balanced against the demands this makes on their time, taking them away from direct patient care and the consequent increase in the cost of contracting.

4.9 The importance of involving doctors in contracting is illustrated in an example of contracting for cardiology services at the Royal Hull Hospitals Trust. The clinician was not involved in contract negotiation. There appeared to be a mismatch in the contract for angiograms (an x-ray examination of a blood vessel) and angioplasties (surgery to a blood vessel). His experience showed that one in every six or seven patients who have an angiogram would go on to have an angioplasty, whereas the contracted activity only allowed for one in every ten patients to have an angioplasty. A greater clinician involvement in the process of contracting would have alerted the hospital to this mismatch.

4.10 Since May 1993, there has been an explicit call for greater involvement of nurses in contracting. At the time of this study, it was too soon to draw any conclusions about the extent of nursing involvement.

Involving general practitioners and community health councils

4.11 An important aspect of the health authorities' contracting work is that of enabling general practitioners and the community at large to influence contracting decisions. Health authorities visited said that they were making efforts to consult local general practitioners and community health councils in a variety of ways to ensure their contracts met their wishes.

4.12 All 12 community health council respondents in the areas visited were generally satisfied with the level of consultation from the health authority on their purchasing intentions. Seven of the 12 community health councils stated that they were always consulted. All 12 found that some of their comments were taken on board by their health authorities. Health authorities appear to have adequate mechanisms for keeping the local community representatives informed of plans and progress.

4.13 The National Audit Office surveyed a random sample of general practices in the six family health services authorities covering the health authorities visited. The six areas used for the survey were City and East London, Enfield and Haringey, Leeds, Humberside, Buckinghamshire and Berkshire. The results are representative of the six areas. Technical details about the survey are shown in Appendix 4. Practices were asked whether their local health authority consulted them on their purchasing intentions with acute hospitals. While there was a marked variation across the six family health services authorities, 39 per cent of the respondents stated that their local health authority never consulted them

(Figure 5 opposite). Over 40 per cent of the respondents felt that some or all of their comments on their health authority's purchasing intentions, had been taken into account. But 25 per cent said that any comments they had made had not been taken into account and no reason had been given by their health authority (Figure 6 opposite).

4.14 In Buckinghamshire Family Health Services Authority, where only 15 per cent of general practice respondents said they had not been consulted (Figure 5), the local health authority have established local purchasing teams for each of the three local areas within their district. Each team visits the practices in their area every six months to discuss contracts issues and purchasing intentions. The health authority also have two general practitioners on the negotiation teams of each of their five main contracts, one fundholder and one non-fundholder. The inclusion of a general practitioner fundholder in the team has enabled the health authority to ensure they secure contract terms and conditions similar to those achieved by fundholding practices, for example, day surgery targets have been agreed for the 1993-94 contracts. In Berkshire Family Health Services Authority, where 22 per cent of respondents said they had not been consulted (Figure 5) the local health authority has staff who visit all general practices for informal lunchtime meetings. At each of these meetings the health authority staff go through the local health plan and discuss any procedures the health authority does not intend to purchase in the future. The health authority has also surveyed general practices' views on contracting and uses the Local Medical Committee newsletter to inform general practices of proposed contract changes.

4.15 When asked whether the contracts health authorities had made with acute hospitals were appropriate for their patients' needs, 26 per cent of all respondents considered that they were always appropriate. A further 61 per cent considered that they were sometimes appropriate for their patients' needs (Figure 7 on page 24).

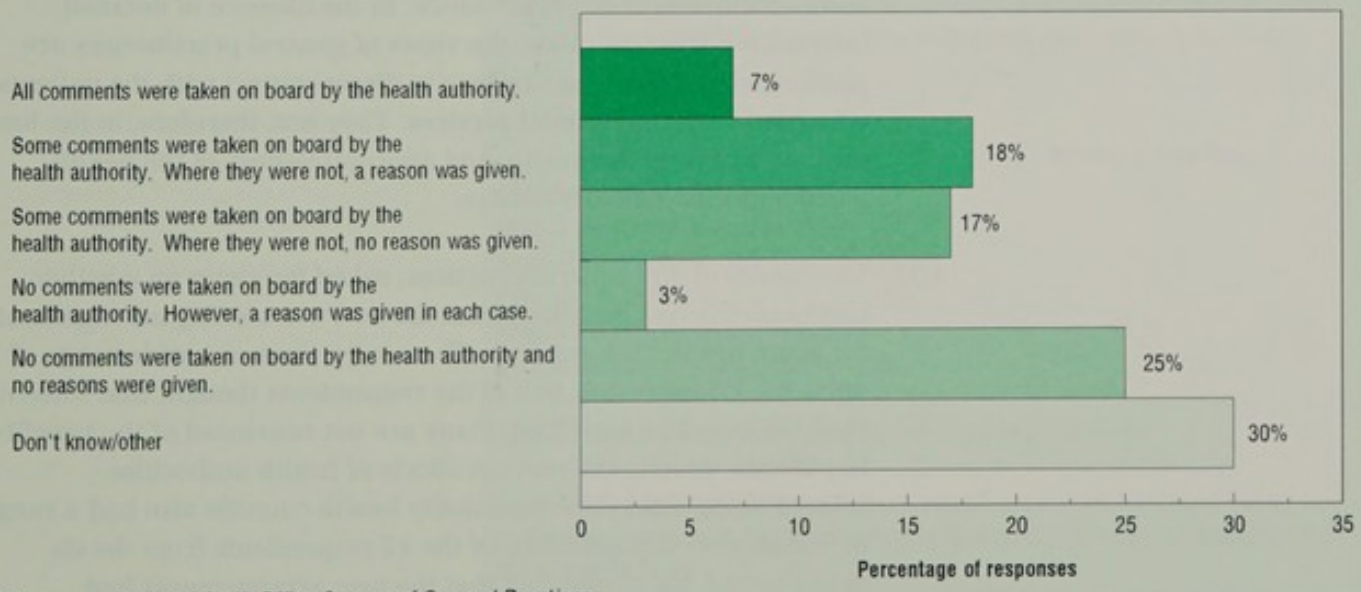
4.16 The NHS Management Executive have also encouraged health authorities to involve general practitioners and community health councils in monitoring how well hospitals meet the requirements of the contracts. The community health council role in monitoring hospital services is well established, and the community health council respondents were content with their role in the monitoring process, though they would have liked to have received more information from the health authorities' own monitoring activities.

Figure 5: General practices responses on whether they were consulted by their local health authority on purchasing intentions with acute hospitals

Source: National Audit Office Survey of General Practices.

Figure 5 shows that there was a marked variation in the level of consultation of general practices across the family health services authorities.

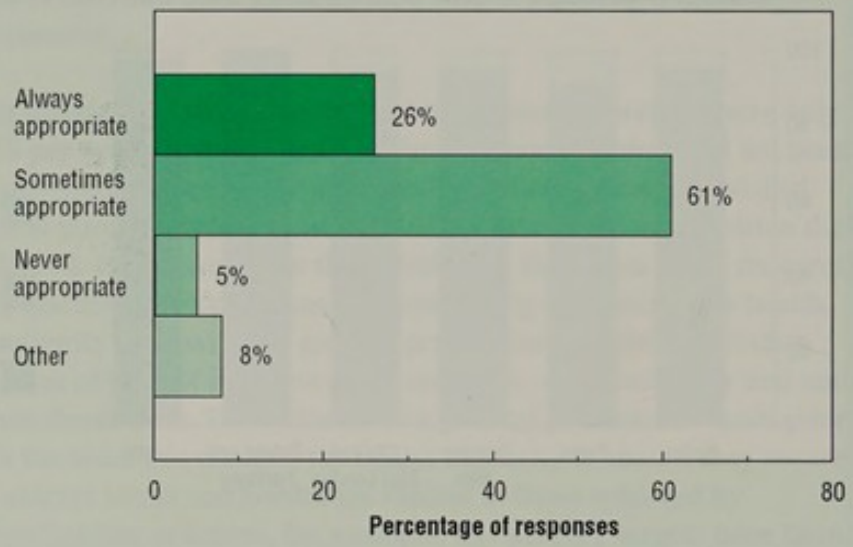
Figure 6: General practices' responses on whether their views on their local health authority's purchasing intentions were taken into account by their local health authority



Source: National Audit Office Survey of General Practices.

Figure 6 shows that while over 40 per cent of general practice respondents considered that all or some of their comments had been taken into account, a significant proportion considered that none had been.

Figure 7: General practitioners' views on whether their health authorities' contracts with acute hospitals were appropriate for their patient needs



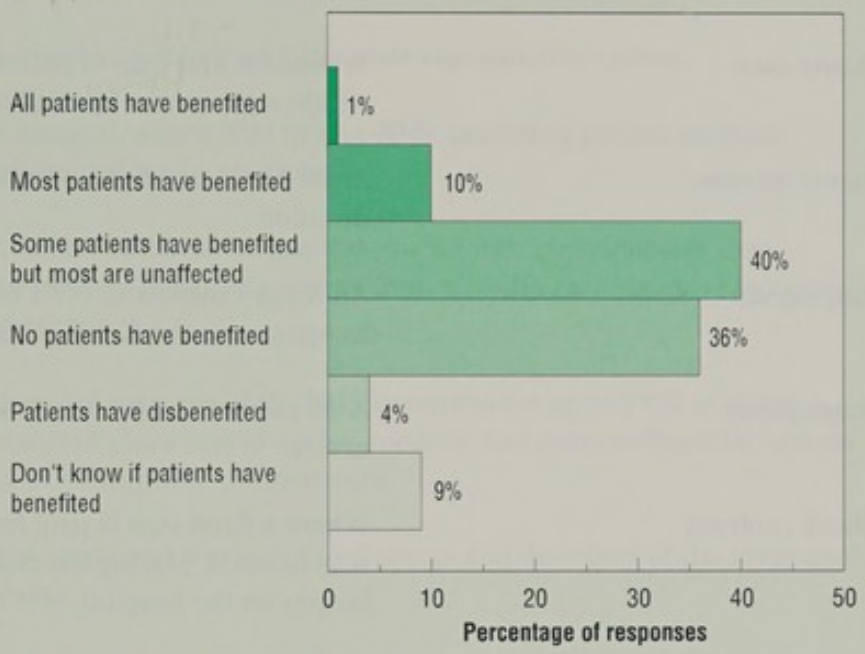
Source: National Audit Office Survey of General Practices.

Figure 7 shows that about a quarter of general practitioner respondents considered that acute contracts were always appropriate for their patients' needs and the majority considered that they were sometimes appropriate.

4.17 General practitioners are much less involved in monitoring hospitals' performance against health authority contracts, with only two of the six health authorities examined making efforts to obtain any information from general practitioners which would help them monitor the hospitals' performance. In the absence of detailed information from hospitals, the views of general practitioners are particularly valuable, as they are in direct contact with the patients who have received hospital services. They are, therefore, in the best position to assess the quality and appropriateness of the health treatment their patients receive.

4.18 The survey of 360 general practices, asked for views on whether their patients had benefited from the new contracting arrangements for acute health care services. The survey showed a wide range of opinions. Whilst nearly half of the respondents thought that some of their patients had benefited, many are not convinced of the benefits to patients, despite the current efforts of health authorities (Figure 8 opposite). The community health councils also had a range of opinions on this question. Of the 12 respondents from the six areas visited, six considered that the new arrangements had brought benefits to some of their local population (Figure 9 opposite).

Figure 8: General practitioners' view on whether their patients have benefited from the new contracting arrangments for acute health care



Source: National Audit Office Survey of General Practices.

Figure 8 shows that whilst about half of general practitioner respondents considered that the new contract arrangements had bought benefits to some of their patients, many are not convinced of the benefit to patients.

Figure 9: Community Health Councils' views on whether their local population have benefited from the new contracting arrangements for acute health care

	Number of responses
All of the population have benefited	0
Most of the population have benefited	1
Some of the population have benefited but most are unaffected	6
None of the population have benefited	3
Don't know if the population have benefited	2

Source: National Audit Office Survey of Community Health Councils.

Figure 9 shows that half of community health council respondents considered that the new contracting arrangements had brought benefits to some of their local population, the others had a range of views.

Glossary of terms

Acute care	Treatment and care of patients with acute diseases, usually provided within a general or specialist hospital setting.
Acute disease	A disease in which the attack is sudden, severe and of short duration.
Angiogram	An X-ray examination of a blood vessel using a dye which shows up as opaque on the X-ray picture.
Angioplasty	A surgical technique for restoring normal blood flow through an artery.
Block contract	Where a fixed sum is paid for access to a service for every patient who needs it, placing the risk associated with controlling demand largely on the hospital.
Casemix management system	An information system which shows the complexity of treatments given to patients.
Clinical director	A clinician who also has a management role in a clinical area.
Contract minimum data set	This specifies the information that a provider must send to a purchaser to support an invoice. It contains information on individual patients, the nature of their treatment and method of referral with each patient's treatment being uniquely identified by specifying the provider, purchaser and the unique serial number. The contract which covers each patient's treatment is identified.
Cost and volume contracts	Where cost is based on a specified number of cases.
Cost per case contract	Where cost is limited to the treatment of individual patients.
Extra-contractual referral	Referral of a patient to a hospital which does not have a pre-existing formal agreement with the patient's health authority.
General practitioner fundholder	Larger general medical practitioner practices that have taken the opportunity to manage a fund for purchasing a defined range of health services on behalf of their registered patients.

Healthcare Resource Groups	A basic mechanism for grouping all the range of patient diagnoses which may require treatment into a manageable number of groups which are both clinically similar and which are likely to use similar amounts of resources in treatment.
Prostate gland	A gland associated with the male reproductive system.
Provider	A hospital, either NHS or non-NHS, providing patient services contracted for by a purchaser.
Purchaser	A health authority or general practitioner buying health care services on behalf of patients from a health care provider by means of contracts.
Trust monitoring outposts	Regional outposts of the NHS Executive set up in 1992 to agree business plans and to advise, monitor and oversee financial aspects of trust hospitals' performance.
Urology	The study and treatment of diseases and disorders of the urogenital tract.

Appendix 1

Bodies visited and consulted by the National Audit Office

Table 1: Regional Health Authorities, District Health Authorities, Hospitals and Trust Monitoring Outposts visited by the National Audit Office

(a) North East Thames Regional Health Authority

Purchasers	Providers
East London and City Health Authority	Newham Healthcare
New River Health Authority	Royal London Hospital Trust
	North Middlesex Hospital Trust

* East Trust Monitoring Outpost

(b) Yorkshire Regional Health Authority

Purchasers	Providers
Leeds Healthcare	St James's University Hospital Trust
East Riding Health Authority	Royal Hull Hospitals Trust

North East Trust Monitoring Outpost

(c) Oxford Regional Health Authority

Purchasers	Providers
Buckinghamshire Health Authority	Milton Keynes General NHS Trust
+Berkshire Health Purchasing Consortium	Royal Berkshire and Battle Hospitals Trust

Midlands Trust Monitoring Outpost

Note: ** East Trust Monitoring Outpost is now known as North Thames Monitoring Outpost following reorganisation in 1993.*
+ Berkshire Health Purchasing Consortium was formed in April 1993 to replace the two health authorities of East and West Berkshire. They became Berkshire Health Authority in Autumn 1993.

Table 2: Bodies consulted by the National Audit Office

BUPA
Royal College of General Practitioners
NHS Trust Federation
Institute of Health Service Management
Healthcare Financial Management Association
National Association of Health Authorities and Trusts
British Medical Association
Leeds Family Health Services Authority
City and East London Family Health Services Authority
Berkshire Family Health Services Authority
Enfield and Haringey Family Health Services Authority
Humberside Family Health Services Authority
Buckinghamshire Family Health Services Authority
Netherlands National Ziekenhuisinstituut

Table 3: Professional advisers consulted by the National Audit Office

Mr Robert Dearden, Chair of Dearden Management who has a special interest in international health care delivery systems and corporate and organisation development.

Professor Christopher Ham, Director of the Health Services Management Centre of the University of Birmingham who is an expert commentator on health service management with a continuing interest in contracting for health services.

Appendix 2

Planned stages for progress in contracting

	Pre-reforms	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Calculating costs	Sophisticated costing systems not necessary. Hospitals had to apply realistic pricing policies. Basic financial principles had to be applied. Full cost recovery with no planned cross subsidisation. Marginal cost pricing was acceptable to use spare capacity.	National Steering Group on Costing established in February 1992 to standardise the costing approach for contract prices.	National Costing for Contracting project established in July 1992 to develop a standard methodology for costing.	First phase of National Steering Group on Costing guidance released in April 1993. Second phase of guidance, the development of comparative costs data based on HRGs, produced in July 1993.	Standardised costing methodology used in all contracts. Implementation of comparative costs data in one of three specialties at every acute hospital.	Every acute hospital to use methodology in one of three specialties to inform contracts. Implementation of comparative costs data for between three and 10 specialties in all acute hospitals.	Implementation of comparative costs data for all specialties in all acute hospitals.	
Treatment groupings	National Casemix Office established in 1990 to plan the development of Healthcare Resource Groups (HRGs), for grouping treatments for use in hospitals.		The first version of HRGs was released in May 1992 and was used for resource management purposes in a number of hospitals.	The second version of HRGs was released for consultation in November 1993. The National Casemix Office also developed standard contract categories, based upon HRGs, within specialties.	One of three nationally selected specialties to be costed using costed HRGs. The second version of HRGs to be officially released in August 1994.	One of three nationally selected specialties to have contract price based on costed HRGs. Three to 11 specialties to be costed using costed HRGs.	All specialties to be costed using costed HRGs. Three to 11 specialties to have contract prices based on costed HRGs.	All contracts to use prices based on costed HRGs for all specialties.
Contract types	The NHS Management Executive stated that for block contracts it should be feasible to specify the contract in terms of the number of inpatients - by specialty, the number of outpatients, A&E patients etc, and to specify prices accordingly.		Block contracts were appropriate to purchase local emergency services. More sophisticated contracts could be used for purchasing acute elective work.	There should be a move towards more sophisticated block contracts and towards cost and volume and cost per case contracts. Contract types should be appropriate to the service being purchased and consistent with the information available.	Last year of simple block contracts. No negotiation of such contracts for 1995-96. Contracts should include indicative volumes, and contracts and costs should be broken down to specialties. An increased use of rolling, longer and shorter term contracts. Special contracts, ECRs or cost per case contracts for specialised services.	No simple block contracts to be used without indicating the contract volume of services.		

The NHS Management Executive may subject the implementation and timing of plans to change, in response to continuing evaluation.

Appendix 3
Comparative data

Comparative data for contracting for acute services

1 The NHS Management Executive have stated that comparative cost data, including casemix and numbers of treatments, are essential to demonstrate the efficient use of public funds in contracting for acute health care, for public accountability and for health authorities and hospitals to assess relative efficiency.

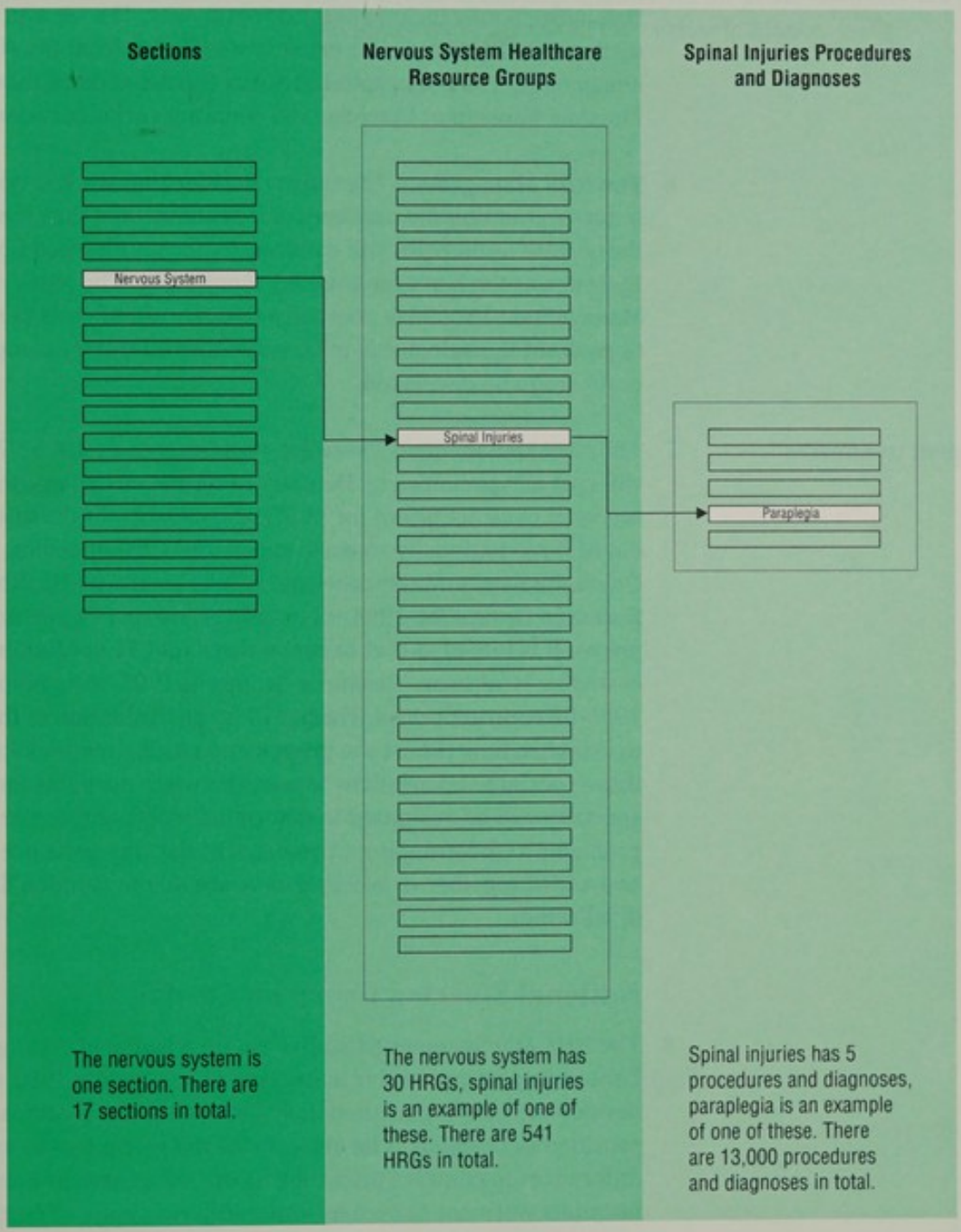
Grouping patient treatments

2 To help develop consistency in the way that the range of patient treatments are grouped into related types of treatments, the NHS Management Executive established the National Casemix Office in 1990. The office have developed Healthcare Resource Groups. These are a basic mechanism for grouping the range of patient diagnoses which may require treatment into a manageable number of groups which are both clinically similar and which are likely to use similar amounts of resources in treatment.

3 The first version of Healthcare Resource Groups was produced in May 1992 and was piloted in a number of hospitals in England. A second version for consultation was produced in November 1993. This version has 17 different sections, such as nervous system, respiratory system and cardiovascular system (Figure 10 opposite). Within each section, each Healthcare Resource Group is shown separately. There are 541 groups in total. The number varies from section to section. For example, the nervous system is broken down into 30 Healthcare Resource Groups, such as spinal injuries and epilepsy. Within each Healthcare Resource Group is the list of the diagnoses and procedures which are included. For an individual Healthcare Resource Group, there can be over 100 diagnoses and procedures included or fewer than five.

4 The second version of Healthcare Resource Groups is intended to be used to calculate the cost of each Healthcare Resource Group in all hospitals. This information can then be used when each hospital is contracting for acute health care. It can also allow health authorities to compare cost data.

Figure 10: The Healthcare Resource Group (HRG) Breakdown



Source: *National Audit Office.*

Figure 10 shows how healthcare resource groups are a mechanism for grouping all treatments for use in hospital. The example shows how the nervous system section is divided into 30 HRGs one of which is spinal injuries, comprising 5 procedures and diagnoses, of which one is paraplegia.

Finished Consultant Episodes

Measuring patient treatments

5 Workload within acute hospitals is currently measured in Finished Consultant Episodes, which may produce misleading information. One episode may include several treatments. The measure does not distinguish the complex or expensive episodes from the simple or cheap ones; a single hospital stay can consist of more than one Finished Consultant Episode, and counting varies between hospitals.

6 The NHS Management Executive consider that work is needed to improve counting the numbers of treatments and that it is unlikely that health authorities will continue to accept Finished Consultant Episodes as the basis for contract monitoring. The NHS Management Executive recognise that the use of costs per Finished Consultant Episode needs to be reconsidered if truly comparable costs are to be developed.

Costing patient treatments

7 The NHS Management Executive propose that by 1996-97, hospitals will cost all specialties by Healthcare Resource Groups, to help arrive at contract prices for 1997-98 contracts. In the interim two out of three nationally selected specialties (Orthopaedics, Ophthalmology and Gynaecology) will be costed by Healthcare Resource Groups for 1994-95 to help arrive at 1995-96 contract prices. It is intended that between three and 11 specialties will be costed by Healthcare Resource Groups in 1995-96 to help arrive at 1996-97 contract prices. There will be an evaluation of the first year to establish how robust the groups and costing methodology are for these specialties. Variations in costs between hospitals for this specialty will be evaluated to determine whether these are due to problems in the groupings, problems in the way costs are identified and added together or whether they are due to genuine differences in efficiency.

National Steering Group on Costing

8 The NHS Management Executive set up a National Costing for Contracting project under a Steering Group in July 1992 to further develop the existing methodology for costing the healthcare services provided in hospitals. The objective of the group was to ensure that differences in contract prices for health care services between hospitals were not caused by either differing ways of costing these services or inconsistent ways of defining the health care services being provided. The group have published guidance to hospitals. The first phase of guidance was published in April 1993. This established a minimum level of categorising each type of cost, (as either direct, indirect or overhead), for the method of apportioning indirect or overhead costs to direct cost areas, and for cost

classification (whether the cost of a service is fixed, semi-fixed or variable - dependent upon the numbers of patients being treated for a condition). The second phase was published in July 1993. Its purpose was to develop and extend for acute hospitals the principles and approaches set out in the earlier guidance.

Appendix 4

National Audit Office survey of general practices in the six family health services authorities covering the health authorities visited

Method of survey

The National Audit Office surveyed a random sample of general practices in the six family health services authorities covering the health authorities visited. The sample was designed so that 60 general practices were selected from each of the six family health services authorities. The general practices were selected by a random sampling method that gave a chance of selection proportional to the number of general practitioners at each practice. This meant that a general practice with four general practitioners had a chance of selection equal to four practices with one general practitioner at each. In Berkshire, the number of general practitioners at each general practice was not readily available. Therefore, the number of patients registered with each general practice was used as a proxy.

An examination of the original sample and the responses received was carried out to check whether the distribution of general practice size was altered by the non-response rate. This examination excluded Berkshire where the information was not readily available. This found that, although there was no large difference, there was a tendency for a greater response from the larger general practices - 68 per cent of the general practices who responded had more than two general practitioners compared to 62 per cent of the original sample. No particular differences in responses were identified between those who responded promptly and those who responded after a reminder. This homogeneity of immediate and deferred respondents provides some limited support for the hypothesis that non-respondents were not very different from respondents and so suggests that there may have been relatively little response bias in the survey results. The proportion of general practices which responded who were fundholding practices was 23 per cent.

The survey was designed and carried out by the National Audit Office.

Objective

The objective of the survey was to seek the views and experiences of general practitioner practices, around the areas visited, on aspects of the contracting process. The questions included, asked about general practices' experiences of how health authorities provided information to them and consulted them, and about general practices' views of how the contracting process had affected their patients. Whilst in preparation, the medical adviser at each of the family health services authorities, was invited to comment on the questionnaire. The Department and the Royal College of General Practitioners were also invited to comment on the questionnaire whilst in preparation and agreed to the carrying out of the survey.

Appendix 5

National Audit Office survey of Community Health Councils in the six health authorities visited and surveys of regional health authorities and trust monitoring outposts

Survey of community health councils in the six health authorities visited

Method of survey

The National Audit Office carried out a full postal survey of the 13 community health councils in the six areas visited. The questionnaire was addressed to the Chair of each community health council. A reminder was sent to those who did not initially reply. Of the 13, 12 returned the questionnaire completed and one replied by letter. The survey was designed and carried out by the National Audit Office. Two community health councils outside the areas visited, completed and commented on the survey whilst in preparation. The Department agreed to the carrying out of this survey.

Objective of survey

The objective of the survey was to seek the views and experiences of community health councils, on aspects of the contracting process. The questions included, asked about community health councils' experiences of how health authorities consulted them, and their views of how the contracting process had affected their local population.

Surveys of regional health authorities and trust monitoring outposts

Method of surveys

The National Audit Office carried out full postal surveys of the 11 regional health authorities and the three trust monitoring outposts not visited during the study. The questionnaire for regional health authorities was addressed to the Chief Executive in each case and the questionnaire for trust monitoring outposts was addressed to the Executive Director in each case. A reminder was sent to those who did not initially reply. All regional health authorities and trust monitoring outposts replied to the surveys. The surveys were designed and carried out by the National Audit Office. They were

based on questions already asked of those regional health authorities and trust monitoring outposts visited during the study. The Department agreed to the carrying out of these surveys.

Objective of the surveys

The objective of the survey of regional health authorities was to gather information on the contract types, contracting processes and use of arbitration for finalisation of contracts within each region. It was also designed to seek regional health authorities' views on the relationships between acute trusts and health authorities over acute service contracts.

The objective of the survey of trust monitoring outposts was to gather information on their financial monitoring of acute trusts, their examination of acute trusts' business planning and their involvement in arbitration for finalisation of acute contracts between acute trust hospitals and health authorities. It was also designed to seek trust monitoring outposts' views on the relationships between acute trusts and health authorities over acute service contracts.

Reports by the Comptroller and Auditor General Session 1994-95

The Comptroller and Auditor General has to date, in Session 1994-95, presented to the House of Commons the following reports under Section 9 of the National Audit Act, 1983:

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