HEALTH SERVICES MANAGEMENT

DEVELOPING CO-OPERATION BETWEEN PUBLIC AND PRIVATE HOSPITALS

A practical guide and handbook

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EDITORIAL NOTE

In 1984 the Trust, following a commission to Thornton Baker Associates, now Grant Thornton, Management Consultants, published the results of a study of competitive tendering in the provision of domestic, catering and laundry services, in the form of a Practical Guide and Handbook.

Subsequently, the Trust commissioned Grant Thornton to carry out a further study into the potential for co-operation between the public and private health sectors, in the clinical field of acute treatment and medical services.

In the event, the Trustees have decided to publish the report of this study in two parts, since in effect it conveniently divides between what might generally be called issues of policy, and observations which are suitable for a practical guide and handbook which deals with those practical questions concerned with the development of co-operation between public and private hospitals.

The first part is published in the Occasional Paper series of the Trust under the title *Health Services Management; Competition and Co-operation*, being concerned with policy. It deals with the nature of co-operation, the alternative ways of developing it, and certain changes which are required to maximise the effect of the resources available in each sector for the improvement of health services in general, and provides basic material for the discussion of long-term policy, an essential stage in policy-making to distinguish the myths from the facts and it is hoped help dispel many of the confusions which bedevil the public and private mix of health services.

This Handbook is designed as a practical guide for the co-operation desirable between public and private hospitals and it is hoped will be helpful to managers in both the public and private sectors.

Acknowledgement

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G.McL

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PREFACE

PREFACE

SUMMARY OF CONTENTS

The preface consists of two short introductory sections:

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THE STUDY BACKGROUND	Describes the aims of the study and the reporting arrangements.	3
SUMMARY OF THE HANDBOOK	Describes the key issues examined and summarises the contents of each part of the handbook.	4

PREFACE

THE STUDY BACKGROUND

THE STUDY AND ITS AIMS

1 The Nuffield Provincial Hospitals Trust has been involved for a number of years in research into the potential for co-operation between the U.K. public and private health care sectors. In 1982 the NPHT published a major study - The Public/Private Mix for Health, and then in 1983 commissioned Thornton Baker Associates, (now called Grant Thornton, Management Consultants) to prepare a Practical Guide and Handbook concerning competitive tendering in the provision of hospital domestic, catering and laundry services.

2 Since that time, the debate about the public/private sector for health has continued and in 1985 the Trust asked Grant Thornton to make a further study. The purpose of this second study was to consider co-operation between the public and private health sectors in relation to patient treatment and medical services.

3 The study takes as its base the present position in which two separate health sectors exist side by side, both with valuable resources and skills. The study explores the question of how the two sectors might operate a policy of co-operation as a means of obtaining best use of their resources in the overall provision of the country's health care. The study has concentrated on the acute sector but many of its conclusions will also be relevant in other aspects of health care.

THE STUDY REPORT AND HANDBOOK

4 The study began by reviewing the co-operative ventures which have already taken place between the two sectors, and discussing the general needs of such ventures with senior management. From these discussions the team prepared a series of guidelines, setting out the lessons to be learnt from the existing practice, and providing general suggestions for the way in which co-operative arrangements should be set up. These detailed results of the study are being published by the NPHT in this Practical Guide and Handbook.

5 However, it was clear to the team that there were a number of important and fundamental matters relating to the NHS and to the private sector where major change would be needed before a policy of co-operation could be operated at anything other than at a relatively low level. It was decided that the discussion of these more fundamental issues should be published by the Trust separately from this handbook in a report called **Competition and Co-operation - a way to improve health sector performance.**

PREFACE

SUMMARY OF THE HANDBOOK

INTRODUCTION

1 The handbook has been divided into four main parts. An appendix has been attached in which a number of brief case studies have been given of a sample of existing co-operative arrangements. A brief summary of each of the four parts of the handbook is given below.

PART I - THE NATURE OF CO-OPERATION BETWEEN THE TWO SECTORS

2 There are many reasons why management will buy and sell services. For example, it may be to reduce costs, it may be to earn extra revenue by selling surplus capacity, or it may be to obtain a specialist service. It is important to be clear on what these reasons are, as they will form the basis of co-operation between the two sectors. The first chapter of part I lists and discusses the main reasons why management buy and sell services and the situations in which they are likely to arise.

3 The remaining two chapters of part I deal with the types of contract which may be appropriate for co-operation between the health sectors. Particular importance is given to the way in which risk is allocated, as the form of contract in which all the risk falls on one party is likely to be less successful in co-operative arrangements than when some form of risk sharing takes place. In particular, the use of the joint venture form of contract is discussed in this context.

PART II - HOSPITAL MANAGEMENT CONTRACTS

4 One of the particular questions which has raised interest recently has been whether the management of an NHS hospital could be contracted to private sector management, and the extent to which treatment for individual NHS patients might be purchased from the private sector. These two matters are discussed in Part II of the report.

5 Contracting the management of an NHS hospital to a private sector management team would be one of the most far reaching forms of arrangement which could be set up between the two sectors. To do so for the private bed wing of an NHS hospital would clearly be a relatively straightforward step. To do so for a non paybed activity would pose problems of a quite different nature. However, it appears that it may be possible to structure a workable form of contract for private sector management to take over the management of a non-paybed NHS hospital and chapter 5 outlines a possible basis on which this might be done. The use of private sector management in managing an NHS hospital would be a major move in initiating a policy of increased competition in the NHS and of co-operation with the private sector.

6 The purchase of treatment for NHS patients in private hospitals is already being done to a limited extent. If developed further it could become an important source of co-operation between the two sectors. In chapter 6 the possible forms of contract for purchasing this treatment are considered, with particular reference to the differing roles which can be taken by the consultants.

PART III - THE SERVICES EXAMINED

7 In part III of the handbook, the team examines a number of medical services such as pathology and pharmacy with a view to assessing how co-operative arrangements might be made. Clearly, the team was not in a position to discuss the medical or technical aspects of these services, and the aim has been to consider a sample of those services which demonstrate particular management characteristics. X-ray services, for example, are characteristic of high capital cost services, with the management problems which those kinds of services pose. For each type of service the management characteristics are identified, the kinds of buying and selling relevant to those characteristics are described and, where possible, suggestions as to appropriate forms of contract are made.

PART IV - THE CASE STUDIES AND SUGGESTED BEST PRACTICE

8 As part of the study, the team collected a number of case studies where co-operative arrangements between the two sectors are in operation. A sample of these case studies has been attached in the appendix to the handbook.

9 In this final part of the report, an analysis of the case studies is made to identify the strong and weak points in them. That analysis is then used to outline a suggested "best practice" for health authorities to follow in investigating and setting up co-operative buying and selling arrangements.

10 The suggested approach is based on the concept of a commercial manager to be appointed by authorities. The title "commercial manager" has been selected to emphasise the commercial nature of the buying and selling aspects of co-operative arrangements. The commercial manager should work with a small support group providing the necessary medical and technical knowledge, and should take the lead in developing the authority's relationship with the private sector markets.

PART I

THE NATURE OF CO-OPERATION BETWEEN THE TWO SECTORS

PART I

THE NATURE OF CO-OPERATION BETWEEN THE TWO SECTORS

SUMMARY OF CONTENTS

Part I of the report describes why managements should be buying and selling services as a means of improving effectiveness, and considers the forms of contract which may be appropriate.

		Page
CHAPTER 1	**Reasons for buying and selling services**	9
	Describes the various reasons why management should consider buying and selling services in the short and long-term and gives examples of the reasons which may arise in relation to health care.	
CHAPTER 2	**Form and content of contracts for health care**	16
	Considers the way in which risk can be allocated in contracts and the effect on the provider and receiver of the services. Provides suggestions as to the kinds of contracts most likely to be effective in co-operation between the two sectors.	
CHAPTER 3	**Competitive tendering and in-house bids**	20
	Describes the use of competitive tendering and the need for in-house bids to be obtained in certain situations.	

PART I

CHAPTER 1

THE REASONS FOR BUYING AND SELLING SERVICES

INTRODUCTION

1 Co-operation between the private and public health sectors may take many forms. It may take the form of long-term planning and strategic arrangements in a given region, or it may take the form of ad-hoc arrangements to meet a particular short-term need. But whatever form co-operation takes it is important to remember that fundamentally it simply means the buying and selling of services between the two sectors.

2 In all buying and selling arrangements, the buyer will want to be convinced that in buying the service specific benefits are being purchased which will enable the buyer's aims to be met; similarly, the seller has to be certain that the service is being sold for the right price and that adequate revenue is being received.

3 Even though the NHS as the public health sector has broad aims unconnected with commercial profit, these general principles of buying and selling will form the basis of its co-operation with the private sector. Similarly, except in the case of purely religious organisations, there is no sense in which the private sector will be able to seek co-operation other than on terms which are commercially viable.

The reasons for buying and selling services

4 The buying and selling of services is a normal feature of the management of many different activities in an organisation. In each case, the service is bought or sold by managers as a means of managing their departments effectively and efficiently.

5 The main reasons why managers enter into buying and selling arrangements are described in the following sections of this chapter under the headings of:

(1) Buying services - short-term
- long-term

(2) Selling services - short-term
- long-term

BUYING IN SERVICES - SHORT-TERM

6 The main reasons why managers in both public and private sector hospitals will buy in services on a short-term basis are:

(1) **To meet short-term peak demands:** Organisations rarely have adequate resources to meet short-term peak work-loads and normal practice is to buy in services to meet peak demand. In the health sector, buying in beds or treatment to deal with a short-term crisis, or with short-term waiting lists are examples of purchasing to meet peak demand.

Decision level: operational management
Comparative cost data: not applicable
In-house tender: not applicable

(2) **To increase limiting factor capacity:** An important function of management is to obtain maximum throughput for a given resource level. In trying to achieve maximum throughput it is often found that there is one particular resource which is limited in capacity and which restricts overall throughput. The short-term buying in of extra capacity for that particular resource can enable total throughput through all resources to be maximised until such time as the resource can be acquired permanently. An example of this in the health sector might be the short-term purchase of additional beds in a neighbouring unit, to enable operating theatre time to be maximised.

Decision level: operational management
Comparative cost data: not applicable
In-house tender: not applicable

(3) **To provide continuity of service:** It is normal practice to buy in services to provide short-term cover for staff shortages, break down of equipment, and repairs and maintenance. In the health sector, examples are the use of agency nurses, and the use of another hospital's services during repairs.

Decision level: operational manager
Comparative cost data: not applicable
In-house tender: not applicable

(4) **To obtain specialist skills:** Instances arise when an unforeseen need arises for a special skill, service or equipment, which is not provided in-house. The only source is an outside supplier and the skill or service has to be purchased on a one off or short-term basis. Examples in the health sector might be the use of an unusual requirement for certain pathology tests.

Decision level: operational managers
Comparative cost data: not applicable
In-house tender: not applicable

(5) **To react to opportunities:** There is an element in all successful management of being able to react quickly to opportunities when they arise. Opportunities may arise unexpectedly to purchase a service, for a short period, at low cost and managers need to be able to take advantage of such positions. For example, a NHS hospital might well be able to purchase bed vacancies at marginal cost which have become available at short notice in a private hospital.

Decision level: operational managers
Comparative cost data: not applicable
In-house tender: not applicable

7 In conclusion, it is important to appreciate that when buying in services on a short-term basis, cost is generally not the main consideration. In most cases, the main reason for buying in the service is operational need (for example to provide cover during repairs to an existing resource, or to meet a crisis), or to achieve the aims of the organisation (for example to reduce waiting lists). Although cost is clearly a factor to be considered in purchasing services on a short-term basis, the aim of buying such services is generally operational, and is not to save costs.

BUYING IN SERVICES - LONG-TERM

8 The buying in of services on a long-term basis requires a very different decision making process from that involved in short-term buying activities. Buying a service on a long-term basis may require strategic decisions to be made, and will need to be related to long-term planning and policy arrangements. The decision will place far more emphasis on costs, both revenue and capital, and cost may often be the main reason for long-term buying decisions. For all these reasons, long-term buying decisions will generally be taken at top management level.

9 The main situations in which long-term buy in decisions will be taken are described in the following list:

(1) **To reduce operating costs:** A service can be purchased on a long-term basis solely to reduce operating cost. An outside supplier may be able to provide a service on a long-term basis at a lower cost than an in-house department for a number of reasons such as staffing management, throughput, and market conditions. The NHS is already familiar with this form of purchasing for laundry, cleaning and catering. It requires careful cost analysis and may well involve competitive tendering by an existing in-house department. Examples, relating to medical services, would be the buying in of all or part of pathology or pharmaceutical services.

Decision level: middle/senior management
Comparative cost data: revenue: required in detail
capital: probably also required
In-house tender: essential

(2) **To reduce the need for capital investment:** For those services which require high capital investment, there may well be advantages in purchasing the service from an outside supplier on a long-term basis. In these cases, the supplier provides the initial capital and this allows the purchaser to use their own capital for other possible more urgent uses. It may for example be relatively easy for an outside supplier to raise capital for a marketable activity such as laundry, which would allow a hospital's own capital resources to be allocated to medical activities. Examples in the health sector would be kidney dialysis units, and CT scanner equipment. Long-term purchasing of this kind may often involve a "trade off" between capital and revenue spending and this involves advanced project and cost evaluation techniques.

Decision level: senior management
Comparative cost data: revenue: detailed cost study
capital: detailed cost study
In-house tender: essential

(3) **To reduce risk:** Investment in resources involves any organisation in risk. This is more easily seen in the case of a private sector organisation where lack of success of investment in a particular activity will put profit at risk, but it also applies in the public sector where the results of the introduction of a new trial service are uncertain. In risk situations it may well be wiser for the initiating organisation to buy in the service, in order to minimise its own exposure to loss of capital investment or excess revenue cost. Examples in the health sector relate to investment in new methods of health care such as the use of screening and HMO's.

Decision level: senior management
Comparative cost data: revenue: detailed cost study
capital: detailed cost study
In-house tender: probably not applicable

(4) **To acquire management expertise:** Organisations may well buy in a service or a skill in order to obtain the management expertise that goes with that service. This may be done because the organisation's own management is weak, but it is frequently done by strong management groups which recognise that they need particular management skills or a specialist expertise which they do not have. Examples in the health sector are management only contracts relating to hotel services, and contracts to manage an entire hospital. Contracts to purchase management will take many different forms and

are discussed elsewhere in this report. They may frequently involve an element of joint venture and sharing of financial savings.

Decision level: senior management
Comparative cost data: not applicable
In-house tender: not applicable

(5) **To acquire a specialist service:** Organisations may decide to buy in on a long-term basis specialist services. Such services may be highly technical services for which the organisation has a regular demand, but not at a frequency which justifies setting up the service in-house. (The use of a mobile CT scanner would be an example).

Decision level: middle management
Comparative cost data: revenue: depending on throughput may capital: not be critical to the decision
In-house tender: probably not required

(6) **To implement a policy decision:** Organisations may adopt as a formal policy a decision themselves not to operate in a given activity. Policies of this kind may relate to commercial or, in the case of the public sector, social reasons, and they may be implemented either by not operating at all in the activity concerned or by always buying in the service required. In the health sector, the care of the elderly is a policy matter which may well fall within this category.

Decision level: top management
Comparative cost data: not applicable
In-house tender: not applicable

10 In conclusion, the buying in of services on a long-term basis involves very different considerations than short-term buying. It nearly always involves policy matters and this requires decisions to be taken by top management. Cost considerations are invariably an important factor in reaching a decision, and those considerations will often require both capital and revenue to be taken into account. This means that the decision to proceed has to be taken by the level of management which controls capital spending as well as management controlling revenue spending and that is a further reason why senior management has to be involved in the decision making process. In the NHS, the need to consider capital spending considerations will tend to involve regional as well as district management.

SELLING SERVICES - SHORT-TERM

11 In the same way that management needs to be able to buy in services on a short-term basis to optimise the effectiveness of a department, it also needs to be able to sell the services of that department to outside users on a short-term basis. It needs to be able to sell such things as short

term spare capacity in the department in order to generate revenue and reduce overall operating costs. Selling services on a short-term basis is not to be confused with selling on a long-term basis which arises from specific policy decisions to enter a market on a permanent footing.

12 The two main situations in which short-term selling of this kind can be appropriate are:

(1) **To use short-term spare capacity:** In most organisation spare capacity will arise from time to time. To be effective, management needs to fill that spare capacity either with productive work from within the organisation, or by selling that capacity to an external user. An example in the health sector would be the selling of surplus laboratory capacity to private industry.

Decision level:	operating management
Profit criteria:	sufficient to ensure that revenue exceeds direct costs.

(2) **To use ad-hoc opportunities to earn revenue:** In working to achieve effective and efficient operations management needs constantly to be alert to the possibilities of earning additional revenue from unforeseen situations which arise from time to time in the general market place. A manager may hear for example that a particular need has arisen locally, which he sees his department could satisfy, and earn surplus revenue for his organisation. Provided they do not detract from the main work of the department, such entrepreneurial activities can be effective in reducing operating costs.

Decision level:	operational management
Profit criteria:	to ensure that revenue exceeds direct costs

SELLING SERVICES - LONG-TERM

13 The selling of services on a long-term basis will normally require both capital and revenue considerations to be taken into account, and will be based on policy decisions. It is normally a matter on which senior management have to make the decisions.

14 Examples of long-term selling arrangements are given in the following list:

(1) **To sell surplus assets:** Assets may become surplus to requirements. If they are permanently surplus, then a decision to make an outright sale should be taken. If however, it is seen that the asset may well be needed again in the future, then renting or leasing will be appropriate. In any event, the essential point is that assets surplus to immediate needs are not left idle, but are used to earn revenue. Examples in the health sector are redundant hospital buildings or major items of medical equipment.

Decisions level:	senior management
Cost data:	asset values
Profit criteria:	not applicable

(2) **To make optimum use of major assets:** Situations will arise in which a particular facility is required by an organisation which requires substantial investment, but which will not be used on a full time basis. The sharing or selling of the spare capacity of the facility on a permanat basis is excellent management, and can be used to reduce the costs of the facility. In the health sector, this approach is applicable to the purchase of large and costly items of equipment and possibly also buildings.

Decision level:	senior management
Cost data:	detailed capital and revenue data to calculate viability and calculation of selling prices
Profit criteria:	full commercial basis

(3) **To develop permanent business ventures:** Organisations may acquire facilities with the specific objective of entering a market and selling them for a profit. This is quite a different matter from the selling of surplus capacity of assets acquired for the normal activities of the organisation in the way described so far in this chapter. The development of business ventures requires market study financial evaluation and implementation on a commercial basis. The NHS is engaged in business ventures of this kind, through its provision of private beds and the selling of services. It will be appreciated that when engaged in business ventures of this kind, there is no element of co-operation between the public and private health sectors as they may well be in competition.

Decision level:	senior management to make policy decisions to enter a market sector
Cost data:	full commercial and financial evaluation
Profit criteria:	full commercial basis

PART I

CHAPTER 2

FORM AND CONTENT OF CONTRACTS FOR HEALTH CARE SERVICES

INTRODUCTION

1 The public sector has been accustomed to contracting for work from private companies for many years. Recently, however, there has been useful thinking about the form such contracts should take following government initiatives to encourage the use of private contractors in local authority, health services and government generally.

2 All business contracts provide a certain degree of "risk" to both parties entering into the arrangement. This element of risk will also be present in contracts for the provision of services between the public and private health sectors. It is important to understand that in this context the word "risk" is being used in its technical commercial sense to cover both a downside and an upside risk, and does not just mean risk in the negative sense of the word (i.e. risk of making a loss on the contract). For example, a supplier with a fixed price contract for say £10,000 might expect a profit of £1,000 on which there might be an upside risk that by good management the profit could be increased to £1,300, with a downside risk that extra work would have to be done to meet the contract which would reduce the profit to £800.

3 Depending on the form of the contract, the risk can be made to fall either on the provider, or on the receiver. Contracts can also be structured so that the element of risk is shared on some agreed basis between both parties.

4 The way in which risk is dealt with is important in the provision of service contracts in the health sector as it concerns the effectiveness and efficiency with which the contract is fulfilled. The greater the extent to which the risk falls to the provider of the service, the greater the incentive to provide a low cost and efficient service even reaching to a point when the incentive becomes such that the provider will "cut corners" and produce a service which is below standard. On the other hand, the greater the extent to which the risk lies with the receiver of the service, the less the incentive to the provider to be efficient, with in the extreme the receiver of the service paying for all the inefficiencies in the provider's operation.

5 The balancing of risk in health service contracts is thus an important factor in arriving at successful buying and selling arrangements between the public and private sectors. Listed below are some of the main forms of contract, which are discussed in the remainder of this chapter with a description in each case of the relevant risk pattern:

(1) Purchaser's risk contracts
(2) Seller's risk contracts

(3) Risk sharing contracts
(4) Joint venture contracts
(5) Franchise arrangements

PURCHASER'S RISK CONTRACTS

6 Contracts can be structured on the basis that the risk falls entirely or almost entirely on the receiver of the service. The contracts known as "cost plus" contracts tend to be of this category. In cost plus contracts, the purchaser agrees to pay for all the costs of a particular piece of work, plus a percentage for overhead and profit. This type of contract means that the purchaser pays for all the inefficiencies and waste incurred by the provider of the service who bears no downside risk at all. In the health sector, such contracts would tend to take the form of a service charge based on time, such as an hourly rate, or in the case of treatment, charges based on an item by item basis.

7 Contracts in which all the risk falls on the purchaser should generally be avoided; they tend to increase costs and provide no incentive to improve efficiency.

SELLER'S RISK CONTRACTS

8 Contracts can be structured so that the main element of risk falls on the seller of the service. In the extreme case, such contracts are fixed price with no recourse for cost increases caused by variations in the mix or unforseen problems. An example of such a contract in the health sector would be contracts to provide hip replacement surgery, which were on the basis of an "all in" fixed price. In this case the provider of the surgery bears the risk of extra cost of the difficult cases where post operative problems arise and long stay becomes necessary.

9 Seller's risk contracts provide considerable incentive on the seller to improve efficiency and reduce costs. In general terms, they are for that reason normally preferable to the purchaser's risk form of contract. In the health sector, however, the incentive pressure of such contracts could be taken too far and could result in the providers of health care being forced to reduce the quality of care in order to make a particular contract profitable.

RISK SHARING CONTRACTS

10 The risk sharing form of contract is an attempt to overcome the deficiencies of purchaser's risk and seller's risk contracts while still providing incentives to improve efficiency. The aim is to see that quality of service is not threatened and that both parties to the contract are concerned in the outcome of the contract with both benefiting or losing, rather than one party only bearing the total cost.

11 Risk sharing contracts can be structured in many different ways, but one useful way is to base them on the fixed price form of contract, (in which

the risk falls mainly on the seller) but to put some limits on the risk in the form of maxima and minima to the contract. For example, again in relation to a contract for hip replacement, the contract might be structured on the basis of a fixed price for a number of operations over a period of time, but with a maximum and minimum number of days stay. In that way, the provider of the service would not be bearing the risk of exceptionally difficult cases, but would have the incentive to reduce normal operational costs.

12 In health care work, where quality of service is of such critical importance the risk sharing form of contract is generally likely to be the most effective approach.

JOINT VENTURE CONTRACTS

13 The joint venture form of contract is the ultimate form of risk sharing contract. In a joint venture contract, both parties are agreeing to pool resources, costs and revenues, and to share profits and losses on an agreed basis. Risk is shared between the parties, although not necessarily on an equal basis.

14 Two types of joint venture can be identified as being appropriate in the health sector:

(1) **Business joint ventures:** When the NHS is involved in a business venture, such as the provision of private beds, then it is possible to see that it could enter into a joint venture with a private hospital in the normal commercial sense of the word; for example, a private wing of an NHS hospital might be operated on a joint venture basis. The NHS might put the premises into the joint venture, with the private hospital company providing capital for refurbishment. Separate accounts would be prepared for the venture, and profit and losses shared on an agreed basis.

(2) **Non-business joint ventures:** The NHS is essentially engaged in not for profit activities in which the business form of joint venture with the private sector would not be apropriate. However it is possible to devise non-business forms of joint venture in which costs and benefits of a project are shared, but in which there is no annual sharing of profit or loss. For example, an NHS and a local private hospital might have use for a major piece of equipment. They might agree to contribute to the capital cost of the equipment and to share in operating costs in accordance with their actual usage. This would be a joint venture between the parties, but there would be no element of profit sharing.

15 Different forms of contract would be required for these two types of joint venture, and in the case of the business form of joint venture it might well be appropriate to create a separate legal entity in which both parties would hold shares in proportion to the way in which profits and losses were to be shared. In both cases, however, there are a number of

elements which would have to be included in any joint venture arrangement. The main ones are:

(1) A statement of the resources each party was to put into the joint venture (such as cash, physical assets, and operational resources and who would retain ownership of them).

(2) A statement of the way in which running costs are to be calculated and included in the joint venture.

(3) A statement of the way in which revenue is to be calculated and included.

(4) An agreement as to the form of the periodic accounts which will have to be prepared and any verification procedures.

(5) An agreement as to the way in which profits and losses are to be calculated and shared.

(6) An agreement as to when and how the joint venture is to be wound up, and how its assets and liabilities would be shared at that time.

FRANCHISE CONTRACTS

16 The form of contract known as a franchise is an interesting form of contract which has not been used in the health care sector, but which may well be worth consideration in the future.

17 In a franchise contract, the owner of a facility (franchisor) allows an operator (franchisee) to make use of that facility, usually in return for payment. Decisions regarding the way the facility is used, and the profits and losses arising from it are left to the franchisee, possibly subject to broad limitations imposed by the franchisor.

18 Franchise operations have often been used in the catering industry, where an example might be for a hospital to grant a franchise to a catering contractor to provide staff meals. In this case, the franchise might be on the basis that the operator provided whatever meal, service and price structure found to be profitable, subject only to the requirement to provide a service at certain hours, and to provide one meal a day at the fixed price agreed in the staff council negotiations. Franchise arrangements are thus highly flexible, but can be controlled in broad terms by the franchisor. They give the franchisee maximum freedom to provide an efficient service which meets the demands placed upon it.

19 At this time, although franchise operations are used in many fields, such as catering and public transport, no use appears to have been made of it in relation to health care. It appears, however, that it is an approach which might well be explored further, and might have considerable potential in many of the newer forms of health care which are being discussed. Health screening is perhaps an example of where a franchise activity might be appropriate.

PART I

CHAPTER 3

COMPETITIVE TENDERING AND IN-HOUSE BIDS

INTRODUCTION

1 The concept of competitive tendering is, of course, familiar to the public and private sectors generally. Competitive bids are sought from suppliers for a particular service or product, bids are opened using formal procedures designed to be fair to all bidders, and the lowest bidder is awarded the contract.

2 In recent years, the concept of competitive tendering has been expanded so that a competitive bid is also put forward by the in-house department which is already providing the service for consideration with the bids received from external suppliers. The procedures and practices to be adopted in preparing the in-house bids and making the comparisons with external bidders are fully dealt with in the previous Nuffield report Health Services Management - competitive tendering for laundry cleaning and catering and will not be repeated here.

3 However, it is necessary to consider the use of competitive tendering, in relation to the clinical and other services which are the subject of this report and particularly regarding the need to incorporate an in-house bid into the process.

THE NEED FOR IN-HOUSE BIDS

4 In nearly all cases where a service is being purchased, it will be wise to obtain competitive tenders from a range of suppliers. (Within the NHS, a supplier can, of course, be another region, district or unit). But, there are many cases when it will not be appropriate to obtain a competitive bid from an in-house department. This may be because there is no in-house department available or because the reasons for bringing in the service are such that an in-house bid is not applicable.

5 In a previous chapter (The nature of co-operation between the two sectors) a list was given of the main reasons why services are purchased, and in each case the need for an in-house tender was noted.

6 That list is summarised below.

	Purchasing reason	In-house tender
Short-Term		
(1)	To meet short-term peak demand	- not applicable

(2)	To increase limiting factor capacity	- not applicable
(3)	To provide continuity of service	- not applicable
(4)	To obtain specialist skills	- not applicable
(5)	To react to opportunities	- not applicable

Long-Term

(1)	To reduce operating costs	- essential
(2)	To reduce need for capital investment	- may be required
(3)	To reduce risk	- probably not required
(4)	To acquire management expertise	- not applicable
(5)	To acquire a specialist service	- may be required

7 It is clear from the above list that the main buying situations when in-house tenders are required is where the aim is to obtain a permanent reduction in operating cost through the use of new techniques, and new working practices, and possible lower staff numbers.

8 However, for all other situations where buying in of services can be useful, particularly those where there is a short-term need, there may be no need for an in-house bid, as there is no question of trying to achieve permanent savings in costs and staff. In many cases where there is a short-term need to purchase a service, an in-house bid is simply not applicable as there is no existing in-house capacity. It is important for this point to be appreciated by staff as there may well be a tendency for the purchase of all services from outside contractors for, whatever reason, to be seen as a threat to job security.

PART II

CONTRACTS FOR HOSPITAL MANAGEMENT AND PATIENT TREATMENT

PART II

CONTRACTS FOR HOSPITAL MANAGEMENT AND PATIENT TREATMENT

SUMMARY OF CONTENTS

The purpose of Part II of the report is to discuss the practicality of contracting the management of a hospital to an outside management team and to consider the various forms of contract which might be used. It also deals with the way in which contracts for patient treatment might be awarded to private hospitals by health authorities.

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	Discusses the various bases on which management contracts for NHS pay beds might be structured.	
CHAPTER 5	**Hospital management contracts - NHS beds**	29
	Discusses the various bases on which management contracts for NHS hospitals might be structured.	
CHAPTER 6	**NHS purchase of beds and treatment**	33
	Discusses the ways in which the NHS might purchase treatment for NHS patients in private hospitals.	

PART II

CHAPTER 4

HOSPITAL MANAGEMENT CONTRACTS - PAY BEDS

INTRODUCTION

1 The purchase from the private sector by the NHS of many different kinds of service has been discussed in this report. In all these cases, the overall management of the hospital has remained as at present with NHS employed staff. The question has, however, also been raised as to whether it would be useful for the NHS to move a step further and buy in the management of a hospital from the private sector. This would, clearly, be a major new development and a discussion of it has been allocated to this chapter, in which management contracts for pay bed activity are considered, and to the following chapter which deal with management contracts for NHS beds.

SEGREGATION OF PRIVATE BED ACTIVITIES

2 In the report of the study referred to in the preface and published separately from this handbook the point was made that to control NHS private bed activities effectively it would be advisable for each health authority to segregate its pay beds as a separate business activity. It is only by doing this that it will be possible to identify the assets and resources being used by pay beds, give management financial targets, and ensure that the activity is earning maximum net revenue for the NHS. The suggestion was also made that consideration should be given to putting the activity into a separate division, charitable trust or subsidiary company owned by the NHS. In any event, the segregration of the activity by this or other means would be essential if the management of it was to be contracted out on a clearly defined basis to a private sector operator.

3 A number of steps would have to be taken to achieve this segregation and these could be taken prior to, or as part of, the process of contracting the management out to the private sector:

(1) The assets used full-time by the pay bed activity would have to be identified and valued.

(2) Some physical regrouping of pay beds into separate premises or wings might well be required to enable a specific physically identifiable pay bed unit to be created.

(3) The arrangements for using NHS services and staff on the pay bed activity would have to be formalised; in particular the financial charges to be made to the pay bed activity would have to be calculated on a commercial basis.

(4) The financial operating targets and accounting arrangements on a normal commercial basis would have to be agreed, and set up.

(5) The position of the consultants vis-a-vis the new pay bed activity would have to be confirmed as being similar to their present relationship with a private hospital.

(6) A decision would have to be taken and implemented regarding the creation of a separate subsidiary company, operating division or trust within which to operate the pay bed activity.

4 The final step in this process would be a decision whether to appoint NHS employees as the management team of the pay bed subsidiary or whether to contract out the management to a private sector operator. Some of the main different forms in which an arrangement with private sector management could be structured are considered in the following paragraphs.

FIXED FEE MANAGEMENT CONTRACTS

5 In the previous chapter of this report, the question of risk in relation to contracts was discussed, with particular reference to who should bear the risk. Risk, it will be remembered, was defined as including both a "downside" and an "upside" risk, (i.e. meaning that the person carrying the risk could fare worse or better than predicted). The point was also made that in setting up a contract it is important to be clear where the risk lies as it may have an important effect on contract performance.

6 A fixed fee management contract for an NHS pay bed unit might be structured on the basis that the private sector operator would provide a senior management team, and possibly other staff, together with the necessary management and administration systems and procedures. Their contract would be to manage the pay bed activity according to the specific policy and instructions given to them by the authority.

7 In a fixed fee contract of this nature, the total risk would be carried by the health authority which would take the financial surpluses which arose and which would bear all losses arising from the pay bed activity. The private sector management team would be unaffected by the commercial results of the activity and would receive their fixed fee in any event.

8 Fixed fee contracts of this kind are relatively simple to set up, and to operate, but quite clearly, they would provide no incentive for the private sector management to improve the performance of the pay bed unit and earn maximum net revenue for the NHS.

MODIFIED FIXED FEE MANAGEMENT CONTRACTS

9 In order to overcome the shortcomings of a fixed fee contract, and provid the outside contractor with an incentive to perform effectively it may be possible to modify a fixed fee contract. This could be done by building into the contract penalties or bonuses depending on performance. In this way, the risk element would be to some extent shared.

10 For example, a contract might provide for the annual management fee to be dependant on achieving certain quantified results. Cost and revenue

targets could be set for which under or over performance could be penalised or rewarded in the annual management fee by for example sharing cost savings or by sharing the overall profitability of the contract. Such targets might take the form of:

(1) Unit cost targets
(2) Savings in procurement costs
(3) Bed utilisation
(4) Gross revenue

11 At first sight, modified fixed fee contracts appear to be an attractive approach; they go some way to sharing risk and rewarding performance, while leaving all policy decisions with the health authority. In practice, however, difficulties may arise from two sources. First, to be effective, the performance targets on which the management fee will be based would have to be calculated with great precision, and this necessarily has to be done in advance. Relatively small inaccuracies in calculating these targets can have a substantial effect on the contractor's performance and on the management fee. More importantly, however, the operation of a management fee based on targets could cause dispute between the outside management and the health authority relating to policy. This is because the adoption of, or changes to, certain policies may have an important effect on management's ability to achieve its targets and hence its management fee.

12 On balance, therefore, it is considered that although there may well be a place for modified fixed fee contracts, they will require careful structuring, and should not be such that the amount of the management fee is too dependent on the achievement of predetermined targets.

JOINT VENTURE MANAGEMENT CONTRACTS

13 The joint venture form of arrangement should also be considered in connection with management contracts for pay bed activities. The purposes of the joint venture arrangement would be to align the aims of both the health authority and the private hospital management and to share surpluses or deficits equitably. The joint venture arrangement is perhaps particularly appropriate where the venture is a commercial one aimed at generating surpluses, as would be the case with a pay bed activity.

14 A joint venture arrangement for pay beds might take a number of different forms. An example, of a suitable arrangement would be as follows:

(1) The pay bed activity of the authority concerned would be segregated from other activities in the way already described and the relevant assets would be identified and valued.

(2) A separate company or trust would be set up to hold the pay bed assets and liabilities and to carry out the pay bed activity. Normal commercial accounting arrangements would apply, including depreciation accounting.

(3) Additional finance needed to bring the assets up to the required standard, and to provide working capital could be obtained from a commercial bank, or from the proposed partner in the joint venture.

(4) The management of the joint venture company would be employees of the new company or the trust; initially they could be provided on secondment from the private sector partner in the venture if particular expertise and skills were required.

(5) The ownership of the new company would be held by the health authority concerned, and by the private sector partner. The shares would be held in proportion to the way in which it was proposed that profits and losses were to be shared. Shareholding would also be affected by the proportion in which the two parties had supplied the assets and finance. The health authority could retain overall control if that were required. If a trust were the structure selected, similar arrangements could be devised.

(6) The joint venture company or trust would be controlled by a board or trustees provided by both parties on an agreed basis.

15 The joint venture arrangement for using private sector management in operating a pay bed activity would overcome the weaknesses of the other forms of contract and would provide incentives for all parties to optimise results.

OTHER CONSIDERATIONS

16 There is another matter which authorities will need to consider in relation to using private sector management in connection with pay bed activities. When an authority engages in pay bed activity it enters into the private sector and competes with private sector management. Clearly, a conflict will arise if a private sector company takes on the management of an NHS pay bed activity which is in competition with its own private hospital group. Proximity of the two units will be relevent in this context, and it would probably be unwise to set up management arrangement with a private sector company which operated its own hospital in the same geographical area as the NHS pay bed activity. Contracts which include adequate profit sharing arrangements, as in the joint venture type of arrangement, will also tend to mitigate the possible adverse effects of any conflict of interest.

PART II

CHAPTER 5

HOSPITAL MANAGEMENT CONTRACTS - NHS BEDS

INTRODUCTION

1 The second main topic discussed in Part II is the feasibility of issuing contracts to the private sector for the management of the public beds and services in NHS hospitals. This would represent a major development requiring fundamental policy decisions. It would be a development which would be technically far more difficult to achieve than letting a management contract for the pay bed activity only. It is a topic which would require considerably more investigation than has been possible in this study where it has been possible to examine only some of the main issues which would be involved.

2 The approach used in this study has been to describe two possible scenarios for the way in which NHS hospital management might be contracted to a private sector company and to evaluate and comment on the main elements of each. The two scenarios are:

(1) A management only contract.

(2) A total resource provision contract.

MANAGEMENT ONLY CONTRACTS FOR NHS HOSPITALS

3 One approach to using private sector management in an NHS hospital would be to offer management only contracts. In contracts of that kind, the private contractor would provide the senior management team, together with any appropriate management procedures and systems and would manage the hospital in accordance with the authority's policies and instructions. All assets, equipment, resources and staff would be provided by the health authority. Payment would be by fixed fee, with the possible addition of penalties and bonuses related to performance on certain specified activities.

Comments on management only form of contracts

4 It is difficult to see how the management only form of contract described above could be successful in practice, or how the private contractor's management could in practice operate more effectively than the existing NHS management. This becomes apparent after considering a number of difficulties the private contractor's management would face, in particular those relating to:

(1) Staffing and NHS employment practices: the private contractor would have to operate within the existing staffing and working practices of the hospital. They would have no power to change those practices other than that already available to NHS management.

(2) Financial arrangements: the private contractor would have to work within the constraints of the existing NHS financial and reporting arrangements.

(3) Relations with consultants: the private contractors would have to work with the existing arrangements with consultants, and so would not control resource utilisation,and patient mix.

(4) Authority policy: the private contractor would have to implement the authority's social and health policy which would necessarily have to take priority and may cause conflict with the contractor's management proposals.

5 In summary, then, it is not considered that a simple management only contract for the management of an NHS hospital would be practicable, or would necessarily enable the private sector management to perform more effectively than the existing NHS management.

TOTAL RESOURCE PROVISION CONTRACTS

6 The total resource provision form of contract was therefore examined to see whether it would be possible to devise an arrangement in which private sector management might be able to make use of its management skills without being subject to the restraints applying to the management only form of contract.

7 The total resource provision form of contract would be based on the concept of contracting with the private operator for the total provision of the hospital's services and requirements. The arrangement would be based on the following main elements:

(1) The private contractor would undertake to provide all the services of the hospital, relating to beds, nursing, technical and hotel services.

(2) All staff and nurses would be the employees of the private contractor, including management. All doctors and consultants would continue to be health authority employees or under health authority contracts.

(3) The assets and equipment would continue to be owned by the health authority. Maintenance would be by negotiation with the contractor.

(4) The management, operating and financial systems would be provided and operated by the contractor.

(5) The present NHS accounting systems would not be operated in the hospital but the contractor would be obliged by the contract to provide certain statistical information.

(6) The payment to the contractor would have to be based on patient throughput and case mix (but see below).

Basis of payment for a total resource contract

8 In the total resource form of contract the basis of payment to the private contractor would be of critical importance. It needs to be a basis which will give the private contractor an incentive to improve efficiency, while allowing the health authority to share in any cost savings which are being made.

9 In this context it has to be remembered that although a private contractor would have control over the operation and cost of the various hospital services, the contractor would have no control over the amount of use of those services which is in practice the result of patient mix and the treatment methods selected by the consultants. Any fixed price form of payment would therefore not be acceptable to an outside contractor as they would have no power to manage the hospital in a way which would enable them to ensure they kept costs within their contract price.

10 For these reasons, it would be necessary for the payment basis in a total resource contract to take into account both throughput and resource utilisation. To do this, it might be possible to devise a contract payment formula based on a given mix of patient numbers and treatments in which variations above or below a defined mix were used to vary the contract price. Such a system would encourage the contractor to reduce costs, while protecting them from major variations in patient mix and consultant's use of resources.

11 However, it appears that the most appropriate way of structuring the payment basis for total resource contracts may well be for the contractor to undertake to provide the hospitals various services at agreed unit prices (i.e. for example, a price per bed-day, a price per theatre session, and a price per X-ray test). A pricing basis of this kind would provide incentive to the contractor to reduce costs and to work with consultants to acheive maximum throughput of patients as by doing so the contractors return would be increased. The contractor would however be protected from losses arising from matters outside their control, namely patient mix, consultant's treatment decisions and the effects of the health authority's policies on social and health matters.

12 In a contract pricing mechanism of this kind, the health authority would in effect pay per person treated according to the length of stay, and treatment method. Their costs for each year would not therefore be fixed as they tend to be now. The authority's aim would therfore be to control costs by continuous monitoring with consultants of treatment methods and by annual negotiation with the contractor's about their unit charges for each type of service.

Commentary on total resource provision contracts

13 The concept of total resource provision for an NHS hospital by a private contractor is an interesting one. When combined with an appropriate formula for payment of the contractor it would have a number of important features:

(1) The health authority would remain fully in control of overall health policy; it would remain fully in control of resource allocation.

(2) The authority would not have to become involved in detailed management control of hospitals and staff, but would remain in overall control of total costs.

(3) It would introduce an element of open market competition into the provision of hospital services which might operate in conjunction with the development of an internal NHS market for services.

(4) The contractor providing the total resource provision would be in the same position as when managing a private hospital, and would be able to adopt similar operating systems and practices.

14 In summary, then, the provision of total resource form of contract may well have a role to play in the development of the NHS. It may well be an option which could usefully be explored further, and for example might be adopted on a test basis in a new hospital where there would be no implementation problems relating to changeover procedures.

PART II

CHAPTER 6

NHS PURCHASE OF BEDS AND TREATMENT

INTRODUCTION

1 In this chapter the potential for purchasing beds and treatment from the private sector by NHS hospitals is discussed. There are basically two different forms of purchasing in this context:

(1) Purchasing beds and basic nursing care only.
(2) Purchasing beds, nursing and medical treatment or surgery.

2 These two different forms of purchasing will be discussed separately, and the chapter concludes with a note on legal matters.

PURCHASING BEDS AND BASIC CARE

3 A contract for the purchase from a private sector hospital of beds and basic care for NHS patients would provide for the use of the bed for the patient, together with basic nursing care. It would not include any medical treatment where the manual arrangements for the provision of primary care by NHS. general practioners would apply. Where the services are provided by a charity the basis of payment is probably best structured as a daily charge for the smaller, short-term form of contract, or by reimbursement of costs for the longer form of contact. In general, contracts for beds and basic care only will tend to be with the smaller private unit, which has little or no medical facilities.

4 In Part I of the report a list of the main reasons for purchasing services was given. That list is repeated below, with an indication of the relevance in each case to the purchasing of beds and basic care.

BEDS AND BASIC CARE

SHORT-TERM PURCHASING REASONS

To meet peak demand	:	Possible
To increase limiting factor capacity	:	A potentially useful application
To provide continuity of service	:	Possible
To obtain specialist skills	:	Not normally applicable in the short-term
To react to opportunities	:	Possible

LONG-TERM PURCHASING REASONS

To reduce operating costs	:	Major reasons e.g. elderly patients

To reduce capital invesments	:	Minor reasons e.g. elderly patients
To reduce risks	:	Not applicable
To acquire management expertise	:	Not applicable
To acquire a specialist service	:	Not applicable
To implement a particular policy	:	Major reasons e.g. elderly patients

5 The summary shows that the main reasons for purchasing beds and basic care only, will tend to be the setting up of longer term purchasing arrangement to deal with the needs for the longer stay patient. The aim here will be to set up longer term contracts with the private sector for this kind of care in order to reduce the authority's need for capital funds, and to reduce operating costs. Competitive tendering would be essential, and careful evaluation of tenders would have to be made in comparison with thee costs to be incurred if the authority provided the car in-house. Longer term care arrangements of this kind were not included in the work of this study, and so the topic is not discussed further here. There is no doubt, however, that longer term care arrangements of this kind could be a major source of co-operation between the two sectors and a source of growth for the private sector.

Purchase of beds to reduce limiting factor restriction

6 The above summary also shows that the reduction of limiting factor restriction may be a useful reason why beds and basic care might be the subject of short-term purchasing contracts.

7 It will be remembered from Part I that limiting factors arise when one particular resource or service with inadequate capacity acts as a bottleneck which restricts total throughput through all the other services. It may be that in certain situations a limitation in the number of beds is restricting patient throughput when all the other services in the unit could deal with a far greater volume of work. By moving certain categories of patients who have reached the stage of their treatment at which they require basic care only to private sector beds under care only contracts, it might be possible to increase total patient throughput for the unit as a whole.

PURCHASING BEDS AND TREATMENT

8 The purchasing of beds together with medical treatment involves different considerations from the purchase of beds and basic care only. The contracts will be with private sector hospitals with adequate medical treatment facilities, and not with private sector units offering nursing care only. The need for medical treatment also means that the position of the consultant has to be considered.

9 In general terms, the purchase of beds and treatment from the private sector could be used when a NHS patient had been diagnosed as having a condition which required a certain operation or treatment. The patient would be offered the opportunity of receiving the treatment at the named

private hospital while remaining an NHS patient. The contract with the private hospital would include, bed cost, nursing cost, and costs for use of special facilities and services. The consultant's fees might be dealt with as part of the contract or might be dealt with separately. Liability to the patient would continue to be that of the NHS throughout. Contracts might be set up with private sector hospitals on a case by case basis, or probably more usefully, on the basis of a contract for a certain number of treatments of the same nature.

10 A summary of the main reasons why it may be appropriate to the NHS to purchase beds combined with treatment is given below, again using the headings given in Part I:

BEDS AND TREATMENT

SHORT-TERM PURCHASING REASONS

To meet peak demand	:	A major reason (N.B. waiting lists)
To increase limiting factor capacity	:	Not applicable
To provide continuity of service	:	Possible application
To obtain specialist skills	:	Possible application
To react to opportunities	:	Possible application

LONG-TERM PURCHASING REASONS

To reduce operating costs	:	Not usually applicable
To reduce capital costs	:	Not usually applicable
To reduce risks	:	Not applicable
To acquire management expertise	:	Not applicable
To acquire a specialist service	:	A potentially useful application
To implement a particular policy	:	Not applicable

11 The summary shows that the most important short-term reasons for purchasing beds and treatment from the private sector, is that of meeting short term peak demand. A peak demand might arise from a number of reasons, but the principal aim of short-term purchasing of capacity may well be to reduce waiting lists.

12 The use of short-term purchasing contracts is well suited to the reduction of waiting lists as it enables a reduction in the list to be made without the NHS incurring continuing costs or requiring major capital investment. The contracts could be made the subject of competitive tendering from private hospitals, and as has been suggested previously in this report, tenders could also be sought from other health authorities. Contracts would probably be most useful if they were for a given number of operations or treatments of a certain type, rather than for individual patients.

13 The summary also shows that for the longer term types of contracts, the purchasing of beds and treatment to acquire a specialist service is the one which has the most potential. This type of contract would be appropriate where a private hospital has demonstrated a useful and cost effective service in a given specialisation. The local health authority might decide that it would use that private sector operator to meet all its requirements for beds and treatment in that specialisation, and would enter into suitable long-term contracts. Its decision to do so might be based on cost considerations, but might also be based on the need to have access to particular specialist skills. In both these situations it would be appropriate to obtain competitive proposals for the private sector operations and also from NHS units or districts.

14 In considering the nature of contracts for patient treatment the concepts of risk discussed in Part I should be borne in mind. In patient treatment contracts, the element of financial risk is borne by the hospital providing the treatment which would carry the cost of a longer than expected patient stay, and would receive the additional profit of a shorter than expected stay. It may be found advisable to base these contracts on a shared risk basis in which, for example, the unit price agreed for a particular treatment could be varied up or down depending on the average length of patient stay experienced over the period of the contract.

The position of the consultant in the purchase of beds and treatment

15 It is necessary to consider the position of the consultant in relation to the purchase by the NHS of beds and treatment from the private sector. The first situation to consider is where the contract is placed with a private hospital to provide the bed, nursing care and specialist facilities for a NHS patient but where the consultant provides the treatment or surgery as part of the consultant's normal NHS workload. This is the most straightforward type of contract; there is no payment to the consultant for the work, other than that under the consultant's NHS contract and there is no need for the patient to be referred to a second consultant. It would be preferable for this form of contract to be used where possible, as it is the least complex form of arrangement.

16 Situations will however, occur when it is decided to purchase from a private sector hospital treatment or surgery for a number of patients for whom the consultants at the NHS unit concerned have no spare capacity under their NHS contract arrangements. In these cases the consultants would be paid a sum which would form part of their private practice earnings as permitted by their NHS contracts. In practice such sums might be the subject of direct negotiations between the consultant and the NHS, or they might form part of the "all in" price paid to the private hospital which would then negotiate a fee with the consultant.

17 In any event, contracts where the consultant is to be paid for the work in this way give rise to additional considerations. It could be argued that, as a general principle, it would not be good practice for the same consultant to be involved in the original consultation with a patient

under the consultant's NHS contract and then to receive an additional payment for treating that patient as part of an NHS purchase agreement with a private hospital. For this reason, it is suggested that either:

(1) the administrative arrangements are such that the consultant concerned with a particular NHS patient or group of patients is not involved in the decision to purchase treatment for them from a private source;

or,

(2) the health authority sets up in advance contracts with consultants for sessions to be worked in the private hospital to be paid at a sessional rate;

or,

(3) a different consultant is used when treating the patients in the private hospital from the consultant in the NHS on whose lists the patients initially belonged; in this case the consultant in the private hospital might well wish to confirm the diagnosis of the patient's condition before taking responsibility for treatment.

Legal liability and operational standards

18 The NHS has a liability to its patients who may take appropriate action for negligence. Patients transferred for surgery or treatment to a private hospital under contracts of the kind discussed in this chapter would be asked if they wished to be treated in this way, but even so, it seems that from a legal point of view they might be considered to remain NHS patients, and in that case their recourse in case of negligence would appear be to the NHS, and not to the private hospital.

19 This matter appears to have two implications:

(1) The contract between the health authority and the private hospital may well have to be such that enables the health authority to have recourse against the private hospital in the event of successful claims against them by a patient.

(2) The health authority must satisfy themselves that the private hospitals' standards and facilities are appropriate to the particular type of surgery or treatment being given. This may go beyond the authority's more general responsibilities regarding the regulation and inspection of private hospitals and may require the specification of particular standards in the contract.

20 The question of legal liability for patients is a matter which is beyond the scope of this study; clearly, however, it is one which hospital managements will wish to consider when they are setting up contracts for patient treatment.

PART III

THE SERVICES EXAMINED

PART III

THE SERVICES EXAMINED

SUMMARY OF CONTENTS

Part III of the report considers a number of services and examines the particular characteristics of each one in relation to co-operation arrangements.

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	Describe the way in which the study has reviewed the potential for co-operation in different types of services.	
CHAPTER 8	**High capital cost services**	42
	Sets out the approach to be considered in high capital cost services such as radiography.	
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	Sets out the approach to be considered in high volume technical services such as pathology.	
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	Sets out the approach to be considered in high material content services such as pharmacy.	

PART III

CHAPTER 7

THE APPROACH TAKEN TO THE SERVICES

INTRODUCTION

1 An important part of the study was to examine a number of the various services provided by hospitals and to make an assessment of the scope for buying and selling arrangements between the private and public sector. It was not practicable to examine in detail all the services which are provided by hospitals and so the approach was to select a sample of services each of which exhibited a particular management characteristic and to comment on them in relation to possible co-operation arrangements in a way which would be helpful when considering services with similar characteristics. It will, of course, be appreciated that the team did not view the services from a technical medical point of view, and that their comments relate to general management matters only.

2 The particular services dealt with in Part III are as follows:

(1) High capital cost service (radiography and radiology).
(2) High personnel content service (physiotherapy, speech therapy, chiropody).
(3) High volume technical service (pathology).
(4) High material cost service (pharmacy).

Each of the above services is examined in turn in the remainder of Part III. The assessment is set out in a similar way for each of the services under the following headings:

(1) The general characteristics of the services.
(2) The technical practicality of using outside contractors.
(3) The existing experience of co-operation.
(4) The scope for buying or selling the services.
(5) The appropriate form of contracts.
(6) Conclusions.

PART III

CHAPTER 8

HIGH CAPITAL COST SERVICES (Radiography and Radiological Services)

INTRODUCTION

1 High capital cost services are of increasing importance as the technical developments taking place in health care give rise to a trend towards advanced, high cost equipment. The example which was selected of this kind of service was radiography and radiology.

GENERAL CHARACTERISTICS OF THE SERVICE.

2 Radiography and radiological services use equipment for both diagnosis and for treatment. Although, the two have very different purposes and different technical equipment and practices, they have been grouped together in this report because they represent examples of services using high-cost capital equipment supported by technical staff.

3 The organisation of radiological services in the NHS is normally on the basis of a single or multiple 'suite' of rooms providing administrative, patient reception and changing facilities as well as the treatment area. The trend in recent years has been for centralisation of facilities where possible, although some procedures such as ultrasound, CT scanning and the newer specialities of nuclear medicine may be in specialised dispersed locations. Many radiotherapy services are provided on a region-wide basis because of the very high cost of equipment.

4 Excluding the capital costs of equipment, which may be considerable, the cost of a typical department consists of salary cost representing 70% of revenue expenditure with films and other consumables accounting for a further 15%, with the remaining 15% being clerical and other overheads.

5 In recent years, radiography and radiological services have been subject to a number of technical developments resulting in new forms of equipment. This equipment is generally high cost capital equipment. It seems likely that this trend to increasingly advanced and costly equipment is one which will continue and be important for the future.

6 The source of work for radiology services dictates the difficulty experienced by the service in planning and scheduling its work load. In a typical X-ray diagnosis installation, 50% of throughput will be via accident and emergency, the level of which by its very nature will be unpredictable. Other sources of activity, notably, in and out patients, GP referrals and patients from other hospitals offer greater scope for scheduling, but in general terms it seems that only 30% of X-ray diagnostic cases can be planned. X-ray therapy units can schedule their work load in advance more readily.

7 A key feature of high capital cost installations of this kind is thus the problems of matching the capacity of high capital cost equipment to a largely unpredictable demand. The traditional means of providing an adequate level of service in this case has been by providing and maintaining spare capacity. An alternative may well be through co-operative, or joint venture arrangements between the sectors in which a more even flow of work may be achieved and optimum equipment utilisation obtained.

PRACTICALITY OF USING OUTSIDE PROVIDERS

8 There would appear to be no legal, management or technical reasons why a hospital should not enter into purchase and sale arrangements to provide services involving high cost capital equipment such as radiography or radiology. Clearly, any contract for the work would have to specify appropriate standards and would have to define precisely where the legal liability to patients remained. On a practical operational level however, a number of problems would have to be dealt with such as:

(1) Logistical problems of moving patients to and from equipment.

(2) Scheduling patients; the importance of being able to obtain an even flow of work through high capital cost equipment has already been mentioned.

(3) The availability of technical staff. Problems may well arise in using an outside contractor where advanced procedures involve experienced medical staff. On these cases interpretation and discussion of results is often essential and needs close physical proximity to the patient's clinician. The use of off-site facilities could thus cause difficulties and this might well be a restriction on the development of co-operative ventures in this form of service provision.

THE EXISTING EXPERIENCE OF CO-OPERATION

9 The study shows that a number of co-operative arrangements have been attempted in the area of high capital cost services such as radiography and radiology. Generally, these have concerned the joint provision of the high cost capital equipment needed for these services and have been aimed at sharing costs, and at achieving high equipment utilisation.

10 The arrangements which have been entered into have been either in the form of joint ventures between users, to purchase and operate equipment, or have been with private service operators who provide mobile equipment on a rental basis.

Relevant case studies are:

(1) Case study No. 1. An advanced medical imaging service.
(2) Case study No. 2. A mobile CT scanning service.
(3) Case study No. 3. A partnership approach to advanced techniques in kidney disorder treatment.

The case studies are discussed in Part IV and are given in the Appendix.

THE REASONS FOR BUYING AND SELLING HIGH CAPITAL COST SERVICES

11 The main reasons why managers buy and sell services as a means of improving performance were explained in Part I. The reasons given in that chapter are listed below with an indication in each case of their relevance to high capital cost services such as radiography and radiology.

REASONS FOR SHORT-TERM BUYING

To meet short-term peak demand	-	Possible, but not a major need
To increase limiting factor capacity	-	Possible
To provide continuity of services	-	Possible during emergency or maintenance
To obtain specialist skill	-	Possible to meet exceptional need
To react to opportunities	-	Unlikely

REASONS FOR LONG-TERM BUYING

To reduce operating costs To reduce capital expenditure	-	Both important reasons for seeking co-operative ventures
To reduce risk To acquire management expertise To acquire a specialist service	-	Possible use re new techniques and new equipment
To implement policy	-	Not applicable

REASONS FOR SHORT-TERM SELLING

To use short-term supply capacity To use ad-hoc opportunities	-	Both possible but not major areas

REASONS FOR LONG-TERM SELLING

To sell surplus assets	-	Possible use as assets are replaced by newer equipment
To make optimum use of major assets	-	A potentially major reason for entering a market
To develop permanent business ventures	-	As above

12 The above summary shows that reasons for buying and selling high capital cost services such as radiography and radiological services can arise in both long-term and short-term situations. However, the main potential for co-operation between the two sectors may tend to be in longer term buying and selling arrangements.

13 The reason for this is that whenever high cost capital equipment is in use, an essential factor is to obtain the maximum utilisation. The higher the cost of the equipment, the greater is the amount of the lost resource when the equipment is not in use. In the health sector, high utlilisation means achieving the maximum throughput of patients. Individual hospitals may find they cannot provide enough patients to enable a continuous use of high and specialised equipment to be achieved and therefore they may well find it necessary to look for co-operative arrangements with other hospitals.

THE APPROPRIATE FORMS OF CONTRACT FOR HIGH CAPITAL COST SERVICES

14 Contracts for dealing with short-term arrangements for buying or selling high capital cost services such as radiography or radiological services should be relatively straightforward to set up and will not be discussed in any length here. Contracts must include an exact specification of the service to be provided, and the basis for charging which will probably be based on a cost per patient. In most cases the contract will also need to define precisely where the legal responsibility for the work lies.

15 Contracts for longer term arrangements are likely to represent the main requirement in dealing with high capital cost services such as radiography and radiological services and these have been dealt with under separate headings of:

(1) purchase and sale contracts,
(2) joint venture contracts.

Long-term purchase and sale contracts for high capital cost services

16 Where an organisation is considering purchasing a major new piece of capital equipment, the aim is to ensure in advance that sufficient throughput will be available to make use of the equipment and so recover the high capital cost. The organisation's aim is therefore to set up long-term arrangements for using the equipment with another organisation and for such an arrangement to be enforceable at law. In this way, the high capital cost will be recovered, and the risk is carried by both parties, although not necessarily equally.

17 It is suggested that this principle should be followed where possible in any long-term purchasing and selling arrangement relating to services with high cost capital equipment such as used for radiography and radiology. In these cases the organisation which is to incur the initial capital cost and which will subsequently operate the equipment should aim to issue contracts to purchasers of the service which will include:

(1) The service unit purchase price, (for example per patient treated) to cover operating costs and capital costs.
(2) The minimum number of units to be purchased in a year.
(3) The number of years for the contract to run (ideally that number to be such that capital costs will be recovered).

(4) The financial penalty to be incurred for early withdrawal from the contract.

18 Contracts based on these principles are likely to be implemented successfully as risks will be being shared and both parties will have a long-term interest in their success. It is interesting to note that during the study, the team found instances where proposed high cost capital projects failed because contracts for the service were entered into which did not ensure that a long-term financial commitment was made in the way proposed above.

Joint venture contracts for high capital cost services

19 An alternative to long-term purchase and sale form of contract is the joint venture contract. These arise when, as in an example found by the team, one party agrees to purchase a high cost piece of specialist equipment and the other party agrees to provide physical accommodation and related services. At first sight, such arrangements appear to be ideal examples of co-operation. In practice, however, unless the precise responsibilities, costs and benefits are clearly worked out and monitored, such arrangements can be extremely difficult to operate.

It is suggested that joint venture contracts for high capital cost projects need to incorporate the following main features:

(1) A statement as to which party is to manage the service.

(2) A statement as to where the liability to patients lies.

(3) The amount of the initial capital and set up costs to be provided by each party; where assets are to be provided, rather than cash, the value of those assets needs to be stated.

(4) The operating services to be provided by each party and the way they are to be costed.

(5) The basis on which each party is to make use of the service provided, and the way in which that use is to be valued.

(6) The arrangements under which periodic accounts for the joint venture are to be prepared, and the way in which surpluses or deficits are to be divided.

CONCLUSION

20 The high capital cost type of service would appear to be one which offers good potential for co-operative buying and selling between the two sectors. The nature of these services, with the critical importance of ensuring high patient throughput, means that advantages may well be derived for both the private and public sectors. Particularly good potential appears to arise from the installation of new equipment offering technically advanced treatment.

PART III

CHAPTER 9

HIGH PERSONNEL CONTENT SERVICES (Physiotherapy, speech therapy, chiropody)

INTRODUCTION

1 High personnel content services are those in which the main parts of the service are provided by people with specialised training, and in which the cost of equipment is relatively low. The services selected as examples in this chapter are physiotherapy, speech therapy and chiropody.

GENERAL CHARACTERISTIC OF THE SERVICES

2 The general characteristics of the three services are described briefly below.

Physiotherapy

3 The place of physiotherapy in the overall treatment needs of patients can be judged via the source of referrals. In a typical department 46% of referrals come via consultants, 31% from physiotherapists' own assessment of need and 13% from general practitioners. The remaining 10% come from nurses, accident/emergency, other districts or social services, in order of importance. Physiotherapy is usually practised in centralised unit based facilities using a variety of equipment and in some cases a gymnasium or water therapy unit. Community units, and special need cases treated away from hospital sites will often form part of an authority's provision.

4 A typical physiotherapy service will be organised around speciality sub-groupings. These groupings will reflect the specific needs of patients and will reflect the type of treatment given, where the treatment is performed, and what facilities are involved. Staff possessing suitable academic qualifications do practical training in post with a tendency to specialise after five years service.

5 A people intensive service such as physiotherapy is susceptible to a highly variable pattern of supply of suitably qualified personnel. The movement of staff into and out of employment is a result of the high proportion of women engaged in the profession. Away from major centres of population the supply of staff can be a critical constraint. Many departments make use of part time staff on a freelance basis to maintain an adequate level of service. Scope for private work is high although restricted in nature due to the need to provide specialised equipment. Several agencies exist to provide staff although these are again concentrated in major centres of population.

Speech Therapy

6 A typical speech therapy service will operate within health centres, clinics, hospitals, schools, special schools, training centres and on a domiciliary basis. Referrals to the service will therefore come via health visitors, GP's, teachers, consultants and child care services such as clinical or educational psychologists.

7 Treatment periods can be lengthy following initial testing and assessment. The service by its very nature requires a high therapist/patient ratio and despite the verbal and audiological aspect of the work it does require the use of specialised equipment.

Chiropody

8 The characteristics of chiropody services in the NHS bear certain similarities to those service areas already discussed. This situation is further complicated in chiropody by the open nature of the profession and the existence of a sizeable private sector provision.

9 Whilst small in total numbers the service constitutes an important aspect in the treatment of priority areas such as children and the elderly or handicapped. There are at present problems of attracting staff in all but the most populated regions, with a large proportion of part time staff employed.

THE TECHNICAL PRACTICALITY OF USING OUTSIDE PROVIDERS

10 There would seem to be no legal, management or technical reason why a hospital should not use outside providers for services with a high personnel content such as physiotherapy, speech therapy and chiropody.

THE EXISTING EXPERIENCE OF CO-OPERATION

11 During the study some existing experience of co-operative provision of such services between the two sectors was identified, but none of the case studies attached to this report deal with such services.

THE SCOPE FOR BUYING AND SELLING HIGH PERSONNEL CONTENT SERVICES

12 The main reasons why management buys and sells services as a means of improving performance were explained in part I. The reasons are listed below with an indication in each case of their relevance to high personnel content services such as physiotherapy, speech therapy and chiropody.

REASONS FOR SHORT-TERM BUYING

To meet short-term peak demand	Possible
To increase limiting factor capacity	Unlikely

To provide continuity of service	Possible
To obtain specialist skill	Probably main short-term reason

REASONS FOR LONG-TERM BUYING

To reduce operating costs	Unlikely
To reduce capital expenditure	Not applicable
To reduce risk	Not applicable
To acquire management expertise	Not applicable
To acquire specialist service	Probably main long-term reason
To implement policy	Not applicable

REASONS FOR SHORT-TERM SELLING

To use short term surplus capacity	Unlikely
To use ad-hoc opportunities	Unlikely

REASONS FOR LONG-TERM SELLING

To sell surplus assets	Not applicable
To make optimum use of major assets	Potentially useful
To develop permanent business ventures	Not applicable

13 The above summary shows that the opportunities for buying and selling services with a high personnel content are generally limited. The main concern of management in dealing with these types of service tends to be the shortage of staff with the necessary qualifications, and it is this which would form the reasoning behind many buying and selling decisions.

FORMS OF CONTRACT FOR HIGH PERSONNEL CONTENT SERVICES

14 The buying of high personnel content services to meet short-term demands will take the form of contracts with individual practitioners. Contracts in these cases will be the normal form of contract, and no special requirements appear necessary.

15 In many cases, a continuing shortage of permanent staff may lead to the relatively long-term use of external staff, either full or part-time, to enable the service to be continued. In these cases it may be necessary to modify contracts to enable the staff concerned to be integrated to some extent into the hospital's administrative arrangements.

16 Regarding the selling of these services the main potential appears to be the selling of facilities to practitioners working privately in the discipline concerned. For example, equipment and work areas are required in physiotherapy and it might well be possible for these facilities to be sold to private practitioners on a rental basis. Clearly, this would have to be set up in a way which did not disrupt the hospital's own patients and where an NHS hospital was concerned would have to be within NHS regulations. It would, however, provide a source of additional revenue. Contracts for rental of facilities in this way would be straightforward, with no special requirements.

CONCLUSION

17 The high personnel content type of service would not appear to offer great scope at the present time for developing important forms of buying and selling services between the two sectors beyond the present use of agency personnel and private practitioners.

PART III

CHAPTER 10

HIGH VOLUME TECHNICAL SERVICE (Pathology)

INTRODUCTION

1 High volume technical services are those services which require a high degree of technical expertise, often combined with the need to be able to process a large volume of work. The characteristics of these services are senior staff with high skills and qualifications combined with numbers of less skilled staff who carry out the detailed work. The high volume nature of the work makes it suitable for the application of automated equipment, with the corresponding reduction in the numbers of less skilled staff. An example of this kind of service in the health sector is the pathology service, and that has been selected as the example discussed in this chapter.

GENERAL CHARACTERISTICS OF THE SERVICE

2 A pathology department is normally sub-divided into the specialities of chemical pathology, haematology, histopathology, cytology, immunology and microbiology although not all specialisms will be present in every department.

3 Pathology laboratories undertake a wide and increasingly complex range of investigation. Developments in technology whilst improving the productivity and quality of investigations have also resulted in pressures to expand the range and numbers of tests performed. As a result the majority of pathology departments attempt to contain this expansion by structuring the rights of access to tests and education of service demanders.

4 The service offered by pathology is both diagnostic and interpretive. The communication of results and their discussion with clinicians is an important aspect in pathology procedures. Considerable emphasis is placed on quality of both staff and procedures. Adherence to national and locally developed standards and the need to meet and improve on all aspects of quality have an important influence on the service.

5 It is evident from the survey of private hospitals which the team conducted that although a substantial proportion of private hospitals have their own pathology facilities, very few depend totally on their own resources. Indeed, a majority of private hospitals questioned make use of NHS facilities for at least some procedures. These arrangements are usually locally established and often involve a consultant pathologist acting in a private capacity. Charges for the use of NHS facilities are established nationally by the DHSS and revised periodically.

THE TECHNICAL PRACTICALITY OF USING OUTSIDE PROVIDERS

6 There would appear to be no overriding technical, legal or managerial reason why a high-volume technical service such as pathology should not be provided by an outside contractor. In practical terms, there may be some difficulty in providing a total pathology service away from the hospital concerned. This is because the service is both diagnostic and interpretive and clinicians may need to discuss the results of pathology procedures with the pathologists and clearly it is more difficult to do this when the service is provided from a remote site.

THE EXISTING EXPERIENCE OF CO-OPERATION

7 During the study the team did not locate any major instance where a total pathology service was being provided to a hospital by an outside contractor. No case studies relating to pathology are given in this report.

8 There were however many instances where parts of the service were being purchased from an outside provider, usually on the basis of requesting specific specialist tests which could not be carried out by the hospital's own pathology department.

9 One instance was located where an NHS pathology department was providing a complete service to a small local private hospital. Charges were based on the number of tests requested and the flow of work was not substantial. The survey of private hospital services carried out by the team referred to in the report "Developing Co-operation Between Public and Private Hospitals", showed that many private hospitals operated in this way, but none of the arrangements appeared to be sufficiently large to serve as the basis for a case study.

THE SCOPE FOR BUYING AND SELLING HIGH VOLUME TECHNICAL SERVICES

10 The main reasons for management to buy and sell services as a means of improving performance were explained in Part I. The reasons given in that chapter are listed below with an indication in each case of their relevance to high volume technical services such as pathology.

REASONS FOR SHORT-TERM BUYING

To meet short-term peak demand	- An important reason
To increase limiting factor capacity	- Potentially important
To provide continuity of service	- Possible
To obtain specialist skills	- An important reason
To react to opportunities	- Not applicable

REASONS FOR LONG-TERM BUYING

To reduce operating costs	- Possible
To reduce capital expenditure	- Possible

To reduce risks	- Not applicable
To acquire management expertise	- Not applicable
To acquire specialist service	- An important reason
To implement policy	- Not applicable

REASONS FOR SHORT-TERM SELLING

To use short-term surplus capacity	- Unlikely
To use ad-hoc opportunities	- Possible

REASONS FOR LONG-TERM SELLING

To sell surplus assets	- Not applicable
To make optimum use of major assets	- Possible
To develop permanent business ventures	- Potentially important

11 The above summary of reasons for buying and selling high volume technical services such as pathology shows that in the short-term, buying will be useful to meet peak demands and to deal with bottlenecks in particular aspects of the service where for example a backlog of certain pathology tests was delaying patient treatment. The long-term arrangements by a hospital to purchase all its pathology service from an outside supplier as a means for the smaller hospital to obtain low cost access to specialist skills would appear to be an important area in which purchase contracts could be developed.

12 Regarding selling the service, although some short-term opportunities may arise, the main opportunity would appear to be the longer term selling arrangements in which the larger hospitals in both the private and public sectors sell pathology services to the smaller units.

FORMS OF CONTRACT FOR HIGH VOLUME TECHNICAL SERVICES

13 The key elements of contracts for the provision of high volume technical services, will relate to the technical quality of the service, and also to the level of throughput. Contracts for providing these kinds of service must specify the quality required, and must define the means to be used to test quality on a regular basis. The payment means adopted in the contract must be such as to reflect the throughput and mix of the various services to be provided.

14 Where short-term arrangements are made, or arrangements to buy services on an occasional basis, then the payment basis is likely to be a payment for each unit of service provided. In the case of pathology, for example this would be a payment for each test carried out.

15 In the case of longer term arrangements covering the provision of a wide range of services over an extended period more complex charging arrangements will have to be devised. It will be remembered that in a previous chapter the consequences of risk relating to contracts was discussed, together with the importance of risk being shared between the provider and the receiver if the contractor was to have an incentive to perform effectively.

16 Bearing that concept in mind it is possible to envisage two bases for charging for high volume technical services such as pathology, namely:

(1) To agree a total fixed annual fee to be paid to the contractor in return for which the contractor will provide a given number of staff and associated equipment, to be available to carry out whatever tests are required; a basic contract of this kind would provide little incentive to the contractor to improve efficiency, and is not recommended.

(2) To agree separate unit charge for each test provided, combined with a minimum and maximum number of tests of each type, or alternatively to agree charges on a scale which reduces with volume; charging arrangements of this kind provide an incentive for the contractor to operate competitively and for some sharing of the cost savings which may arise through increases in volume.

17 The potential use of high volume technical services for health screening applications, may make the franchising concept a useful one to consider. Franchising was discussed in Part I.

CONCLUSION

18 The high volume technical service should provide useful opportunities for buying and selling arrangements between the two sectors and also between NHS units. Service of this kind where high volumes can be expected will tend to make the larger departments more efficient and able to provide a wider range of services than the smaller units. The smaller hospitals in both the public and private sectors may increasingly find that a wider range of services at lower cost can be obtained through long-term purchasing arrangements.

PART III

CHAPTER 11

HIGH MATERIAL CONTENT SERVICE (Pharmacy)

INTRODUCTION

1 High material cost services are those in which the value of the materials forms the main element of costs and where costs of equipment and staff are of less significance. In the health sector, pharmacy represents this type of service, and is used as the example discussed in this chapter.

GENERAL CHARACTERISTICS OF THE SERVICE

2 The pharmaceutical service cost is heavily weighted towards drugs and other dispensed items. In a typical health authority an 80:20 split between non-staff and staff costs would be a normal proportion. A large unit pharmacy in a general hospital will provide drugs and materials to in-patients, either from ward stocks or directly dispensed and to out-patients for continuing treatment, or on discharge following treatment.

3 A typical weekly issue pattern of drugs in a general hospital will be: 59% issues to ward stocks, 17% out-patient items, 15% individually prescribed items, 9% issues on discharge. An 'issue' may consist of multiple items. Several thousand line items will be held in stock and supplies are normally purchased via wholesalers or in some cases direct from manufacturers. The majority of high usage items will be purchased under region-wide contracts, these will involve an agreed price for a defined time period.

4 The organisation of hospital pharmaceutical services and its place in the wider DHA structure were influenced by the Noel Hall report (1970). The guiding principle that pharmacy services should, for reasons of economy and efficiency be organised on a "hospital group" basis has led to a dual reporting structure with district responsibilities and professional reporting via the district medical officer or in some cases a district pharmaceutical officer to a region. In many cases the district pharmaceutical officer is also a unit based officer responsible to unit management for non-professional matters.

5 It appears likely that this dual reporting relationship will continue under new unit level management structures although in some cases a district wide service could be supplied to units on an agency basis. An agency form of service of that kind would require considerable upgrading of pharmacy costing systems to provide a more detailed analysis of services and supplies to enable adequate charging arrangements to be implemented. These service costing issues are already under consideration with the move towards speciality or patient costing systems implementation.

6 An interesting aspect of an agency type service of this kind is that it is a form of internal subcontracting within the NHS internal market and many of the organisational and operational issues involved in contracting both within the NHS and with the private sector will be relevent. The need for adequate definitions of service levels and related cost analyses along with computerised data capture will be necessary elements of this type of service provision.

THE TECHNICAL PRACTICALITY OF USING OUTSIDE PROVIDERS

7 There would appear to be no technical or management reason why high material content services such as pharmacy should not be provided to a hospital by an outside contractor. In the case of pharmacy, it would be necessary to comply with the legislation relating to controlled drugs, but it is understood that would be unlikely to cause difficulty in most circumstances.

THE EXISTING EXPERIENCE OF CO-OPERATION

8 During the study a number of instances of co-operation between the two sectors in services with a high value material content such as pharmacy were discovered. For example, the survey the team made of private hospitals, suggests that only about one third of acute private hospitals have available an in-house pharmacy service. Of those without a pharmacy service a proportion obtained their supplies from a local dispensing pharmacy but some 16% obtained the service from the NHS.

Two case studies were identified in this area and are given in the appendix;

(1) Case study no. 4 describes a successful co-operative venture in the provision of specialised services using a private company's specialised knowledge of handling and preparing toxic substances. An important aspect of this venture is the additional provision of management systems using computer based reporting and access to large potential markets for the service using the private company's skills and expertise in this area.

(2) Case study no. 7 describes a successful co-operative venture relating to pharmacy between the NHS and a private hospital. The benefits to the NHS in terms of additional staff funding and experience are matched by benefits to the private hospital in quality of service, specialist advice and economies via access to large-scale contract purchase prices.

THE SCOPE FOR BUYING AND SELLING HIGH MATERIAL CONTENT SERVICES

9 The main reasons why management buys and sells services as a means of improving performance were explained in Part I. The reasons are listed below with an indication in each case of their relevence to high material content services such as pharmacy.

REASONS FOR SHORT-TERM BUYING

To meet short-term peak demand	- unlikely
To increase limiting factor capacity	- not applicable
To provide continuity of service	- possible
To obtain specialist skills	- possible
To react to opportunities	- unlikely

REASONS FOR LONG-TERM BUYING

To reduce operating costs	- main reason
To reduce capital expenditure	- possible
To reduce risk	- not applicable
To acquire management expertise	- main reason
To acquire specialist service	- main reason
To implement policy	- unlikely

REASONS FOR SHORT-TERM SELLING

To use short-term surplus capacity	- not applicable
To use ad-hoc opportunities	- possible

REASONS FOR LONG-TERM SELLING

To sell surplus assets	- not applicable
To make optimum use of major assets	- not applicable
To develop permanent business ventures	- main reason

10 The above summary of reasons for buying and selling shows that although there may be some scope for buying and selling services such as pharmacy on a short-term basis, the main scope lies in the longer term form of arrangement. In such arrangements, management will have decided not to operate its own pharmacy service but to purchase all pharmacy from an outside provider as a means of reducing operating costs, acquiring management systems and specialist technical knowledge.

FORMS OF CONTRACT FOR HIGH MATERIAL CONTENT SERVICES

11 With high material content services, such as pharmacy, where there is a relatively low element of staff cost, the most significant aspects of contracts for purchasing the service will concern the provision of the materials, the levels of stocks and to a lesser extent, staff costs.
In the case of pharmacy, drug prices are a major factor in total cost, and it may be that it will be possible in certain instances to develop contracts for pharmacy which enable better prices for drugs to be obtained. However, the pricing of pharmaceuticals is a highly complex subject, which has not been dealt with in this study and so the drug price element of contracts will not be dealt with further in this report.

12 The main aim of contracts for the provision of services with a high material content will be:

(1) To obtain the materials at optimum prices.
(2) To control and if possible reduce the levels of stocks held.
(3) To achieve adequate delivery times.
(4) To reduce staff costs.

13 In order to achieve these aims, contracts for such services as pharmacy could be constructed on a basis in which the provider is paid a fee which is varied according to the achievement of target stock levels and delivery times. In that way, the contractor is given an incentive to reduce and control stock levels and there is some sharing in the resulting financial savings. In summary, a suitable form of contract might contain the following elements:

(1) The contractor to provide the management and the staff.

(2) The contractor to provide the service to a specified standard relating to the numbers and qualification of staff and to the lead time between ordering and receipt of materials.

(3) The contractor to provide and operate all management systems related to controlling stock levels within the agreed levels.

(4) The hospital to provide premises.

14 Regarding the arrangements for purchasing the materials themselves, the contract may be on the basis that the contractor purchases and provides all materials, charging the hospital either at cost, or at cost plus a handling charge, or that the hospital makes use of its existing material purchasing arrangements, whichever will result in the lowest levels of material cost.

CONCLUSION

15 The use of an outside contractor to provide a management service for services with a high material cost content, such as pharmacy, would appear to be a useful concept which could well be used more extensively than at present.

16 From the NHS point of view, it is a service which the NHS could provide to private hospitals and thus use existing NHS skills and facilities to earn additional revenue. The NHS could also be interested in the concept as a purchaser of such services from the private sector as a means of acquiring private sector stock management systems and skills.

17 From the private sector point of view, the concept is of interest as a potential opportunity to sell advanced stock management systems, and also regarding the smaller private hospital where it would be more appropriate to purchase the service than make an excessive investment in the necessary specialist skills and facilities.

PART IV

THE CASE STUDIES AND SUGGESTED BEST PRACTICE

PART IV

THE CASE STUDIES AND SUGGESTED BEST PRACTICE

CONTENTS

In Part IV of the report an analysis of the case studies collected during the study is given and is used to develop a suggested "best practice" for dealing with co-operative arrangements.

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PART IV

CHAPTER 12

THE CASE STUDIES ANALYSED

INTRODUCTION

1 A number of case studies of existing co-operative arrangements between the two sectors which were identified by the team have been attached to this report, as an appendix. In this chapter, a brief description of the case studies is given, together with an analysis of the lessons which can be learnt from them regarding the way in which co-operative arrangements should be set up. In the two final chapters of Part IV, the lessons learnt from this analysis have been used to develop a suggested "best practice" procedure to be followed by health authorities in dealing with co-operative arrangements.

THE CASE STUDIES

2 The case studies listed below were identified by the study team from a variety of sources and were prepared following discussions with the main party involved in each case. Each case study has been written to cover such aspects as the detailed nature of the service, the decision process and the nature of the agreement concluded. The details of the case studies have been approved by the main party involved in each one, but the conclusions presented in this chapter are the study team's own analysis.

3 The case studies are listed below and are given in the appendix:

(1) An advanced medical imaging service.

(2) A mobile CT scanning service.

(3) A partnership approach to the provision of advanced techniques in kidney disorder treatment.

(4) A partnership venture in the provision of a cytotoxic drug preparation unit.

(5) A contracted service for treatment of renal failure.

(6) Contracted provision of general surgery to maintain service continuity.

(7) A contracted pharmacy service to a private hospital.

(8) Contracted treatment for total hip replacement.

(9) Contracted treatment for ear, nose and throat surgery.

(10) A contract with a private hospital to reduce waiting time for surgery involving children.

4 All the case studies concern ventures which are currently operating or have finished at the end of an agreed contract period.

PROJECT STAGES

5 The team identified five main stages through which new projects were taken. The five stages begin with the initial idea for a possible co-operation arrangement and proceed through evaluation and decision making processes, and conclude with implementation. These five stages have been used as the basis for analysing the case studies, and also for the suggested "best practice" procedures described in a later chapter.

In summary, the five stages are:

STAGE I	**INITIATION**	This stage covers the ways in which ideas for new arrangements are initiated.
STAGE II	**INVESTIGATION**	This stage deals with the preliminary investigation of new ideas for co-operation to assess whether they are worth proceding with further.
STAGE III	**PROJECT EVALUATION**	This stage deals with the preparation of detailed proposals for those ideas which "pass" stage II and the evaluation and selection of the best option. It concludes with the formal approval of top management to proceed.
STAGE IV	**CONTRACT**	This stage deals with the competitive tendering process where applicable, and the agreement of contracts.
STAGE V	**IMPLEMENTATION**	Stage five is the implementation and operation of the new arrangements.

6 The study team's conclusion relating to the way in which the case studies were dealt with during each of these stages are sumamrised in the remainder of this chapter. For the most part the case studies given in this report are those which were satisfactorily implemented. The team have however sometimes based their comments on other, perhaps less successful, projects which came to their notice.

CASE STUDY CONCLUSIONS - STAGE I INITIATION

7 The initiation stage is concerned with the development of new ideas and their source. The team found that the **strong points** in the present practices were:

(1) Many ideas were initiated by clinicians; they were thus ideas which were considered to be of practical help by those closest to patient care and were not simply ideas imposed from elsewhere.

(2) Ideas were also initiated by Members, who were thus making use of their more general perspective of health care requirements.

(3) Many ideas were initiated by the private sector making use of private sector innovative skills.

8 There were however a number of important **weak points** in the general practices followed at present:

(1) Although there seemed to be a useful range of different sources of innovative proposals for co-operative ventures, the number of such proposals is very low.

(2) Neither sector appeared to be actively looking for co-operative, innovative arrangements as a means of managing resources more effectively.

(3) The private sector did not know whom to contact in the public sector with particular proposals; even when contact had been made some private operators found the decision making process relating to NHS capital and revenue, and district and regional responsibilities prevented a decision being reached.

9 Generally, then, the team's **conclusions** were that although new and innovative co-operation approaches were being attempted, they were few in number. There was an important lack of any systematic approach for searching out and developing new ideas in a consistent and structured way. The procedure suggested in the next chapter is intended to help with this problem.

CASE STUDY CONCLUSIONS - STAGE II INVESTIGATION

10 The aim of stage II of the process is to make a preliminary investigation of the new ideas for co-operation which have been put forward to see whether there is sufficient substance in them to merit a detailed evaluation in the subsequent stages. The team found that the **strong points** in the present practices during Stage II were:

(1) On a number of occasions, useful searches of the market were made at this stage to make sure that all potential providers were found.

(2) Often, discussions were held with potential providers at this early stage, providing a useful means for obtaining a wide range of different possibilities for meeting the requirements.

11 On the other hand, there was often a number of **weak points** in the preliminary investigation stages of the work, namely:

(1) There was a lack of awareness and enquiry about the way in which other similar ventures by other authorities had been carried out.

(2) Generally, management was slow to form a defined management group to make the initial investigations, with the result that the investigation process tended to be prolonged and on an ad-hoc basis.

(3) There was often delay in preparing carefully thought out definitions of the proposal to serve as a basis for investigation and development.

12 The team's general **conclusion** about the present practices relating to the preliminary investigation stage is that once ideas for co-operative ventures have been put forward, there was a lack of a formal and disciplined approach to dealing with them to make sure that ideas with potential were explored fully.

CASE STUDY CONCLUSIONS - STAGE III OPTION EVALUATION

13 During Stage III, option evaluation, those ideas and proposals which have passed the initial screening given them by the previous stage and which are thus considered as having useful potential are given a thorough and detailed evaluation. The final step of stage III is either the rejection of the project as not being viable, or the presentation of a detailed proposal for final approval by senior management to implement the project.

14 Stage III is thus a critical stage in the process of developing viable co-operation projects, and many of the unsuccessful projects which the team was told about had resulted from inadequate evaluation at this stage.

Generally, the team found no significant **strong points** in the present practices, but a number of **weak points** are listed below:

(1) There was generally inadequate definition of the precise objectives of the proposed project, leading eventually to disatisfaction with the results actually achieved.

(2) There was generally inadequate consideration of alternative ways of achieving those objectives.

(3) The detailed specification and evaluation of projects was often not sufficiently well thought through leading to difficulties with implementation and operation.

(4) There was a tendency to adopt a project simply on a trial basis and then make amendments, rather than trying to ensure the success of the project from the start. The results being that the project lost credibility through problems arising in the trial.

(5) During the evaluation process, it seems to be generally accepted that any one discipline can put a veto on the project at any stage and cause it to be stopped. After an initial investigation stage it may well be more fruitful for the evaluation of projects to be completed for a final decision by senior management.

(6) There was a tendency for the composition of the evaluation team to be changed during the investigation into a project with new members introducing new and often unrelated issues which delayed or prevented projects being realised.

15 In summary, the team's **conclusions** relating to the present practices used in option evaluation during Stage III need very considerable strengthening if useful new ideas for co-operation between the two sectors are to be successfully investigated and introduced. The procedures need to become more formalised and to be defined as the responsibility of specified persons. Suggested procedures are described in the next chapter.

CASE STUDY CONCLUSIONS - STAGE IV CONTRACT

16 The work of Stage IV of the process is to develop firm contractual arrangements for those projects which the assessments of the previous stages have shown to be valid and for which senior management approval has been obtained. Stage IV thus comprises the preparation of draft contracts and invitations to tender, leading to evaluation of tenders and selection of supplier. The team found that the **strong points** in the general practices used in the case studies were:

(1) Where it was a case of using an outside supplier to provide or supplement an existing service, the tendering process appeared to work quickly and effectively.

(2) Initiative was shown in one case study, where an apparant lack of possible suppliers who could submit tenders was ovecome by widening the scope of the tender, and issuing it on an international basis.

17 There were however some important **weak points** in the present practices:

(1) There were often insufficient numbers of potential local providers to provide a good range of tenders, and apart from the case mentioned above, insufficient efforts were made to increase the numbers submitting quotations.

(2) In a number of cases competitive tendering was not used; the approach was to develop agreements with selected suppliers.

(3) In certain cases, the potential supplier did a great deal of preliminary work in collecting data and developing the form of the proposed arrangement with the result that it was difficult to carry out an effective competitive tendering process.

18 In **conclusion**, these points indicate an important problem which will arise from time to time in setting up co-operation arrangements between the two sectors. Where these arrangements concern an existing service which is well-known and generally available there is no difficulty in adopting the usual competitive tendering arrangements; there is an adequate range of potential providers of the service, and the form of the service can be easily specified in advance.

19 However, certain types of arrangement for co-operation between the two sectors will concern completely new products, or new techniques and will not have been undertaken before. In these cases, both parties to the arrangement will be working together to create an arrangement which will be workable and be beneficial to both sides. It may not be appropriate or practicable to put such arrangements out to competitive tender. More importantly, the knowledge that all such arrangements would be put through the competitive tendering process might well inhibit suppliers in putting forward new ideas and in being prepared to invest in their development.

20 The case studies clearly illustrate this difficulty; the normal requirement to obtain competitive tenders for services which are purchased is a sensible one in both the public and private sectors, and the relaxation of that requirement needs to be considered carefully. In the next chapter, a number of proposals for dealing with this difficulty are given.

CASE STUDY CONCLUSIONS - STAGE V IMPLEMENTATION

21 Stage V consists of implementing the contract which has been agreed between the various partners involved in the co-operation project, making sure that the arrangements work in practice and monitoring the results. The **strong points** relating to implementation which the team noted in the case studies and their discussions were:

(1) There was frequently a strong commitment from individual people (often the initiator of the idea) to make the co-operative arrangement work in practice, and this was an important factor in overcoming implementation difficulties.

(2) Generally, the implementation of arrangements concerning existing services (such as those concerning treatment) proceeded smoothly. This was because as these are services which are known and well understood, it was possible to prepare accurate work specifications, and to define responsibilities, legal rights, and working procedures.

22 The **weak points** which the team identified in the case study projects tended to relate to those projects where new arrangements were being developed for providing new services or using new technology. Weaknesses which become apparent during implementation included:

(1) No identification of a specific person of sufficient authority to be responsible for the successful operation of the project.

(2) Poor identification in Stage III of the duties, responsibilities and rewards of the various parties in the project. This was particularly so in the joint venture type of arrangement.

(3) Poor definition in the work specification of the relationship of the project to the user departments.

(4) Contractual arrangements entered into which did not divide risk, duties, costs and benefits on a satisfactory basis, resulting in inadequate commitment to implementation.

(5) The review period and review criteria for contracts and joint ventures not adequately defined.

(6) The inclusion in the work specification of standards required from the supplier which are higher than those normally operated by the purchaser.

23 The team's general **conclusion** relating to implementation is that difficulties on implementation tend to arise on the new forms of co-operation arrangement. Difficulties will inevitably arise where the arrangement has not been thought out fully in earlier stages of the project, and the team felt that particular effort was required in structuring the overall nature of the arrangements. Many implementation difficulties appeared to arise because of the failure to structure the co-operation agreements in a commercial way such that all parties shared costs and gained benefits on a fair basis which gave them an incentive to make the project work effectively. In this connection, attention is drawn to Chapter 2, "The form and content of contracts for health services" in which the allocation of risk is discussed.

PART IV

CHAPTER 13

THE COMMERCIAL MANAGER AND THE COMMERCIAL SUPPORT GROUP

1 The case studies prepared during the team's work show that individual cases of buying and selling services between the two sectors have generally arisen as a result of ad-hoc proposals made by individuals, and not as a result of a concerted approach by management. If co-operation is to be furthered as a means of improving NHS efficiency, then a specific programme of action will have to be adopted by health authorities. In this chapter, the team describes the proposed new roles of the commercial manager and the commercial support group which it is suggested that authorities should consider appointing. A suitable action programme is described in the next chapter.

THE COMMERCIAL MANAGER

2 The buying and selling of services between the NHS and the private sector involves important management and commercial considerations, as well as technical ones. It may well be that the results of a particular transaction relate to improved patient care, or to technical matters, but nevertheless, each purchase or sale has to be structured on sound commercial, management and financial terms.

3 For this reason, it is suggested that health authorities may find it useful to appoint a commercial manager to be responsible to the general manager for all business activities in relation to the private sector. In summary it is suggested that the main responsibilities of the commercial manager should be:

(1) To act as the focal point for the receipt of all proposals from the private sector.

(2) To take the lead in helping management to identify and investigate situations where the authority may be able to buy from or sell to the private sector.

(3) To help management develop and evaluate those situations into firm proposals for the approval of the general manager.

(4) To help managers to deal with contracting and competitive tendering arrangements.

(5) To monitor the operation of all commercial arrangements with the private sector, and report to the general manager on their continuing effectiveness.

4 It can be seen from this summary that the role of the proposed commercial manager will be an important one. The person has to become generally known in the private sector as the person to contact with proposals. In

many of the team's discussions with commercial companies the point was made that it was difficult to know who to approach in the NHS with proposals and the commercial manager's first task must be to overcome this barrier.

5 The commercial manager should then take the lead in identifying particular situations within the authority where there is an opportunity for buying and selling services. To do this the role will be one of helping the line managers of particular functions to see where it may be possible to improve their function by buying in services, or by generating additional revenue by selling services.

6 Having identified a potential opportunity the commercial manager's role should be to help the line manager concerned to evaluate the proposal and structure it in a way suitable for presentation to the general manager for approval. Once approved, the next step should be for the commercial manager to assist the line manager in negotiating with the private sector and in structuring the purchase or sale agreement on a satisfactory basis.

7 Once agreed, the day to day operation of the arrangement with the private sector would be the responsibility of the particular line manager of the activity concerned. The commercial manager should, however, have a continuing responsibility to monitor all buying and selling arrangements with the private sector and report regularly to the general manager on whether each arrangement continues to be beneficial.

8 It is emphasised that the role of the commercial manager is not to take over heads' of department responsibilities in buying or selling a service but is to stimulate ideas for improving NHS performance by these means and to ensure that all buying and selling arrangements are structured on sound commercial and financial bases.

THE COMMERCIAL SUPPORT GROUP

9 The role of the proposed commercial manager would thus be one of taking the lead in encouraging and developing buying and selling arrangements with the private sector. However, many of these arrangements will be complex matters affecting many aspects of a hospital's work, and it will be advisable for the commercial manager to be supported by a small working group of senior management to meet from time-to-time to review proposed projects and to provide advice and guidance.

10 In general terms, it is suggested that the role of the commercial support group should be to monitor the progress of projects from the initial idea through to implementation. To do this they must ensure that each project is properly evaluated and at the appropriate stage they must recommend to the general manager which projects should be proceeded with and which rejected.

11 It will be remembered that in this report five stages have been identified as being those through which projects will normally progress. The

commercial support group will have a role to play in each of these stages and that role is described in the next chapter.

12 The proposed commercial support group could usefully be structured on the following lines:

(1) The membership should be limited to three or four including the commercial manager.

(2) The group should contain representation from medical, management and financial service areas.

(3) The personnel should be of sufficient seniority to have an adequate understanding of service area details as well as a level of authority to gain access to information sources and decision-making channels.

(4) The group should be supplemented from time-to-time by other specialist personnel on a need basis only. This would allow the group to benefit from detailed knowledge and experience while minimising the drawbacks of a large committee structure.

(5) It is important that the group are allowed to gain experience in developing co-operative arrangements. To this end the permanent membership of the group should be kept stable and adequate means of maintaining the experience level found by way of training replacements when needed.

13 In practical terms, the proposed group will be working very closely with the commercial manager who will be responsible for the detailed monitoring of development projects. It may therefore be advisable for the commercial manager to act as the chairman of the group, although that is not seen as essential. In any event, the commercial manager should be the person responsible for arranging the group's meetings, preparing its agenda and structuring its work, generally.

UNIT, DISTRICT AND REGIONAL GROUPS

14 Although an idea for a co-operation project may have arisen at unit, district or regional level it may well be that the project may be one which should be operated on a unit, district or regional basis. For this reason, it seems likely that it may be useful to have commercial managers and commercial support groups both at district and regional level as well as at unit level, although this will depend on the particular management structure which is adopted. Projects could then be transfered between the various levels for investigation and implementation in whatever way was appropriate.

15 It is suggested that a structure of this kind will be important in developing co-operation between the two sectors to make sure that useful new ideas are fully explored, and do not fail because the level of management initiating the idea cannot exploit it fully. The team were told of co-operation projects which did not develop fully because there

was uncertainty as to whether they were "regional" or "district" projects. The existence of commercial support groups at each level would help to deal with this kind of problem. Similarly, a structure of this kind would help to overcome the difficulty experienced by some private sector operators in not knowing whether to approach a unit, district or region with their proposals.

PART IV

CHAPTER 14

PROCEDURE FOR DEVELOPING CO-OPERATIVE VENTURES

INTRODUCTION

1 In a previous chapter, a review of the case studies and existing experience of co-operative ventures was made and conclusions drawn about the strengths and weaknesses of the practices used. Based on those conclusions, a suggested "best practice" procedure for developing potential co-operative ventures is given in this chapter.

2 It will be remembered that the case studies were evaluated under each of the five stages through which a project will normally pass, namely:

STAGE I	**INITIATION**
STAGE II	**INVESTIGATION**
STAGE III	**PROJECT EVALUATION**
STAGE IV	**CONTRACT**
STAGE V	**IMPLEMENTATION**

3 It will be appreciated that co-operation projects will vary in complexity. Some projects will concern existing services and known suppliers and will be relatively simple to carry out. These kinds of projects may well move very quickly from Stage I through to Stage IV and the preparation of contracts, with no need for the detailed investigation and evaluation stages. On the other hand, projects based on new and untried ideas for co-operation and joint ventures will need careful evaluation, and it will be necessary for them to progress through each of the five stages.

4 The suggested procedures for each of the five stages are summarised in the remainder of this chapter indicating the roles of the commercial manager and commercial support group in each stage.

PROCEDURE FOR STAGE I - INITIATION

5 The principal aim during stage I should be to initiate new ideas, and to develop a portfolio of suggestions for the purchase and sale of services. The role of the **commercial manager** will be a very important one in this stage and that part of this manager's work is listed below:

(1) Obtain publicity for the new role within the private sector by:

(a) Announcing to the private sector that a commercial manager has been appointed.

(b) Publicising the nature of the role, emphasising that it is the main contact point relating to proposals from the private sector for co-operation with the authority.

(c) Making contact with the main private sector providers in the area, and with the main medical manufacturers and medical service providers.

(d) Discussing with main providers possible areas which they think may be suitable for co-operation and encouraging them to make specific proposals.

(2) Make an assessment of the existing co-operation arrangements operated by the authority by:

(a) Carrying out a review to identify all the co-operation arrangements (both buying and selling) at present operated by the authority with the private sector

(b) Investigating the validity of each arrangement, including financial aspects, to assess whether the arrangement should be continued, amended or terminated.

(c) Discussing and agreeing the future of each arrangement with the manager of the department concerned and with the general manager.

(3) Carry out a programme to identify potential arrangements for co-operation ventures by:

(a) Meeting the main heads of department (including consultants).

(b) Discussing with them where they believe that purchase or sale arrangements with the private sector could assist in the work of their department. Use the list of reasons for purchasing and selling given in Part I as a check list.

(c) Referring the list of ideas for purchasing and selling to the commercial support group.

6 The role of the **commercial support** group in this stage should be to provide an initial review of the possible projects which have been identified by the commercial manager. It would be advisable at this stage to rank the projects relative to each other broadly in order of preference according to their expected benefits and urgency. Some projects may well be rejected at this stage by the group as not being feasible or beneficial or as not conforming with general policy. Some projects might be referred to regional or district support groups at this stage if that appeared appropriate.

7 The aim should thus be for the commercial group to maintain a "portfolio" of possible projects ranked in broad order of priority. These projects can then proceed to subsequent stages according to the group's judgement

of their urgency and difficulty. For example, the group might decide to proceed immediately with a complex but urgent project and with two relatively simple projects, while holding other projects in the portfolio until staff were available to deal with them.

8 It is suggested that it would help the group to carry out their initial review of projects if the commercial manager were to submit brief details of each project in a standard format. A suitable contents would be as follows:

(1) The project definition, consisting of a concise statement of the subject matter and aims.

(2) The possible impact of the proposal on the department's activity in terms of:

- likely cost compared to current costs
- impact on levels of service
- use of resources.

(3) The key factors for success in the proposal with an estimation of:

- specialist knowledge available
- further investigation required
- the degree of difficulty in removing external constraints.

(4) The likely time scale of the project to implementation.

(5) The degree of integration of the proposal with other departments' units.

PROCEDURE FOR STAGE II - INVESTIGATION

9 Having developed a portfolio of possible projects, the next stage should be to make a brief preliminary investigation of each project in order to make sure that it is a valid proposal before substantial work and effort is put in to developing detailed proposals, evaluations and draft contracts.

10 The role of the **commercial manager** during this stage should be to decide what investigation is needed, and to "commission" the investigation work from the various departments. Typically, the commercial manager should:

(1) Request the person or department initiating the new idea to provide additional technical or operating details, and to indicate what other options exist.

(2) Commission specific functions to make reports on the proposal and on alternative options; the reports to deal with such matters as cost analysis, staffing, use of resources, medical considerations and patient care.

(3) Hold preliminary discussions with outside suppliers where the idea for the project has arisen from that source and obtain further details of the suggested operation and financing. Arrange for the outside provider to meet the commercial support group if that would be useful.

(4) Commission specific studies either to be performed by the commercial manager or outside bodies into the relevent markets and their characteristics.

(5) Develop an outline timetable for the project and the other options considered.

11 The role of the **commercial support group** during Stage II should be to review the results of the preliminary investigations into the project and the other options identified and make a decision whether or not to proceed further.

12 The decisions available to the group at this stage are:

(1) To reject the project and all other options considered.

(2) To reject the project, but to proceed with one of the other options suggested.

(3) To accept the project for further investigation, possibly with one of the other options being considered further as well.

13 A decision to proceed at this stage would not mean formal and final acceptance of the project, it would mean only that the group considers the project to be a valid one which is worth developing in detail in the next stage.

14 At this stage, the group should again consider whether the project is one which should be carried out by their unit alone, or whether it is one which district or region involvement is appropriate. In that event, the group should formally transfer the project to the district or regional commercial manager.

PROCEDURE FOR STAGE III - PROJECT EVALUATION

15 Projects coming forward to Stage III will be projects which the commercial support group regard as being valid and potentially useful. During Stage III therefore, the aim should be to develop the project into its full detail, together with any other options which the commercial support group consider should be investigated at that level of detail. The final step of Stage III should be the formal presentation of the preferred project to the general manager for final agreement to proceed.

16 The first task for the commercial manager and the support group during Stage III should be to obtain the nomination of the line manager who will have overall responsibility for running the project if it is implemented.

17 Many of the new ideas for co-operative ventures involve complex arrangements affecting internal departments and external suppliers. One of the reasons identified in the case studies for difficulties during implementation of projects was the absence of a senior manager who was responsible for the project. It is recommended that all projects should be made the responsibility of a named senior manager and that this manager should be appointed at the start of Stage III. By appointing the manager at this stage it will be possible for the manager to become fully involved and committed to the project during the development stage, and be in a position to manage it through implementation and operation.

18 In many cases, the line manager to be nominated will be the person who initiated the idea for the project and that will clearly be the most suitable solution. In other cases it may be that some other manager will be more appropriate for the job, for example the manager of the department to be most effected by the new project.

19 The role of the **commercial manager** in Stage III should be to work with the line manager in preparing a comprehensive evaluation of the proposed project for approval by the commercial support group and finally by the general manager. The evaluation document will take many forms depending on the nature and complexity of the project. In general terms, however, it should deal with the following:

(1) A detailed description of the project and its working arrangements.

(2) A financial statement showing forecast costs, savings and revenue.

(3) A statement of the expected benefits and difficulties arising from the project.

(4) A comparison with other options considered, and the reasons why the selected option was chosen.

(5) A description of the legal and commercial arrangements with any outside organisations which are to be involved.

(6) A description of the joint venture arrangements where this form of co-operative venture is being set up, including the proposals for separate companies or trusts, and the related financial arrangements.

20 When completed, the project evaluation should be presented by the line manager for the project to the commercial support group for their final decision. It is important that the line manager makes the presentation, and not the commercial manager, as it must be clearly understood that the success or otherwise of the project is the responsibility of the line manager.

21 The role of the **commercial support group** at this stage is to make a final review of the project, and either to reject it, or to pass it to the general manager for final approval. In passing a project forward in this way the commercial support group is not only stating that the

project has been properly evaluated, but is making a recommendation that the project should be accepted. The general manager is thus obtaining with each project, the line manager's commitment, and the support group's recommendation.

22 The general manager will make use of the authority's normal authorisation procedures in giving final approval for the project to proceed.

PROCEDURES FOR STAGE IV - CONTRACT

23 Projects which have received formal general manager approval can then go forward to Stage IV. This stage involves the preparation of invitations to tender, receipt of quotations, preparation of in-house tenders, selection of the best bid, and signing of formal contracts. The procedures for this part of the process are well established in health authorities, and have been described in the Nuffield Provincial Hospital Trust's previous book. Practical Guide and Handbook, competitive tendering in the provision of domestic, catering and laundry services.

24 The line manager for the project should be the person with overall responsibility for this part of the procedure. The role of the **commercial manager** will be to advise the line manager on commercial aspects and assist in negotiations with suppliers. The role of the **commercial support group** will be to monitor progress, and in many cases it may well be appropriate for them to act as the evaluation panel making the comparative evaluation of the tenders received.

The requirement for trial arrangements

25 In the chapter describing the strengths and weaknesses in the case studies, the problem was identified of the need for trial arrangements. Generally in government regulations relating to contracts, there is a requirement to obtain competitive bids before awarding contracts, and the regulations usually incorporate safeguards to ensure that no bidder is in a preferential position to win the contract.

26 One of the aims of seeking co-operation between the two sectors is to encourage new ideas, and new experiments for working together. But, the need to obtain competitive tenders from a number of suppliers may not always be compatible with this aim. There may not be more than one supplier capable of providing the kind of service envisaged in a new or experimental proposal. More importantly, private sector suppliers will be unlikely to come forward with new or innovative proposals and spend considerable amounts of time researching and discussing those ideas with an authority if they know that the proposal will have to be subjected to competitive tender.

27 It is suggested that consideration should be given to modifying the regulation relating to competitive tendering, in order to overcome these difficulties:

(1) It should be permissible to enter into trial arrangements for the provision of a service without going through a full competitive tendering procedure. The trial should be for a limited period after which the contract could be renewed only after obtaining competitive bids.

(2) Arrangements which come under the heading of joint ventures, (ie. in which there is a sharing of costs, and revenues on an agreed basis) should not fall within the competitive tendering regulations.

PROCEDURES FOR STAGE V - IMPLEMENTATION

28 Once contracts have been awarded for the new service, the final stage of the process is implementation and operation of the new arrangements. Implementation of contracts for provision of services was described in the NPHT's Practical Guide and Handbook - competitive tendering in the provision of domestic, catering and laundry services, and will not be repeated here.

29 Implementation and operation of the project should be the task of the line manager responsible for the project, who should report in the normal way in accordance with the management structure of the authority.

30 The role of the **commercial manager** will be to assist the line manager where required, particularly in relation to the commercial arrangements with any third parties involved in the project. The principal role of the commercial manager during implementation and subsequent operation should however be to monitor the effectiveness of the project. To do this, the commercial manager should:

(1) Design the procedures needed to monitor all the authority's purchasing and revenue earning arrangements with the private sector.

(Note: the responsibility for managing the purchase or sale arrangement will be that of the department manager concerned; the commercial manager's responsibility is to monitor overall effectiveness).

(2) Ensure that the monitoring procedures include assessment of:

(a) continuing satisfactory performance;
(b) continuing satisfactory financial results;
(c) continuing suitability of the arrangement.

(3) Report regularly (quarterly or half yearly) to the commercial support group and to the general manager on all arrangements with the private sector.

31 It is suggested that the **commercial support group** should also have a role in monitoring. For each project, they should ask for reports from the commercial manager to enable them to:

(1) To assess the degree to which the project has achieved its aims.

(2) To identify whether any unplanned consequences or factors have affected the project.

(3) To isolate specific problem areas encountered in the project's conception or implementation.

32 Where monitoring reveals difficulties with a project's implementation or operation the support group and the commercial manager may be able to provide advice or assistance from the increasing level of experience of co-operative ventures which they will acquire.

APPENDIX

CASE STUDIES

HEALTH SERVICES MANAGEMENT

DEVELOPING CO-OPERATION BETWEEN PUBLIC AND PRIVATE HOSPITALS

APPENDIX

CASE STUDIES

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CASE STUDY NUMBER 1

AN ADVANCED MEDICAL IMAGING SERVICE VIA A SUBSIDIARY COMPANY AND A MANAGEMENT CONTRACT

INTRODUCTION

1 Magnetic Reasonance Imaging is an advanced technique related to CT scanning which involves considerable investment in hardware and software. The installation is large and, including ancillary computer equipment and administrative areas, occupies several rooms. Whilst the techniques involved are similar to CT scanning the methods are complementary and produce different outcomes.

BACKGROUND

2 The facility is sited in a postgraduate teaching hospital which is a special health authority. Previous experience of the machine had been gained with a similar installation used for research into nervous diseases. This first machine was funded by grants from a charity.

THE DECISION PROCESS

3 As part of a review instituted by the hospital's finance and general purposes committee into the scope for the development of new forms of service provision, the proposal for the expansion of the imaging service was considered. It was felt by senior clinicians that the leading position of the hospital in the particular field could be expanded to the benefit of the hospital and its patients. A working group was formed by the finance and general purposes committee consisting of medical and management personnel with member input. The brief of the working group had included looking at all possible forms of co-operative development involving the private sector and any other initiatives which would develop not only the hospital's resources but also a more 'visible' presence in treatment specialisms.

4 As part of this wide ranging investigation into possibilities, discussions were held with a private hospital group. A range of options were investigated, including joint or separate provision of capital and revenue, both approaches involving shared use of the facility. A management contract for operation of an in-house provided facility was also considered.

From these initial discussions lasting eight to nine months several issues emerged.

(1) A more thorough analysis of needs for such a service, particularly the scope for external market development, was required. A firm of chartered accountants was engaged to report on this aspect.

(2) Capital funding constraints on the hospital and the returns required by a commercial provider suggested that no suitable arrangement

between the hospital and a private sector company could be developed which would satisfy both parties needs for adequate return on the investment.

(3) Whichever option was finally chosen considerable market development and management skills would have to be obtained from sources external to the hospital to ensure the long term viability of the project.

5 As a result of these findings it was decided to proceed with the project, but that it would be necessary to use the following form of organisation:

(1) A separate company would be established with shareholders drawn from the trustees of the hospital's endowment funds.

(2) This company would lease the equipment using a commercial bank as the original provider of capital. The bank was satisfied by the business plan that the company would generate sufficient revenue to meet the leasing agreement.

(3) The hospital would grant the company a lease on buildings and facilities for a seven year period, the same period as the equipment lease. This arrangement was approved by the DHSS.

(4) Management of the facility would be contracted to the private hospital operator by the new company for a fixed period. This fee contract would include performance and escape clauses. Market development of the service would be a prime responsibility of the contractor.

(5) The financial philosophy would be that the venture would be self supporting in the long-term with income generated from the private sector enabling the hospital to provide scans for NHS patients.

THE UNIT IN OPERATION

6 The fully operational unit commenced work 18 months after the original proposal was discussed. Staff are provided to the company by the hospital under contract to the company. The staff are charged at full employer cost.

7 Patient throughput has been targetted at a minimum of 3,000 patients with a ratio of 2:1 externally sourced to internal patients. External patients can be from the private sector or NHS transfers from other authorities. A different pricing basis is used for NHS patients and private sector patients.

8 Scheduling of patients is an important responsibility of the management contractor as it is undesirable to accumulate a waiting list of beyond one week.

9 The management contractors took up their duties at the pre-commissioning phase of the project and their responsibilities include accounting, and administration. A permanent medical secretary/administrator is in post and reports to the management contractor.

10 It had been felt by the hospital governors that their role as shareholders would be temporary and operating responsibility for the company should be handed to officers of the hospital thus avoiding any conflict of interest. For this reason changes to the control structure of the operating company were instituted early in the company's existence. These involved the donation of the shares by the two original company directors, who were hospital governors, to the endowment fund trustees. The directorships were then passed to the hospital general manager and treasurer, who along with the deputy secretary to the board of governors acting in the capacity of company secretary constitute the board of directors.

11 The service has been in operation for several months and the directors of the operating company are considering extending the hours of operation and the range of examinations provided. Expansion of the company's services into specialisms not covered by the host hospital but related to experience gained in the development and operation of advanced technology is also being considered.

CASE STUDY NUMBER 2

A MOBILE CT SCANNING SERVICE

INTRODUCTION

1 CT (computerised tomography) scanning combines advanced X-ray technology with computer systems to produce detailed cross sectional images of any part of the body. It was developed during the 1960's and improvements in technology have resulted in significant advances during the 1970's both in performance and quality of results.

2 It has been estimated that the United Kingdom has one scanner per 500,000 of population. In Europe the figure is one or two per 300,000 of population, and some estimates of the U.S. go as far as one to 100,000 of population. Depending on specification a scanner can cost between £300-£500 thousand, exclusive of accommodation and staffing.

3 In the U.S. a significant market has developed for the provision of mobile CT scanning. There are currently estimated to be ten companies operating a total of 300 mobile units.

4 Because of the size of investment needed the pattern of development in the U.K. has been for a region wide provision using designated 'key sites'. The desire to make available a local CT scanning service to more district hospitals prompted one region to examine a mobile service as part of its long term strategy, and that is the subject of this case study.

BACKGROUND

5 During 1977-1979 as part of a regional strategy study into scanning, a consultant radiologist who was aware of the possibilities of a mobile service proposed that such a service should be instituted as a transitional phase to complete regional coverage with fixed units. This approach was consistent with the regional strategy of fixed units as it was seen to be a temporary arrangement. The need to expand the provision of CT scanning in the short-term was seen as the overriding concern. The regional scientific advisory personnel were favourable to the concept and funds were made available by regional grants to institute a trial mobile service. A steering group was established consisting of the trial site district administrator, regional medical and scientific officers and a senior consultant radiologist to examine and report on the options available.

THE INITIAL TRIAL PERIOD

6 A commercial operator of mobile scanning equipment was contracted to supply the service during 1983. The test site was situated close to the main X-ray department of a general hospital with the necessary power and telephone link-ups being installed by the hospital. The contractor provided a driver who assisted in the processing of films and an experienced radiologist to operate the equipment. Because the unit was

sited close to the main department, existing clerical, nursing and portering staff were utilised. Patients were chosen to represent as wide a range of conditions and ages as possible and over the 16 visits made by the mobile unit over 160 patients were examined. Examinations were supervised by the hospitals consultant radiologist.

THE DECISION PROCESS

7 The result of the evaluation trial led to a report by the steering group which noted favourable opinions both on the operation and technical quality of the service. Staff response was enthusiastic and considerable interest was shown by other radiologists in the region. The test hospital continued with the service after the end of the trial period.

8 A major part of the steering committee's report on the trial period consisted of a fully costed option appraisal. The options were:

(1) Rental of a mobile scanner.
(2) The purchase and operation of an NHS mobile scanner.
(3) The provision of a fixed site.

9 Features of the option appraisal included patient throughput figures and other support and operating cost data gathered during the trial period.

10 On an annual cost basis the major variations in the option appraisals were the treatment of capital equipment under each option. It was assumed that the commercial contract would require discounting over the 3 year period of the contract rather than the 7 years of the NHS options. Other variable costs assumptions were common to all options.

11 The steering commitee's report on the trial period having examined the above options came to the following conclusions: **"The decision to be made is whether the additional costs involved in a mobile are justified by the advantages of such a service, which is more flexible, more convenient for patients, and provides more opportunities for a larger number of staff to become familiar with CT scanning technology. Equally, does the convenience of contracting out the service and the experience in operating the unit possessed by an external contractor justify the higher cost?"**

12 Following the steering committee's report, it was evident that to maintain momentum with the project greater detail would be needed to confirm assumptions made. A discussion document was issued to districts to identify the demand for a 'mobile service, and having received a favourable result, it was decided to issue a tender document to confirm the costing analysis of the options, in particular the cost of a mobile service.

13 A tender was drawn up by region covering a mobile service for five district authorities. This specified the contractor's proposed responsibilities in detail and the technical specification of equipment required.

THE REVISED OPTION EVALUATION

14 The tender was published on a European wide basis to attract a wide response. Twelve companies replied, nine of whom actually tendered, only one was U.K. based.

15 The results of the tendering process confirmed the comparative cost analysis already undertaken. When compared to the NHS mobile or NHS fixed options the contracted service was considerably more expensive due to the need for the company to write off the investment over the period of the contract, and the higher cost of capital experienced by a commercial operator.

16 Given that both the steering group's report and district attitudes were favourable to an expanded service, there was a need to re-examine the permutations of the service provision options.

17 Further examination of the options identified the key cost factors of each option. Despite the higher capital investment element of the cost from a commercial contractor it was nevertheless felt that a commmercial provider could achieve lower operating costs resulting from experience gained in the provision of a mobile service and more flexible staffing arrangements. As a result, it was decided to issue two new invitations to tender.

18 The two invitations for tender were for a management contract and quite separately an equipment only supply for an NHS owned mobile scanner. The specification for the equipment tender was drawn up in consultation with district radiologists. To provide a comparison of management costs, districts were asked to tender for the management contract under the same conditions as external contractors.

19 The results of the tendering showed that a commercial contractor could provide a management service to the detailed specification at lower cost than an internal provider in both cases using NHS owned equipment. The final contracts were drafted during 1984/5, both were let in early 1985 and the service started in the autumn of 1985.

CASE STUDY NUMBER 3

A PARTNERSHIP APPROACH TO THE PROVISION OF ADVANCED TECHNIQUES IN KIDNEY DISORDER TREATMENT

INTRODUCTION

1 Research into aerospace problems associated with shock wave destruction of components during the 1970's produced a "spin-off" into medical technology. A German aerospace company involved in the research pioneered the treatment of urinary stones using controlled shock waves. The technique uses a large complex machine that generates shock waves which, transmitted through a liquid medium and focussed on a predetermined location pulverises kidney stones. It is a non-invasive technique and offers considerable savings in patient stay and discomfort levels associated with conventional surgery.

BACKGROUND

2 The equipment and techniques used had been developed and were in use in continental Europe when in 1982 a senior consultant urologist at a major London teaching hospital took the initiative in promoting the development of a similar service for the NHS. A major U.K. commercial health care company became involved in the examination of the technique at the same time as part of its strategy for the continued development of new techniques in treatment.

3 During 1982 the hospital, the health care company and the manufacturer explored the possibility of establishing a service in London.

THE DECISION PROCESS

4 It was evident that the capital costs of the machine would be in excess of £1 million excluding installation and ancillary equipment costs. Operating costs per treatment would be considerable and a form of collaborative venture would be required to share the high costs involved. During 1983 the commercial health care company took the lead in offering to pay the capital cost of the machine. The NHS host hospital offered to fund, via trust monies, the accommodation as part of a general upgrading of urology department facilities. As this was a pioneering application in the U.K. the DHSS expressed a research interest and agreed to fund the running costs for a defined period via the local DHA

5 During 1984 the hospital and the commercial health care company entered into a formal agreement appointing responsibility for the provision of the service. The main features of this agreement are:

(1) Patient throughput was to be 75% NHS and 25% private.

(2) The commercial operator was to manage the service.

(3) The operator was to be responsible for maintenance and consumable items the cost of which was to be incorporated into a treatment charge which also included an element of return on investment for the operator.

(4) Private patients resident in the hospital would be charged a treatment fee collected by the operator. Private patients external to the hospital would be charged a day care fee in addition to the treatment fee. This was to be collected by the operator on behalf of the health authority.

(5) The commercial operator appointed a patient liaison officer and undertook to provide for the majority of the funding for this post.

The agreement is under continual review and the full service became operational in April 1985.

CONCLUSION

6 The pioneering nature of the service and the considerable demands of a research orientation have resulted in a flexible approach having to be taken to the responsibilities of the parties involved.

7 As the project evolved it has been found difficult to define exactly the scope and detail of each party's responsibilities. As a result, difficulties with the supply of suitable patients, the performance of ancillary equipment, and administrative responsibilities were confronted and resolved during the early periods of operation. Considerable experience has been gained by the commercial operator and the health authority into the special requirements of operating a unique service at the boundaries of available technology.

CASE STUDY NUMBER 4

A PARTNERSHIP VENTURE IN THE PROVISION OF A CYTOTOXIC DRUG PREPARATION UNIT

INTRODUCTION

1 The reconstitution of cytotoxic drugs before administration represents significant hazards for those involved in handling the drugs. These drugs, used in the treatment of cancer are harmful to living human cells and mixing or preparatory operations typically performed on wards by doctors or nurses carry additional hazards of contamination, and higher levels of wastage. There is therefore considerable advantage in the centralised preparation of these drugs. Additional savings in doctor and nurse time are also possible as well as multiple use of equipment used in preparation.

BACKGROUND

2 A company specialising in the production of processing equipment for drug therapy, but not the drugs themselves, carried out a survey of cytotoxic drug handling on behalf of a district health authority. The results of the survey revealed that drug mixing and preparation was carried out not only in radiotherapy wards but also in medical and surgical wards and theatres in three hospitals within the district. A management services analysis showed that an average of 28 hours per week were spent in preparation of the drugs across the sites studied. Additional costs were incurred in the use of disposable equipment and safety clothing.

THE DECISION PROCESS

3 The district pharmaceutical officer took a leading role in the investigation. Having identified the problems and gained greater understanding of the details an option appraisal procedure was instituted. The aim at this stage of the project was to study the inherent problems in depth, raise issues for discussion and develop criteria of cost and service quality against which options could be judged. To perform these tasks a consultative group was established consisting of representatives from hospital management, pharmacy, medical, nursing, and works departments as well as regional pharmaceutical officers and representatives from the external company. The aim of this group was to explore the various options, and a key feature of its constitution was the lack of any power of veto by any member on any subject.

THE OPTION APPRAISAL

4 The study group carried out its work during a five-month period at the end of which a formal report was prepared. This defined five options

which were subjected to a common set of criteria including: scope and commencement of any new service, procedures, hours of operation, response times, training, documentation and packaging and transport. Financial analysis was carried out for each option. The five options considered were:

(1) To continue the present operation.

(2) To continue the present operation, but with improved facilities.

(3) To provide a centralised pharmacy service with sub-option of a satellite pharmacy unit.

(4) To operate a partnership service with the external company providing some joint funding.

(5) To purchase ready-to-administer drugs from manufacturers.

5 After ranking and weighting the options against the criteria the results were:

Option 1: the possibilities of future litigation over health and safety issues and the urgent need to do something about the service removed this option.

Option 2: this option required additional costs and would not produce the benefits of a centralised service.

Option 3: this option would require considerable capital investment by the authority as well as revenue costs for additional staff. After a detailed study it was clear that the additional costs could not be offset by selling the service to other authorities.

Option 4: the external company would fund the capital works and provide the staff. Usage of the service by the authority would be on a fee per dispensed item. Additional service economies would flow from spreading costs over a wider external market volume and advanced handling and administrative procedures already in use by the company.

Option 5: lack of interest by manufacturers in providing the exact requirements and to the specified criteria removed this as an option.

CONCLUSION

6 The results of the option appraisal produced a definitive statement on the preferred development. The partnership option (Option 4) was chosen, to be fully operational 6 months after agreement date, 11 months after the establishment of the working group. In operation the agreement is for 7 years with reversion of facilities and equipment to the authority at the end of the contract. Detailed operating procedures are agreed, with specified standards of quality. Service reporting is to the district pharmaceutial officer. A sliding scale of dispensed item fees

are used which are guaranteed for future price movements over the contract life using an agreed formula.

7 The site was prepared, a prefabricated unit was assembled in close proximity to the hospital pharmacy and all equipment including a computerised control and reporting facility installed within the agreed target dates.

8 In operation, the savings obtained by using the company's access to wider potential markets and overhead economies has resulted in costs lower than the health authority's additional revenue charge alone under option 2.

CASE STUDY NUMBER 5

A CONTRACTED SERVICE FOR THE TREATMENT OF RENAL FAILURE BY A COMMERCIAL COMPANY

INTRODUCTION

1 At the end of 1984 there were 9,374 patients alive on treatment for chronic renal failure in the 14 English health regions. An average of 49% of these had been treated by replacement transplant. Other treatments are home or hospital based Haemodialysis, IPD (Intermittent Peritoneal Dialysis), and CAPD (Continual Ambulatory peritoneal Dialysis). Of the major methods of treatment an average of 33% of all patients receive treatment via Haemodialysis and 18% via IPB and CAPD.

2 New patients treated during 1984 in the English regions represented 35.7 per million of the population. It is generally accepted that the occurrence level of acute kidney failure is between 55 and 70 cases per million of the population and the general trend is upwards, particularly as a result of the long term clinical management problems of diabetics.

3 There are approximately 60 renal units in the United Kingdom, these are regionally based, and this provision is significantly below the availability in other European countries. Whilst the emphasis in the U.K. has been the provision of home based treatment there is a continuing need to expand renal treatment facilities to increase the provision of facilities in more localised subsidiary units thus reducing the need for patients to travel long distances. This pattern of development will also contribute to the improvement of service provision and raise the incidence of treatment to a figure closer to levels of potential demand. This case study considers the experience of one contractor chosen to provide and operate a subsidiary renal unit.

THE DEVELOPMENT OF A CONTRACTED SERVICE

4 The initiative for the development of two subsidiary units in the region concerned was taken by the Secretary of State for Wales. District Health Authorities in Wales report directly to the Welsh Office and ultimate responsibility for policy falls to the Secretary of State.

5 For some time before the tender was announced the company concerned had developed proposals and a service specification of a subsidiary unit for discussion with regional health authorities. These were based on the company's experience as a major worldwide supplier of equipment and services for renal therapy and provider of home dialysis programmes. An invitation to tender was announced in December 1984 for the establishment of two subsidiary treatment units to be funded by the Welsh Office acting as the regional health authority.

THE CONTRACT PROCEDURE

6 The Welsh Office performed a project management role and was responsible for selecting the chosen contractors. Detailed specifications were drawn up in consultation with the district health authorities, the contractors and the Welsh Office. The aim was to develop a sufficiently detailed specification against which costed tenders could be reviewed. The resulting tender document covered three main areas:

(1) A planning section, dealing with the physical facilities and equipment.

(2) A staffing and procedural section detailing the type of staff, responsibilities and schedules of cover.

(3) The operational procedures and the programme of evaluation.

7 The time period allowed for preparing the specification was relatively short and considerable difficulty was experienced over a number of aspects, notably:

(1) The definition of levels of support service required and their cost.

(2) The type of facility required and whether the elements included directly contributed to patient welfare and were therefore strictly necessary for the service.

8 Discussion between the DHA's and the contractors took place, about the volume of each type of service required. By its very nature as an entirely new approach to the provision of kidney disorder treatment the specification stage involved a considerable amount of work in defining all aspects of a service where no similar model was available on which to base decisions.

9 Significant differences also emerged during the specification stage over the type and standard of physical facilities to be provided. Negotiations concerned the provision of enhanced facilities such as air conditioning and double glazing and the final specification required substantial changes to the original proposal by the contractor. As a means of containing the total tendered cost the contract period was extended by 2 years to allow for elements included as additions to the original proposal.

10 When the specification had finally been agreed, invitations to tender were issued to the two commercial contractors who tendered for both sites and in each case an in-house tender was also developed.

The final form of contract

11 A commercial company provided the successful tender and contracts were signed in April 1985 with a specified service commencement date of October 1985. The unit became operational in August 1985. Contract cost is based on a fee per patient adjusted by the index of hospital prices on an annual review basis. This fee per patient is funded by the Welsh Office acting in its capacity as the RHA. The fee charged by the contractor includes a return on the capital investment in the facilities (£150,000), the cost of support services charged by the DHA and the employment of staff by the contractor to run the unit.

12 A variety of treatments is available and patient throughput has been targetted at 24 patients per week. The unit is not available to private patients and all referals are made by relevant consultants in adjoining hospitals. Clinical responsibility is thus retained by the DHA although service development requires a close working relationship between members of the renal unit and staff of the "host" hospital. The unit is managed by a nurse manager employed by the contractor who is responsible for day to day running, along with two other qualified nurses.

13 Medical cover is provided by the DHA, funded by the Welsh Office who have also established a consultant grade post in nephrology.

14 The contractor is also responsible for the cost control aspects of the service. The provision of this aspect in the total specification is an important element in the future evaluation of the different treatment procedures employed by the contractor. The cost implications of different forms of patient treatment programmes are important features of future service development. The use of the contractor's skills in cost management was seen as an important benefit resulting from the decision to award the contract to a commercial operator.

15 The contract is monitored both for quality of service and value for money. The Welsh Office have appointed an academic specialist to assess the achievement of target treatment levels and the relevance of varied forms of treatment to different groups of patients. Efficiency and cost effectiveness will be assessed by a firm of chartered accountants.

CONCLUSION

16 This case study represents an interesting development in the provision of a patient service. The main points to note are:

(1) The case study demonstrates that it is possible to specify a range of complex procedures by involving the parties in a developmental role.

(2) The project demonstrates the way in which contractors of services can be asked to produce regular cost information and other statistical data to enable the implications of differing types of

facility and treatments to be evaluated and monitored on a regular basis.

(3) The benefits of a turn-key approach to the project implementation, where a totally operational facility can be provided by a contractor within a relatively short time scale, are many. Once clearly defined project responsibilities and methods of performance evaluation have been established, this form of contract provides an effective framework for client involvement in the scheme.

(4) The ability of a commercial contractor to expand its range of services into new areas of operation. In this case the contractor has moved away from the typical role of equipment supplier into a service management role.

17 The case can be judged a success at this stage in its development as the unit opened ahead of schedule. Evaluation of the performance by the contractor in achieving the specified service and cost aspects of the venture can only be made once sufficient data is available from the monitoring exercises.

CASE STUDY NUMBER 6

CONTRACTED PROVISION OF GENERAL SURGERY TO MAINTAIN SERVICE CONTINUITY

INTRODUCTION

1 As part of a reorganisation of treatment facilities a district health authority had decided to close two peripheral treatment units and concentrate activity on a centralised facility.

2 The health authority experienced staffing shortages as a result of these moves and a delay in the opening of the new operating facilities. A gap developed in service provision, waiting lists were becoming longer and the health authority decided to search for alternative provision.

DEVELOPMENT OF THE AGREEMENT

3 Officers of the health authority had already been contacted by a private hospital. The cyclical nature of in-patient flow in the private hospital resulted in spare capacity for treatment arising from time to time, particularly during holiday periods. The private hospital manager made the DHA aware of this situation and indicated that the spare capacity of the private hospital could be made available if needed.

4 However, there were several private hospitals in the local area and so several private hospitals were invited to tender for specified surgical procedures for a time period to be defined. The DHA reviewed the proposals received, and within three months the final contract agreement was made.

ELEMENTS OF THE AGREEMENT

5 The main elements of the contract were as follows:

(1) The cost of the patient stay was expressed as a day rate based on an average figure for the number of days typically spent in the hospital for the specified procedures. For stays less than the agreed period the cost would be adjusted upwards and conversely for stays longer than average, the cost would be adjusted downwards. The final agreement contained a clause which enabled the net effect of these adjustments to be incorportated in the period payment.

(2) Provision of medical staff was the responsibility of the DHA. In the event the closure of the two units had resulted in consultants having spare sessions of time which could be used as operating time at the private hospital.

(3) Referral responsibility rested with the consultants concerned and the cases would be drawn from existing waiting lists.

(4) Theatre staff, drugs and pathology, were provided by the private hospital although the anaethesthetist was provided by the health authority.

(5) The private hospital undertook the normal insurance conditions for contracts with the NHS and accepted liability for acts, ommissions and faults on the part of their staff and equipment.

(6) Scheduling of case load required the consultants to contact the private hospital and arrange suitable admission and operating times. Patient contact was the responsibility of the health authority.

(7) The private hospital took no part in publicising the arrangement. All requests for information were handled by the DHA. In total over 30 patients were treated involving three surgeons over a five month period.

(8) To minimise the administrative cost and complexity of charging for blood, this was provided at no cost to the hospital by the authority for the NHS patients. The alternative charging chain of blood transfusion service to health authority to private hospital and back to the health authority was too cumbersome to operate and administratively expensive.

THE AGREEMENT IN OPERATION

6 Whilst the agreement was for specific types of procedure notably hernias and varicose veins, in practice a much more varied case load was treated. This did not lead to significant problems at the stage of total cost calculation since the actual range of operations performed did not involve abnormally short or long periods of residence. The agreement had anticipated the need for this form of end of contract adjustment and further discussions proceeded to resolve total cost differences. The final agreement did not specify a termination date although it was understood that availability of the private hospital resources would be limited at certain times of the year.

CASE STUDY NUMBER 7

A CONTRACTED PHARMACY SERVICE TO A PRIVATE HOSPITAL

INTRODUCTION

1 As part of a review of options available in the provision of pharmacy services in one of its hospitals a major private hospital group has contracted out the whole of the service to a local NHS district general hospital. The decision to put out to open tender the supply and management of the hospital's pharmacy was based primarily on an assessment of the economic costs and benefits of an in-house versus a contracted on-call service. It was also felt that additional benefits would be gained by having access to a large general hospital pharmacy service. These benefits included better quality control, up to date drug information and sterile preparation facilities than would be achieved with an in-house or commercially provided service.

THE ELEMENTS OF THE CONTRACT

2 The initial period of the contract was 12 months and this has recently been renewed for a further five years. The contract was negotiated with the unit pharmacist who is also the regional pharmacy adviser and the district general manager. The representatives of the private hospital group were the local unit manager with assistance from the head office pharmaceutical advisor.

3 The contract is made up of 2 parts, a professional and advisory service and a purchase and stock maintenance element. These operate as follows:

(1) The private hospital pays an agreed annual sum for the services of a fully qualified pharmacist. This pharmacist will visit the hospital every week day for an agreed number of hours to provide a ward service. An on-call service is also provided on a fee per call basis with availability being the same as that to which the health authority has access. A dedicated telephone answering is provided at the district general hospital during working hours and part of the weekend. The visiting pharmacist also acts as the channel of communication on all technical, quality control and manufacturing matters.

(2) The private hospital maintains an agreed limited stock of basic and theatre drugs and dressings. All drugs are issued on the basis of individual prescriptions made up for the patient and these are charged to the hospital at cost plus a dispensing fee. Deliveries are made daily during the working week and other drugs are brought by the pharmacist under the on-call system. The contract also specifies the performance of stock control, stock rotation and the management of hazardous drugs procedures.

4 The contract includes a procedure for termination. It is reviewed annually for price increases using the Whitley Council and index of drug prices for labour and material costs respectively.

CONCLUSION

5 Evidence from the private sector suggests that many relationships with the NHS for pharmacy and pathology are ad-hoc and operate on a loosely defined basis. This case demonstrates the conclusion of a long-term agreement where both buyer and seller are each satisfied that the benefits of the services provided adequately exceed the costs. The private hospital group have obtained a service at or below the cost of an in-house provision, capital investment is reduced and considerable expertise in the service area is gained. The NHS unit benefits in revenue terms, which allows the expansion of the in-house service.

CASE STUDY NO 8

CONTRACTED TREATMENT FOR TOTAL HIP REPLACEMENT

INTRODUCTION

1 In 1984 the officers and members of a district health authority in the north of England were becoming increasingly concerned at the length of waiting lists for surgery, particularly in the orthopaedic speciality.

2 Funds were available and were dedicated to improving the situation of patients waiting for total hip replacement. The search for an alternative form of service provision led the DHA to issue an invitation to tender to the private acute hospital sector.

3 Replies were received from a number of private hospitals and the DHA reviewed these proposals not only from the standpoint of total cost but also the geographic location of these facilities. The logistical problems of treating patients who were elderly at a considerable distance from their home area was a major factor in the decision process.

4 Consideration was also given to the capacity of hospitals to undertake this form of surgery and the experience of the hospital in the assessment and management of total hip replacement was also reviewed. The officers of the DHA also consulted another DHA in a neighbouring region who had already gained experience of contracted service provision to understand the procedures and contractual provisions involved.

THE CONTRACT

5 The DHA eventually selected a private hospital which was part of a large charitable group. As well as satisfying the location constraints on the service, this hospital already had considerable experience of the type of procedures involved. As a preliminary to the agreement the DHA undertook a period of consultation with general practitioners to allow patient referrals to be changed in line with the new arrangements.

6 Contractual arrangements for the consultant surgeon and anaesthetist were the responsibility of the DHA. Senior academic staff from a teaching facility close to the private hospital agreed to undertake the case load. These arrangements were handled by the district medical officer and payments received by the consultants were donated to the university's medical research funds.

7 The contracted fee charged by the private hospital covered the following aspects:

(1) nursing care and "hotel" residence costs
(2) operating theatre time
(3) drugs, dressings and post operative radiology
(4) haematology and physiotherapy

8 The DHA was responsible for the supply of the hip prosthesis and the patient was responsible for all additional residence costs such as telephone usage.

9 Patients were drawn from waiting lists in chronological order and were reviewed by the surgeon performing the operation prior to admission. It was agreed that the length of stay of the patient would be fourteen days but the private hospital would bear the cost of two extra days if needed. Returns to the operating theatre whilst still in residence in the hospital would incur no further charges to the DHA and if a review procedure was required within three months of the operation there would again be no further charge to the DHA. No provision was made for changes to the patient fee in the event of residence time being below the 14 days anticipated.

10 The contract was scheduled to run for 6 months during which time in excess of 50 patients would be treated, although provision was made for increasing the throughput at times where more capacity was available in the private hospital.

CONCLUSION

11 The contract proceeded and made a significant contribution to the reduction of waiting lists for the procedure. The final number of patients treated under the arrangement was below the contract provision as the waiting lists did not reflect the up to date situation. Deaths, transfers to other regions or patients making their own arrangements had already reduced the number of potential patients. Early assessment of waiting lists is desireable as a preliminary to a contracted service provision if the full benefit of such arrangements is to be gained.

12 The sourcing of clinical staff from outside the DHA and the use made of academic staff non-dedicated time also demonstrate one possible method of avoiding potential conflicts of interest between clinicians and contracting DHA's.

CASE STUDY NUMBER 9

CONTRACTED TREATMENT FOR EAR, NOSE AND THROAT SURGERY

INTRODUCTION

1 During the early part of 1985 the members of a district health authority expressed concern at the large numbers of patients on the waiting list for ear, nose and throat surgery. The waiting list included a large proportion of children awaiting relatively straightforward tonsillectomy operations.

2 The authority was experiencing difficulty in filling an approved second post for an ENT consultant at the general hospital. During the same period they were also attempting to find a replacement for the first post consultant who had left the authority. The health authority was maintaining a degree of service cover by employing locums or by transferring patients to other hospitals some distance away, a situation which was less than adequate as a long-term solution.

DEVELOPMENT OF A CONTRACTED PROVISION

3 Financial resources were available to implement some form of alternative service provision, and the health authority chairman together with senior officers met to develop an approach to the problem. Three private hospitals within the region were initially contacted to identify whether they were willing to enter into an arrangement for treatment services and to evaluate if they possessed the relevant facilities and experience. Contact was also established with a neighbouring health authority in the same region which had previously concluded a similar arrangement with the private sector.

4 During the period when detailed proposals were being developed agreement to the principle of an agreement with the private sector was gained both with the district management team and the health authority members.

5 Formal discussions proceeded with the private sector hospitals and concluded with the establishment of a contract. The private hospital chosen to perform the service was the same one which had previously carried out work for the neighbouring authority. The form of contract and financial terms agreed were very similar in both cases and were based on the experience gained.

6 The DHA officers also approached the general practitioners whose patients were likely subjects for inclusion in the arrangement. As a result approval was given to change the consultant referrals in line with the new scheme. The approval of the parents of the children was also sought and obtained.

ELEMENTS OF THE CONTRACT

7 The contract was initially for a three month period with an option to extend. Patients were to be admitted on Saturday and discharged on Monday or Tuesday, with an agreed throughput of six cases per operating session. As the private hospital concerned was located outside the DHA boundariès, the selection of consultants was the responsibility of the private hospital who acted as the contractor for their services. These consultants assumed responsibility for the patient both pre and post operatively once admitted. Selection of cases for inclusion in the arrangement was performed by one of the health authority's consultants from another hospital.

8 Contract fees charged by the private hospital were £450 per case and included all medical, theatre and drugs costs for pre operation assessment, the operation, and one follow up consultation. Also included in this amount was the cost of two nights residence and free accomodation for one parent, if required. Transport to and from the hospital was the responsibility of the patient and in practice no problems were encountered with this aspect despite the often considerable distance of travel needed.

9 The patient records travelled with the patient on admission and were returned after the post operative follow up consultation. They therefore provided a cross check to invoices received claiming payment for each case.

CONCLUSION

10 The effect of this arrangement was to significantly reduce waiting lists for ENT operations and a number of issues emerged which are important for the future development of this form of service provision:

(1) The possibility of concluding a package deal type of arrangement for treatment depends on the ability to accurately define expected residence times in hospital. In this case the operations concerned were such that an accurate assessment could be made based on experience and knowledge of the type of procedures involved.

(2) The contract included consultants fees as part of the package cost. The private hospital was therefore responsible for obtaining their services and a key feature of the contract was that operations were to be performed outside the times when the surgeon had a commitment to the NHS.

(3) The only problem associated with the contract in operation concerned a small breakdown in communications. The full six cases per session were initially not always taken up. This was quickly corrected and demonstrates the importance of providing suitable administration systems to support such arrangements.

(4) Considerable interest was shown by other specialist departments as a result of this arrangement. As well as sigificantly reducing ENT waiting lists department morale was raised as the authority was seen to be taking action to resolve a problem. At the termination of this contract a subsequent arrangement was developed by the DHA, again using a competitive tender with a more local hospital thus reducing patient travelling time and expense.

CASE STUDY NUMBER 10

A CONTRACT WITH A PRIVATE HOSPITAL TO REDUCE WAITING TIME FOR SURGERY INVOLVING CHILDREN

INTRODUCTION

1 A district health authority in the north of England was concerned at the increasing length of waiting lists for operations in the childrens ear, nose and throat speciality. Whilst out patient sessions were held within the DHA boundaries the in patient treatment arrangements involved travel to neighbouring districts one of which was in a different region. These arrangements had existed for some time and allowed the DHA to provide this speciality without the need for a consultant post within the authority. The retirement of one of the consultant surgeons in the adjoining authority with the resulting lengthening of waiting lists for procedures prompted the DHA to look for alternative means of service provision.

2 It was clear that difficulty was being experienced in replacing the consultant, and after nearly two years of operating a reduced service the DHA decided to use funds available from a delayed priority service development to purchase the ENT service from the private hospital sector.

3 After reviewing the possible sources of service available in the surrounding districts the DHA entered into negotiations with a private hospital which is part of a large charitable group. A review was undertaken of the facilities available and the capacity of the private hospital to perform the task. The hospital considered had spare capacity particularly during weekends, and during the winter months operating theatre time was available.

4 Negotiations continued during the latter part of 1984 and led to an agreement in January 1985. The permission of general practitioners and parents was sought and gained to change referral and operating consent authority. Geographical factors in this case were not at issue as the private hospital is located in an adjoining authority and no additional travel was required above the existing form of arrangement.

THE CONTRACT

5 The final contract developed took account of the relevant insurance indemnities required by the DHA for treatment outside the NHS and provided for the treatment of six cases per week over a six month period or until the waiting list of suitable patients was completed.

6 The cost of each operation was agreed at £475 and included:

(1) all nursing care and residence charges
(2) drugs, dressings and theatre charges
(3) fees for surgeons and anaesthetists

7 The assessment and discharge of patients were the responsibility of the consultants performing the surgery and the patients selected for operation were drawn from the waiting list in chronological order by the DHA's community physician. The type of procedure undertaken, notably tonsillectomy, allowed the residence time of patients to be accúrately predicted at three days. Admissions took place on Saturday for surgery on Sunday with discharge the following day.

8 Patient transport was the responsibility of individual parents and case records were transferred with each patient and acted as the administrative record for payment of services. The clinicians involved in the treatment were contracted by the DHA and in addition to operating outside the hours of their NHS committments agreed to donate their fees to the purchase of specific piece of diagnostic equipment used in ENT surgery.

CONCLUSION

9 The arrangement proceeded normally with no specific problem areas until the waiting list was exhausted, before the specified contract end date. During the period of the contract the DHA in the neighbouring region who previously undertook a large part of the case load successfully appointed a second consultant in ENT surgery and this consultant was able to take up the post without a substantial backlog of cases.

10 This case study shows how a DHA without a resident speciality provision can use all available facilities for treatment within both the NHS and private sectors to provide adequate levels of service cover in the short- and long-term.

11 The form of agreement and review procedures undertaken provided a model on which several other DHA's have based similar arrangements.