

Experience from the health service

Managing Agencies: Experience from the Health Service

Ron Kerr

Head of NHS Income Generation Unit

It would be wrong of me to imply that in any way NHS authorities have long standing and comprehensive experience as managing agencies; certainly not in the role envisaged by Griffiths for social services departments. The discussion surrounding the current review of the NHS does suggest, however, that the managing agency in health care may be about to have its day. It is useful, therefore, for health authorities to review their experience to date and to share that experience with social services departments. There will be a clear need, in any event, for both of us to sharpen up the nature of our present relationship.

Contractual arrangements within the NHS

Like social services, the NHS role involves dealing with the vulnerable in society and our role as a managing agent has had to take this readily into account.

Three areas of NHS experience can be identified in this field:

- long term contracts for basic NHS care
- short term or emergency contracts to overcome particular problems or temporary difficulties
- wider competitive tendering experience.

Long term contracts

Long term contracts for basic NHS services are well established, some dating back to the foundation of the NHS. Some, like certain military hospitals, have, in times past at least, made a significant contribution to total health care in a locality. Nationally, however, they are of little significance. Table 1 shows a breakdown of the patient numbers receiving care through formal contractual arrangements in 1986 - some 26,000 inpatients and 65,000 outpatients. To put this in context the NHS provision in that year was for 6.4 million inpatient cases treated, 37.4 million outpatient attendances and a further 13.8 million Accident and Emergency attendances.

The contracts are biased, unsurprisingly, towards minor surgery, convalescent care and terminal care, with the developing hospice movement entering this last category in recent years. These formal arrangements do not include other patients referred individually by their GP, for example, to Sue Ryder Homes. Where such use is locally significant it is common but not universal that a DHA financed contribution will be made.

In the main these contract cases cover gaps in local NHS provision and are revoked when NHS provision is made. Given the DHA role in licensing independent units, there is not generally any formal monitoring of care standards or a formal contract involving quality and outcome. However, the medical and nursing staff are frequently known to the District. Monitoring tends to relate only to output and finance and any experience of such arrangements in the future will require a far greater level of sophistication.

New developments in this field in very recent times are probably of more interest. For example, renal dialysis services in Bangor, North Wales are now provided under contract with a private firm who recruit and employ nurses, and provide a total management contract for the service including home dialysis. This service is not available for private patients and all referrals must come direct from a consultant. It is an arrangement which by all accounts is working well.

Oxfordshire Health Authority negotiated recently a joint venture with a private company for provision of a day surgical unit. The partner has provided the capital to develop the unit on NHS land and has guaranteed the Authority a revenue stream, as well as accepting

Social services departments as managing agencies

responsibility for a given number of NHS patients in addition to the private patient surgery which is their source of income. Other examples of this type of close relationship are developing elsewhere.

Even more radical, and perhaps of greater relevance to social services, is the Coventry proposal to contract long stay geriatric care to a housing association which will initially take over the running of the local geriatric hospital but aims ultimately to provide more locally based community type care for the elderly. The housing association has declared hopes to build a retirement village.

The proposal has attracted considerable criticism from trade unions and public pressure groups concerned particularly about the ability to guarantee appropriate services over time. The DHA benefits from the proposal as it need only meet the actual care cost, with the housing cost in future coming from patients themselves or DHSS. How this will work in practice will be interesting to see, but surely such experiments offer the opportunity to question the present approach without comprehensive charge.

Given the recent interest in internal markets in health care, it might be expected that there will be increasing use of the formal contract even between health authorities. It should be remembered, however, that it is a national health service with health authorities themselves having little control over cross boundary flows, particularly in acute specialties where there is near sanctity given to the ability of the GP and patient to choose the place of referral with funding adjustment being made after the event.

Despite this, the most significant experience of health authorities as managing agencies may well be in an area unrecognised by authorities themselves. Regional specialties such as cardiac or neurosurgery, radiotherapy and oncology are for good financial and effectiveness reasons provided by one District for several, generally funded directly by the Regional Health Authority. In the past there has been inadequate recognition of the need for an equal relationship between the host and client districts. The management of the service was totally contracted to the host or providing hospital and such monitoring arrangements as did exist were unofficial on the part of the client. Increasingly though this is changing and host districts are acknowledging the need to agree protocols which will determine the

operational policy within these units. In this way arguments about equality of access and value for money are more easily resolved without jeopardising the ability of the host hospital to manage the service on a day to day basis.

Short term contracts

The growth of temporary project related contracts has been more rapid than long term contracts in recent years. These have tended to be of three types

- purchasing clinical support services
- purchasing temporary provision
- contracts related to the government waiting list initiative.

The clinical service contracts have mainly related to routine aspects of pathology, for example, cytology, and to specialist radiology, for example, CT Scanning, although specialist pathology and general radiology services are increasingly being considered for contracting where local circumstances suggest that this will improve clinical services and cost-effectiveness. The issue of establishing control over quality has not been entirely resolved in what is a key area in diagnosis. Health authorities have been understandably wary that they will lose control of quality but ways of ensuring this is not the case are being identified.

Short term problems such as ward upgrading have always forced health authorities to look to short term contracts with non NHS facilities. These institutions both private and charitable are licensed of course by NHS authorities and the basic standard of service is known. It might legitimately be expected that this fact and the ability to withdraw the licence ensures adequate standards during such contracts. The financial basis of contract has usually been per bed or per patient. Per diem contracts have been resisted as encouraging inefficiency and cost drift.

The government initiative directing money to specific projects reducing waiting lists for treatment has stimulated an expansion in short term contracts, particularly with the private sector. In 1987/88 over 45,000 cases were dealt with in 40 such projects. Price is the main determinant in such cases. The private facilities used are already well established.

Evaluating managed contracts

There is much debate at present surrounding the Prime Ministerial Review of the NHS and whether it will propose the use of internal markets where DHAs will buy services offering best value for money from other authorities and from the private and voluntary sector. The extent of the change this would bring and the complexity of the managing agency principle involved might well put the Griffiths proposals in the shade.

The messages from this albeit limited experience with managing agencies in the clinical field are worth sharing. The NHS has found that the decision to award a service to a particular institution or organisation should be based on analysis of people, costs and systems - in that order. The people involved in a proposed contract are the most critical resource. What is their track record? Have they succeeded in similar work elsewhere? The ability of both professionals and managers is a critical variable to be assessed, as indeed is a realistic judgement as to their liability to recruit and retain the staff required to provide the quality of service aimed at.

However important the key variable of quality, cost is a major determinant. At the end of the day only limited funds are available. Value for money is the aim therefore and all things being equal (a big qualifier) cheapest must be best. However, non-financial benefits should not be overlooked - for example how well integrated will the proposed contract be with other service provision. To avoid making the wrong decision, it is essential that good cost information exists regarding the 'in-house' service as well as proposed alternatives.

The system by which contracts are let is a third crucial determinant. The brief to be met should not be over prescriptive. It should leave room for innovative proposals to be considered. Much as we like to think it, we do not have a monopoly of answers. Most of the welfare and caring professions, including managers in these areas, have an unfortunate tendency to arrogance in their approach to rival systems. New ideas should be allowed to develop and specifications drawn so that can happen.

The decision to award a contract to one company, organisation or institution is not easy. Although I have said the lowest cost should be

accepted where all things are equal, they rarely are equal. Table 2 lists the major determining variables which should be used in appraisal.

Competitive tendering

Before concluding, it is perhaps worthwhile talking briefly on the issues which have proved to be relevant in successful competitive tendering for support services within the NHS. As you will know, in the last few years all health authorities have had to put domestic, catering and laundry services out to tender. Some authorities have chosen to offer other services for tender as well, including portering, and sterile supplies, whilst there is now widespread debate about services, such as pathology and pharmacy, more directly related to patient care being tendered.

Although the existing tendering arrangements have covered so-called hotel services, there are lessons in it for the managing agents' role within caring services. Ask a nurse about the importance in the ward team of the domestic staff. Table 3 lists the main issues involved.

Some of the points raised are obvious, but I would just like to pick up one or two.

Firstly the need for independent assessment. There is a view that in much of the competitive tendering within the NHS double standards prevailed in assessment to the advantage of the in-house tender or private contractor as prejudice dictated. This is clearly nonsense if we are looking for best quality and value for money. Secondly I would like to emphasise the nature of partnership. In too many cases, in my view, health authorities and contractors saw themselves as scoring points, finding fault or getting away with something. This cannot be beneficial. A good working relationship with a contractor along the lines of Marks and Spencer's relationship with their suppliers is to be preferred. This is of vital importance when the contract being let is for clinical or caring services rather than for support services and need not breach the competitive nature of the process.

Finally there is the issue of new entrants - contractors who are newly established. Care should be taken here to ensure adequate management and financial capacity, but once again the track record of the people involved in the operation is crucial as to whether the contractor is worth the risk.

Social services departments as managing agencies

I hope these words have been of some help. I am only too aware that we are almost as inexperienced in this field as people in social services departments. Like most NHS managers I see Griffiths as a challenge for us too. Inevitably we worry whether the social services department as managing agency would meet our own aspirations. Will the differing cultures we possess still collide? More importantly, how practical is the managing agency concept when faced with the general practitioner with the desire and power to refer as he sees fit in his patients' interest? I will watch the experience of social services departments with interest and hope that some of the lessons we have learnt in managing our own contracts will help.

If there are three points I would want to leave in your mind, they are the following:

- Don't overspecify: draw a specification which is broad but encompasses your key requirements. Don't be afraid of some subjectivity in your decision.
- Remember to evaluate the people as well as the firms' financial base. It is they who will make or break the contract.
- Lastly, above all, do not attempt to pass on your responsibility with the contract. As the managing agent you are the ultimate guardian of the patient or client. The vulnerable should never become pawns in a contractual game.

Table 1 Contractual arrangements with institutes outside NHS

Care group	1986 Patient nos	
	Inpatients	Outpatients
Medical	1,850	7,250
Surgical	8,800	30,700
Pre Conv. and Pre Op.	160	2,000
Convalescent	5,800	—
Geriatric	950	2,900
Chest Medicine	1,020	3,550
Maternity	620	2,070
Mental Illness	660	1,050
Mental Handicap	640	50
Rehabilitation	350	7,860
Terminal	4,980	1,960
Other	<u>610</u>	<u>5,760</u>
	26,440	65,150

Table 2 Evaluating managed contracts for clinical services

Pricing policy	– sustainable
	– loss leaders
Motivation of contractor	
Nominating rights for admission	– guarantee of access
Outcome measurement	– how monitor
Case mix	– comparable with requirement
Comprehensive care	– no significant omissions
Quality	– patient access
	– treatment standards
	– aftercare
Appropriate managing role	– seat on board for managing agent?
	– non executive role
Assumptions about	– on-costs
	– supplies
	– equipment provision
	– support from DHA/SSD

Table 3 Major issues involved in competitive tendering

Length of contract	-	capital involvement will increase contract length
Broad specification	-	don't overprescribe
Independent assessment	-	no double standards - in-house or private can be best
Flexibility of contract	-	contingency
	-	variation clause
Management capacity of contractor		
Financial base of contractor		
Recruitment/personnel policies of contractor		
Track record of contract	-	on that scale
Monitoring arrangements agreed		
Partnership		
New entrants	-	how deal
Consultation	-	patients' representatives
	-	trade unions