Contracting out in the NHS: can we afford to take the risk?

This paper considers the experiences of Medway Health Authority in contracting out its ancillary services to private companies. This process, accelerated by recent government directives, has been going on in Medway for many years.

On September 8th last year, the DHSS issued a circular to Health Authorities.[1] The action they were asked to take was this:

> 'to test the cost effectiveness of their domestic, catering and laundry services by putting them out to tender (including in-house tenders). Where these tenders show that savings can be made, a contract should be let.'

The circular also stated that 'authorities need . . . to demonstrate that those services are provided as efficiently and economically as possible.' This circular followed an earlier Draft issued in February 1983[2] along simlar lines. No-one could say they were not warned.

If health authorities were slow to respond to start with, the private sector was ready and raring to go. The target? The three-billion pound market in the NHS ancillary services: almost one-fifth of the total health service budget.

For the private contract companies, the importance of these moves could not be overstated. As Jeremy Warner commented in an article in *The Times* on 24 August 1983:

> 'If only a fifth of that sum were eventually to be contracted out to the private sector, it would roughly double the turnover of what is still a fairly small industry.'

But, as he pointed out in the same article:

> 'If the experience of Pritchard in Wandsworth is anything to go by, contracting out of National Health Service work could be a messy business in which the rewards in the early years are small.'

Stockbroker Andrew Melrose shared this view. He told *The Times*, 'I think it will be a much longer and much more acrimonious process than people in the City generally appreciate.'[3]

One Health Authority has already got into a mess with the business of contracting-out. That story, and some of its implications, are discussed here.

CONTRACTING OUT IN MEDWAY[4]

The first major industrial dispute over health service privatisation took place at the end of 1983 in Medway Health Authority – an authority which has been contracting out for many years.

On 13 December 1983, after a five-week strike by hospital domestics, the Health Authority awarded the contract for domestic services at four hospitals and nineteen clinics to Exclusive Health Care Services Ltd, a newly-formed subsidiary of the Brengreen Group.

The Health Authority is still reeling from the impact of the decision. It has been fought by the health service unions, by hospital consultants, and by Crothalls, the contractor currently operating the services.

Crothalls stand to lose a contract of close on £1 million a year. Over 260 domestic staff face the sack. Cleaning hours look like being halved. Industrial relations are at an all-time low, and staff morale is badly hit by division and bitterness at the way the decision has been taken. There are real fears amongst medical staff and patients over the future standards of Medway's domestic services. The Health Authority has been promised a saving of £1 million over the next three years on the basis of the Exclusive tender. Few believe such savings can realistically be achieved without a drastic fall in cleaning standards and consequent risks to patients and staff. The only clear winner at this stage (apart from Exclusive Health Care Services) is the DHSS, which has played a key role in pressurising the authority to accept the outside bid. But whether the promised savings will be achieved, and at what costs, are questions that are at the centre of the row.

In the future, only two of the Authority's hospitals – Medway and St. Bartholomews – will be cleaned by NHS staff. Four out of six of the District's hospitals (Sheppy General, St. Williams, Canada House and All Saint's Hospital) and all the NHS clinics in the area will use contract labour supplied by Exclusive when the firm takes over the services in April 1984.

Contractors are not new in Medway hospitals. For 18 years, hospital domestic services have been contracted out to Crothalls, a subsidiary of Pritchards Services Group. Unlike Exclusive, Crothalls have many years experience within the NHS, although not all of that experience has been happy. Exclusive Health Care Services have almost no experience of hospitals. In Medway the arrangement with Crothalls has been a peculiar one.

The arrangement is this: the District awards Crothalls the contract for the entire domestic service 'en bloc'; the cost to the NHS is put at just under £1 million per year, of which £100,000 goes to Crothalls in profits (NUPE's estimate). But Crothalls only employ supervisory and managerial staff. The cleaners are employed directly by the NHS, and the Health Authority is then re-imbursed by Crothalls for the costs of employing cleaners. This means that the majority of domestic staff are NHS staff, employed on Whitley Council terms and conditions of employment, but working under contractor's supervision and partly under their management.

From April 1st this year all this will change. Crothall's contract expires at the end of March, and all their staff will lose their jobs in the hospitals. The Health Authority will have to sack all the cleaners bar those it keeps on in the two hospitals which will remain outside the new contract. Domestics employed by the new contractor will not be taken on with full Whitley Council conditions, and will be worse off. Even the cleaning staff kept on by the Authority as in-house staff will have their working conditions changed as a result of the tendering process. Just what those changes are is not yet known, although it is known that the in-house tender involves cuts in cleaning hours of around 20 per cent, on existing levels. Unions were not consulted over the in-house bid, which was one of six tenders considered by the Authority. This bid was accepted only for two of the hospitals – NUPE members claim this is because the Authority saw these as the 'noisy' hospitals likely to protest. But early on the district administrators had expressed a wish to keep the services in-house if possible. What changed their minds was money – and the DHSS.

The following summary shows the calendar of events in Medway last year:

1983 NUPE write to the District Personal Officer seeking information on future provision of services, seeking early consultative discussions.

July NUPE and COHSE representatives meet with members of the District Management Team to discuss privatisation of domestic services, the first meeting on the subject. This meeting takes place on July 11th. The DMT tells the unions that contract specifications are being sent out on July 15th. (Four days later!). Notes on that meeting state:

> 'following discussion with DHSS officials... the Authority had been clearly advised that stipulation of rates of pay for ancillary staff would be acceptable. However, the Health Authority would not be permitted to attach any pre-conditions to the tender documents on staffing matters that were not related to work specifications. The Authority could not therefore insist what Whitley Council Conditions of Service and superannuation were operated by the contractors'

Unions meet with the DMT and representatives of the 5 contractors invited to tender on July 22nd. (The five contractors involved are Crothalls, Home Counties Cleaning Services, ISS Hospital Service, Reckitt Cleaning Service, and Exclusive Health Care).
The Authority offer the contractors at this meeting:
– free medical surveillance of staff on appointment;
– free laundry services; (also being put out to tender – JP)
– supplies of refuse sacks and germicidal solutions.

August 3 weeks before the closing date for tenders, the Deputy Chief Administrator admits that the Health Authority has not specifically agreed details of tender conditions.

DHSS Regional Principal writes to the District Administrator (30.8.83) expressing concern that invitations to tender, 'include conditions which are not compatible with our central policy' indicating that the tender documents should not even *ask* about the contractor's proposed terms and conditions of employment.

September 1946 Fair Wages Resolution ceases to have effect.
Closing date for tenders (12.9.83) In-house tender is submitted without consultation with the unions concerned.

October Another letter from the DHSS Regional Principal (12.10.83) warns: 'If your authority does not, without compelling reason, accept the lowest tender, it will be open to serious public criticism as well as audit query.'
According to NUPE, the DHSS does not refer at any stage to cleaning standards, only costs.

November Article in *Health and Social Service Journal* reveals that one of the DHSS Officials closely involved with the Medway situation has been given two years unpaid leave to take up post as Director of Care Service Group, parent company of Hospital Hygeine Services, a contractor seeking NHS contracts elsewhere in the UK.
3 tenders are shortlisted for DHA meeting: Crothalls, Exclusive and the in-house tender.
41 domestics at All Saints Hospital, Chatham, begin a five-week strike to fight for their jobs and stop privatisation.
Crothalls openly criticise rival bids for the contract as unrealistic.

December DHA meet on 13.12.83 and approve the recommendation that the contract be awarded to Exclusive with requirement that a performance bond of £150,000 be provided by the company against default. Exclusive offers the Authority 'savings' of £378,915 a year, compared with in-house tender 'savings' of £254,912 and Crothalls' 'savings' of £236,000 a year. NUPE estimates redundancy costs are in the region of £140,000. Accrued holiday payments to staff add a further £62,000 – the cost to the Authority in the first year being £202,000. NUPE claims £80,000 would be saved if the Authority sacked all contractors and employed its own management and supervision for domestic services immediately, guaranteeing existing terms and conditions of employment for staff. Exclusive's tender shows that 82 full-time equivalents will replace 157 full-time equivalents currently employed to clean the hospitals and clinics.

The significance of this level of cuts in cleaning time cannot be overstated. As one of the joint union leaflets points out:

'Ask yourself. Could we really be that lazy? Do you think your hospital could be *safe* with only half of us? . . . Cross infection is always a danger in hospitals. Without the highest standards of hygeine they can be death traps. Our job matters. WE PROTECT YOUR LIFE. Don't let them gamble with it.'

Apparently what interests the DHSS is price, and price alone. Yet cleaning standards are critical to the efficient and safe running of the service as a whole. As union members point out, cleaners in hospitals have a caring role as part of the medical service. Reduced cleaning hours will mean more work for other staff. If cleaning hours are cut, they say, the risks to patients, public and the staff are very great. Standards will inevitably fall. The risk of accidents, of cross-infection and contamination will increase. Lower wages and greatly reduced sick-pay entitlements will mean that domestics will be coming in to work when they are sick because they cannot afford to stay away.

NUPE fear that Exclusive's bid for the Medway contract may turn out to be a loss-leader, and that real costs have been understated to ensure the bid is low enough to win the tender. Union members' fears are fuelled by a statement made by Exclusive Health Care Services' Managing Director in a letter to the Medway Deputy Chief Administrator of 6 December 1983:

'We also confirm that if we have in any way underestimated the price for this contract we would subsidise the contract to ensure that we provide your Authority with the service and the standards you are seeking.'

Such an approach clearly calls into question the whole basis of cost-comparison between tenders.

But apart from presentation brochures and apparent savings, Exclusive have offered the Authority something more: a strike-breaking agreement. Prompted perhaps by the Authority's earlier request to contractors that they pay regard to 'industrial relations implications' in their costings (designed to encourage contractors to pay fair wages and match NHS conditions) Exclusive set out company policy on strikes and emergencies as follows:

'In the event of a strike at one or more of the hospitals, we would take the following action in order to provide our services.

We would discuss the problems with the union(s) to try to reach an agreement enabling our employees to carry out their work . . . if the union(s) refuse, we would use our Medway Hospital's Management and Supervisory staff and other management staff from our Exclusive contracts in the area; our non-unionised staff such as our temporary/relief staff; and our cleaning staff employed by the Exclusive Group on commercial and other contracts in the area . . . We would provide a bus service to transport our staff to and from the hospitals during the dispute.'

On the question of cover during emergencies, the company promises to, 'put all our staff on call for 24 hours, and . . . supplement our labour force at short notice by bringing in our managers, supervisors and cleaning staff from other Exclusive contracts in the area.

It would be interesting to know whether the other Exclusive clients in the area are aware of this undertaking, which would take staff from their premises, and to know how Exclusive propose to provide the essential training in NHS procedures for this sudden influx of untrained staff; how would Exclusive

staff, many of whom will be women with family responsibilities, be able to cope with being put on call for 24 hours at such short notice? What is clear is that the company is prepared to go to considerable lengths to organise scab labour during an industrial dispute. The Exclusive Group has a very poor record of industrial relations elsewhere, both in the public and the private sector. The prospects for harmonious relations in the Medway hospitals do not look good.

Many of Medway's hospital domestics face redundancy in March. Some may be taken on by the new contractor, but they will have no protection from unfair dismissal for at least a year – five years if they work for less than 16 hours a week. They will lose their access to the extensive grievance and disciplinary procedures of the health service. They will get far less entitlement to sick pay if they fall ill – probably a maximum of four weeks after one year's service, compared with NHS sick pay which lasts up to 26 weeks. It will be difficult for a domestic working for the contractor in one hospital to accept that she should only get four weeks sick leave, while her counterpart working directly for the NHS in the hospital up the road gets 26 weeks. Staff morale is bound to suffer, and the situation will be extremely divisive.

Medway Health Authority is only one of many now involved in the process of contracting-out. In the past, contract services have been tried – and have proved unsatisfactory – in many areas. Services once contracted-out have reverted back to in-house ones. Authority's complaints have included problems of poor standards of work, short-staffing, inadequate supervision, use of untrained staff, shortages of supplies, inflexibility of services provided by the contractor, and serious problems of overseeing the contract. These problems have meant major problems for health service managers whose job it is to monitor the contractor's performance.

But the real problem of contracting-out lies not with any one contractor as against another, but with the *structure* of the contract system, and the effects of competition on the services concerned. These effects will be felt even when it is the in-house tender that is successful.

Events in Barking Hospital in East London provide clear illustrations of the insecurity and unreliability of the contract system. Like Medway, Barking contracts out domestic services to Crothalls. Unlike Medway, in Barking the domestics are employed by Crothalls, not the NHS. Their terms and conditions of employment do currently match most of those in the health service, except for superannuation and procedural matters. There are about 100 domestic staff employed by the contractor, but they have all been given notice of dismissal because the contract is expiring. Tenders have been invited for the new contract – this happens every three years. Crothalls have warned their staff that even if the contract is renewed, the firm cannot guarantee to maintain existing pay and conditions in the future. No information has been given to the unions by the health authority about the tendering process, and there has been no indication of any possible use of in-house services in the future, although NUPE is pressing for this. Staff are insecure, and angry. One of the cleaners spoke out publicly in protest at redundancy notices sent out in October:

> 'It is ludicrous. We are the only hospital cleaners in the area not employed directly by a hospital – and this happens to us every few years. The letter says even if the

> contract is won there may still need to be changes in the number of cleaners needed, work patterns, and conditions of employment ... How can we plan for Christmas or holidays not knowing whether we will have jobs to go to in January?'[5]

Some years ago, Crothalls were replaced for a short period by another rival contractor who offered to do the job cheaper. That firm went bust after six months, and Crothalls were called back in hurriedly. Continuity was lost, and services were disrupted. It was neither economic nor efficient.

WIDER IMPLICATIONS OF CONTRACTING OUT

Competitive tendering is a minefield. It concerns comparison of price for a service that cannot be tested before the contract is awarded. No-one would buy a car without a test-drive of some sort – but Authorities are now expected to buy services on the basis of untested performance. Most important of all, the contract system provides for a fundamentally different basis for structuring of services. It is inefficient and destructive: it fragments services, divides management and staff, and undermines planning, control and accountability in the day-to-day running of those services. There are three features of the system which provide 'compelling reason' (to coin a phrase from the DHSS) for rejecting competitive tendering *per se*. They are these:

1. contracts are for a fixed term and are not permanent

This applies even to in-house tenders and has several implications: a) continuity only lasts as long as the contract runs. There is no long-term guarantee of continuity of management, supervision or labour in the service. Changes in contractors can mean disruption of services, loss of experienced staff, increased training costs, and the entire workforce can change with a new contractor. The morale of in-house staff forced to bid periodically for their own jobs can be greatly undermined by this process, affecting productivity and confidence. b) Periodic revision of contracts and tenders mean that in-house labour costs are effectively regulated by private sector markets and commercial factors – not by the requirements and locally-adjusted needs of the particular authority.

2. contract management serves the company, not the authority

Where services are operated by private contractors, there are two separate managerial structures affecting the contract: private management across contracts, and NHS management through the authority. This distinction is critical; the two structures serve different sets of interests which must conflict; a) In-house services: these are under the direct control of the health authority which runs all the inter-related services. The authority's job is to provide a service geared to public – and local – needs for health care. Contract managers are responsible to company management and the shareholders. The aim of companies is to make profits and meet the financial interests of the company and its investors. Any extra costs incurred in performing the contract are bound to conflict with the company's need to maximise profits.

Contractors will seek economies of scale by expanding their markets, while authorities will find their own economies of scale reduced by any increases in contracting-out. b) Management structures for contract companies cover work 'laterally' across contracts. They span large and varied geographic areas and a variety of services often in both the public and the private sector. These services vary from client to client, not only in scale but also in the degree of specialism required. Approaches to the different types of work – and training for it (if there is any) can vary greatly, and staff, including management, are moved around from site to site, sometimes at very short notice. This means management and supervision may change without warning. It also means that higher management within a contract company may be the job of someone who has no regular or practical involvement with the particular health authority, and who lacks knowledge of local conditions.

By contrast, in-house services have an integrated, 'vertical' managerial structure co-ordinating the running of various parts of the health service in the area. Management of services is therefore closely involved with the authority at all levels.

Put simply, the difference with contractors is that responsibility and control is never direct – the higher the level of management, the more remote it is from the individual service or authority.

3. the effects of market forces

Competitive tendering is concerned with price, not quality of services. Successful tendering depends on market forces outside the control of the authority which may be quite unrelated to the specialised work required in the NHS. Commercial factors may affect the basis for costings – influencing prices but not quality or reliability. These factors include: a) current market rates for labour in the private sector for untrained staff in unspecialised services; b) economies of scale, including those affecting supplies and capital outlay required on the contract; these are not uniform between contractors, and will influence rival tenders' costs; c) the ability of a contractor to 'cross-subsidise' contracts and therefore price artificially low in order to undercut competitors.

In other words, when price determines who wins the contract, experience in the field, or proven quality of work within the particular conditions of specific service or locality, counts for nothing if the cost is high. Cost considerations may rule out adequate training and staffing levels, proper maintenance of equipment, and adequate supplies of materials on the contract. They will encourage cost-cutting in supervision, wages and conditions for staff, training, (especially in the area of health and safety) and other measures designed to cut labour costs to a minimum, such as increased part-time working.

Successful 'window-dressing' in tender documents submitted for the contract can disguise many of these measures. There is no guarantee that a contractor will live up to the promises. Any cross-subsidisation of contracts resulting from underestimated costings is likely to remain undetected in the course of the contract, although it will still influence the decision as to who

wins it. It makes a nonsense of the notion of 'fair competition', and makes attempts to compare relative cost-efficiency futile.

CUTTING THE COSTS OF ANCILLARY SERVICES

The pressure to reduce costs in the NHS comes from two main sources: from the government, intent on reducing public service spending (except defence expenditure); and from private enterprise seeking to maximise profits from NHS contracts. However, there are hidden costs involved in some apparent 'savings' – costs which are simply offset, either onto the taxpayer (redundancy payments and social security benefits) or onto other parts of the service (increased burdens on other staff such as nurses, pathologists and health service managers). There are also the costs of increased workloads and worsening conditions, which fall on the ancillary staff. But one point often overlooked in the rush to balance the books is the hidden cost to patients and the public at large.

If standards fall in ancillary work, the health service becomes unhealthy. When costs are cut in labour-intensive services, standards are bound to fall. Corners are cut to get the job done in less time with fewer staff. Cleaning will be less thorough and less frequent. Laundry will be less carefully checked and sorted, risking contamination of 'clean' linen from other sources. Training will be minimal and less effectively monitored. Supplies will run short or may be rationed. Nutritional standards will fall. In every case, the service will be less flexible and less responsive to the immediate needs of the authority, the patients and the other medical staff. The real danger is that hygeine and safety standards will drop – resulting in more cross-infection, wound infections and post-operative problems, with more accidents to patients, staff and equipment, and there will be increased public risks if serious diseases or dangerous pathogens are inadvertantly spread to the community outside. This will mean more sick people, and higher treatment costs. The saving will turn out much more expensive in the longer-term.

No-one likes a chore. Especially a dirty, routine one. It may be tempting to hand the job over to someone else. But if that happens in the NHS, the cost will have to be met in other ways. These are economies that none of us can afford, because the health and safety of patients and public are at stake. So is the future of the NHS. For competitive tendering does nothing to promote the financial or physical health of the service, and the enormous risks involved are sound reasons for rejecting it. The DHSS circular is reckless and irresponsible – competitive tendering is a recipe for disaster in the NHS.

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