Disclaimer

The views and opinions expressed in this presentation are solely mine and do not necessarily reflect those of the English Department of Health.

This presentation reflects my experience of outsourcing decontamination in England during 2005 to 2010.

“Experience is a dear teacher, and only fools will learn from no other”

Benjamin Franklin
Introduction
Case for Change

1999:
- perceived vCJD transmission risks in reprocessing surgical instruments
- Government advisory body statement that effective decontamination is key to reducing the transmission risk

2000:
- First in a series of reviews of hospital decontamination practices over 5 years
- “The assessors found some examples of good practice, but also many instances where decontamination processes fell significantly short of current standards. In some cases, practice was unacceptably poor.”
Case for Change

Only 5mg of CJD-infected brain tissue on a surgical instrument could contain enough of the causal agent to infect 10,000,000 patients by neurosurgery – Institute for Animal Health, 2003.
Case for Change

• 2001:
  – Circa £120M made available for immediate investments needs to move all poor SSD’s to a minimum acceptable standard in short term
  – Long term issues remained unfunded
  – Lack of public capital funds above the initial funding

• 2003:
  – Decontamination strategy launched by English Health Department with 55 key recommendations for hospitals to implement
  – Requirements for a Medical Devices Directive compliant service by 2007 whether registered against the directive or not!
UK Specific Guidance

• Health Act 2006 Code of Practice for Prevention and Control of Healthcare Associate Infection:
  – to provide a safe decontamination service that generates a clean and sterile product
  – formalises status of Health Technical Memoranda and policy statements

• Specific prion transmission guidance relating to high risk tissues
Why Offer An Outsourced Route?

Figure 7. Histogram showing overall compliance of 29 SSDs surveyed in the Snapshot and Operational Review.
Objectives of the Outsourcing Initiative

- Modern, efficient decontamination services
- Minimising HAI risk whilst delivering Directive compliant services
- Sustainable improvements in safety & quality of the service for patients and staff
- Scaleable service for the whole health system coping with growth
- Deliver value for money whilst avoiding the need for over £1B of public capital funds
Implementation

• Business case submitted to government outlining proposed process
• National, centrally funded support team set-up to roll out procurements
• Local procurement teams responsible for their own projects but offered a support package
• Liaison groups set up with national professional bodies, trade unions and suppliers
Procurement Route

• Standard European Union procurement process (OJEU)

• Initially a 4 stage process:
  – Pre qualification and selection questionnaire (6 – 8 suppliers)
  – Invitation to negotiate stage (4 suppliers)
  – Invitation to submit final offer (2 suppliers)
  – Negotiation (2 suppliers)

• Typical 3 year+ process including internal business case
Collaborative Working

- Organisations grouped into “collaborations” with a base level demand in excess of 250,000 trays
- Collaborations of 3 - 14 hospitals (1 – 8 organisations)
- Bound together by a collaboration agreement
- Non-financial/non-equity, contractual joint venture with the successful supplier
- Individual local customer contracts with the supplier
- Joint Management Board
Contract Structure

JMB

CM

PM

Customer 1

Contract

Customer 2

Contract

Supplier

Co-Op

Agreement
Support Mechanisms

• Technical, human resources and project advisors provided by central team on a revenue loan basis

• Capital funding provided for:
  – short supply instrumentation (subject to an audit)
  – Collection and delivery hub creation
  – Limited emergency equipment replacement during procurement

• Peer group networks with other projects
Technical Standards

• Centres are owned and operated by the private sector supplier
• Output based contract & length typically 15 years
• Contracts require MDD accreditation at all times
• Session to Session turnaround time (16-19 hours) and 5 hour fast-track service
• Performance regime developed, with financial penalties for late deliveries, service failures and cancelled operations
• Hospitals step-in as ultimate sanction
• Payment - volume related with a minimum payment
Solutions?

• 1 or more centres each serving 200,000 - 300,000 trays per annum
• Located off site from clinical activity but within compliant 5 hour fast track turnaround envelope
• Customer tailored opening hours to reflect local evening demand and emergency requirements
• Robust contingency arrangements
• Flexible equipment configurations
Business Cases

• Often as long as the procurement process!

• Outline case prior to procurement being advertised identifying a preferred option

• Test of:
  – Do nothing, Do minimum, public sector on-site, public sector build best option
  – Market is then compared with the best public sector option (PSC)

• Full business case at selection of preferred bidder
Evaluation of Costs

• Prices received at bid stages were compared with the public sector comparator (PSC)
• Suppliers did not see the PSC
• Process only proceeded if the received prices offer better value for money than the PSC
• Prices are also often compared to the current cost of service but....
  – What is value for money?
  – What is the current cost of service?
How do you compare – public capital cost model vs private sector revenue model

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Base Services Payment

VRSA
## Cost Comparison

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Are We Measuring Like for Like?

- Net book value analysis allows comparison of a public sector capital and revenue funded project against a private sector revenue solution.
- What part of the service remains with the public sector?
  - Pre-sterile consumable ordering
  - Instrument repairs
  - Portering/internal distribution
  - Single use instrumentation management
- Agreement of retained costs is key.
- Payment of additional service extras such as fast track and low temperature item sterilization.
- Careful analysis of financial models is essential.
Lessons Learned – Technical

- Collection and delivery hub provision
- Tray and supplementary coding
- Data sign off and population of systems:
  - Tray build sheets
  - Delivery/user locations
  - System users
- IT systems installation and testing both at customer and supplier
- User communication, training and briefing
- Internal/external logistics preparation and testing
- Customer Manager appointment and key role retention
- Transition Order
- Supplementary and high risk instrument marking
Lessons Learned – Contract

• Profit is not a dirty word:
  – Contracts need to be profitable to be stable
  – Profitable contracts = stable, larger market place
• Contracts should be balanced; Risk Up = Price Up
• Know what it is you really need before you procure
• Performance mechanisms should encourage good service and have proportional impact based penalties (No Pain- No Penalty)
• Payment mechanisms need to be transparent and all inclusive where possible
• As a customer you get the service you deserve!
  – Outsourcing still requires in-house management but the skill set is different
Lessons Learned – General

• This is a staff based service
  – Who ever provides the service needs good, skilled dedicated staff
  – High staff transfer rates are key to success during early service days
  – Training is, and remains important; contracts need to reflect that

• Measure the service before and after any service configuration changes – know where you started from!

• Sufficient resources must be allocated by both parties during both transition and migration of service

• Sharing of information and communication is key
Finally

Communication is the key!