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EXPERIENCES IN OUTSOURCING NONCLINICAL SERVICES AMONG PUBLIC HOSPITALS IN BOTSWANA



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It was prepared by Heather Cogswell, Mompoti Buzwani, Louise Myers, Elizabeth Ohadi, Naz Todini and Carlos Avila for the Health Finance and Governance Project.

The Health Finance and Governance Project

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Abt Associates Inc. | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

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ACRONYMS

ART	Antiretroviral Therapy
BOCCIM	Botswana Confederation of Commerce, Industry, and Manpower
COHSASA	Council of Health Services Accreditation of Southern Africa
DPSM	Directorate of Public Service Management
GDP	Gross Domestic Product
HFG	Health Finance and Governance
HLCC	High-Level Consultative Council
KPI	Key Performance Indicator
MoFDP	Ministry of Finance and Development Planning
MoH	Ministry of Health
MTC	Ministerial Tender Committee
OSM	Office of Strategy Management
PEEPA	Public Enterprise Evaluation and Privatisation Agency
PEPFAR	President's Emergency Plan For AIDS Relief
PIC	Project Implementation Committee
PMP	Privatisation Master Plan
PPADB	Public Procurement and Asset Disposal Board
PPP	Public-Private Partnership
PSOP	Public Services Outsourcing Programme
SLA	Service-Level Agreement
USAID	United States Agency for International Development



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EXECUTIVE SUMMARY

Background

Since gaining independence in 1966, Botswana has served as an example of development success—experiencing high economic growth and progressing to a middle-income country classification. Throughout this process, the private sector presence in Botswana has remained small while the government has grown to become the dominant player in the economy and the country’s main employer. With the national Privatisation Policy of 2000, the government began implementing a broad set of reforms to diversify the economy, address the volatility of its two main sources of domestic revenue, cattle and diamonds, and increase the efficiency of the public sector.

While privatisation is a national policy, its uptake by the various line ministries within the government has been slow. Fifteen years after the policy was enacted, the Ministry of Health (MoH) is the leader in the government’s outsourcing and privatisation initiatives. The MoH, through the Ministerial Office of Strategy Management (OSM) and the Public-Private Partnerships Unit, has designed and implemented a number of outsourcing agreements for nonclinical services at seven regional and district hospitals in the country (S’brana, Nyangabgwe, Princess Marina, Sekgoma, Mahalapye, Letsholathebe II Memorial, and Scottish Livingstone). These nonclinical services include cleaning, laundry, security, grounds, and porter services. Food service is expected to be outsourced in a few facilities in the near future.

As a leader in outsourcing, the MoH has encountered and overcome challenges that are documented in this report. The material and lessons learned are intended to serve as a resource for others as they undertake outsourcing initiatives.

Outsourcing Capacity-Building Resources

As outsourcing is a new initiative for the MoH, a series of three workshops were conducted to build the capacity of the MoH, Public-Private Partnership Unit, and the hospital administrators and contract managers in outsourcing. (Materials from each of these workshops are included as appendices to this report so that they can serve as resources for other entities that are considering outsourcing.)

1. *Strengthening Outsourcing Services at the Ministry of Health.* A four-day intensive workshop on “Outsourcing Nonclinical Hospital Services” was delivered to hospital and Ministry of Health staff involved in tendering and managing outsourced services. The workshop covered a comprehensive list of the issues related to outsourcing services, from pre-bid preparatory work to the development of Service-Level Agreements (SLAs), to management of a concluded contract.
2. *Building Capacity to Develop and Monitor SLAs.* A three-day technical assistance workshop was held for participants from the MoH and seven regional and referral hospitals to assist the hospitals in developing SLAs for incorporation into an outsourcing service contract. The workshop goal was to improve MoH and hospital staff capacity around developing, negotiating, and monitoring SLAs.
3. *Strengthening Public-Private Partnerships: Collaborative Approaches, Negotiation, and Conflict Resolution.* To strengthen the capacity of MoH staff and hospital managers around managing conflict and negotiating appropriate solutions to problems that arise between hospitals and contractors, a highly participatory three-day training was held in conflict resolution and negotiation skills for hospital managers and Ministry of Health staff including senior

administrators, contracts managers, head matrons, and the Office of Strategic Management/Public-Private Partnership Unit staff.

Service-Level Agreements

Service-Level Agreements can be the key to successful outsourcing initiatives. The SLA is a component of the overall contract between the hospital and the vendor that creates a common understanding about services, priorities, and responsibilities. It is, most importantly, a “living document” that with mutual agreement can be modified. Properly done, it is a communication tool that can help to minimise conflict between the contracting parties by carefully defining and managing expectations and monitoring the effectiveness of services. An SLA takes time to write, as it includes negotiated, detailed task descriptions, task availability information, standards for timeliness, frequency tables, and quality measures for the provided services.

A contract to outsource a service can be signed without an SLA, as has been the case with all of the current outsourcing contracts in Botswana. Many challenges that have arisen with the quality of the outsourced nonclinical services at the seven hospitals would have been mitigated with properly developed and detailed SLAs. The greatest challenge, therefore, with the outsourcing contracts at the hospitals is the lack of SLAs, and one of the greatest lessons learned is the importance of incorporating SLAs into outsourcing contracts from the outset.

Initial Findings

Financial and budgetary implications: Outsourcing contracts have significant financial and budgetary implications. At the time of the study, seven major district and referral hospitals were operating contracts for laundry, cleaning, porter, security, and landscaping services, with a combined recurring budget of US\$19.4 million (excluding capital and labour). On average, these contracts represented 41 percent of the recurring budget. Cleaning contracts had the largest contract value, representing, on average, 18 percent of the hospitals’ annual recurring budgets. Laundry contracts represented 13 percent of the hospitals’ annual recurring budgets, security contracts represented 3 percent, grounds/landscaping contracts represented 3 percent, and portering represented 2 percent.

Governance and regulation: At the start of the MoH outsourcing initiative, the Public-Private Partnership (PPP) Unit had heavy central control and oversight in the contracting process, and hospitals had a very small role in the decision making. The goal is to institutionalise the PPP work in the hospitals as quickly as possible. To achieve this goal, the PPP Unit will remain small and support the work of the hospitals in contracting so that the initiative can be institutionalised at the hospital level.

Service quality: A survey of over 200 hospital nursing staff indicated that the perceived service quality of cleaning, laundry, and security services has improved since outsourcing. The largest quality improvements were seen in the number and adequacy of staff after outsourcing, adherence to infection control policies, and improvements in the supply and quality of linen. Across all seven hospitals currently outsourcing cleaning services, an average of 61 percent of respondents noted that the quality of cleaning has improved since outsourcing. For linen and laundry services, an average of 75 percent across all seven hospitals felt the quality of linen and laundry services had improved since outsourcing. However, for security services, on average, only 50 percent saw improvement in the overall quality of security services since outsourcing.

Contract management: As a result of the HFG capacity-building workshops, hospitals have made significant changes in the way they manage their outsourcing contracts. Specifically, the hospital contract managers and vendor managers have started performing weekly “walk abouts” to jointly assess service quality. As part of these “walk abouts,” the hospitals have started using checklists (taken from the workshops) to monitor service quality. The checklists allow the hospital and vendor to identify, discuss, and address any concerns. In addition, the hospital has requested and receives

more-frequent/more-complete service reports from the vendor. Generally, before the workshops, the hospital did not receive service reports or received incomplete or infrequent reports. The new methods of contract management have resulted in better communication between the hospitals and vendors and improvements in service quality.

Gender: Botswana's relatively low scores on international indicators relating to gender and human development demonstrate room for improvement in these areas. Economic diversification represents an opportunity to increase the economic empowerment of women. To do so, hospitals need to incorporate nondiscrimination policies into their contracts. To date, no nondiscrimination policies have been incorporated into the outsourced contracts. Despite this, there is initial evidence that outsourcing creates job opportunities for women. On average, the proportion of women in security, laundry, and cleaning services increased by 20 percent after outsourcing, with security services seeing the largest change in employment of women.

HIV: The public sector serves as the largest provider of antiretroviral therapy (ART), with approximately 85 percent of patients treated receiving treatment free of charge in the public sector (WHO 2005). The roughly 250,000 patients receiving ART in Botswana generate a total of 54,000 admissions per year and 1,415,000 outpatient visits per year. In absolute numbers, ART patients contribute to a large number of hospital visits per year and, in relation to total outpatient visits per year, represent a large proportion of visits—in some facilities ART patients contribute a quarter to a third of all outpatient visits. The President's Emergency Plan For AIDS Relief (PEPFAR) 3.0 lays out a strategy to accelerate core interventions for HIV control to ensure transparency and accountability for impact. Outsourcing of nonclinical services contributes not only to comfort, cleanliness, and client satisfaction, but also to unmeasured quality of care and prevention of nosocomial infections. This contributes to PEPFAR's action agendas by ensuring patient satisfaction with the health care system and thereby improving adherence to care; improving the efficiency of hospital financing and operations and thus maximising the investment to HIV and AIDS care and treatment; and advancing the human rights initiative to provide safe and dignified care to people living with HIV.

Lessons Learned and Recommendations

Several key messages and lessons learned from the successful outsourcing of nonclinical services include:

- Contractual relationships result in a win-win situation for both parties, and outsourcing can be successful only if there is a true partnership between the hospitals and the service providers. The relationship between the hospital and the vendor/service provider is complex, and will always involve a degree of tension based on inherent differences in goals. This complexity requires a level of management sophistication on the part of both the hospital and the vendor. It is, therefore, important to practise empathy—i.e., putting oneself in the other's shoes. Hospitals must treat contractors with respect, and not involve themselves in the vendor's operational issues unless there are signs of serious problems.
- Hospitals can play an important role in assisting in the capacity development of new, fledgling service providers in Botswana. Assistance may include training and orientation to the special requirements of hospitals (in exchange for a price break in the contract for the first year), a stepped approach to contracting some services, and detailed service information provided in the SLAs.
- Seeking consensus between all actors affected by a contractual policy facilitates compliance. Taking the time to understand the issues and working out solutions at each stage is critical.
- Involve expert external parties to oversee competitive bidding and selection processes.
- The SLA requires a good faith effort on the part of both entities (the will to succeed needs to be stronger than the will to fail). The SLA allows the hospital considerable leverage and flexibility to

address and correct vendor performance issues short of complete contract termination (which is the only remediation the current MoH outsourced contracts allow). Under the SLA approach, hospitals may create and refine a point-based performance system to encourage/enforce the level of performance desired. “The devil is in the details”: the SLA needs to include enough service information for the vendor to clearly understand the hospital’s expectations (i.e., what constitutes “good performance”).

- A breach in the management cycle of the SLA effectively compromises the entire system: without sufficient monitoring, reports are useless; without good reporting, performance issues cannot be identified and addressed.
- The role of the hospital in outsourcing is to manage the contract, not the contractor’s staff. The service provider monitors the day-to-day performance of its line workers, and the hospital monitors the key performance indicators to measure overall compliance and assure quality.
- The mobilisation phase is critical to ensuring a smooth and safe transition; it requires careful planning and monitoring on the part of both the hospital and the vendor.
- Hospitals must not underestimate how much time it takes to manage a contract. Companies try to sell contracts with promises of great time savings for hospital management. Contract monitoring needs to be rigorous and routine. Hospital management needs to schedule department manager meetings for outsourced service departments with the same frequency as for services that are not outsourced. Hospital management needs to make scheduled and nonscheduled inspections. The hospital needs to periodically audit the contractor’s budget reports and supply and equipment inventories.
- The contract department manager is most successful when (s)he is an equal and participating member of the hospital department management team. The outsourcing relationship should not be one of a supplier mentality but rather a partner mentality, with contract department manager participation on hospital emergency response teams and on multi-disciplinary hospital committees.
- An annual performance appraisal of the department manager needs to be conducted jointly by the hospital administrator and contractor.
- The contract should be regularly re-bid to assure that the hospital continues to pay a fair price for the service and is not missing the opportunity for the introduction of new technology or methodologies.
- The hospitals need to clarify the channels and modes of communication so both sides understand them.
- Ask the vendors’ site managers to serve on relevant hospital committees (infectious disease control, risk management, accreditation).
- Develop monitoring tools together so both sides understand their purpose and application; conduct audits in a highly professional manner to focus on performance improvement; review reports together to identify problems and determine how to resolve (collaborative approach).
- Conduct an orientation for the vendor at the very start of the contract; this should help the vendor better understand the mission and organisation of the hospital and the uniqueness of the hospital environment. This orientation should also serve as a way for the vendor to introduce itself to all hospital staff so everyone knows who’s who.
- The hospital should provide training to the vendor in infection control and other risk areas, to avoid critical mistakes and to help the vendor understand the rationale for hospital protocols and how the vendor’s procedures must respect these. The hospital should continue to provide periodic in-service training, particularly for vendors who have little or no prior experience working with hospitals.



- The hospital should provide free medical exams to the vendor (as a good faith concession) and look for other ways to reach out with support. For example, office space could be provided for the vendor at a minimal cost to the hospital. This will encourage the vendor to reciprocate in future situations when the hospital may need concessions from the vendor.
- Contractors should receive a copy of the South Africa hospital accreditation standards to study and use—the standards promulgated by the Council of Health Services Accreditation of Southern Africa (COHSASA). The hospital should clarify what these are, how the hospital is working towards the standards, and what role the vendor will have in the hospital achieving COHSASA certification.
- The hospital should get agreement with the contractor on a clear payment timeline and stick to it.
- Timeliness is critical on both sides: services delivered, reports submitted, payment for services completed, issues identified and addressed, etc.
- Both hospitals and vendors must operate within legal frameworks.
- Both sides should negotiate in good faith.

Next Steps

The availability of detailed cost benchmark data is critical to determining the impact and success of outsourcing. While challenges remain and the outsourcing process will continue to be refined based on lessons learned, without detailed cost information it is not possible to judge the value for cost that outsourcing brings.

The decision whether to outsource nonclinical services, and which services to outsource, requires careful consideration and study; hospital senior management needs a clear understanding of current costs and service issues that need to be addressed before the advantages and disadvantages of outsourcing can be weighed. Similarly, without thorough and detailed cost information and service-level specifications in a vendor's proposal, an objective comparison to current operations is not possible. The lack of benchmark data on what it costs the hospitals to provide the nonclinical services in-house has impeded the hospital management teams and the MoH, because they have nothing with which to compare the cost of the bids they receive. Currently it is not possible to judge the value for cost that outsourcing does or does not bring to a hospital department.

As part of HFG's technical assistance, a costing study of nonclinical services was conducted in five hospitals in Botswana that have not yet initiated outsourcing. The costing report by Stegman et al. (2015) provides estimates of the current costs of nonclinical services (i.e. cleaning, laundry, catering, and grounds maintenance) at public hospitals before outsourcing begins. As outsourcing expands, it is important for the MoH to develop a better understanding of the total annual cost for the provision of nonclinical services, the drivers of those costs, and the unit cost of production for each service. Such information will aid the MoH in determining a fair contract price when outsourcing, and will help the MoH and hospitals make strategic outsourcing decisions that are cost-effective and truly increase the quality and efficiency of public sector service delivery.

I. THE OUTSOURCING POLICY IN BOTSWANA

I.1 Impetus for Privatisation

During the African post-independence era, the existence of weak private sectors led governments to rely on large public sectors to stimulate economic development (Harsch 2000). However, bureaucratic control, inefficiency, and waste that can occur in the public sector have, in some cases, prompted creditor institutions like the International Monetary Fund and the World Bank to push for economic liberalisation (Harsch 2000). Since the late 1980s, governments in Africa have been undertaking privatisation efforts to enhance efficiency in the delivery of public services, to develop private businesses, and to relieve the government of both financial and administrative burdens. Most African countries have now instigated some sort of privatisation programme (Harsch 2000). Defined broadly, “privatisation encompasses all the measures and policies aimed at strengthening the role of the private sector in the economy” (Ministry of Finance and Development Planning (MoFDP) 2000).

Since gaining independence in 1966, Botswana has experienced high economic growth, and progressed from World Bank classification as a low-income country to a middle-income country classification. The private sector presence in Botswana has remained small. In contrast, the government has grown to become the dominant player in the economy and serve as the country’s main employer (MoFDP 2000). Public spending currently accounts for 46 percent of Gross Domestic Product (GDP) (World Bank 2010). The government has established parastatals; created the Botswana Development Corporation, which serves as the government’s investment arm; and created departments like the Central Transport Organisation, which perform tasks “that in most developed economies would be performed predominantly by the private sector” (MoFDP 2000). Over the past 40 years, the government has extended its investment into virtually every sector of the economy, including hotels, tourism, repair and maintenance operations, construction services including architectural services, publishing, transport, financial institutions, and agricultural and estate management (MoFDP 2000). The government now believes that the public sector has grown too large, and as a result has become cumbersome to effectively manage.

Botswana’s growth and development has largely been financed by a steady source of mining, largely diamond, revenues. However, Botswana is facing the long-term decline of its diamond revenues—estimates predict that Botswana’s diamond deposits will be depleted by 2030 (World Bank 2010). Real GDP growth, averaging 7 percent in the early 1990s, had declined to an average of 3 percent by 2010. The World Bank’s May 2010 Public Expenditure Review supports Botswana’s privatisation policy, and stresses that the government should focus less on the provision of basic infrastructure and social services, and, instead, focus on effectiveness and efficiency in service delivery (World Bank 2010). Similarly, the International Monetary Fund reports that to sustain growth rates, Botswana needs an ambitious set of policies and reforms to create a leaner, more effective public sector and promote private sector-led growth (International Monetary Fund 2013).

The Government of Botswana has several key interests at stake (African Development Bank/Organisation for Economic Co-operation and Development 2007):

- Macroeconomic stability—the economy is currently subject to large fluctuations and shocks, such as droughts and unanticipated shifts in earnings from mining.
- Private sector development—the government is looking to create an environment conducive to private-sector development.
- Export diversification—expanding the type and variety of exports coming out of the country will reduce risks associated with fluctuations in any one export.



“The impetus for privatisation in Botswana has come from a desire to improve efficiency in the delivery of services, to raise the country’s growth potential by securing stronger flows of foreign direct investment and technology transfer, and to create further opportunities for the development and growth of the citizen business sector” (MoFDP 2000). The efficiency of the public sector tends to be low; total investment in public enterprises exceeds 15 percent of Botswana’s GDP, but contributes only 6 percent of GDP (MoFDP 2000). The government recognises that public enterprises need to operate in a more efficient and business-like manner, and established the Botswana National Productivity Centre as an act of Parliament in 1993. This special programme aims to figure out how to increase worker productivity and enhance organisational productivity (Botswana National Productivity Centre 2005).

Privatisation is a political, commercial, and economic process that diminishes the state’s control of the economy. The government is committed to reducing the dependence of the economy on diamond mining and to improving the private sector business climate. Botswana’s development roadmap, Vision 2016, and the National Development Plans to implement programmes and policies to achieve Vision 2016 have all emphasised the need to diversify the economy.

1.2 Privatisation Policy Goals

The Privatisation Policy of 2000 and the subsequent Privatisation Master Plan (PMP) I and PMP II are premised on the position that the private sector is better positioned than the government to deal with market forces that drive the economy (MoFDP 2013). The overall goal is to achieve economic growth and diversification by reducing the size of the public sector and improving its performance. To that end, the public sector will “progressively diminish its role in the provision of marketable goods and services and will seek to facilitate and, where necessary, regulate the operation of the private sector” (MoFDP 2000).

The main objectives of privatisation include (MoFDP 2013):

- Improving the efficiency, competitiveness, and productivity of public enterprises, and therefore, service delivery
- Strengthening the role of the private sector in the economy
- Enhancing institutional capacity in the public sector to implement privatisation and related reforms
- Bringing market efficiencies in activities in which the government will continue to be involved
- Ensuring promotion and participation of citizens and citizen businesses in the economy, and promoting foreign direct investment flows

1.3 Privatisation Policy Design

The Botswana Privatisation Plan is a national policy that is quite broad in scope and covers several means of privatisation including (MoFDP 2013):¹

- (i) **Performance monitoring** of current public enterprise initiatives to enhance oversight and increase efficiency.
- (ii) **Divestiture of parastatals.** The Botswana Telecommunications Company will be the first parastatal to be divested. It is anticipated that the National Development Bank and several other parastatals will follow.

¹ While privatisation is a national policy, for the purposes of this paper we will focus on the outsourcing of non-clinical services within the Ministry of Health only.

- (iii) **Re-structuring of parastatals.** This includes merging parastatals with overlapping mandates and re-structuring parastatals to increase coordination and efficiencies.
- (iv) **Outsourcing of services.** Outsourcing involves the “transfer of provision of services to the private sector with government retaining responsibility for ensuring the quality of the services and the efficiency with which the services are being delivered” (MoFDP 2005). The majority of privatisation in Botswana is currently occurring through outsourcing. Outsourcing’s relatively short implementation timeline contributes to the large volume of outsourcing initiatives in Botswana.

Outsourcing of noncore services is designed to improve efficiency in the public sector by progressively passing over to the private sector the commercial management of services currently undertaken by the public sector (MoFDP 2005).

1.4 Privatisation Policy: Implementation and Timeline

Botswana’s Privatisation Policy was implemented within the broader national macroeconomic policy framework. The implementation strategy uses a sectorial approach to align the privatisation projects with sectorial objectives in addition to the national objectives (MoFDP 2013).

In 2000, the MoFDP published the *Privatisation Policy for Botswana*. This policy introduced the government’s commitment to economic reforms that strengthen the private sector and reduce the role of the public sector in providing marketable goods and services. An outcome of the privatisation policy was the call for the establishment of the Public Enterprise Evaluation and Privatisation Agency (PEEPA), an agency under the MoFDP that would serve as a government advisor and lead implementation of the privatisation policy. In 2001, PEEPA was established.

In 2005, PEEPA developed a detailed plan of commercialisation and privatisation known as the “Guide to Contracting out Public Services”; all outsourcing projects identified going forward were implemented in line with PEEPA’s plan (MoFDP 2013). In the same year, the MoFDP published its first Privatisation Master Plan of 2005. The purpose of the PMP I was to provide criteria by which selection of suitable enterprises for privatisation were to be made, and to provide principles and practices to be followed to achieve privatisation. Around this time, PEEPA established a Project Implementation Committee (PIC), which was composed of Permanent Secretaries from each line ministry. PIC’s adoption of the “Outsourcing Strategy and Programme” in March of 2006 created a committee of outsourcing “champions” that could kick-start the process in each of their line ministries. Unfortunately, PIC did not work as intended due to a disconnect between the privatisation policy goals and the different priorities of the ministry leaders. Most line ministries have not started outsourcing.

In 2010 the Presidential Directive Cab 16(B)/2010 called for the Cabinet as the ultimate decision maker on privatisation transactions. The Ministry of Finance and Development Planning serves as the coordinator of the privatisation programme at the Cabinet level. Sector ministries are responsible for sector policy formation and regulation, and for financing all studies relating to privatisation within their respective sectors (MoFDP 2013). In this same year, both the Procurement Unit and Office of Strategy Management were established within the MoH.

The concept of the OSM emerged from the MoH’s challenges in implementing strategic programmes. The OSM was established in November 2010 and is PEPFAR-supported (OSM 2014). An office of 13 staff, it prioritises both MoH and donor-funded projects that fulfill strategic objectives, and oversees MoH strategy including project management, performance improvement, and public-private partnerships. In collaboration with PEEPA, the OSM published the Ministry of Health Outsourcing Strategy and Programme in 2011. This is a five-year MoH strategy focused on outsourcing nonclinical services in the country’s hospitals. The strategy follows a phased approach:

- Phase I (2011-2013): Outsource nonclinical services in the three referral hospitals.
- Phase II (2013-2015): Outsource nonclinical services in the four district hospitals.
- Phase III (2015 onward): Expand outsourcing of nonclinical services to over 20 regional hospitals and health centers.

Presidential Directive CAB 3(8)/2011 approved the Public Services Outsourcing Programme (PSOP) in 2011. The Public PSOP listed mandatory outsourcing for landscaping and gardening services, while outsourcing cleaning and security services was listed as optional (MoFDP 2013). The PSOP also calls for public sector capacity-building to empower officials to develop output-based SLAs and exercise appropriate contract management (MoFDP 2013).

A nine-week public sector strike over wage disputes was held from 18 April through 12 June 2011, in which close to 100,000 public sector workers refused to work. This put a large strain on the economy and occurred during a time when the government was already feeling pressure by the International Monetary Fund and the World Bank to reduce the size of the public sector in the economy. During the strike the government dismissed many public sector workers and then chose not to reinstate those workers after the strike had ended. The strike served as an impetus for the MoH to accelerate its outsourcing plans (Van Niekerk 2011).

The MoFDP published a second Privatisation Master Plan (PMP II) in 2013. The focus of PMP II (from 2013 to 2018) is on the following sectors: 1) transport and works, 2) energy, 3) agriculture, 4) health, and 5) waste management. Activities in other sectors will be implemented if the need arises and if they have been approved for implementation during PMP II.

See Annex A for a privatisation timeline.

1.4.1 Implementing Entities

Botswana has a decentralised model for ownership and control of its public enterprises, in which sector ministries are responsible for overseeing public enterprise operations (MoFDP 2013). Therefore, it is the responsibility of the individual ministries to undertake all aspects of the outsourcing process, including contract management of private sector service providers (MoFDP 2005).

Nationally, there is a legal and regulatory structure in place through which the outsourcing process must pass, but each line ministry is responsible for its own strategy and programme. PEEPA is available to manage the outsourcing process by providing coordination and oversight, but it is ultimately up to the line ministry leadership to implement outsourcing. Leadership is key. It is believed that a main reason why outsourcing has been slow to take off in the various line ministries is a lack of government leadership—the OSM has seen a disconnect between the privatisation policy goals and the different priorities of the ministry leaders.

The MoH is leading the way with respect to outsourcing. All ministries are supposed to be outsourcing, but for most other ministries outsourcing is still just an abstract idea, and there has yet to be any bold effort from these other ministries. PEEPA conducted a survey of all ministries and independent departments and local authorities to determine the extent of current and planned outsourcing initiatives as of March 2013. The MoH's outsourcing initiatives as of 2013 represented 10 percent of the total outsourcing initiatives in the country (PEEPA 2013). This proportion is likely to be underestimated, as the Ministry of Transport and Communications, which reported 84 percent of total reported outsourcing initiatives, included vehicle purchasing and repairs as part of their outsourcing figure. In addition, the MoH's proportion is likely to be higher now, given that the MoH has more than doubled the number of facilities that have outsourced some services since 2013. The MoH moved from three facilities to seven facilities, with plans for further expansion.

1.4.2 Selection of Services

In their Outsourcing Strategy and Programme (2011–2016), the MoH used Kralijic’s matrix to categorise 18 hospital services according to the service’s financial impact and supply risk. The impact on financial results includes factors such as direct and indirect costs of the purchased service, and percentage of total costs in the provision of health services. The supply risk is usually determined by the number of suppliers in the market, availability of reserves or alternatives, stability of suppliers in the market, and cost of switching to alternative suppliers.

In reality, very few criteria of quality exist, and virtually nothing is known about the current cost of these hospital services. The private sector for these services is almost non-existent, which makes conducting any type of supply risk analysis almost futile. Therefore, the selection process deviated slightly from the original policy. In the Outsourcing Strategy and Programme (2011–2016), the MoH “embarked in an arbitrary process of determining the financial impact as well as the supply risk of the prioritised services” (p. 23). Of the initial services selected for outsourcing, with the exception of laundry services, all of the services fell into the “noncritical/routine services” category. This category has low financial impact and low supply risk. Part of the intent in choosing these noncritical services as the starting point for outsourcing was to pilot the process on services that have low overall risk, so that lessons learned can be applied to the higher-impact, higher-risk services. In addition, all of this outsourcing work was happening during the economic crash of 2008, so there was a large emphasis put on outsourcing support services that were not too costly to contract out. While the assumption was that the selected services would not be too costly to contract, in fact, at the time of service selection, the real cost of providing these services was unknown.

In an interview with Dr. Ndwapi Ndwapi, the former director of the OSM, he said that the MoH’s goal is to stick to their “core” business of health, and outsource all of the noncore services. The risk aspect of outsourcing was considered—many core components of the hospital system are working well, and a decision was made not to tinker with core components that are working well.

Of the services currently outsourced at the hospitals, security is the only one that has experienced substantial outsourcing across the entire government. Security services are controlled and managed by the Central Government, which eliminates bottlenecks that result from working through individual line ministries. While centrally controlled services may be easier to manage from a contracting point of view, they may not automatically be the best solution for ensuring service quality and at the facility level; for example, if a company is selected and managed centrally but has never worked in a health care setting or has no training programme geared for a health care setting it can create added safety concerns for hospitals.

In 2013, in an effort to improve maintenance of government health facilities, the MoH outsourced facilities management to the Stobech Facilities Management company. While managed centrally, Stobech is responsible for mechanical, electrical, and other building maintenance needs at a variety of health facilities. Central management of the maintenance contract often resulted in hospitals being left out of the contracting process entirely, to the point where some hospitals never even received a copy of the maintenance contract, and therefore were unaware of what services Stobech was expected to provide for the facility. In fact, out of all of the services outsourced at hospitals, the experience with outsourcing of centrally managed services like security and maintenance has consistently been poor across facilities.

1.4.3 Hospital Selection and Implementation

According to the PMP I, enterprises are to be selected for privatisation based on “desirability” and “feasibility” of privatising them (MoFDP 2005). A “desirable” enterprise for privatisation is one that has “a clear understanding of the relative advantages (and disadvantages) the private sector may have over government in providing the particular good or service considered” (MoFDP 2005). “Feasibility” is determined by “the ease of privatisation (within the guidelines outlined under the

policy) and the attractiveness of the activity to the private sector” (MoFDP 2005). The policy further states that “contracts with the private sector will be awarded only after a transparent tendering exercise involving objective scoring of bids against agreed criteria of quality and cost” (MoFDP 2005).

The famous saying that “20 percent of facilities cause 80 percent of the problems” was used to inform hospital selection: the hospitals were chosen for privatisation of nonclinical services based on their size and patient volume; and out of these larger-volume hospitals, the MoH decided to tackle the most troublesome facilities first – those with the greatest potential for positive impact.

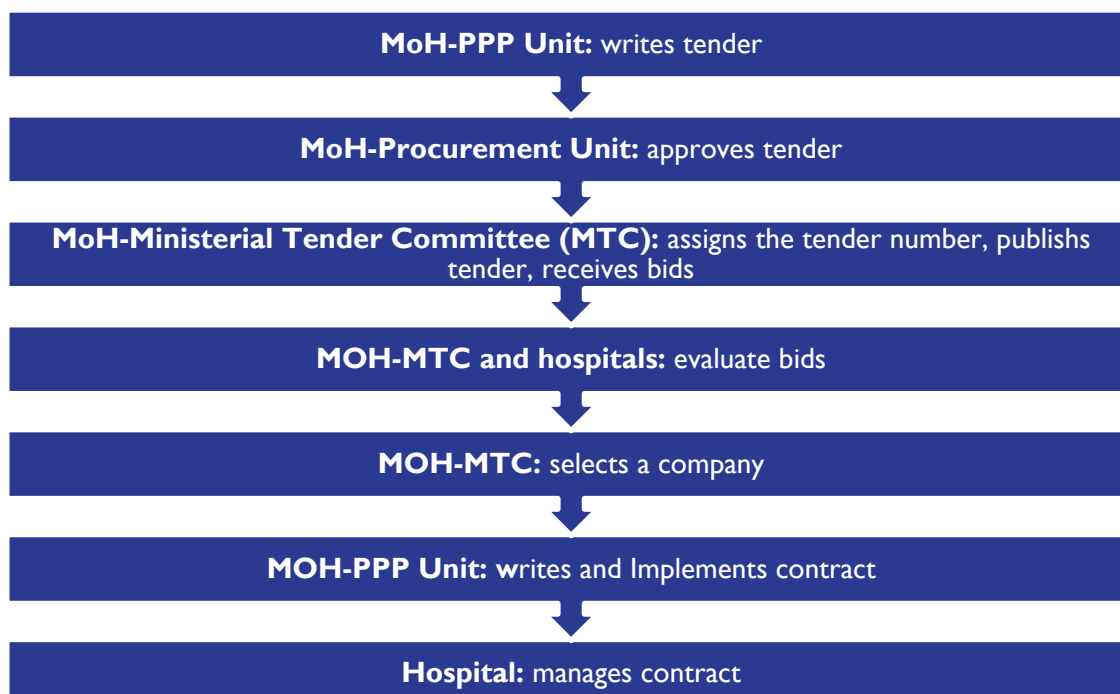
The MoH employed a three-stage approach to outsourcing nonclinical services at the hospitals:

- **Stage 1 (2011– 2013):** Pilot outsourcing of laundry, cleaning, porter, security, and landscaping services in three referral hospitals.
- **Stage 2 (2013– 2015):** Expand outsourcing to the four district hospitals, and begin outsourcing catering services too.
- **Stage 3 (2015–2016):** Expand outsourcing to approximately 20 50-bed primary hospitals in the country. These primary hospitals are part of catchment areas that include 25-bed maternity clinics. For some of the services, there may be one outsourcing contract for hospitals and clinics in a particular catchment area. For example, outsourcing of laundry would cover the primary hospitals as well as the ~100 maternity clinics that fall into those hospital’s catchment areas. For other services, like cleaning, the catchment area will not be relevant; instead, individual companies will be hired for each of the 120 hospitals/clinics.

1.4.4 Contract Process

The diagram below represents the steps and stages of the contracting process.

Figure 1: Steps and stages of the contracting process



1.5 Stakeholders Involved in the Privatisation Process

Many stakeholders are involved in Botswana's privatisation process; this means the process is more regulated, with sufficient checks and balances. The large number of stakeholders also means that the government departments, committees, councils, boards, and directorates may have overlapping roles that create confusion over who has authority, decrease accountability, and build into the system inefficiency and long time delays.

Initial proponents of the Privatisation Policy did a lot of lobbying and, as a result, privatisation became somewhat of a mantra in the country. The highest levels of government have bought into it, and that has been critical in pushing privatisation policies through: there is a lot of support from the president and cabinet. The president especially is determined to see privatisation through. A key component is making sure that line ministries have strong leadership that is fully invested in the outsourcing initiative. In addition, the government needs to reorganise the privatisation process in order to ensure clarity of roles and reduce inefficiencies in the system.

1.5.1 Ministry of Health Level Stakeholders²

- **Office of Strategy Management:** The concept of OSM emerged from challenges that the Ministry of Health found in implementing strategic programmes. The OSM was established in November 2010 and is supported by the President's Emergency Plan For AIDS Relief (OSM 2014). It prioritises both MoH and donor-funded projects that fulfill strategic objectives, and oversees MoH strategy including project management, performance improvement, and public-private partnerships. Thirteen people work in this office.
- **Public-Private Partnership Unit:** The PPP Unit falls under the OSM. The unit is responsible for overseeing and managing outsourcing of nonclinical services at the hospital level. The PPP Unit shares eight staff with the OSM's Project Management Unit.
- **Ministry of Health Procurement Unit:** The Procurement Unit fulfills a generic function across all procurement activities, and supports the implementation of the Public Procurement and Asset Disposal Board. The Procurement Unit collaborates with the Ministerial Tender Committee to make sure that rules are followed.
- **Hospitals:** Hospitals assist in writing tenders, analysing bids, and writing contracts and Service-Level Agreements for selected companies. The hospital serves an important role in managing outsourced service contracts. Hospital managers have generally supported outsourcing.
- **Unions:** A "Public Service Union" exists; it is an umbrella union covering all hospital employees including nursing staff. The unions tried to fight privatisation and outsourcing, but were never united in their protest and therefore failed.
- **MoH Internal Stakeholders:** These include for example government ministry staff, MoH management, and rank and file staff.
- **Council of Health Services Accreditation of Southern Africa:** COHSASA is the only internationally accredited quality improvement and accreditation body for health care facilities based in Africa. No COHSASA-accredited facilities currently exist in Botswana, but facilities are working to meet accreditation standards.
- **Current suppliers:** Some businesses currently selling supplies to the hospitals may lose business from outsourcing if the companies choose different suppliers.

² See Annex B for an organization chart.

1.5.2 National-Level Stakeholders

- **Attorneys General Chambers:** Attorneys General Chambers provide oversight and advise the government on legal issues pertaining to privatisation (MoFDP 2013). They manage all legal agreements for the government, and draft the contracts. Each ministry has an Attorneys General representative.
- **Botswana Confederation of Commerce, Industry and Manpower (BOCCIM):** A private sector association of employers representing all sectors of the Botswana economy, BOCCIM negotiates with the government to make a conducive environment for the private sector players. Health is just one of many sectors that BOCCIM works in. The OSM did not talk with BOCCIM directly during the initial outsourcing work, but going forward, the OSM plans to work with BOCCIM.
- **Business and Economic Advisory Council:** This council, established in 2005, works on strategies to diversify the economy including: identifying constraints that hinder economic diversification, formulating diversification strategies and action plans, and identifying future diversification projects.
- **The Cabinet and Parliament:** The government has three branches: 1) Judicial, 2) Legislative (e.g., Parliament), and 3) Executive Cabinet (issues directives). “The Cabinet and Parliament are the ultimate decisionmakers on privatisation. Their responsibilities include: approval of the Privatisation Master Plan; approval of sector policies and legislative changes; approval of enterprise divestiture strategies and plans; approval of outcomes of privatisation bidding process prior to closing major privatisation transactions” (MoFDP 2013).
- **Citizen Entrepreneurial Development Agency:** This empowerment fund targets small and medium-sized enterprises.
- **Directorate of Public Service Management:** DPSM is the official employer of all government employees; DPSM appoints and sanctions job appointments and authorises payroll payments. Outsourcing will mean that some staff have to be terminated because others, from the private sector, will be fulfilling their roles, so DPSM is involved in the process.
- **Divestiture Reference Committee:** This technical working committee reports to the MoFDP. It is responsible for providing advice on all privatisation matters. It approves Terms of Reference, and oversees sector studies relating to privatisation. Members of the Committee will consist of the MoFDP, the Public Enterprise Evaluation and Privatisation Agency, the relevant sector ministries, Attorneys General, Ministry of Labour and Home Affairs, DPSM, Directorate on Corruption and Economic Crime, National Strategy Office, BOCCIM, and Workers Unions (MoFDP 2013).
- **General public/consumers:** Public perception of hospital service quality, including the cleanliness and general environment of the clinic or hospital, influences patient satisfaction and whether or not the general public will decide to use that facility for care and treatment.
- **High-Level Consultative Council (HLCC):** Chaired by the President, this council consists of government and private-sector representatives. It includes a high-level representative from BOCCIM.
- **Health HLCC:** Sectorial HLCCs, like the Health HLCC, were established to identify constraints at the industry level. The Health HLCC provides a briefing on the work done in the health sector to date, and prepares health sector recommendations and submits them to the main HLCC meeting.
- **Health Innovation Hub:** A part of the MoH, the group looks for areas under health to be outsourced.

- **Local and International Media:** The media reports on hospital quality indicators and other hospital ratings influencing public perception of the facilities.
- **Local Enterprise Agency:** This targets small and medium-sized enterprises with training and other forms of assistance.
- **Line Ministries:** Line ministries are responsible for identifying functions that require outsourcing, and for managing the procurement process, and monitoring the private sector service providers after the services have been contracted out (MoFDP 2005). PEEPA, in consultation with line Ministries, will conduct studies around sector reforms that are linked to privatisation.
- **Ministry of Finance and Development Planning:** The Ministry of Finance, advised by PEEPA, is responsible for overall coordination of the Privatisation Programme. The minister is also responsible for coordinating and integrating the reform process through liaison with line ministries.
- **Ministerial Tender Committee:** The MTC serves a statutory function and manages all aspects of public procurement on behalf of the Public Procurement and Asset Disposal Board (PPADB) for contracts valued at up to 25 million pula. (PPADB handles contracts for 25 million pula and above.) The management task includes vetting tender documents, adjudication, and awarding of tenders. Each line ministry has its own MTC, which operates as a branch of PPADB.
- **Ministry of Finance PPP Unit:** This unit of the MoF has played only a limited role in privatisation.
- **Project Implementation Committee:** The government, via PEEPA, selected Permanent Secretaries from each line ministry to kick-start the outsourcing process.
- **Public Enterprise Evaluation and Privatisation Agency:** Formed by an act of Parliament, this agency under the Ministry of Finance fills a coordination and oversight role. It is responsible for managing the outsourcing process, including carrying out a business case assessment and procuring private sector service providers, and working in close collaboration with the procuring entities. PEEPA is supported by stakeholders such as the Attorneys General's Chambers and the PPADB.
- **Public Procurement and Asset Disposal Board:** This national board was set up by the privatisation act; it regulates and approves the sale of government assets as well as the procurement of goods and services for contract values of 25 million pula and above. This includes the sale of shares by government, and the procurement of services under the outsourcing programme (MoFDP 2013). PPADB regulates all procurement and has the potential to be a stakeholder with the most influence—for example, if the OSM-PPP disagrees with PPADB's decision, the OSM-PPP has no one to appeal to. PPADB is the regulatory body, while PEEPA actually executes and facilitates the work.
- **Sector ministries:** Sector ministries develop sector policies and propose legal reform and regulations. With PEEPA's assistance, the sector ministries review, approve, and monitor the performance of public enterprises, which remain under their jurisdiction (MoFDP 2005).

2. INTERNATIONAL EXPERIENCES IN OUTSOURCING HOSPITAL SERVICES

Outsourcing in the public sector occurs when a public entity decides to stop carrying out an activity and hires a private sector actor to do it in its place (Perrot 2006). The government may retain responsibility for ensuring the quality and efficiency of the outsourced services. The most frequent reasons cited for outsourcing include improving service delivery performance by increasing access to underserved populations (thus addressing issues of equity), improving quality of care, reducing costs, and increasing efficiency (Liu et al. 2004; Loevinsohn and Harding 2005; Siddiqi et al. 2006).

Outsourcing is often done in the form of a contractual agreement, or by “contracting out.” Contracting out is a “purchasing mechanism used to acquire specified services of a defined quality at an agreed price from a specific private provider and for a specific period of time” (Patouillard et al. 2007). The contract binds two actors into a formal relationship where both actors expect to benefit from the relationship (Perrot 2004).

Contracting out in the health sector often originates with nonclinical services, such as food preparation, laundry, and cleaning services; it is sometimes later extended to cover clinical services, but it has largely been applied to noncore ancillary activities as opposed to clinical services, where “employment of more qualified and organised workforce” could be threatened by it (Moran and Batley 2004). While contracting out has been more common for nonclinical than clinical services, the types and frequency of these contracts differ by country. See Annex C for a table of country examples of outsourcing of nonclinical services.

2.1 The Rationale for Outsourcing

In addition to improved quality of service and new business development opportunities for the community, the outsourcing of services often creates gains in efficiency. Efficiency gains arise as experienced and specialised managers are able to reduce and control operating costs and introduce new technologies and methodologies in the way a service is delivered. Additional reasons for outsourcing include:

- **Inadequate coverage of government services for the poor:** Contracting out in nine countries—Cambodia, Bangladesh, Bolivia, Guatemala, Haiti, India, Pakistan, Madagascar, and Senegal—was found to be motivated by inadequate quality and coverage of government services, especially for the poor (Loevinsohn and Harding 2005).
- **Gaps in public sector’s capacity to provide health care:** Contracting out can fill gaps in the public sector’s ability to provide health care. In Cambodia, governance issues in the public system necessitated contracting out (Lagarde and Palmer 2009).
- **Geographic drivers:** The gaps in the public sector may be geographically driven. For example, in El Salvador, the MoH contracted an NGO to provide primary health services in the difficult-to-reach rural Municipality of San Julian (Waters et al. 2002).
- **Decentralisation reforms:** Contracting out may be motivated by decentralisation reforms in the health system.



- **Encourage competition:** Contracting out may be implemented to encourage competition in provision of primary health care services, as in the case of South Africa and Colombia (Mills and Broomberg 1998).
- **Tap into private sector economies of scale:** Outsourcing may be used to motivate the private sector to assist with public health goals. The private sector (for-profit and not-for-profit) is often well resourced for health care and has access to resources that may not be available in the public sector.
- **In response to national-level policies:** For some countries, contracting out is triggered by national-level policies.
- **Lack of public sector provision in conflict zones:** Outsourcing may be motivated by the public sector's inability to provide for its population, especially after conflict.

2.2 Cost and Benefits of Outsourcing Services

The literature on the cost-effectiveness of contracting out is scant. Some studies suggest that contracted providers can deliver services at a lower cost than public providers; however, it is unclear whether contracting actually lowers the overall cost of service delivery (Liu et al. 2004). Furthermore, it has not yet been demonstrated that contracting out increases the efficiency of the overall health system (Liu et al. 2004).³ The intervention of contracting out is very complex, and studies to empirically determine cost-effectiveness or efficiency are extremely difficult to do. These studies need to consider a panoply of factors, including:

- type of service (clinical vs. nonclinical)
- type of subservice (nonclinical: catering vs. security; or clinical: primary health care vs. specialty care)
- type of payment mechanism
- country and geographic region
- bidding process
- government capacity
- private sector environment/market structure
- types of costs to include (e.g., transaction costs, contract implementation costs)
- finding an appropriate comparison group

Some studies have demonstrated that contracted providers can deliver services at lower unit costs than their public sector counterparts, while maintaining quality—indicating improvement in efficiency at the provider level. For example, experiences from Cambodia have shown that contracting out Reproductive Health/Family Planning services costs less and improves equity and access (PSP-One 2006). In a similar example, at the Mahatma Gandhi Hospital in Durban, South Africa, a calculation of the cost per client for provision of Reproductive Health/Family Planning services found that contracted services were a cost-effective strategy (Corby et al. 2012). In South Africa, comparisons of three contracted hospitals with three government hospitals found that the contracted hospitals provided similar care at significantly lower unit costs (Patouillard et al. 2007). In Zimbabwe, performance of two government district hospitals was compared with that of two not-for-profit hospitals; again, the contracted hospitals delivered services at the same level at substantially lower unit costs (Liu et al. 2004).

³ From Liu: “This is all the more surprising given that one of the reasons there has been a movement toward contracting is its perceived potential for greater efficiency when compared with direct public sector provision.”

In contrast, in Tunisia, several university teaching hospitals subcontracted their catering and cleaning services, which resulted in better quality of services but at a higher price (Perrot 2004). The same was found in Jamaica, where contracting out cleaning and portering services resulted in 25 percent higher costs, but also in higher quality and increased scope (Mills and Broomberg 1998). In the Czech Republic, hospital catering services provided by SODEZHO, a French international company, were found to be cost-prohibitive, and the public hospital ended up resuming provision of catering services itself (Perrot 2004). In India, a catering contract resulted in lower costs to the hospitals, but the quality and quantity of food was worse (Corby et al. 2012).

In Zimbabwe, faith-based hospitals were found to have lower unit costs compared to public hospitals, along with more-motivated staff, with greater autonomy—suggesting greater efficiency. However, there was significant fragmentation and low coordination with public health services at the district level—which suggests lower efficiency (Mills and Broomberg 1998).

2.3 Best Contracting Practices from International Experiences

A review of the literature identified a list of “best practices” around contracting from international experiences:

- Contractual relationships should result in a win-win situation for both parties. The experience of Marie Stopes International in Bangladesh, India, and South Africa as contracted to provide family planning and reproductive health services demonstrates how the NGO filled a gap in the public system while meeting organisational goals (Corby et al. 2012).
- Commitment from politicians helps with compliance to a contractual policy. Morocco had internal contracts between the central ministerial level and health regions, and regional directors were motivated to implement the policy because they “understood the political determination to implement the reform” (Kadai et al. 2006; McPake and Mills 2000).
- Seeking consensus between all actors affected by a contractual policy will facilitate compliance. Chad, Madagascar, and Senegal sought mutual understanding of all actors throughout the process of developing the contractual policy. Similarly, in Benin, when the MoH realised that “some trade unions were vehemently opposed to certain forms of contracting,” it chose to discuss the strategy with the unions rather than imposing unpopular regulation (Kadai et al. 2006).
- Taking the time to understand the issues and working out solutions at each stage is critical. In Benin, it took 12 months of discussions between the different partners of the Health Development Support Programme to clarify each partners’ role. If contracting is a new experience, then even more time should be spent in each stage (Kadai et al. 2006).
- Invest in continuous relationship building and maintenance. Strong relationships allow contractors to best understand the government’s needs, improve the likelihood of meeting those needs, and ensure prompt response. These relationships should be maintained despite the high turnover often seen in the public sector. In some instances, it may be necessary to appoint a strategic staff member to serve this relationship-building role; in India, Marie Stopes International appointed a former government staff member to specifically serve as the government liaison (Corby et al. 2012). Sometimes, contract monitoring may simply require follow-up. “It is not uncommon for partners to have made considerable efforts during the preparatory stage of the contract, only then to cease their efforts once it has been signed” (Perrot 2004).

- Involve expert external parties to oversee competitive bidding and selection processes. In the Bangladesh Integrated Nutrition project, experts from UNICEF and civil society helped select contractors for two of the four bidding periods. The experts assisted with establishing scoring criteria and ensured that they were followed, resulting in a rapid selection of NGOs. In another example in Bangladesh—selection processes for the Urban Primary Health Care Programme—an expert panel of members from the Ministry of Health and Family Welfare, WHO, United Nations Population Fund, and the private sector evaluated the technical proposals and carefully documented the process in a transparent evaluation procedure.

3. DEVELOPING SERVICE-LEVEL AGREEMENTS FOR OUTSOURCING SERVICES

Around the world many hospitals are considering outsourcing the management of nonclinical hospital services (e.g., security services, laundry, cleaning, food service, grounds) to a private company or vendor. Hospital executive directors, who are often senior-level physicians with little to no formal training in hospital administration, hope that external service providers with expertise in nonclinical services will provide better management and a higher level of service than in-hospital management is able to deliver. Another major motivation for the expansion of outsourced nonclinical services is the development of local businesses in the community to support the public health care sector.

The decision whether to outsource nonclinical services, and which services to outsource, requires careful consideration and study, as it can have great impact on hospital operations. Hospital senior management needs a clear understanding of current costs and service issues that need to be addressed before the advantages and disadvantages of outsourcing management of a particular hospital department can be weighed. Similarly, without thorough and detailed cost information and service-level specifications in a vendor's proposal, an objective comparison to current operations is not possible. Evaluating a vendor's true capabilities and ability to meet the needs of the hospital takes time, time that will be well spent.

3.1 Five Major Steps in the Outsourcing Process

4. **The Pre-Bid Study:** This is the work to determine whether outsourcing a hospital service is a strategically good idea for the hospital and whether the business capacity is available in the private sector.
5. **Developing the Bid Document:** Having decided to test the market, the hospital develops a bid document (also known as a tender request), which details all the information that a vendor needs to provide to compete for the hospital's business.
6. **Bid Evaluation:** This is the analysis of the submitted tenders.
7. **Developing the SLA:** This is the difficult task of drafting the legal contract between the hospital and the service provider. The SLA is a component of the overall contract between the hospital and vendor that includes detailed information on the specific services to be provided, with what frequency and by whom; it also includes the monitoring tools and processes to be used to determine that service levels are being met.
8. **Contract Management:** After the hospital and service provider have a signed contract, the vendor is mobilised and begins providing services, and hospital management must begin to actively manage the contract.

3.2 The Pre-Bid Study

The first step towards outsourcing is the identification of which service or services the hospital wants to consider for external management. Nonclinical departments that hospitals frequently outsource include security, cleaning, laundry, food service, and plant operations. Research must be done on potential bidders for each service identified for possible outsourcing. Questions you should ask during the pre-bid study include: How many vendors are working in the market and do any of them have experience working in a hospital? Are they local businesses, or are potential vendors multi-national companies? What is their use of new technologies, electronic data reporting, or new methodologies? How thorough are their orientation and employee training programmes? What kind of corporate support capability exists for additional management back-up during mobilisation, emergencies, or unexpected management staff turn-over? Is there competition or is there a monopoly in the marketplace, and how do other customers rate the service? Estimating the amount of time a Pre-Bid Study will take is difficult. This will depend upon how many services are being considered for outsourcing and how many vendors are in the marketplace to be assessed.

For each service to be bid, data is collected on the current cost of providing that service. The hospital cannot properly evaluate a contractor's bid against current cost unless the current cost is known. Similarly, the quality of service that a vendor provides can, legitimately, vary dramatically. The hospital needs to decide where on the cost/quality scale the hospital wants to bid.

Another important consideration for the hospital during the pre-bid phase is the tactical approach it wants to make to contracting. If the strongest vendor(s) are international companies, does the hospital want to require a partnership with a local vendor to help build the capability of local business? Does more than one hospital want to join together for a group purchasing tender? If there are vendors in the marketplace with capability to provide more than one service, for example cleaning and laundry, does the hospital want to use an "umbrella approach" and bid for multiple services under a single contract? And most significantly, does the hospital prefer to keep staff workers in an outsourced department as hospital employees or have staff work as employees of the contract company? The introduction of a private company to manage a hospital service usually changes the conditions of work for hospital employees in the outsourced department. Staffing levels may be decreased. Work requirements may be changed. Performance measures may be instituted or changed. The hospital needs to be capable of managing labour unrest during a transition period.

Often the outsourcing process identifies the need for new equipment or infrastructure improvements to support the service delivery requirements. During the Pre-Bid phase the hospital will need to determine how the funding of capital equipment and/or capital improvements is to be accomplished, who owns the equipment, and what happens if the service contract is cancelled or not renewed.

Based on the information gathered, the hospital decides whether enough qualified bidders exist to issue a tender for outsourcing a specific service. If there are too few, the hospital must decide how to proceed. Alternatives include:

- Make a "no-go" decision and decide to continue with a hospital-managed service.
- Seek qualified bidders outside the original geographic boundaries. A bid document could be drafted requiring a local company partnership.
- Assume the risk of negotiating a sole-source contract, if permitted.

3.3 The Bid Document

A well-drafted, carefully thought through bid document is a critical component of successful outsourcing. The bid document is where the hospital provides a very specific definition of activities to be carried out under the contract agreement to meet the service needs of the hospital, and the frequency of these activities. Without specificity, the vendor will not understand the hospital's requirements and will lack any basis upon which to determine costs.

The bid document begins with a "General Conditions" section, which includes a description of the hospital, with a focus on details that pertain to the nonclinical service being outsourced. For example, food service vendors need patient census data to estimate and bid on food cost. Laundry vendors need an average daily census, bed turnover rates, and operating room volumes to estimate laundry volume and linen needs. Other "General Conditions" include contract duration, required permits, licenses, insurance certificates, a statement of compliance with all applicable laws and government regulations, and a statement of confidentiality. Client rights are defined, including the ability to invoke penalties for nonperformance up to and including terminating the contract.

"Service Requirements" are the foundation upon which the SLA component of the overall contract will be based. The bid document *must* detail these requirements. For example, the bidder for managing an outsourced cleaning department is asked to specify how often the space will be routinely cleaned *for each room* in the hospital, internal and external public areas, stairways, etc. The document must: specify the frequency for all "special projects cleaning," such as window washing; and must detail housekeeper training programmes, and specify the frequency and method for removal of all trash and hazardous waste.

A "Mobilisation Plan" is also required. This is the detailed activity plan, schedule, and additional resources required for contract start-up, generally defined as the first three months of in-hospital operations.

In the "Price and Payment" section of the bid document, the bidder is asked to provide a detailed cost proposal based on the "Service Requirements." This will include the vendor's proposed staffing pattern, coverage and costs, an equipment and supply budget, training expense, and the proposed Management Fee to the company. Invoice frequency is specified.

The "Contract Service Management" section details how the management duties of the contractor's representative, such as the supervision of staff and administration of the nonclinical service, interface with the hospital management team. This interface between the contractor manager and the hospital management team includes service planning, cost control, and monitoring the performance against the contractually agreed-upon performance measures.

The "Procurement of Supplies and Equipment" section of the bid document requires the contractor to detail its procurement process with adequate visibility of costs, quality, inventory tracking, receipt, and issues of supplies used for the delivery of the service.

The bid document is clear that the contractor must agree to fully participate in the hospital's Incident Reporting system, all hospital emergency response protocols, and disaster preparedness training. It defines the expected company response to an interruption of service delivery including penalties and company contingency plans. The bid document requires the company to agree to participate fully in the hospital Quality Assurance programme and Infection Control requirements, and requires the company to present a quality monitoring plan that includes the definition of Key Performance Indicators (KPIs) that are both qualitative and quantitative, and to agree to quality monitoring inspections by the hospital administration, both scheduled and unannounced. A negotiated Performance Monitoring Plan becomes part of the final contract document.

Finally, the bid document must require a detailed staff orientation and training programme, and a defined schedule for a continuous re-training programme for all workers. Specific skill competencies are to be evaluated and tested for each position.

3.4 Bid Evaluation

A carefully drafted bid document that clearly defines all the information that a potential vendor needs to provide makes the bid evaluation process more objective and easier to complete. A checklist is developed of all the required data elements the vendor is asked to submit, with a scoring system for completeness of the data.

The hospital Chief Financial Officer will want to immediately evaluate the proposed cost of outsourcing the service. Has the vendor provided financial details that include assumptions, projected profit and loss statements, projected cash flow reports, projected balance sheets, and all direct costs for operating the service?

The Hospital Director will certainly focus on the vendor's proposed management team structure, curricula vitae for proposed on-site managers, and responsibility chart for management positions to evaluate the capability of the company to effectively manage the service. Is there a detailed staffing plan, by position and by shift, for the service? Are there required competencies defined for each position, and proof of consistency with the proposed budget? What is the retention rate and average longevity of company department managers? Does the company have reliable patient satisfaction survey data from other hospitals?

What is the quality of the staff orientation and training programme materials that have been supplied as part of the bidding process? If employees of the service department are not retained as hospital employees managed by the company, but are employees of the service company, has a copy of the company employee handbook been provided, with details of employment terms and conditions for staff who will be working in the hospital?

A bid evaluation also requires careful consideration of the information provided by the vendor on health and safety policies. What does the company do to regularly assess health and safety risks, and what are its auditing and accident reporting procedures? Has the company provided any proof of a health and safety improvement programme?

The company's capability to collect, organise, analyse, and report data needs to be evaluated. What is the company's management information systems capacity? Have examples of management reports been provided? Is the company's management information system compatible with the hospital's system so that data can be easily shared and incorporated into reports?

If the company wins the outsourcing contract, has it provided a realistic, adequate Mobilisation Plan that draws on its prior experience? Is there a detailed Communication Plan for how the company will regularly update hospital management on implementation progress? Are critical milestones identified? Are critical time line points noted?

After a thorough, objective evaluation process, the top vendor is selected to begin the process of negotiating an SLA, the document that will create a common understanding between the vendor and the hospital about services, priorities, and responsibilities.

3.5 Developing SLAs

The SLA is a component of the overall contract between the hospital and the vendor that creates a common understanding about services, priorities, and responsibilities. It is, most importantly, a "living document" that with mutual agreement can be modified. Properly done, it is a communication tool that can help to minimise conflict between the contracting parties by carefully defining and managing expectations and monitoring the effectiveness of services.

An SLA takes time to write, as it includes negotiated, detailed task descriptions, task availability information, standards for timeliness, frequency tables, and quality measures for the provided services. The vendor's response to the bid document forms the basis for the start of negotiations of the definition of tasks, and on the frequency, staffing, and standards for each task.

The contracting parties understand that changes to the level or quality of service upon which the vendor's bid was based may result in a negotiated change to the contract cost. Many hospitals assume that management of a nonclinical service by a company specialised in providing that service will save costs for the hospital, but if the level of service the hospital is providing has been inadequate or the qualifications of staff have been poor, outsourcing may not save costs. The vendor's success or failure in complying with agreed-to KPIs can also influence the payment amount and schedule. Poor scoring on KPIs needs to trigger development and implementation of a Performance Improvement Plan, and payment deductions if KPI scoring does not improve to agreed-upon acceptable levels.

Over time hospitals change; change occurs in patient populations and disease profiles, clinical service mix, economic conditions, facility infrastructures, and nonclinical service delivery methodology (with the introduction of new technology). Within the SLA a process is defined to allow the regular review and amendment of the agreement if warranted.

A contract to outsource a service can be signed without an SLA, as has been the case with all of the current outsourcing contracts in Botswana. Many challenges that have arisen with the quality of the outsourced nonclinical services at the seven hospitals would have been mitigated with properly developed and detailed SLAs.

3.6 Contract Management and Monitoring Performance

The decision to outsource a nonclinical service can significantly affect many aspects of hospital operations. Almost inevitably there will be occasions when tension develops between the company and the hospital. The company's profit depends on maximising efficiency and minimising the use of resources. The hospital interest is to ensure that the level and quality of service it has been guaranteed is being delivered every day. Hospital administrators should keep in mind the "Recommendations and Lessons Learned" in Section 7 of this report.

4. EXPERIENCES IN BUILDING CAPACITY AND TRAINING HOSPITAL STAFF

4.1 Existing Knowledge Management Tools

The PPP Unit has an important knowledge management role in collecting and sharing best practices in outsourcing across hospital facilities, facilitating communication, and serving as an auditor across facility contracts. The PPP Unit is the only entity that has the full picture of outsourcing across all hospitals. It knows if one company is contracting with a number of the hospitals, and this puts the PPP Unit at an advantage, enabling it to aggregate the purchasing power of the hospitals and better negotiate contract values based on these economies of scale.

This is an area for continued improvement as the outsourcing initiative expands: to date, hospitals have been working independently on their nonclinical service bids. For example, currently the seven hospitals that have started outsourcing nonclinical services are all using the same laundry vendor. However, some hospitals were unaware of this, and each hospital tendered individually with the laundry vendor.

There has been little or no discussion across hospitals related to the bid development or the management of the services once a vendor has been selected. Each hospital has a separate tender, and each hospital committee evaluated its tenders individually. There is an opportunity for increased knowledge management and regular communication between the hospitals and PPP Unit and within the hospitals themselves.

Finally, the PPP Unit serves an important knowledge management role in maintaining the transparency and accountability of the outsourcing initiative by making sure that reports and findings are documented and disseminated to key stakeholders.

A couple of resources are available to capture and share organisational knowledge around existing outsourcing efforts:

- I. **Database of private sector suppliers:** PEEPA has developed a Supplier Intelligence Resource, which is a database of both quantitative and qualitative information on current and potential private sector service suppliers, and Ministry in-house service providers. The information collected (MoFDP 2013) can be used to:
 - Advise ministries on the suitability of contracting with a specific company
 - Support companies in identifying and addressing weaknesses as suppliers to government
 - Assess local private sector capacity in addressing the feasibility of outsourcing services
 - Benchmark private service delivery performance against that of the in-house public sector employees
 - Assist ministries to terminate contracts of nonperforming suppliers

The PPP Unit within the MoH is working on bolstering the database of private sector suppliers, specifically by collecting information on companies specialising in nonclinical services. The PPP Unit expects to have a database of 90 companies in the country—to date they have information on approximately 45 companies, and are collecting information from additional companies. This database is creating political buzz because it is strengthening local companies and broadening participation across the economy.

2. **Contract templates:** The PPP Unit has worked with the regional and district hospitals in Botswana to develop draft contract templates for several service areas that can be outsourced, including security, cleaning, and food service. These templates identify key performance indicators, service elements, and other service specifications. These framework contracts can then be customised further to a particular facility, but serve to help standardise the outsourcing process.

4.2 Strengthening Outsourcing Services at the Ministry of Health

The first request of the MoH was to strengthen the capacity of the Public-Private Partnership Unit to develop, negotiate, and monitor contracts in order to improve overall performance related to the new outsourced services. A four-day intensive workshop in “Outsourcing Nonclinical Hospital Services” was delivered in Gaborone on 4 to 7 February 2014. It was attended by 48 hospital and Ministry of Health staff, including senior administrators, contracts managers, head matrons, and other hospital and MoH staff who currently play a role in tendering and managing outsourced services, or who will be tasked with that role in the near future.

The workshop goals were:

- Describe the key elements in the pre-contract bidding process: pre-bid study, tendering, and evaluation of bids.
- Describe the role of hospital administrator in managing outsourced services, and identify good practices for service management based on real experiences to date.
- Explain the purpose and key elements of the SLA and how it serves as a tool for managing expectations, improving communications, and strengthening relationships with the vendor/supplier.
- Apply a methodical process for describing services to be outsourced and setting service standards, including performance indicators.
- Strengthen intra-and inter-hospital communication so that administrators may learn from one another and share promising practices and lessons learned.

Major workshop planning activities included a) a two-day macro design meeting held at the HFG office in mid-January, followed by micro-level session development; b) in-country hospital visits to assess the ministry’s outsourcing process thus far, establish the current outsourcing management baseline capacity (see Annex D), and identify priority training and technical assistance needs; and c) refining the final workshop design based on what was learned during the hospital visits. Workshop materials, including the agenda, facilitator guidelines, participant manual, and handouts, appear in Annexes E through I.

4.2.1 Observations

Based on training team observations and solicited and unsolicited feedback from participants, the workshop was highly successful in meeting its goals. The majority of participants were fully engaged throughout the four days of the workshop: they posed thoughtful questions and offered candid commentary based on their outsourcing experiences to date, they rolled up their sleeves and worked hard during the table group exercises, and they openly challenged assumptions (their own and those of their colleagues) about the roles and responsibilities of the hospital vis-à-vis the service providers.

Perhaps most significant was a noticeable attitudinal shift among hospital senior leaders across the workshop week: they began with a top-down, rather obstructionist position on outsourced service management and ended the week embracing the notion of a good faith partnership with their service providers.

Several factors contributed to workshop success:

- During the mid-January design meeting, the team decided to take a two-part approach to cover the necessary material. Part 1 focused on the entire bidding process leading up to the contract execution, and Part 2 focused on the contracting process with an emphasis on the drafting of SLAs. The segregation of topics made it easier for participants to learn the major steps and caveats and to apply these to their current contexts and future outsourcing goals.
- The design team also decided to focus the practical activities on the four service areas currently being outsourced by the hospitals: security, food service, cleaning, and laundry. The group outputs/products would then be able to be refined and incorporated into the actual processes and contract documents.
- Following the hospital visits during the week preceding the workshop, the training team made last-minute strategic adjustments in the workshop design to target the challenges faced by the hospital managers and MoH coordinators. Additionally, trainers were able to reference and use real-time challenges to illustrate key course elements.
- The team also made design adjustments to accommodate a much larger participant group than originally planned (in fact, the group doubled in size from the original estimate).
- The two technical trainers were highly credible and skillful, and they complemented one another both technically and stylistically.
- The training design included a number of opportunities for practical, hands-on participation and an excellent balance and sequencing of “theory” and “application.”
- The workshop provided a much-needed venue for senior managers from the seven major hospitals (referral and district) to share experiences, exchange views, and consider how to pool and maximise their expertise to address future outsourcing challenges.

A pre- and post-test was developed and administered to every participant at the February 4–7 Outsourcing Workshop in Gaborone, Botswana (see Annex J for a copy of the test). The test was designed to measure the change in the participant’s knowledge of the outsourcing process and SLAs from the beginning to the end of the workshop. Thirty-eight and 39 participants completed the pre- and post-test, respectively. On average, participants’ total scores on the test increased by over 8 percent from pre- to post-test.

4.3 Building Capacity to Develop and Monitor SLAs

Following the first HFG workshop, which presented the development of Service-Level Agreements, the Ministry of Health PPP Unit convened a multi-day meeting of key ministry personnel and representatives from the seven participating hospital management teams to begin to write SLAs. Learning from the workshop informed the good work that was done to formulate the first draft of SLAs for the nonclinical services of cleaning, laundry, catering, and security. Task descriptions, task standards, activities, key performance indicators, monitoring methodology, and reporting were all addressed to varying degree of detail, but it was acknowledged and evident that the group struggled to develop clear and concise contract documents. The draft SLAs were forwarded to the consultant to review. It was agreed that in July the group would re-convene with the consultant to work together to refine the draft SLAs.

In July 2014 a three-day technical assistance meeting was conducted for 28 participants from the MoH and seven regional and referral hospitals to assist the hospitals in developing and revising their SLAs. Following this meeting the hospital consultant worked one on one with hospital administration contract managers, and spent one day visiting and working with staff at five of the seven hospitals to provide technical support and capacity-building around facility-specific outsourcing issues. The purpose of this trip was to strengthen the contract development and management skills of the hospital administration staff and PPP Unit. This work included several components:

- Conduct a three-day technical assistance workshop with seven hospital management teams and Ministry of Health representatives to review the drafted SLAs for cleaning, laundry, catering, and security services, with the goal of strengthening and clarifying the agreements.
- Assist the workshop participants with elements of customisation needed in the SLAs to meet the unique needs of the individual hospitals.
- Review the roles and responsibilities of the hospital contract managers and the vendor site managers to ensure a clear understanding of the need to separate service operations from contract oversight.
- Work with the PPP Unit to improve their institutional capacity for drafting, evaluating, and managing SLAs, and define the roles and responsibilities of hospital management and the Ministry of Health in contract management.
- Conduct on-site visits to the participating hospitals to meet with vendor representatives, hospital contract managers, and hospital senior management, to explore vendor/hospital business relationships, hospital contract management capabilities, performance monitoring, and vendor performance.
- Demonstrate hospital Administrative Rounds.
- Continue the collection of data and information to be used in documenting the outsourcing programme in Botswana.

4.3.1 Accomplishments

A number of technical assistance goals were evident to the consultant after reviewing the draft SLAs and following the hospital site assessments made during the first trip. These goals formed the basis for the Technical Assistance Workshop Outline (see Annex K).

1. Participants are able to define the issues that have caused conflict in the past between the hospital and outsourced service vendors, and identify how in a carefully drafted Service-Level Agreement these points of past conflict can be addressed and potentially minimised.
2. Participants clearly understand the difference between vendor company Policies and Procedures on the one hand, and Service-Level Agreement definitions and monitoring of Key Performance Indicators on the other. Policies and Procedures are the key to understanding how the company intends to do its work; Service-Level Agreements define performance expectations and performance monitoring for completing the activities.
3. Participants are able to identify key potential impacts on a Service-Level Agreement that are institution- specific. These potential impacts (i.e., building architectural design elements) inform where a Service-Level Agreement needs to be customised for the individual health care institution.

4. Hospital contract managers clearly understand the difference between their role and the role of the vendor site manager. Accountability for the delivery of the service and the operations of the department rests with the company providing the service. Managing the service contract is understood not to involve direction of the operations.
5. Participants understand that outsourcing of services in a hospital will not be successful if the effort is not seen as a critical partnership in which both sides need “a win.” In an environment of weak and/or inexperienced vendors the hospital understands that it may need to provide more technical support than anticipated to make the partnership work to achieve a high quality of patient care and a safe hospital environment.

Participants from seven hospitals and the Ministry of Health attended the Technical Assistance Workshop on Outsourcing of Hospital Nonclinical Services. The hospitals vary as to the extent of outsourcing in their facilities, but all hospitals were struggling with contract management, poor performance by contractors, tension and conflict between vendors and hospital management, and contractual arrangements that have not defined key performance indicators, service standards, or quality monitoring tools.

The workshop began with each hospital team creating a list of issues that since the initiation of outsourcing have created conflict in their institutions between hospital management and service vendors (Annex L). Not surprisingly, the hospitals shared many conflict points. Three of the most common were:

- Vendors are not providing qualified supervisory personnel.
- Needed supplies are not stocked or distributed.
- Agreed-upon staffing levels are not being maintained.

Conflicts between the vendors and hospital seem rarely to get resolved; issues simmer and the hospitals respond by deducting funds from vendor payments. The vendors’ response to this action is often late payment to their workers, who can ill afford not to be paid for their labour. This creates serious labour relations problems and occasional work-stoppage actions, leaving the hospitals with disturbing security gaps and cleanliness issues that compromise patient, visitor, and staff safety.

Throughout the workshop continual reference was made back to the Identified Points of Conflict, to refine the SLAs to directly address where and how these conflict points could be minimised. The Identified Points of Conflict was also used by the consultant developing the Conflict Resolution and Negotiation workshop conducted by the HFG Project in Botswana from 30 July through 7 August 2014.

Often, when outsourcing services hospitals have unrealistic expectations of service providers. It is falsely believed that outsourcing a service will result in hospital management no longer needing to worry about that service, and that management attention can now be concentrated on clinical care. That assumption is false, especially in a business environment like Botswana, where service vendors are small companies with little or no experience working in hospitals. The reality is that the hospitals often need to teach inexperienced vendors how to work in a hospital. Infection control, disruptive or dying patients, and distraught visitors are not encountered by cleaners or security guards working in office buildings or shopping malls.

The consultant spent time reviewing information that hospitals must have from their service providers, such as detailed Policies and Procedures for how their work will be done. Hospital experts need to review these Policies and Procedures, and, if necessary, help the vendors refine or redraft them. Service providers have also not consistently provided hospitals with proper organisational charts for their departments, CVs of their site managers and supervisors, copies of their training curriculum and training materials, contingency plans, performance standard monitoring tools, or staffing allocations. All of this information should be required as per the legal contract.

Service Level Agreements must address key quality issues, and service vendors must be held to quality performance standards. Strong emphasis was made that the *ultimate responsibility for what happens in the hospital rests with the Hospital Superintendent*. Outsourcing nonclinical services does not change this fact.

Botswana's effort to meet the COHSASA hospital accreditation standards needs to be articulated in the SLAs, and vendor performance improvements working toward that goal must be built into the SLAs. Auditing processes and monitoring tools were reviewed, and hospital provision and/or supervision of vendor employee training in technical areas such as infection control discussed in detail.

Following the first half-day general overview of conflict points, expectations of service providers, and important quality issues that must be addressed in the SLAs for outsourced services, the workshop moved to focusing on discussing and improving the draft SLAs that had been developed for catering, cleaning, laundry, and security services. The consultant noted redundancy and confusion between task standards and task definitions, and most important, confusion between what are policies and procedures for how a service provider is to do its work and what are standards for monitoring and assessing the quality of that work. To develop understanding of this point, each hospital team was tasked with developing an SLA standard for eight catering services tasks, noting the task availability or frequency and responsiveness or timeliness standard for each task. Each hospital presented its work, and discussion was focused on how a Key Performance Indicator is identified, a standard is set, a monitoring tool is identified for measuring compliance, and a reporting mechanism is identified.

Copies of the SLAs drafted in May were distributed to all the participants, and the consultant reviewed strengths and weakness identified in each. Many comments related to imprecise language such as reference being made to "relevant standards" but those standards not being defined. Adherence to "dietary guidelines" was mentioned but which guidelines were not defined. Ambiguous language such as the service provider "meeting and maintaining acceptable standards" was highlighted as needing change. Overlapping points of responsibility were noted, such as for pest control, where two vendors were assigned responsibilities, setting up potential conflict.

During the second day of the workshop the consultant presented a more detailed categorisation of Functional Area Risk Categories for cleaning services, and a sample audit tool for monitoring the quality of a vendor's cleaning services. This helped inform the work participants did later on refining the draft cleaning service SLA. Other issues the consultant covered related to cleaning services involved management by the vendor of sub-contractors (i.e. window washing, pest control) and the need for a clear understanding between departments on what equipment is or is not the responsibility of the cleaning service vendor. The U.S. Center for Disease Control and Prevention recommendation for checklist delineation of those responsibilities was reviewed.

During the consultant's visits to hospitals in February, a significant problem was noted with how dirty laundry is managed on the nursing units. It appeared to be a significant infection control issue not being addressed by either hospital management or the laundry service vendor. This observation was used as an example for a discussion of current issues with the laundry service vendor, who currently is the sole vendor in the country for laundry services. Having a single source for service throughout the country poses unique problems and challenges, but might in fact be an improvement over the current situation, in which broken laundry equipment in various hospitals has resulted in the need to transport hospital linen all over the country for processing where equipment is functional.

Midway through the second day of the workshop three teams were organised, one each for catering, cleaning, and laundry, with representatives from each of the hospitals and the Ministry of Health on each team. The teams were tasked with defining five SLA Key Performance Indicators for the service, what monitoring tools would measure performance, performance targets, monitoring frequency, and the management reporting process.

On the third day of the workshop each of the teams presented its five Key Performance Indicators. They were critiqued by the group and the consultant. Feedback focused on the need to set more-reasonable performance targets; it is unrealistic to expect 100 percent performance or 100 percent staffing coverage in any department or service in a hospital, and it is unfair to set that as a standard for an outsourcing vendor. Monitoring frequencies were also often unrealistically high. Company supervisors are expected to monitor the work of their employees every shift and every day, but hospital contract managers monitor *their* staff periodically (and randomly).

The need to customise SLAs for the specific conditions, patient population, architectural layout, and service mix of each hospital was noted. That will be a major “next step” item supervised by the PPP Unit in the Ministry of Health.

During the week following the technical assistance workshop, full-day assessment visits were conducted at the participating hospitals. These assessments included walking Administrative Rounds of the facilities, and holding meetings with hospital managers and vendor representatives at the hospital.

Hospital site visits generally started with a tour of hospital outsourced departments and a walk-through of at least two patient care areas to observe operations, level of cleanliness, availability of supplies, and adherence to proper procedures as described by vendor supervisors and site managers. Throughout the tour, the consultant stopped to ask questions of company representatives, hospital management staff, and department line staff to gain a better understanding of the operational challenges each party is experiencing, and to role-model how critical it is for managers to be visible, observing and supporting staff. In all hospitals the cleaning service storerooms and linen store rooms were inspected to check on stock levels, inventory control systems, missing items, unapproved substitutions, and general management of consumables and cleaning chemicals. The hospital laundry facilities were inspected for linen processing procedures and equipment condition. Although the outsourcing of catering services has not yet begun, inspections of several kitchen facilities noted food stock inventories and the general level of cleanliness.

Following the hospital tour, the consultant and MoH staff met with the vendor site managers, contract managers, and hospital senior management to review what had been observed during the walkthrough and reiterate a list of documents that the vendors must submit to the hospitals for review.

By the end of the visit, hospital and MoH staff were able to clearly define issues of conflict in outsourced service contracts and identify how carefully drafted SLAs can be used to address and minimise these conflicts.

“The workshop in Maun really made us serious about following up with our vendors...the quality goes down if the manager never follows up.”

—Thebang Nong,
Nyangabgwe Hospital

4.3.2 Findings, Challenges, Lessons Learned

Several key findings and challenges were identified and discussed with hospital and PPP Unit staff:

1. Until this workshop, there had been no systematic, scheduled communication with vendor site managers to jointly review management reports on staffing, inventory, incidents, quality monitoring, and budget performance.
2. There had been a lack of systematic monitoring by the hospital of contractor staffing levels, attrition rates, and shift coverage.
3. Vendors were not regularly reporting to hospital management stock room inventory levels for required supplies, stock-out emergencies, or stock substitutions that needed hospital approval.

4. Hospital contract managers did not understand their role as monitors of contract performance, not supervisors of vendor staff.
5. Facility and equipment maintenance responsibilities outside the purview of the service vendors have been poorly managed; this has a negative impact on the vendors' ability to perform their work.
6. Despite the hard work that hospitals are putting into developing SLAs, a year after the first workshop, hospitals still do not have SLAs incorporated into their contracts.

4.4 Strengthening Public-Private Partnerships: Collaborative Approaches, Negotiation, and Conflict Resolution

The MoH wanted to strengthen the capacity of hospital managers and Ministry of Health staff overseeing nonclinical outsourced services to manage conflict and negotiate appropriate solutions to problems that arise between hospitals and contractors in the relatively new outsourcing environment. To accomplish this goal, a highly participatory three-day training was held in conflict resolution and negotiation skills for 37 hospital managers and Ministry of Health staff including senior administrators, contracts managers, head matrons, and the Office of Strategic Management/Public-Private Partnership Unit staff. To accommodate as many participants as possible, the training was delivered twice, first on 29 July through 1 August 2014 and again on 5 through 7 August; both workshops were conducted in Gaborone (see Annexes M-P for workshop materials).

The need for capacity-building in conflict resolution and negotiation was identified during the first Outsourcing Nonclinical Services training workshop conducted in February 2014. At that time, the PPP Unit and hospitals had already undertaken the outsourcing of several nonclinical services, and were engaged in the tendering process for additional contracts. The MoH outsourcing initiative was being rolled out quickly before the PPP Unit had sufficient capacity to manage the tendering process, and before hospital teams had had time to appropriately transition into new roles as contract managers of outside service providers. The capacity-building need was further confirmed and documented in early July 2014 by the hospital consultant, who gathered information about the types and nature of the conflicts between hospitals and vendors to inform the workshop training curriculum and materials. Several factors were identified that conspired to create or exacerbate conflict, namely that the hospitals were still struggling with managing the essential role change from direct service manager to indirect contracts manager, that the hospitals were backlogged on drafting the SLAs that are meant to serve as the key guidance for defining and monitoring expected vendor performance, that some of the vendors were incapable of delivering professional-quality services without substantial orientation and other assistance from the hospitals themselves, and that the PPP Unit was severely understaffed and unable to provide the monitoring and oversight required for the level of outsourcing undertaken.

While a three-day workshop in conflict resolution and negotiation skills cannot “fix” all these problems, it can provide practical tools and practice for resolving differences, and, perhaps most importantly, it can challenge and influence the attitudes of hospital managers toward their private contractors. To this end, the constant and consistent message for this workshop was how to achieve “win-win solutions.”

Specific workshop goals were:

- Identify types and sources of conflict that commonly occur in the context of outsourcing of nonclinical hospital services.

- Determine appropriate conflict resolution approaches for a variety of conflict situations that present in this setting; identify one's own preferences for particular conflict resolution approaches.
- Build skills in the critical communication areas of assertiveness and cooperativeness as applied to conflict resolution.
- Describe the keys to successful negotiation of a conflict/disagreement between hospitals and vendors, particularly those behaviours and practices that lead to “win-win” results.
- Identify best practices for strengthening MoH-hospital-vendor relationships such that conflict situations are prevented or addressed in timely and effective ways.
- Identify and commit to future actions that will advance MoH, hospital, and vendor staff capacity to identify and resolve problems before they become intractable.

4.4.1 Findings, Challenges, Lessons Learned

The starting point for the Conflict Resolution-Negotiation Skills workshop was succinctly captured by the hospital consultant:

Conflicts between the vendors and hospital seem rarely to get resolved; issues simmer and the hospitals respond by deducting funds from vendor payments. The vendors' response to this action is often late payment to their workers who can ill-afford not to be paid for their labour. This creates serious labour relations problems and occasional work-stoppage actions leaving the hospitals with disturbing security gaps and cleanliness issues that compromise patient, visitor and staff safety.

During the workshop discussions and PPP-vendor meeting, participants revealed additional beliefs/behaviours/practices that contribute to conflict. Key examples include:

- Hospital staff members believe the vendors are interested only in making money rather than contributing to the overall goal of the hospital to provide quality care for its patients. This “in it for the money” belief colours the way hospital staff regard vendors, often with an attitude of superiority.
- In some cases the contract managers are holding vendors to a higher level of performance than the hospitals held themselves before the outsourcing venture began. In other cases, the contracts managers express a conscious expectation that the vendor should perform better than the hospital was able to do. Whichever the case, the understanding of what quality means/looks like is not clear, and that in turn leaves the vendor uncertain and vulnerable; ultimately this lack of clarity may expose the hospital to greater risk. Vendors also cite “quality” as an issue, stating that different hospitals seem to have different expectations/levels of quality; since several of the vendors have contracts with more than one hospital, they want the MoH to promote standardisation.
- In some cases, particularly where a contract manager used to hold the very position now occupied by the vendor's site manager, s/he plays a “gotcha” game, i.e., catching the vendor making mistakes and ignoring anything the vendor might be doing well. The next higher level of hospital supervision may acknowledge this phenomenon, but does not take adequate steps to address it.
- In some cases, hospital administrators are grossly slowing down the vendor payment process; whether this is intentional or not is unclear, but the impact on the vendors, especially the fledgling companies, is serious. In one egregious case, a small cleaning company who had begun work in May had yet to receive any payment for services as of mid-August.

- Both hospital contract managers and vendors admit the monitoring systems and tools are not effective. The hospital contracts managers understand they need to measure performance, but are not sufficiently skilled to approach that responsibility with sensitivity and efficiency. The vendors vary in their capacity to collect and report appropriate information. In some cases, the hospitals are asking for a great deal of information that, in the vendor's view, does not serve any real purpose and is very time-consuming to produce ("distracting us from our real work").
- In a number of cases, the vendors are falling short in their performance, e.g., staff training and supervision, restocking of consumables, and machine repair. Neither side has done enough to explore, document, and understand the reasons for the underperformance so that best solutions may be sought.
- Vendor absenteeism/attrition is a very real problem in some instances. This may be related to pay levels, lack of job orientation/training, lack of appropriate supervision, or the negative performance pay docking cycle.
- In some cases, general managers/CEOs do not give vendor site managers enough power to make operational-level decisions, and this hampers/postpones the resolution of problems; in a number of cases, the site supervisor appears unable to fix small problems before they get bigger.
- A pervasive cultural norm of avoidance of conflict often results in a passive aggressive response (e.g., not confronting the actual vendor performance problem but deducting funds from the vendor's payment).
- Neither the hospitals nor the vendors are taking proactive steps to build a relationship with one another.
- The PPP Unit is striving to improve the SLAs and encourage better partnership between the hospitals and vendors, but it is woefully understaffed and trying to turn over the outsourcing responsibilities to the hospitals as quickly as possible.

The Conflict Resolution-Negotiation Skills workshop tackled these issues through presentation of tested models, hands-on skill practice using real case examples, behaviour modeling, and a continuous forum for open and candid discussion among participants.

The workshop presented two well-regarded models that provided participants with frameworks from which to analyse their current conflict situations and practices, and enabled them to see the choices they have for problem resolution and successful negotiation. The first model, the Thomas-Killmann conflict resolution modes, helped participants understand their own tendencies/preferred styles for addressing conflict and how to be more intentional about the way they approach resolving different types of conflict by constantly measuring the relative importance of the "issue" and the "relationship." In particular, participants realised the consequences of avoiding conflict and the need to use assertive and cooperative behaviours carefully to engage in real problem-solving dialogue with their vendors. The second model, interest-based negotiation, focused participants away from taking hard positions and more toward understanding the underlying interests and needs of each of the involved parties and then looking for integrative solutions that satisfy both sides. In effect, the model forces one to see the issues from the other's perspective, which then expands the field of possible solutions and promotes two-way communication.

For the skills practice part of the workshop, participants analysed real or near-real case scenarios and participated in simulated negotiation meetings based on the cases. The case examples underscored that many conflict situations are complex and involve multiple issues and players, including various offices in the Ministry of Health over which neither the hospital nor the vendor has much control; participants realised these situations often call for creative interim solutions and then longer-term problem-solving that might involve ways for both vendor and hospital to strategically influence the higher-level decisionmakers. Over and over, the negotiation practice revealed and reinforced the need for: consistent and timely two-way communication between the hospitals and

vendors; clarity on roles and expectations; give-and-take on the part of both sides; approaching negotiation meetings with a positive attitude; and checking one's assumptions for accuracy when in doubt. As one mid-level manager expressed it, "Too often our approach with our vendors has been adversarial rather than respectful. We need to change that and start treating our vendors as partners and real people who care about their work like we do."

A constant workshop message was that while conflict is natural and inevitable, it is much easier to address if there is a good relationship between the hospital and vendor.

5. RESULTS FROM A FIRST ROUND OF ASSESSMENTS

The nonclinical outsourcing was initiated quickly in Botswana, and, as a result, no baseline assessment was conducted in the seven hospitals before the services were outsourced. However, several assessments have been conducted since the outsourcing process started. Initial qualitative and quantitative data on perceived changes indicate that there have been changes between the first and second phase of contracts.

5.1 Financial and Budgetary Implications

A significant challenge for Botswana's health system is the efficient and effective allocation of health resources (MoH 2012). Operational reforms in the hospital system focus on privatisation and outsourcing of nonclinical services.

Data including hospital size, occupation rates, length of stay, and hospital budgets and expenditures were analysed in order to document and assess use of services, costs, and budgetary implications of Botswana's privatisation policy. In addition, data were collected and analysed from interviews and standardised questionnaires from the staff at seven district and referral hospitals.

Hospitals in Botswana spent 53 percent of the country's reported US\$789 million in total health expenditures in 2010 (MoH 2012). District and referral hospitals accounted for 26.6 percent of total health expenditures and represent a significant portion of health spending in Botswana. At the time of the study, seven major district and referral hospitals (S'brana, Nyangabgwe, Princess Marina, Sekgoma, Mahalapye, Letsholathebe II Memorial, and Scottish Livingstone) were operating contracts for laundry, cleaning, portering, security, and landscaping services, with a combined recurring budget of US\$19.4 million (excluding capital and labour). On average, these contracts represented 41 percent of the recurring budget.

On average, cleaning contracts had the largest contract value, representing 18 percent of the hospitals' annual recurring budgets. Laundry contracts represented 13 percent, security contracts represented 3 percent, grounds/landscaping contracts represented 3 percent, and portering represented 2 percent of the hospitals' annual recurring budgets.

These contracts are output-based and operate under fixed-rate reimbursement for delivery of services. Without cost benchmarks, paying lower prices has the potential to affect quality and undermine the development of the market, while paying higher prices can stimulate competition and help a nascent market thrive.

Privatisation is an essential component in the design of a value-based system of health care delivery, and these contracts have significant financial and budgetary implications. Health systems can drive economic development through local procurement of goods and services, but first it is necessary to determine fair prices and evaluate changes in efficiency, cost, and quality.

Lack of benchmark data around what it cost the hospitals to provide the nonclinical services in-house has impeded the hospital management teams and the MoH because they have nothing with which to compare the cost of the bids they receive. In the current state, it is not readily possible to judge the value for cost that outsourcing does or does not bring to a hospital department. As part of HFG's technical assistance, costing of nonclinical services was conducted in five hospitals in Botswana that have not yet initiated outsourcing (Stegman et al. 2015).

5.2 Governance and Regulation

At the start of the outsourcing initiative, the PPP Unit had heavy central control and oversight in the contracting process, and hospitals had a very small role in the decisionmaking. The goal is to institutionalise the PPP work in the hospitals as quickly as possible. To achieve this goal, the PPP Unit will remain small and support the work of the hospitals in contracting. If the PPP Unit becomes too large and takes on too much of the contracting work, then the initiative will never be institutionalised at the hospital level.

Governance with proper transparency is key. Reforms like outsourcing are hard to pass, because people are generally resistant to change, especially for an initiative like outsourcing that is relatively new. The PPP Unit recognises the need to make a big impact with these initial contracts and clearly share the results of the initial outsourcing experiences so that people see the value of outsourcing. A lot of the institutionalisation process has to do with people accepting and seeing the value in the initiative—and realising that, while this is an iterative learning process, the solution is not going back to what they had before.

An important aspect of governance and regulation is ensuring that there is broad buy-in for the outsourcing initiative. Institutionalisation does not work if the whole outsourcing initiative is personality-dependent and being driven by one or two key advocates. Instead, the personalities need to be written out of the script so that the initiative will survive past the initial driving personalities.

5.3 Service Quality

In March 2015, service quality assessments were conducted at all seven public hospitals currently outsourcing nonclinical services to private vendors, specifically laundry, cleaning, and security services. The objectives of this data collection were to document the changes in service quality since initiation of the outsourcing initiative.

At each hospital, the following data was collected:

- A qualitative interview with the hospital manager and/or head matron on changes in the quality of the services that have been outsourced. These interviews focused specifically on perceived changes in the quality of services since the service was outsourced.
- Quantitative service quality assessment questionnaires distributed to a sample of hospital staff, primarily nursing staff, that have been employed at the hospital since before outsourcing of services began (see Annex Q). These questionnaires probed for perceived changes in the quality of laundry, cleaning, and security services.

5.3.1 Service Quality Assessment Findings

5.3.1.1 General changes in quality for each service following outsourcing

For all three services, the majority of respondents across all hospitals currently outsourcing services indicated that the perceived quality of the services delivered has improved since outsourcing. Across all seven hospitals currently outsourcing cleaning services, an average of 61 percent of respondents noted that the quality of cleaning has improved since outsourcing. Scottish Livingstone Hospital was the only hospital in which the greatest number of respondents (40 percent) felt that there was not a noticeable difference in the quality of cleaning services since outsourcing compared to the quality of services prior to outsourcing.

For linen and laundry services, an average of 75 percent across all seven hospitals felt the quality of linen and laundry services had improved since outsourcing. For security services, on average, only 50 percent saw improvement in the overall quality of security services since outsourcing.

5.3.1.2 Changes in the number/adequacy of staff following outsourcing

For all three services, the greatest percentage of respondents across all hospitals currently outsourcing services indicated that there has been an improvement in the number of people staffed to provide the service. However, only for the linen and laundry service did the respondents feel that this improvement in the number of staff was sufficient.

For cleaning, an average of 40 percent (the category receiving the greatest number of responses) of respondents across all hospitals currently outsourcing services felt that the number of cleaning staff has improved since outsourcing; however, an average of 70 percent of respondents still felt that this number was insufficient. An average of 46 percent of respondents indicated that the number of security guards has improved since outsourcing; however, an average of 63 percent felt that this number was still insufficient. In contrast, for linen and laundry services, an average of 63 percent of respondents across all seven hospitals indicated that the number of staff has improved since outsourcing, and 68 percent of respondents felt that this level of staff was adequate.

5.3.1.3 Changes in Adherence to Infection Control Policies Following Outsourcing

The perception of adherence to infection control practices has improved for cleaning and linen and laundry services since outsourcing. An average of 38 percent and 48 percent of respondents, both categories receiving the greatest number of responses, noted that infection control practices have improved since outsourcing for cleaning and linen and laundry services, respectively.

For security services, a majority of respondents (53 percent) selected the “Unknown/No response” option when asked about security guards’ knowledge of infection control responses.

Figure 2: The Nyangabgwe cleaning vendor, CleanTime, picks up trash on a more timely basis than before outsourcing.



“Before outsourcing, they couldn’t really pursue infection control because it was very difficult to get hospital employees to change their practice. Now, there are contractual obligations that the company must comply with.”

—Nyangabgwe Infection Control Board Member

5.3.1.4 Supply/quality of Clean Linen

On average, the majority of respondents perceived that the availability and quality of clean linen available for patients has improved since outsourcing. Sixty-two percent of respondents noted that the quantity of clean linen available for patients has improved since outsourcing, and an average of 67 percent of respondents felt that the cleanliness and state of repair of linens has improved since outsourcing.

“Outsourcing is very important—especially to improve quality.”

—Hospital Manager,
Princess Marina Hospital

Figure 3: Changes in linen quality before and after outsourcing



Before outsourcing, having a consistent supply of clean linen was a challenge. Since outsourcing, the quality and availability of linen has greatly improved.

Before outsourcing at Sekgoma Hospital, the laundry machines were out of order due to lack of maintenance. With outsourcing, the vendor is responsible for maintaining the machines and they are now all in working order.

Figure 4: Washing machines that were broken before outsourcing are now in working order



5.3.1.5 Changes in Security

Perceptions of the quality of outsourced security services are mixed. An average of 44 percent of respondents, the category receiving the greatest number of responses, felt that the response time for security guards has improved since outsourcing. An average of 39 percent of respondents, again the category receiving the greatest number of responses, indicated that the handling of disruptive patients, family members, or visitors is better since outsourcing. But an average of 47 respondents said that their safety in the hospital has not changed since outsourcing.

“Before [outsourcing], [security] was non-existent. The watchmen would basically just sleep at the gate.”

—Mahalapye Hospital Manager

5.4 Contract Management

Qualitative interviews were conducted at all seven public hospitals currently outsourcing nonclinical services. The objectives of this data collection were to document the challenges, successes, and lessons learned since initiation of the outsourcing initiative; and document any changes in contract management, specifically around incorporating SLAs into existing contracts with private vendors and managing relationships with vendors, including negotiation and conflict resolution skills.

At each hospital qualitative interviews were conducted with the hospital manager and/or hospital superintendent on the challenges, successes, and lessons learned with the outsourcing of nonclinical services (see Annex R). This includes any changes in the management of these contracted services as a result of HFG’s technical assistance—specifically the workshops on incorporating SLAs into existing contracts with private vendors, and a workshop for hospital managers on managing relationships with vendors, including negotiation and conflict resolution skills.

5.4.1 Contract Management Findings

As a result of the HFG workshops, hospitals have made changes in the way they manage their outsourcing contracts (even in the absence of SLAs formally incorporated into the contracts). The hospital contract managers and vendor managers have started performing weekly “walk abouts” to jointly assess service quality. As part of these “walk abouts,” the hospitals have started using checklists (taken from the SLAs and HFG workshops) to monitor service quality. The checklists allow the hospital and vendor to identify, discuss, and address any concerns. Before the hospital was just “telling the vendor that [the hospital] isn’t clean” but then nothing would happen. The hospital has requested and receives more frequent/complete service reports from the vendor. Generally, before outsourcing, the hospital did not receive service reports, or received incomplete or infrequent reports. Before the HFG workshop on developing and monitoring SLAs, a lot of the hospitals talked directly to the employees when there was a problem (which was not effective), but now they talk to the supervisors so that changes and adjustments can be made at a higher level and across the board. The new methods of contract management have resulted in better communication between the hospitals and vendors. Now, as a result of the changes in contract management, when there are service issues the hospital engages with the companies in dialogue instead of withholding payments.

Figure 5: As a result of HFG's workshops, hospitals have implemented checklist tools to track vendor service quality and improve management of the vendor contract.

10/21/15

SBRANA PSYCHIATRIC HOSPITAL
 DAILY CLEANING CHECKLIST AREA Fow 2 DATE (FROM).....(TO).....
 NAME (CLEANING SUPERVISOR)..... (CHECKING OFFICER).....

DATE TIME	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Floor cleaned			✓							
Walls cleaned			✓							
Window panes			✓	✓						
Window seals			✓							
Passages clean			✓							
Stairs clean			✓							
Door handles clean			✓							
Furniture			✓							
Hand basins clean			✓							
Hand Tissue available			✓							
Sinks clean			✓							
Hand soap available			✓							
Kitchen clean			✓							
Tables			✓							
Chair			✓							
Ceiling			✓							
Toilet clean			✓							
Shower/Bathtub			✓							
Sluice room			✓							
Bins less than 3/4 full			✓							
Bins lined			✓							
Courtyard				✓						

“Until the [HFG] trainings we didn’t know how to start [with managing a contract]. Now, after attending the workshops, we hold weekly meetings and inspections with our contractors. On our own we are able to perform spot checks and identify areas for the vendors to improve, we give feedback to the management and the contractors. The companies receive it well and make the necessary changes”

—Hospital Manager, S’brana Psychiatric Hospital.

The vendors tend to be more professional and have better staff capacity to perform the services. Outsourcing brought more-adequate staffing, which improves service quality. For example, S'brana went from only ~15 cleaners before outsourcing to 105 cleaning employees after outsourcing. In addition, the S'brana cleaners from the vendor are more focused on cleaning, whereas before outsourcing, the cleaners performed a lot of other tasks for the nurses, which detracted from their ability to clean properly.

It is incorrect to assume that outsourcing will reduce the workload on the hospital administration. Instead, with outsourcing, the management focus of the hospital changes— instead of having the headache of working with ~100 cleaners directly, with outsourcing the hospital works with the vendor manager. Equipment maintenance is now the responsibility of the vendor—the hospital used to have to repair equipment all of the time. For laundry, the hospital used to have to arrange for transport logistics to other facilities when their laundry machines were down. Now the laundry company takes care of transport and logistics and it runs much more smoothly. But despite this shift in management focus, the hospital administration still has to be involved in actively managing contracts and meeting with vendors regularly to monitor quality.

Several hospital managers and superintendents believe that the lessons learned from this first round of outsourcing of nonclinical services will enable the hospital to transition towards outsourcing clinical services in the future.

5.5 Opportunities to Develop Microenterprises Led and Staffed by Women: a Gender Perspective

As the Botswana government expands its efforts to diversify the economy it has the responsibility to investigate the gender implications of these newly created entrepreneurship opportunities, and particularly whether the small businesses that public hospitals are forming business relationships with play a role in increasing economic empowerment for women. While Botswana is classified as an upper-middle-income country by the World Bank, the country's relatively low scores on international indicators relating to gender and human development demonstrate room for improvement in these areas. Botswana's gender inequality index in the 2014 U.N. Human Development Report was 0.486, 100th out of 187 countries with data. The country's overall human development score was 0.683, or 109th out of 187 countries. In 2013, only 7.9 percent of seats in Botswana's parliament were held by women. The percentage of Botswana with at least some secondary education is roughly the same across genders, about three in four. However, at 71.8 percent (UNDP 2014), female participation in the labour force lags 10 percent behind that of men.

Economic diversification represents an opportunity to increase the economic empowerment of women. To do so, the following questions should be considered during the evaluation of a contractor and bid.

- Is the policy of outsourcing gender neutral?
 - Does the hospital have a nondiscrimination policy in its hiring and subcontracting?
 - Is there language to encourage women, minorities, or other marginalised groups to apply to this opportunity?
 - Of the total number of applications, what percentage were submitted by women-owned businesses?
 - Of the total number of contracts awarded what percentage were to women-owned businesses?
- Is there evidence that hospitals' outsourcing has had an impact on creating entrepreneurship opportunities for women?

- What are the unintended effects of hospitals' outsourcing functions? For example:
 - Of the hospital staff that lost their jobs due to outsourcing how many were women? And men?
 - Do the businesses awarded outsourcing contracts have nondiscriminatory policies in their hiring?
 - Could outsourcing cause labour market discrimination if women do not start small businesses or if women are not hired by private companies due to lack of training and skills or social norms?

5.5.1 Existing Gender Considerations in Outsourcing

To date, none of the seven hospitals has any operating nondiscrimination policies, and there are not any nondiscrimination policies currently in their outsourced contracts. The hospital administrators acknowledged that nondiscrimination policies would be useful to incorporate into future contracts, and that it would be up to the hospital to push the vendor to include nondiscrimination clauses as the vendors most likely would not incorporate these policies on their own.

Out of the 23 companies that provide nonclinical services to Botswana hospitals, only 4 are women-owned companies. Thus women-owned companies represent 17 percent of the outsourced companies currently employed by hospitals. The four women-owned companies include one security company, two catering companies, and one cleaning company (the cleaning company is co-owned by a husband and wife).

5.5.2 Number of Women Occupying Senior Management Roles by Service

Security companies: The number of women occupying senior management roles varies by company. Top Security company at Scottish Livingstone Hospital has 60 percent of its senior roles filled by women—there are three women in senior roles out of a total of five management positions. The management roles filled by women include a site supervisor and manager positions. Shamah Security at S'brana Psychiatric Hospital has 25 percent supervisor roles filled by women. In addition, the site manager for United Security at Nyangabgwe Referral Hospital is a woman. The remaining security companies at the other hospitals have only men in senior roles.

Cleaning: Cleaning companies tend to have a larger number of women in senior roles. At S'brana Psychiatric Hospital, 90 percent of the cleaning supervisor roles with StockSure are filled by women. Princess Marina Hospital also has a large proportion of women in senior roles, with approximately 50 percent of senior management roles filled by women. At Nyangabgwe Referral Hospital, the operation manager and site manager are both women. At the remaining hospitals, men fill senior management roles within the cleaning companies.

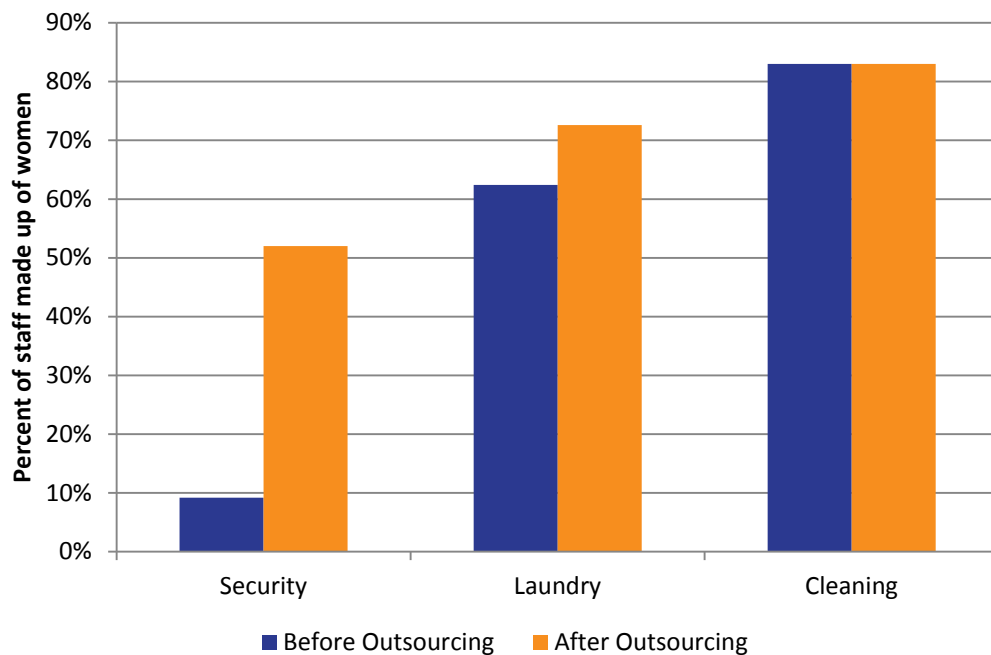
Laundry: All laundry services across the seven hospitals have been outsourced to the same laundry company, DryTex. The DryTex senior and regional managers are both women. At S'brana Psychiatric Hospital, all of the DryTex managers and supervisors are women. The site manager at Nyangabgwe Referral Hospital is a woman.

Grounds: Most of the hospitals have not yet outsourced landscaping and grounds. However, at S'brana Psychiatric Hospital, where grounds has been outsourced, 50 percent of the supervisors are women.

5.5.3 Outsourcing Creates Job Opportunities for Women

An analysis of the change in the proportion of women employed by service area reveals that outsourcing has created more opportunities for women. Figure 1 shows the average proportion of women in comparison to total employees across security, laundry, and cleaning services, before and after outsourcing. Overall, the opportunity for women's employment in these service areas has increased. The largest increase in employment of women was seen with security services—before outsourcing, women occupied less than 10 percent of security jobs across these seven hospitals. After outsourcing, women now occupy on average over 50 percent of the available jobs in security. Laundry also saw an approximately 10 percent increase in the employment of women after the laundry service was outsourced. On average, across cleaning companies, the proportion of women employed before and after outsourcing has remained constant. Cleaning jobs tend to be heavily gender-biased, and Figure 1 shows that the majority of cleaning employees are women. It is important to note that in addition to seeing increases in the *proportion* of women to men employed in each of these service areas, there is also a general increase in the *absolute* number of women employed after outsourcing, as the outsourcing companies tend to have better staff capacity and employ more staff to perform the services as compared to before outsourcing.

Figure 6: Average proportion of security, laundry, and cleaning staff made up of women, before and after outsourcing



6. BENEFITS TO PEOPLE LIVING WITH HIV AND LINKAGES TO PEPFAR 3.0

6.1 Background on HIV in Botswana

Botswana has the third highest HIV prevalence in the world, with 21.9 percent of the adult population aged 15–49 years estimated to be infected (CIA 2013). HIV prevalence is estimated to be even higher among pregnant women (aged 15–49) attending government antenatal clinics, where prevalence in 2013 was estimated around 30 percent. As of 2013, 320,000 people were living with HIV in Botswana. Of these, 250,000 are receiving ART, representing 79 percent coverage for adults (ages 15+) (UNAIDS 2013). The estimated percentage of pregnant women living with HIV who receive ART for PMTCT is greater than 95 percent.

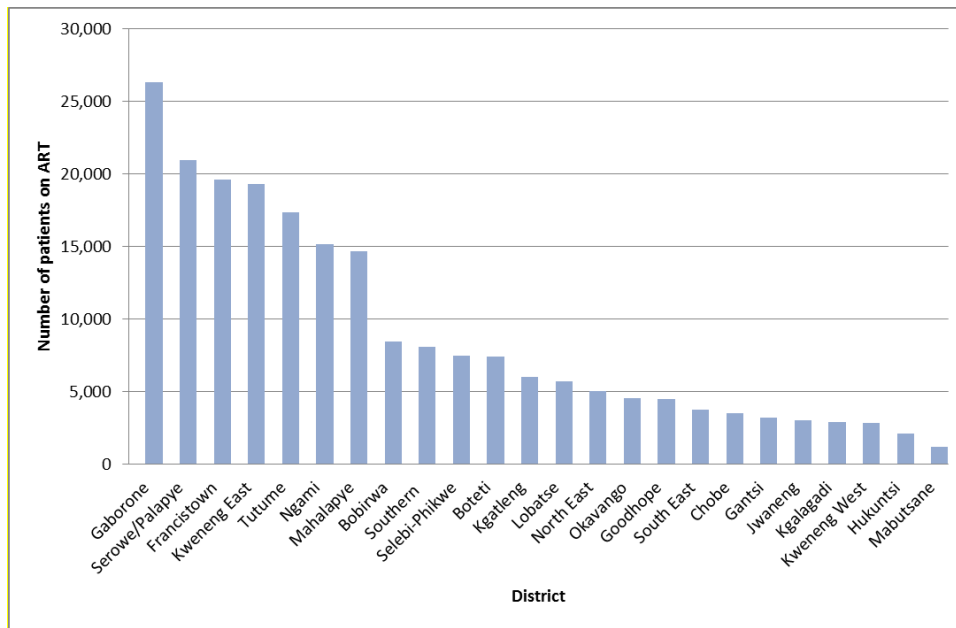
Botswana initiated a strategic response to the HIV epidemic starting in 1987 with a blood screening programme, then in the 1990s with an information, education, and communication programme, accompanied in 2001 by provision of free ART to all citizens of Botswana who qualify for treatment. The effective scale-up of this ART programme has reduced mortality, but HIV remains a major health concern.

The MoH has initiated outsourcing on nonclinical services. This outsourcing initiative directly benefits people living with HIV.

6.2 Public Sector in Botswana Treats 85 Percent of ART Patients

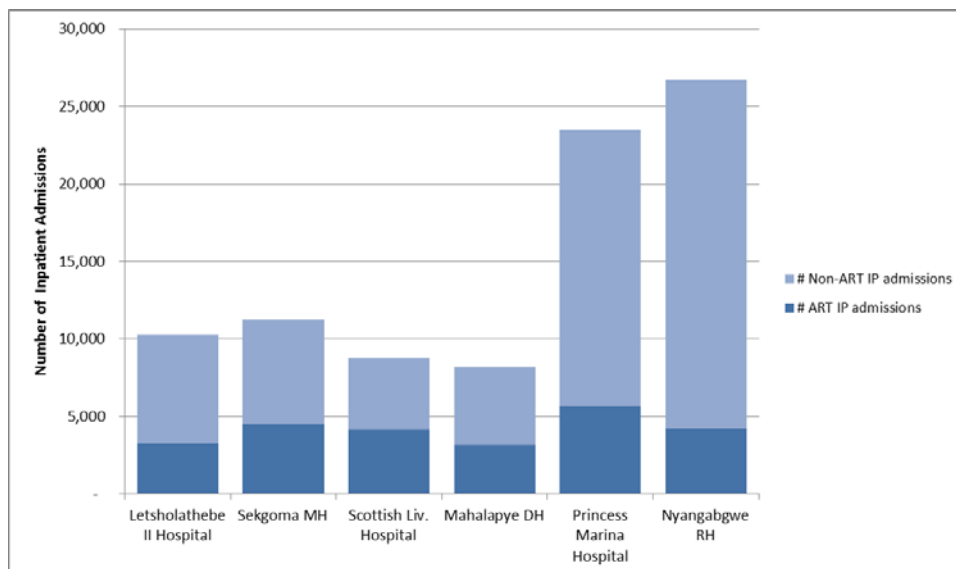
The public sector serves as the largest provider of ART, with approximately 85 percent of patients treated receiving treatment free of charge in the public sector (WHO 2005). All of the district and regional hospitals in Botswana provide ART, including the seven hospitals that have initiated outsourcing of nonclinical services. Figure 2 shows the distribution of people receiving ART by district. The seven hospitals that have initiated outsourcing fall in the districts with the largest number of highly active antiretroviral therapy patients—Gaborone, Serowe/Palapye, Francistown, Kweneng East, Ngami, Mahalapye, and Lobatse.

Figure 7: Distribution of people receiving ART services by district in 2014



We estimated that the currently 250,000 patients receiving ART in Botswana would generate a total of 54,000 admissions per year due to comorbidities among people living with HIV⁴. There are 28 referral and district hospitals in Botswana. The seven hospitals considered in the current study provide over 50 percent of inpatient bed capacity (UNAIDS 2014). Figure 3 shows the proportion of inpatient admissions for ART patients out of the total number of hospitalisations. ART patients comprise a large portion of hospital inpatient admissions—in some hospitals ART patients make up close to half of all inpatient admissions.

Figure 8: Proportion of inpatient admissions for ART patients out of the total number of hospitalisations in 2014.

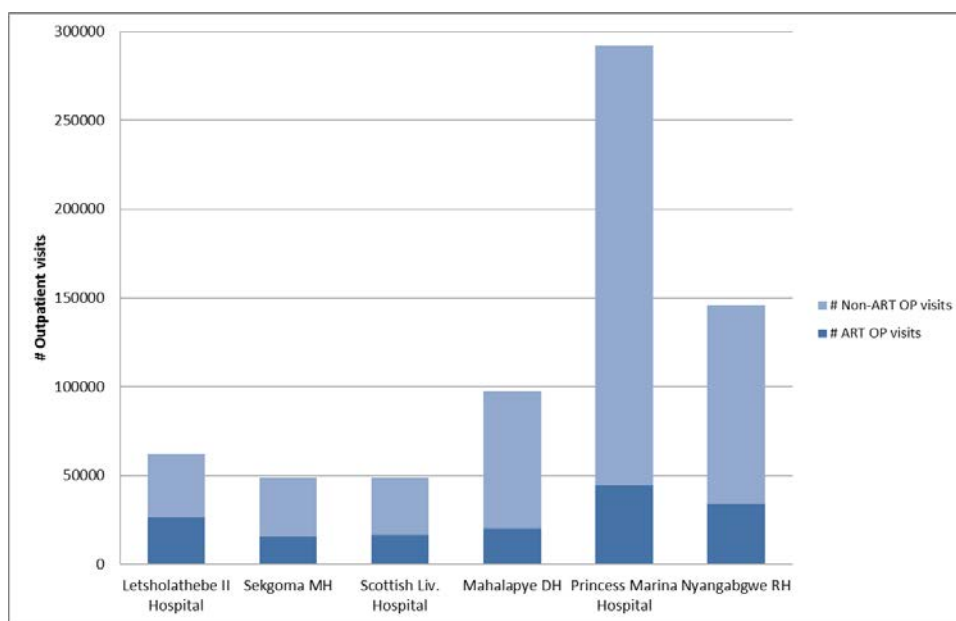


⁴ It is estimated that the incidence rate of severe morbid events among people living with HIV and AIDS is 21.5 events per 100 person-years (Luz et al. 2014). These estimates are conservative because the quality of ART care is likely better in the reported countries, which would reduce comorbidities and use of services.

We also estimated that the 250,000 patients receiving ART in Botswana would generate 1,415,000 outpatient visits per year.⁵ Figure 4 shows the proportion of outpatient visits from ART patients versus total outpatient visits that occurred during the year. Figure 5 shows the districts of Botswana with data on the seven facilities implementing outsourcing services, including total ART patients by district and the number of outpatient visits and inpatient admissions by ART patients across the hospitals that have initiated outsourcing.⁶ The hospital data in Figure 5 are plotted on a map of Botswana published by Kandala et al. (2012). Kandala et al.'s map depicts the rate of HIV infection (in terms of posterior odds ratios); green districts have lower rates of HIV infection and red districts have higher rates of HIV infection.

In absolute numbers, ART patients contribute to a large number of hospital visits per year and, in relation to total outpatient visits per year, represent a large proportion of visits—in some facilities ART patients contribute a quarter to a third of all outpatient visits.

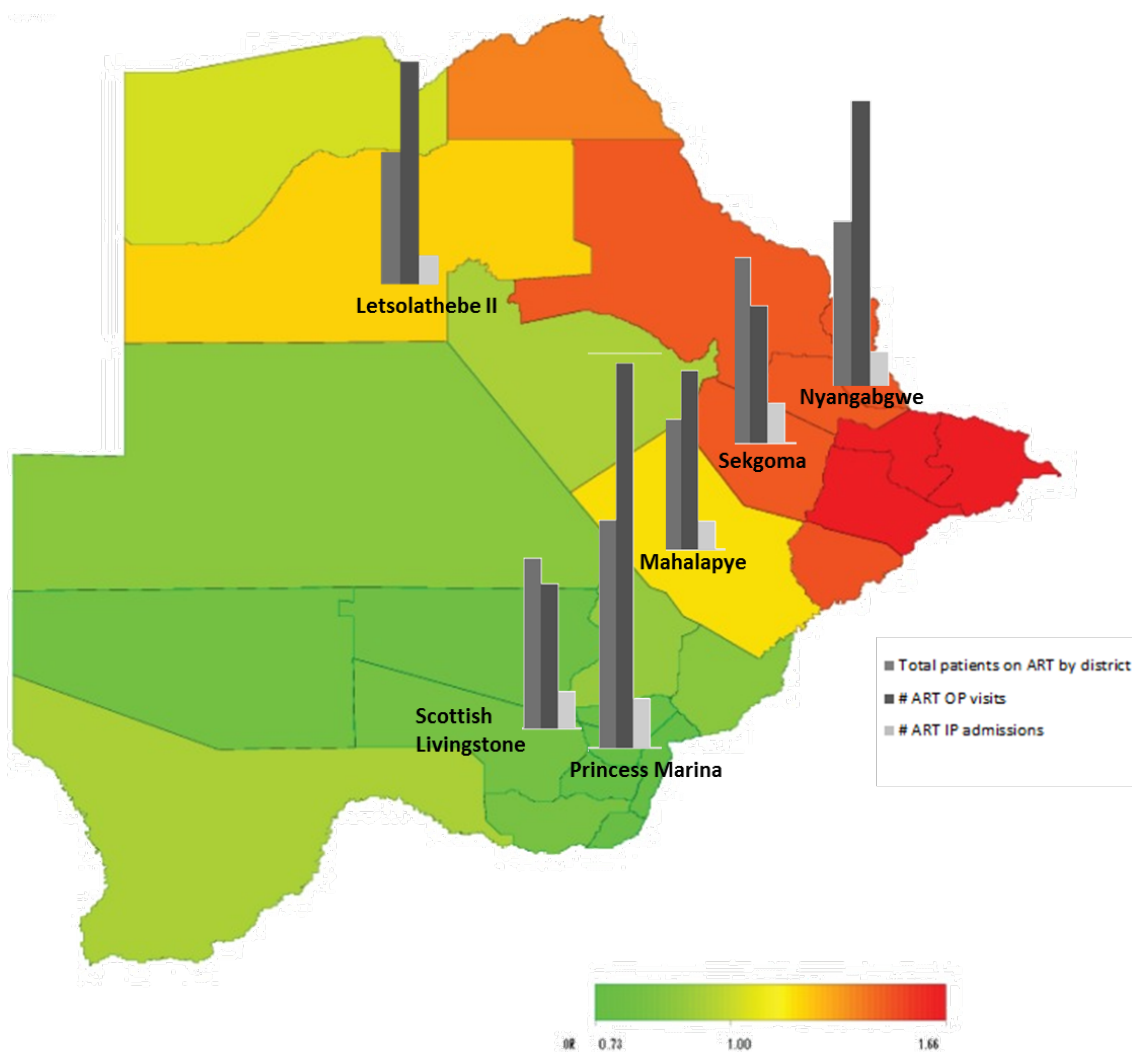
Figure 9: Proportion of Outpatient Visits by ART patients out of the total number of outpatient visits in 2014



⁵ Studies show that mean annual outpatient visits average 5.66 visits per person living with HIV per year (Fleishman et al. 2005).

⁶ A breakdown of ART patients was not available for S'brana Psychiatric Hospital; therefore, that hospital is not included in the figures below.

Figure 10: Estimated number of ART patients benefited along with estimates of outpatient visits and discharges per hospital (using graph from Kandala et al.)⁷



Improvements in cleaning, laundering, and security represent benefits to all hospitalised patients at the regional and district hospitals. Benefits not only include more comfort, cleanliness, and client satisfaction, but also unmeasured aspects of quality of care and prevention of nosocomial infections. Since HIV patients represent such a significant portion of inpatient hospitalisations, these service improvements have a particular impact on HIV and AIDS care and treatment. General admissions as well as HIV patient admissions—estimated in a quarter of all discharges—benefit directly from improvements in hospital operation from the outsources services.

⁷ Note: these hospital graphs have been overlaid on a color-coded map of Botswana published by Kandala et al. (2012) that depicts the rate of HIV infection (in terms of posterior odds ratios), where green districts have lower rates of HIV infection and red districts have higher rates of HIV infection.

6.3 How Outsourcing Hospital Services Accelerates PEPFAR 3.0's Agenda

PEPFAR 3.0 lays out a strategy to accelerate core interventions for HIV control to ensure transparency and accountability for impact. PEPFAR's five action agendas include: impact, efficiency, sustainability, partnership, and human rights (Office of the US Global AIDS Coordinator 2014). The outsourcing of nonclinical services in Botswana directly supports PEPFAR's agenda in several key ways.

1. The Impact Action Agenda focuses on using finances to address the most vulnerable populations. In addition to scaling up access to core interventions, this also includes overcoming the barriers that prevent key populations from receiving treatment and care. A number of factors affect ART adherence, including patient characteristics, treatment regimens, disease characteristics, and the clinic setting. A study by Chesney (2000) found that dissatisfaction with past experiences in the health care system is a predictor of non-adherence to ART. This means that the clinic or hospital setting—including cleanliness, safety, general environment, perceived confidentiality, and satisfaction with past experience in the health care system—impacts whether or not an ART patient will decide to return for follow-up care. The nonclinical services that have been outsourced in Botswana are highly visible to patients, meaning that a patient will quickly get a sense of whether or not he/she feels safe in the facility, and whether or not it appears clean and well maintained. These visible indicators become first-line proxies for the patient's perceptions of the quality of medical care, and directly influence whether or not a patient will return for future care or medications. In this way, outsourcing of nonclinical services could improve access and adherence to treatment.
2. The Efficiency Action Agenda aims to increase transparency, oversight, and accountability, to ensure that each PEPFAR dollar is optimally invested. Outsourcing has the opportunity to improve health system financing and increase efficiency gains of services, by increasing service quality at the same cost or by maintaining service quality at a lower cost. HIV and AIDS patients comprise a significant portion of the population in Botswana that is accessing the health system. Improving the efficiency of hospital financing and operations creates improvements in the efficiency of HIV and AIDS service delivery, and maximises the investment of each dollar in HIV and AIDS care and treatment.
3. PEPFAR's Sustainability Action Agenda aims to strengthen the health system by ensuring that hospitals and health facilities have the infrastructure, workforce, and internal resources to adequately provide services to key patient populations. A key finding in this first round of MoH outsourcing in Botswana is that the outsourced companies tend to be more professional and have better staff capacity to perform the services. The sufficient human and financial resources, along with the systems and technology to support service delivery, that the outsourced companies bring to the hospitals allows for better service provision to key populations, including people living with HIV.
4. The Partnership Action Agenda speaks specifically to the development of Public-Private Partnerships "whose impact will be greater than the sum of any individual investment." PEPFAR 3.0 states, "The potential to scale-up interventions and control the epidemic is much greater with the support and collaboration of the private sector" (p. 20). Botswana's National Privatisation Policy is built around the notion of diversifying the economy and developing the private sector. The MoH, through the establishment of a PPP Unit and the initiation of outsourcing, has been a leader in implementing this national policy. In doing this, the MoH is contributing to the sustainability of the HIV response by supporting the development and strengthening of markets and private companies that are investing in and establishing roots in the local communities and health systems.

5. The Human Rights Action Agenda aims to protect and address the human rights of those living with HIV/AIDS. In addition to the human right to health care, recognising the human right to adequate sanitation can lead health facilities to become “models of clean, safe, and dignified care” (Bartram et al. 2015). HIV-positive pregnant women have the right to deliver in a birthing environment that, at a minimum, does not place them or their baby at risk. Globally, infections cause nearly half of late neonatal deaths; many of these late neonatal deaths are attributable to inadequate hygiene (Bartram et al. 2015). In addition, these same unhygienic conditions can contribute to other hospital-acquired infections and disease outbreaks. HIV patients are already immunocompromised, and HIV infection is often accompanied by additional opportunistic infections such as TB and pneumonia. A retrospective chart review of admissions to Princess Marina Hospital found that up to 70 percent of all patients presenting with pneumonia are known to be HIV-positive (MoH 2012b). In 2013, HIV-associated TB contributed to 25 percent of all HIV and AIDS deaths (Office of the US Global AIDS Coordinator 2014). Improved hygiene in health-care facilities is an important investment towards providing safe and dignified care to people living with HIV.

7. LESSONS LEARNED AND RECOMMENDATIONS

The following is a set of “lessons learned” and recommendations for future outsourcing initiatives in Botswana and across other countries that are looking to undertake similar programmes.

7.1 Communication Strategy for a New Policy

From the outset, there has been poor communication surrounding the outsourcing initiative. This was complicated by the fact that the MoH was ramping up its outsourcing initiative very quickly; as a result, the communication campaign got pushed down on the priority list. Members of the OSM did visit each hospital to discuss outsourcing and explain its benefits. They found that the more participation they received from the hospitals, the more unproductive the conversations became. So, they ended up decreasing their time spent on communication, and used their own political force to move the outsourcing projects along. The OSM is working on a communication plan going forward, and the OSM says that “it will be informed by battle scars!” Investing in the time and resources in proper communication from the outset of the initiative would have been beneficial and facilitated the outsourcing process.

The need for MoH management and rank and file staff support was really underestimated in the privatisation process. The government thought they were communicating and connecting with these staff, but later learned that a lot of managers were simply ignoring this communication and not paying attention to the concept of moving toward privatisation/outsourcing. Botswana has served as an example of development success, experiencing high economic growth, development, and progressing to a middle-income country classification. Therefore, there is a lot of complacency among government staff, and people question the need to tinker with a system that is already working. Similarly, there was a lack of ownership of the outsourcing initiatives at the facility level. The hospital managers/facilities need to be involved from the beginning and throughout the process.

Private sector suppliers have generally been left out of the picture. Going forward, the MoH wants to form better relationships with the private companies and actually teach suppliers how to outsource, write, and manage contracts, along with the hospital staff and management.

The MoH ran into a lot of resistance from Ministry and hospital employees. The government did a poor job of communicating to hospital employees who would be losing their jobs when services were outsourced. Employees were notified months in advance of their termination and so many employees started to look for new jobs. The hospitals did not fill the vacant positions, which resulted in the hospitals having months (and more months when contracting was delayed) of being short-staffed, with a serious negative impact on hospital operations. A lesson learned is that the strategy should be a very short notification period with a severance pay package to minimise service disruption. Transition planning from government-run to outsourced services is important to ensure a smooth handover with minimal disruption to service quality.

Maintaining proper communication is a challenge—every hospital management team reported struggling with a perceived lack of timely and thorough communication with the MoH on the outsourcing of nonclinical services. Hospitals do not receive copies of signed agreements as soon as they are executed; hospitals do not receive necessary time-line information to adequately prepare for vendor mobilisation; hospitals are not made promptly aware of the final outcome on vendor selection after tender evaluations are completed. These communication gaps impose unnecessary uncertainties on the hospital management teams charged with effectively managing the complex operations of the hospital.

PEEPA has an outsourcing communication strategy in place now. As part of this strategy, the Chief Operating Officer of PEEPA now informs and addresses local authorities, elected chancellors, and members of parliament to raise awareness around outsourcing. PEEPA makes presentations to the PIC Force (the group of Permanent Secretaries from each line ministry). PEEPA meets with BOCCIM to see if they are ready for various industries to start outsourcing (e.g., they met with BOCCIM to discuss outsourcing security). As part of their awareness-raising efforts, PEEPA discusses the outsourcing process and goes through the outsourcing guidelines with key stakeholders. In 2010, PEEPA conducted a training with a group of hospital managers and OSM staff. The training consisted of about five or six short sessions spread across the various hospitals before the first tenders were issued.

In terms of broader communication, PEEPA recognises that there has not been an attempt to communicate outsourcing to the general population, and stressed the need to inform the general population so that they are aware of the changes in service and are equipped to buy shares in the new companies if they so desire.

7.2 Financing and Budgetary Considerations

With outsourcing initiatives, the MoH expects to see reform in the organisational structure around financing for these outsourced services. Part of the current struggle with service costs is that they are spread across multiple line ministries—the MoH, the ministry of finance, the ministry of labour, ministry of transport, etc. Hospitals do not have their own budgets to manage, and hospital administrators often have no idea about their total hospital operating budget, as labour and capital and equipment costs are each controlled in a different location. There is supposed to be one budget for outsourced services but the ministry of finance has not established this yet. It may be a better idea to have each hospital management team responsible for the management of both the out

7.3 Strengthening Management—Ministry of Health

The MoH's strong leadership has enabled it to become the frontrunner of the outsourcing policy. The MoH Permanent Secretary used to be head of Princess Marina Hospital—so he knows the issues. In addition, the Minister of Health is a doctor, and the head of the PPP Unit used to work for PEEPA—so the mix of leadership is right. Beyond this core group from the MoH, there are few outsourcing “champions.” In addition, it was pointed out that Botswana's privatisation policy is not a law, so some say that PEEPA does not “have teeth” to force ministries to get involved. The 2006 document *Implementation of Outsourcing Strategy and Programme* was supposed to drive champions through the PIC Force, but did not work as expected. As a result, there are few outsourcing leaders outside of the MoH, and the challenge going forward is to figure out how to engage stakeholders, strengthen management around outsourcing, and enable the various stakeholder groups (PEEPA, PPP, Procurement Unit, PPADB, MTC, etc.) to work together effectively. Many of the different groups are beginning to talk about outsourcing; therefore, increasing their coordination and efficiency will be key.

The first round of MoH outsourcing raised a change management issue, with a lot of backlash and doubts from key stakeholders and hospital administrations. The MoH decided that despite this backlash, they needed to remain faithful to the long-term concept of outsourcing and continue to push forward. The MoH recognises that incorporating “change management” into future outsourcing initiatives will be crucial for ensuring key stakeholder buy-in.

7.4 Strengthening Management—Hospitals

Generally, hospital administrators and staff in Botswana were rushed into outsourcing contracts without proper training in managing contracts, and without being equipped with contract management tools. As a result, “contract management” ended when the contract was signed, because the staff did not have any tools or skills to monitor and assess the work of the company providing the outsourced services. Combined with the inexperience of service vendors, this has resulted in significant quality issues and conflict with contract service providers. When hospital staff saw issues with the way outsourced services were being provided, they were unaware of what steps could be taken to rectify the situation, and therefore were generally reluctant to do anything.

Going forward, hospital management needs to do a better job of clarifying and managing departmental boundaries before outsourcing is under way. Current operational duties in many of the hospitals involve a mixing of responsibilities between nonclinical service departments, one example being cleaning staff assigned the task of delivering patient meals. Hospital management needs to identify all areas where task assignments cross traditional department lines, and clarify which outsourced vendor will be responsible for the task before contract execution. Additionally, when one vendor is contracted for service provision of more than one service such as providing cleaners and porters, hospital management must ensure that staff are not randomly transferred between assignments, especially when patient safety and infection control issues pose a patient safety risk.

The hospital staff needs to “manage the contract, not the workers.” The hospitals, because of the lack of professional skills and knowledge of contract management, ended up duplicating the outsourced department management staff roles and responsibilities. As a result, the outsourced service department ended up with two managers (the hospital manager and the company manager), who were both directing the work and the workers. This caused conflict and confusion. Instead, the hospital manager should have focused on managing the contract and let the company manager manage the staff.

Hospitals should schedule new contract implementation based on an agreed-upon mobilisation plan and timeline. Continued delay in the implementation of new outsourced service agreements will result in further human resources disruptions (growing vacancy rates, absenteeism, declining morale, and eroding productivity). But implementing a new service contract with inadequately trained staff, equipment, and supplies not on-site, vendor management unfamiliar with hospital protocols, and no clear definition of service requirements will potentially cause even more disruption to hospital operations than a start-up delay.

Several key messages evolved around successful contract management. These include:

- Outsourcing can be successful only if there is a true partnership between the hospitals and the service providers.
- Hospitals can play an important role in assisting the capacity development of fledgling service providers in Botswana. “Assistance” may include training and orientation to the special requirements of hospitals (in exchange for a price break in the contract for the first year), a stepped approach to contracting some services, and detailed service information provided in the SLAs.
- The role of the hospital in outsourcing is to manage the contract, not the contractor’s staff. The service provider monitors the day-to-day performance of its line workers, and the hospital monitors the key performance indicators to measure overall compliance and assure quality.
- The mobilisation phase is critical to ensuring a smooth and safe transition; it requires careful planning and monitoring on the part of both the hospital and the vendor.

- The relationship between the hospital and the vendor/service provider is complex, and will always involve a degree of tension based on inherent differences in goals. This complexity requires a level of management sophistication on the part of both the hospital and the vendor.
- A general service contract requires a good faith effort on the part of both entities. The SLA component of the contract provides the details needed for all parties to understand specific requirements and standards and monitor compliance with those standards.
- The SLA allows the hospital considerable leverage and flexibility to address and correct vendor performance issues, short of complete contract termination (which is the only remediation the current MoH outsourced contracts allow). Under the SLA approach, hospitals may create and refine a point-based performance system to encourage/enforce the level of performance desired.
- “The devil is in the details”: the SLA needs to include sufficient service information that the vendor clearly understands the hospital’s expectations (i.e., what constitutes “good performance”).
- A breach in the management cycle of the SLA effectively compromises the entire system. Without sufficient monitoring, reports are useless; without good reporting, performance issues cannot be identified and addressed; and so forth.

7.5 Lessons to a Successful Management of SLAs

It is recommended that with the development and implementation of sound tendering procedures and well-written contracts that contain SLAs, hospital contract management staff intentionally redirect their efforts to managing outsourced service contracts and not outsourced service workers and daily operations. Similarly, nursing unit managers should be relieved of responsibility for supervising nonclinical services. Nursing unit managers need an effective communication channel for feedback to outsourced service department managers about concerns or questions involving vendor staff performance on the nursing units, but regular performance monitoring and supervision is the responsibility of the company.

Several key messages evolved around strong management of outsourcing contracts containing SLAs:

- Do not underestimate how much time it takes to manage a contract. Companies try to sell contracts with promises of great time savings for hospital management. Contract monitoring needs to be rigorous and routine.
- Hospital management need to schedule department manager meetings for outsourced service departments with the same frequency as they do for non-outsourced department manager meetings.
- Hospital management need to make scheduled and nonscheduled inspections.
- The hospital needs to periodically audit the contractor’s budget reports and supply and equipment inventories.
- The contract department manager is most successful when (s)he is an equal and participating member of the hospital department management team. The outsourcing relationship should not be one of a supplier mentality, but rather a partner mentality, with contract department managers participating on hospital emergency response teams and on multi-disciplinary hospital committees.
- The hospital administrator and contractor need to conduct a joint annual performance appraisal of the department manager.
- The contract should be regularly re-bid to ensure that the hospital continues to pay a fair price for the service and is not missing the opportunity to introduce new technology or methodologies.

7.6 Lack of Private Providers, and Vendor Inexperience

In Botswana, the lack of an existing private sector means that the current companies that are bidding on outsourcing contracts have low capacity and little to no prior experience working in hospital settings. Therefore, a lot of these companies are learning on the job, resulting in initially poor outcomes. The MoH OSM recognises that it is trading off short-term quality of hospital services for long-term development of the private sector. In an interview, a MoH staff member said, “It’s not a bad thing to develop and then lose strong managers to the private sector.” This statement emphasises the MoH’s desire to use outsourcing as a way to develop and strengthen the private sector in Botswana.

Across the country, vendors with the experience, size, and skill to effectively perform the level of service required by the hospitals are in very short supply. This places an unexpected burden on the hospital staff to provide the knowledge, supervision, and training normally expected and required from a contract service. Vendors repeatedly promise to place experienced staff in the hospitals, but have so far largely failed to deliver on the promise. The management cost of hospital support for extremely weak vendors is unknown, but it is likely to be significant.

At the start of the contracting, none of the hospitals were receiving any customary-and-usual management reports from outsourced service vendors. This can be ascribed to weak contractual mechanisms: contracts with vendors have not specified either daily/weekly monitoring reports or monthly management reports to enable hospital management to assess the performance of the vendor.

In general, contract vendors have not demonstrated the capability to train staff, and have not been required by contract to procure training services for their staff. As a result, staff are placed in the hospital with access to the wards but with no knowledge of infection control requirements and procedures, and a lack of sensitivity and adherence to requirements for confidentiality.

Vendors have provided no basic information technology support to be able to electronically produce simple Excel spreadsheet summaries on staff attendance and turn-over, supply inventories, or security incidents.

Several key steps were taken to enable the private sector in the outsourcing process. As a result, the quality of the bids that the MoH and hospitals are receiving is improving. These key steps include:

- Initially, the OSM was receiving a lot of bids from “tenderpreneurs”—people that searched the internet to develop a great-sounding bid that had no substance or backing to it. The OSM has been learning how to distinguish tenderpreneurs from valid companies. The Supplier Intelligence Resource database that PEEPA developed helps to compile both quantitative and qualitative information on current and potential private sector service suppliers, and reduce some of the engagement of tenderpreneurs.
- The OSM made a deliberate decision to loosen their qualifications/specifications of vendors in order to allow industries to develop in Botswana.
 - The OSM eased up on the hospital-cleaning experience that companies were required to have in order to bid on the service. This was, in part, a political decision: if you disqualify the nascent local companies too soon you may run out of political support for the outsourcing initiative in general.
 - The OSM decided that they would be willing to teach/train companies with minimal experience. In most instances, the hospital provided training to the company around infection control and other hospital-specific knowledge. A conscious decision was made to let the hospital provide the training and not to bring in an outside training company, because this would take ownership away from the hospital management.

- A decision was made to focus on developing Botswana companies, as local economic empowerment is a key outcome of the outsourcing initiative. All of the companies currently employed in the hospitals are Botswana companies.
- The MoH is interested in putting a limit on the number of contracts that a contractor can win. This would prevent one company from monopolising the market, and would result in broader participation and more diversification of the economy.
- To date, nothing has been done to incentivise the market: however, one goal is to bring agencies from across the government together to identify additional ways to support small businesses in Botswana.

7.7 Strengthening Hospital-Vendor Relationships

A healthy relationship between the hospital and the vendor is key to ensuring proper service delivery and that the outsourcing initiative succeeds. To foster the hospital-vendor relationship, regularly scheduled meetings should be conducted between the hospital contracts manager and the vendor site manager; these meetings should be used to review the vendor reports, identify any areas that need attention, and address any questions/concerns on either side. In addition, once a month, one of these meetings should be used as a joint “walk about” to observe and discuss what is going well and what needs attention. Periodic meetings between the higher-level hospital manager and the vendor’s general manager/CEO are also important to discuss the partnership.

Several key messages evolved around strengthening the hospital-vendor relationship.

- Clarify the channels and modes of communication so both sides understand them.
- Ask the vendors’ site managers to serve on relevant hospital committees (infectious disease control, risk management, accreditation).
- Develop monitoring tools together so both sides understand their purpose and application; conduct audits in a highly professional manner to focus on performance improvement; review reports together to identify problems and determine how to resolve (collaborative approach).
- Conduct an orientation for the vendor at the very start of the contract; this should help the vendor better understand the mission and organisation of the hospital and the uniqueness of the hospital environment; the orientation should also serve as a way for the vendor to introduce itself to all hospital staff so everyone knows who’s who.
- Provide training to the vendor in infection control and other risk areas to avoid critical mistakes and to help the vendor understand the rationale for hospital protocols and how the vendor’s procedures must respect these. Continue to provide periodic in-service training, particularly for vendors who have little or no prior experience working with hospitals.
- Give medical exams free to the vendor (as a good faith concession) and look for other ways to reach out with support, e.g., office space, that could be provided at a minimal cost to the hospital. This will encourage the vendor to reciprocate in future situations when the hospital may need concessions from the vendor.
- Give contractors a copy of the COHSASA certification standards (South Africa hospital accreditation standards) for their understanding and use; clarify what these are, how the hospital is working towards the standards, and how the vendor’s role is critical.
- Treat contractors with respect and do not get into their operational issues unless there are signs of serious problems.
- Get agreement with the contractor on a clear payment timeline and stick to it.

- Timeliness is critical on both sides: services delivered, reports submitted, payment for services completed, issues identified and addressed, and so forth.
- Operate within legal frameworks.
- Negotiate in good faith.
- Practise empathy: put yourself in the other's shoes.

8. NEXT STEPS

Several outsourcing challenges and key next steps remain. The greatest challenge that needs priority attention is the need to incorporate SLAs in the hospital outsourcing contracts. Currently, none of the hospitals have SLAs for any outsourced service. Hospitals need to draft and finalise SLAs for each service area so that they can be incorporated into the next round of contracts.

There is generally high staff turnover among the vendor employees. Staff turnover disrupts the service quality as the new staff have to constantly be retrained. The turnover is likely due to the fact that the vendors tend to underpay their staff and are not offering a proper package (that is competitive with government salaries). Mechanisms need to be built into the vetting of bidders to ensure vendor staff are compensated at an acceptable level to help minimise turnover.

There remains room for improved management of the services by contractors. Some hospitals explained that sometimes a vendor manager covers several facilities and is not stationed at one hospital facility full-time. This results in management absence that can negatively impact department operations. Several vendors have had cash flow problems. If the hospital does not pay the vendor on time then the vendor is not able to pay its employees. This has resulted in a few instances of employee strikes, which disrupts service quality. Mechanisms need to be built into the vetting of bidders to ensure sufficient cash flow capability, and hospitals need to ensure that payment mechanisms allow for timely payment to vendors.

Companies write good tenders but then do not always follow them. In some instances, companies compromise on their site supervisor qualifications; sometimes this is because there is a shortage of well-qualified people to draw from. In other instances, companies do not train their staff as they promise they will. Hospitals should write the contracts to ensure that they have the authority to review and approve all managers working in their facilities and have the authority to remove any manager at any time if performance is not up to agreed-upon standards.

With laundry specifically, the hospital is responsible for providing steam and water for the vendor. Steam and water service frequently fails, in which case, the vendor needs to send the laundry to another facility for cleaning. This can result in delays or loss of linen. Hospital managers need to ensure that procedures are in place both to minimise these problems and to properly reimburse vendors for unexpected incurred expenses.

The availability of detailed cost benchmark data is critical to determining the impact and success of outsourcing. The decision whether to outsource nonclinical services, and which services to outsource, requires careful consideration and study. Without thorough and detailed cost information and service-level specifications in a vendor's proposal, an objective comparison to current operations is not possible. The lack of benchmark data around what it cost the hospitals to provide the nonclinical services in-house has impeded the hospital management teams and the MoH because they have nothing with which to compare the cost of the bids they receive. In the current state, it is not readily possible to judge the value for cost that outsourcing does or does not bring to a hospital department.

As part of HFG's technical assistance, a costing study of nonclinical services that complements this report was conducted in five hospitals in Botswana that have not yet initiated outsourcing. The costing report by Stegman et al. (2015) provides estimates of the current costs of nonclinical services (i.e. cleaning, laundry, catering, and grounds maintenance) at public hospitals before outsourcing begins. As outsourcing expands, it is important for the MoH to develop a better understanding of the total annual cost for the provision of nonclinical services, the drivers of those costs, and the unit cost of production for each service. Such information will aid the MoH in

determining a fair contract price when outsourcing, and will help the MoH and hospitals make strategic outsourcing decisions that are cost-effective and truly increase the quality and efficiency of public sector service delivery.

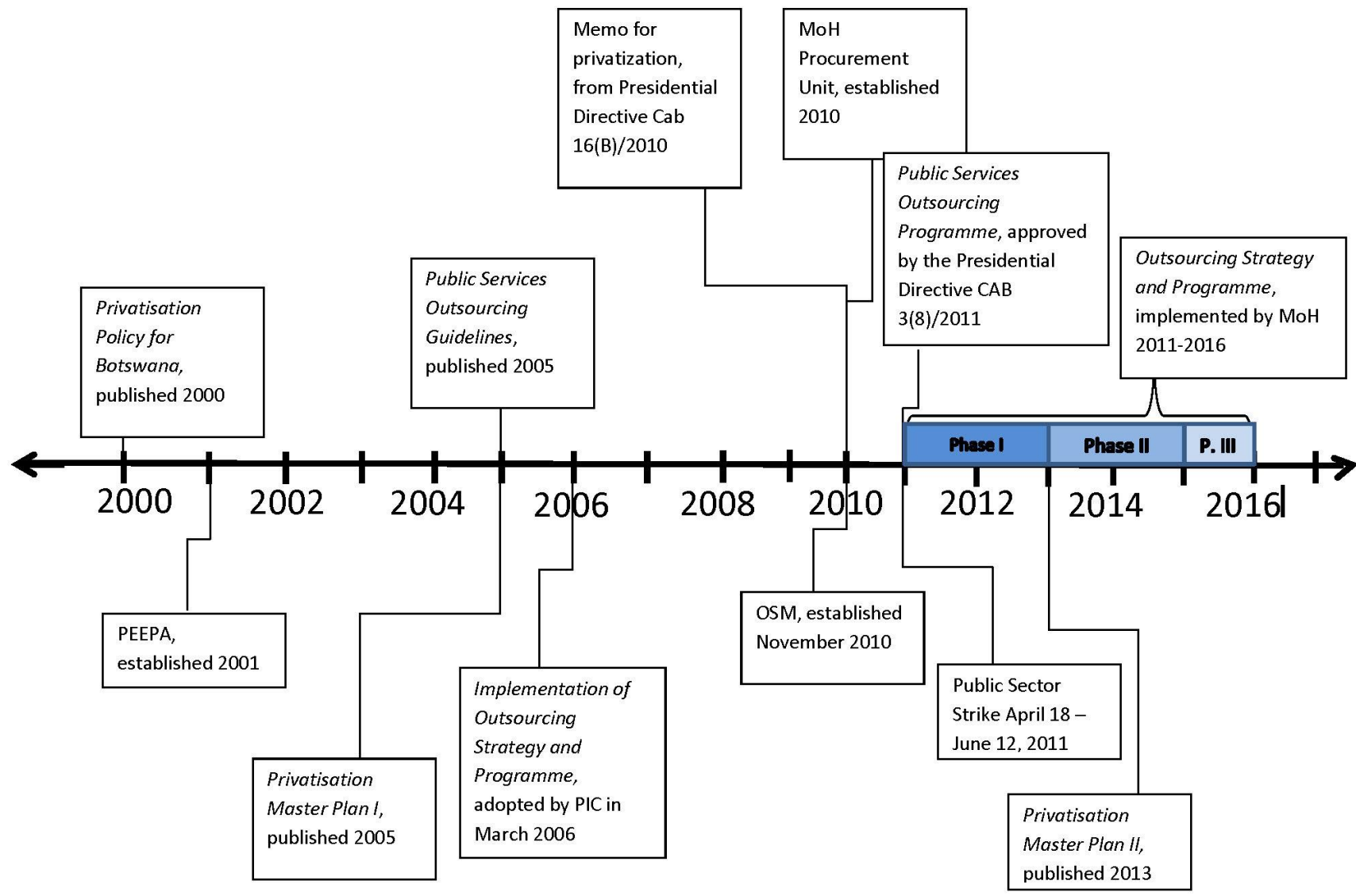
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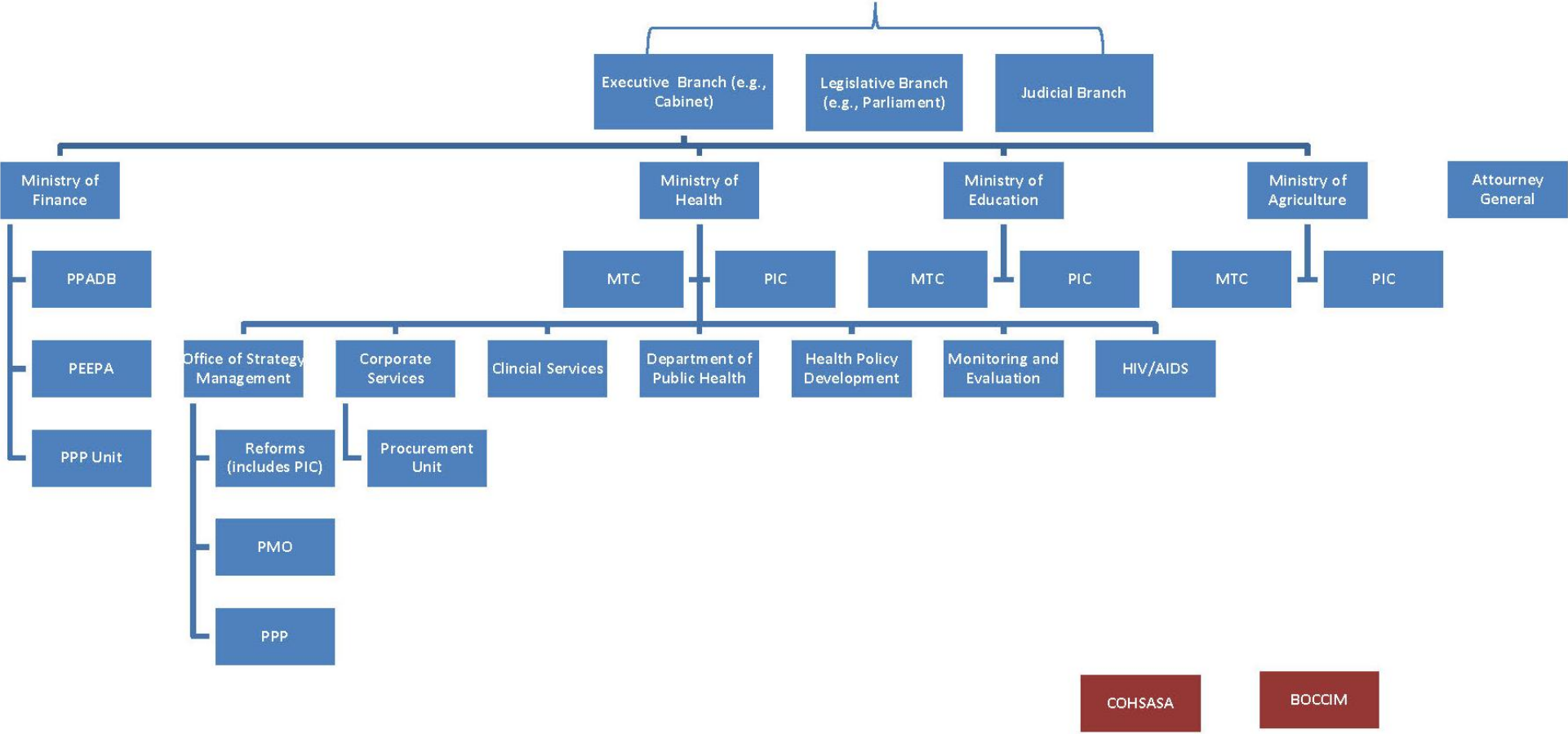
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ANNEX A. OUTSOURCING POLICY TIMELINE



ANNEX B. STAKEHOLDER DIAGRAM

Federal Government



ANNEX C. COUNTRY EXAMPLES OF OUTSOURCING

Country	Nonclinical services outsourced
India, Sri Lanka and Thailand	Contracting out of support services – catering, laundry, cleaning, security, equipment, and ground maintenance – has been longstanding, and was driven by pragmatic decisions rather than policy reform agendas (Mills 1998).
Mumbai, India	Catering was outsourced to reduce load on management as well as reduce waste and pilfering; it was also expected to be cheaper and not affected by strikes of civil servants (Mills 1998).
Bangkok, Thailand	Cleaning services were outsourced to obtain cheaper, and better quality service (Mills 1998). Contracting out of support services was part of a hospital initiative and a national plan to restrict the growth of the civil service. Contracting out was widely encouraged, and regulations relaxed. However, regulations did not sufficiently encourage competition, and did not allow the government to leverage purchasing power to obtain favorable terms (McPake and Mills 2000).
Bahrain, Morocco and Syria	MoHs contracted out through a competitive process for equipment and hospital building, as well as support services such as cleaning, catering, gardening and security. Monitoring mechanisms varied among the countries, and payments were made as block grants on a quarterly or annual basis. In Bahrain, an external party, the Tender Board in the Ministry of Finance, ensured transparency in the selection process (Siddiqi et al. 2006).
Zimbabwe	Contracting of support services in the main hospitals succeeded for many reasons. The capacity of the MoH staff was carefully built, and arrangements were made for public sector staff whose jobs were affected by outsourcing to either to be employed by the contractors, or assisted in starting their own companies that could bid for the contracts. There was strong cabinet support for the change and a strong private sector to bid for contracts. Also, the contracting process encouraged private sector bids (McPake and Mills 2000).
Eastern Cape, South Africa	Contract management expertise was outsourced so that private management consultants provided mentoring support to public sector management (Leon and Mabope 2005).

For nonclinical services, contract success depends on the detailed specification of performance standards within the contract. In practice, however, contracts are often “broadly focused, informally worded, deliberately incomplete, and reliant on informal mechanisms for dealing with disputes” (Mills and Broomberg 1998). As examples of performance standards for nonclinical services contracts: catering contracts in Mumbai specified meals of a specific content, and a PNG security contract specified the number of guards; in Thailand, the area to be cleaned was specified, and, in an equipment contract, the type of equipment was detailed, as was the specification that it should be new. Fines were the most common sanction for non-performance, although many contracts did not specify any sanctions (Mills and Broomberg 1998).

Outsourcing of nonclinical services did not succeed in Lesotho or Ghana. In Lesotho, there were only two companies that bid for the contract creating a “seller’s market” in which the supplier was able to charge higher than competitive rates for a catering services contract (Lambo and Sambo 2003). Ghana tried to apply their clinical contracting experience to contract out support services to church providers, but did not make much progress due to the lack of capacity within the MoH to design these contracts. There was also the sense that this proposal would generate strong staff and union opposition. Progress was further impeded by the low level of private sector development, low level interest of among private firms in taking on a government contract, and comparatively higher wages within the private sector that limited the cost-effectiveness of the contracted service (McPake and Mills 2000).

ANNEX D. HOSPITAL CONTRACT OVERVIEW

On-site assessments were conducted at the seven participating hospitals. The purpose of the site visits was to gather important information on the history and experience with outsourcing in the hospitals, to tour the facilities to assess levels of service, to talk with key hospital and vendor staff involved in outsourced service delivery, and to understand the challenges and impact on hospital operations that outsourcing has had or is anticipated will soon have in the hospitals.

S'brana Psychiatric Hospital: S'brana Psychiatric Hospital, built in 2009, is an acute mental health facility with 300 beds. The average daily census is 210 patients and the average length of stay is 30-33 days. S'brana was the first hospital in Botswana to outsource non-clinical services.

Mahalapye Hospital: Mahalapye Hospital, built in 2008, is a center for orthopedics with 260 beds. The average daily census is 218 patients.

Sekgoma Memorial Hospital: Sekgoma Memorial Hospital, built in 2007, serves as a center of excellence for eyes and ears. The hospital has 350 beds with an average daily census of 200 patients.

Nyangabgwe Referral Hospital: Nyangabgwe Referral Hospital was built in 1988. The hospital has 600 beds with an average daily census of 536 patients.

Princess Marina Hospital: Princess Marina Hospital is a national referral hospital. The hospital was built in 1966 and renovated in the 1980s. The hospital has 528 beds, and is often overcrowded resulting in an average daily census of 528+ patients

Letsholathebe II Memorial Hospital: Letsholathebe II Memorial Hospital was built in 2008. It has 270 beds and an average daily census of 200 patients.

Scottish Livingstone Hospital: Scottish Livingstone Hospital was built in 2007. It has 350 beds.

The following table lists the various services that have been outsourced at each hospital:

Hospital	Service	Date Outsourcing Contract Commenced	Contract Length (in years)
S'brana Psychiatric Hospital	Security	January 2011	2 years
	Security	August 2013	2 years
	Laundry	December 2013	3 years
	Cleaning	December 2010	2 years
	Cleaning	April 2013	3 years
	Grounds	September 2013	3 years
	Foodservice	Expected to be outsourced June 2015	3 years
Mahalapye Hospital	Security	Since 2011	2 years
	Security (for hospital only)	October 2013	2 years
	Security (for neighboring clinics only)	November 2013	2 years
	Laundry	April 2014	3 years
	Cleaning	May 2014	3 years
Sekgoma Memorial Hospital	Security	March 2011	2 years
	Security	September 2014	2 years
	Laundry	March 2014	3 years
	Cleaning	May 2014	3 years
Nyangabgwe Referral Hospital	Security	January 2013	2 years
	Security	September 2010	2 years + 4 month extension
	Laundry	February 2013	2 years
	Laundry	Feb 2015	3 month extension
	Cleaning, Portering, and Grounds (one contract)	Dec 2011	2 years + 4 month extension
	Cleaning & portering (one contract)	April 2014	3 years
	Grounds	January 2013	3 years
Princess Marina Hospital	Foodservice	Expected to be outsourced June 2015	3 years
	Security	March 2012	2 years
	Security	April 2014	2 years
	Laundry	February 2013	2 years
	Cleaning, Portering, and Grounds (one contract)	August 2012	2 years – but contract was terminated early
	Cleaning, Portering, and Grounds (one contract)	May 2014	5 months
Letsholathebe II Memorial Hospital	Cleaning, Portering, and Grounds (one contract)	September 2014	3 years
	Security	May 2013	2 years
	Laundry	March 2014	3 years
	Cleaning	March 2014	3 years

Hospital	Service	Date Outsourcing Contract Commenced	Contract Length (in years)
Scottish Livingstone Hospital	Security	December 2012	2 years + 3 month extension
	Laundry	March 2014	3 years
	Cleaning	March 2014	3 years

ANNEX E. WORKSHOP AGENDA - OUTSOURCING NON-CLINICAL SERVICES



Out-Sourcing Non-Clinical Hospital Services

Capacity-Building Workshop for Senior Hospital Managers and

MoH Office of Strategy Management/PPP Unit

February 4-7, 2014

Gaborone, Botswana

Workshop Goals:

- Describe the key elements in the pre-contract bidding process: pre-bid study, tendering and evaluation of bids
- Describe the role of hospital administrator in managing outsourced services and identify good practices for service management based on real experiences to-date
- Explain the purpose and key elements of the Service Level Agreement (SLA) and how it serves as a tool for managing expectations, improving communications, and strengthening relationships with the vendor/supplier.
- Apply a methodical process for describing services to be outsourced and setting service standards including performance indicators
- Strengthen intra-and inter-hospital communication so that administrators may learn from one another and share promising practices and lessons learned

Workshop Agenda for Part 1: Bidding Process for Outsourcing Services

Tuesday, February 4

8:00 am Registration

8:15 am Workshop Opening

- Workshop Welcome and opening remarks
 - Dr. Ndwapi, Office of Strategy Management, MoH
- Participants and Trainer Introductions
- Workshop Goals and Agenda Review
 - Part 1 – Bidding Process (Tuesday – Wednesday)
 - Part 2 – Contracting Process (Thursday – Friday)

9:30 Session 1: Project Start-Up

Summary and Discussion of Findings from Hospital Site Visits

Examination of key elements and sharing of experiences relating to:

- Selection of Study Team
- Goals of out-sourcing,
- Criteria for selecting which services to out-source
- Setting a timeline.

10:30 Coffee Break

11:00 Session 2: The Pre-Bid Study (continues after lunch)

- Market capabilities – How to determine vendor capabilities. Sharing recent experiences and mapping future approach to market analysis
- Cost analysis –How to determine current costs in order to evaluate bidders' proposed costs

12:30 Lunch

1:30 Session 2: The Pre-Bid Study (continued)

- Risk identification—potential risks to the hospital and how to mitigate
- Policy issues—key trade-offs and stakeholder considerations
- Contracting approaches- possible options; advantages + disadvantages

3:45 Wrap-Up

4:00 End of Day

Wednesday, February 5

- 8:00am** **Key Learning from Tuesday and Review of Wednesday Agenda**
- 8:15** **Session 3: Offer-to-Bid Document (continues after coffee break)**
- Review of General Conditions to include in document
 - Service Requirements – Level of specificity of service requirements to be described in the offer-to-big document; Practice exercise using housekeeping as case example
- 10:30 Coffee Break
- 11:00** **Session 3: Offer-to-Bid Document (continued)**
- Mobilization – How to emphasize to ensure a smooth project start-up. Sharing of start-up experiences at hospitals with outsourced services.
 - Price & payment schedule – Are all costs and fee categories identified?
 - Contractor’s management services – What is the staffing plan and provision for supervision?
 - Procurement of supplies and equipment and other essential plans/information bidders need to include.
- 12:30 Lunch
- 1:30** **Session 4: Evaluating the Bid**
- Critical areas for evaluating and comparing bids including cost, key personnel and staffing, references on current contracts, proposed management approaches, health and safety policies, project mobilization plan.
- 2:15** **Session 5: Hospital Management of Out-Sourced Services**
- Role of hospital in actively administering the contracted services
 - Partnering approach for successful team integration
 - Keys to successful management of services—for both hospital and company; brainstorming exercise
- 3:45** **Wrap-Up**
- 4:00** **End of day/End of Part 1 of Workshop**

Workshop Agenda for Part 2: Service Level Agreements and the Contracting Process

Thursday, February 6

8:00am **Bridging from the Bidding Process (Part 1) to the Contracting Process (Part 2)**

8:15 **Session 6: Understanding Purpose and Role of Service Level Agreements (SLA)**

- What a SLA is and what it is not – group brainstorm and synthesis
- Overview of key service and management elements in the SLA
- Walk-Through the SLA Template

9:30 **Session 7: Key Service Elements and Small Group Work to Draft Task Descriptions for 5 Services**

Drawing from hospital experience and current contracts, participants will examine the key service elements to specify in the SLA to ensure a complete contractual document.

- Context-setting → Why
- Task Descriptions → What
- Task Standards, including performance indicators → How

10:15 **Coffee Break**

10:45 **Session 7 cont'd: Small Group Work - Task Descriptions for Out-Source Services**

In order to advance the quality of the contracting process for hospitals and the capability of hospital administrators to manage that process, participants divide into small work groups to draft task descriptions and standards for non-clinical services: (Each small group will focus on one service) The resulting descriptions and standards will serve as 'draft templates', which may be adapted and used for future outsourcing bidding and contract processes to ensure good partnerships with service providers.

- 12:15 Lunch
- 1:15 Session 7 (cont'd): Small Groups present their Task Descriptions**
Small groups present their work in plenary; colleagues provide feedback and suggestions for improving the descriptions.
- 2:30 Session 8: Task Standards and Key Performance Indicators (KPIs)**
Small Group Work to Draft Task Standards and KPIs from the 5 Services
Group reviews key standards (availability, responsiveness, rate/frequency, timeliness, quality) drawing on actual contract or in-house examples from their work. Teams go back into their small groups to draft Key Performance Indicators (KPIs) and service standards for the tasks they identified.
- 3:45 Reflections on Today/Preview of Tomorrow**
- 4:00 End-of-Day**

Friday, February 7

- 8:00 am Key Learning from Thursday and Review of Friday Agenda**
- 8:15 Session 8 (cont'd): Small Groups present their Task Standards and PMIs.**
Small groups present their work in plenary. Participants offer feedback and recommendations for how to improve the standards. Discussion includes a focus on risks and caveats to consider in setting service standards.
- 10:00 Coffee break
- 10:30 Session 9: Management Elements of the SLA and Small Group Exercise on Tracking and monitoring**
Drawing once again from their real experiences, participants examine key elements of oversight and management including
- Service Tracking and Reporting
 - Periodic Review
 - Change Process
- 11:30 Session 9 cont'd: Small Group exercise - Tracking and Reporting**
Participants work in their small groups to outline how they would monitor and report on the service standards for their assigned service area.
- 12:30 Lunch
- 1:30 Session 9 (cont'd): Small Groups share tracking/reporting ideas for the 5 target services**
Small groups present their work in plenary. Participants offer feedback and recommendations for how to improve the tracking and reporting approaches. Discussion focuses on quantitative and qualitative measures for tracking; best practices for tracking and reporting; and the process for making formal changes/improvements in service delivery.
- 3:00 Session 10: Summary and Next Steps**
Participants identify concrete actions they will take to apply the learning, tools, and templates from the workshop to their actual and/or near future bidding and contracting processes.
- 3:45 Workshop Wrap-Up and Evaluation**
- 4:00 End of Day/End of Part 2 of Workshop**

ANNEX F. PARTICIPANT REFERENCE GUIDE



Outsourcing Non-Clinical Hospital Services

Capacity-Building Workshop for
Senior Hospital Managers and
MoH Office of Strategy Management/PPP Unit
February 4-7, 2014
Gaborone, Botswana

PARTICIPANT REFERENCE GUIDE

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OUTSOURCING OF NON-CLINICAL SERVICES

SECTION ONE

PROJECT START-UP

Definition of “Out-Sourcing”: The transfer of a business function to an external service provider.

1. Selection of a Study Team

- 1.1 The decision of whether to outsource non-clinical services and which services to outsource requires careful consideration and study as it can have great impact on hospital operations. The first step towards implementing outsourcing is the appointment of a Study Team.
- 1.2 The Hospital CEO selects a Study Team captain to lead the effort and establishes a project schedule with deadline dates for the completion of a Pre-Bid Study, development of specifications for bid documents, and tender reviews.
- 1.3 Together, the Hospital CEO and team captain select Study Team members. Expertise in managing hospital non-clinical services, procurement, contracting (legal), accounting and nursing administration is needed. If the hospital staff is lacking in knowledge or experience, consideration is given to looking beyond institutional employees to gather the technical assistance required.

2. Goals

2.1 Why Outsource?

- Improved Quality of Service
- Reduce and control operating costs
- Gains in Efficiency
- Incorporation of external expertise into hospital operations

2.2 Questions to Consider:

- What if the hospital has been spending too little on a service and that to deliver a better quality outsourcing will not result in cost reduction?
- What if to properly engage with a private company and carefully monitor contract performance it takes more time to manage an outsourced service?
- How much risk is hospital management willing to take if no private sector companies have directly applicable experience?

3. Which Non-Clinical Services to Outsource? - Preliminary Determination

3.1 The list of non-clinical services that potentially can be managed by a private company is long. The Study Team decides, based on the hospital's strategic goals, current problems with service delivery, and knowledge of the business environment of the community, which non-clinical services are to be selected to study for outsourcing feasibility.

- Housekeeping – (can include Pest Control)
- Laundry Service
- Food Service
- Plant Operation and Maintenance (can include Grounds Maintenance)
- Security
- Transportation

SECTION TWO

THE PRE-BID STUDY

1. **Introduction** - After the Study Team has determined which services to evaluate for out-sourcing, the Pre-Bid Study begins.

2. **Format for the Pre-Bid Study**

- | |
|---|
| <ul style="list-style-type: none">• Executive Summary• Market Capabilities• Cost Data• Risk Identification• Policy Issues• Approach to Outsourcing |
|---|

2.1 **Executive Summary** – Highlights the key findings.

2.2 **Market Capabilities** – For *each* service that the Study Team has identified for possible outsourcing, research is done on potential bidders for the service.

- Who are the vendors in the market that provide the service?
- How many vendors are working in the market? Is there competition or is there a monopoly?
- What experience does each company have? Does the company have management experience working in a hospital, or is the company's experience only in other types of institutions?
- Is the company a local company or a multi-national company? If the company has no hospital experience in Albania, does the company have hospital experience elsewhere that assures knowledge of specific hospital needs, regulations and staff training requirements?
- How do other customers rate the service?
 - Availability
 - Timeliness
 - Effectiveness
 - Continuity of service provision
 - Adherence to health and safety guidelines
 - Efficiency
 - Sensitivity and respect for the client's organization
- What have been the greatest challenges of working with the company?
- Will the company bring to the hospital new technology and methodologies?
- What kind of training does the company provide department employees?
- What is the distance to the company headquarters? Will corporate staff be regularly available for meetings with hospital administration and oversight of the account?

2.2.1 Based on the information gathered on available bidders, the Study Team determines if enough qualified bidders exist to issue a tender for outsourcing a specific service.

2.3 **Cost Data** - For each service to be bid, the Study Team collects data on the current cost of providing that service. The hospital cannot properly evaluate contractor bids against current cost unless the current cost is known. There are many types of cost measures that can be used. Examples of cost measures:

2.3.1 Food Service:

- Cost per patient day
- Food cost per patient day
- Annual staffing cost

2.3.2 Housekeeping

- Cost per square meter
- Annual cost of chemicals and cleaning supplies
- Annual staffing cost
- Annual cost of cleaning contracts (i.e., window washing)

2.3.3 Linen and Laundry

- Cost per patient day
- Laundry cost per kilogram of weighed dirty laundry
- Annual staffing cost
- Annual linen replacement cost

2.3.4 Plant Operations

- Building operation cost per square meter
- Annual emergency repair expense
- Annual staffing cost
- Annual cost of preventive maintenance program
- Annual cost of plant equipment maintenance agreements

2.3.5 Security

- Annual value of reported loss
- Annual staffing cost

2.4 **Risk Identification** – Outsourcing non-clinical services has risks. The Study Team determines what those risks are for the hospital and considers the risks when deciding whether to outsource the service

2.4.1 **Poor Contract Document** - Successful outsourcing happens when good results are achieved for both the hospital and the private business. This requires a fair and balanced contract. It requires clear specifications for service delivery, performance measures and penalties for lack of performance. A major risk for the

- hospital is a poorly written contract. Does the hospital have good legal and technical help on drafting the contract document?
- 2.4.2 Lack of Management Experience - Does the current hospital management team have experience managing service contracts? Has hospital management accurately estimated the level of effort required to properly manage outsourcing contracts?
- 2.4.3 Loss of Control – If a hospital service is outsourced, and the company fails to deliver the quality of service expected and paid for by the hospital, can the hospital cancel the contract without major interruption to hospital operations? Are there options that can be exercised by hospital management when this happens?
- 2.4.4 Labor Unrest – The introduction of a private company to manage a hospital service usually changes the conditions of work for hospital employees in the outsourced department. Staffing levels may be decreased. Work requirements may be changed. Performance measures may be instituted or changed. Is the hospital capable of managing labor unrest during the transition period?
- 2.5 Policy Issues – The decision to outsource services in a public hospital potentially raises a number of issues that require policy decisions.
- 2.5.1 Cost/Quality Tradeoff – The quality of service that can be provided by a vendor reaches across a broad spectrum. Menus can vary from basic offerings to gourmet entrees for those patients on regular diets. Public spaces can be cleaned once per day or once per shift. The Study Team decides where on the cost/quality spectrum the hospital wants to bid.
- 2.5.2 International Companies – If the hospital wants to outsource a service but finds during its review of market capabilities that locally based companies do not exist that can provide an adequate service, is the hospital interested in inviting international companies to tender?
- 2.5.3 Group Purchasing - Hospitals outside Tirana may find it difficult to interest companies to bid on an outsourcing contract if there is not a sufficient volume of business in the region to make it economically worthwhile for the vendor. In that case, the hospital needs to consider joining with other hospitals for a group purchasing tender. This mechanism may entice companies to risk entry into a new market, but group agreement on contract specifications can be difficult.
- 2.6 Approaches to Out-Sourcing – There are different tactical approaches to outsourcing non-clinical services.

2.6.1 “Umbrella” Approach: In some markets there are companies that can come into a hospital and manage more than one type of service. For example, one company might be hired to manage the food service, laundry and housekeeping departments under a single contract. This is called an *“Umbrella” Approach*. The benefits and disadvantages to this approach need to be carefully weighed.

- Advantages:
 - Simplified contract process – only one contract to negotiate
 - One point of contact for hospital management
 - Tend to be larger companies with more experience
- Disadvantages:
 - Services tend to be sub-contracted out by the company
 - The company often has unequal experience and expertise in the services being provided
 - Difficulty in achieving true transparency in accounting and understanding costs for each service department
 - If the contractor under-performs and the hospital decides to cancel the contract, all service department operations covered by the contract are disrupted simultaneously. Hospital management has the great challenge of re-contracting and transitioning management for multiple departments at the same time.

2.6.2 Single Service Approach – This is the more traditional approach where one company with specific expertise is hired to manage one hospital service department.

2.6.3 Hospital vs. Company Employees: Hospital management considers whether it is preferred to keep staff workers in an outsourced department as hospital employees, or have staff work as employees of the contract company.

- When workers remain employees of the hospital, there is often less labor unrest during the management transition and better morale in the hospital.
- Retaining staff as hospital employees can signal the value management places on the hospital staff working together as a team.
- The hospital must evaluate existing labor contracts and severance pay policies to calculate the cost of terminating hospital employees.
- The hospital determines if the company is able to employ workers at lower compensation levels than established government salaries. The hospital potentially may benefit from lower staffing costs.

2.6.4. Letter of Interest – If companies with hospital experience do not exist in the locale, a different approach is for the hospital to look for companies in the region that have the potential to provide non-clinical services to the hospital *provided they can learn and meet hospital requirements*.

- The Study Team identifies companies with good management and meets with the company to discuss the company’s interest and capability to enter the hospital market.

- A “Letter of Interest” is sent to the companies outlining the hospital’s interest in finding businesses capable of expanding and meeting hospital service requirements.
- The hospital shares with the companies international hospital accreditation standards for the non-clinical service.
- Interested companies respond to the Letter of Interest with a pre-bid statement explaining how the company would develop its internal capability and expertise in order to be a qualified bidder for the tender.

3. **Capital Equipment** – Often during the out-sourcing tendering process the need for new equipment or infrastructure improvements to support the service delivery requirements are identified. The Study Team needs to determine how the funding of this can be accomplished. Options may include:

- Equipment is acquired from the Ministry (i.e., new laundry equipment)
- The bid document states that the company is to provide the equipment needed to perform the service levels specified. Different approaches to how the company recovers the cost of procuring the equipment include:
 - The company retains ownership of the equipment and charges the hospital a monthly equipment user fee. If the contract is cancelled or not renewed, the equipment is removed by the company unless the hospital is able to negotiate a purchase of the used equipment.
 - The cost of the equipment plus financing charges is charged back to the hospital over the length of the contract. At the end of the contract, the hospital owns the equipment.

SECTION THREE

TENDERING – OFFER TO BID DOCUMENT

1. General Conditions

- 1.1 Description of the Facility – Facility management companies, depending on which service is to be provided, will need to have basic information about hospital operations that affect that department’s operations. For example, Food Service vendors need patient census data to estimate and bid on food cost.
- 1.2 Description of the hospital’s approach to out-sourcing – (Discussed in Pre-Bid Study, Sec. 2.6 above)
- 1.3 Definition of Contract Duration – The start-up costs for a company opening a new account can be substantial. There are bidding costs, extra staffing costs for the mobilization period, additional administrative capacity to be added to support the new client, and potential capital equipment costs that will be amortized over the life of the contract. A minimum of three years for an initial start-up may be required by a private company. This, and contract renewal terms, need to be negotiated.
- 1.4 Required Permits and Licenses including Certificate of Insurance.
- 1.5 Statement of Compliance with all applicable local, regional and national laws and regulations
- 1.6 Statement of Commitment to Confidentiality by both Hospital and Bidder
- 1.7 Statement of Commitment to adhere to all government regulations for Health, Safety and the Environment by both Hospital and Bidder

2. Service Requirements

- 2.1 For each service, the bidder provides a very specific definition and frequency of activities to be carried out under the contract agreement.

Examples of service definitions required from bidders:

- Housekeeping:
 - The bidder specifies for each room, internal and external public area, elevator, stairways, etc. in the hospital how often the space will be routinely cleaned.
 - The frequency of all “special projects cleaning”, such as window washing, is also specified.

- The housekeeper training program is detailed: a) Initial training curriculum, with time specified; and b) frequency, scope and time of worker re-training
- The frequency and method for removal of all trash and hazardous waste is specified.
- **Food Service**
 - The bidder provides proposed menus and specifies the frequency of menu rotation.
 - Staff and Visitor Catering service requirements are defined – menu options, time and place of service, prices, etc.
- **Laundry –**
 - The bidder specifies procedures for segregation and collection of used linen and frequency of service.
 - The level of effort for linen repair is defined
 - Staff uniform service requirements are detailed

2.2. **Mobilization** - Contract start-up requires additional management resources from the company. The number of additional personnel, their expertise, and the amount of time to be committed to the contract start-up is defined.

2.2.1 The company provides hospital management with a mobilization schedule and activity plan.

3. Price and Payment

For each service, the bidder presents a detailed cost proposal

- Proposed staffing pattern, coverage and costs
- Equipment and Supply budget
- Training Expense
- Management Fee to company

3.1 A monthly invoicing schedule is documented

4. Contract Service Management

4.1 The outsourcing contract details the management duties that the contractor's representative must perform. These include:

- Supervision of staff and administration of the services to be performed
- Planning and cost control
- Management of sub-contractors
- Interface with hospital management team
- Monitoring performance against contractually agreed upon performance measures

5. Procurement of Supplies and Equipment

5.1 The Contractor is responsible for the procurement process associated with the delivery of the service. The Contractor assures that all enquiry and purchase requisitions are processed correctly and on schedule.

5.1.1 Purchasing is carried out using the Contractor's systems with adequate visibility of costs and quality, also with the potential to interface with the Employer's systems.

5.1.2 The Contractor is responsible for inventory tracking, receipt and issue of supplies used for the delivery of service.

6. Incident Reporting and Emergency Response

6.1 The Contractor agrees to fully participate in the hospital's Incident Reporting and Tracking system that monitors all patient, staff and visitor events that are considered abnormal.

6.2 The Contractor agrees to fully participate in the hospital emergency response protocols and disaster preparedness training.

6.3 The Outsourcing contract defines the expected company response for an interruption of service delivery including penalties and company contingency plans.

7. Quality Assurance

7.1 As part of the Contractor bid proposal, the company will present a quality monitoring plan that includes the definition of Key Performance Indicators that are both qualitative and quantitative. The negotiated Performance Monitoring Plan is part of the final contract document.

7.2 The Contractor agrees to both scheduled and unannounced quality monitoring inspections by hospital administration.

7.3 The Contractor agrees to full participation in the hospital Quality Assurance program including adherence to all Infection Control requirements.

8. Orientation and Training

8.1 The Contractor provides a detailed staff orientation, training, and A defined schedule continuous re-training program for all workers.

8.2 Specific skill competencies are evaluated and tested for each position

8.3 In coordination with the hospital safety and infection control officers, the Contractor provides affected workers training for the safe handling of chemicals and medical waste, and safe equipment operation and maintenance.

9. Client Rights

9.1 As defined in the outsourcing contract, the client has the ability to invoke penalties for non-performance up to and including the termination of the contract.

SECTION FOUR

EXAMPLE - OFFER TO BID with BID EVALUATION CHECKLIST

Further to your expression of interest, your company has been selected to submit an offer for facilities management services to _____ Hospital, in accordance with the Conditions of Contract for Provision of Services and is subject to the terms of offer contained within this documentation.

The Hospital is inviting bids for facilities management for the following services:

- Laundry Service
- Food Service
- Plant Operations and Maintenance
- Housekeeping

The Hospital wishes to put in place service agreements for the provision of these services that maximizes value and quality. The length of the contract will be three years.

If you are one company bidding to manage under one management contract multiple services (*an "Umbrella" Approach*), you must list which services your bid covers. However, consistent with the Hospital's intention to put in place a robust performance management framework, each service package is to be clearly identified as a separate service and pricing of that service done separately. The expected savings from a consolidated management structure should be demonstrated. If a bidder only wishes to bid on one non-clinical service, clearly state the service for which a tender is offered.

Definitions:

Contractor: The company the Hospital contracts with to manage the out-sourced service(s).

Sub-Contractor: A company hired by the Contractor, working under the direction of the Contractor, to provide a service the Contractor is contractually obligated to provide to the Hospital.

It is our intention to ensure that this development attracts the best in local resources and supports the development of local enterprise. Bids incorporating contributions from local companies and those that sub-contract particular services to local enterprises will be viewed and evaluated favorably.

The rest of this document is structured as follows:

1. **Project Introduction** -- A general description of the hospital
2. **Requirements** – Outlines the general requirements and expectations for delivery of the services to the hospital.

3. **Instructions for Bidders** -- Provides the bidder guidance on the form of its written bid submission and financial submission
4. **Performance Management** -- Written description of proposed performance management expectations. Outline the approach to rectifying service failings and explains the proposed system for penalties for poor performance.

Reference Documents

1. Project Documents – (Provided by hospital) Additional information about the design of the facility, clinical activity and other documentation that may be relevant for the bidder to determine service level requirements.
2. Compliance Documents – (Provided by bidder) A list of standards to which services are to be provided.
3. Financial Response Documents – (Provided by bidder) Detailed operations budget, capital equipment budget and staffing plan.

1. Project Introduction

Description of the hospital including geographic location, total size of the hospital (number of beds, number of operation rooms, number and size of ambulatory care clinics, etc.).

Operational Data

- Inpatient Admissions – Total
- Inpatient Days – Total
- Inpatient Days by Unit
- Inpatient Number of Surgical Cases
- Outpatient Visits Total
- Outpatient Number of Surgical Cases
- Outpatient Dialysis Visits
- Outpatient Chemotherapy Visits
- Accident and Emergency Visits
- Average Length of Stay – Inpatients

2. Requirements

The Contractor's scope of work for the Hospital shall include the following main activities:

- Food Service
- Laundry Service
- Housekeeping
- Plant Operations and Maintenance

(Umbrella Approach) Each category will be managed as an individual service but where appropriate sharing facilities and coordinated under a single management structure in coordination with the hospital's site representative. Bidders are expected to demonstrate in their submissions efficiencies and savings arising from the use of shared facilities and resources.

It is anticipated that the contractor will put in place his own network of specialist contracts to support specific equipment and services for which the contractor is responsible.

- Example: Pest Control, Window Washing, Elevator Maintenance

Food Service - The contractor's scope of work for the Food Service shall include, but not be limited to the following main activities:

- Catering facilities management & operations
- Selection and training of department personnel
- Food supply & storage
- Food transportation and handling
- Food production and presentation
- Provision of all consumables associated with catering services

Laundry Service – The contractor's scope of work for Laundry Service shall include, but not be limited to the following main activities:

- Overall laundering of patient linen, surgical gowns and staff uniforms
- Provision of all consumables associated with laundry services
- Selection and training of departmental personnel.

Housekeeping – The contractor's scope of work for Housekeeping shall include, but not be limited to the following main activities:

- Overall cleaning of all areas of the hospital and related buildings according to the agreed cleaning regimes of defined departments
- Provision of all consumables associated with the cleaning services
- Selection and training of departmental personnel

Plant Operations and Maintenance – The contractor's scope of work for Plant Operations and Maintenance shall include but not be limited to the following main activities:

- Provision of Technically Competent Operations and maintenance personnel
- Achieve the maximum efficiency/reliability of the facilities consistent with economic operation, Equipment Monitoring, First line Maintenance
- Ownership and ongoing development of maintenance / inspection strategies and plans
- Execution of planned maintenance / inspection routines and ad-hoc or breakdown maintenance
- Provision of maintenance spares and materials

- Provision and operation of computerized systems for the management of inspection and maintenance activities including certification management
- Spares and materials management strategy, operations and provision of associated personnel and provision and operation of a computerized spare part and materials stock and storage management system.

Facilities provided by the Contractor

The Contractor shall provide facilities and services including but not limited to:

- The Contractor's IT systems
- All materials, supplies and consumables needed to provide the service

Facilities provided by the Hospital for the Contractor's use

The Hospital shall provide the following facilities and services for the contractor's use at commencement of services or if required during mobilization:

- Offices and office furniture (to be agreed with the Hospital)
- Telephone system. Note: The contractor shall be billed for telephone use, at cost.
- Catering facilities and equipment
- Laundry facilities and equipment
- Workshops and stores
- Parking
- Access to engineering document information
- Overall management system structure and policies
- Major spares items
- Links for controlled access of Hospital's IT system

Management

The Contractor shall provide all management, supervision, technical, administration, services and facilities deemed necessary to provide the services required for the Hospital. The Contractor shall be responsible for the management and execution of the services including but not limited to, all aspects of planning, control, reporting, supervision, administration, quality management, HSE management, permits and licenses. The Contractor's organization shall be responsible for establishing and maintaining all necessary systems, controls and procedures.

The Contractor's management function shall be to ensure that the Contractor, all sub-contractors and others contributing to and undertaking the services within the Contractor's scope shall comply in full with its responsibilities. This includes taking and/or implementing corrective action where necessary and as instructed by the Employer, to ensure that the services are performed in a safe, effective manner. The Contractor's Management activities shall include but not be limited to the following functions:

- Management, supervision and administration of the services

- Development, co-ordination, organization and management of all interfaces with the Hospital and others as required
- Logistics - operate and maintain an efficient supply chain to provide and maintain adequate stocks.
- Assuring the coordination of the Contractor's IT systems with the Hospital's IT systems to manage the services
- Realistic based performance forecasting
- Planning and cost control and scheduling of the services
- Health Safety and Environmental management
- Quality management, control and assurance
- HR management, training and competency
- Management of all sub-contractors

Interfaces with the Employer

The Contractor's Site Manager shall report to the Hospital's Representative (or his delegate) who will have a full time presence on site. The Hospital's Representative shall be the focal point for all the works and of the services delivered by the Contractor.

Permits & Licenses

It is the responsibility of the Contractor to obtain all relevant licenses, permits, approvals from the Authorities required for operation and maintenance of the facilities in the country within the Contractor's scope of work. These are to be reviewed and licenses, permits and approvals are to be obtained as part of the mobilization process. The Contractor shall then, continue to review them and update them as necessary throughout the period of the contract

Upon the Hospital's request the Contractor shall provide licensing and permit support information to the Contractor in a timely manner.

The contractor shall provide the Hospital with names of permitting personnel, their contact details and a clear plan of how to progress through regulatory needs. The Contractor shall follow-up on any changes in the country's Laws and Regulations associated with the scope of work. The Contractor shall provide the Hospital with copies of all relevant licenses, permits, and approvals obtained by the Contractor from the Authorities. The Contractor shall pay all fees and dues for licenses and permits within the Contractor's responsibility.

It is the Contractor's responsibility to comply with all legal requirements concerning certification of Contractor's equipment and materials. The Contractor shall be responsible for obtaining the relevant certificates on time for the performance of its duties under any one of the service contracts. The Contractor shall deliver to the Hospital all relevant certificates in original. The Contractor shall keep all documentation related to the obtained certificates and shall make the documentation available to the Company on request.

Health Safety & Environment (HSE)

The works shall be executed in accordance with the HSE practices of the Hospital, which take all reasonable precautions to protect personnel, installation, facilities, and environment.

The contractor is responsible for local management and implementation on behalf of the client. The Contractor's Site Manager is the nominated HSE officer responsible for all personnel regardless for whom they work. The Site Manager shall:

- Ensure that the Hospital's HSE plan is implemented and reported
- Ensure that all accidents and incidents are adequately investigated and reported according to local regulations and the Hospital's policy
- Fulfill the role of Emergency Response Site Coordinator
- Ensure all audits and inspections are carried out and reported
- Be responsible for the health, safety and welfare of the all personnel within the hospital.

The Contractor shall work with the Hospital to develop site-specific HSE plans in accordance with the Hospital's policies and philosophies. Risk to the health of personnel involved in operation and maintenance work shall be assessed by the Contractor and appropriate measures effected to minimize any risk.

Safety is a function of safe plant and equipment, safe systems of work, competent personnel, sound organization, communication and emergency planning. The Contractor shall ensure that safety goals or outline performance standards are identified to ensure safe working. Performance standards shall relate to the purpose of the system, item of equipment, procedure etc. The Contractor shall take all measures necessary to ensure the safety and security of all personnel, plant, equipment and materials during the execution of operation and maintenance work.

Prior to the commencement of work, the Contractor shall provide to the Hospital, for approval copies of their HSE policy statements, health and safety manual, site specific HSE plan, operating procedures, and site specific emergency response plan that shall be enforced at all times until final demobilization from the facilities.

The Contractor shall appoint designated HSE personnel, who shall be responsible for day-to-day supervision of the work, and for co-ordination with the Hospital's HSE Representatives on all matters relating to safety and security aspects of the work.

HSE induction training is mandatory for the Contractor's personnel. The Contractor shall supply his own personnel, sub-contractors and vendor personnel with suitable and adequate protective clothing, (PPE) and any other such protective clothing and/or equipment as may be required.

The Contractor shall ensure that all test equipment, shall be inspected and tested, by a competent person for accuracy. Such tests shall be supported with test verification documentation.

The Contractor shall provide adequate first aid equipment, other such safety equipment, of an approved type and in sufficient quantities, as may be specified, (or expected in accordance with good working practices), and shall maintain this equipment in accordance with regulatory and industry standards. In addition, the Contractor shall keep up-to-date records of all such equipment.

The Contractor shall provide first aid to ensure the continued health, safety and welfare of his employees. The Contractor's personnel shall have access to the Hospital's medical facilities.

Environmental Commitment

The Hospital is committed to achieving excellence in environmental performance. To this end, International Standards for Organizations (ISO) 14001-Environmental Management Systems has been adopted as the Hospital quality standard.

The Hospital acknowledges its responsibility, and that of all those who work with and for the Employer, to ensure that all activities are conducted with a full and proper regard for the environment.

The Hospital is committed to being open about its environmental performance and to working with the Contractor, suppliers, partners and other third parties to encourage a responsible and effective approach to Health and Safety issues.

Expectations

The Hospital requires its contractors and their sub-contractors to be committed to the safety of individuals, and to protecting the environment. It further requires them to follow any procedures the Hospital or relevant legislation has put in place to ensure or assure this safety and protection. The Hospital requires its Contractors and their sub-contractors to take an active part in developing and promoting safe and environmentally sound work practices

People Development and Transfer of Know-How

It is the Hospital's expectation that the Contractor includes a program and approach for the transfer of know-how, skills and technology to a site based facilities management team. The Contractor is to indicate the key knowledge / technology elements to be addressed and any specific initiatives / activities planned.

The Contractor is to develop a strategy to employ and train local citizens to take over key positions at all levels during the course of the contract. All skills labor transfer policies and requirements implemented by the Ministry of Labor and Home Affairs (Labor Department) are to be adhered to.

Planning and Cost Control

The Contractor shall ensure that there is a planning and cost control system in place to manage the activities associated with the service.

Planning – Such activities shall include but not be limited to preparing overall schedules and updates as required:

- Yearly Plan extended on three and five years
- Monthly Plan extended on 1 year – updated quarterly
- Weekly Activity Schedules

The Contractor shall develop detailed schedules, work plans, manpower plans and include details of all required resources, labor and spare parts.

Cost Control – Such activities include the production of an operations cost report for the services. This shall include but not be limited to:

- Monthly updates covering all cost elements – manpower, materials, subcontracts, management fees etc
- Variances against budget

The Hospital will set an agreed budget with the Contractor, which shall be used as the basis for reporting against.

Corporate Support

The Contractor's Site Manager will be supported from the Contractor's corporate head office, and shall be responsible for coordinating any corporate resources and all communications with head office. Any document related to the execution of the Contract will be managed by Contractor's Site Manager.

It is envisaged that the Contractor will receive at least the following aspects of corporate support from the Contractor's corporate office:

- Overall management and technical support
- Finance and Payroll
- Commercial
- Sub contract management
- Human Resources & training
- Contract focal point

The Contractor shall ensure a comprehensive technical support service is available for its personnel and sub-contractors for all aspects of the services provided under the contract

Innovation and Improvements

The Contractor shall be proactive throughout the contract with new ways of working to maximum the uptime of the equipment and meeting the Hospital's business objectives, for example:

- Application of new technologies

- Benchmarking internally and externally highlighted best practices
- Trending failures that directly affect service delivery
- Monitor routine / non-routine ratios to highlight areas of high non-routine maintenance
- Developing methods of reducing costs whilst improving turnaround times or repairs without compromising safety

Staff and Organization

The Contractor shall provide all resources necessary for the safe and efficient management, administration, planning, and execution of the services on a 7 days per week basis. The Contractor shall provide an organization to manage and control the services from award of contract.

Key Personnel

The Contractor shall appoint key personnel for the management services.

The Contractor shall define the organization structure including key positions and support requirements, both specialist and corporate, as part of this tender process. All personnel nominated by the Contractor shall have the relevant qualifications, experience, general training and key competencies for their respective positions

The Contractor shall appoint a dedicated Site Manager who shall have the responsibility and authority for the overall management, administration, monitoring, reviewing and coordinating all aspects of the services for the hospital.

Hospital Personnel

The Hospital's liaison person will be the Chief Operations Officer or designate.

Roles and Responsibilities

The Contractor shall develop and maintain clear roles and responsibilities statements for all personnel associated with the services. The Contractor shall carry out a skills review of all personnel. These are to be assessed against skills requirements for all roles. From these studies the Contractor shall carry out a skills gap analysis and details how these gaps are to be closed.

Staff Movement

Should the Contractor wish to replace any of the key personnel during this contract the Contractor shall advise the Hospital giving thirty (30) days notice and shall obtain written approval to replace this employee with one with the same or better qualification and experience to ensure that the contracted level of service is delivered satisfactorily.

Specialist Sub Contractors

The Hospital recognizes that the Contractor will require the services of specialist sub-contractor from time to time to provide 'non-core' services. The Contractor will be fully responsible for the results of any sub-contractor's work.

The Contractor shall provide a list of their intended specialist sub-contractor's the cost and the services they are likely to cover, for advance approval by the Hospital.

Personal Protective Equipment (PPE)

The Contractor shall provide suitable PPE for all aspects of the service where the Contractor personnel and sub-contractors are exposed to risks and hazards.

Training and Competencies

The Hospital requires the adoption of a competency based approach to staff training and development, encompassing all areas of performance management from recruitment, through development to promotion, succession and career management has a number of advantages. As the concept is results oriented, attention remains focused on primary business needs. This approach will enable the Contractor to recruit, evaluate and manage staff more effectively and ensure that the right person is placed in the right place at the right time.

Experience in related industries has demonstrated that a highly skilled workforce is vital to a company's competitiveness and business success and will make a positive contribution to safety and overall performance. In order to meet its training objectives the Contractor will implement a Competence Assurance based training program to ensure that individual employees have the correct attitude and possess the necessary experience, skills and knowledge together with the ability to apply them to their job. The Contractor will provide the conditions necessary to ensure success including the active commitment and support of Senior Management, the organization necessary to enable learning to take place and the availability of suitable expertise. The Contractor shall:

- Create a training and competency program that compliments the Hospital's philosophy
- Select and recruit local personnel in compliance with local Labor Laws. A general understanding of English and the relevant industry shall be required.
- Provide safety and environmental training prior to employment according to the Contractor's training program procedure for personnel. This shall be maintained, regularly reviewed including personnel training record audits.
- Ensure all personnel are familiar with hygiene and local environmental legislation.
- Provide experienced key personnel to manage the operation to the Hospital's satisfaction.
- Ensure all personnel have undergone regular medical and eye examinations.

Safety Training

In addition to the above, the Contractor shall provide full training in the hospital on equipment operation and maintenance and minor repair procedures. Training shall be for the core crew and any other personnel as required. Should core crew personnel change and additional training be required, then the Contractor shall ensure that all training is carried out as per the agreed training matrix produced by the Contractor as part of the mobilization plan.

The training shall include but not be limited to the following areas of safety:

- Site inductions
- Emergency response
- First aid
- Minor fire fighting
- Manual handling
- Permit to work
- Risk assessment
- Health and hygiene

Training for Equipment Operation

Training shall include but not be limited to the following areas:

- Kitchen equipment
- Laundry equipment
- Proper use of chemical and cleaning agents
- Plant operations equipment and first line maintenance
- Specialist equipment troubleshooting / maintenance
- Plant control including shutdown/safety systems
- Security equipment

Training for Equipment Maintenance

Training shall include but not be limited to the following areas:

- Basic routine maintenance, e.g. levels, lubrication oil, checks etc.
- Use of special tools and work practices/methods
- Fault finding and rectification
- All routine maintenance
- Methods to facilitate the early detection of major failures
- Condition monitoring
- Specialist vendor training

The Contractor shall provide certification evidence of all training to the Hospital's satisfaction. Further training for new the Contractor personnel may be required through the life of the contract and shall be the Contractor's responsibility.

Employee and Industrial Relations

The Contractor shall be responsible for developing an Employee Relations Management Plan (ERMP) and procedures, which shall address issues including, but not limited to:

- Human resource management and industrial relations
- Employment conditions
- Avoidance and resolution of disputes
- Employment, redundancy and/or special arrangements
- Local labor issues

Working Environment and Access Authorization

The Hospital's Permit to Work system shall be operational in the hospital. The Contractor shall utilize this system for all activities as defined as requiring a permit. Specific local

rules may need to be developed for activities where the Permit to Work system is considered unnecessarily restrictive. Written permits will be required for:

- All hot work in a designated hot work area
- All cold work classed as non-routine activity
- Electrical work and isolations
- Confined space entry
- Excavations
- Gaseous hazardous activities
- Any areas where the work can impact on the Hospital's business operations

Quality Assurance and Quality Awareness

The Contractor shall implement a Quality Management System that complies with ISO 9001- 2000. The Contractor shall ensure that any sub-contractors apply a consistent Quality Management System appropriate to their scope of work.

The assurance of quality and safety shall be a fundamental philosophy of all activities carried out by the Contractor in delivering the services. It shall therefore be an objective of the Contractor, to insist on real evidence of quality rather than rely on assumptions or beliefs that such quality exists. To achieve this objective the Contractor shall have in place a system to establish what their quality performance standards are.

To achieve this objective the Contractor shall:

- Review and assess all the contractual requirements
- Develop and implement an overall Quality System to cover all activities, which shall be clearly identified within the Quality Plan
- Develop and implement a schedule of Quality Reviews and Audits Implement a Continuous Improvement Program.

The contractor shall provide at an early stage 'Quality Awareness' induction program for all Senior/Supervisory personnel assigned to the project for more than 2 months duration. The intent of the course shall be aimed at familiarizing personnel with contract requirements and promoting quality awareness

Emergency Response

The Client shall define the Emergency Response requirements in conjunction with the Contractor. Fire-fighting and security support will be provided by the Contractor. The Contractor will be required to provide the following:

- Emergency Response Site Coordination
- Emergency Response Administration
- Fire Wardens
- Operations and Maintenance Emergency Response support

These arrangements will be defined during mobilization.

Incident Reporting and Management

The Contractor will comply with and follow the Incident Reporting system established by the Hospital.

The Contractor shall provide details of the company's existing incident management system and how it will be incorporated into the Hospital Incident Reporting program. The Contractor shall also be prepared to show its Incident Reporting data to the Hospital.

Operational Risk Management

As part of the mobilization process, the Contractor shall carry out a full operational risk review of all the facilities and operations at the hospital. This shall include all the risks to successful operations critical to supporting the hospital. The Contractor shall clearly show how the risks will be mitigated and how residual risks will be managed.

All contractors will comply with and follow the procedures of the hospital risk management program.

Business Continuity

The Contractor shall demonstrate to the Hospital the measures in place that enable the Contractor to support the Hospital's operations. These measures shall include Business Continuity Plans (BCP) that will enable the Contractor to continue to support the Hospital in the event of disruption to the Contractor's business operations (fire, flood, supply chain disruption, sickness of personnel etc)

Help Desk

The Contractor shall supply and operate, on behalf of the Hospital Help Desk. The Help Desk shall provide a 24/7 service for recording all help requests. The system supporting the Help Desk shall allow all those who have logged a request to track its progress and delivery

The Help Desk personnel shall record the initiation of the help request, their contact details, when the request was made, details of the request and, where the request has been allocated, progress on its completion / delivery and close out details. All entries made are to be time stamped.

Computerized Management Information Systems

The Hospital anticipates the use of a range of computer-based applications to support the services that will be provided by the Contractor. These applications are provided by the Contractor.

The Contractor shall ensure the correct, regular, and continuous use of all computer systems that support his activities under the contract.

The Contractor shall submit for the Hospital's approval, the system(s) he proposes to adopt for managing all the aspects of maintenance and materials management associated with the service scope of work in accordance with the Hospital's approved processes and procedures

The Hospital reserves the right to audit the correct usage of all computer applications used by the Contractor in support of his responsibilities under this contract and to have access to all reports and data created by these applications.

The Contractor shall be responsible for all license fees, IT costs, system set up and configuration (including any interfaces), data transfer / load, testing, training, documentation, and ongoing support for all his systems.

Maintenance Management

The Contractor shall supply and operate a web enabled computerized system to support the management of inspection and maintenance activities carried out as part of his responsibilities for the services. All data held on this system (and all other management systems pertaining to the works should be the property of the Hospital.

The Contractor's system is expected to be capable of providing the following:

- Asset Register holding details of all tagged equipment together with technical data, asset information, spare parts etc.
- A Register of all routine maintenance tasks together with a full work description and instructions, scheduling information, and the materials to be used. The system may automatically create work orders as these tasks fall due.
- Provide a maintenance history on plant by capturing and storing data on all completed jobs, recording equipment faults, and enabling the analysis of the labor and materials cost of maintenance.
- Calculate or otherwise present information relevant to the standards of maintenance performance on the facilities included in the Contractor's responsibilities. Produce reports that are accepted by the Employer as key performance indicators of effective and efficient maintenance.
- Allow an auditable inspection by an independent verification body (IVB) of all maintenance carried out on safety systems, in order to demonstrate compliance with the relevant safety performance standards.

Inspection Management

The Contractor shall provide applications that allow the recording and analysis of inspection and corrosion data. Such applications will also enable the production of trend reports, and track actions rose from inspection reports.

Purchasing, Procurement and Inventory Management

The Contractor is assigned with the overall responsibility for the Procurement Process associated with delivery of the service.

The Contractor shall be responsible for ensuring that all enquiry and purchase requisitions are processed correctly and on schedule. Purchasing will be carried out using the Contractor's systems with adequate visibility of costs and quality, also with the potential to interface with the Hospital's systems.

A system for the procurement of all materials, consumables, spare parts, tools, and provisions related to the contractor's responsibilities will be provided. This will include the ability to create and authorize purchase orders and to reconcile these purchase invoices with invoices from suppliers and sub-contractors.

The term purchasing in this case is defined as covering the following activities:

- Preparing recommendations of suitable bidders (Requisition)
- Preparing enquiries (Invitation to Bid)
- Dealing with commercial and technical clarifications during the bidding period
- Expediting, receiving and distributing bids.
- Finalizing commercial bid evaluations, as applicable.
- Negotiations with bidders.
- Preparing purchase orders.
- Expediting return of purchase order acceptances
- Negotiation of purchase order variations and claims.
- Preparing purchase order amendments.
- Assisting in the clearance of invoices for payments, as applicable.
- Reporting status of procurement activity.
- Closing out of files on completion and reporting of sub-contractor performance, if required.

The Contractor shall provide a computer system for the management of spare parts and material inventories related to the maintenance of the plant and equipment. The system shall be capable of on-line updating of all materials movements to allow immediate access to accurate stock information (on-line error checking) and available warehouse space (stock map), with an audit trail of all inventory and related logistics activities providing detailed accountability and traceability.

Planning and Scheduling

Computer applications shall be used for planning and scheduling of the Contractor's activities related to the provision of the services. The extent of the use of these applications, which will include inspection and maintenance tasks, will be agreed with the Employer.

The applications will identify the planned durations of activities, the allocated resources and any special tools and materials required. Actual progress of tasks will also be recorded by the applications and will be used as the basis of relevant management reports to the Hospital.

Data Export

The Hospital expects to monitor various parameters relating to the status of the facilities using its own computer systems. These parameters include inventories of spare parts and key materials, and associated procurement activities.

The Contractor shall prepare electronic files that define the values of these parameters and submit them to the Hospital's system(s) via the defined processes and procedures. The precise information to be supplied by the Contractor and the frequency of submission to the Hospital will be agreed.

Hardware

The Contractor shall provide any servers and other hardware required specifically to support his computer systems as outlined above. The Hospital expects that the Contractor's hardware will be connected to the Hospital's network

Software

The Contractor will supply the following computer systems which will be used by the Contractor in support of his responsibilities for service delivery as outlined elsewhere in this document:

- A Document Management system for the storage and controlled access to technical, administrative and regulatory documents associated with the services carried out by the Contractor. Details of this system will be provided to the Contractor.
- Condition monitoring systems that are procured as part of individual items of plant and equipment.
- Desktop applications including word processor, spreadsheet, browser, and other office applications.

Hospital Supplied Systems

The Hospital will supply the IT systems infrastructure within the Hospital's facilities, including network cabling and communications hardware. Details of these systems will be provided to the Contractor.

The Hospital will provide email services and limited internal access to the contractor from its desktops.

The Contractor will provide desktop and associated hardware (PC's, printers etc.) that will be used by the Contractor.

Hospital's Rights of Inspection and Audit

In order to confirm that the requirements of the Contract are met, the Hospital shall have the right, but not the obligation, at all times to inspect, make audits, test and examine all materials, supplies, machinery and equipment provided and all work or services, or documentation relating thereto, performed by the Contractor or any sub contractor. The Hospital shall have the right to require the Contractor to uncover or open up any part of the facilities and to reinstate such uncovered or open part following inspection or testing by the Contractor. The Hospital has the sole option to use a Third Party to carry out any inspection.

3. Bidder Instructions

This section explains the stages of the bidding process from the date this document is issued.

Bidders are advised that the client may at their discretion vary the selection procedures to ensure that it achieves the best value outcome for this procurement.

The table below outlines the various stages of this process, showing the key dates and activities to be undertaken during this time. This is the intended timetable for this procurement, however the client reserves the right to change the dates as required to meet the demands of the project. We will endeavor to ensure that any such changes are communicated to the bidders as soon as possible.

Stage	Description	Date
Confirmation of receipt	The bidder is to confirm that they have received this document and provide contact details for the ongoing process	
Clarification period	The period during which the bidder may ask for additional information or clarification to support their submission	
Response date	The date when the submission is due from the bidder	
Bid evaluation period	The period during which submissions will be evaluated and scored. This period may also be used to clarify areas of the bid that are unclear.	

Selection process	The client will select one or more providers to continue discussions with	
Negotiation phase	Discussions with the preferred bidder to finalize details of the contract	
Contract finalization	Confirmation of the contractual and commercial agreement that has been reached to the provision of the services	
Contract signature	Execution of the contract by all parties	
Service commencement	The date or dates upon which the provision of these services will commence	

Receipt Confirmation and Notification of Bid Manager

Within three (3) working days of the date of issue of this offer to bid, each Bidder must confirm receipt and provide contact details for the Bid Manager to whom all future correspondence regarding this procurement should be addressed.

The Bid Manager must have the full authority to represent the Bidder and negotiate on its behalf.

Confirmation of receipt of the offer to bid must be sent to: (postal address or email)

Changes to the Bid Process

The Client may:

- Amend the Timetable for any stage of the Selection Process;
- Vary any aspect of the Selection Process and/or introduce additional steps or stages into the Selection Process.
- The Hospital will notify each Bidder's Bid Manager of any changes made to the Selection Process and Outline Timetable.
- Under no circumstances will the Hospital be liable for any costs or expenses incurred by Bidders, as a result, directly or indirectly, of any such changes to the selection process or the outlined timetable

The Hospital may decide not to award any contract or contracts pursuant to this Offer to Bid where no satisfactory bids are received

It is the bidder's responsibility to notify the client of any change in contact details, the validity period of the bid, or if the bid manager changes.

Any information additional to that contained in this document will be sent to the contact details provided by the bidder

Where the bidder intends to use sub-contractors to provide services it is the bidder's responsibility to ensure the appropriate information is passed to that sub-contractor

All requests for clarification of this offer to bid must be sent to the Hospital in writing. Confirmation of receipt will be provided by the Hospital.

Where Bidders consider that the response to a question is commercially confidential, written communication labeled "Commercial in Confidence" will be sent, and Bidders are to specify, where possible, such changes as would render the request and any response non-confidential.

During the evaluation process the Hospital may wish to raise clarification questions with the bidder. The response is to be sent by mail or e-mail.

Bidders should be prepared to attend meetings to discuss their tender. The Hospital will attempt to provide appropriate notice of any such meeting and will endeavor to use teleconferencing where appropriate to minimize travel and cost. Bidders should confirm their ability to attend at least 24 hours prior to the arranged time of the meeting.

Submission Instructions

Each bidder's submission should clearly state the services for which a tender is being offered.

All bids submitted must be compliant with the requirements as stated in this document.

All bids must include fully priced proposals and complete budgets

Bidders may propose additional options within their bids, to the extent that these options can be described in the response to questions within the response pro forma and do not affect the responses to the requirements in other sections

Variant bids are acceptable, however they must still satisfy the requirements, provide complete financial pro forma statements and provide a summary of the advantages such a variant bid will provide over the expected form of submission.

Two hard copies of bids must be sent to:

The Hospital

(Address)

By email to:

Bids must be delivered no later than 12:00 on the response date.

All bids must be written in English

Electronic files should be provided in the following formats:

- Text documents -- Microsoft Word 2007 or a later version that is compatible with Word 2007, any organization charts (or similar graphics) should be embedded and not submitted as Visio files or similar applications. It is the bidders responsibility to ensure they remain legible when printed in standard documents format (A3 or A4)
- Financial submissions -- Microsoft Excel 2007
- Drawings or sketches -- AutoCAD 14

Evaluation of Bids

The Hospital is seeking the best value offer for the services. The evaluation will assess the extent to which the proposed solution meets the requirements while meeting the cost objectives of the client

Bid evaluation will gauge the expected service delivery outputs for each service by considering the bidders understanding of the requirements, evidence of past experience and any other justifications for confidence in the bidder being able to deliver the services at or above the required standard.

The quality and clarity of the presentation of the bid will be an important criteria by which the bidder's submissions are assessed.

Bidder Changes

If the bidder wishes to substitute or change one of their sub-contractors or the organization itself changes significantly they should inform the client as soon as possible and certainly prior to the end of the evaluation period.

Costs and Expenses

Bidders are responsible for all costs incurred by them in connection with their responses to this document and all future stages of this procurement.

Questions and Response Pro Forma

The table below lists the specific questions that are to be answered in response to this offer document.

Bidders should answer the questions as listed and assume the same numbering convention as that in the table. In the event that a bidder submission is for one or more of Food Service, Laundry, Housekeeping or Plant Operations and Maintenance, then the bidder should only complete the general requirements section (marking any questions which they believe are not relevant to their submission N/A) and in addition, complete the Service Specific questions which are relevant to the service/s for which a bid is being submitted.

GENERAL REQUIREMENTS

1. Bidders are requested to provide an executive summary of their overall Bid which sets out the following, in no more than 1,500 words:

their overall approach for delivering the services for this project;

key features of their Bid and how these meet the Service Requirements as a whole;

internal management arrangements, including proposals for working with the Client and other stakeholders at all levels;

details of where their proposed Solution provides added value to the Project in comparison to the Requirements;

Brief description of, and confirmation of the number of the bids provided as part of this Response.

In the description, Bidders must discuss management of risks and other uncertainties affecting service delivery.

Bidders should note that the executive summary is for information only and will not form part of the evaluation.

Environment & Amenities

2. Bidders must describe how their Solution will:

Ensure their Facilities are always clean and hygienic to the highest standards recognised for international medical facilities

3. Bidders must provide for the previous 12 months the number and average complaint rate per month relating to Facilities they are currently managing (or were managing during the prior 24 month period)

Waste handling;

Cleanliness of the Facility, including all patient accessible areas;

Security; and

Serious incidents involving staff or patients;

Continual improvement investigation into shortcomings for all of the above and consequent service improvements.

Sourcing

Description of Resource Strategy

4. Bidders must provide a description of the approach to sourcing delivery of these services (maximum 2000 words) that demonstrates how they will deliver the Services and as a minimum how they propose to:

Meet the essential day-to-day staff leadership, management and supervisory requirements including during the Mobilization Period;

Attract and retain Staff in the numbers, competencies, and qualities required to ensure the safe and high quality provision of the required Services;

Support local employment objectives

Achieve and maintain a positive employee relations environment;

Cover any identified workforce risks and uncertainties;

Comply with all relevant employment legislation applicable in the country

5. Bidder is to outline its strategy for employing and training nationals to take over key positions at all levels during the course of the contract.

Resource Plan

6. Bidders must provide the following:

Draft staffing plan to deliver the Solution, demonstrating how the Bidder's proposed staffing arrangements will consistently and reliably contribute to the provision of the Services. This plan should be consistent with the cost plan

Management Organization Structure

7. Bidders must provide a proposed management organization structure chart illustrating the interaction of management and reporting relationships in the delivery of the Services.

Staff Training and Development

Orientation

<p>8. Bidders must provide a proposed orientation program for all new recruits</p>
<p>Staff Handbook</p>
<p>9. Bidders must provide a Staff Handbook containing details of their existing employment terms and conditions, which includes as a minimum the following existing policies, or a detailed description of the policies they will have in place in order to deliver the Services</p> <p style="padding-left: 40px;">Staff involvement, consultation and communication;</p> <p style="padding-left: 40px;">Disciplinary;</p> <p style="padding-left: 40px;">Bullying and harassment;</p> <p style="padding-left: 40px;">Grievance;</p> <p style="padding-left: 40px;">Whistle blowing;</p> <p style="padding-left: 40px;">Confidentiality;</p> <p style="padding-left: 40px;">Compensation;</p> <p style="padding-left: 40px;">Performance management/appraisal;</p> <p style="padding-left: 40px;">Training and development;</p> <p style="padding-left: 40px;">Sickness absence;</p> <p style="padding-left: 40px;">Leave/cover arrangements;</p>
<p style="padding-left: 40px;">Lone/remote working;</p> <p style="padding-left: 40px;">Drug and alcohol misuse;</p> <p style="padding-left: 40px;">Smoking; and</p> <p style="padding-left: 40px;">Relocation.</p>
<p>Health And Safety Policies</p>
<p>10. Bidders must describe in detail how their health and safety policies will support the Solution. Responses should include a detailed explanation of their approach to:</p> <p style="padding-left: 40px;">Managerial accountabilities;</p> <p style="padding-left: 40px;">Assessment of health and safety risks;</p>

Health and safety improvement measures;
 Staff consultation and counselling processes;
 Safety audit procedures;
 Accident reporting processes; and
 Health and safety record-keeping and reporting.

Benefits of proposed Terms, Conditions and Policies

11. Bidders must demonstrate how their existing employment terms and conditions, and HR policies will:

Support their Solution;
 Reflect good practice and comply with relevant employment legislation applicable in the country;
 Encourage the recruitment and retention of high quality, competent staff;

Promote a positive working environment; and
 Resolve any employee relations issues which may arise.

Workforce Information Management

12. Bidders must describe the systems and processes that they have in place to monitor and manage workforce information. Bidders must demonstrate how these will facilitate the:

Day-to-day management of their Staff

CONTRACT MANAGEMENT REQUIREMENTS

Reporting Requirements

13. Bidders must describe how they will manage the invoicing process including verification of invoices, provision of supporting documentation and how they will minimize any discrepancies.

14. Bidders must describe how they will ensure the quality of their data, timeliness of reports, and proposals for presentation of data for ease of review.

<p>15. Bidders must describe how they will create and deliver minimum data set required for the management reporting and performance management requirements</p>
<p>Contract Management Structure</p>
<p>16. Bidders are required to demonstrate how they intend to manage their subcontractors to ensure quality of service provision, and manage directly any issues arising during the term of the contract.</p>
<p>Business Continuity</p>
<p>17. Bidders must outline their approach to Business Continuity (The final requirement would be jointly developed between the successful bidder and the Client)</p>
<p>Mobilization Plan</p>
<p>Overall Mobilization Plan</p> <p>18. Bidders must provide a draft Mobilization Plan for delivery of the Services including:</p> <p style="padding-left: 40px;">Indication of the reporting lines required during the mobilization period. Specific areas where the provider will expect direct involvement with the rest of the Project Team to ensure successful mobilisation</p> <p style="padding-left: 40px;">How they will resource the Mobilization Period to ensure a smooth transition to service commencement;</p> <p style="padding-left: 40px;">Key Mobilization Milestones, activities and likely lead times to complete mobilisation and ensure completion prior to service commencement</p> <p style="padding-left: 40px;">From where the different categories of staff will be recruited</p> <p style="padding-left: 40px;">Time-scales and lead times for recruitment, pre-employment checks, work permits and entry requirements (if relevant).</p>
<p>19. Bidders must describe how their mobilization strategy has been influenced by previous experience in contractual mobilization, detailing key lessons learnt and how these have been applied to this Project. Where relevant, this should link to the risk register provided.</p>

Risk and Contingency Management	
20. Bidders must provide a risk register identifying the key risks during the Mobilization Period and Service Delivery and identifying their strategy for avoiding and minimizing these risks.	
21. Bidders must:	
	Confirm the processes that formally apply Risk Management to enhance the operational effectiveness.
	Confirm the management controls of the quality of service delivery by third party contractors.
	Confirm the processes to ensure that the service delivery complies with all required statutory appointments, certificates and inspections and that it is effectively fulfilling its duty of care.
22. Bidders must demonstrate how they will provide adequate resource to support the procurement and mobilization phases, through to Service Commencement.	
Service Specific Questions	
Food Service	
23. Bidders should outline their approach to purchasing the following:	
	Fresh produce –sourcing policy etc.
	Dry or preserved goods
	Frozen produce
24. Bidders should outline their approach to menu development and maintenance of nutritional standards and variety	
25. Bidder should provide details of their approach to the following:	
	Receipt of goods
	Food storage
	Stock rotation
	Food handling
	Chilling and reheating of cooked foods

Food samples
Re-use of over produced foods
Equipment checks
26. Bidders should provide details of their approach to the following staffing issues:
Qualifications
Training plan
Qualified staff in attendance
Customer care
Uniform
Safety footwear
Food service supervision
Food production supervision
27. Bidders should give an outline specification for equipment and area required to deliver the catering services by the following area types:
Goods receipt and storage
Food prep and kitchen
Servery
Wash up, waste handling, disposal and storage
28. Bidders should outline their approach to managing the following health and hygiene issues:
Personnel hygiene
Waste and rubbish
Washing up crockery, cutlery, trays, water jugs, glasses
Cleaning procedures

29. Bidders should give details of their approach to the following areas of catering management:
Quality control
Health and safety
Major incident management – food poisoning outbreaks, traceability etc.
Laundry Service
30. Bidders must provide details of their approach to the following aspects of their laundry and linen service:
Textile Control Procedures
Occupational Safety & Hygiene
Quality Control and Process Monitoring
Handling, Collection and Transportation of Soiled Healthcare Textiles
Sorting
Washing, Extraction and Drying
Finishing
Packaging & Storage
Delivery of Cleaned Healthcare Textiles
Housekeeping
31. Bidders should provide details of the staffing levels and ratio of staffing supervision they intend to put in place to operate this contract.
32. Bidders should provide details of the standards and method statements they will employ to clean the following area types.
General
Floors
Vertical Services & High Level

Furniture, Fixtures and Fittings
Sanitary Fittings
Clinical Areas
33. Bidders should provide details of their approach to deep cleaning the following types of areas:
Hospital wards
Toilet and wash areas
Operating rooms
Catering areas -- kitchen and cafeteria spaces
34. Bidders should outline their approach to the following issues:
Staff training
Use and control of hazardous cleaning products
Risk assessment of cleaning in clinical areas
Plant Operations and Maintenance
35. Bidders should provide details of the processes they use to carry out the following:
Service activation & request handling and escalation process
Work allocation, execution, status tracking and feedback and close out process (i.e. at individual work order level)
Reactive and Planned Preventative Maintenance (PPM) scheduling and tracking process (i.e. at aggregate level)
Plant & equipment change control process
Quality control and corrective action process
Performance measurement and improvement process
Minor capital works program planning and tracking process
Selection and development of sub-contractors

36. Confirm the key elements of your approach to the development of a coherent integrated maintenance strategy. As a minimum indicate the proposed approach to the development of:
The maintenance and associated logistic support concepts and strategies.
All maintenance & engineering standards, processes, policies and procedures.
Detailed maintenance schedules and plans for preventive, condition based and corrective maintenance tasks as well as all statutory inspections / tests.
Annual Facility Condition Surveys and Maintenance Management/Compliance Audits.
Innovation and improvement
Confirm the key elements of innovation associated with your service offer? Also indicate their tangible benefit

Financial Submission

Bidders must provide financial details for their Bids, based on the minimum requirements set out below:

The Financial details shall comprise at least the following:

- Assumptions
- Projected profit and loss statements
- Projected cash flow report
- Projected balance sheet

The Financial Details must be presented on the following bases:

All monetary figures must be denominated in local currency.

- A detailed analysis of all direct costs and overheads including, but not limited to, staff costs, consumables, maintenance, IT, depreciation, financing costs, lease rentals and taxation;
- Where the Bidder proposes subcontracting any services to any third party, the costs associated with each individual service should be input as a separate line item and clearly identified as being the cost associated with a subcontract;

The format for submission of the Financial Model should adhere to the following:

- Bidders must submit one copy of the financial details for each bid on CD Rom.
- Be submitted in Microsoft Excel 2000 or versions above
- Data submitted on CD should be checked to ensure that it is free from any viruses or other malicious software
- All inputs should be provided and no externally linked files submitted; files should not be password protected

4. Performance Management

Introduction

In order to maintain a high standard of service delivery and ensure excellent value for money from the facilities management Contractor/s, it is intended to put in place a robust performance management and continuous improvement system with the Contractor. The intention of this system is that the Hospital and Contractor work together to ensure that the appropriate level of service is delivered and that all parties understand the issues and expectations that arise from the delivery of the services. It is designed to ensure that the Contractor is held accountable for the delivery of the services.

Operation

During the operation of the hospital the Contractor of services will be required to submit regular performance reports to the operations manager at the hospital. The period of these reports is monthly and is consistent with the invoicing for services. The report will contain data directly relating to the quality of each service provided, the agreed upon Key Performance Indicators (KPIs). The data will be both quantitative and qualitative. Key Performance Indicators are decided during the contract negotiation period. In addition, reports will include written incident reports documenting any significant events occurring in the reporting period during the delivery of these services.

In the event that the Contractor does not achieve, within an agreed percentage of the threshold, e.g. 10%, or that the trend shows a deterioration in the delivery of services over a longer period (e.g., three contiguous months), then the Contractor will be required to put in place a service improvement plan. Delivery of the service improvement plan will be the responsibility of the provider, and costs associated with its delivery will also be the Contractor's responsibility (except in exceptional circumstances and by prior agreement).

Service improvement plans are monitored by the Contractor and Hospital management. If the provider fails to reach a predetermined level of performance, then the Hospital reserves the right to withhold revenue for that portion of the service that is deemed to be unacceptable. At the same time the Contractor will remain responsible for the costs associated with restoring the service to an acceptable level.

In the event that the Contractor, after the service improvement plan has been implemented, is unable to deliver or restore to an acceptable level the service in question, the Hospital reserves the right to terminate the agreement in part or in whole and find and install a replacement Contractor for those services in question.

It is anticipated that the Hospital may wish to carry out planned as well as unannounced inspections and audits of the reporting data. In the event that such audits reveal anomalies in the data or reporting, the Contractor will be required to provide justification for the anomaly, correction of the data and if required retrospective adjustments to any payments received.

SECTION FIVE

HOSPITAL MANAGEMENT OF OUTSOURCED SERVICES

1. Management by the Hospital Administrator

- 1.1 The contract company deploys an experienced department manager to run the out-sourced service department. The department manager has two co-equal reporting lines to: a) The hospital administrator; and b) the company manager.
- 1.2 The hospital administrator meets regularly with *all* hospital department managers, contract department managers and non-contract department managers, to review department performance, discuss and solve problems, monitor budgets and respond to new or unusual events.
- 1.3 The contract department manager also has reporting requirements to the company executive overseeing the account. This dual reporting burden on the department manager of the out-sourced service department does not change the oversight responsibility of the hospital administrator.

2. Integration into the Hospital Management Team

- 2.1 The contract department manager is most successful when (s)he is an equal and participating member of the hospital department management team. The outsourcing relationship is *not* one of a supplier mentality but rather a partner mentality.
- 2.2 The contract department manager is integrated into the hospital management team and works as a team member towards fulfillment of the hospital mission. That often involves multi-department collaborations on projects and response to unanticipated events that disrupt normal service.

3. Tension and Conflict Management

- 3.1 Almost inevitably there will be occasions when tension develops between the company and the hospital over the use of resources. The company's profit depends upon maximizing efficiency and minimizing the use of resources. The hospital is continually monitoring to assure that the promised level of service is not being decreased to increase company profit.
- 3.2 The contract specifications are the reference point for negotiating. Disagreements are first discussed with the department manager. If not resolved, the hospital administrator engages in negotiation with the company manager. The hospital administrator retains the right to request a new department manager.

- 3.1 Before signing an out-sourcing agreement, the hospital administrator develops a general contingency plan for an unexpected termination of contract. Alternative companies who can mobilize on short notice are identified.

Keys to Success

- Don't underestimate how much time it takes to manage a contract. Companies try to sell contracts with promises of great time savings for hospital management. Contract monitoring needs to be rigorous and routine.
- Hospital management needs to schedule department manager meetings for outsourced service departments with the same frequency as non-outsourced department manager meetings.
- Hospital management needs to make scheduled and non-scheduled inspections
- The hospital needs to periodically audit the contractor's budget reports and supply and equipment inventories.
- An annual performance appraisal of the department manager needs to be conducted jointly by the hospital administrator and contractor.
- The contract should be regularly re-bid to assure that the hospital continues to pay a fair price for the service and is not missing the opportunity for the introduction of new technology or methodologies.

ANNEX G. WORKSHOP TRAINER GUIDE

Out-Sourcing Nonclinical Hospital Services
Workshop Trainer’s Guide
Part 1: Bidding Process for Outsourcing Services

Day 1		
Session/Time	Content	Methodology
Workshop Opening 8:15-9:30 1 hour, 15 min	Workshop welcome + opening remarks	<ul style="list-style-type: none"> • Dr. Ndwapi, Office of Strategy Management, MoH, gives remarks • HFG project and purpose of this training; who’s who on HFG team
	Participants Introductions (slide) + Outsourcing Snapshot	Have prepared flipchart (FC) titled “Outsourcing Snapshot” with the 7 hospitals and the outsourcing services listed (matrix style) Ask hospital teams to introduce their members (slide): <ul style="list-style-type: none"> • <i>Your name, hospital + official position</i> • <i>What is your particular role in the outsourcing of nonclinical services?</i> • <i>(To hospital manager) What services are currently under contract OR Which services are in the planning to become outsourced (but you have no direct experience yet) Check off this information on Outsourcing Snapshot FC.</i>
	Workshop Goals and Agenda (slide0	Review the workshop goals (slide) Explain the two parts of the workshop and the design approach- Part 1 – Bidding Process (Days 1-2): from the pre-bid study up to the point of getting ready to negotiate the contract Part 2 – Contracting using the Service Learning Agreement (Days 3-4) <ul style="list-style-type: none"> • Design is based on needs assessment through site visits to hospitals and meetings with MoH and stakeholders. • Will cover the entire outsourcing bidding process, how to develop and use SLAs as a key contracting approach, and some aspects of hospital management of outsourced services. • Course will not cover contract negotiation, modifications, terminations, etc. Those topics will be addressed in future trainings.
	Workshop methodology slides	<ul style="list-style-type: none"> • Active participation: You are the hospital experts and now have some degree of experience in outsourcing serviced. You have much to contribute. • Interactive Presentations with emphasis on interaction between the presenter and group. • Sharing among hospitals re: lessons learned and promising

		<p>practices; important to build/strengthen the network among yourselves</p> <ul style="list-style-type: none"> • Tools and concrete information about how to conduct the tendering process and develop SLAs • Small Group Work to draft the service elements and some standards for SLAs in 5 main outsourcing areas (Part 2, Days 3-4) • Parking Lot for pending questions/concerns
	Major challenges and matrix of hospitals and current outsourcing slides	<p>Ask each of the hospital managers: <i>What has your hospital found to be THE biggest challenge you have experienced with outsourcing so far (no matter where you are in the process)?</i></p> <p>Write their answers on FC and leave posted for reference.</p>
	Pre-Test of technical knowledge	Explain purpose of pre- and post-test; distribute and have participants complete; collect the tests and thank the group.
<p>Session 1</p> <p>Project Start-Up</p> <p>9:30-10:30</p> <p>1 hour</p>	<p>Summary /Discussion Hospital Visits “Take-Aways”</p> <p>Part 1 Agenda Slide 2</p>	<ul style="list-style-type: none"> • Give brief explanation of the site-visits and interviews; general remarks/take-aways about the outsourcing experiences of hospitals to-date. • Give some brief examples of outsourcing challenges that relate to what the hospital administrators just identified as their biggest challenges (validation) • Segue into the Part 1 agenda and show the group what we will be covering today and tomorrow and how it will address many of their outsourcing challenges. Mention that we will use “housekeeping services” as a case example to illustrate and practice some of the steps in the bidding process.
	<p>Selecting Study Team</p> <p>Slide 4</p>	<p><u>Key point:</u> Main purpose of pre-bid study is to decide if you want to outsource a given service. You study the pros and cons and make go/no-go decision; need to be very intentional about whom you select to be on the (multidisciplinary) study team.</p> <p>In our situation here, the MoH made a centralized determination of which services to outsource, but in the future, the hospitals will assume more responsibility.</p> <p>Ask the group: <i>What kinds of experts (internal/external) would you need to put together for a housekeeping study team? Chart answers.</i> Review their inputs re: all needed disciplines identified here?</p>
	<p>Goals of out-sourcing</p> <p>Slide 5</p>	<p>Show title of slide first and ask group: <i>Why do you want to outsource? What are the goals/benefits to</i></p>

	ACTION SLIDE	<i>be gained?</i> Chart answers (if many) Then show rest of slide and clarify any additional outsourcing goals they may not have mentioned.
	Criteria for selecting which services to out-source. Slide 6	Explain points on slide Ask the MoH (assuming they've done the selection thus far): <i>How did you determine which services would be outsourced first?</i> To the hospitals: What criteria might be important to you to consider in future outsourcing? (e.g., hospital can't recruit qualified people for x service, etc.)
	Establish a timeline Slide 7	Key points: Need to establish deadlines so everyone is aware of the process and that there are firm dates for having a contract in place. Not keeping to timelines causes hospital disruption (happened in repeatedly here in the pilot). <i>Solicit examples of the types of disruption this can cause (e.g., labor unrest, break downs in quality of service delivery, etc.)</i>
Break 30 min.	Break	Break
Session 2 The Pre-Bid Study 11:00 – 12:30 1.5 hours (continues after lunch)	Overview of Key Elements of Study (slide 9)	Briefly walk through key elements <ul style="list-style-type: none"> • Executive Summary (even though this section appears first on this list, it is actually written at the end of study) • Market Capabilities • Cost Data • Risk Identification • Policy Issues • Approach to Outsourcing
	Market Capabilities (slide 10) Table group Task Slide 11	Explain the elements of market capability listed on the slide; emphasize their role to do 'due diligence' to verify the credentials of the prospective bidders. Ask the group to take our housekeeping example and do the following task at their tables: Scenario: You are currently conducting a market survey to determine if you have enough housekeeping service vendors for a pre-qualification round. <ul style="list-style-type: none"> • HOW would you go about finding information on market capability for this service? • Discuss this question with your colleagues at your table and be prepared to offer your ideas to the large group. (Sample responses: Send someone who understands this service to go out and talk to prospective companies; draft a questionnaire that would solicit a response from the company

		<p>indicating their capacity; get copies of their financial statements; visit their offices/facilities; etc.)</p> <p>Explore with group: Consider a pre-qualification round.</p> <p>National vs international? What about low national capability—how can you build that up? What is the role of PPP unit (vs the hospital) in conducting the market capability study?</p>
	Cost Data (slide 12)	<p>Key points: If you don't know what it costs, how can you evaluate your bid costs? Hospital administrators need to know what it costs to run their hospitals; if they are going to have responsibility for outsourcing, then they need to know what it costs today. Staff and supply data are essential to being able to evaluate whether or not a bid is high or low!</p> <p>Use the food service and housekeeping examples on the slide to illustrate: How much do your HK/FS supervisory and staff cost? Supply costs? Equipment maintenance/replacement costs? What did you spend in 2013 on these services compared to what your bidder/s say they can do it for in 2014? (Note: we are not asking for answers here but rather using the questions to drive home the point that hospitals need to know their costs, including most useful ways to calculate the unit costs.)</p>
LUNCH 1 hour	LUNCH	LUNCH
<p>Session 2 The Pre-Bid Study</p> <p>1:30 – 3:45</p> <p>2 hours, 15 min.</p> <p>(continued from am)</p>	Risk Identification (slide 13)	<p>Risks: “Okay, where can we get into trouble with outsourcing process? What are our risks? For example, if you don't have good data and no one can ID the unit costs, then that is a risk. Poorly drafted contracts are a risk, etc.</p> <p>Refer the group to the types of risks identified on the slide and ask: <i>Which of these are most relevant to your situation? What else would you add to this list?</i></p> <p>Underscore that this workshop is meant to help you minimize/lower these risks.</p>
	Policy Issues (slide 14)	<p>Key Points: These are policy decisions that need to be made during the outsourcing process (e.g., where do you as a hospital administrator come down on the question of paying more tomorrow than today to get a cleaner hospital? Are you willing to reduce the size of the HR dept. (for example) to ensure that you have adequate coverage in cleaning? These are the types of trade-off decisions you will need to make.</p> <p>Re: International competition—if the market study shows there are no companies in Maun that are a good risk for x service, then</p>

		<p>do I have the authority to hire a SA company?</p> <p>Would hospitals want to tender together—one tender for two hospitals to drive the price down in exchange for higher volume.</p> <p>Capital equipment: example of policy decision at Princess Marina hospital to buy the equipment in-house. Sometimes you enter into an agreement to have the company buy it but if they don't work out, you have to buy back.</p> <p>Ask the group for questions/comments.</p>
	Approaches to Outsourcing (slide 15)	<p>Single vs multiple contracts: If your market survey reveals that there are some companies who can do both laundry and HK, do you want to contract them for both services?</p> <p>Hospital vs Company Employees: Possible alternative to consider—</p> <ul style="list-style-type: none"> • Keep existing staff as hospital employees and bring in company to manage them; • Tell the employees that they have a sure job for the first year under the contract, but that they have to perform to acceptable level to be rehired for the second year. Top 60 get selected. The advantage to this type of approach--No transition problem with forcing labor out plus people are motivated to perform at higher level in order to keep their jobs. If you are currently transferring underperforming people to another gov't job, then you are not accomplishing the goals of outsourcing. <p>Acknowledge to the group that there may be certain labor restrictions that would limit your choices here. Point is to know what the restrictions AND explore all possible alternatives within those restrictions.</p> <p>Ask the group: <i>Based on your outsourcing experiences to date, what are your reactions to these ideas or what other approaches might work here?</i> Let discussion continue, time permitting.</p> <p>Conclude the session by showing slide 9 again (overview of Pre-Bid Study elements). Ask the group: <i>Which of these elements are particularly challenging for you right now?</i></p>
End-of-Day Wrap-Up 3:45 pm	Summary of Day 1 Preview of Day 2	Show flipchart or slide with overall flowchart to summarize what we've covered so far and where we pick up tomorrow. Check the Parking Lot and address any pending questions/requests.

15 minutes.		Check in with group re: pacing of the presentation and discussion and other aspects of the learning environment.
Day 2/Part 1: Bidding Process for Outsourcing Services		
Morning Opener 15 min.	Key Learning from Yesterday/Review of Today's Agenda	<p>Ask participants to share "take-aways" from the first day of the workshop:</p> <ul style="list-style-type: none"> • <i>What was one of the most significant things you learned yesterday? Why was it important?</i> • <i>Are there any burning questions from yesterday? (Address as much as possible)</i> <p>After a few participants have shared, move on to review the agenda for today (written on flipchart) and indicate where we are in the overall process using the flowchart as a reference.</p> <p>At the end, ask participants to count off and form new table groups for the day.</p>
Session 3: Offer-to-Bid Document/ Intent to Tender (ITT) 2 hrs, 15 min.	Overview + General Conditions Slides 17-18	Show the overview slide of the key sections included in the offer-to-bid document
	<p>Service Requirements Slide 19</p> <p>Table Group Task Slide 20</p> <p>Note: this activity will take approx. 60 min.</p>	<p>Show the Service Requirements slide and use it to set the stage for the exercise that follows.</p> <p>Explain that we will examine service requirements in detail by doing a group exercise that will draw heavily on their expertise as hospital managers. ASK THEM TO PUT AWAY THEIR SLIDE NOTES AND CLOSE THEIR FOLDERS!</p> <p>Explain the task: (slide 20)</p> <p><i>Your hospital is getting ready to tender for housekeeping services. As a team, confer and answer the following questions:</i></p> <ol style="list-style-type: none"> 1) <i>What kind of specific information about the housekeeping service do you want the <u>company to provide to you</u> to be able to evaluate their bid? (Don't worry about 'cost' for the moment)</i> 2) <i>Based on your answer to question 1, what do <u>you need to give the company</u> in order for them to adequately respond to your bid?</i> <p><i>Write your responses on the flipchart provided and post on the wall when you are done.</i></p>

		<p>When the groups have finished, post all the charts on the wall and ask the group to do a Gallery Walk to review all the groups' work. Ask them to pay attention to: common elements; level of detail in what is expected from the company and/or provided by the hospital; important information that is left off all lists; elements on the hospital list that might be better placed on the company list, etc.</p> <p>Have participants take their seats and have a discussion based on their work. Underscore: If you want the company to give you a thorough bid then YOU have to give the vendor enough information for to get back the detail you want. E.g. You should give the company a blueprint of every room in the hospital so they know how many beds, the layout, size of rooms, etc.</p> <p>Tell the group we will keep these lists up on the wall for reference as we walk through each of the pertinent areas of the bid document.</p> <p>(Note: the next few slides will likely relate to some of the elements the table groups noted on their charts. As appropriate pull from their ideas as you move through service requirements, mobilization, training, etc.)</p>
	<p>Service Requirements</p> <p>Slide 19 (back to this slide after exercise)</p>	<p>Show the Service Requirements slide again and draw from their flipchart lists to identify any examples that are relevant here.</p> <p>Key points:</p> <p>Hospital needs to provide essential specific information about the facility spaces to be cleaned, e.g.,</p> <ul style="list-style-type: none"> • Give companies a copy of the hospital blueprint; Offer companies the opportunity to tour the hospital to see what types of surfaces they will need to clean. • Provide information on furniture, types of equipment to be cleaned; • Information on norm for maternity ward (24-hour turnover?) • Other data about patient discharge/day, etc. • Requirement for special projects cleaning (e.g., windows); • Ask to see copy of training program they give their people. <p>Key here is to provide them enough of the right kind of service data so they will be able to accurately calculate</p>

		number of staff needed, staff qualifications, supplies and equipment, needs and other aspects of their bid.
Break 30 min.	Break	Break
Session 3: Offer-to-Bid Document (continued) 11:00 – 12:30 1.5 hours	Mobilization/ Start-up Phase Slide 21	Walk-through the key elements in the mobilization phase, drawing on the experiences of the hospitals that have already started outsourcing services. <ul style="list-style-type: none"> • What was your experience during your mobilization period? (e.g. did your contractor provide additional personnel? For how long? etc.) • What were some of the problems you encountered and how did you resolve them? Ask the groups if they included mobilization in their lists of bid information they expect from companies. Bottom line: Ask your companies to provide you with their plan for mobilization. Then compare it to other companies' plans— which of the bidders has the best start-up plan?
	Price and Payment Slide 22	Review key points on slide Note that sometimes hospitals have leverage with the training costs. For example, if the company doesn't have the capacity to provide their staff with certain specialized training, then the hospital can offer to provide that to their staff in exchange for a reduction in staff training costs in the bid (promotes a partnership approach on training) Bottom line: Financial people need to sit down and review costs.
	Contractor's management services Slide 23	Is the staffing plan and provision for supervision that the company is offering in line with the service requirements? (Remember: they can't give you the 'right' staffing and supervision if you don't give them enough service information on which to base their proposal/offer. Ask the group these two key questions: MARSHA prepares these on flipchart. (Note: If time allows do this as buzz groups at the tables; half the tables consider the first question; the other half address the second question) <ol style="list-style-type: none"> 1) <i>What is your role vis-à-vis outsourced employee supervision?</i> 2) <i>What is the role of nurses in supervising outsourced support staff?</i>

		<p>Key point: YOU manage the CONTRACT; THEY manage the EMPLOYEES!</p> <p>If companies aren't doing the supervision, then something is wrong with the contract. (Or some cases, the supervision maybe hospital's role because the hospital didn't want to lose good supervisors who were already working at the hospital.)</p>
	<p>Procurement of supplies and equipment</p> <p>Slide 24</p>	<p>Company needs to be very clear about their system for procuring and managing supplies, standards of quantities, transparent system for tracking and accounting, etc.</p> <p><i>What are some examples of strong/poor systems among the hospitals that are currently outsourcing services?</i></p>
	<p>Emergency response</p> <p>Slide 25</p>	<p>What are the company's emergency response capabilities and procedures? E.g., If there is a fire in the hospital, what is your procedure for responding? E.g., if a fire in the laundry damages the major equipment and it can't operate—how would you respond to this? Can't anticipate every emergency, but the company needs to show the capacity to mitigate interruption of service. Ask for their emergency response capability as part of their bid.</p>
	<p>Quality assurance</p> <p>Slide 26</p>	<p>Look back at the table group worksheets on the wall and ask: <i>Did you include monitoring plans/system in your list of what you expect from the company?</i></p> <p>Walk through the key element of the plan and emphasize that the hospital asks the bidder for their plan-- "You tell us how you will monitor your services and ensure the quality in our hospital).</p> <p>E.g. Hospital has infection control plan. The hospital superintendent says it's a requirement that every employee is screened for TB before they can start to work; company bid needs to include state that we will adhere to the plan and that no one we hire will start without screening.</p> <p>Handout the monitoring checklist tool for housekeeping and show how it has been used to monitor and track quality.</p> <p>Explain that the monitoring plan needs to be detailed in the final contract and include ways to objectively measure performance quality (KPI's). Teel the group we will address this in more detail on Friday when we cover SLA's.</p>
	<p>Orientation and training</p> <p>Slide 27</p>	<p>Always ask for this plan.</p>

	Client's rights Slide 28	This section explains the hospital's policy for non-performance and that there will be penalties.
LUNCH		
Session 4: Evaluating the Bid 1:30 – 2:15 45 minutes (maybe less)	Evaluating the bid- Slides 30-38	<p>Show the overview slide and explain that in this session we will simply walk through a consolidated list of the 'pieces' that the company needs to include in its bid and upon which it will be evaluated by the hospital using a formal scoring system.</p> <p>The sections include:</p> <ul style="list-style-type: none"> • Cost • Proposed manager's (What is most important to look for in this section? How do you check the qualifications of key staff? CVs of managers? Interviews? References?) • Organizational chart • Current contracts • Staff training • Health & Safety Procedures • Information Systems Is their MIS capacity sufficient? Is it compatible with the hospital? (Housekeeping example) Is the company thinking 5 years ahead with their systems? What should you require the contract to give you and what do you do with that information? • Mobilization Plan <p>Mention the recent case of a bidding process where the hospital decided to reject all 3 bids and put the tender out for re-bid</p>
Session 5: Hospital Management of Out-Sourced Services 2:15 – 3:45 1.5 hours	Active Administration Slide 40	<p>Segue to this section by saying that we've actually discussed and addressed some of the management issues already in the earlier sessions: the more complete your tendering process, the better your chances are for getting good bids that can then be negotiated into sound contracts that are easy to manage. In this session, we'll look at several best practices that will enable you to have strong, healthy relationships with your outsourcing companies and staff.</p> <p>Show the slide and focus the group on the statement: "The Out-Sourced Dept. Manager has 2 Co-Equal Bosses"</p> <p>Ask the group: <i>What does this mean to you? Agree/disagree?</i></p>

		<p><i>What problems does this raise for the outsourced department head (e.g., DryTex manager)</i></p> <p>Discuss with the group the pressure that this Dept. Head faces: Company and hospital have different goals--making money and delivering patient care; the Dept. Head is accountable to the company <u>and</u> to the hospital. This type of position requires an experienced, sophisticated person. What should the hospital care about in the end? That the company gets us a Dept. head that can do the job.</p>
	<p>Team Integration- Partner Mentality Slide 41</p>	<p>Key Point: Outsourcing can only succeed if there is a true partnership. It's a complicated relationship.</p> <p>Sekgoma torn linen example: Linen is coming out of laundry with little tears and only lasting 1/3 of the time it should...company is saying "it's not our machine"; hospital saying, "yes it is". Could have to do with substitution and or mislabeling of detergents. Now protracted and becoming bigger issue. How to resolve this?</p>
	<p>Company vs Hospital Slide 42</p>	<p>Key Point: Should always be able to request a new manager; don't even have to list the reasons, but hospital retains the right. Don't abuse it but have it there in case they don't have the right person who integrates in with your team, gets along, etc.</p> <p>Contingency plan: E.g., what if your security company files for bankruptcy? What is your Plan B?</p>
	<p>Keys to success Slide 43</p>	<p>Are there any other keys to success you would add?</p>
<p>Wrap Up of Part 1 and Bridge Forward to Part 2</p>	<p>Reference Guide Other sources of information Slides 44-45</p>	<p>Distribute copies of the Reference Guide to participants and explain that it will provide in-depth information on the areas we covered here in these past 2 days. Review the table of contents so participants see what is included.</p> <p>Also offer any other references—web-based or other—that you would suggest as sources for outsourcing information pertinent to the bidding process.</p> <p>Give the group a taste of what the next two days will include: The focus will shift to the Service Level Agreement—clarifying what it is and what it isn't, and then drafting actual sections of the agreement to include in their outsourcing contracts.</p>

Out-Sourcing Nonclinical Hospital Services
Workshop Trainer’s Guide
Part 2 – Service Level Agreements and the Contracting Process

Day 3		
Session/Time	Content	Methodology
Bridge from Part 1 to Part 2 8:30 – 8:45 15 minutes	Workshop overview diagram Slide 2	Use the workshop overview slide (repeated here in slide deck) to bridge from Part 1 to Part 2.
	Why choose SLA and Part 2 objectives + agenda Slides 3-5	Show slide 3 with the contract options: <ul style="list-style-type: none"> • Vendor knows best: the supplier’s proposal becomes the core of the agreement; • Employer knows best: the bid document specifies all the details that go into the contract; • Midway point: a Service Level Agreement might be the right option. <p><i>Ask: What are the pros and cons of each of these?</i></p> <p>Point out that option 3 is likely the most flexible for the outsourcing context here. Use the dialogue with the group to segue to the next slide with the objectives and agenda for days 3-4.</p>
Session 6 Understanding Purpose and Role of Service Level Agreements 8:45-10:00 75 minutes	Purpose of SLA; what it is and what it is not. Slides 7-11	On Slide 7, read the definition of SLA out-loud and underscore the 3 key words (negotiated, agreement, and common understanding). Emphasize that the SLA is integrated into the contract and is not meant to detract from or substitute for the aspects of the contract that are managed by the procurement and legal offices. <p>Ask the group for their reactions to the definition.</p> <p>Walk through the key points on the rest of the slides soliciting inputs from participants based on their outsourcing experiences to-date</p> <p>Underscore that the SLA is a “living document” not a static one.</p>

<p>Case study Exercise: <i>Outsourcing, Common Sense and Good Faith</i></p> <p>Slide 12</p>	<p>Hand out the case study and have participants read it individually. Have a brief plenary discussion:</p> <ul style="list-style-type: none"> • <i>What went wrong here?</i> (E.g., poor communication, “gotcha” attitude on the part of the hospital, etc.) • <i>How would you handle the situation differently to avoid this level of escalation?</i> (E.g., develop good communication processes early so problems can be identified and dealt with in a more timely way; use common sense approaches to working with the service provider; apply the “spirit of the law’ vs the ‘letter of the law’; if a problem situation indicates the need for a change in some descriptions and/or terms of the SLA, then make that adjustment and move on, etc.) <p>Key point: If you go into a relationship with bad faith, an SLA will not help you; an SLA requires a good faith effort on the part of both entities. (In other words, the will to succeed needs to be stronger than the will to fail.) The SLA is an agreement, not a weapon!</p>
<p>Critical steps and checklist; summary slide of service and mgt. elements Slides 13-15</p>	<p>(Slide 13) Introduce the critical steps by explaining that these are the practical steps in implementing an agreement. Note the following:</p> <ul style="list-style-type: none"> • The SLA team may have some of the same players as those on the team that conducted the earlier pre-bid study. • ‘Educate all parties’ means educating all hospital managers (including the head matrons and ward head nurses) to the nature of the SLA (i.e., it’s an agreement based on a common understanding...) • Sticking to the timeline is critical to ensure a smooth transition and mobilization period. <p>Review the SLA checklist (slide 14)</p> <p>Ask group to provide specific experience on assessment:</p> <p><i>How would you establish a baseline? Quantitatively? (e.g., measuring how long key tasks take to execute; establishing service costs, etc.) Anecdotally? (Patient satisfaction surveys, etc.)</i></p> <p>Make sure the group understands how the SLA gets drafted and vetted. I.e., the hospital drafts the SLA incorporating in</p>

		<p>as much of the vendor’s proposed implementation approaches as is desirable (from the hospital’s viewpoint); hospital negotiates the agreement back and forth with the vendor until both parties agree on the terms.)</p> <p>Slide 14—Ask participants to answer these two questions:</p> <ul style="list-style-type: none"> • <i>Distinguishing the Process from the Document: why it is not about filling the blanks?</i> (It requires iterative work by a team and negotiation with the vendor.) • <i>Who establishes the SLA?</i> (The hospital in partnership with the vendor) <p>Slide 15. Present the 3 service elements and 4 management elements and explain that we will work on the service elements for the rest of the day today and then tackle the management elements tomorrow.</p>
<p>Session 7:</p> <p>Key service elements and Small Group Work to Draft Task Descriptions and Standards for 4 Services</p> <p>Total time: 4.5 hours</p> <p>10:00 – 10:30 (continues after break and through to end of the day)</p>	<p>Graphic of the 3 elements; Walk-through the context section</p> <p>Slides 18- 19</p>	<p>Slide 18 - Explain the graphic of context (why), task descriptions (what) and task standards (how)</p> <p>Show slide 19 and also distribute the SLA Outline document (Note: the slides here follow the order of the 3 sections of the SLA listed in the document.)</p> <p>Very briefly walk participants through the elements of ‘context’ but tell the group we will not spend time here in the workshop on these items because hospital managers and the MoH know them already. Instead, our emphasis will be on the service information and management information sections of the SLA.</p>
	<p>Task Descriptions and Standards; Sample Task</p> <p>Slides 20-23</p> <p>(this section= 30 min.)</p>	<p>Present the definition of task descriptions (slides 20-22) Clarify each of the elements, illustrating with examples drawn from the group.</p> <p>Show the sample task description (slide 23) and use it to illustrate:</p> <ul style="list-style-type: none"> • The distinction between a task (output) and an activity (sub-task) • The standards that define in precise terms how the task should be executed • The methodology which you would likely use for quality assurance purposes (how you will monitor)

		<ul style="list-style-type: none"> This work to define tasks also helps you cost your activities, by providing a level of detail that facilitates the calculation each costing element.
Break 30 minutes		
<p>Session 7 cont'd Key Service Elements 11:00 – 1:00</p>	<p>Table Group Exercise 1: Identifying Tasks, Task Standards, and Quality Assurance Methodology for 4 service areas.</p> <p>Slide 23</p> <p>Timing breakdown: ID group leaders and table groups: 15 min.</p> <p>Table Group Exercise 1 45-55 minutes</p>	<p>Explain to the group that we will now have a table group exercise on drafting task descriptions for 4 service elements:</p> <ul style="list-style-type: none"> Housekeeping/cleaning Food Service Laundry Security <p>Explain: This group work will accomplish two things: it will teach the process for drafting SLA service information for any nonclinical service, and it will enable the group here to get a head start of the SLAs they need to put into place with their current and near-future providers.</p> <p>Identify a group leader for each of the 7 groups. Group leader = someone with experience/knowledge in the service area. Once the group leaders are identified, ask the rest of the participants to either join the service area table where they are already sitting or move to a different service area table. Facilitate this regrouping quickly. (Note: is the group is large, then have 2 groups work on housekeeping, 2 on security, etc.; table groups should not have more than about 6-7 members.)</p> <p>Hand out copies of the blank worksheets to each table group to use to capture their work. Also give them a copy of the sample worksheet for reference. (Note: If some table groups have a computer, then give them the e-copy of the template and let them input their work directly.)</p> <p>Give this instruction:</p> <ul style="list-style-type: none"> Brainstorm a list of all possible tasks for your assigned service areas. Select 5 tasks from your list to focus on for this exercise and enter them onto the worksheets (1 task per worksheet). For each task, identify the standards of task execution (those that apply) and the methodology you would use to assure quality (monitoring). Pick one of your complete tasks to present to the

		<p>large group; write this task on the flipchart template (provided) for presentation. Tell the groups not to worry about identifying the activities for now—that is the next exercise.)</p> <p>(Note: Trainers circulate among the tables and support the groups during their initial brainstorm. Help the groups gauge the scope of the ‘tasks’ (not too broad; not too narrow).</p>
	<p>Table groups present to plenary</p> <p>30 - 40 minutes</p>	<p>When the groups are finished, ask a representative from each of the groups to come forward and present their task, standards, and quality assurance methodology. Allow a couple of minutes for clarifications and suggestions from the other groups but keep the pace moving.</p> <p>As the groups show their tasks and standards, provide guidance as appropriate. For example: If the groups say they expect the vendor to be available 24/7, push them to think about whether or not that is absolutely critical and if the hospital can afford that level of coverage (i.e., are there other ways to provide coverage that would be less costly? Etc.)</p> <p>For the quality assurance methodology, make the point that the monitoring should not be burdensome. It should be the minimum effort that will assure the needed quality.</p>
Lunch 1 hour		
<p>Session 7 cont’d Key Service Elements</p> <p>1 hour, 50 minutes</p>	<p>Table Group Exercise 2 Identifying Activities for Each Task Slide 24</p> <p>45-55 minutes</p>	<p>Have the participants reconvene in the same groups they were in for the previous task. Explain that they will now complete the service information template by adding the detailed activities for each task. Review the instructions on the slide:</p> <ul style="list-style-type: none"> • <i>For each of your 5 target tasks, identify all of the activities (sub-tasks) that must be performed by the service workers in order to accomplish the task</i> • <i>List these activities in the appropriate field on the worksheets.</i> • <i>If there are specific activities relating to the task which the service provide should NOT perform you may a) list those separately or b) note that ONLY the tasks listed should be undertaken and no others.</i> • <i>Prepare a flipchart with one of your tasks and associated activities to present to the group.</i>

	Table groups present exercise 2 to plenary 30 - 40 minutes	Ask a representative from each of the groups to come forward and present their selected task and activities. In similar fashion to the previous group sharing, allow a couple of minutes for clarifications and suggestions from the other groups but keep the pace moving.
End-of-Day Wrap-Up 3:50 pm 10 minutes.	Summary of Day 1 Preview of Day 2	Wrap-up the day by asking participants to comment on the experience of detailing out the service information: What was easy/difficult about the exercise? What does it reveal to you? Underscore the point that hospitals owe service providers a clear explanation of their needs—if we don't tell them what we need them to do, then we haven't done our homework. Use slide 16 (service and management elements in the SLA) to summarize what we've covered in today's sessions and where we are headed tomorrow. Congratulate the group on their active participation in the table group exercises.
Day 4		
Morning Take-Aways 8:30 – 8:45 15 min.	Key Learning from Yesterday/Review of Today's Agenda	Ask participants to share "take-aways" from yesterday's sessions, in particular the table group work: <ul style="list-style-type: none"> • <i>What was one of the most significant things you learned yesterday? Why was it important?</i> • <i>Are there any burning questions from yesterday?</i> (Address as much as possible) After a few participants have shared, move on to review the agenda for today (written on flipchart) and indicate where we are in the overall process using the flowchart as a reference.
Session 8 Key Performance Indicators and Service Point Approaches for Contract Management 8:45 – 9:45 1 hour	Definition of KPIs and examples of current KPIs hospitals are using Slide 27 20 minutes	Ask the group to share some of the KPIs they are currently using in their hospitals to measure performance (be it an out-sourced service or an internal department, e.g., pharmacy). Draw from their examples to define KPIs. Key points: <ul style="list-style-type: none"> • Hospitals need to select the fewest possible KPIs that will enable them to measure vendor performance: Test: If these KPIs are achieved,

	<p>Identifying KPIs for the 4 key service areas</p> <p>Slide 28</p> <p>20 minutes</p>	<p>then will we be getting the level of performance we need?</p> <ul style="list-style-type: none"> The hospital does not need to monitor all the activities leading up to the KPI (vendor does the day-to-day monitoring at the activity and task levels; hospital uses the KPIs to determine vendor’s contractual performance. <p>As a check on understanding, do the following brief exercise:</p> <ul style="list-style-type: none"> Consider the service information you drafted yesterday for each of the 4 service areas. What are 1-2 examples of KPI for each of those areas? <p>Possible examples of KPIs: Cleaning - Promised level of staffing on key shifts. Laundry: Always X level of clean linen on the unit.</p> <p>(Note: time-permitting, do this as a table group exercise. If time is short, simply ask participants to offer examples and write these on the flipchart for group critique.)</p>
	<p>Service Point approaches for performance management</p> <p>Slide 29</p> <p>20 minutes</p>	<p>Explain the different types of service point approaches hospitals may include in their SLAs to manage their vendor’s performance. Using the service information the groups generated on the previous day, give 1-2 concrete examples of how service points might be applied.</p> <p>Illustrative example for a Housekeeping SLA:</p> <p>You establish 10 KPIs with a value of 10 points each. Using the monitoring data derived from reports and verified using spot checks, you rate the vendor’s performance and apply the points to determine payment-</p> <p>81-100 points =all is well = full pay 80 and below = problems to resolve = deduct % (this is a simplified approach)</p> <p>Options: wait to reduce while you try to work with the vendor to resolve the performance problem; also, can repay the vendor if they remediate the problem within a specified time.</p> <p>Ask if any participants have had experience with this type of performance-based system and if so, to share their lessons learned and good practices. Emphasize the need to apply the system with consistency and a “good faith” attitude (unlike the hospital in the earlier case study).</p>

<p>Session 9</p> <p>SLA Management Elements</p> <p>9:30 – 10:30 (continues after break)</p> <p>Total session time: 3 hours</p>	<p>Management Cycle Slide 31</p> <p>30 minutes</p>	<p>Show the diagram of the management cycle and walk participants through the 4 components. Explain that we have already delved into monitoring during the table group exercises yesterday (e.g., monitoring methodologies such as checklists based on the individual activities for a given task)</p> <p>Key point: If there is a breakdown anywhere in this cycle, then the entire system will be compromised! (e.g., no need to monitor is you are not reporting; if you are not getting the reports you need, they hard to do periodic evaluation, and so forth.)</p>
<p>Break 30 minutes</p>		
<p>Session 9</p> <p>SLA Management Elements (Continued)</p>	<p>Objective and subjective monitoring of contract/KPIs Slide 32</p> <p>Approx. 50-60 minutes</p>	<p>Drive home the point that ‘Monitoring’ here refers to the contract itself (and more specifically, the KPIs that have been established,) not the employees of the vendor. The vendor can do most of the day-to-day monitoring, but spot checks have to been performed by the Hospital as part of ‘due diligence’.</p> <p>Monitoring at this level is done to assess compliance in task execution and Customer Organization satisfaction.</p> <p>Focus participants back on the KPI examples they identified in the previous session. Select 1-2 and have participants identify objective and subjective means to monitor these.</p>
	<p>Reporting Slide 33-35</p>	<p>Ask the group: <i>What would be the management reports that you want to see?</i> <i>What is the current system? For example, what kind of monthly summary report is the hospital administration getting from the laundry department manager?</i></p> <p><i>What kinds of reports do you expect from your pharmacy department (i.e., an internal dept.) How is this similar/different from what you expect of your outsourced vendors? Why?</i></p> <p>Key points: Two levels of monitoring and reporting: 1) Day-to-day monitoring (done by vendor) 2) Management level reporting, i.e., summary report on key aspects of the department service—staffing issues, quality issues, etc.</p> <p>Ideal scenario:</p>

	<p>Reporting Exercise: Slide 36</p>	<p>Vendor Department Head consolidates reports on staffing issues, quality issues, etc. S/he creates a summary report to send up to vendor supervisor and to hospital administration. This approach separates the hospital from the day-to-day running of the department. If the hospital has reason to believe the reports are not accurate (are fudged) then they can request to see the monitoring audit checklists and other raw data.</p> <p>Reports might include:</p> <ul style="list-style-type: none"> • Monthly staffing report – turnover; vacancies • Monthly budget report—is it running according to the contract? • Inventory on-hand (special level of supplies on hand) • Major machine downtime. • Summary totals of quality reviews (by major units) <p>Relationship of KPI and reports: If the laundry contract has a KPI stipulating “Always X level of clean linen on the unit”, then the management report will focus on the vendor’s quality check to ensure x level of clean linen on the unit.)</p> <p>(Note: Concrete current issue at Princess Marina Hospital: Laundry department has mounds of wet linen waiting to be dried because 2 dryers are broken and the functioning dryer has to be run many more hours/day to get sufficient laundry done and out. Up on the ward floor—shortage of linens.)</p> <p>KPI—Infection monitoring: this is trickier to address. E.g., Housekeeping is not doing a good job. Hospital-acquired infection rate goes up. Hospital says, “it’s housekeeping’s fault”. Housekeeping vendor says: “how do you know your instruments were sterilized properly”? Can’t confirm the problem is actually with the housekeeping service unless you do an appropriate clinical investigation.</p> <p>Show the reporting table and the examples. Have participants suggest other reports they expect from their providers, based on the task descriptions and KPIs for the 4 service areas.</p>
	<p>Evaluation Periodic Review Change Process</p>	<p>Explain these final 3 steps in the management cycle and engage the group in discussion about how they are doing this now versus how they would like to do it in the future.</p>

	Problem Resolution Slides 37-40	<p>Reinforce the earlier messages about:</p> <ul style="list-style-type: none"> • The need to establish a partnership with the vendors and manage the contracts based on good faith effort from both of the parties. • Issues should emerge from an objective monitoring and reporting based on the KPIs not on arbitrary ‘feelings’. • Sometimes mediation and arbitration are needed if the parties cannot come to agreement on how to resolve a particular issue. • In many ways, the SLA sets up a vendor and hospital relationship not unlike an arranged marriage! • Hospitals have every right to expect quality from their vendors but if you are trying to build local capacity in the service areas, then you may need to provide some specialized training to the vendor that they are not prepared to do at this point in time (e.g., infection control); in this situation, you may ask for a reduction in the contract costs to off-set the hospital’s expenses incurred to provide the training • In general, contract management requires good skills in supervision, communication, problem solving and conflict resolution; hospitals and MoH will need to make sure their staff members get opportunities to build/strengthen their capacity in these areas.
	Additional Appendices Slides 41-42	Time-permitting, show the two slides listing possible appendices to include in the SLA.
Lunch 1 hour		
Session 10 Final Summary, Burning Questions and Next Steps 60-90 minutes	Final Summary + Burning Questions Slide 44	<p>Summarize the workshop by asking participants to identify key messages they are taking away from both Part 1 and Part 2 of the workshop:</p> <p>What are the most important messages/learning about the bidding process (pre-bid study, the offer-to-bid document, evaluating the bid and overall management considerations and best practices) and the SLA process and document (service information, management elements and cycle?)</p> <p>After participants have provided their responses, query the group to see if anyone has a burning question they would like to pose (more information, greater clarity).</p>
	Next Steps	Ask the group to create a brief action plan that will help them bridge from the learning and exchange here to the

	Slide 45	<p>work ahead with their actual bidding, contract negotiations and contract management roles and responsibilities.</p> <p>Examples of possible actions:</p> <ul style="list-style-type: none"> • Keep working on the Service level section of SLA tasks and standards—create task forces or other ways to pool the effort. • With current vendors: Meet to clarify issues and move forward. Weekly meetings with the vendors to discuss monitoring and request monthly management reports if they are not doing them now. • MoH to clarify how they will work the hospitals—key steps they will take to move forward. Also, clarify delegation of authority.
<p>Post-Test + Workshop Evaluation</p> <p>20 minutes</p> <p>WORKSHOP ENDS</p>		<p>Have participants complete both the post-test document and the workshop evaluation.</p> <p>Ask for any closing remarks and then thank the group for all their attention, hard work, and sharing of insights, lessons and good practices with colleagues.</p>

ANNEX H: SAMPLE TASK WORKSHEET

Task Name	Availability	Frequency	Responsiveness	Timeliness
Between Case Cleaning of the Operating Room (OR)	12 hour/day, 12 hour/day on call, 7 days a week	after every operation: (between case cleaning)	OR room cleaning starts within 15 minutes during staffed hours	OR cleaned in 25 minutes
Activities (NB, items not listed here are off limits for cleaners)				Quality Assurance Methodology
Remove medical waste Sanitize the floor Wipe down table				Detailed audit tool for OR cleaning elements (e.g., no stains on walls, floor visibly cleaned) Other Methods, possibly not applicable here: <ul style="list-style-type: none"> • Visual Inspection • Nurses' complaint report • Patient questionnaires • Swabs cultures

ANNEX I: SAMPLE SLA TEMPLATE

SLA Template

I. Context-Setting Information

- Cover page
- Glossary of key terms
- Table of contents
- Parties to the agreement
- Purpose of the SLA
- Scope of the SLA
- Related documents
- Signatures and date

II. Service Information

A. Description of Tasks

1. The environment for which the service is being provided
2. The tasks covered by the SLA, including such information as:
 - (i). Task description, including activities involved if relevant
 - (ii). Task availability (Standard hours and extended or limited availability, during weekends, holidays, etc.)
 - (iii). How implementation of the task is triggered (this could be automatically at every shift, or every 6 hours, or through a specific call e.g. for maintenance of an electrical fuse)
 - (iv). Prerequisites
 - (v). Contact information
 - (vi). Financial information (cost per task, if relevant, budget if relevant)
 - (vii). References
3. Tasks *not* covered by the SLA, if Customer Organization might reasonably assume the Service Provider might cover these tasks

B. Standards of Task execution

Standards of Task Execution generally revolve around, but are not limited to, the following.

1. **Availability:** the dates or time periods during which personnel will be available and/or the task will be performed
2. **Responsiveness:** time periods within which certain actions or outcomes will occur under different conditions
3. **Timeliness:** date or time by which certain actions will be taken or outcomes will occur under different conditions
4. **Rate or Frequency:** the rate or frequency of specified tasks, results or outcomes
5. **Quality:** the occurrence of specific positive or negative outcomes

C. Identification of Key Performance Indicators (KPIs)

1. Once the standards have been determined for each task, a subset of priority and easily measurable standards has to be selected to identify KPIs. Success or failure of the Service Provider in complying with KPIs will influence payment amount and schedule.

2. Each KPI can be associated with “service points”. Failure to reach a certain level of performance will result in collecting failure points. The percentage ratio of failure points to total available service point will serve as the basis for proportional reduction in payments, to be assessed at the Evaluation stage (see below).

D. Monitoring

Describe the monitoring that will be done to assess compliance in task execution and Customer Organization satisfaction.

1. Monitoring of key performance indicators

This refers to monitoring objectively pre-established indicators that closely align with the level of performance required by the Customer Organization

2. Monitoring of subjective perceptions

This can be as relevant as the previous monitoring level and can be referred to third parties, such as clients of the Customer Organization

E. Reporting

Provide information about the reports that will be generated from the Monitoring of any relevant data. Details may include:

1. Reports to be generated;
2. Party responsible for generating each report ;
3. Report recipients;
4. Frequency and schedule of reports;
5. Report medium;
6. Aspects of the reported information of particular interest.

F. Evaluation

Provide information about the periodic evaluation and reports as it is done both at the Customer Organization and Service Provider level as well as in joint sessions. The Evaluation of the reports will influence payment schedule and/or amount as per prearranged service points system. Steps in the Evaluation Stage might include, at Customer Organization level:

1. Collection of reports and scoring of KPI's;
2. Sharing evaluation with Service Provider;
3. Establish Service Improvement Plan if applicable;
4. Preparation of payment deductions if applicable.

III. Management Information

A. Periodic Review

1. Review objectives;
2. Review frequency.

B. Change Process

1. Establish a contract review & revision panel;
2. Identify conditions warranting change in SLA;
3. Establish review and revision frequency;
4. Establish change procedures;
5. Update a change log.

C. Problem Resolution

1. Discussion negative evaluations with Service Provider;
2. Arbitration with pre-arranged third party if necessary;
3. Filing of evaluation in permanent record kept for Service Provider.

IV. Appendices

- Pricing/cost/budget information
- Additional service details
- Product information
- Glossary of service definitions
- Contact information
- Change log
- Holiday list

Possible Additional SLA Sections

- Procedure for establishing a Service Improvement Plan;
- Escalation path in case of failure to meet service standards;
- Renegotiation procedures;
- Conditions and procedures for termination of the SLA.

ANNEX J: OUTSOURCING WORKSHOP PRE-POST TEST

Outsourcing Nonclinical Hospital Services
Capacity-Building Workshop
Pre-Post Test

1. Who is responsible for managing an outsourced contract?
 - The outsourced company headquarters
 - The hospital manager
 - The Ministry of Health PPP Unit
 - Both the company and hospital managers
 - The company department head

2. Who is responsible for supervising outsourced service workers?
 - The hospital outsource managers
 - The company managers
 - The Ministry of Health
 - Both the hospital outsource managers and the company managers
 - Nursing unit managers

3. A company bid submission will include (select all that apply):
 - Mobilization plan
 - Guaranteed staffing levels
 - Worker orientation and training program curriculum
 - CVs for proposed department managers and supervisors
 - Quality assurance reporting plan
 - Specifications for required supplies and equipment
 - All of the above

4. True or False? The bid document should contain a general overview of the services to be provided in the contract, but it is not necessary to go into the detail of those services.
 - True
 - False

5. General conditions of the bid document include: (select all that apply)
- Description of the facility
 - Staffing levels per day per shift
 - Contract duration
 - Permits and licenses
 - Statement of compliance with legal requirements
 - Confidentiality
 - All of the above
6. What is a Service Level Agreement (SLA)? (select all that apply)
- Communication Tool
 - A tool for defining and managing expectations
 - A way to assure the company will comply with the agreed-upon level of service and quality
 - All of the above
7. What do you find in an SLA (Select all that apply)?
- A definition of the major tasks
 - A set of escalation steps for conflict resolution
 - Information about the hospital circumstances and context
 - Setting of task standards
 - All of the above
8. What are management elements in an SLA? (select all that apply)
- Change process
 - Definition of the tasks
 - Management of fiduciary risks
 - Monitoring
 - Reporting
9. Key Performance Indicators can be used in an SLA to assign: (Select all that apply)
- Credit Points
 - Service Points
 - Debit Points
 - Failure Points
 - None of the above
10. An SLA should not be used to: (Select all that apply)
- Discuss negative evaluations with the company
 - Conduct arbitration with a pre-arranged third party if necessary
 - File evaluations in permanent record kept for the company
 - Oblige the company to comply with any hospital request

ANNEX K. SLA TECHNICAL ASSISTANCE WORKSHOP OUTLINE

Day #1 – July 8, 2014

Introduction

This is a Technical Consultation that will be conducted in the form of a “[Laboratory Workshop](#)”. We will be working together to strengthen the SLAs for:

- Catering
- Security
- Cleaning
- Laundry

The hospitals have done some good work on:

- Defining tasks
- Standards
- Reports
- Monitoring systems

But there are many details missing that will cause confusion and disagreements between the hospital and contractor. We are going to drill down and fill in the blanks where detail is missing.

Activity: Each hospital makes a list of Conflict Points with Current Vendors

- When has Friction developed?
- When have Emotions been involved?
- When has a Lack of Respect been demonstrated?

Goal: To help the hospitals minimize potential points of conflict using contracts that clearly articulate standards, expectations, processes and monitoring procedures.

- List will be continually referred to during the work on SLA's to demonstrate how carefully drafted and detailed SLA's can reduce conflict;
- List will be used to help develop the [Negotiation and Conflict Resolution Workshop](#) to assure that examples and exercises are relevant to participants.



Review List of Conflict Points with Current Vendors

Important Quality Issues that must be addressed in managing Outsourced Services:

- **Accountability:** roles and responsibilities of hospital vs. contractor. Ultimate responsibility rests with the hospital CEO for ensuring that the contract requirements have been met.
- **Accreditation Standards:** how will they be applied?
- **Infection Prevention and Control:** relevant professional within the health care institution is responsible for training oversight, audits. Accountability for infection prevention and control *always* remains with the health care institution.
- **Training and Education:** The accountability for training needs to be clearly stated in the service specifications – who is conducting the training, qualifications needed to be attained by the workers and managers.
- **Service Specifications:** “A good contract is one in which the organization knows what it wants and states it clearly. It contains quantitative and qualitative acceptance criteria and provides thresholds for rejection.”
- **Infrastructure, Maintenance and Facility Management:** Where contract service responsibility ends and maintenance or engineering work begins is a common point of dispute.
- **Auditing Processes to Measure Outcomes:** define in detail. Examples of tools, frequency, responsible parties, etc.

Expectations of Service Provider

1. Service Delivery Procedures

- Minimum frequencies and methods – services are to be provided at *whatever* frequencies are deemed necessary in order to meet required standards
- Staffing – rosters for full-time, part-time and relief staffing numbers as well as for management and supervisory positions
- Equipment – including provision of consumable items
- Management Functions

2. Organizational Chart

- Function reporting lines
- Organization reporting lines
- Relationship between units, including the role of any subcontractors
- Details of any other personnel responsibilities

3. Skills and Qualifications

- 4. **Training:** details of staff training programmes for all levels including course type and level, course objectives, course provider, length of course and frequency of training. Orientation program details

5. **Staffing Levels:** applied to each area. Details for multi-tasking and how such personnel would be managed and supervised to ensure there is no decrease in service performance
6. **Peak Loads and Contingency Planning:** industrial action, utility failure, community disaster
7. **Performance Standards:** KPI's

*From: Cleaning Standards for Victorian Public Hospitals 2011

www.health.gov.au/cleaningstandards/standards.htm

Task Descriptions vs. Task Standards in draft SLAs

Description: Availability/Trigger/Prerequisite/Contact Person (Keep costing data separate).

Standards: Availability/Frequency/Responsiveness/Timeliness

- This is vague and confusing; they overlap.

Let's work to simplify and clarify this.

Activity – Food Service: Each hospital makes a comprehensive list of current issues, concerns, barriers to good service at their institution

Food Service - Potential Impacts

- Physical layout of hospital space
 - Location of kitchen
 - Pantries on the units
 - Storage capacity
 - Energy/Water systems
 - Loading Dock capacity
- Patient population – age, ethnic mix, religion
- Service Mix – Need for special diets
- Geographic location of hospital
- Labor relations
- Food preferences vs. costs
- Job Tasks mixing
- Staffing pattern
- Wastage levels
- Hygiene
- Dietician coverage, expertise

Groups present their lists. Discussion:

How do you expect out-sourcing to address these?

Which problems will out-sourcing not solve?

What are your priorities for solving these problems?

Do you know your costs? How much more will you need to pay to fix some of these?

Activity – Defining Tasks and Standards

Food service: 8 Tasks:

Task 1: Purchasing

Task 2: Receiving



Task 3: Storage

Task 4: Food Preparation

Task 5: Plating

Task 6: Transporting and Serving

Task 7: Clearing and Wash-Up

Task 8: Cleaning of Kitchen

Discussion: Company Policies & Procedures vs. Service Level Agreement Task Descriptions

Task 1: Purchasing

Company Policies and Procedures: Absolute key to understanding how the company intends to do its work.

- What are the P&P the company follows for vetting suppliers, assuring food quality, bidding contracts, reporting costs?
- Proprietary Information – may need to guarantee protection

Service Level Agreement

- **Availability:** Procurement personnel on-site or at company?
- **Frequency:** How often are orders placed to assure agreed upon stock levels? (This may be influenced by geography)
- **Responsiveness/Timeliness:** When is hospital notified of problems and by whom?
- **Quality Assurance:** Stock room quantity checks, menu substitutions

Task 2: Receiving

Company Policies & Procedures –Defines the Activities

Service Level Agreement – Defines facility specifics for completing the activities

- **Availability/Frequency:** Company provides delivery schedule for coordination of Loading Dock space and personnel x number of days prior to scheduled delivery
- **Responsiveness/Timeliness:** Hospital delivery schedule change notification provided when? Who is the food service supervisor/manager responsible for this function?
- **Hygiene – Part of all Tasks:** What are the P&P that govern employee hygiene? How do food service supervisors monitor hygiene of employees, equipment, kitchen, unit pantries?

Activity: Group completes the Task Availability/Frequency/Responsiveness/Timeliness Grid for the 8 Tasks.

Review of Current Draft SLA Provision of Food Service Document:

I. Client vs. Service Provider Responsibilities:

- Food safe for consumption?
- Ensuring that suppliers comply with “set regulations” ?

- Service provider “meeting and maintaining “acceptable standards”?”
- Dietary guidelines? Which ones
- Pest control – whose responsibility?

2. Description of Tasks

References – “relevant standards” – define

3. Mobilization Tasks/Schedule – missing

4. Menus/menu rotation/special diets/coordination with professional Dieticians

5. Bulk vs. Plated – Methodology for Service - ?

6. Monitoring – client right for access/monitoring at anytime

Day #2 – July 9, 2014

Activity - Environmental Services: Each hospital makes a comprehensive list of current issues, concerns, barriers to good service at their institution:

Cleaning – Potential Impacts

- Architectural Design
- Unit configuration (i.e., housekeeping closets on every unit?)
- Adjacencies
- Building Materials
- Infrastructure Problems
- Traffic patterns
- Inventory and Quality of Equipment
- Equipment Maintenance
- System for staff assignments
- Consistency of Supervision
- Customer Service Attitude
- Medical Procedure scheduling
- Fluctuations in Patient Volumes by shift, days, months

Groups present their lists. Discussion:

How do you expect out-sourcing to address these?

Which problems will out-sourcing not solve?

What are your priorities for solving these problems?

Do you know your costs? How much more will you need to pay to fix some of these?

Capital vs. Labor costs analysis for equipment investment

Functional Area Risk Categories: - Compare SLA Draft with Australian document

A. Very High Risk

- Operating Theatres
- Invasive Procedure Rooms
- ICU
- Neo-Natal Nursery
- Central Sterile Supply
- Special Needs Patient areas: i.e., immune-suppressed patients wards

B. High Risk

- Sterile Stock Storage
- Emergency Department
- Pharmacy Clean Area
- General Ward

C. Moderate Risk

- Rehabilitation Area
- Pathology
- General Pharmacy
- Kitchen/Pantry – (E.S. department responsibility?)
- Laboratory
- Morgue
- Radiology (non-invasive)
- Outpatient Clinic
- Waiting Room
- Day Activity
- Residential Area
- Cafeteria
- Equipment Cleaning room

D. Low Risk

- Administration - offices
- Non-Sterile Supply
- Record Storage
- Engineering Workshop/Plant Room

Activity – Each hospital defines for each functional area:

- Availability
- Frequency
- Timeliness – Timeframe for rectifying identified problems
- Quality Assurance Methodology - Audit tools

Sample Audit Tool for Routine Daily Patient Room Cleaning

Area Monitored	Compliance			Deficiency Noted
	Yes	No	N/A	
Supplies				
There is a one-day supply of toilet paper, paper towels, soap, ABHR, gloves				
The sharps container is less than 3/4 full				
Waste has been removed				
Soiled linen has been removed				
Surface Cleaning				
Doors, door handle, frame and push plate				
Walls (visible soiling)				
Curtains (visible soiling)				
Light switches				
Thermostat				
Wall mounted items (e.g., ABHR dispenser, glove box holder)				
Glass partitions, door panels, mirrors and windows				
Chairs				
Window sill				
Television plus cords				
Telephone				
Computer keypads				
Night table, overbed table, side tables, desks				
Top of suction bottles				
Blood pressure manometer				
IV poles				
Intercom				
Bedrails, bed controls				
Call bell and cord				
Mobile equipment (e.g., walker, wheelchair)				
Linen hamper (all surfaces)				
Bathroom Cleaning				
Mirror				
All dispensers and frames				
Chrome wall attachments				
Door handle and frame				
Light switch				
Wall mounted dispensing machines				
Call bell and cord				
Support railings				
Ledges, shelves				
Sink and faucets				
Shower, including faucets, shower head, soap dish, grout				
Toilet, including attached seats, handle, underside of flush rim				
Floor Cleaning				
Floors				
Carpets				
Compliance Rate				
Total number of 'Yes'				Compliance Rate:
Total number of 'No'				
Total number of items ('Yes' and 'No', exclude 'N/A')				

Cleaning Standards Audit

- Hospitals require a comprehensive, continuous, systematic approach to monitoring cleaning outcomes
- Internal audits should be performed in all functional areas across all function area risk categories
- Audits are documented and shared between contractor and hospital
- Audit teams – contractor and hospital representatives
- Standards set – for functional area risk categories
 - Very high risk – 90%. Over a period of one month 50% of the rooms at least once per month
 - High Risk – 85%. Over a period of one month 50% of the rooms at least once per month
 - Moderate Risk – 85%. Over a period of three months 50% of rooms at least once
 - Low Risk – 85%. Over a period of 12 months all rooms at least once

Unannounced “rounds” a hospital right –

Remember: Contractor Policies & Procedures define Activities

Assure Management of Sub-Contractors

- Window washing
- Pest Control
- Grounds

Roles and Responsibilities:

Institute for Health care Improvement: Safety First Blog

“Our hospital uses the tiered approach to environmental hygiene that’s been recommended by the [Centers for Disease Control and Prevention](#) (CDC). This starts with a checklist to be sure we’re all in agreement about not just what needs to get cleaned, but also who is responsible for cleaning. In certain areas, nursing staff are responsible for cleaning particular items in a room. Our housekeepers are responsible for cleaning other items in a room. In the OR, anesthesia may be responsible for cleaning their carts. Dietary is responsible for cleaning specific things. So, we use a checklist to delineate those responsibilities.”

Activity – Laundry and Linen Services: Each hospital makes a comprehensive list of current issues, concerns, barriers to good service at their institution:

Laundry and Linen Service – Potential impacts:

- Census/seasonal variations
- Laundry Equipment quantity and condition
- Functional layout of department

- Unit clean and dirty linen storage facilities
- Water temperature
- Transportation method and routes
- Laundry from other facilities also processed
- Sluicing – (Noted as an infection control hospital issue by consultant)

<http://www.laundry.co.za/useful-info/handling-info2.php>

Ward sluice room

No sorting or counting of linen should take place in the ward sluice room. Sluicing at ward level is a fairly common practice at hospitals and should be discouraged as the handling of infected linen, particularly in its dry state creates considerable airborne lint close to patients and may result in cross-infection. Sorting and sluicing must be done in a dedicated central area remote from patient care areas.

Discuss list of Current Issues:

One vendor for all the laundries:

Have the hospitals have different experiences?

What do you think contributed to those differences?

Review Draft SLA Agreement – Discussion:

How does this compare to existing contracts?

Does it address points of dispute? What is missing?

Has it addressed targets for strengthening?

Do existing contracts allow hospital to adjust contractor staff on site?

Client: Provide “reasonable” repair and maintenance to infrastructural defects – what is this?

Service Provider: “Meeting and maintaining acceptable standards” – what is that?

Which accreditation standards?

What is the schedule for personnel medical exams?

“Ensure that appropriate equipment is used for executing specific service tasks” – how is this defined?

“Protecting client property against damage and theft” – Fights with Security contractor!!

On-call availability of contract managers?

Want list of supplies and specifications for supplies

How much equipment will be available – who supplies the equipment? i.e., trollies



A Deadly Fungus and Questions at a Hospital

By IAN URBINA and SHERI FINK APRIL 28, 2014

NEW ORLEANS — The first victim was a premature boy in the intensive care unit whose mother noticed a mysterious irritation in his groin; it grew into an open wound burrowing into the baby's abdomen. The last patient to die was a 10-year-old girl, whose face was ravaged.

Three other patients at [Children's Hospital](#) here were also stricken, including a 13-year-old boy who his parents said endured over 20 surgical procedures in 54 days in a futile effort to save him.

The children died of various causes between August 2008 and July 2009 during an outbreak of a flesh-eating fungal infection, mucormycosis, most likely spread by bed linens, towels or gowns, according to a medical journal.

Fungi thrive in moist environments, and the 40,000-square-foot washing warehouse owned by the hospital's off-site launderer, TLC Linen Services, was just that.

The company, which was not accredited by the main voluntary group that inspects health care laundries, also lacked proper filters on ventilation fans to block spores and dust from the street, records showed. There was also reason to suspect that the outbreak was due to myriad problems with the way hospital workers handled linens, court documents showed.

In the rare instances when linens have been associated with transmitting illnesses, the problem is usually caused by improper transportation or storage, said Lisa Waldowski, an infection control specialist with the Joint Commission, the organization that accredits most American hospitals.

. . . discovered workers at the hospital washing bed linens in a machine there after the outbreak — using a method intended for cleaning floor mops. He said he had explained that the chemicals were too weak and the water temperatures too low to be hygienic.

Day #3 – July 10, 2014

Activity - Security Services: Each hospital makes a comprehensive list of current issues, concerns, barriers to good service at their institution:

Security – Potential Impacts

- Facility layout – internal and external
- Number of entrances/exits; access control
- History of incidents – types, location, time, trends, patterns
- Internal traffic control rules and regulations – visitor, staff and patient
- Identification policies and procedures
- Clinical services with special requirements
 - Psychiatry?
 - Newborn Nursery?
 - Police Lock-up Unit?
- Communications coordination abilities – Internal and External (Community)

Groups present their lists. Discussion:

Why has out-sourcing failed to address these?

What are your priorities for solving these problems?

Do you know your costs? Will spending more fix these problems?

Experience with:

- Staffing adequacy?
- Supervision of workers?
- Management capability?
- Quality of staff?
- Adequacy of orientation and training?
- Integration with hospital systems?
- Customer Service mentality?
- Quality of Reporting to hospital management?
- Monitoring methodology?

Key Performance Indicators – Security – Review Draft Document

- What kind of technical expertise?
- Standards vs. Activities?
- Target vs. Standard? (3 searching operations per month? For # of patrols?)
- “Qualified” personnel – how is this defined

- Number of reported cases of restraining and managing patient movement – 100% target?
- “compliance to standards”?
- Equipment – what equipment. Measure = compliance?
- Protective clothing? Vs. Uniforms – what is “proper”?

Activity

1. Each hospital develops a list of key security service tasks. For each routine task the availability and frequency is determined. For non-routine tasks timeliness of response is determined.
 2. A list of required reports from the contractor is developed
- Hospital contract manager compares Incident Reports with Security reports
3. A proposed schedule of meetings with the contractor is developed:
 - Who meets?
 - How often?
 - Agenda?

Wrap-Up

Go back to Quality Issues that must be addressed. Have our edited SLA’s addressed these issues?

Next Steps

Individual hospital visits

- Identify key operational issues
- Review roles and responsibilities of contract managers
- Meetings w vendors
- Demonstrate Administrative Rounds

Complete drafting of Service Level Agreements including customization by hospitals – hospital management teams with Ministry of Health

ANNEX L. CONFLICTS WITH OUTSOURCING VENDORS

Hospital #1:

1. Absenteeism
2. Wrong qualification and experience
3. Late Payments
4. Lack of Professionalism
5. Security not willing to pay for theft or damages occurred on the hospital
6. Negligence of Duty
7. Supply of poor quality consumables and short supply of consumables
8. Breach of confidentiality
9. Code of conduct of employees
10. Employees not knowing the extent of services, i.e., areas to be covered by the company

Hospital #2:

1. Payments not done on time; as a result the company lodged a complaint to the Permanent Secretary
2. The employees went on strike (mini) because they were not paid on time and their payment structure and hours of operation were not clear.
3. The vendor not providing enough consumables and a meeting was held. Vendor showed that it was not his vault but hospital's because they were not paid on time.
4. There is shortage of staff which leads to insufficient service delivery.
5. Misconduct of employees- One day a security guard got violent because he was not paid. Police were called.
6. Inexperienced managers failing to comply with quality standards and contract requirements.

Hospital #3:

1. Conflict Points:
 1. Vendor did not abide with the personnel qualification as stated in the contract
 2. The vendor included a service that was not supposed to be paid for the first year of the contract (payment for maintenance team)
 3. Vendor not providing all consumables (sanitizers)
 4. Providing low quality consumables (i.e. toilet paper)
2. Lack of Respect:
 1. Not following payment protocol – skipping a relevant officer (laundry supervisor) and taking invoices for authorization to another officer)
3. Emotions:
 1. Poor reaction to feedback on the services the vendor is providing
 2. Emotions flaring due to miscommunication over not properly washed linen (stains and foul smell)

Hospital #4

1. Conflict:
 1. Failure to provide cleaning equipment and chemicals
 2. Payment deductions
 3. Late payment
 4. Cleanliness according to the required standard
 5. Lack of supervision by the vendor – leads to absenteeism
2. Emotions:
 1. Deduction of payments which led to late payments while issue being contested

Hospital #5

1. Conflict:
 1. During Mobilization – internal audits
 2. Failure to comply with contract terms
 3. Poor communication
 4. Lack of professionalism (language, task execution)
 5. Confidentiality
 6. Poor staff allocation
2. Emotions:
 1. During meetings

2. Audit sessions and spot checks (internal & external)
 3. Launching of customer complaints
 4. Complaint letters
 5. Contract employee strike
 6. Notification of contract termination
3. Lack of Respect:
 1. During meetings
 2. During audits and inspections

Hospital #6

1. Conflict:
 1. Compliance to infection control standards
 - a. cleanliness of the kitchen (by swabs)
 - b. food sampling
 - c. testing of food handlers (Med exam)
 2. Serving of left-over food
 3. Failure to adhere to meal service times
 4. Provision of protective clothes
 5. Failure to provide alternative meals when patients do not want prepared meal
 6. Failure to cater for excess patients from out-patient department
2. Emotions:
 1. Non-acceptance of clientele
 2. Late payments to vendors/penalties
 3. Spot checks – unscheduled
3. Lack of Respect:
 1. Nature of hospital stigmatization

Hospital #7

1. Conflict:
 1. Failure to provide qualified key personnel
 2. Damaged linen
 3. Dishonest billing/invoicing (key personnel, maintenance)
 4. Failure to comply with labor legislation (i.e. Residence and Work Permit for non-citizens)
 5. Lack of Communication
2. Emotions:
 1. They go high when clarification on operational issues is suggested.

ANNEX M. CONFLICT RESOLUTION-NEGOTIATION WORKSHOP AGENDA



How to Achieve Win-Win Solutions and Strengthen Relationships Between Hospitals and Vendors

Capacity-Building Workshop in Conflict Resolution and Negotiation for Senior Hospital Managers and MoH Office of Strategy Management/PPP Unit

Workshop 1: July 30-August 1, 2014

Workshop 2: August 5-7, 2014

Gaborone, Botswana

Workshop Goals

Participants will be able to...

- Identify types and sources of conflict that commonly occur in the context of outsourcing of non-clinical hospital services.
- Determine appropriate conflict resolution modes for a variety of conflict situations that present in this setting; identify one's own preferences for particular conflict resolution modes.
- Build skills in the critical communication areas of 'assertiveness' and 'cooperativeness' as applied to conflict resolution.
- Describe the keys to successful negotiation of a conflict/disagreement between hospitals and vendors, particularly those behaviors and practices that lead to "win-win" results.
- Identify best practices for strengthening MOH-hospital-vendor relationships such that conflict situations are prevented or addressed in timely and effective ways.
- Identify and commit to future actions that will advance MOH, hospital and vendor staff capacity to identify and resolve problems before they become intractable.

Workshop Outline/Agenda

DAY ONE

8:30-9:30

Opening Session

- Welcome/Opening Remarks from Mr. Buzwani
- Participant Introductions /Ice-Breaker Exercise
- Introduction to the Workshop Themes, Objectives and Agenda

9:30 – 10:30

Session 1: What is conflict and what are key approaches for handling it?

- Definition of conflict; types and nature of conflict

- Conflict Resolution Modes conceptual model; self-Inventory and scoring to determine preferred styles
- Interpretation of the model; examples of appropriate use of the 5 different modes and the skills required.

10:30-11:00 Coffee Break

11:00 – 12:30 Session 1: Key Modes for Handling Conflict (continued)

12:30 – 1:30 Lunch

1:30 – 3:45 Session 2: Conflict Resolution Skills- Assertiveness and Cooperativeness

- Presentation and Modeling of skills
- Practice conflict communication skills using scenarios and/or real cases identified by the group
- Debrief and conclusions from small group practice
- Controlling emotion in conflict situations and negotiation meetings

3:45 – 4:00 Wrap-Up of Day 1/Preview of Day 2

4:00 Adjourn

DAY TWO

8:30-9:00 Getting Started

- “Take-Aways” from yesterday

9:00- 10:30 Session 3: Keys to Successful Negotiation

- What is negotiation? Examples of negotiation situations from participants (what worked/what didn't work and why?)
- Interactive presentation on Keys to Successful Negotiation using case example/s in the hospital outsourcing context and modeling of specific negotiation skills

10:30 –11:00 Coffee Break

11:00 – 12:30 Session 3 continues (Keys to Successful Negotiation)

12:30 – 1:30 Lunch

1:30 – 3:45 Session 4: Negotiation Scenarios – Planning, Practice, and Debrief

Note: Session 4 will continue into the next morning

- Small group practice steps in planning and conducting negotiation meetings using ‘near-real’ cases involving key players (Hospital Administrators, Contract Managers, Vendor Owners, Vendor Managers, MOH/PPP personnel, etc.).

3:45 – 4:00 Wrap-Up and Preview of Day 3

DAY THREE

- 8:30-9:00 Getting Started**
- “Take-Aways” from yesterday; linkages
- 9:00 – 10:30 Session 4 continues**
- Participants continue with the role-play negotiation meetings
 - At the end, group draws conclusions re: best practices to continue practicing; application to their current/near future outsourcing situations.
- 10:30- 11:00 Coffee Break**
- 11:00 – 12:30 Session 5: Building Good Relationships to Reduce Conflict and Improve Negotiations**
- Drawing from the previous scenarios, participants identify strategies, actions, attitudes and behaviors that are needed for building good relationships between hospitals and vendors.
 - Using a contracting continuum (bidding period, negotiation of terms, mobilization period, on-going contract management), the group will develop a set of good practices to implement toward establishing and maintaining good relations between/among the parties involved in outsourcing.
- 12:30 – 1:30 Lunch**
- 1:30 – 3:30 Session 6: Hospital Team Action Plans**
- Participants regroup by hospital and work in their team to identify specific actions they want to take in the next 6 months to improve relationships and performance in outsourcing.
- 3:30 – 4:00 Final wrap-up, post-test and workshop evaluation**
- 4:00 End of workshop; participants depart**

ANNEX N. CONFLICT CASE SCENARIOS AND SCRIPTS

Scenario 1: Wet Laundry on Mondays

At Healthy Hospital, the laundry service has been outsourced now for several months and both the hospital staff and the vendor are unhappy with the situation. The laundry equipment is in poor condition and breakdowns are happening regularly. None of the 4 electrical washers currently works and the vendor has temporarily addressed this problem by transporting the dirty linen to another hospital where they wash it and then transport it back to Healthy Hospital. Of the two dryers, one is electric and does not work with any dependability and the other is a steam dryer, which works fine but is dependent on its fuel from the steam plant.

Recently, several Nursing Unit Managers have noticed near stock-outs of clean linen, at the start of the week. Since Mondays are generally very busy, the nurses find this to be an untenable situation. Clean and sufficient linen is essential everyday at the hospital. By Tuesday or Wednesday, the situation gets back to 'normal'. The nurses want the Contracts Manager to do something about this unacceptable situation!

Scenario 1 Script- Hospital Laundry Contract Manager

You realize there are major equipment issues in the laundry. The vendor is not responsible for the repair of the machines and you have put in requests with the hospital manager/MoH to look into refurbishing the existing machines or purchasing new ones. In the meantime, you know the vendor is trying to 'make do' by taking the laundry to be washed at another hospital where they have a separate contract with the Ministry. You know this 'remote washing' approach is riskier for the hospital and you'd like that to stop as soon as possible,

Yesterday, one of the Nursing Unit Managers told you that her unit had no linen on Monday and that she and some of the other units have experienced insufficient linen stocks on Mondays for the past several weeks. Now, this is a problem you were not aware of until now. You went down to the laundry to find the Site Manager but found that he was away for a couple of hours; you plan to try to find him again later. While you were in the laundry area you noticed piles of wet laundry waiting to be dried and asked one of the workers what had caused the back-up situation. She shrugged her shoulders and said she didn't really know but told you that the laundry had definitely been washed well at the other hospital and was "just waiting to be dried". You walked around and verified that the steam dryer seems to be working fine. You also observed that several laundry staff were just standing around and not looking very busy and you don't like that situation. It seems to you that, if they were well supervised, there wouldn't be this kind of back up. You leave the vendor site manager a message that you want to have a meeting to discuss the low linen stocks on Mondays. This situation clearly can't continue.

Scenario 1 Script - Vendor's Laundry Site Manager

The laundry contract here at healthy hospital has been one big headache for you. Since the electric washers are broken most of the time, you have resorted to transporting the dirty laundry to another hospital where your company has a contract and you are washing it there and returning it to Healthy Hospital to dry, fold and stock. Not only are you incurring costs from the transportation but you also have the added hassle of ensuring that the bagging of dirty and clean laundry is handled well (according to protocol) during the transportation process to ensure there is no contamination. This includes disinfecting the vehicle, which of course, is another expense you have to incur.

For the drying part of the laundry process, you were hoping to have a smoother operation but there are problems here too! The hospital contracts with a service to run the steam plant that powers the only working dryer on site and for reasons you don't entirely understand, the steam availability drops way down on the weekends. You've heard rumors that the steam plant workers just aren't showing up to do their job on the weekend and it doesn't seem like the hospital is doing their part to monitor and fix that situation. The effect on your operation is a backup of wet laundry waiting to be dried on Monday morning when the steam plant starts operating again a full capacity. The situation with the steam dryer has also impacted on the smoothness of your operation—sometimes you have your staff literally standing around waiting for the dryer to catch up with the flow of wet laundry so they can continue with their tasks of ironing, folding and stocking.

You know you need to talk to the Contract Manager about this situation. She came by yesterday to find you but you were supervising the remote washing at the other facility. You feel like you're going to be blamed for a situation that the hospital should be responsible for fixing—namely, the weekend slowdown at the steam plant. You are a professional person but the Contracts Manager doesn't really treat you as a peer.

Scenario 2: No Hand Soap on the Ward

For the past few weeks, Healthy Hospital has not had hand soap available on a dependable basis. The hospital is responsible for “availing working soap dispensers” throughout the facilities but at present only half of them are functioning and the hospital administrator doesn’t know when the Ministry will replace them. To put a stopgap measure in place, the hospital manager has asked the cleaning vendor to provide small containers of soap at the sites of the broken dispensers. The vendor has complied with this request by filling recycled water bottles with the liquid soap they purchase in large bulk containers and placing a bottle at each broken dispenser site. The Infection Control Nurse has now noted that the screw cap bottles do not pass her inspection because they require excessive handling by the user who could pass an infection along to subsequent users.

Scenario 2 Script- Hospital Manager

The soap problem has been a headache for you. You thought you had it solved when the contractor agreed to provide soap in bottles on an interim basis but now the Infection Control Nurse has found the solution unacceptable. Now you’ll have to go back to the vendor to try to get them to purchase pump-style bottles, which are more expensive but considered a safer alternative. What you really want is to get the soap dispensers replaced because, according to the contract with the cleaning company, they will be responsible for the repair and replacement of the dispensers at that point. You and your staff have already provided a lot of extra support to the cleaning contractor—infection disease control training for their staff and free vaccinations for example—and you feel they should agree to handle this newest request at no additional cost to the hospital.

Scenario 2 Script- Cleaning Service Site Manager (or General Manager)

The soap problem has been a headache for you. You have already complied with one request by purchasing bottles, filling them with soap and stocking them at each site. Now the Hospital Manager is asking for pump-style bottles, which cost more than 10 times what the water bottles cost, and there is no budget for this in your contract because it is technically not your responsibility. You want the hospital to get the dispensers replaced as soon as possible because any interim solution using bottles is costing you money in terms of container costs, time, and loss. It takes a long time for your personnel to fill and refill the bottles. Spillage and theft of bottles and soap are also significant problems. People can walk out with the soap bottle under their jacket! Even the soap dispensers could be a problem in the future. You want the hospital to purchase quality dispensers that will last and have fewer repair problems but you are worried the Ministry will just go with the cheapest bid. You’ve actually done some research on this and would like to discuss it with the Hospital Manager. You also want to negotiate the price the hospital should pay your company for the pump-bottles they now want you to purchase.

Scenario 3: Insufficient Security Coverage

Healthy Hospital is located on a huge tract of land on the outskirts of Gaborone. The backside of the property has no fence to secure it though there are fences on the other three sides. The hospital has a total of 5 entrance areas and a total of 15 doors accessing the various facilities. For the past year, the MoH/hospital has contracted with a company that provides a staff of six guards 24 hours/day to 'protect' the grounds and facilities. Since the contract was awarded, there has been an up-shoot in theft (from the pharmacy, and from personal property including cars) and the kitchen manager reports food is disappearing from the hospital kitchen.

Scenario 3 Script- Hospital Manager

You have lately been apprised of a deteriorating security situation at your hospital. You knew the problem was bad but now it seems to be getting even more complicated. The contractor has only a total of 6 guards on the premises at any given time (2 guards at 3 main entrances; no one anywhere else unless there is an incident reported). Your kitchen manager told you last week that food is "going missing" from the storeroom and she can't be responsible for that without more assistance. Also, two of the physicians' cars were broken into in the parking lot and they showed up at your door demanding that the hospital cover the damages and losses. As if things couldn't get worse, the border police found 4 boxes of retroviral meds clearly stamped "property of GOB" and they were traced back to the Healthy Hospital pharmacy!

Security has always been an issue here even before the outsourcing contract was awarded but now there seems to be more petty crime in the urban areas. One issue with this vendor is the quality of the security staff—they seem to be hired off the street corner, given a uniform to wear and put at their position without any real training. You suspect they have no clue what their duties are. On the other hand, you've seen the contract the MoH Procurement Office signed with the security company and it is ridiculously underfunded—no one could provide security for that price! Still, the vendor made the offer and signed the contract so he is still responsible, isn't he?

Scenario 3 Script - Security Vendor General Manager/Owner

You are the owner and general manager of your company, which you created about 3 years ago. Healthy Hospital was your first 'big' contract and is it not going so well so far. During the tendering process, you heard through informal channels that you were bidding against some better-qualified firms so to make sure your price point would be appealing. You really wanted to win a big contract like this one so it would allow you to get your company more established and growing over time. To that end, you gave the hospital a very low price for the services. Now you see that you underestimated what it takes to provide coverage for the size of this hospital and its surrounding property. Someone during the tendering process told you that the hospital was planning to complete the fencing around the grounds but that hasn't happened yet. Right now, you have only sufficient funds in your budget for 6 guards (posted in pairs at the 3 main entrances per protocol). Now you realize you need at least 3 times that number to provide the level of prevention and response this type of facility needs. In the year you've been managing this contract, you've learned a lot about the complexities of the hospital environment, from food disappearing from the kitchen storeroom to guards

being attacked and injured in the psychiatric ward to agitated crowds outside the ER when there has been a major disaster in the city. You wish the MoH had given you a better idea of what the work entails and you also wish they had allowed you to tour the entire facility and grounds before formulating your bid. You requested permission but they said they did not have personnel available to accommodate your request.

The other headache you have is the quality of your guards—you realize they are not well-trained or motivated and you need to do something about that. Maybe you should shift a couple of your more experienced guard from another contract over to this one? The bottom-line is you realize you priced this contract too low and can't provide the services without taking a big loss that would risk closing down your company. The hospital manager has requested a meeting to talk about the coverage issue and the "poor service".

Scenario 4: Filthy Bathrooms on the Pediatric Unit

It's Wednesday afternoon at the pediatrics ward at Healthy Hospital, and the Nursing Unit Manager has not yet seen the cleaner who was supposed to be on-duty since 08:00. One of the patient's mothers visiting her daughter has approached the nurse's desk to complain about the condition of the bathroom, saying it is so filthy she won't allow her daughter to use it. The Unit nurse manager checks out the bathroom and finds the condition as reported by the mother. She calls the Housekeeping supervisor responsible for this ward area to ask why there is no cleaner on the floor. The housekeeping supervisor says she was unaware the cleaner hadn't shown up and mentions that the evening shift cleaner will arrive in a few hours. The unit nurse manager thinks to herself, "This isn't the first time the supervisor says she hasn't been aware of one of her worker's absences". In general, the unit nurse manager wonders exactly what the vendor's supervisors are supposed to be doing. The unit manager herself has been showing the cleaners what to do because she "knows exactly how to clean a hospital ward after so many years of experience". Today, she is fed up with the hassle of a dirty bathroom and having to deal with a complaining parent, so she contacts the contract manager to ask him to please address the situation.

Scenario 4 Script - Hospital Cleaning Contracts Manager

You just received a call from the pediatrics unit nurse manager complaining about problems with the housekeeping service. You have been alerted about some issues with cleaners not showing up for their shifts and that the cleaning supervisors and the housekeeping site manager aren't addressing the problem. You don't know if the issue is absenteeism or turnover but either way, it's an issue that needs to be addressed. You want to know what the vendor site manager proposes to do to provide timely coverage when there are absences. The nurse manager also cited issues with the quality of cleaning explaining the workers aren't properly supervised and doing a "quality cleaning job". You thought you and the vendor site manager had reviewed the procedures and were clear on these. How hard can the cleaning management be?! You want to talk to the Vendor Site Manager to address these issues.

Scenario 4 Script - Cleaning Vendor Site Manager

You've been trying to get your housekeeping service set up and running smoothly at Healthy Hospital but it is a challenge. It is a more complex job than you had expected (your background is in the hospitality industry). Although you are supposed to be working with the hospital contract manager for cleaning you now realize that the nurse unit managers think they are the bosses for you and your workers. The Unit Managers seem to be telling your workers how they want their wards cleaned and your workers are getting different messages/instructions from them that they are from you. The Unit Managers don't even agree with each other—it seems they each have a somewhat different approach to what they call "quality cleaning" and how to do it. Your supervisors and workers wind up getting very confused about which way to do things. This is one of the problems you are having and you want to raise it with Contracts Manager.

Another problem came up today that you know you need to address: a worker didn't show up on the pediatrics ward and your supervisor didn't report it back to you so no did the

cleaning during the day shift and the bathrooms we unacceptably dirty. You need to think of a better way to organize so that you know immediately if there are any absences and can reallocate some of your staff to provide temporary coverage. Of course, one of the issues there is that the unit managers refuse to allow you to take any of your workers off their ward even if it's only temporary. As you see it, the contracts manager asks you to do things one way and then the unit nurse managers want it another way. You feel like the hospital needs to "get on one page" so your staff are not receiving different demands from different people. There should be a set of standard procedures set and agreed upon by everyone!

Scenario 5: Food Service Failures

Healthy Hospital is into its third month with a new food service vendor and, as expected, some problems are emerging. The vendor is not complying with the regular or the special-diet menus. Some days, especially Mondays, the patients are getting meals with no fruits or vegetables. The hospital dietician has reported that the vendor's dietician and staff are making substitutions in the special diet meals that are clearly unacceptable.

Scenario 5 Script – Hospital Food Service Contracts Manager:

You are dissatisfied with the food service vendor and want improvement. Yesterday, after the dietician called you to complain about their service, you went by the main refrigerator storage room and noticed it was virtually empty—no fresh food in sight even though the menus are supposed to include these multiple times/day. You really aren't sure what they are serving and what the problems might be. The dietician told you that the vendor's dietician is creating different menus than what she ordered and she is not happy about that. She says that she doesn't trust the vendor's dietician to know what she's doing.

Scenario 5 Script - Food Service Vendor Site Manager

This is the first time your company has contracted to provide food service for a hospital and you are a new manager with the company. You believe you are doing a pretty good job so far though there are some problems. Recently, you've had problems with some of your distributors and when they haven't delivered on time, you were forced to "be creative" with the meals and substitute foods that were not on the required menus. It seems to you that the per-meal cost your company negotiated with the MoH/hospital is not really realistic. Another issue: the refrigerated storeroom has broken down twice and you lost large amounts of food that spoiled before you could get the repairs done. You were forced to do some substitutions in the meals and you conferred with your dietitian to see what substitutions would be acceptable. She gave "acceptable substitutions" of some of the food types but now the hospital dietician has informed you and your dietician that these "altered" diets are not acceptable. Now your dietician is frustrated with you and the hospital dietician—she says the hospital dietician is trying to just "look important" and isn't being reasonable about the substitutions. You want to get the food service on a better track.

ANNEX 0. CONFLICT RESOLUTION-NEGOTIATION PARTICIPANT MANUAL



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Health Finance
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Expanding Access. Improving Health.

HOW TO ACHIEVE WIN-WIN SOLUTIONS AND STRENGTHEN RELATIONSHIPS BETWEEN HOSPITALS AND VENDORS

PARTICIPANT MANUAL

Workshop 1: July 30-August 1, 2014

Workshop 2: August 5-7, 2014

Gaborone, Botswana

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WORKSHOP OVERVIEW

Workshop Goals:

Participants will be able to

- Identify types and sources of conflict that commonly occur in the context of outsourcing of non-clinical hospital services.
- Determine appropriate conflict resolution modes for a variety of conflict situations that present in this setting; identify one’s own preferences for particular conflict resolution modes.
- Build skills in the critical communication areas of ‘assertiveness’ and ‘cooperativeness’ as applied to conflict resolution.
- Describe the keys to successful negotiation of a conflict/disagreement between hospitals and vendors, particularly those behaviors and practices that lead to “win-win” results.
- Identify best practices for strengthening MOH-hospital-vendor relationships such that conflict situations are prevented or addressed in timely and effective ways.
- Identify and commit to future actions that will advance MOH, hospital and vendor staff capacity to identify and resolve problems before they become intractable.

Workshop Calendar

Day 1	Day 2	Day 3
<p>Opening Session</p> <p>Welcome, icebreaker review of agenda</p> <p>Session 1:</p> <p>What is conflict and what are key modes/ approaches for handling it?</p>	<p>Session 3:</p> <p>Keys to Successful Negotiation</p>	<p>Session 4:</p> <p>Negotiation Scenarios (continues)</p> <p>Session 5:</p> <p>Building Good Relationships to Reduce Conflict and Improve Negotiations</p>
<p>Session 2:</p> <p>Conflict Resolution Skills- Assertiveness and Cooperativeness</p>	<p>Session 4:</p> <p>Negotiation Scenarios – Planning, Practice, Debrief</p>	<p>Session 5 (continues)</p> <p>Session 6:</p> <p>Hospital Team Action Plans</p> <p>Wrap-up + evaluation</p>



SESSION I: WHAT IS CONFLICT AND WHAT ARE KEY MODES/APPROACHES FOR HANDLING IT?

Session Objectives:

- Define the nature and sources of conflict in the context of hospital-vendor roles, services and relationships
- Describe five key modes or approaches to handling conflict and most appropriate uses for each one.
- Identify one's own preferred approaches of handling conflict and ways to draw from other approaches when appropriate.

I.I CONFLICT RESOLUTION

Defining the Nature of Conflict

Conflict occurs over differing ideas, opinions, needs and wishes. It is neither good nor bad in itself; it simply is.

Nature uses conflict as its primary motivator for change, creating beaches, canyons, mountains, and pearls through the interaction of opposing forces.

Conflict is not a contest. Winning and losing are goals for games, not conflict.

To resolve conflict one must have the goals of learning, growing and cooperating.

Conflict can be seen as a gift of energy in which neither side loses and a new dance is created.

Resolving conflicts effectively rarely involves a determination of who is "right;" instead it emphasizes appreciation of differences.

The outcome of a conflict situation is positive or negative, based on how it is managed.

The Point of Contention

It is difficult to manage the conflict until the point of contention is clear. The point of contention can fall in any of the following areas:

<i>Low Emotion</i>	FACTS
	METHODS
	GOALS
	VISION
<i>High Emotion</i>	VALUES

If you believe the point of contention is in facts or methods, but yet emotions are high in one or both parties, then keep looking for the point of contention. Think of an onion when you think about the point of contention – you may need to peel back several layers before you find it. What may at first seem to be a dispute over a method (e.g., how to approach a problem) may actually be a values conflict. For example, one party believes the other party is not treating him or her fairly or with respect.

Causes of Conflict — Organizational Preconditions

There are a variety of organizational factors or preconditions that can increase the likelihood of workplace conflict. These include:

- ⇒ Ambiguous (or rapidly changing) goals, roles or responsibilities, and authorities.
- ⇒ Mismatch between espoused values and acted-out or organizationally rewarded values. (Does the work unit “walk its talk”? For example, are the rewards for individual contribution while the rhetoric is about teamwork and collaborative effort?)
- ⇒ Different measures of success (people have differing professional, work, or personal measures for what is excellence).
- ⇒ Communication filters: Distance, time, space, jargon/specialized language, or over-relying on impersonal electronic communications.
- ⇒ Interdependency of work activities (the more people depend on each other for their work, the greater the need for collaboration norms and conflict-resolution mechanisms).
- ⇒ Work units are compartmentalized (a high degree of differentiation can make cross-unit collaboration more difficult, especially if these work units have different work styles or cultures).
- ⇒ Lack of overt, agreed-upon procedures for handling disagreements or conflicts. (In some professional organizations, it is assumed that conflict shouldn’t exist, therefore they are few, if any, norms for how disagreements should be handled. Resolving conflicts then becomes an issue of personal style or positional authority.)
- ⇒ Personality factors (people’s preferences, values, worldview, or the just plain “Jerk” factor can create seeds for conflict).
- ⇒ Work force diversity (different cultural or ethnic backgrounds or work discipline experiences can lead to misunderstandings and conflict).

Conflict Situations in the Hospital-Outsourced Services Context

In the space below, list some of the situations you have either observed or directly experienced that have involved a conflict between two or more parties. For each situation, note:

- ✓ Who was involved?

- ✓ What type of conflict was this? What was the nature of the problem/dispute?
 - Goals: the end results or what you are trying to accomplish
 - Roles: who can and or should do what
 - Procedures: methods, strategies or tactics
 - Relationships: how people will relate to each other
 - Limits: what is or is not possible or what is the authority
 - Timing: when things should be done
 - Information: fact, figures, data
 - Values: right, wrong, fair, ethical, moral

Conflict Situation:

Conflict Situation:

I.2 FIVE CONFLICT HANDLING MODES

COMPETING

- Assertive and Uncooperative
- Standing up for your rights
- Defending a position you believe is right
- Trying to win
- Asserting your own concerns

AVOIDING

- Unassertive and Uncooperative
- Diplomatically sidestepping
- Postponing
- Withdrawing
- Disengaging

COMPROMISING

- Intermediate in both assertiveness and cooperativeness
- Splitting the difference
- Exchanging concessions
- Seeking quick middle ground

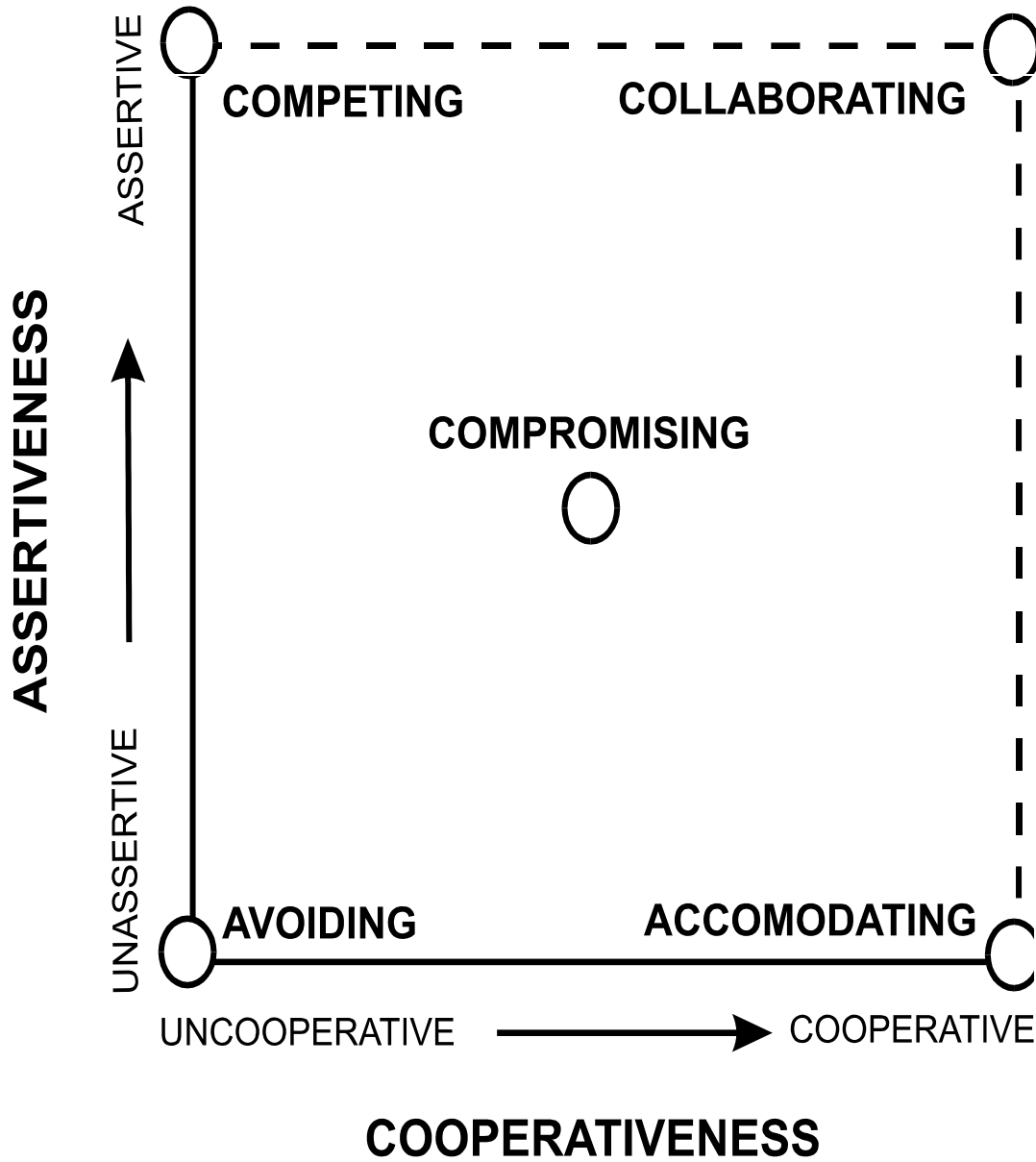
COLLABORATING

- Assertive and Cooperative
- Exploring disagreement to learn from others
- Agreeing to resolve instead of competing
- Looking for solutions that meet the needs of both parties (A win-win)

ACCOMMODATING

- Unassertive and cooperative
- Selfless generosity
- Obeying when you would rather not
- Yielding
- Putting other's concerns over your own

Thomas - Kilmann
Five Conflict Handling Modes¹



¹ Thomas-Kilmann CONFLICT MODE Instrument. Copyright 1974, 2002, 2007.

IF YOUR SITUATION LOOKS LIKE THIS

1. When quick, decisive action is vital, e.g., emergencies.
2. On important issues where unpopular courses of action need implementing, e.g., cost cutting, enforcing unpopular rules, discipline.
3. On issues vital to the organization's welfare when you know you are right.
4. To protect yourself against people who take advantage of non-competitive behavior.

...Then you choose **COMPETE**

1. When an issue is trivial, of only passing importance, or when other more important issues are pressing.
2. When you perceive no chance of satisfying your concerns, e.g., when you have low power or you are frustrated by something which would be very difficult to change (national policies, someone's personality, etc).
3. When the potential damage of confronting a conflict outweighs the benefits of its resolution.
4. To let people cool down – to reduce tensions to a productive level and to regain perspective and composure.
5. When gathering more information outweighs the advantages of an immediate decision.
6. When others can resolve the conflict more effectively.

...Then you choose **AVOID**

1. When goals are moderately important, but not worth the effort or potential disruption of more assertive modes.
2. When two opponents with equal power are strongly committed to mutually exclusive goals – as in labor management bargaining.
3. To achieve temporary settlements to complex issues; to arrive at expedient solutions under time pressure.
4. As a backup mode when collaboration or competition is unsuccessful.

...Then you choose **COMPROMISE**

1. To find an integrated solution when both sides of concern are too important to be compromised.
2. To merge insights from people with different perspectives on a problem.
3. To gain commitment by incorporating others' concerns into a consensual decision.
4. To work through hard feelings which have been interfering with an interpersonal relationship.

...Then you choose **COLLABORATE**

1. When you realize that you are wrong.
2. To allow a better position to be heard, to learn from others, or show that you are reasonable.
3. When the issue is much more important to the other person than to yourself – to satisfy the needs of others, as a goodwill gesture to help maintain a cooperative relationship.
4. To build up social credits for later issues which are important to you.
5. When continued competition would only damage your cause – when you are overmatched and losing.
6. When preserving harmony and avoiding disruption are especially important.
7. To aid in managerial development of subordinates by allowing them to experiment and learn from their own mistakes.

...Then you choose **ACCOMMODATE**

Profile of Each Conflict Handling Mode

Competing/Dominating

Concerns: High degree of concern for attaining individual goals and low concern for the relationship. “Winning” is a primary consideration.

Behavior Pattern

- Employs assertive to aggressive behavior.
- Uses power associated with status, rank, size, expertise, etc.
- Uses persuasive, “airtight” arguments.
- Listens to the other for the purpose of finding “holes” in his/her argument and for preparing rebuttal.

Rationale/Assumptions

- Persuasion, power, and force are acceptable tools to achieve goals.
- There is a right answer!
- Losing means weakness, incompetence, and loss of power and control.
- Personal feelings are not as important as resolving the issue “correctly.”

Situational Uses of Style

Appropriate:

- Emergencies—quick action is needed.
- Enforcing unpopular rules/policies.
- Issue is vital to your own or other’s welfare.
- Decision requires compliance, but not commitment.

Inappropriate:

- Issue is trivial and/or not very important to you.
- Issue requires commitment of others to implement.

Results of Overuse or Inappropriate Use of Style

- Individual is closed off from input from others.
- Others are intimidated and may be less than candid in interactions.
- Loser in confrontation expends energy finding ways to “get even.”

Accommodating

Concerns: High concern for relationship with relatively low concern for achievement of individual goals. Pleasing the other and protecting self from attack or negative consequences.

Behavior Pattern

- Denies or smooths over differences.
- Is passive and unassertive.
- Is cooperative to the point of sacrificing personal objectives.
- Suppresses anger or strong negative emotions.
- In the extreme, enters into false agreements or insincere cooperation to restore harmony.

Rationale/Assumptions

- Differences/conflict only serve to drive people apart.
- To differ is to reject or be rejected.
- It is better to ignore differences than to confront them.
- Some relationships are so fragile that they cannot endure the trauma of working through differences.

Situational Uses of Style

Appropriate

- Issue is more important to the other person than to you.
- You are willing to give up something now in exchange for something in the future.
- Preserving the relationship is important.
- You have less power than the other person and want to avoid negative consequences.
- You believe you may be wrong.

Inappropriate

- The issue is important to you.
- You believe you can demonstrate that you are right.
- Preservation of the relationship is not important, or you do not have a relationship with the other, e.g., acquaintance or stranger.

Results of Overuse or Inappropriate Use of Style

- The parties' agreement can be false; therefore both can lose.
- Your willingness to "always" accommodate can be exploited.
- Unexpressed feelings and thwarted personal goals may cause resentment.

Avoiding

Concerns: Low concern for the relationship and low concern for personal goals.

Avoidance of threatening situation and maintaining self-control.

Behavior Pattern

- Withdraws physically or psychologically from situation.
- Ignores problems or differences.
- Refuses to engage in either “fighting” or problem solving. Adopts a detached observer stance.

Rationale/Assumptions

- Conflict is uncomfortable, and I will probably lose anyway.
- Being rational and in control of emotions is more important than achieving personal goals.
- I do not have the power to influence the other person. It is hopeless.

Situational Uses of Style

Appropriate:

- Issue is not important.
- Disengaging allows both parties to “cool off,” or gives you time to think.
- Direct confrontation of the other would lead to negative consequences that you are unwilling to accept.

Inappropriate:

- Issue is important and should be resolved.
- Disengaging, physically or psychologically, is likely to escalate the conflict.

Results of Overuse or Inappropriate Use of Style

- Both parties may end up feeling frustrated because differences are not worked through to the satisfaction of either party. May ultimately result in termination of relationship.



Compromising

Concerns: Intermediate concern for relationship and for achievement of personal goals. Seeking middle ground acceptable to both.

Behavior Pattern

- Negotiates or bargains to achieve goals.
- Makes concessions to reach agreement.
- Is reasonably flexible.

Rationale/Assumptions

- Finding a middle course in which you each give up something is preferable to a deadlock.
- It is better to get half a loaf than none at all.
- Compromising is a “civilized” approach to resolving the inevitable differences between people.

Situational Uses of Style

Appropriate:

- Goals of the parties are mutually exclusive.
- Parties are equally powerful.
- Consensus cannot be reached.
- Collaborating style has not been successful.
- Compromise solution may lead to increased trust, allowing parties to engage in problem solving in the future.

Inappropriate:

- One party is more powerful than the other.
- The parties have not taken the time to be sure that goals are mutually exclusive.
- There is a lack of trust that one or both parties will honor the agreement.

Results of Overuse or Inappropriate Use of Style

- Compromise solution may ignore real issues.
- Commitment to solution may be low.
- Can be manipulative (i.e., can be used to keep the other from “winning”).

Collaborating

Concerns: High degree of concern for relationship and for achieving personal goals. Solving the problem in a way that both parties are committed to the decision.

Behavior Pattern

- Engages the other in an exploration of their differences (attitudinal and substantive).
- Expresses self openly and candidly.
- Acknowledges legitimacy of own and other's strong feelings about the situation.
- Listens with an open mind to the other's feelings, concerns, perceptions, and position.
- Exhibits patience in exploring alternative ways of meeting each party's needs and/or goals in the situation.

Rationale/Assumptions

- Differences are natural events in relationships and should be perceived as problems to be resolved rather than as fights to be won.
- Conflict can be managed so that no one has to lose.
- If both parties communicate openly and candidly and are committed to understanding the nature of the problem, the problem can be solved.
- Who is at fault is not an important consideration.

Situational Uses of Style

Appropriate:

- The issue is complex and important to you.
- Decision requires commitment.
- Parties are interdependent and it is as important to preserve the relationship as it is to resolve the problem.
- Time is available to work through the problem-solving process. The other person has a stake in the outcome.

Inappropriate:

- Issue is simple and not very important to you.
- Immediate decision is required.
- You already are committed to a particular course of action.

Results of Overuse or Inappropriate Use of Style

- Can be perceived as manipulative and self-serving if used inappropriately and/or unskillfully.

SESSION 2: CONFLICT RESOLUTION SKILLS- ASSERTIVENESS AND COOPERATIVENESS

Session Objectives:

- Use assertiveness and cooperativeness communication skills in a balance appropriate to the conflict situation
- Describe behaviors that exacerbate and behaviors that promote good problem-solving in conflict situations.
- Apply good planning steps to prepare for meetings to resolve conflict
- Explain ways to control emotions during conflict resolution meetings and in general interactions with vendors, hospital colleagues and others.

2.1 NEGOTIATIONS AND CONFLICT RESOLUTION SKILLS

Assertiveness Skills

- Stating clearly your expectations, needs and interests, and appropriately expressing your feelings about the situation.
- Being careful to describe the issue(s). Self-manage the expression of your emotions, both verbally and non-verbally.
- Organizing your thoughts and presenting your understanding of the facts, and your analysis of what has happened.
- Putting forth solutions for the other's consideration.
- Thinking about what the other person's interests are, and being prepared to say why you think your solution is the best. Being prepared to repeat your proposed solution and the reasons why – several times if necessary.

Cooperativeness Skills

- Actively listening to other with empathy – imagining yourself in the place of the other person and seeing the conflict from his or her perspective.
- Clarifying and paraphrasing the other person's perspectives and feelings.
- Asking open-ended questions to surface more information about the issue in the spirit of trying to better understand one another.
- Acknowledge your own feelings – your concerns, fears, etc.
- Show your willingness to explore other solutions, look for ways to “give” freely, places to say “I’ll cooperate” or “I agree with you” and come forward with alternative solutions.

Collaborating Skills

Pre-meeting

- Be clear in your own mind what you need
- Anticipate what others need
- Identify common ground

During the meeting

- Be clear that you want to collaborate – say so
- Articulate common ground, state incentives
- Put forth win/win proposals
- Be open about your own feelings
- Back up proposals with three reasons
- Avoid "irritators" -- others values, condescension
- If the situation prevents collaboration (e.g. tension becomes too high), disengage and plan to re-engage
- Acknowledge others' needs by paraphrasing and summarizing
- Ask open-ended, trustful questions
- Explore alternatives creatively

CONFLICT CASE WORKSHEET

Think of a conflict situation you are currently facing or that you tried to resolve but it didn't work out so well. Use the following questions to analyze the situation:

What is the issue/s as you see it?

What do you need from the other party and what do you think they need from you? What is at stake for each of you here? What assumptions might you be making about each other that we need to check-out?

What might be some viable options for solving the problem? Think about options that you believe would be acceptable for the other person(s) involved.

Additional Ideas/Insights from your colleagues: (Jot down some notes here)

2.2 COMMUNICATION IN CONFLICT SITUATIONS

Behaviors that Exacerbate Conflict

- Using language that labels, blames, or judges the other person.
- Demanding that the other person change.
- Refusing to acknowledge the other person's needs/wants/goals, or values.
- Not listening.
- Refusing to accept responsibility for your actions.

Behaviors that Support Problem-Solving in Conflict Situations

- Clarify differing perceptions. Define and agree on the issue(s) in contention (What is happening here? Whose problem is it? How would I/you like things to be? What do I/you want that we are not getting?)
- Separate the person from the behavior (de-personalize the issue).
- Listen for feelings as well as for facts (emotions are real and can be relevant to the analysis of the situation and to its resolution).
- Treat the other person with respect (focus on the behavior rather than assume motives or intentions of the other person).
- Be clear about your specific needs and wants.
- Emphasize common ground.
- Acknowledge—and talk about—feelings.
- Use “I” (versus “you”) statements—take responsibility for your interpretations and reactions.

Emotional Hijacking and the Pause-Reflect-Choose Approach

Can you remember a situation in the recent past where you felt your emotions run out of control? (It was sudden, unexpected and against your will, you lost control.)

This is called **Emotional hijacking** and it occurs when the limbic part of our brains (i.e., where we experience emotion) is triggered by an “event” and senses a need to “flee or fight”; this temporarily blocks the other more rational part of our brains from functioning well to keep us more in control.

Losing control often “looks like” one or more of the following:

- Raising your voice and cutting off the other person
- Using strong language
- Sending an angry email
- Withdrawal and isolation (pull away, avoid meetings or certain people)
- Slamming a door or other similar grand gestures
- Holding grudges or getting even
- Criticism intended to hurt another
- Playing the victim
- Sarcasm and inappropriate humor

What triggers your emotional hijacking?

Fortunately, we can learn to prevent or lessen the intensity of emotional hijacking by becoming more aware of what **triggers** them. What experiences, behaviors, seems to affect your self-control?

What are some ways you can you control your triggers?

In the immediate moment, try the **P R-C approach**:

Pause (breathe deeply if needed)

Reflect (think about the desired end result you want right now)

Choose (carefully chose your verbal, vocal and visual response)

2.3 STEPS INVOLVED IN MEDIATING 3RD PARTY CONFLICT

Step One: Address or Avoid

You need to determine if it is necessary to address the conflict, if it is important to the larger team, and if it is there a real possibility for resolution.

1. What is the impact of the conflict on organizational effectiveness, achievement of goals, and morale?
2. How am I impacted as the senior manager?
3. Who is involved and who should be involved?
4. How willing are the parties to deal with the conflict? What has been tried before to resolve their issues?
5. What forces would support addressing the conflict and what would push against resolving the conflict?

If, after answering these questions, you believe that it would be beneficial to mediate the conflict, move on to Step Two.

Step Two: Analyze the Conflict

You need to be clear about the nature of the conflict, the issues, and the different positions and points of view of those involved.

You need to meet with the involved parties – set up separate meetings – to understand the conflict.

Have a meeting and ask each participant in the conflict:

1. What do they currently see as the point of contention?
2. What would be the benefits to resolving the conflict?
3. What would they like to resolution to look like in regards to the other person and the conflict?
4. What would they like to have the other person do?
5. What do they think the other person would like to have happen in regards to the conflict?
6. What changes are they willing to discuss?

[Note that these questions are good *coaching* questions!]

Ask yourself:

1. What is the real issue – the point of contention?
2. What would be the goal for mediating this conflict? (e.g., the hoped-for outcomes?)
3. How do or will the parties perceive your role as mediator?
4. What style of conflict management has each party been using so far?
5. How ready are the participants to work together?
6. What are your expectations as the senior manager for each party?
7. What agreements do you want the parties to reach?
8. How will you state your expectations for moving forward productively?

After you have answered these questions, move to Step 3 – conducting the meeting.

Step Three: Facilitate a Meeting

After one or more meeting with the individuals involved, you will want to have a meeting together to clarify and develop agreements for resolving the conflict.

1. Set the climate for the discussion, try to put everyone at ease and clarify the goal of the meeting.
2. State your expectations as the senior manager.
3. Ask each party to share how he or she sees the issue.
4. Have each party paraphrase the other's position – work at getting them to paraphrase content and affect
5. Reach agreement on what the issue/problem is that is causing the conflict.
6. Have each party identify the benefits they see to resolving the conflict.
7. Have each party share what they would like the other person to do differently to help resolve the conflict and what they would be willing to do themselves.
8. Discuss the requested changes and reach agreement on some changes that will be made.
9. Have both parties summarize their understanding of the agreements.
10. Test for commitment.
11. Re-state your expectations for how the parties will follow-through on their agreements, and what you expect to see as the parties move forward.
12. Make an appointment to “check-in” and see how things are going.

SESSION 3: KEYS TO SUCCESSFUL NEGOTIATION

Session Objectives:

- Explain the desirability for win-win style negotiation in the context of hospital-vendor relations.
- Describe best practices for adequately planning and preparing for a negotiation.
- Describe concrete approaches to take to turn a win-lose situation into a win-win negotiation outcome.

3.1 KEYS TO SUCCESSFUL NEGOTIATIONS

"In a successful negotiation, everyone wins. The objective should be agreement, not victory."

"The key to successful negotiation is to shift the situation to a "win-win" even if it looks like a "win-lose" situation. Almost all negotiation has at least some elements of win-win. Successful negotiations often depend on finding the win-win aspects in any situation. Only shift to a win-lose mode if all else fails."

Keys to Successful Negotiations

- Orient yourself towards a win-win approach: your attitude going into negotiation plays a huge role in the outcome
- Plan and have a concrete strategy...be clear on what is important to you and why it is important
- Know your BATNA (Best Alternative to a Negotiated Alternative)
- Separate people from the problem
- Focus on interests, not positions; consider the other party's situation:
- Create Options for Mutual Gain: Generate a variety of possibilities before deciding what to do
- Aim for an outcome based on some objective standard
- Pay a lot of attention to the flow of negotiation
- Take the Intangibles into account; communicate carefully
- Use Active Listening Skills; rephrase, ask questions and then ask some more

I. Orient yourself towards a win-win approach

Many studies support the view that how you approach a negotiation will play a key role in how the negotiation proceeds. You have a much better chance of coming to an outcome involving mutual gains if you approach the negotiation wanting to reach this kind of outcome. It is critical to constantly reinforce your interest in the other side's concerns and your determination to find a mutually satisfactory resolution.

Even in what appears to be win-lose situations, there are often win-win solutions; look for an integrative solution. This includes trying to create additional alternatives such as low cost concessions that might have high value to the other person; frame options in terms of the other person's interests; look for alternatives that allow your opponent to declare victory.

2. Plan – do some thinking ahead of time

Before the negotiation, it is helpful to plan. Know whether you are in a win-win or win-lose situation. Be sure of your goals, positions, and underlying interests. Try to figure out the best resolution you can expect, what is a fair and reasonable deal and what is a minimally acceptable deal. What information do you have and what do you need? What are your competitive advantages and disadvantages? What are the other's advantages and disadvantages? Give some thought to your strategy.

It is very important to be clear on what is important to you. Be clear about your real goals and real issues and try to figure out the other person's real goals and issues. Too many negotiations fail because people are so worried about being taken advantage of that they forget their needs. People who lose track of their own goals will break off negotiations even if they have achieved their needs because they become more concerned with whether the other side "won."

Equally important is to be clear and communicate **why** your goals and issues are important to you. The other side needs to know why issues are important to you, not just that they are important.

It is important to be clear about your reservation position (or best alternative).

It is important to know your competitive advantage – your strongest points. Also you need to know the advantages to the other's argument. Similarly, know your weaknesses and the other's weaknesses.

In most conflict resolution or negotiation situations you will have a continuing relationship with the other person so it is important to leave the situation with both sides feeling they have "won." It is very important that the other person doesn't feel that he or she "lost." When the other person loses, the results are often lack of commitment to the agreement or even worse, retaliation. *The most common failure is the failure of negotiating parties to recognize (or search for) the integrative potential in a negotiating problem; beneath hardened positions are often common or shared interests.*

3. Know your BATNA (best alternative to a negotiated agreement)

Going into any negotiation it is important to be very clear on your BATNA – the course of action you would take if you do not reach an agreement. If you are negotiating over salary, your alternatives might include a specific job elsewhere, a longer job search, or remaining at your current job. This is important because the negotiation needs to aim to match or do better than your BATNA. The BATNA establishes a threshold for the settlement.

Determining your BATNA is not always easy. You have to establish a concrete value for various alternatives. For example, what is the value of keeping a current job or taking a new one at a higher salary that involves a move?

In simple negotiations, there may be just one issue but often negotiations involve multiple issues making the determination of BATNA's even more difficult.

In the planning process it is also important (and difficult) to estimate the other side's BATNA. A goal of negotiation is to come as close to the other person's BATNA as you can and you need to estimate the BATNA to do this. Skilled negotiators also often try to influence the other person's BATNA. This happens when you convince the other person that his alternatives are not as good as the other perceives them to be.

4. Separate people from the problem

It is critical to address problems, not personalities, and avoid the tendency to attack your opponent personally. If the other person feels threatened, he defends his self-esteem and makes attacking the real problem more difficult. Try to maintain a rational, goal oriented frame of mind. If your opponent attacks you personally, don't let him hook you into an emotional reaction. Let the other blow off steam without taking it personally. Try to understand the problem behind the aggression.

Make sure you send signals that you know the conflict is about the issues at hand and not personal. This will help to prevent the other side from getting defensive.

5. Find underlying interests

A key to success is finding the "integrative" issues – often they can be found in underlying interests. We need to be very clear about our interests and this may not be as easy as it would appear. Equally important is the need to find out the other person's key interests.

We are used to identifying our own interests, but a critical element in negotiation is to come to understanding the other person's underlying interests and underlying needs. With probing and exchanging information we can find the commonalities between us and minimize the differences that seem to be evident. The biggest source of failure in negotiation is the failure to see the "integrative" element of most negotiation. Too often we think a situation is win-lose when it is actually a win-win situation. This mistaken view causes us to often use the wrong strategy.

A key part in finding common interests is the **problem identification**. It is important to define the problem in a way that is mutually acceptable to both sides. This involves depersonalizing the problem so as not to raise the defensiveness of the other person. Thus the contracts manager for laundry is likely to be more effective by defining the problem as "I need to understand these mechanical breakdowns better" rather than "You're way behind on getting the closets stocked!"

6. Create options

A good outcome should be among the best of all possible ways to deal with our differing interests. By options, we mean possible agreements or pieces of possible agreement. The more options we are able to put on the table, the more likely we are to have one that will reconcile our interests well.

7. Use an objective standard if possible

Try to have the result be based on some objective standard. Make your negotiated decision based on principles and results, not emotions or pressure. Try to find objective criteria that both parties can use to evaluate alternatives—a well-developed, user-friendly SLA can serve this function. Don't succumb to emotional pleas, assertiveness, or stubbornness.

8. Pay attention to the flow of negotiation – negotiation is a sequence of events, not an incident

There is a tendency to think about conflict or the negotiating situation as an isolated incident. It is probably more useful to think about negotiation as a process, or a complex series of events over time involving both external factors and internal social and psychological factors.

A negotiation usually involves a number of steps including the exchange of proposals and counter proposals. In good-faith negotiation, both sides are expected to make offers and concessions. Your goal here is not only to try to solve the problem, but to gain information that will enable you to get a clearer notion of what the true issues might be and how your "opponent" sees reality.

Both parties experience emotional reactions during a negotiation process and how these are recognized and managed is crucial to the outcome of the process. For example, a negotiation can be greatly affected if people react in anger perhaps resulting from past conflict.

Based on the thoughts and emotions that arise in the process of conflict resolution, we formulate specific intentions about the strategies we will use in the negotiation. These may be quite general (e.g., plan to use a cooperative approach) or quite specific (e.g., use a specific negotiating tactic).

This approach suggests we pay particular attention to these generalizations:

- Conflict is an ongoing process that occurs against a backdrop of continuing relationships and events
- Conflict involves the thoughts, perceptions, memories, and emotions of the people involved; these must be considered.
- Negotiations are like a chess match – have a strategy; anticipate how the other will respond; how strong is your position, and situation; how important is the issue; and how important will it be to stick to a hardened position
- Begin with a positive approach. Try to establish rapport and mutual trust before starting and try for a small concession early
- Pay little attention to initial offers. These are points of departure. They tend to be extreme and idealistic. Focus on the other person's interests and your own goals and principles, while you generate other possibilities.

9. The intangibles: other elements that affect negotiation

It is important to communicate very carefully. Subtle verbal and body language can make a difference in how your negotiation progresses. Spend more time listening than talking and make direct eye contact. Use the word "and" instead of "but." This helps to send the signal that you are interested in the other party and are seeking common ground.

Intangibles are often the key factors in many negotiations. Some of these intangibles are:

- **Communications**

Be careful about using the phone, e-mail, and other non-visual communication vehicles when negotiating. A lack of facial expressions, vocal intonation, and other cues can result in a negotiation breakdown. Constantly reiterate your interest in the other side's concerns and your determination to find a mutually satisfactory resolution.

- **Personalities**

Be conscious of aspects of your personality such of your own needs and interpersonal style as well as the other person's personality. These factors will play a key role and understanding yourself will be an important factor

- **Your own personality and style**

How much you trust the person; how free with your emotions; and how much you want to conceal or reveal.

- **Physical space**

Sometimes where the negotiation takes place can be important. Are we negotiating in a space we are uncomfortable and the other party is comfortable?

- **Past interaction**

If there is a history of conflict resolution with this person, think about how this history might affect the upcoming negotiation.

- **Time pressure**

Think about whether time pressure will affect the negotiation and whether you need to try to change this variable.

10. Be an active listener – ask a lot of questions, and test for accuracy

Good communication skills are critical although it is easy to forget them in the "heat of battle."

- **Try to avoid...**

Talking at the other side, focusing on the past, or blaming the other person.

- **Be an "active listener and test for accuracy"**

Doing so involves continuously checking to be sure you understand the other person. Focus on the future; talk about what is to be done; tackle the problem jointly. Constantly ask questions about whether you understand the other side; restate the other's position to make sure you are hearing him or her correctly

How can I change what seems like a "win-lose" situation to a "win-win"...or what if the other person doesn't play by these rules?

There are many advantages to trying to shift a win/lose situation to a win/win. Yet we will be in situations where the other person either doesn't wish to reach a "win-win" or doesn't realize it is in his or her best interest to achieve a collaborative solution. In these situations it is necessary for us to open lines of communication, and try to increase trust and cooperativeness.

Sometimes conflicts escalate, the atmosphere becomes charged with anger, frustration, resentment, mistrust, hostility, and a sense of futility. Communication channels close down or are used to criticize and blame the other. We focus on our next assault. The original issues become blurred and ill-defined and new issues are added as the conflict becomes personalized. Even if one side is willing to make concessions often hostility prevents agreements. In such a conflict, perceived differences become magnified, each side gets locked into their initial positions and each side resorts to lies, threats, distortions, and other attempts to force the other party to comply with demands.

It is not easy to shift this situation to a win-win but the following lists some techniques that you might use:

- Let the other "vent," acknowledge the other's views, listen actively, make a small concession as a signal of good faith
- Increase the accuracy of communication; listen hard in the middle of conflict; rephrase the other's comments to make sure you hear them; mirror the other's views
- Control issues: search for ways to slice the large issue into smaller pieces; depersonalize the conflict – separate the issues from the people
- Establish commonalities: since conflict tends to magnify perceived differences and minimize similarities, look for greater common goals (we are in this together); find a common enemy; focus on what you have in common
- Focus less on your position and more on a clear understanding of the other's needs and figure out ways to move toward them

- Make a "yes we can" proposal; refine their demand; reformulate; repackage; emphasize the positives
- Find a legitimate or objective criteria to evaluate the solution (e.g., accredited protocol for hospital OR cleaning)

If we pursue "win-win negotiations," we try to create gains for both parties. An example is offering something less valuable to us but more valuable to the other person. The following are ways of creating joint gains:

- Negotiators look for differences. For example, if you buy a car, price may be of most importance and timing may be of lesser importance. To the dealer, closing the deal today (the last day of the month) may be more crucial than making a profit on the sale.
- Negotiators look for items to trade off, items that may be more important to one side than the other, and that can be traded for items in reverse preference to the other side.

Getting to Yes

All of us engage in many negotiations during a week but that doesn't mean we become better at it. To become better we need to become aware of the structure and dynamics of negotiation and we need to think systematically, objectively, and critically about our own negotiations. After engaging in a negotiation, reflect on what happened and figure out what you did effectively and what you need to do better.

There is no one "best" style; each of us has to find a style that is comfortable for us. Yet, everyone can negotiate successfully; everyone can reach agreements where all sides feel at least some of their needs have been satisfied. This involves a lot of alertness, active listening, good communication skills, great flexibility, good preparation, and above all it involves a sharing of responsibility for solving the problem, not a view that this is "their" problem.

To summarize the most important keys to successful negotiation:

- Negotiate over interests, not predetermined positions
- De-personalize the problem (separate the person from the problem)
- Separate the problem definition from the search for solutions
- Try to generate alternative solutions; try to use objective criteria as much as possible
- Reflect on your negotiations; learn from your successes and mistakes

Final Advice

Be unconditionally constructive. Approach a negotiation with this: "I accept you as an equal negotiating partner; I respect your right to differ; I will be receptive."

Some criticize this approach as being too soft. But negotiating by these principles is a sign of strength.

Excerpts from paper prepared by Professor E. Wertheim, College of Business Administration, Northeastern University, and drawn from:

- Nierenberg, Gerard, **Fundamentals of Negotiation** James Ware and Louis B. Barnes, "Managing Interpersonal Conflict," HBR, 1978.
- Fisher, Roger and William Ury, **Getting to Yes**, 1991.
- Lax, D. A. and J. K. Sebenius, **The Manager as Negotiator**, (New York: Free Press, 1986).

SESSION 4: NEGOTIATION SCENARIOS — PLANNING, PRACTICE, DEBRIEF

Session Objectives:

- Analyze and plan for effective negotiation sessions to solve conflicts between hospitals and vendors.
- Apply effective conflict communication skills during negotiation meetings
- Identify concrete ways to strengthen relationships during negotiation process/meetings

NEGOTIATION WORKSHEET I: CLARIFY THE INTERESTS

Mine	Theirs	Others
What do I care about? Why is this important? What purpose does it serve?	If I were in their shoes, what would I care or worry about?	What are the concerns of others who may be significantly affected?
		Other 1:
		Other 2:
		Other 3:

Place a star next to the interests that are most important for you.

NEGOTIATION WORKSHEET 2: CREATE OPTIONS TO MEET INTERESTS

Look at your interests on worksheet 2, then list possible ways to meet the interests on both sides. (List interests in order of their relative importance.)

My Interests →	Possible Options	← Their Interests

NEGOTIATION WORKSHEET 3: SEPARATE PEOPLE ISSUES FROM SUBSTANTIVE ISSUES

Describe your relationship:	
Substantive issues and problems	Relationship Issues and Problems
(terms, money, dates, conditions, etc)	(reliability, high emotions, lack of respect, etc.)
Substantive Options and Remedies	Ways to improve the relationship

REFLECTION NOTES ON THE NEGOTIATING MEETING:

1. How well were you able to identify the underlying interests of the other party? What helped or hindered you in this step?
2. How well were you able to find viable options for addressing your and their interests? What helped or hindered you in this step?
3. How well did you separate the substantive issues from the relationship? What did you learn about relationship building from this experience?

SESSION 5: BUILDING GOOD RELATIONSHIPS TO REDUCE CONFLICT AND IMPROVE NEGOTIATIONS

Session Objectives:

- Identify concrete actions and management practices that will enhance constructive communication, clarification of roles, and timely resolution of problems between hospitals and vendors.
- Identify specific actions the different hospital actors may do to strengthen the relationships between hospitals and vendors and the skills required.

ACTIONS FOR RELATIONSHIP STRENGTHENING

During Bidding Period:

Who? What?

During negotiation of terms?

Who? What?

During mobilization period?

Who? What?

During on-going contract management?

Who? What?

SESSION 6: HOSPITAL TEAM ACTION PLANS

Session Objectives:

- Identify specific actions your hospital team will take in the next 6 months to prevent/address problems in service delivery/quality and other types of conflict between hospital leaders/staff and your vendors.
- Identify specific practices/behaviors you want to use that would build stronger relations with your vendors and prevent/mitigate conflict? (How you will build greater trust and understanding between you and your vendors?)

HOSPITAL TEAM ACTION PLAN

Action (management practice, behavior, training, etc.)	Who is responsible?	What purpose will this serve?	When?
e.g., regular meeting to review service quality issues and specific problems to address	Contract manager and vendor's on-site manager	Build better understanding of expectations and work place challenges, etc.; identify issues that need immediate attention.	Weekly or bi-weekly meetings

INDIVIDUAL REFLECTIONS AND PLANNING

1. What particular skills/behaviors do you want to work on to improve your capacity to resolve conflict, negotiate good solutions to problems and build healthy relationships with vendors?
2. How will you serve as role model for effective conflict resolution and relationship building?
3. What is the first thing you want to start doing differently that would help you understand and communicate better with vendors?



**BOLD THINKERS DRIVING
REAL-WORLD IMPACT**

ANNEX P. CONFLICT RESOLUTION-NEGOTIATION TRAINER GUIDE

Trainer's Guide

How to Achieve Win-Win Solutions and Strengthen Relationships Between Hospitals and Vendors

Capacity-Building Workshop in Conflict Resolution and Negotiation For Senior Hospital Managers and MoH Office of Strategy Management/PPP Unit

Workshop Goals

Participants will be able to...

- Identify types and sources of conflict that commonly occur in the context of outsourcing of non-clinical hospital services.
- Determine appropriate conflict resolution modes for a variety of conflict situations that present in this setting; identify one's own preferences for particular conflict resolution modes.
- Build skills in the critical communication areas of 'assertiveness' and 'cooperativeness' as applied to conflict resolution.
- Describe the keys to successful negotiation of a conflict/disagreement between hospitals and vendors, particularly those behaviors and practices that lead to "win-win" results.
- Identify best practices for strengthening MoH-hospital-vendor relationships such that conflict situations are prevented or addressed in timely and effective ways.
- Identify and commit to future actions that will advance MoH, hospital and vendor staff capacity to identify and resolve problems before they become intractable.

Session Notes

Day One

8:30-9:30 Session 1: Opening Session

Welcome/Opening Remarks from Mr. Buzwani, MoH/OSM/PPP

Participant Introductions – Ask participants to give: their name, position, hospital affiliation and the role they play in managing the outsourced services.

Introduce the workshop theme with a word association exercise. Write the word "Conflict" in the center of a flipchart page and ask participants to call out the first thing that comes into their minds when they hear/see the word. Work quickly to capture all

their responses, writing them all around the central theme “conflict” using a single-color marker. Afterwards, have the group observe the sheet and talk about what they see. Usually, the sheet will be filled with negative words/ideas. Ask them to consider for a moment what might be positive or constructive about “conflict” and record this round of answers using a different colored marker. Use both the positive and negative ideas about conflict to introduce the Workshop Themes, Objectives and Agenda. Leave the flipchart posted on the wall for the duration of the workshop.

9:30 – 12:30 Session 1: What is conflict and what are key approaches for handling it? (including coffee break)

Show the definitions of conflict on the slide and ask someone in the room to read them out loud. Refer to their list of words or phrases on the flipchart and have them compare their ideas to these definitions/points.

- What do you think about these descriptions/comments on conflict? Do they conflict with your views of conflict and if so how?

Underscore the point that conflict is a natural and inevitable but needs to be appropriately managed.

Show the list of types of conflict (on slide) and review it with the group, then handout the list of conflict examples the hospitals identified (during Louise Meyer’s STTA trip). Ask participants to draw from the list or their own direct experiences to give examples of each type of conflict. Point out that conflicts involving goals and values are the most difficult to resolve.

Introduce the Thomas-Killmann Modes of Conflict Model and Inventory. Briefly review the five different conflict modes or approaches and then have participants complete the self-inventory and score it to determine preferred styles. Once they have their scores, ask for a raise of hands to show who scored highest in each of the categories. Repeat the show of hands by asking participants in which category they scored lowest.

Using the slides and a flipchart version of the model graphic, explain the 5 different modes and their relative degrees of assertiveness and cooperativeness. To make the model as concrete as possible, have participants provide examples of appropriate use of each of the 5 different modes in the hospital context. Also review what happens when someone overuses/misuse one of the approaches. Key point: always consider the relative importance of the issues/problem you are trying to solve and the relationship you have with the other party (i.e., how long-term is it, how closely do you have to work with this person, how interdependent are your respective roles, etc.).

12:30 – 1:30 Lunch

1:30 – 3:45 Session 2: Conflict Resolution Skills- Assertiveness and Cooperativeness

Using the slides, define assertiveness and cooperativeness skills in tangible terms. Demonstrate/model the skills using real situations pulled from the workshop discussion and/or the list of conflict situations on the handout. Start by showing separate examples of each skill area and then demonstrate what they look like when you put them both together in a collaborative problem-solving approach.

Explain to the group they will practice the skills using real cases they are currently dealing with or have tried to resolve in the recent past. Ask them to identify a concrete conflict case and to use the worksheet in their notebooks to analyze it. Review each of the questions on the worksheet and answer any questions the group may have.

When they are finished completing the worksheet, have them form trios and do the following task:

- In your trio, share your conflict case with your colleagues and discuss how you think it should be handled. What conflict resolution approach should you use in this case? What does it require in terms of the Assertive and Cooperative communication skills?
- Once you have discussed the cases, each of you will practice applying the skills by roleplaying a meeting between you and the other party involved in the situation.
- As you take turns practicing your skills with your colleague, the third person will serve as an observer to give feedback

At the end of the trio practice, debrief the experience:

- How easy/difficult was it to use the skills in a problem solving discussion with the other party?
- What kind of response did you get from the other party when you were in the 'assertive mode'? In the 'cooperative mode'?
- What might be some of the pitfalls with using each of these skills in your real conflict situations?

As a final activity for the day, introduce the concept of 'emotional hijacking' and the importance of understanding and managing one's emotions. Ask participants to offer examples of what 'triggers' their emotions and causes them to lose control, and what they can do to control the triggers. Explain the pause-reflect-choose method as one option that has proven effective for many people.

3:45 – 4:00 Wrap-Up of Day 1/Preview of Day 2

DAY TWO

8:30-9:00 Take-Aways from Yesterday

Start the day by asking participants to share “Take-Aways” from yesterday—i.e., of all the material we covered yesterday, what was particularly significant for you and why? Did anything surprise you? What questions or concerns do you have at this point? Make linkages between their responses and the topics we will move into today (e.g., the importance of good communication skills to understanding the other party’s interests and needs during a negotiation sessions; etc.)

9:00- 12:30 Session 3: Keys to Successful Negotiation (including coffee break)

Begin the session by having someone read the phases on slide 31 and ask the group to react to these. Also solicit examples of negotiation situations from participants—when have you been involved in a negotiation? What worked/what didn’t work and why? Use their experiences or offer one of your own to segue into the presentation.

Using the slides, give an interactive presentation on the 10 Keys to Successful Negotiation. Use case example/s in the hospital outsourcing context and model specific negotiation skills. Emphasize that this approach to negotiation is based on achieving a ‘win-win’ solution with the other party. Ask participants to offer examples of a win-win negotiation in which they have been involved or observed. Explain that win-win negotiations are achieved because they are interest/needs-based, that is, they are solutions based on satisfying the interests/needs of both parties rather than one party at the expense of the other (which would be a win-lose situation).

Draw in the themes and skills practice from yesterday by explaining that win-win negotiations are similar to the collaborative approach and sometimes also the compromise as an interim solution until the two parties can agree on a truly collaborative approach and solution. As such, win-win solutions require careful use of the assertive and collaborative skills and can’t be successful if the parties are too one-sided (i.e., too competing/demanding or too accommodating).

Underscore the importance of separating the relationship issues and the substantive issues in a win-win negotiation. Explain that both need to be addressed but require different sets of solutions.

12:30 – 1:30 Lunch

1:30 – 3:45 Session 4: Negotiation Scenarios – Planning, Practice, Debrief

Note: Session 4 will continue into the morning of Day 3

Explaining the exercise and setting up the negotiation groups (20 min.)

Explain that now participants will have the opportunity to practice the negotiation skills using five real or 'near-real' cases involving hospital contracts managers and vendors. The exercise will start with a planning activity and then continue with a simulated meeting of the two parties involved in the case. After each meeting simulation, the group will provide feedback to the negotiators regarding their use of the skills and overall success in achieving a win-win solution with the other party.

Have participants self-select to work on one of the cases (5 cases X 4 persons/case). If some managers have particular expertise in one of the out-sourced services (laundry, cleaning, security, etc.) then ask them to work on that case if possible. Write the names and scenario numbers/titles on a flipchart so the group is clear on their assignments. For each of the scenario teams, assign 2 people to assume the role of the hospital managers and 2 people to assume the role of the vendor's managers. Explain to the group that each pair will prepare for their meeting and then select one of the two to be their representative in the actual 'negotiation meeting'. Also explain that each scenario has two written elements: a) a scenario description that everyone can see and b) a scenario script that is customized for either the hospital manager or the vendor manager and should not be seen by the other party in advance of the negotiation meeting. Note: the scripts contain additional information for that party only.

Negotiation Meeting Planning Phase (30-40 min.)

Review the 3 negotiation worksheets and explain how to use them. Hand out extra copies of the worksheets for the teams to use during the prep phase.

Have the participants divide into their pairs and sit together for the planning phase. Circulate around the room to answer questions about the scripts (particularly the scripts for the "vendors") and the planning worksheets and ensure that everyone understands the task.

Meeting Simulations

Run each meeting simulation. Have the two parties sit in chairs at the front of the room so everyone can see and hear the discussion. Allow the simulation to run for 15-20 minutes or so, until the two parties have had a chance to propose possible solutions and hopefully come to agreement on some of those. If the negotiation stalls or if one of the parties takes off in a direction that exceeds the bounds of the scenario or is too confusing for the other party, gently intervene and help the parties get the conversation back on track.

After each negotiation meeting, have a 10-15 minute feedback session:

- What did each party do that helped/hindered the negotiation? (Concrete examples)

- To what degree did each side appear to understand the other side’s needs and interests?
- What do you think about the proposed solutions? To what degree do they take into account the needs/interests of each side? What might be some other solutions you could offer?
- What else might improve this meeting?

3:45 – 4:00 Wrap-Up and Preview of Day 3

DAY THREE

8:30-9:00 Getting Started

As done at the start of Day 2, ask the group again for their “Take-Aways” from yesterday.

**9:00 – 11:30 Session 4: Negotiation Scenarios – Planning, Practice, Debrief
(continues from Day 2 pm, includes break)**

Participants continue with the role-play negotiation meetings

At the end, ask the group to draw conclusions from the simulated meetings:

- What are good practices you saw being used here? How did these practices contribute to the success of the meetings?
- What lessons did you learn through the process?
- How do you want to apply this learning to your situations with vendors? (specific examples if possible)
- What have you learned about your own negotiation skills?

**11:30– 12:30 Session 5: Building Good Relationships to Reduce Conflict and
Improve Negotiations (continues after lunch)**

Remind the group that the best way to deal with conflict is to build strong relationships between hospitals and vendors. Start the exercise by asking the group to think back to their scenarios from the previous session and identify what could be/could have been done to strengthen the relationships in these examples.

Have the group count off and form mixed small groups for the following exercise:

- Identify strategies, actions, attitudes and behaviors that are needed for building good relationships between hospitals and vendors. Think about what you need to do to establish good relations during the mobilization phase and then what you need to do to maintain the partnership

throughout the contract period. (For example, the use of regularly scheduled meetings at the different levels to conduct performance reviews and flag issues before they become bigger problems.). Also think about pitfalls you want to avoid.

12:30 – 1:30 Lunch

1:30 – 2:30 Session 5: Building Good Relationships to Reduce Conflict and Improve Negotiations (continued from am)

Have the groups share their relationship-building ideas and create a master list that the group is willing to commit to in the future. Point out any cases where the group may be confusing monitoring and relationship building and clarify the differences between these two actions/roles.

2:30 – 3:30 Session 6: Hospital Team Action Plans

As a final exercise, have participants regroup by hospital and work in their team to identify specific actions they want to take in the next 3-6 months to improve relationships and performance in outsourcing. This may include:

- Identifying specific situations that may need conflict mitigation and actions to take (i.e., situations that are ripe for negotiation)
- Additional skill-building/mentoring in conflict resolution and negotiation, communication skills, etc.
- Improving particular current relationships and steps for getting started
- Looking at up-coming contracts- how to predispose these to be successful partnerships between hospital and vendor.

Time permitting, have each team shares their plan with the other groups.

3:30 – 4:00 Final wrap-up and workshop evaluation

ANNEX Q. QUANTITATIVE SERVICE QUALITY QUESTIONNAIRE FOR NURSING STAFF

Security Questionnaire

The USAID-funded, Health Finance and Governance Project (HFG), in collaboration with the Ministry of Health, is currently evaluating changes in the quality of certain non-clinical services in hospitals before and after outsourcing those services. We kindly request your participation in this survey. Your participation is entirely voluntary.

1 Are you aware that this hospital currently outsources its security services? Please select one answer:

- Yes. No.

If your answer is "Yes," continue to question #2. If your answer is "No," you don't need to complete the rest of this Security Questionnaire.

2 In your opinion, since security services have been out-sourced at the hospital, what is the overall service quality when compared with the quality of security services prior to outsourcing? Please select one answer:

- Quality is the same. Quality is worse since outsourcing. Quality is better since outsourcing.

3 Does it seem to you that there has been a change in the number of thefts since security services were outsourced at the hospital?

Please select one answer:

- There has been no change in the number of thefts. The number of thefts has increased since outsourcing. The number of thefts has decreased since outsourcing. Unknown/No response.

4 In your opinion, has there been a change in the response time of security guards since outsourcing the service?

Please select one answer:

- There has been no change in the response time. It is taking security guards more time to respond to calls (e.g. they are slower to respond) since outsourcing. It is taking security guards less time to respond to calls (e.g. they are faster to respond) since outsourcing. Unknown/No response.

5 In your opinion, has there been a change in the ability of security guards to handle a disruptive patient, family member, or visitor since outsourcing the service?

Please select one answer:

- The handling of disruptive patients, family members or visitors is the same. The handling of disruptive patients, family members or visitors is worse since outsourcing. The handling of disruptive patients, family members or visitors is better since outsourcing. Unknown/No response.

6 In your opinion, has there been a change in the security guard's knowledge of hospital infection control practices since outsourcing? Please select one answer:

- Knowledge is the same. Security guards are less knowledgeable since outsourcing. Security guards are more knowledgeable since outsourcing. Unknown/No response.

7a Currently, in your opinion, is the number of security guards sufficient for the facility all days and all shifts? Please select one answer:

- Yes. No.

7b And how does this compare to prior to outsourcing? Please select one answer:

- It is the same. It has improved since outsourcing. It has been worse since outsourcing. Unknown/No response.

8 If the hospital has a Visitor Control Policy, has there been a change in the enforcement of the approved visitor control procedures by security guards since outsourcing?

Please select one answer:

- Enforcement is the same. Enforcement has improved since outsourcing. Enforcement has been worse since outsourcing. The hospital does not have a Visitor Control Policy. Unknown/No response.

9 Has there been a change in the degree to which staff feel safe at all hours both inside and outside on the grounds of the hospital facility since outsourcing?

Please select one answer:

- Staff feel the same degree of safety. Staff feel safer since outsourcing. Staff feel less safe since outsourcing. Unknown/No response.

Linen/Laundry Questionnaire

The USAID-funded, Health Finance and Governance Project (HFG), in collaboration with the Ministry of Health, is currently evaluating changes in the quality of certain non-clinical services in hospitals before and after outsourcing those services. We kindly request your participation in this survey. Your participation is entirely voluntary.

1 Are you aware that this hospital currently outsources its linen/laundry services?

Please select one answer:

Yes.

No.

If your answer is "Yes," continue to question #2. If your answer is "No," you don't need to complete the rest of this Linen/Laundry Questionnaire.

2 In your opinion, since linen/laundry services have been outsourced at the hospital, what is the overall service quality when compared with the quality of security services prior to outsourcing?

Please select one answer:

Quality is the same.

Quality is worse since outsourcing.

Quality is better since outsourcing.

3 In your opinion, has there been a change in the quantity of clean linen for patient care needs available in the nursing units since linen/laundry services were outsourced?

Please select one answer:

There has been no change in the quantity of clean linen available.

The quantity of clean linen available has increased since outsourcing.

The quantity of clean linen available has decreased since outsourcing.

Unknown/No response.

4 In your opinion, has there been a change in the quality of patient linen since linen/laundry services were outsourced? Please select one answer:

There has been no change in the cleanliness and state of repair of linens.

The cleanliness and state of repair of linens has improved since outsourcing.

The cleanliness and state of repair of linens has been worse since outsourcing.

Unknown/No response.

5 In your opinion, has there been a change in the linen/laundry workers' knowledge of hospital infection control practices since outsourcing? Please select one answer:

Knowledge is the same.

Linen/laundry workers are less knowledgeable since outsourcing.

Linen/laundry workers are more knowledgeable since outsourcing.

Unknown/No response.

6 In your opinion, has there been a change in the linen/laundry workers' practice of hospital infection control practices since outsourcing? Please select one answer:

Practice is the same.

Linen/laundry workers practice less infection control since outsourcing.

Linen/laundry workers practice more infection control since outsourcing.

Unknown/No response.

7a Currently, in your opinion, is the number of linen/laundry staff sufficient for the facility all days and all shifts? Please select one answer:

Yes.

No.

7b And how does this compare to prior to outsourcing? Please select one answer:

It is the same.

It has improved since outsourcing.

It has been worse since outsourcing.

Unknown/No response.

8 In your opinion, has there been a change in the maintenance of the laundry facility since outsourcing? Please select one answer:

The cleanliness and maintenance of the laundry facility equipment is the same.

The cleanliness and maintenance of the laundry facility equipment has improved since outsourcing.

The cleanliness and maintenance of the laundry facility equipment has been worse since outsourcing.

Unknown/No response.

Housekeeping Questionnaire

The USAID-funded, Health Finance and Governance Project (HFG), in collaboration with the Ministry of Health, is currently evaluating changes in the quality of certain non-clinical services in hospitals before and after outsourcing those services. We kindly request your participation in this survey. Your participation is entirely voluntary.

1 Are you aware that this hospital currently outsources its housekeeping services? Please select one answer:

Yes.

No.

If your answer is "Yes," continue to question #2. If your answer is "No," you don't need to complete the rest of this Housekeeping Questionnaire.

2 In your opinion, since housekeeping services have been outsourced at the hospital, what is the overall service quality when compared with the quality of security services prior to outsourcing?

Please select one answer:

Quality is the same.

Quality is worse since outsourcing.

Quality is better since outsourcing.

3 In your opinion, has there been a change in the housekeepers' knowledge of hospital infection control practices since outsourcing? Please select one answer:

Knowledge is the same.

Housekeepers are less knowledgeable since outsourcing.

Housekeepers are more knowledgeable since outsourcing.

Unknown/No response.

4 In your opinion, has there been a change in the housekeepers' practice of hospital infection control practices since outsourcing? Please select one answer:

Practice is the same.

Housekeepers practice less infection control since outsourcing.

Housekeepers practice more infection control since outsourcing.

Unknown/No response.

5 In your opinion, has there been a change in the availability of supplies and equipment needed to adequately clean the hospital? Please select one answer:

Availability of adequate supplies and equipment is the same.

Adequate supplies and equipment are less available since outsourcing.

Adequate supplies and equipment are more available since outsourcing.

Unknown/No response.

6 In your opinion, has there been a change in the way cleaning supplies are mixed and used? Please select one answer:

There has been no change in the way cleaning supplies are mixed and used.

Cleaning supplies are more likely to be mixed and used according to manufacturers' directions since outsourcing.

Cleaning supplies are less likely to be mixed and used according to manufacturers' directions since outsourcing.

Unknown/No response.

7a Currently, in your opinion, is the number of housekeeping staff sufficient for the facility all days and all shifts? Please select one answer:

Yes.

No.

7b And how does this compare to prior to outsourcing? Please select one answer:

It is the same.

It has improved since outsourcing.

It has been worse since outsourcing.

Unknown/No response.

8 In your opinion, has there been a change in the regular collection and proper transport of trash and domestic waste regularly through the hospital since outsourcing? Please select one answer:

There has been no change in the collection and transport of trash and domestic waste.

The collection and transport of trash and domestic waste has improved since outsourcing.

The collection and transport of trash and domestic waste has been worse since outsourcing.

Unknown/No response.

ANNEX R. QUALITATIVE SERVICE QUALITY ASSESSMENT QUESTIONNAIRE

SERVICE QUALITY ASSESSMENT QUESTIONNAIRE

Hospital Name: _____

Hospital Address: _____

Respondent Name(s):

Hospital Administrator: _____

Contract Manager: _____

Hospital Superintendent: _____

Other: _____

Other: _____

Interview Conducted by (Name): _____

My name is (INTERVIEWER NAME) and I am working with the USAID-funded, Health Finance and Governance Project (HFG). HFG, in collaboration with the Ministry of Health, is currently evaluating changes in the quality of certain non-clinical services in hospitals before and after outsourcing those services. Your participation is entirely voluntary.

A. IMPLEMENTATION OF THE OUTSOURCING POLICY

(To be completed by the Hospital Administrator)

1. What is the update on contracting at your hospital (since April 2014)?
 - a. What new contracts have been signed?
 - b. Where are they in implementation?
 - c. What have been the mobilization issues
 - d. Have SLAs been incorporated into the contracts? YES / NO (circle one)
 - i. If yes, have SLAs improved management of outsourced services?
 - ii. If no, have you made any contract modifications or other changes to allow for improved contract management?
2. Have there been any changes in the way your hospital manages its contracts? If so, how and what caused the changes?
3. What has been your biggest improvement/success with regards to outsourcing?
4. What remains your biggest challenge with regards to outsourcing?
5. How have the different hospital experiences been shared across the group and what have been the lessons learned?
6. Have hospital managers been following the agreed-upon “action steps” from the conflict resolution workshop (workshop was in August 2014):
 - a. Hold regularly scheduled meetings between the hospital contracts manager and the vendor site manager to review the vendor reports, identify any areas that need attention, and address any questions/concerns on either side.
 - i. YES / NO (circle one)
 - ii. Comments:
 - b. Plan one meeting each month as a joint “walk about” to observe and discuss what is going well and what needs attention.
 - i. YES / NO (circle one)
 - ii. Comments:
 - c. Hold periodic meetings between the higher-level hospital manager and the vendor’s general manager.
 - i. YES / NO (circle one)
 - ii. Comments:
7. Where have you seen progress in hospital-vendor relationships? Are there any efficiencies that have resulted?
8. What has been the reaction of the vendors? Is there a particular vendor that we could talk to get insight into their experience?

9. Has the PPP Unit held any meetings with the vendor senior managers/CEOs? *(Note: At the end of the vendor meeting in August, there was some discussion about having the senior managers come in every couple of months to discuss their progress toward providing good service and to identify issues that need addressing.)*
10. What about moving towards outsourcing of clinical services – is the hospital ready? How do they feel about this? Would the implications of this transition create a unique set of challenges?
11. Gender considerations:
 - a. Are there any gender non-discrimination policies at the hospital?
 - b. Before outsourcing, what was the rough estimate of proportion of women to men working in:
 - i. Security
 - ii. Laundry
 - iii. Cleaning
 - c. After outsourcing, was there any change in the proportion of women to men working in:
 - i. Security
 - ii. Laundry
 - iii. Cleaning
 - d. Are any of the outsourcing companies working at your hospital that are women-owned? If so, which ones?
 - e. Do you have an estimate of the number of women in senior management roles at the outsourced company?

B. SECURITY:

(To be completed by the Hospital Administrator and/or Hospital Superintendent)

1. Please rate the overall quality of security services at this hospital before outsourcing this service and after outsourcing this service on a scale of one to ten with ten representing the highest quality of services and one representing the lowest quality of services.

a. Before outsourcing?

b. After outsourcing?

2. On what days/hours are the security staff contracted to be present?

3. Are staffing levels adequate for the efficient operation of the security service? How does this compare to prior to outsourcing?

4a. According to hospital records, what was the total number of reported security incidents in the past year (please note the start and end dates of the year reported) of outsourced security?

4b. Additionally and where possible, please categorize the incidents (e.g. thefts, unauthorized entry, trespassing, disturbance, workplace violence, etc.), including the number of those incidents during the same time period examined.

4c. Are you able to access hospital records for the year prior to outsourcing? If so, what was the total number of reported security incidents in that year (please note the start and end dates of the year reported)?

4d. Additionally and where possible, please categorize the incidents (e.g. thefts, unauthorized entry, trespassing, disturbance, workplace violence, etc.), including the number of those incidents during the same time period examined.

5. As reported by the hospital staff, how does the response time for a call to security personnel compare before and after outsourcing security services?

6a. Is the outsourced security staff adequately trained to handle a disruptive patient, family member or visitor? What trainings do they receive?

6b. Was security staff adequately trained to handle a disruptive patient, family member or visitor prior to outsourcing? What trainings did they receive?

7a. Is the outsourced security staff adequately trained on hospital infection control practices? What trainings do they receive?

7b. Was security staff adequately trained on hospital infection control practices prior to outsourcing? What trainings did they receive?

8. How does the number of security staff for the facility during all days and all shifts compare to the number prior to outsourcing?

9. If the hospital has a Visitor Control Policy, how does security staff enforcement of the approved visitor control procedures compare to prior to outsourcing?

10a. Are management reports from the outsourced security staff complete and received on time?

10b. How does this compare with the completeness and timeliness of reports received from security staff prior to outsourcing?

11. How does the extent to which the staff currently feels safe at all hours both inside and outside on the grounds of the hospital facility compare with prior to outsourcing?

12a. Are all hospital entry/access points secure?

12b. Has there been a change in the number of secured hospital entry/access points since outsourcing the service?

13a. Does the hospital have a security management plan? If so, when was this plan drafted?

13b. Did the hospital perform a security risk assessment? If so, when was this assessment conducted?

14. What have been the major challenges with outsourcing Security Services and how have these challenges been addressed?

15. What hospital resources does the outsourced Security Service still require?

- a. Personnel (including management) and how much time for each person.
- b. Infrastructure (building space/rooms)
- c. Equipment
- d. Utilities

C. LINEN and LAUNDRY

(To be completed by the Hospital Administrator and/or Contract Manager)

1. Please rate the overall quality of laundry services before outsourcing this service and after outsourcing this service at this hospital on a scale of one to ten with ten representing the highest quality of services and one representing the lowest quality of services.

- a. Before outsourcing?
- b. After outsourcing?

2. On what days/hours do the laundry staff work?

3. Are staffing levels adequate for the efficient operation of the laundry service? How does this compare to prior to outsourcing?

4. Has daily linen per patient usage increased, decreased or stayed the same after outsourcing?

5. Have laundry and linen costs per patient day increased, decreased or stayed the same after outsourcing?

6. Does hospital administration receive regular reports on laundry equipment breakdowns, length of time for repair, and all supply procurement and usage? How does this compare to prior to outsourcing?

7. Is an adequate quantity of clean linen for patient care needs available in the nursing units at least 80% of the time? How does this compare to prior to outsourcing?

8. Does patient linen appear to be clean and in acceptable condition? How does this compare to prior to outsourcing?

9. Is dirty linen picked up regularly and within an acceptable amount of time since outsourcing? How does this compare to prior to outsourcing?

10. Is dirty linen transported separately from clean linen? How does this compare to prior to outsourcing?

11a. Do laundry workers from the outsourced service understand infection control and follow infection control guidelines for the safe handling of dirty linen? What trainings do they receive?

11b. Did laundry workers understand infection control and follow infection control guidelines for the safe handling of dirty linen prior to outsourcing? What trainings did they receive?

12. To your knowledge, are dirty and clean linens stored in separate, clearly-marked areas? How does this compare to prior to outsourcing?

13a. Is the laundry facility clean and equipment well maintained? How does this compare to prior to outsourcing?

13b. Is the laundry facility located in an area that steam, odors, lint, and objectionable noise do not reach patients or other hospital personnel? How does this compare to prior to outsourcing?

14. What have been the major challenges with outsourcing the Laundry Service and how have these challenges been addressed?

15. What hospital resources does the outsourced service still require?

- a. Personnel (including management) and how much time for each person.
- b. Infrastructure (building space/rooms)
- c. Equipment
- d. Utilities

D. HOUSEKEEPING:

(To be completed by the Hospital Administrator and/or Contract Manager)

1. Please rate the overall quality of housekeeping services before outsourcing this service and after outsourcing this service at this hospital on a scale of one to ten with ten representing the highest quality of services and one representing the lowest quality of services.
 - a. Before outsourcing?
 - b. After outsourcing?

2. On what days/hours do the housekeeping staff work?

3. Are staffing levels adequate for the efficient operation of the housekeeping service? How does this compare to prior to outsourcing?

4. If there guidelines/procedures specific to the cleaning of specialized areas within the hospital, such as the theatre, obstetrical unit, newborn nursery, etc., how does adherence to these guidelines compare to prior to outsourcing?

5. Does hospital management receive regular management reports on cleaning supply, procurement, inventory levels, costs, and equipment breakdowns? How does this compare to prior to outsourcing?

6. Does a cleaning schedule exist? If so, is this scheduled adhered to by the housekeeping staff? How does this compare to prior to outsourcing?

7. Does the hospital have procedures for evaluating the effectiveness of the housekeeping staff's cleaning? If so, how does the effectiveness of the outsourced housekeeping staff compare to prior to outsourcing?

- 8a. Do all housekeepers from the outsourced service understand infection control and follow infection control guidelines for the safe handling of dirty linen? What trainings do they receive?

- 8b. Did housekeepers understand infection control and follow infection control guidelines for the safe handling of dirty linen prior to outsourcing? What trainings did they receive?

9. Is trash and domestic waste regularly collected and properly transported through the hospital? How does this compare to prior to outsourcing?

10. Do housekeepers have the supplies and equipment needed to adequately clean the hospital? How does this compare to prior to outsourcing?

I 1a. Are cleaning supplies mixed and used according to manufacturers' directions? How does this compare to prior to outsourcing?

I 1b. Are potentially hazardous cleaning supplies labeled and stored in a safe place? How does this compare to prior to outsourcing?

I 2. Does housekeeping staff thoroughly clean each patient's area/room following discharge? If so, is this done within an acceptable amount of time following the patient's discharge? How does this compare to prior to outsourcing?

I 3a. Is the entire hospital, including but not limited to the floors, walls, windows, doors, ceilings, fixtures, equipment, and furnishings, maintained in good repair, clean and free of insects, rodents and trash? How does this compare to prior to outsourcing?

I 3b. Are the floors thoroughly cleaned on a regular basis? How does this compare to prior to outsourcing?

I 4. What have been the major challenges with outsourcing this service and how have these challenges been addressed?

I 5. What hospital resources does the outsourced service still require?

- a. Personnel (including management) and how much time for each person.
- b. Infrastructure (building space/rooms)
- c. Equipment
- d. Utilities



**BOLD THINKERS DRIVING
REAL-WORLD IMPACT**