

The panel (left to right): Bob Alexander; Peter Carter (top) and Alastair McLellan; Margaret Hodge; Tim Briggs (top) and Katherine Murphy; David Moon (top) and Bill Shields; David Sloman (top) and Terence Stephenson; Nishan Sunthares; Mario Varela; and David Wolfson



WE ARE NOT AMUSED

‘Blame Queen Victoria,’ joked one expert at the *HSJ* roundtable on how to solve the NHS’s historic problem with procurement. But the panel agreed the huge waste of taxpayers’ money in an era of austerity is no laughing matter. By Claire Read

The *HSJ* roundtable on procurement was a rare example of a debate which began with complete agreement. Opening the event, run in collaboration with the Patients Association, chair and *HSJ* editor Alastair McLellan asked whether there was a problem with the way the NHS procured goods and services. Unanimous answer: yes. The only area for discussion, it seemed, was just how entrenched that difficulty is.

“I think from where I sit the NHS hasn’t been delivering best value from procurement for a very long time,” argued David Moon, director of the value for money team at the National Audit Office, which has twice formally reported that better procurement could save the NHS many millions of pounds annually.

“It’s probably been a problem for over 20 years – certainly since NHS trusts first came into being – because the whole idea was that you’re a standalone entity and you look after your own business.

“And of course once you start looking after your own business, a lot of organisations want to do their own procurement. However, that doesn’t

ROUNDTABLE PARTICIPANTS

Bob Alexander director of finance, NHS Trust Development Authority
Professor Tim Briggs consultant orthopaedic surgeon, Royal National Orthopaedic Trust, and president elect of the British Orthopaedic Association
Dr Peter Carter general secretary, Royal College of Nursing
Margaret Hodge MP chair, Commons public accounts committee

Alastair McLellan editor, *HSJ* (chair)
Katherine Murphy chief executive, the Patients Association
David Moon director of the value for money team, National Audit Office
Bill Shields chief financial officer, Imperial College Healthcare Trust
David Sloman chief executive, Royal Free London Foundation Trust
Professor Terence Stephenson chair,

Academy of Medical Royal Colleges
Nishan Sunthares commercial and market access director, Association of British Healthcare Industries
Mario Varela managing director, NHS London Procurement Partnership
Lord David Wolfson Conservative peer and vice president of the Patients Association



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necessarily ensure you get best value.”

Lord David Wolfson, a Conservative peer and the vice president of the Patients Association, saw the roots of the problem as coming from even further back. “I think the person to blame really is Queen Victoria,” he said with a wry smile, “conveniently, because she’s not here to defend herself.

“Hospitals were set up in an era when individuals, to show their gratitude for their place in the world, built hospitals and gave them to the nation and unfortunately that is singular – there was no need to get together.

“So for 100 years hospitals were operating independently, and then we had nationalisation which pretended you didn’t need to merge those units. Now we have a situation where we don’t... and have never had data to say this is what the NHS is buying each year of this particular product – now what is the price if, instead of... 200 separate orders for 200 hospital groups, we give you one order for the NHS? Central buying I would think exists in 999 of the largest purchasers in the world. There’s one exception: the NHS.”

Professor Terence Stephenson, chair of the Academy of Medical Royal Colleges, put it more bluntly still. “Would each battalion in the army buy their own rifles?” he asked.

All on the panel agreed there was no doubt that this lack of cohesion is leading to a significant waste of resources. By placing multiple small orders for multiple different items rather than a few larger ones for fewer products, NHS organisations are failing to negotiate best prices and get best value for money.

It is not only that different organisations are buying different versions of the same product (the 2011 report from the NAO found 61 trusts were purchasing 21 different types of A4 paper, 1,751 different cannulas and 260 different administration sets). It is also that buying practices are not even uniform within organisations. One of the most headline-grabbing of the NAO’s findings on consumables was that one trust alone bought 177 different types of glove.

“We’ve done a couple of hearings around purchasing in the NHS, one on consumables and one on large equipment

‘Would each battalion in the army buy their own rifles?’

such as MRI and CT scanners, and the NAO estimate is that [you could save] half a billion on consumables alone,” Margaret Hodge, chair of the Commons public accounts committee, told the roundtable. “I quite often have to give talks about my work, and I use the findings of that report as one example of the gross inefficiency and enormous potential for better value for money [in the public sector].”

Many questioned whether such waste was in any way excusable in the current climate. “We’re talking about taxpayers’ money,” pointed out Katherine Murphy, chief executive of the Patients Association. “Can we afford to waste valuable resources at a time of austerity in the NHS?”

“With the huge amount of waste, that money could be invested in frontline staff which would obviously reflect more operations, less waiting time, and would simply be in the best interests of patients. What the NHS should be doing is working together... so that patients have access to the best quality care.”

It was a view shared by Dr Peter Carter, general secretary and chief executive of the Royal College of Nursing. He



expressed serious concern that the situation did not seem to be improving. “The 2011 National Audit Office report on this should really have sharpened the mind that, in such an austere climate, when you think of the Nicholson challenge of £4bn a year, better procurement would make a big hole in it,” he argued.

“Yet at the turn of this year, Ernst and Young published a report asking whether it had got better, stayed the same, or got worse. And very depressingly they said it had actually got worse. It beggars belief how in such a difficult environment things have gone backwards.”

With the problem and the need for change firmly established, Mr McLellan posed the natural next question: what is the solution? In contrast to his first query, this one received almost as many answers as there were panel members.

Some argued dramatic change was needed. Professor Tim Briggs, consultant orthopaedic surgeon at the Royal National Orthopaedic Trust and president elect of the British Orthopaedic Association, suggested that nothing short of fundamental service reorganisation would make a sufficient difference in his specialty.

“In terms of prostheses of just the hip and knee we see prices differing across the country and across each individual trust,” he reported. “If you take revision knee replacement as an example,

there are about 5,000 carried out each year in England, but most providers do 20 or less of those per year. They borrow kit from the company, which is a cost to the NHS of between £1,000 and £2,000 a time, and then they pay full market value for the revision prosthesis, which can be anywhere between £5,000 and £7,000.”

He talked of an NHS England sponsored pilot which aims to change all of those numbers. “What I’m proposing is that you have to have the right critical mass of patients in the right institution, which means reorganising our services. I see 50 units in England doing all the revision knee replacements, which would mean they would do 100 a year. They’d be better at doing it, but you’d also be able to negotiate price, you’d get rid of your loan kit costs because all the kit would be on the shelf, and your cost to serve would reduce.

“You will make the savings because you will have the critical mass – the volume of procedures and prostheses you’re doing – to negotiate on a regional level to actually make sure we’re getting best value.”

While Professor Stephenson agreed with the need to concentrate services in a smaller number of centres, he pointed to the extreme difficulty of doing so. “The easy one was Safe and Sustainable for children’s heart surgery. It started with the

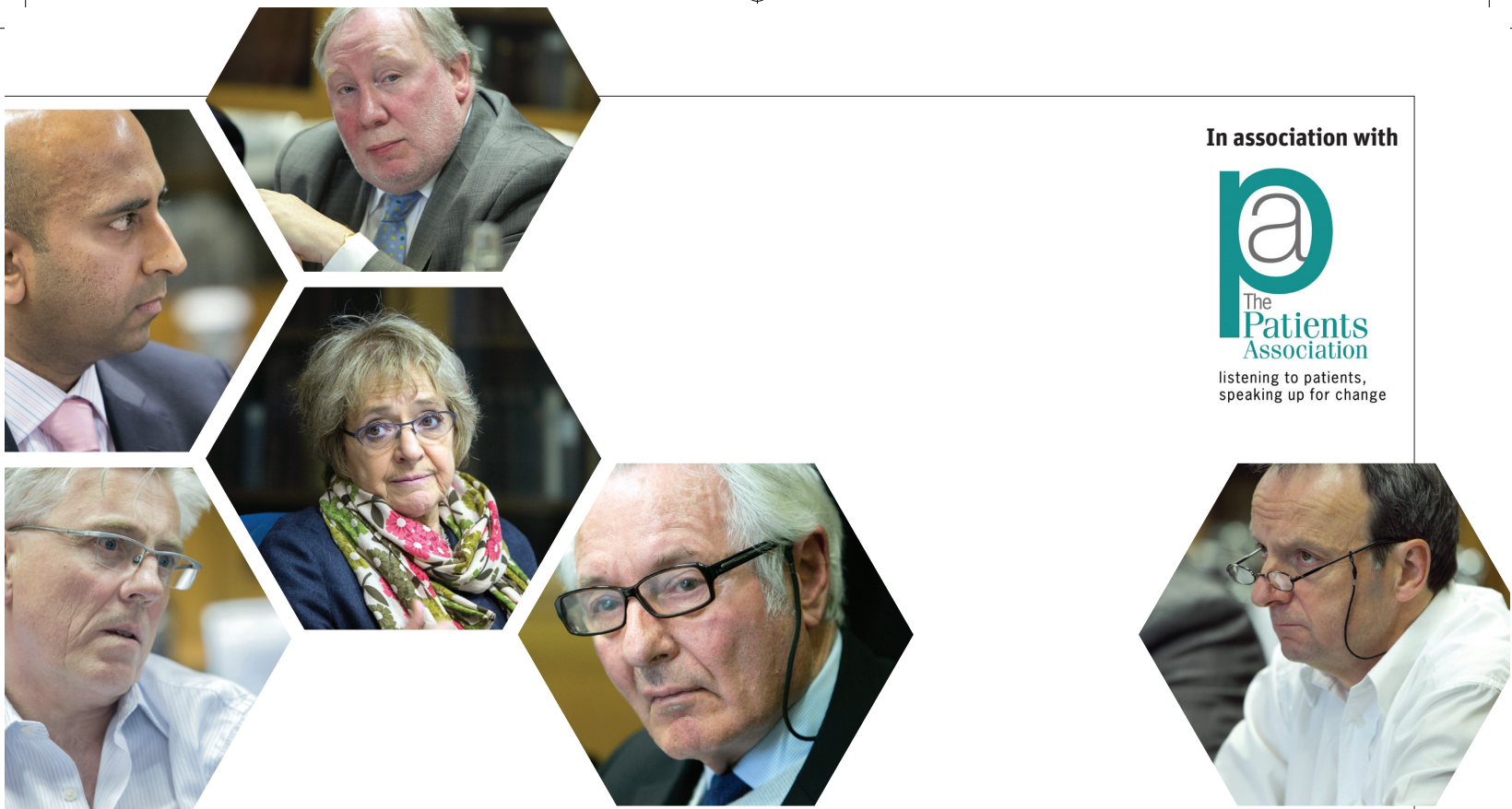
‘We’re in a world where it’s going to be decentralised, so you’ve got to create voluntary partnerships. That’s got to be the way forward’

Bristol inquiry, which got huge public support, and all the profession agreed with going from 11 centres to seven. All the cardiac surgeons, all the nurses, every single royal college agreed with it, every single charity that spoke for patients agreed with it. That was 11 years ago.

“So I don’t think procurement is going to be solved by reshaping services on the scale we’re describing because we couldn’t even do it once in 11 years,” he concluded.

Many concurred, but centralisation and specialisation more generally was a constant theme during the debate. “What organisation in the world spends in excess of £20bn per annum and does not have a strategy to leverage and aggregate that expenditure in the most effective way?” asked Mario Varela, managing director of the NHS London Procurement Partnership.

“The NHS does not have a cohesive strategy at this moment in time,” he continued. “We know the NHS is not a corporate organisation and so it doesn’t use its sizeable purchasing power in the marketplace effectively. And I think its culture and commercial behaviours at the moment are contrary to procurement best



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practice. There are 400-500 NHS organisations just duplicating the same work time and time again.”

“Trusts can’t continue to work in silos,” agreed Ms Murphy. “We’ve got to collaborate and work together on this issue.”

But how? While it seemed to many on the panel as though there had never been a better time for the creation of a central procurement agency, it also seemed as though there had never been a less likely time for it to be created.

“Obviously everyone, across the political spectrum, wants to eliminate what is clear waste,” argued Ms Hodge. “So the political will is there, but will that translate into creating a command structure from the centre? I doubt it, and I doubt it of this government and I doubt it of any future government.

“Thinking you can have prescription from the centre just won’t happen,” she continued. “The government is committed to decentralising and to autonomy of trusts and you’ve got to work on that basis. I also don’t have much confidence in the new commissioning authorities’ clout and capability for encouraging centralised purchasing.

“I was looking at it, and at the moment you can buy through NHS Supply Chain, through NHS Shared Business Services, you’ve got your collaborative procurement hubs, or you can do

joint procurement with another trusts. So already we’ve got a big mess, and I don’t think there is anybody in the centre who is going to instruct you what to do.

“We’re in a world where it’s going to be decentralised, so you’ve somehow got to create voluntary partnerships. That’s got to be the way forward.”

Partnership gains

On the panel was someone who has done just that. David Sloman, chief executive of the Royal Free London Foundation Trust, explained: “I have just merged my procurement department with Great Ormond Street, Moorfields, the North Middlesex, Barnet and Chase Farm, and the Whittington to create a platform which can leverage £700m across the piece,” he said. “And we’ve done it voluntarily. We haven’t been forced... So it can be done.”

Cause for hope, certainly, but Mr Sloman tempered it. “The downside is it’s taken us two and a half years to get there because negotiating across multiple organisations is an incredibly complex and difficult thing to do.”

In fact it was difficult and time consuming enough that, suggested Professor Stephenson, incentives would be needed to get trusts to collaborate. “When I discuss why don’t you get the best people on procurement to speak to the worst performers, the answer is, well, why would

they? Why would they give up their commercially sensitive advantage?”

“And that would suggest to me you need to incentivise this through current arrangements, either through the tariff or through the clinical commissioning groups. They have to commission services where they say, well, actually, we ain’t going to pay that amount for those gloves.”

It was an argument with which both the RCN’s Dr Carter and Bob Alexander, director of finance at the NHS Trust Development Authority, fully agreed. “You’ve got a lack of a hard collaborative incentive,” said Mr Alexander. “In a devolved, delegated sector, you need to put hard collaborative incentives in to get organisations to come together to move across that boundary.

“The incentive is of course to save money. But everybody knows that, and we have a thought process which says collaboration actually in some way gets in the way of our USP, or we do it better here so why should we collaborate with you. And it strikes me that we can do some stuff that is mandated.”

“One of the problems is that within an increasingly fragmented NHS, and with... moving to FTs, you end up with a federated health service,” said Dr Carter. “But for me it’s still a national health service, and there should be some

compulsion to get people to work together for the common aim.

“I do think that if you leave it to local consideration, one of the downsides of this great NHS of ours is that it does suffer from ‘pilot-itis’, and everybody wants to do their own thing.”

“A degree of prescription would help,” agreed Bill Shields, chief financial officer at Imperial College Health Trust. “Whether that’s across the NHS or whether it’s within organisations.”

Where could that compulsion and prescription come from?

Mr Alexander argued that when it comes to individual trusts it could be a regulatory matter. “Where you have got organisations that have got variable procurement practices going on within them in an uncontrolled way – and it’s not because there’s legitimate differences between product ‘x’ and product ‘y’, it’s because they don’t know what’s going on – that’s a board leadership responsibility. End of.

“If you’re making an assessment of organisational quality – and I mean that in the widest sense, not just clinical quality – that could legitimately be a regulatory function. What would be good is if those of us who are in oversight positions take the same approach to asking boards what they’re doing about procurement as we do when we ask them what



they're doing about staffing quality. We can do that and maybe we ought to."

Other things that could and should be done to improve NHS procurement? One area that was keenly debated was whether the staff currently working in the area have sufficient expertise.

"One issue that we encounter across the public sector but is key in this area is having the right skills, that capability," said Ms Hodge.

"There is an enormous number of very committed, bright, great people in the NHS but they don't have appropriate skills and they can be ripped off. Investment in the skills ought I think to be key."

Others argued that most of those currently working in NHS procurement are underpaid and too junior to do the job effectively.

"When I was a trust chief executive, one of the things I made sure that I did was I paid a good salary to my procurement manager," revealed Dr Carter, who spent 12 years heading up Central and North West London Mental Health Trust prior to taking up his current post at the RCN. "If you look at many trusts, people in the buying department are some of the poorest paid and some of the most inexperienced. Typically you might find people who have just graduated, are just on the first rung of the ladder, and are coming in to this for a year or

two before they can further develop their career.

"You end up having people who don't really understand the buying and procurement world. And I think if you do invest more in staff, you will buy the skills and you will get a better product. Some bigger emphasis on that might go some way to ameliorating some of the problems."

At the outset of the debate, Mr McLellan had asked panellists to focus on solutions which could be deemed realistic given the current financial climate. Could spending more money on better staff be deemed to fall into that category, Dr Carter was asked. Does the NHS need more and better procurement people to a greater extent than it needs more and better nurses?

Invest in talent

"I think if you get better procurement people, you invest to save," the RCN chief executive told Mr McLellan. "You will get better use of your money which in some way will obviate the need to lose the number of nurses we're losing. By investing in procurement people and skills, you get a much more efficient NHS, which ultimately would use the existing money much better."

"When we get into debates about procurement people, we start talking about the amount of money spent on procurement staff," said David Sloman. "Well

actually that's not the issue. The issue is the £20bn worth of influential spend that those people are working with. That's where I think the real focus of efforts and energy needs to be.

"I think we need to invest in talent. I think unless we've got good quality people out in the field, working around procurement, anything we do at the top of the office will not have an impact on the ground.

"Now we've created our new shared procurement service, we have 120 people working in the department," he continued.

"What it enables us to do is to sub-specialise to get category experts, really interesting jobs, and people who actually have the seniority and the ability to engage with suppliers.

"At scale, that's the opportunity you have. Prior to bringing the organisations together, my team was about 20 people who were basically processing and placing orders and not doing procurement on the scale and in the way that I think we're talking about today."

Linked to talk of investing in talent was talk of raising the profile of procurement.

"Procurement is an also-ran," admitted Lord Wolfson. "It doesn't get on the agenda."

"I seem to recall there was a report some time ago about the fact that procurement directors should be on trust boards," said Mr Shields. "I can't think of a single trust that has a

procurement director on its board. This isn't going to fix itself and it's an area that traditionally has been really underinvested in. So maybe the collaboration is something we need to be able to look at in terms of being able to afford people with the right skills. They will cost a bit but we can't continue to do this on the cheap."

Get leaders' attention

"We have to make this area sexy," Mr Sloman said. "If it's not particularly sexy, it doesn't engage the leadership, it doesn't necessarily get the clinicians to the table. We have to find ways of making it more at the front of the leadership challenge and at the front of the leadership mind than where it sits currently, which tends to be poorly paid people quite a way down the food chain."

The suggestion that procurement needed to be at the forefront of chief executives' concerns tied tightly to another fundamental change the panel suggested was needed.

"If there's one thing we could do it is about data," argued Nishan Sunthares, commercial and market access director at the Association of British Healthcare Industries. "And that's on both sides of the buy/sell equation: transparency of industries' commercial models and also about the way the NHS shares its data amongst its trusts."

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“One of the things the NHS currently suffers from is it doesn’t know across the whole collective of providers what it is buying, what the variance is in what individual organisations are paying for those items, and hence it can’t actually quantify how big the problem – or the opportunity should I say – truly is,” argued Mr Moon.

“And given that we’ve got a quality, innovation, productivity and prevention challenge for the end of this spending review on procurement of £1.2bn – and the next spending review of, I suspect, a bit more – then, we really, really need to understand exactly what the problem is.

“Trust boards need to take it seriously,” he continued. “They don’t, they haven’t, and that has to be addressed.”

Mr Sloman agreed. “I totally agree with the fundamental importance of being able to cleanse, share and compare data across organisations in a transparent way that leaders can latch on to,” he said. “Because at the moment the chief executive gets figures, not information.”

Others argued that then taking that data and making it more widely available would help improve matters further still.

“Transparency would be a very sensible solution – get it out there, who’s paying what for what,” suggested Dr Carter. “That would certainly help to galvanise people, to really focus

in. Particularly when the public and MPs can do comparisons and say, well, why is x trust paying this and why is y trust paying significantly more.”

Name and shame

“Name and shame,” agreed Professor Stephenson. “How did the food industry get our salt intake down by 50 per cent over 10 years? Not through any coercive regulation or central body – the Food Standards Agency simply threatened to put in the public domain how much salt was in our food.”

“There are lots of opportunities for process and transactional efficiencies that are not possible at the moment because there really is no transparency,” Mr Varela stated.

Getting transparency will first be a matter of getting the data, however. Mr Shields felt that NHS Supply Chain was providing fairly good information on the prices being paid for items from stock. “It depends on the catalogues, the speed with which they are updated and the access to catalogues which individuals in the organisation have. But the data is there,” he said.

Of course this does not represent every single item being used in every single NHS trust across the country, as highlighted by Lord Wolfson. “We’re talking 1.7m different items being procured across the NHS,” he pointed out,

highlighting that in many instances different organisations use different codes for the same product, making comparisons virtually impossible.

“The fundamental requirement is data,” he argued. “Data is the key. If we can’t translate our product codes into universal product codes, we cannot compare anything with anything else. If A1234 is not A1234 at another trust, it’s B1234, how do you ever find out what that price is to compare [it] with this one? Because you don’t know they’re the same item.”

He had been working with an organisation which he believed had a solution to the problem but, again, believed little progress would be made unless universal codes were mandated. “What we’re doing is very similar to what the UN does with translating languages so that you can hear the debate in whatever language you want,” he told the panel.

Universal codes

“We have got a way of translating this particular trust’s catalogue number into a general one which can then go and find similar lines in other trusts. So we’ve solved the biggest problem, the one that has really stopped any development since Victoria’s time. We can now translate data into a common code, but somebody has to say it’s a requirement.

“When we’ve done that, we’ve

now got transparency, we’ve got comparisons. I estimate the saving could be between £2bn and £4bn a year. Savings allied to improved customer service, fewer operations cancelled, and huge benefits to small manufacturers.”

The mention of manufacturers raised another possible obstacle. Never mind the will of the NHS to make progress – what about the will of suppliers to improve transparency?

It was a question Mr McLellan posed specifically to Mr Sunthares of the Association of British Healthcare Industries, which represents the medical technology sector. He sounded a cautiously optimistic note.

“The key point here is everybody’s looking to understand how the cost to serve the NHS can be as minimal as possible,” he said.

“Clearly the way that the NHS then exerts its buying power is going to upset emotions and you can kind of understand that. In general, most of the suppliers understand that behaviour change is needed and over time they will get there.”

He continued: “It’s going to be painful for some, there’s going to be winners and losers in all of that. But most people in time will get to that point where they understand the need.” It was a statement that could equally apply to the NHS in its need to improve procurement. ●