

All trusts now have a procurement strategy and the great majority have identified a lead director to ensure that the strategy is acted upon.

Less than one-half of all trusts are able to place orders for goods and services electronically with suppliers other than NHS Logistics, and only a quarter of trusts are using purchase cards.

procurement and supply

Only 14 per cent of trusts have fully integrated computer systems that can manage electronic requisitioning, ordering, invoice matching and payment.

Many processes known to reduce procurement costs, such as consolidating orders and invoices, rationalising the supplier base and reducing the number of different makes of products, are still not being taken up by many trusts.

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The NHS in England currently spends about £11 billion a year on goods and services...

An average NHS trust processes 23,500 orders per year.

Introduction

1. The NHS in England currently spends about £11 billion^I a year on goods and services from its suppliers, ranging from complex and expensive intensive care and diagnostic equipment, to examination gloves and paper clips. This represents approximately 25 per cent of trusts' total revenue expenditure (including pay). Paying more than is necessary for a particular item is a waste of resources that could be put to other uses. Effective management of the supply function is also critical for NHS trusts for two other reasons. Firstly, many trusts are under extreme financial pressure and reducing the costs of purchases represents a relatively painless means of achieving economy without affecting and often improving patient care. Secondly, procurement and supply professionals need to play a prominent role alongside other professionals in the trust to ensure that goods and services are of adequate quality, do not increase clinical risks and are purchased economically. This means working closely across most departments within a trust and with other organisations outside the trust.

2. Trusts need to give prominence to these important issues, but managing procurement and supply is also about painstaking attention to detail in the way purchases are processed. An average NHS trust processes 23,500 orders per year. Goods have to be checked, invoices processed and payments made. There are risks of errors and of the probity and regularity with which these transactions are handled that can also affect a trust's finances.

3. The Audit Commission first reported on the management of procurement and supply in 1996 in *Goods for Your Health* (Ref. 1).^{II} The main conclusions were that significant savings could be made from better supply management. It recommended that trusts should:

- link procurement and supply objectives to the trust's overall strategic objectives;
- increase the amount of expenditure that is managed by staff who are qualified in procurement;
- reduce processing costs by using computers to automate ordering, invoice matching and payment;
- use competition wherever appropriate;
- reduce the cost of ordering and the number of low value orders by rationalising the supplier base, consolidating orders across the trust, and examining the use of purchase cards for certain buyers;

^I This review is directly relevant to approximately 65 per cent of £11 billion as it covers NHS trusts in England providing acute services. A separate publication will be produced for Wales.

^{II} *Goods for Your Health* (Ref. 1) focused specifically on expenditure relating to clinical functions, such as medical and surgical supplies. It excluded expenditure on drugs, services, payment to utilities and expenditure on staff, such as travelling and removal expenses. This review examines all expenditure on goods and services across the entire trust.

[Trusts should] reduce the clinical risks involved with the use of equipment and consumables by standardising on fewer different makes of products...

- reduce the clinical risks involved with the use of equipment and consumables by standardising on fewer different makes of products as far as possible and involving clinicians and other users in product selection; and
 - manage stock more efficiently.
4. The Government subsequently supported many of these recommendations (Refs. 2, 3) by requiring NHS trusts to:
- identify a board member to take responsibility for procurement and supply;
 - draw up a written procurement strategy approved by the board and linked to the business plan;
 - set clear and challenging targets for procurement and supply efficiency improvements, including delivering savings of at least 3 per cent a year;
 - encourage procurement and supply staff to work towards achieving professional competencies; and
 - work with the NHS Purchasing and Supply Agency and the NHS Logistics Authority to improve procurement and supply processes.
5. The Audit Commission, in partnership with the NHS Purchasing and Supply Agency, has recently surveyed trusts in England and Wales (see footnote 1, page 1) to see what progress has been made. The work is part of the Acute Hospital Portfolio (see back cover). It is based on selected indicators that build on recommendations made in *Goods for Your Health* (Ref. 1) and on current Government policy. Data were collected from the main departments that purchase goods and services – supplies; pharmacy; estates and facilities; catering; and pathology – of each trust for 2000/01. Almost every acute trust provided data. Auditors are providing individual tailored assessments of performance to each trust as part of their responsibilities for performance management.
6. This review presents the national findings. It looks first at the extent to which trusts have effective leadership and policies in procurement and supply matters, and then examines the processes in detail.

Findings

Leadership and Policy

7. Continuous improvement in the procurement and supply function is possible only with the commitment of a trust board and senior managers. They must agree a clear procurement strategy that contributes to the overall objectives of the trust and establish a proper system of accountability. Adequate skills are needed at every level, and the accountability arrangements must be transparent with a system of performance measurement.

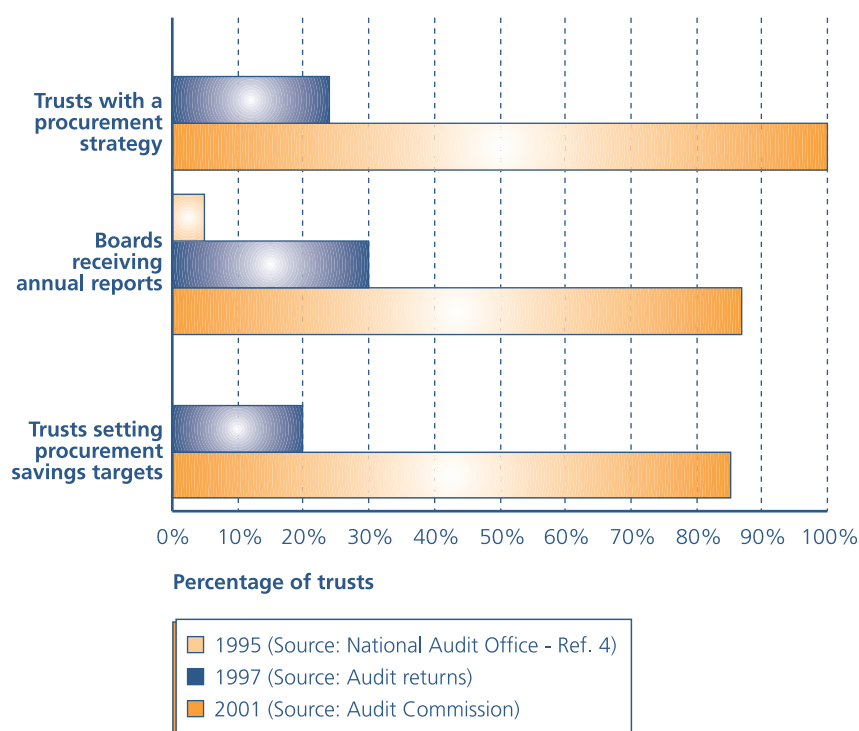
Management and strategy

8. All trusts in England had a procurement strategy in place by April 2001 and all but two had identified a board member responsible for the procurement and supply function in the trust. Procurement and supply was discussed at least once during 2000/01 by a substantial majority of trusts' boards (87 per cent) which shows significant progress compared to 1997 [EXHIBIT 1].

EXHIBIT 1

Senior management commitment to procurement and supply, England 2000/01

There has been a significant increase in the profile of procurement and supply issues at board level.



Source: See legend.

...trusts that had reviewed procurement and supply at their trust board were more likely to link procurement and supply plans with their overall business strategy.

9. In the 2000/01 survey, 62 per cent of trusts said that their procurement strategy was linked to the trust's overall business objectives. When asked about plans for 2001/02, this figure increased to 72 per cent, which suggests that procurement and supply is gaining priority at many trusts. Furthermore, trusts that had reviewed procurement and supply at their trust board were more likely to link procurement and supply plans with their overall business strategy. However, there was still a significant group of trust board members leading on procurement and supply (31 per cent) that did not have explicit objectives for it.

10. In order to be effective, strategies need to drive operational practice. About two-thirds of trusts have written policies for selecting diagnostic and medical equipment, but under half (45 per cent) of trusts have a written policy for consumables, partly reflecting the fact that consumables are supplied by NHS Logistics and are therefore covered by a national contract. Having written strategies for selecting equipment has been identified as an area for attention in the new controls assurance standards on the management of purchasing and supply (Ref. 5).

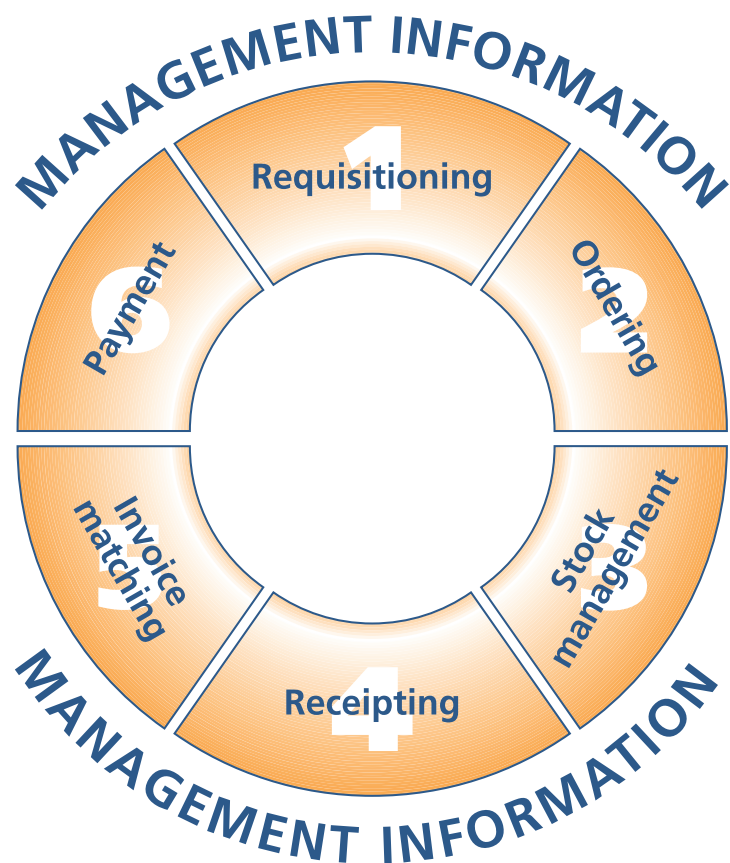
Technology for procurement and supply

11. Information technology is a key requirement for effective procurement and supply management. Trusts' procurement strategies must set out the direction for information technology in procurement and supply, with reference to the work being carried out on the development of an NHS-wide e-commerce strategy led by the NHS Purchasing and Supply Agency.¹ The trust's procurement strategy should include paperless requisitioning and ordering, integration of its finance systems and improved management information and control. There are six key processes in procurement and supply that lend themselves to automation, plus management information [EXHIBIT 2].

¹ Further information on The NHS Purchasing and Supply Agency e-commerce strategy can be found using the following link: <http://www.pasa.doh.gov.uk/e-commerce/strategy/>

EXHIBIT 2

Key procurement processes that lend themselves to automation



Source: Audit Commission

12. Some trusts have made considerable efforts to reduce their reliance on paper and improve information, but the findings of the 2000/01 survey reveal significant scope for improvement. Most trusts have a basic computer system that allows the main departments that purchase to input requisitions received from other departments and wards. The system then generates orders to be sent to the suppliers, electronically in the case of NHS Logistics.

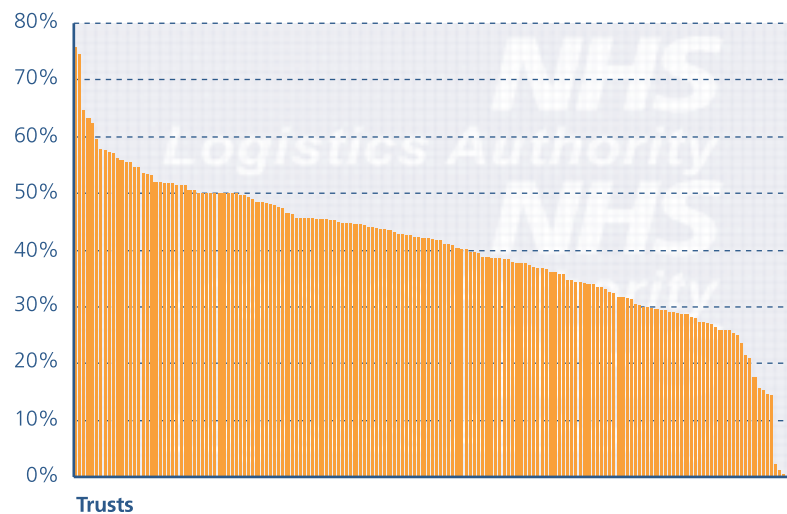
13. NHS Logistics supplies most trusts in England (98 per cent) with the bulk of their consumable products (also known as ‘stock’). All orders placed with NHS Logistics are electronic. The extent to which trusts’ supplies departments purchase goods from NHS Logistics varies from no orders to over 75 per cent of orders, with an average of 40 per cent [EXHIBIT 3].

EXHIBIT 3

Extent of orders placed with NHS Logistics, England 2000/01

The extent ranges from no orders in some trust supplies departments to over 75 per cent of orders in others.

Orders placed with NHS Logistics as a percentage of all orders placed by supplies departments



Source: Audit Commission

14. Using NHS Logistics reduces the volume of paper ordering but does not necessarily reduce the amount of paperwork from wards. However, introducing electronic bar code reading systems as part of a materials management system to optimise stock levels can reduce the amount of requisitions that need to be completed at ward level, as well as enabling trusts to manage stocks more effectively. Materials management was first introduced in the early 1990s, and by 2000/01 accounted for 48 per cent of the demand from trusts to NHS Logistics.¹ *Goods for Your Health* (Ref. 1) found one trust that had been able to make a one-off saving of £25,000 through materials management by recalculating required stock levels across wards and departments. At present, only 5 per cent of supplies expenditure is processed through materials management systems and there is wide variation in its use by trusts [EXHIBIT 4]. However, one trust, Brighton Health Care NHS Trust, uses materials management for more than a quarter of its expenditure on goods and services, by adding products supplied by suppliers other than NHS Logistics onto their materials management system.

1 Source: NHS Logistics

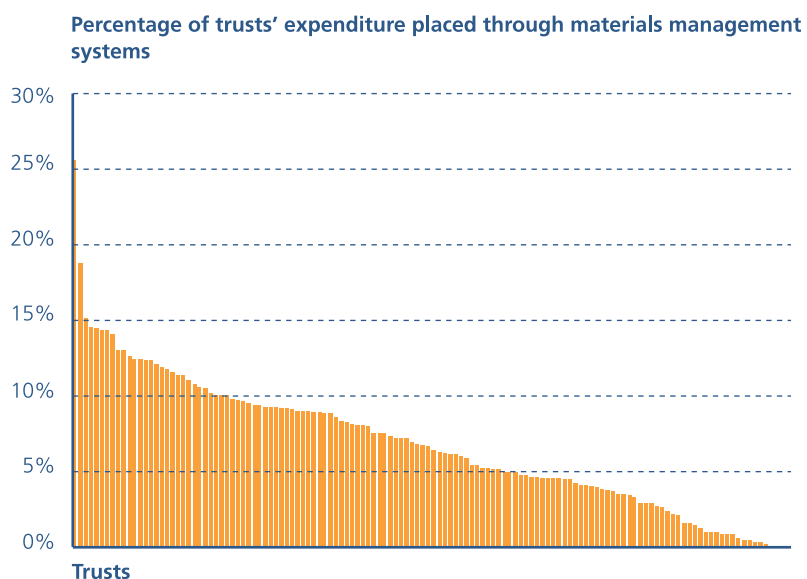
EXHIBIT 4

Use of materials management systems, England 2000/01

There is wide variation in the extent to which trusts use materials management systems.

Note: Expenditure on non-storable items such as maintenance of medical & surgical equipment, postage, business rates, rents and building & engineering contracts has been excluded.

Source: Audit Commission



[Only] 40 per cent [of trusts] were able to send orders electronically to suppliers other than NHS Logistics.

15. Electronic transfer of requisitions to departments that purchase and then onward electronic transfer of orders to more suppliers could speed up the whole process, particularly if coupled with electronic invoicing and payments. It would also reduce the risk of mistakes and facilitate better control of the distribution of stocks within the trust. Only 48 per cent of trusts had the capacity for internal electronic transfer of requisitions (excluding items purchased from NHS Logistics) and 40 per cent were able to send orders electronically to suppliers other than NHS Logistics. Only 14 per cent of trusts had invested in all three of these areas of automation. Although 72 per cent had access to at least one of them, the extent to which they were actually used varied from as little as 1 per cent of activity in one trust to 100 per cent in another [EXHIBIT 5, overleaf]. Fewer than one in five trusts were meeting the Government target that 90 per cent of all orders under £100 should be processed electronically by the end of December 2001 (Ref. 6) [EXHIBIT 6, overleaf].

EXHIBIT 5

Extent to which the trusts' systems were automated, England 2000/01

The request, placement and receipt of an order was rarely made through an electronic system.

Note: Exhibit excludes orders placed with NHS Logistics.

Source: Audit Commission

Percentage of requisitions, orders and invoice receipting made electronically by trusts

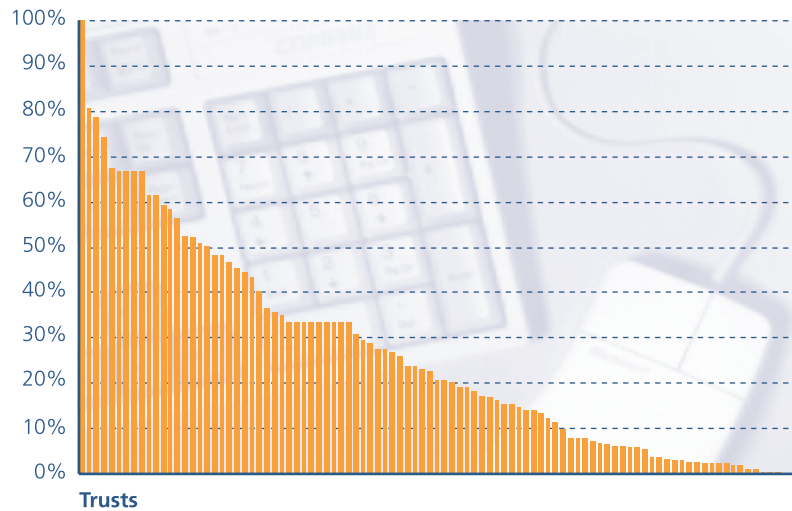


EXHIBIT 6

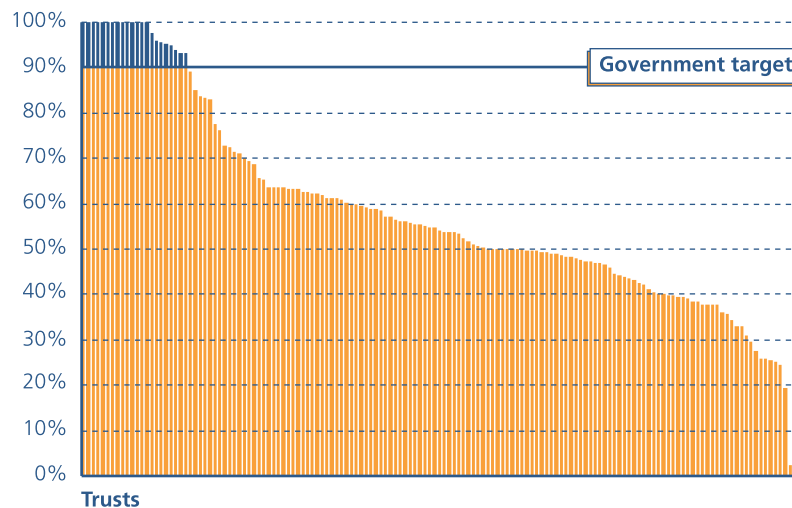
Percentage of orders under £100 placed electronically, England 2000/01

Fewer than one in five trusts were meeting the Government target that 90 per cent of all orders under £100 should be processed electronically.

Note: Exhibit includes orders placed with NHS Logistics.

Source: Audit Commission

Orders under £100 placed electronically as a percentage of all orders placed under £100

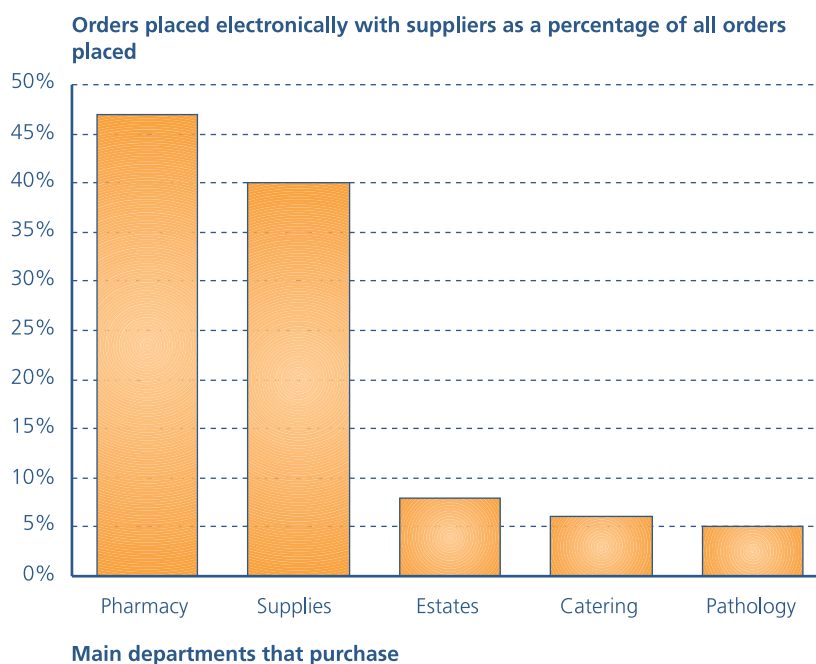


16. There are also differences in the take-up of electronic orders by different departments within trusts. Nearly half of all pharmacy departments have invested in electronic ordering compared to only 8 per cent of estates departments, 6 per cent in catering and 5 per cent of pathology departments [EXHIBIT 7]. There needs to be more take-up of electronic systems by trusts and better integration of the systems across the trust's departments.

EXHIBIT 7

Percentage of orders placed electronically with suppliers, England 2000/01

There is varied take-up of electronic ordering systems in trusts' main departments that purchase.



Source: Audit Commission

Only 26 per cent of trusts in England were using the purchase card facility in any of the main departments that purchase...

17. Another type of automation is the use of purchase cards. *Goods for Your Health* (Ref. 1) found that for certain products the use of purchase cards could help to reduce the average cost of processing an order. However, it cautioned that the use of purchase cards can increase the number of transactions. Trust managers should define which items can be bought with a purchase card so that material benefits of consolidating demand are not lost. Only 26 per cent of trusts in England were using the purchase card facility in any of the main departments that purchase, despite their being a national contract for the provision of purchase cards and associated banking services managed by the NHS Purchasing and Supply Agency.¹

18. Electronic reconciliation of invoices with orders, which avoids an often cumbersome and tedious manual task, was being used by less than half of all trusts in England (41 per cent). Only 6 per cent of trusts dealt with all of their invoices using an electronic system. And only one trust, the University Hospital Birmingham NHS Trust, processed all requisitions (excluding internal requisitions for NHS Logistics items), all orders and all invoices electronically.

¹ For further information on purchase cards use the following link: <http://nwww.pasa.nhs.uk/purchasecards>

People

19. Trusts need sufficient staff with the right skills to carry out the procurement and supply function effectively. Staff are employed in writing tender specifications, developing contracts, monitoring the use of stocks, assessing what services are required, and receipting and distributing goods around the hospital. In addition, staff need the skills to be able to engage with NHS Purchasing and Supply Agency and NHS Logistics staff, network with NHS colleagues, contribute to the development of the supply function in their trust, and have an awareness of national policies and contracts. There is variation between trusts in the cost of staff employed per £1,000 expenditure on goods and services. Generally, the specialist and small acute trusts have relatively higher staff costs, than the larger and teaching trusts [EXHIBIT 8].

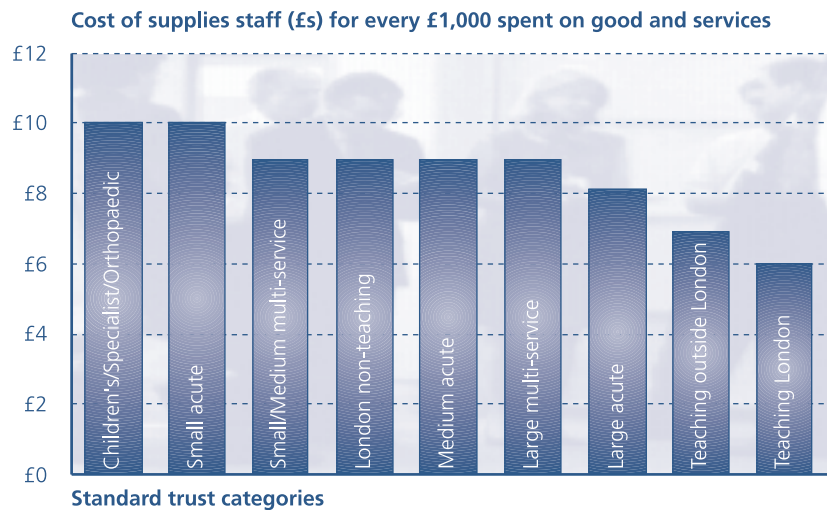
EXHIBIT 8

Cost of supplies staff for every £1,000 spent on goods and services, England 2000/01

Generally, the specialist and small acute trusts have relatively higher staff costs than the larger and teaching trusts.

Note: Supplies staff also includes staff employed to carry out receipt and distribution duties. Expenditure on goods and services excludes drugs expenditure, but includes expenditure on non-NHS staff.

Source: Audit Commission

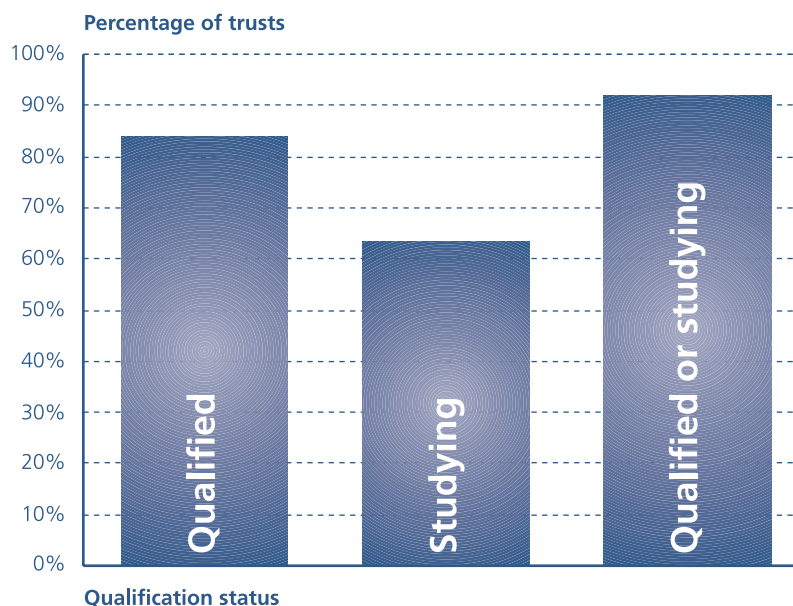


20. There is a similar variation in trusts' access to suitably qualified staff. Well over three-quarters of supplies departments employed at least one individual with a procurement qualification. However, just under one in ten trusts (8 per cent) had neither qualified staff nor staff studying for a procurement qualification [EXHIBIT 9].

EXHIBIT 9

Trusts with any qualified staff or any staff currently studying for procurement qualifications, England 2000/01

There is wide variation in trusts' access to suitably qualified staff.



Source: Audit Commission

21. The purchasing performance within NHS trusts is likely to be affected by the shortage of suitably qualified and experienced procurement and supply managers at both middle and senior levels. Trusts that have been able to attract and retain competent procurement and supply managers, appointed at a sufficiently senior level, are better placed to raise the profile of procurement and supply and to exercise real influence over the trust's expenditure. This applies not just to staff working within supplies, but to all staff who spend the majority of their time on procurement and supply in pharmacy, estates and facilities, catering, pathology and other purchasing departments. The NHS Purchasing and Supply Agency has developed a competency framework¹ that will help trusts identify the competencies needed by different grades of staff.

¹ Competency framework for NHS procurement staff. Further information can be found on: <http://nww.pasa.nhs.uk/training/pm.stm>

About a third of all trusts in England routinely involve a Clinical Supplies Adviser in selecting medical and diagnostic equipment and consumable products.

Procurement and supply processes

22. Successful procurement and supply depends as much on how the process is carried out as on the infrastructure that is in place to support it. There are several key stages and questions in the procurement and supply process that are discussed in this section:

- determining what to buy and from whom;
- applying the rules of competition; and
- placing and managing orders and processing invoices.

Determining what to buy and from whom

23. There are certain products that all trusts require, such as needles, syringes, surgeons' gloves and paper towels. These items are requested frequently and are usually covered by a national contract for the NHS as a whole. In England, national contracts are let and administered by the NHS Purchasing and Supply Agency. The NHS Logistics Authority is the supply route.

24. There is currently no consensus on which goods and services should be bought nationally, by inter-trust consortia or locally. National contracts are available for a range of goods and services,¹ but the degree to which trusts use them varies. Government policy is that trusts should support the use of national contracts and should be discouraged from 'ignoring and reinventing them' (Ref. 7). The advantages of using a national contract apply most convincingly to those goods and services required by all trusts. The buying power of the NHS should mean that prices for such goods and services are more favourable than those acquired by individual trusts negotiating locally. Nevertheless, some trusts use NHS Purchasing and Supply national contracts as the *starting point* for their own negotiation to obtain a short-term price advantage. This is advantageous to those trusts as long as only a small minority of trusts are involved. If large numbers of trusts are involved, purchasing power in the NHS as a whole could be jeopardised.

25. When buying high value goods and services, staff with knowledge of the products should work alongside staff qualified and competent in procurement. Most trusts have a system that ensures medical and clinical staff are involved in deciding what medical and diagnostic equipment is purchased. About a third of all trusts in England routinely involve a Clinical Supplies Adviser in selecting medical and diagnostic equipment and consumable products. Some trusts also have Product Selection Groups which combine the clinical knowledge of the user with the professional purchasing expertise of the buyer to achieve the most advantageous terms, quality and value for money for the trust.

¹ The NHS Purchasing and Supply Agency contracts workplan is available on <http://nww.pasa.nhs.uk/purchasing/shared/contractsworkplan2001-2.doc>

Applying the rules of competition

26. Having determined what they want and identified potential suppliers, trusts should use competition to select suppliers that can deliver the best value for money. This should be done by seeking competitive quotations or tenders (sealed bids). Where competition is not required by virtue of European Union (EU) rules governing public procurement, trusts should consider the process costs of formal tendering and quotation procedures and decide on a minimum value per item at which tendering and quotes become essential. It must be written down in their standing financial instructions. The most common value for tenders cited by trusts in the 2000/01 survey was £25,000. But the inter-quartile range was £15,000 to £30,000. There is an argument for standardisation here. The size of the trust is irrelevant. The NHS Purchasing and Supply Agency should issue guidelines on a standard minimum level of expenditure for competitive tendering and quotes.

Having determined what they want and identified potential suppliers, trusts should use competition to select suppliers that can deliver the best value for money.

27. Most trusts have rules that allow purchasers to waive requirements for competition in certain circumstances. There are sometimes good reasons why this is necessary [BOX A, overleaf]. Trusts' standing financial instructions require approval of their chief executives to waive the requirements for competition for other reasons. It is therefore likely that only a small number of items would be subject to standing order waivers¹ and indeed the average across trusts is 3 per cent. There is twice the rate of reporting standing order waivers in supplies departments compared with the rest of the trust. However, a high number of standing order waivers may simply indicate a high level of recording, rather than a genuinely high prevalence. The average also varies by trust type, from none in small acute and medium acute trusts to over a quarter in small and medium multi-service trusts and teaching hospitals.

28. Trusts cannot waive the requirements of EU rules governing public procurement under any circumstances. These are statutory regulations and trusts must ensure full compliance to avoid legal challenges in the courts. Various EU competition procedures are used in specific circumstances and trusts must seek professional procurement advice to select the correct procedure.

¹ Standing order waivers are where the requirement for competitive tendering has been waived AND a tender is NOT obtained, i.e. the trust's standing orders for tendering have been waived completely.

Box A

Burton Hospitals NHS Trust's accepted criteria for applying a single tender waiver (sometimes known as sole supplier status)

- There is a real patient emergency (forgetting to order is not an emergency)
- The product is a proprietary item and there is no alternative product available¹
- The services are, in the view of Directors, of a specialist nature

Where the goods are a partial replacement or addition to existing equipment and obtaining them from some other company would result in obtaining goods with different characteristics which would result in:

- Incompatibility between existing goods and those to be bought
- Disproportionate technical difficulty in the operation and maintenance of existing goods or installations

A separate procedure document for applying for sole supplier status is held at Burton Hospitals NHS Trust.

Source: Burton Hospitals NHS Trust

Placing and managing orders and processing invoices

29. The third stage to consider is how the trust actually purchases. There are several ways in which trusts can reduce their procurement and supply costs by:

- allowing flexibility of budgets at the end of the financial year;
- consolidating orders and invoices;
- reducing the number of low value orders;
- rationalising the supplier base; and
- standardising on product ranges.

¹ This is where there is only one possible supplier for the product when defined in functional rather than proprietary terms.

On average, almost one-quarter of items purchased by supplies departments takes place in the last two months of the year.

Year-end flexibility

30. Many trusts deny budgetholders the option of carrying surpluses over at the end of the financial year and as a result encourage increased and unnecessary spending. Such spending also tends to be rushed, with poor choices and a lack of sensitivity to price. On average, almost one-quarter of items purchased by supplies departments takes place in the last two months of the year. A trust may hold back a proportion of its equipment budget until late in the year to provide a contingency for emergencies. If and when the contingency is not required, the money can be released for planned expenditure. Other reasons for a late surge in spending include the late release of funds from purchasers or regional offices. Spending in pharmacy, estates and facilities, pathology and catering is more evenly distributed with approximately 17 to 19 per cent being spent in the last two months of the financial year in these other departments. Trusts should be monitoring their expenditure progress to ensure they are operating efficiently.

Consolidation of orders and invoices

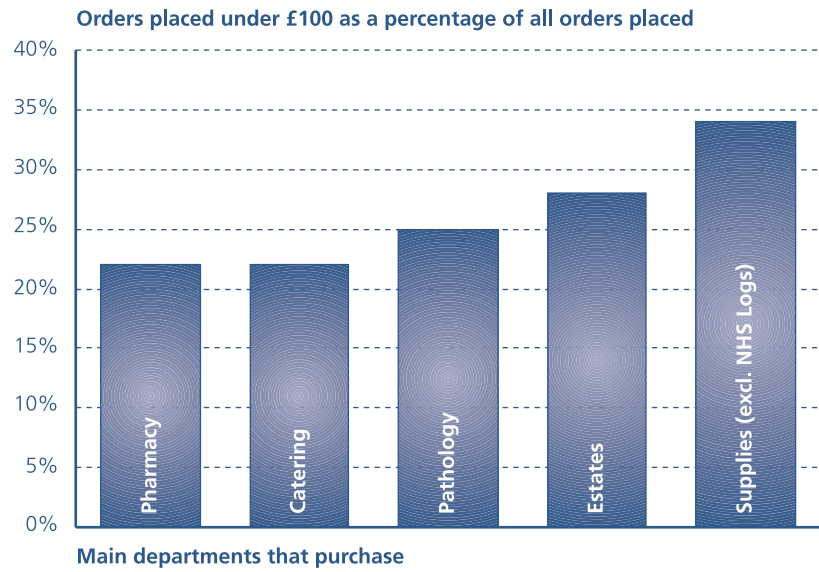
31. A purchase order is a formal contract between a buying organisation (in this case an NHS trust) and a supplier of goods and services. It will include as a minimum details of the terms and conditions under which the order is placed, a statement of the goods and services to be delivered and their cost. The number of departments within a trust that place purchase orders directly with suppliers will vary. The majority of orders from a trust are sent by the supplies department (58 per cent).

32. The average value of each order placed by trusts is approximately £870. This varies by department, with estates and supplies placing orders with an average value of over £1,200, compared with lower value orders in pharmacy (average of £850). However, the proportion of orders under £100 sent by the trust as a whole, as a measure of whether or not departments are consolidating orders, shows pharmacy departments are placing only 20 per cent of their orders under £100, whereas supplies departments are placing 34 per cent of their orders under £100, excluding the electronic orders placed with NHS Logistics [EXHIBIT 10, overleaf].

EXHIBIT 10

Percentage of orders placed worth less than £100, England 2000/01

Pharmacy departments place a third fewer low value orders than supplies departments.



Source: Audit Commission

On average 150 suppliers account for 80 per cent of a typical trust's expenditure...

33. Consolidating orders will not only reduce the transaction costs associated with low value orders, but could also act as a potential lever for negotiating better prices with suppliers, due to the higher volume of goods ordered at one time. Trusts employ different techniques to achieve consolidation. Consolidation of orders can be achieved by entering into consortium arrangements with other acute trusts and primary care trusts. Trusts are becoming more used to working with each other, setting up local groups where managers from nearby trusts meet regularly to review purchasing arrangements.

34. Consolidating invoices, such as the service provided by NHS Logistics, is also recommended as it saves time having to chase up lots of smaller invoices, often from the same supplier. The number of invoices for under £100 for a typical trust is on average in excess of 40 per cent of all invoices received. This is wasteful of a trust's procurement and supply resources. Trusts should encourage their suppliers to hold on to invoices until either a certain value or certain number are owed. London trusts, on average, had a slightly lower proportion of low value invoices than other trusts in England, at about 32 per cent.

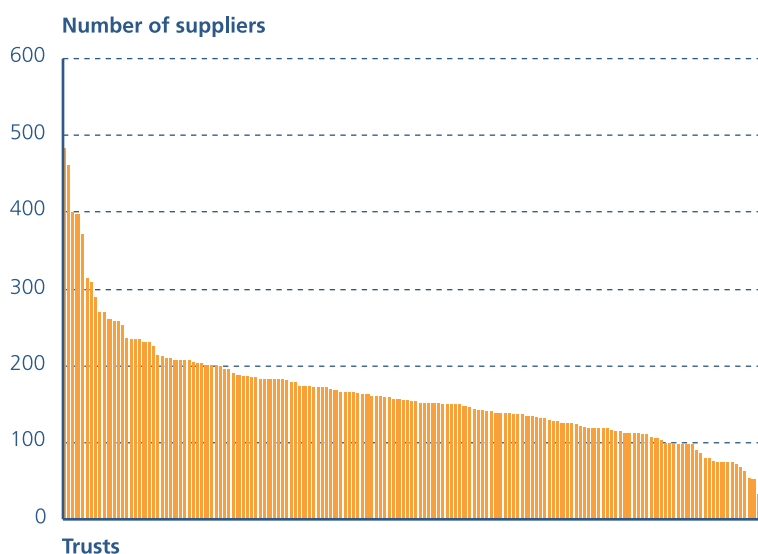
Rationalising the supplier base

35. On average 150 suppliers account for 80 per cent of a typical trust's expenditure and the average spent with any one supplier is just over £14,500. However, some trusts are dealing with as few as 20–30 suppliers within the 80 per cent bracket, whereas others are trying to manage in excess of 400 [EXHIBIT 11]. Larger trusts are likely to have slightly more suppliers than smaller ones simply because of the greater range of services and practices carried out by them. However, having too many suppliers often means that the trust is not consolidating its ordering, which can result in inefficient price variations.

EXHIBIT 11

Number of suppliers accountable for 80 per cent of trust expenditure, England 2000/01

There was a tenfold variation between trusts in the number of suppliers that accounted for 80 per cent of expenditure.



Source: Audit Commission

Standardising products reduces the risk of clinical errors as well as costs.

36. Unfortunately, it is not possible to see the extent to which trusts are using the same suppliers because trusts use different codes and descriptions of suppliers. Examples have been found of a single trust having more than one contract for the same type of product with the same supplier, simply because it has not adequately recorded the information in a systematic way that would allow such inconsistencies to be identified.

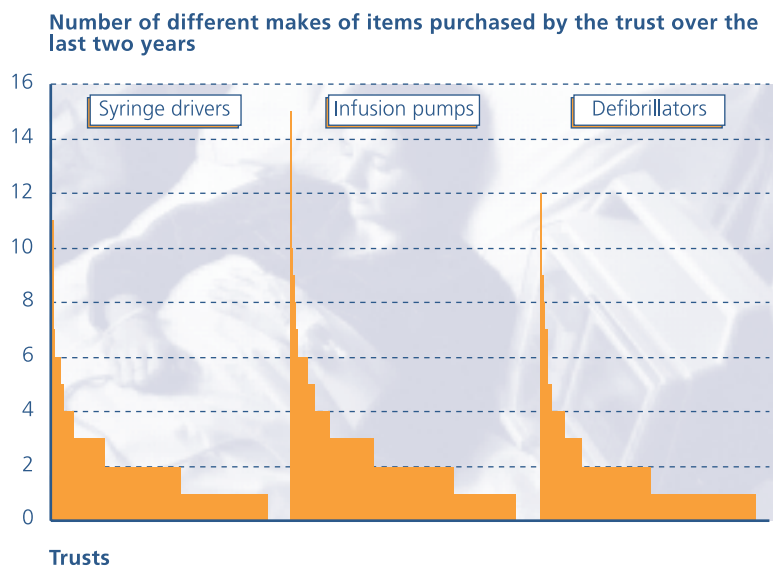
Standardising products

37. Standardising products reduces the risk of clinical errors as well as costs (Ref. 8). It also means that products ought to be easier to maintain and that there is less chance of items being non-obtainable as standard products can be used to compensate for others. Many trusts said they had written policies for selecting medical and diagnostic equipment (paragraph 10). However, the number of different makes of the same basic product ordered by trusts varies tenfold [EXHIBIT 12, overleaf]. It may be that some trusts have only recently established a standardisation policy and its impact has not yet been realised. This is an area in which trusts must be vigilant. Developing better relationships with suppliers and having a more active procedure and product standardisation policy, led by clinicians and supported by the purchasing function, will lead to a reduced number of different products and suppliers. This will in turn reduce the potential for clinical error as fewer different makes of products are in use.

EXHIBIT 12

Range of selected products, England 1999/2000 and 2000/01

The number of different makes of the same basic product ordered by trusts varies tenfold.



Source: Audit Commission

Stock control and usage

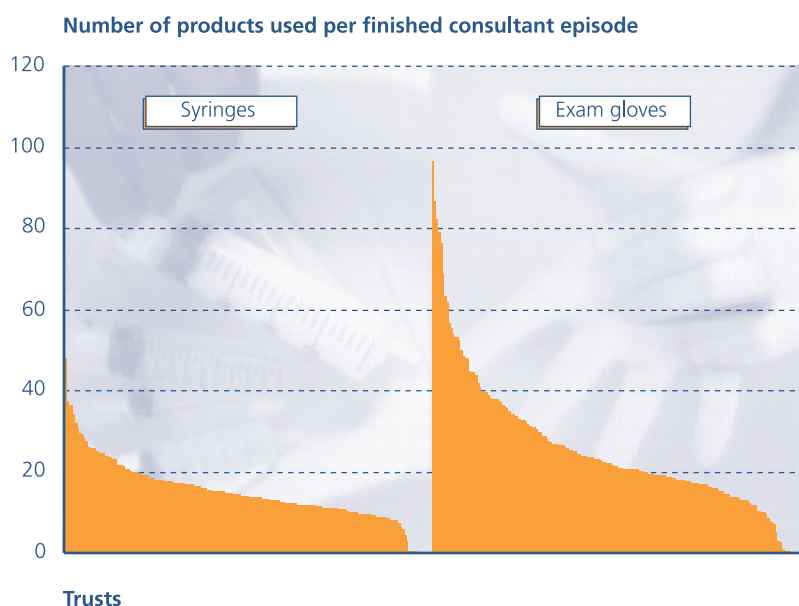
38. Better information on stock management will help to reduce the risk of running out of stocks and so improve confidence. This will depend upon the degree of automation of purchasing, including the uptake of materials management, and on trusts working more closely with suppliers to eliminate stockholding wherever possible. Trusts should also work with NHS Logistics, as the supply chain manager for the NHS, to help identify the potential for stock reduction.

39. Use of certain consumable items also varied widely between similar trusts, with no obvious explanation as to why this might be. The amount of consumables used can have a major impact on a trust's expenditure but is often neglected by trust management as being insignificant. The average number of syringes used per finished consultant episode was 15, with an interquartile range from 11 to 18 [EXHIBIT 13]. There may be some differences in the way trusts record finished consultant episodes, but these are unlikely to explain the full variation. There was a similar variation in examination gloves, cannulae sets and surgeons' gloves. One possible reason that may lead to such variation is the lack of information available on the number of gloves used by different surgeons and wards. Very often managers are not aware of the high (or low) levels of use. Differences in clinical practices can also influence the rates of use. New staff bring their own way of working from other hospitals, and these are seldom noticed let alone questioned. Poor specification of what is needed can also lead to the purchase of unsuitable equipment which is therefore underused.

EXHIBIT 13

Rate of use of syringes and examination gloves by finished consultant episode, England 2000/01

Use of syringes and examination gloves varied widely between similar trusts.



Source: Audit Commission

40. Optimal use of consumable items and elimination of wasteful practices can be achieved if managers and clinicians jointly tackle the problem by improving information, ensuring that products are not over-specified and introducing guidelines on the appropriateness of particular items.

41. The number of orders placed by a trust is also related to stock control policies. During 2000/01, an average trust recorded over £1.3 million worth of stock on its balance sheet; equivalent to about 4 per cent of its expenditure on goods and services. Similar levels of stock were recorded by all types of trusts. Holding too much stock is undesirable: it may become obsolete, is expensive to store, and is vulnerable to damage, loss and theft. During 1992/93 trusts increased their stockholding in real terms (Ref. 1). However, between 1998/99 and 2000/01, there has been a slight reduction in the amount of stock held on average by trusts each year.

Good procurement practice and savings

42. Having strong leadership and efficient procurement and supply practices should result in more expenditure being subject to good procurement practice. This in turn should lead to the right products and services being bought for the right price.

Just over two-thirds (67 per cent) of all acute trusts' expenditure on goods and services was said by them to be subject to good procurement practice.

43. Just over two-thirds (67 per cent) of all acute trusts' expenditure on goods and services was said by them to be subject to good procurement practice [BOX B]. This ranged from a small proportion of trusts that had claimed they had subjected all expenditure on goods and services to good procurement practice, to other trusts that had claimed as little as 13 per cent. There was also a difference of opinion between trusts in terms of which expenditure was viewed by them as not possible to subject to good procurement practice. The average amount of this expenditure was 11 per cent. However, this varied from as little as 6 per cent in the lower quartile to as much as 19 per cent in the upper quartile. Two trusts (1 per cent) said that all expenditure was, or could be, subject to good procurement practice [EXHIBIT 14]. Trusts that have undertaken a comprehensive review of expenditure or a benchmarking exercise are subjecting expenditure to good procurement practice. The NHS Purchasing and Supply Agency has been working with trusts to identify all those areas of expenditure which can be subject to good procurement practice and ways in which to achieve this. This should be produced as a standard and shared across the NHS to help remove variations in practices.

Box B

Analysis of expenditure subject to good procurement practice

Step 1: Identify total expenditure on goods and services

Step 2: Separate NHS Logistics expenditure

Step 3: Identify expenditure where one or more of the practices listed below are applied:

Definition of good procurement practice

- Purchased from NHS Logistics
- Purchased against a current NHS Purchasing and Supply Agency or other government agency period or one-off purchase contract
- Purchased against a current trust collaborative (or individual trust) period or one-off purchase contract
- Purchased following the invitation of competitive tenders or quotations
- Purchased from within the NHS where either a competitive tendering process has been undertaken or where some form of policy compliant benchmarking (or best value appraisal) process has been undertaken
- Purchased in accordance with trust standing orders non-competitively but where it can be demonstrated that the lowest economical cost has been achieved through benchmarking or reference to appropriate indices.

Of expenditure left over

Step 4: Identify how much expenditure is not yet subject to good procurement practice

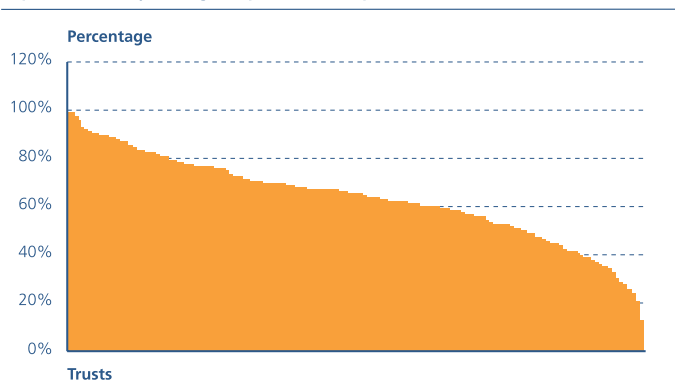
Step 5: Identify how much expenditure is not possible to subject to good procurement practice

EXHIBIT 14

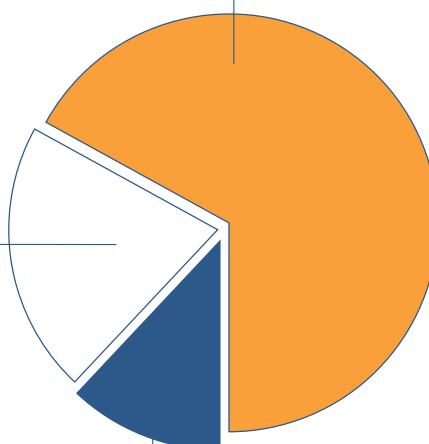
Expenditure on goods and services by procurement practice, England 2000/01

Trusts varied in how much expenditure was subject to good procurement practice and the percentage of expenditure that they viewed as being not possible to subject to good procurement practice.

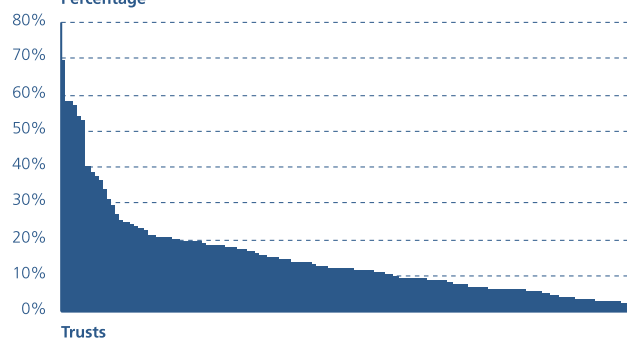
Expenditure subject to good procurement practice (67%)



Expenditure not yet subject to good procurement practice (21%)



Percentage



Expenditure viewed by trusts as not possible to subject to good procurement practice (12%)

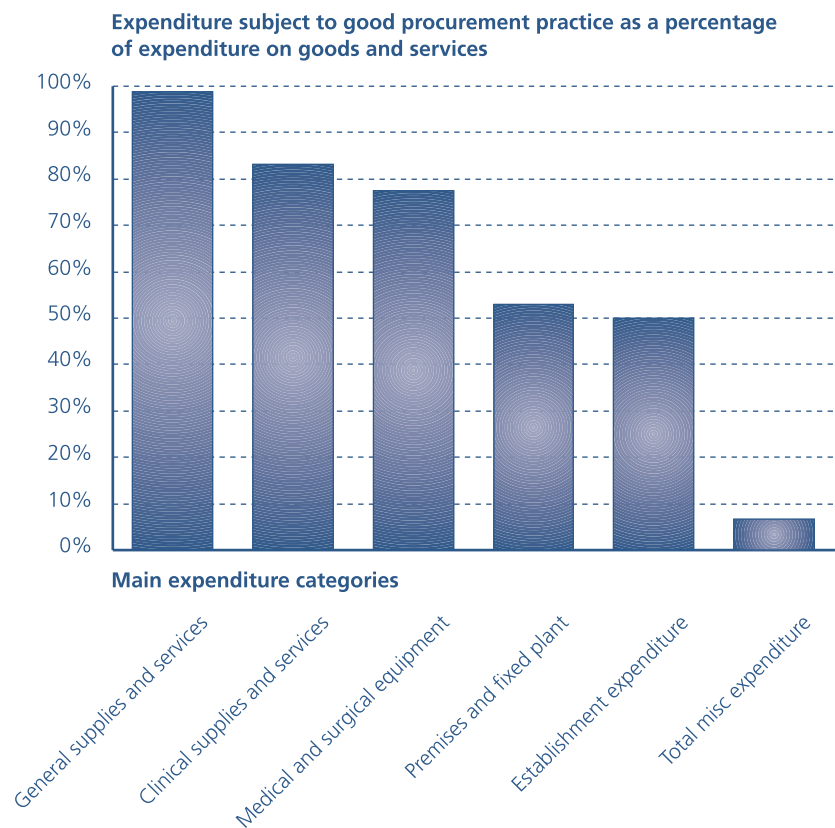
Source: Audit Commission

44. Different categories of trusts' expenditure were more likely to be subject to good procurement practice than others. Nearly all expenditure in general supplies and services was subject to good procurement practice (99 per cent), as were 83 per cent of clinical supplies and services and 78 per cent of medical and surgical equipment. However, only 7 per cent of expenditure in the miscellaneous category was subject to good procurement practice which can account for over 10 per cent of trusts' expenditure on goods and services [EXHIBIT 15].

EXHIBIT 15

Expenditure subject to good procurement practice, England 2000/01

Trusts were better at subjecting expenditure on general supplies and services and clinical supplies to good procurement practice, than expenditure on premises and fixed plant and establishment items.



Source: Audit Commission

45. The 2000/01 survey has shown that trusts include different items in the same financial return category. The Department of Health should advise trusts on what items to include in each category so that consistent measures can be achieved.

Use of good procurement practice should lead to measurable financial savings.

46. Use of good procurement practice should lead to measurable financial savings. In the 2000/01 survey the average savings as a percentage of total expenditure on goods and services was about 1 per cent, but this is between a third and a half of the Government's target, depending on the interpretation of the target (Refs. 2, 9).¹ However, the full benefits of procurement and supply activities are understated in the figures for the following reasons:

- The data tend to reflect cash-releasing savings that are achieved in-year and which lead to actual reductions in original budgets. However, many trusts quite rightly operate incentive schemes whereby a proportion of any savings identified by cost-centres are retained for reinvestment in direct patient care. The retained portion does not lead to a budget reduction and so is not classified as a cash-releasing saving but it does lead to better quality services for patients. For example, introducing an automated materials management system releases considerable nursing time so that they can spend more time with patients, but it would seldom result in a cash-releasing saving.
- When negotiating the annual service and financial framework (SaFF), many commissioners require that trusts include a proportion of unspecified efficiency savings to balance the SaFF. Consequently, many trusts in turn do not fully fund their cost centre managers' base budgets so as to provide a spur to cash-releasing efficiency gains in-year. Better procurement and supply contributes to these efficiencies but the savings achieved are seldom registered because there are not in-year budget reductions.

47. Of those trusts that did set a target for 2000/01 (85 per cent), almost two-thirds managed to achieve it, and a significant number exceeded their target. However, it does seem that the easy wins have been achieved as the average savings target set by trusts for 2001/02 fell to below 1 per cent.

¹ The Government's procurement savings target was set at 3 per cent per annum (Ref. 2). This target was translated by the NHS Executive into 2.2 per cent of trusts' total expenditure on goods and services for the 2000/01 spending round (Ref. 9).

Trusts have made some significant improvements in the priority given to procurement and supply issues over recent years.

...but there is still scope for further improvement.

Conclusions

48. Trusts have made some significant improvements in the priority given to procurement and supply issues over recent years. All trusts now have a procurement strategy and the great majority have acted upon it by discussing such issues at board meetings and ensuring that board members take up their responsibilities on procurement and supply. These improvements partly reflect the welcomed increase in attention given to procurement and supply issues by the Government and the NHS since the publication of *Goods for Your Health* (Ref. 1). In particular, many of the indicators discussed in this review have been incorporated into the new controls assurance standard on the Management of Purchasing and Supply (Ref. 5).

49. Many more trusts now also set targets for financial savings from the procurement and supply function, although average savings achieved in 2000/2001 are about a third of the current Government target for all trusts of 3 per cent. This may be an understatement of what is actually being achieved because some savings may have already been taken out of these figures. The NHS Purchasing and Supply Agency should clarify the calculation of savings targets and achievements to overcome these problems.

50. However, there is still scope for further improvement. The main areas where trusts should look for this in the future are:

- Making sure that their procurement strategy is integrated into the trust's overall business objectives, that the board member with procurement responsibility has explicit objectives for the delivery of improvements and that procurement progress is reported regularly to the board.
- Introducing greater use of information technology, including materials management systems and purchasing cards, to reduce paper and automate the key procurement processes. (Only 14 per cent of trusts have so far invested in fully integrated computer systems and only 26 per cent use purchasing cards.)
- Ensuring there are sufficient competent staff to deal with procurement and supply issues and that staff are properly engaged with all parts of the trust. This means involving other trust staff, particularly clinicians, in purchasing decisions, and ensuring that good procurement practices are observed throughout the trust.
- Applying good procurement practice, including the rules of competition, to all expenditure on goods and services should be the norm. Trusts should work with other trusts and the NHS Purchasing and Supply Agency to cover all areas as a matter of priority.
- Improving procurement and supply practices such as consolidation of orders and invoices to increase efficiency; and reducing the number of different makes and models of similar equipment to reduce risks of clinical errors.

- Developing and sharing good practice in procurement both across all trust departments and between trusts. The NHS Purchasing and Supply Agency has recently published its paper *Modernising supply in the NHS* which provides examples of good practice and ways in which to implement them (Ref. 10).

Trusts should have already been working closely with their auditors, the NHS Purchasing and Supply Agency and the NHS Logistics Authority to identify their specific problems and develop plans for improvement. The Audit Commission will review trusts' procurement and supply performance within four years.

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acute hospital PORTFOLIO

The Acute Hospital Portfolio is a collection of audits that are available for auditors to undertake at acute trusts, according to local priorities. They focus on key service areas or resources within the trust that are of concern to trust managers and patients. Each year the Audit Commission selects up to four topics from the Portfolio to survey across all trusts. Three main stages to the survey work are carried out in sequence on an annual cycle:

Data collection → April-July

- Emphasis on data quality
- Support from auditors

Diagnostic audit → from November

- Independent tailored review by auditors
- Takes account of local context
- Information for decision making

In-depth audit → from February

- Targeted on problem areas
- Action plan for change

The data collection and diagnostic work is the core of the survey, and each trust receives from its auditor a tailored assessment of its performance based on the data collected. In-depth audit work is then carried out at only a minority of trusts – those that demonstrably need it. This survey is repeated for each topic within four years, so that progress can be monitored both at individual trusts and nationally. A maximum of 16 topics is currently envisaged to allow coverage of all the key issues and service areas.

This review reports the results from the survey of Procurement and Supply. It is one of the four topics in the second phase of the Portfolio. Similar reviews will also be produced for each of the other three topics this year – Medical Staffing, Medicines Management, Radiology – and, next year – Outpatients, Bed Management, Operating Theatres, and Waits for Admission. Previous review reports have been published from the first phase of work covering Accident and Emergency, Catering, Day Surgery and Ward Staffing.

More details are available on the Acute Hospital Portfolio website (<http://www.audit-commission.gov.uk/itc/acuteportfolio.shtml>). The data for the first phase of four topics and the accompanying computer software are also available to NHS trusts for comparative purposes. For details see the website.

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