NHS Professionals

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People not things:
A new approach to NHS procurement

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Chief Executive's foreword

Procurement - surely, there are few other words in the NHS manager's lexicon that attract such criticism and misunderstanding.

As April's reforms become a reality and a new Chief Executive is appointed to lead NHS England, we felt this was a particularly apt time to bring a fresh perspective to the role of procurement in the health service landscape. A well-managed procurement process not only delivers vital efficiency savings but, crucially, can improve patient care and reduce risk.

To this end, we convened a roundtable of senior health service managers with particular expertise in procurement, chaired by King's Fund Chief Executive Professor Chris Ham.

At NHS Professionals, our expertise lies in managing flexible workforce solutions for NHS Trusts, including running large banks of nurses and locum doctors. We were therefore particularly interested in exploring ways in which procurement of goods and supplies differs from procurement of people. In the words of health minister Dr Dan Poulter, procurement encompasses everything 'from rubber gloves and stitches to new hips, building work, bed pans and temporary staff'. So how can a single process be suited to such an enormous variety of 'goods'?

While our discussion took place just weeks before the publication of a major new report on procurement, it is fascinating that our roundtable participants teased out the key issues later addressed by Dr Poulter. These ranged from a national framework to procurement hubs, from training to Trust-wide buy-in.

I am proud that NHS Professionals continues to lead the way in providing valuable insight to the NHS, and remains at the forefront of improving understanding, particularly at this most testing of times.

Stephen Dangerfield

Chief Executive, NHS Professionals

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Executive summary

'Procurement has a key role to play in protecting frontline care and in ensuring the NHS can live within the 2015-16 spending round commitments.' Few could disagree with this assertion in NHS England's *Better Procurement, Better Value, Better Care: A Procurement Development Programme for the NHS,* published in August 2013.

When we look at the £2.4 billion NHS spend on contract and agency staff, the opportunities to deliver cost savings, reduce risk and improve patient care are all too clear.

The procurement of agency staff on spot rates is surely the unacceptable face of temporary staffing. Faced with a distress purchase, all too often the best that the overworked, undervalued procurement professional can do is demand a percentage discount on the agency fees.

Typically, agency fees are not negotiable. However, they may be agreed as part of a Trust procurement strategy that recognises that its people are a vital strategic asset. Having the right people with the right skills in the right place at the right time is one part of what good procurement is all about.

One way to achieve this is to develop a procurement strategy that engages managed service providers to carry some of the risk. But the risk is not only about price; it's about achieving quality and continuity of supply in a seller's market. It's about understanding all the cost variables and drivers that affect the Trust, including the costs and risks associated with different employment models. However, if the procurement team doesn't have the full picture, it simply won't be in a position to secure the best deal – for patients, for the Trust and for the taxpayer.

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Introduction

Complacency is not an option

Good procurement models reduce costs, improve patient outcomes and, at the same time, make the NHS a better place in which to do business, as health minister Dr Dan Poulter wrote in *Better Procurement.*

Collaborative procurement organisations such as NHS Supply Chain, the Government Procurement Service, London Procurement Partnership and NHS Commercial Solutions have been trail-blazers, but Trust buy-in has been, at best, limited. The distance between the best and the rest remains a cause of concern.

Roundtable chair Professor Chris Ham, Chief Executive of the King's Fund, pointed out to participants that the time to act is now.

The National Audit Office has already identified the potential for £500 million savings in the NHS. 'I believe the real potential may be even greater,' said the former NHS Chief Executive Sir David Nicholson. These savings are essential if the NHS is to hit its target of delivering £1.5 billion in cost savings by 2015-16.

5 Roundtable

Defining procurement

The starting point for the roundtable was to grapple with the issue of definitions. Is procurement even the correct term when it comes to workforce?

For NHS Professionals' Stewart Buller, Director of Communications, lack of clarity is a crucial and overlooked issue. 'Who has ownership of the NHS procurement framework model, for example? And where does traditional procurement fit in the growing trend towards managed services?

'Traditional procurement is about buying things,' he said. 'But how do you go about procuring a managed service where there are people involved?'

Procurement expert and independent consultant John Yates believes the direction of NHS reform in recent years has heaped problems on NHS procurement. 'Coupled with the fragmented nature of the NHS and increasing autonomy, the NHS misses out on economies of scale that you would have got before the advent of an internal market.'

For Jane Harrison, Procurement Director of NHS Commercial Solutions, widely held misconceptions about procurement are particularly problematic. 'Procurement departments are seen in Trusts as the place where the orders go,' she said.

'There's no investment and no sponsorship at Trust level,' she added. 'Huge numbers of decision makers have conflicting views at local level, let alone national level. When we go into the market, Trusts are competing with one another.'

Barriers to good procurement: unmotivated staff

'Is the perceived poor quality of procurement departments a cause of the problem or a symptom?' asked Professor Ham. He felt that there wasn't a lack of competence among procurement staff. The issue was how those charged with procurement were motivated.

Ali Parsa, founder of Circle, said that when Circle was appointed to run Hinchingbrooke Healthcare NHS Trust in Huntingdon, he found that the procurement staff hated the perception and value ascribed to their job, in relation to other functions in the health service. He said, 'I gave them a purpose, to become the smartest people in the NHS. They were very proud of the savings they achieved [£1.5 million on a £95 million budget]. I brought in an external coach, and I gave them autonomy. They ran their own unit, met their own budgets. I gave them the information they needed and left them alone to deliver.'

Mr Parsa, like many other roundtable participants, observed a vicious circle whereby lack of regard for procurement professionals dissuaded the best from joining the NHS. 'Why would good people be attracted to NHS procurement?' asked Mr Parsa, contrasting the situation with leading business brands such as Tesco, 'where some of the best people sit in procurement roles'.

Neil Baigent, former Senior Category Manager of the London Procurement Partnership, also observed a dispiriting predictability in the current situation: 'If you invest in procurement, and engage from start to finish, efficiency savings can be generated. If there was investment, people would see the benefits.'

He also felt that the lack of specialisation was a barrier to improvement. At Trust level, he said, 'the procurement person has to know everything from aspirin to zinc.'

It was suggested that NHS procurement is not typically promoted as being an attractive career option. It could be argued that this is due to the current lack of investment and ability to attract commercially savvy people.

What to avoid: silos and localism

Where procurement works well, the Trust has buy-in from top to bottom. Lack of understanding of procurement at board level was widely identified as a major barrier to improvement and all participants emphasised the importance of working collaboratively rather than 'everyone doing their own thing'.

Ms Harrison encapsulated the problem when she said, 'If procurement happens at a very local level it's often a quick fix to an immediate need. It shouldn't be an individual's decision; it should be a Trust decision.'

Too often, procurement staff are excluded from strategic decision-making and are called upon simply to expedite a piece of policy that has already been decided upon. Mr Yates said far too often the Trust board took a decision – to buy a new patient electronic record system, for example – 'then procurement and lawyers get to take over'. Good procurement, as all agreed, is based on sound information.

'You need to know your costs or there are no comparators,' pointed out Mr Yates. 'It's impossible to say if you're getting good value if there's no base line.'

Clinical staffing: time to stop the blame game

One of the biggest people costs in the NHS is the spend on medical locums, estimated at £630 million per annum in secondary care. These are procured from medical staffing agencies by medical staffing departments, often at short-notice as distress purchases.

Bill McMillan, Head of Medical Pay and Workforce at NHS Employers, identified medical staffing departments as 'full of un-led folk… it can be a dead-end place, where staff are not valued.' He felt it wasn't surprising that when they are pressed to get short-term (locum) cover they can fail to do 'a particularly good job'.

There is a clear distinction between a strategic workforce initiative, planned perhaps a year in advance, and a last-minute request to fill a short-term staffing gap. As Mr Buller put it, 'If you're not planning your temporary workforce effectively it's a distress purchase.'

Mr Baigent said the path to success was clear: 'Where there is a collaborative procurement and workforce strategy in place, there are Trusts which are successful. It's a whole workforce issue; it's not right to solely blame the procurement vehicle or the chosen "solution". It's about engagement and buy-in from everyone (procurement, HR, finance, temporary staffing, workforce etc) from day one.' He stressed the need for accountability at Trust Board level and recognition of the contribution that procurement can bring.

'The NHS needs a flexible workforce' he remarked. 'However, it does not necessarily need multiple (procurement) framework factories.'

A job for HR?

'There are similarities between procuring lavatory rolls, paper clips and temporary staff,' said Professor Ham. 'But there are differences too, so why do we give the job to the same people?' He suggested that managed services might sit within HR rather than procurement. But there were fears that devolving the task to HR could be another form of silo working: 'If you leave it to the HR director, they will achieve things for the HR function but not for the business as a whole,' said one participant.

Ms Harrison said that most of the successes, especially in South Central, had been achieved by working with HR teams, not procurement. The way forward could be as simple as saying, 'The Trust down the road is doing this; go and visit them.'

Procurement hubs

Mr Buller said that properly organised and managed, procurement hubs can make a difference to procurement practice. In his view, 'you have to take procurement people out of the Trust to get them to serve the Trust's aims'.

But Mr Parsa said that, for him, the old question of how many people it takes to change a light bulb was pertinent in this debate, and he believed outsourcing wasn't invariably the right answer. 'Organisations that just stand on a chair and do it are the best. If something's broken, fix it yourself.

'You want the path of least resistance to getting any job done,' adding that hubs ran the danger of creating what he called 'ginormous bureaucracy'.

Managing demand

Mr Buller, like many of his roundtable colleagues, saw the need to manage demand as the nub of the procurement debate, saying 'it's what we do before we hit the market place that makes the difference.'

Mr McMillan pointed out that the number of consultants had more than doubled since 1997 and there was a 'massively increased pipeline' of junior doctors. 'Are we clear about what we're training doctors to do, and how many we need?'

Should the NHS be paying more for fewer of them to do more effective work? 'Instead, if a gap opens up we fill it with temporary staff,' remarked Mr McMillan.

Measuring the problem: questions, but too few answers

In the non-permanent staffing category, the NHS spends over £2.4 billion, so the issue of a flexible workforce with the right skill mix is imperative.

Mr Buller said NHS Professionals had seen a 20% growth in demand from Trust clients for temporary staff. 'What has driven it? No one has the answer. It's the problems in workforce planning that lead to the demand, at a cost of billions to the NHS.'

It was clear that changes to junior doctors' hours imposed under new working time regulations has played a major role in costs, as had the 2003 consultant contract but, as Professor Ham put it, 'again the issue is how you manage it'.

He suggested that some NHS workers were making a career choice to join the temporary workforce.

While doctors are now required to 'positively affirm' to the General Medical Council that they are fit to practise through revalidation, there are concerns that locums may find it easier to slip through the system.

Mr McMillan agreed, saying he was worried about the 'itinerant locum' who does a poor job in Cornwall and then turns up in Cumbria.

There is clearly an urgent need to find out why there is such an enormous demand for locum doctors. Mr McMillan asked 'Why are locums costing more and being used so extensively when we have more doctors in the UK than ever before, even though we have not yet moved to a seven day service model? Increasing staff numbers and staff pay does not in itself increase the quality of the service provided, or the productivity of those providing it.'

He spoke for many in the room when he said: 'The questions are easy; it's the answers that are more difficult!'

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Where next: a path to progress?

A national framework?

The Government Procurement Service (GPS) has recently announced a national framework for procuring agency nurses. Prices are provided on the basis of hourly charge rates for each job role. Pricing includes all costs so there are no hidden extras.

But the idea of a national framework found few supporters, with most believing that different stakeholders have different demands. 'There is no reason why there has to be just one way forward', said one participant.

Some felt there was excessive focus on frameworks and said the solutions were already there; they simply weren't being used effectively. They called for better education at local level and using solutions such as managed staff banks, which could produce enormous savings. Ms Harrison believed that there was a repetitive cycle whereby every three to four years Trusts bring a focus to bear on reducing agency spend. 'There's an initial improvement, then we take our foot off the pedal.'

Sharing good practice

Sharing good practice and access to case studies of Trusts that had achieved savings were endorsed by the whole group. But Mr Baigent cautioned that a sustained whole-Trust approach to reducing costs was essential, 'It's not a quick win,' he said. 'There needs to be benchmarking between NHS Trusts and time and effort spent on sharing good practice. Everyone has to determine how important it is and be engaged with the decisions made.'

A change in culture

Some wondered whether enforcement was the answer in instances where sharing good practice didn't achieve the desired outcomes. Many recognised that the NHS culture isn't to 'tell people how to do things'. As Mr McMillan put it, 'Culture eats strategy for breakfast. People are determined to do things as they've always done them.'

Region-wide strategy

Ms Harrison said it was essential to demonstrate the value of good practice across a region. 'If you have Trusts that believe they can work alone, that's difficult.'

A national lead

Given the fragmented nature of NHS procurement, is there an argument for an individual to take the lead on procurement? It was felt that the structural complexity of the commissioning-led NHS made it difficult to know who this might be, beyond 'someone in NHS England'.

A case for regulation?

Mr Yates suggested that Monitor's role could be extended to include inspections of Trusts' procurement practice, pointing out that 'how hospitals buy goods and services has a big impact on quality of care'.

However, others saw a danger in potential over-regulation and felt that sufficient oversight already exists. Mr Baigent pointed out that the NHS Litigation Authority and the Care Quality Commission are empowered to ask questions about whether temporary staff pose clinical risk.

Professor Ham said he believed oversight was the job of the Trust board. Mr Baigent noted that *NHS Procurement: Raising our Game* called for a board member to be appointed to this role but the group could not determine whether or not this was a mandated requirement or if it was guidance or best practice.

Model contracts and improved toolkit

Mr Yates pointed out that much NHS procurement was 'repetitive buying'. 'It shouldn't be beyond the wit of man to devise model contracts,' he said, adding that framework agreements tick some of those boxes but have a limited life span.

A procurement academy

With education and training identified as a key stumbling block to improved practice, there was some enthusiasm for this proposal.

Less emphasis on legal compliance

Legal compliance with EU procurement legislation was identified as the overwhelming preoccupation of Trust Boards – and of training – but all of the participants stressed that for effective procurement the focus should be on delivering results for the Trust and for patients.

Ms Harrison said that at NHS Commercial Solutions the approach was 'If you haven't had challenges you haven't been brave enough'.

Mr Parsa agreed, saying, 'If you're not prepared to take risk, you can't have proper procurement.'

Mr Yates said very few letters from complainants develop into legal challenges and many complaints have very little substance. 'Nearly all procurement breaks rules in the form of lots of tiny technical defects. There may have been technical breaches, but has the complainant suffered a loss? In the vast majority of cases, the answer is "no".'

Professor Ham concluded with a reminder that training, model contracts and framework agreements are not just about legal compliance – they must identify good practice and not only safe practice. However, this is difficult to achieve because of deeply entrenched behaviour at the heart of the NHS.

7 Conclusion

As NHS Trusts grapple with delivering the efficiency savings asked of them by government, establishing procurement models that cut costs while enhancing patient care and reducing risk must be at the centre of their ambitions. As the roundtable participants discussed, there are clearly major differences between procuring supplies (objects) and procuring people, particularly when they are being engaged via a managed service contract.

Here, in particular, there must be Trust-wide engagement and buy-in at board level. HR, for example, must play its part in the design and delivery of a Trust-wide strategy.

One thing is clear: procurement, in whatever form, cannot be done successfully in isolation. Yet time and again we hear of procurement professionals being 'brought in' almost as an afterthought once the key decisions have been taken. This is particularly true when it comes to workforce supply contracts, which leaves strategic implications for the Trust. In this way the procurement function is reduced to little more than an administrative task. No wonder we hear dispiriting accounts of disengaged staff who feel they are at the bottom of the workforce heap.

The NHS can do better - and it must.

What bad practice looks like

- **Unmotivated procurement staff**
- **Procurement staff held in low esteem by peers**
- **Lack of understanding of procurement at board level**
- **Procurement unrepresented at board level**
- **Procurement staff involved late in the process**
- **Lack of robust financial data to inform procurement decisions**
- **Distress purchases rather than a workforce strategy**
- **Failure to manage demand**
- **Decisions made by individuals rather than as part of a Trust-wide strategy**
- **Failure to engage at regional level and a preference for 'going it alone'**

Routes to improvement?

- **Involving HR in managed workforce services**
- **Making use of procurement hubs**
- **Managing demand**
- **Having a national framework**
- **Sharing good practice**
- **Changing cultural attitudes and resistance to change**
- **Engaging at regional level**
- **Appointing a national lead for procurement**
- **Ensuring enhanced regulation of procurement process**
- **Using model contracts**
- **Using an improved toolkit**
- **Establishing a procurement academy**
- **Putting less emphasis on legal compliance**

Procurement: the future

- **Procurement Development Programme**
- **NHS Procurement Development Oversight Board**
- **A leading private sector figurehead to act as a 'procurement champion'**
- **NHS Procurement Development Delivery Board**

8 References

1 *Better Procurement, Better Value, Better Care: A Procurement Development Programme for the NHS.* **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226835/procurement_development_programme_for_NHS.pdf**

2 Laing and Buisson, *Healthcare Spend* **report 2012-13**

3 *NHS procurement: Raising Our Game***, 2012, https://www.gov.uk government/publications/nhs-procurement-raising-our-game**

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