AUDITOR GENERAL

PERFORMANCE AUDIT

In good supply?

Managing supplies in the NHS in Scotland

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In good supply? Managing supplies in the NHS in Scotland

A report to the Scottish Parliament by the Auditor General for Scotland

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Audit Scotland is grateful to those who participated in local reviews at trusts.

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Rhona Jack and Fred Talbot developed the study under the general direction of Caroline Gardner, Deputy Auditor General.

Executive summary

Supplies are the largest area of NHS expenditure after staff pay with NHSScotland (NHSS) spending an estimated £600 million each year on goods and services. Supplies management is important to trusts in ensuring that staff have access to the equipment, goods and services they need to treat patients. Despite this, there is considerable room for improvement in the management of supplies. A stronger emphasis should be placed on the Best Value principles of achieving improvements through comparing and challenging current practice, introducing competition where appropriate and consulting with key stakeholders, including suppliers.

This report aims to provide baseline information on the management of supplies in NHSS, along with performance indicators and a good practice guide that will be used to monitor progress. The report is based on the findings of local auditors, along with our own literature review, site visits and discussions with key groups involved in supplies management.

First, basic management information is not routinely available, either to those responsible for managing the supply chain or to those who use supplies. Expenditure on supplies and levels of usage can only be estimated. This lack of information means that it is not possible to manage supplies effectively by identifying unusual patterns of expenditure and usage, and investigating the underlying causes. It also means that there is no way of knowing whether proposed national savings targets are realistic, or whether they have been achieved in practice. For example, a report in 1997[1] recommended that logistics costs should be targeted at 2.5% of turnover. Similarly, a further report[2] in 1999 indicated that a recurring saving of £30 million could be achieved within a three-year period. At present, data are not available to support whether these are reasonable targets or to monitor progress towards them.

There is a second key problem. NHSS has significant purchasing power, allowing it to negotiate favourable contracts with a range of suppliers to improve both cost and quality. Over 300 of these national framework contracts exist, covering approximately 100,000 items, valued at approximately £250 million and involving around 800 suppliers[3]. The benefits of using centrally negotiated contracts include:

- increased purchasing power
- improved value for money
- reliable sources of supply
- scope for suppliers to plan ahead and reduce contracting costs.

But there is no agreement governing which supplies should be purchased at local, regional and national levels. And, more importantly, individual trust chief executives, acting as accountable officers, have a duty to obtain best value for money for their own trusts. Thus, trusts have an incentive to use the national contracts as a starting point for negotiation to push down prices with their own suppliers, bringing the national tendering system into disrepute and leading to a short term gain to one trust at the expense of NHSS as a whole.

There is also real potential to use information technology (IT) more effectively to achieve the benefits of e-commerce. This is likely to mean that trusts will need to invest in both management and in integrated information systems locally if they are to exploit the opportunities that exist for better value for money. For example, good interfaces between supplies, finance, laboratory and theatre systems are required to support user information requirements. In addition, trusts need to participate as far as possible in the general Scottish Executive public sector e-commerce system.

Auditors found that the effects of these problems are evident at local level. For example:

- in 40% of trusts orders are placed by staff outwith the supplies function and therefore without access to formal procurement expertise.
- 28% of trusts express ambivalence about using the national contracts agreed by Scottish Healthcare Supplies (SHS) and prefer to rely on locally negotiated contracts. In total, national contracts account for only about half of total NHSS expenditure on supplies[4].
- performance monitoring is poor across Scotland which undermines trusts' ability to benchmark effectively. Much more work is required in this area to provide the comparative data required for benchmarking. For example, data on the use of supplies are only available at one fifth of trusts, and this tends to be provided on an ad hoc basis; trusts rely on their financial systems to identify changes in usage.
- progress on improving management information and developing performance indicators has been slow, as trusts are reluctant to risk wasting time and money by working in isolation.
- in the absence of e-commerce solutions, a quarter of trusts place high numbers of low value manual orders, leading to high transaction costs.

A fifth of trusts lack systems to allow them to maximise prompt payment discounts. Whilst e-commerce solutions might help, the ability to make prompt payments depends on those receiving goods and services submitting documentation confirming receipt in a timely fashion so that it can be matched to the invoice. Only after this is achieved, can invoices be authorised for payment. Given the size and complexity of NHSS, it is likely that most trusts will need to negotiate a payment period outwith the 30-day CBI target with suppliers. However, auditors drew attention to concerns about this in only three cases.

Tackling these problems requires a national approach to ensure that information requirements are specified and data definitions are consistent in order to support performance management. A working group highlighted the need for national solutions in 1999[5]. The Scottish Executive Health Department (SEHD) did not endorse all the proposals, but it did agree that a group of officials from SEHD and the service should take forward the development of targets for trusts and for SHS[6]. The group never met and no progress was made on this front, mainly due to the disruption caused by trust reconfiguration. However, trust reconfiguration is now complete and the establishment of unified health boards provides a good opportunity to restart the process. This should be done as a matter of priority.

Progress has been made nationally by procurement specialists from trusts and SHS working together through the Strategic Alliance Partnership (SAP) (see appendix 5). Together, they are now looking at a range of issues including:

- working with Audit Scotland on the development of performance indicators (PIs)
- sharing good practice
- identifying opportunities for savings
- reviewing contracting points
- training
- e-commerce.

However, this group is made up of operational procurement specialists who will need sustained high-level support and authority to deliver the changes required. In addition to these procurement initiatives, opportunities to improve the monitoring and management of usage also need to be addressed. Effective management of supplies will depend on strong leadership both nationally and locally – it cannot be left solely to operational managers.

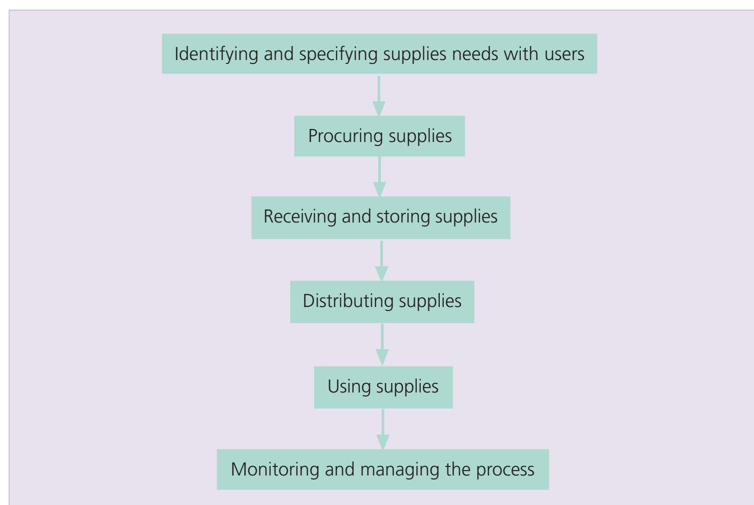
Despite a range of reports and initiatives over the last 20 years, the management of supplies in NHSS remains fragmented and fails to demonstrate good value for money. Given the strategic importance of supplies, and the opportunities that exist to improve value for money, we will work with NHSS to develop and pilot PIs in 2002-03. We will follow up their implementation along with our other recommendations and produce our follow up report in 2004. At this stage the PIs should be available across Scotland; this will provide a clear picture for the first time of where and how value for money can be improved.

Introduction

Why study the management of supplies?

Equipment, goods and services are essential in treating and caring for patients. They represent the second largest area of NHSScotland (NHSS) expenditure after pay, accounting for an estimated £600 million per year[7]. Supplies cover a wide range of items as diverse as stationery, uniforms, surgical gloves and infusion devices. They include the goods and services procured by works and estates departments, catering, laboratories, pharmacies and other specialist clinical support areas such as radiography. Supplies management is therefore a vital support service, covering the whole process from identifying the need for a product or service to its eventual use.

Exhibit 1: Steps involved in supplies management



Source: Audit Scotland

Trusts organise their supplies services in different ways: some have their own supplies organisations, while others buy in services from other parts of the NHS or from commercial organisations. There is no single “right” way to manage this process, which will be influenced by factors such as the size and type of trust and its geographical location. However, trusts must be able to demonstrate that their arrangements are likely to achieve value for money.

Of the £600 million expenditure in 1999, the Working Group on Procurement[8] estimated that around half was spent directly by trusts acting individually or in concert with others; the rest was spent through centrally negotiated contracts. Their report also drew attention to the continuing problems of getting robust data about supplies expenditure. However, the Scottish Healthcare Supplies (SHS) representative on the Working Group identified estimated potential recurring savings of £30 million per annum[9], or 5% of estimated total supplies expenditure. This target for savings was noted by the Management Executive (ME) in 1999 but, in the absence of robust data, it is difficult to establish whether it is realistic or achievable. The

current view of the Scottish Executive Health Department (SEHD) is that it is not achievable without an unacceptable centralisation of the procurement process across NHSS, and it may not even be achievable with centralisation. Other targets have been set in the past: for example, in 1997 it was proposed[10] that logistics costs should be targeted at 2.5% of turnover. Again, data are not available to support whether this is a reasonable target or to monitor progress towards it.

Despite efforts to identify and promote good practice, progress in implementing recommendations for change has been slow. The Working Group on Procurement identified ten reports dealing with procurement over the last 20 years, and highlighted the lack of progress with the implementation of their recommendations. The Working Group also identified a number of barriers to change including:

- the fragmented nature of the supplies organisation
- the low visibility of the supplies function to senior management
- the lack of good information systems.

Whilst SEHD did not endorse all their proposals, they did agree[11] that a group of officials from the ME and the service should take forward the development of targets for trusts and SHS. However, the group never met and no progress was made on this front mainly due to the disruption caused by trust reconfiguration. However, trust reconfiguration is now complete and the establishment of unified health boards provides a good opportunity to restart the process. This should be done as a matter of priority.

Progress has been made nationally by procurement specialists from trusts and SHS working together through the Strategic Alliance Partnership (SAP) (see appendix 5). Together, they are now looking at a range of issues including:

- working with Audit Scotland on the development of performance indicators (PIs)
- sharing good practice
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- training
- e-commerce.

However, this group is made up of operational procurement specialists who will need sustained high-level support and authority to deliver the changes required. In addition to these procurement initiatives, opportunities to improve the monitoring and management of usage also need to be addressed. Effective management of supplies will depend on strong leadership both nationally and locally – it cannot be left solely to operational managers.

Approach

Performance monitoring and benchmarking has been dogged by the lack of robust management information. A major aim of this study has therefore been to identify and agree a set of supplies PIs to be used by all trusts as supplies users, along with a second set of PIs for those trusts which provide a supplies service. Working with the Working Group on Procurement, we used their recommended PIs (see appendix 2 for their proposals) as a starting point. We then sought to establish the extent to which these are already in use in NHSS. We recognised that different trusts would have different baselines in terms of the quality of their management information, especially

since the local studies were undertaken in 1999-2000 when trust reconfiguration was underway. Local studies aimed to provide senior management in the newly formed organisations with a baseline from which to move forward in improving the management of supplies.

A study guide was developed as the basis for local reviews in trusts across Scotland, which included the Working Group's proposals for PIs. Since then we have undertaken further PI development work in partnership with SAP, which involves supplies specialists from 26 trusts working together on supplies issues. Our joint proposals[12] are currently out for consultation and the aim is to launch an agreed set of PIs at the NHSS Supplies Management Conference in October 2001. The study guide also highlighted good practice guidelines that draw on good practice from across the economy (see appendix 3), since there is much that is transferable from industry and other parts of the public sector[13]. Good practice will evolve in response to changes in the environment. Thus, as e-commerce is introduced, this will impact on what should be deemed to be good practice. For example, whilst the use of purchasing cards is deemed to be good practice meantime, their usefulness may be overtaken by e-procurement initiatives. We will keep good practice under review.

The review of the management of supplies was undertaken at 24 of the 28 trusts in Scotland, and at the State Hospital (n = 25). Auditors examined the availability of performance information in each trust, together with the quality of:

- the overall management arrangements for supplies
- procurement processes covering ordering, receipt and payments
- logistics processes governing storage, requisitioning and use of supplies
- IT to support the management of supplies.

The objective of the local audits was to identify areas where improvements could be made, and to agree an action plan with the trust to address these areas in the light of good practice. This should lead to:

- better use of the limited resources available, for example by greater use of standardisation and aggregation in the management of supplies
- improved management information to identify opportunities for better value for money.

Our focus has been on the management of supplies rather than simply on stores management at trusts. We consulted widely with stakeholders, including senior managers and supplies specialists, through site visits and through our advisory panel[14].

This report is based on: the findings of local auditors reported to trusts during 2000-01; our own literature reviews; site visits; discussions with SHS and the Working Group on Procurement; and our work with representatives of SAP.

Effective management of supplies will depend on strong leadership both nationally and locally – it cannot be left solely to operational managers responsible for procurement and usage. Given the strategic importance of supplies, and the opportunities that exist to improve value for money, we will work with the service on the development and piloting of PIs in 2002-03. We will follow up their implementation along with our other recommendations and produce our follow up report in 2004. At this stage the PIs should be available across Scotland; this will provide a clear picture for the first time of where and how value for money can be improved.

Management and organisation

Trusts need to manage supplies to ensure that their staff have access to the equipment, goods and services they need to treat and care for patients. Supplies are also the largest area of NHSS expenditure after staff pay.

Strategy and accountability

NHS boards should not usually need to discuss supplies matters in detail, but they do have a responsibility to ensure that:

- the trust supplies strategy supports the wider organisational objectives
- costs are monitored as part of overall financial management
- roles and responsibilities for supplies management are clear; the trust has access to the skills it requires for managing the whole system of supplies; and performance monitoring reports are presented for consideration by the board.

Despite its strategic importance, four out of five trusts had no (or an inadequate) strategy for supplies. Auditors have recommended that trusts make use of a framework designed to help them develop their supplies strategy[15]. In particular the strategy should help them achieve:

- an understanding of what the trust spends, with whom, for what and why
- identification of risks inherent in that expenditure
- plans for action which will reduce or minimise those risks
- measurements of progress and quantification of outcome.

Management arrangements are influenced by factors such as trust size and type, as well as whether local consortia arrangements are in place. Whatever the model, an executive director at board level should be accountable for supplies matters, providing a channel from the operational level to the policy-making body. Individual trust management and organisation arrangements can cover a range of models:

- the trust may operate its own local stores
- parts of the service such as traditional stores functions may be provided by another NHS body acting as an agent or out-sourced to an external agent such as a distribution company
- the trust itself may operate a stores function on behalf of other NHS bodies.

Only four trust boards (11%) required reports on performance. Eleven trusts (44%) had clearly delegated responsibility for supplies to a director; those most frequently mentioned were director of operations, director of estates and director of finance. The interest the director takes in supplies matters varies from a close operational interest to an arms length arrangement. Since most trusts have supplies or procurement managers, the best approach is for the executive director to maintain a strategic interest, with operational responsibility delegated to supplies professionals.

As expected, the supplies models in place varied, with some trusts running their own stores and others operating service level agreements (SLAs) with other parts of the NHS or contracts with commercial companies. However

auditors reported five instances where SLAs needed to be formalised or updated.

At operational level, trusts need professional expertise to ensure that the best deals are achieved. There has been concern about this in NHSS. For example, the Working Group on Procurement estimated that operational departments are incurring approximately half the expenditure on supplies, by-passing local procurement management[16]; this typically involves departments such as works and estates, laboratories, CSSD, catering, and specialist clinical support areas such as radiography. In addition, pharmacy has tended to develop its own specialist procurement function.

Auditors also confirmed this, drawing attention to ten trusts (40%) where orders were being placed outwith the supplies function and without access to formal procurement expertise, raising concerns about whether the best possible deals are being achieved. At six trusts (24%), auditors reported that supplies staff did not have any formal supplies or procurement qualification although the position was reported as satisfactory in the majority of trusts. Where staff who are able to place orders are not deemed to be suitably qualified, this raises concerns about whether some of those responsible for procurement have the knowledge and skills needed to secure the best deals. Two trusts had recognised the importance of investing in supplies management and were in the process of creating suitable posts to give it a higher profile. In addition, SAP has a training group and is now working with a college to secure appropriate SVQ training suitable for the different types of staff involved.

Product selection and procurement arrangements

Procurement activity starts with product selection. Typically, product selection and standardisation offer the potential for better value for money. Managers should consider fitness for use when judging whether it is worth purchasing a separate or new product; a final decision would also depend on:

- relative costs of supplies
- frequency and different types of use
- process costs of procuring a new line.

Users have an important role to play in product selection, since they need to be confident that what they are using meets their needs. However, individual needs and preferences have to be balanced against corporate needs and constraints. Complete freedom of choice can lead to increased costs, increased risks for training and safety, and poor quality.

By contrast, standardisation, when introduced appropriately, can offer considerable benefits by:

- reducing stockholding
- simplifying ordering and storing processes
- improving training in use of equipment
- developing better relationships with suppliers.

This means that trusts need to agree and implement a policy on standardisation which takes account of the fact that in some areas standardisation is not always appropriate or possible. Users should be fully involved, and will often provide the clinical or professional input needed to evaluate the quality of different products. The approach used for developing and agreeing drugs formularies offers a valuable model. This process informs

the procurement of medicines throughout Scotland at a regional and national level, with only limited contracting for drugs now being undertaken at hospital or trust level. Only a quarter of trusts have a formal policy on standardisation, and user input is limited. For example, product selection groups are in place in a third of trusts but in most of these there is only partial coverage.

Procurement operates at both local and national levels. NHSS spends some £600 million per year on supplies, which should give it significant purchasing power. SHS negotiates and maintains national framework contracts. In 1999 it was estimated that there were over 300 national framework contracts, covering approximately 100,000 items, valued at approximately £250 million and involving around 800 suppliers[17]. The benefits of using centrally negotiated contracts include:

- increased purchasing power
- improved value for money
- reliable sources of supply
- scope for suppliers to plan ahead and reduce contracting costs.

Historically, there has been a lack of commitment to national contracts negotiated by SHS. As far back as April 1992 the ME advised NHSS that it was mandatory to use the contracts negotiated centrally by SHS for goods, supplies and equipment[18]. There was some evidence that central contracts were being used as 'stalking horses' to obtain better deals locally; this was bringing the national tendering system into disrepute, and generating local gains at the expense of NHSS as a whole. The situation was made more complex by the introduction of trusts and the appointment of trust chief executives as accountable officers. As such, they had a clear duty to achieve best value for money for their own organisation. That provided a major dilemma when the interests of the local trust and NHSS nationally were in conflict and this needs to be resolved in the new environment.

Monitoring arrangements were put in place by SHS approximately three years ago to assess the performance of national contracts, progress on expanding the range of goods available under national contracts, and client satisfaction. SHS use trust demand forecasts over a range of products to show potential savings for NHSS if trusts actually take up the planned volumes. However, SHS cannot be sure about the extent to which national contracts are taken up by trusts as the only data available are provided by suppliers and even this is patchy. As a result, it is not known whether trusts actually achieve the potential savings. In order to monitor savings at national level and ensure SHS can deliver optimum savings through the contracting process, it is essential that timely uptake figures are provided by trusts. Whilst these are being provided on a voluntary basis through SAP, this should be formalised.

There is evidence of a lack of commitment to national contracts and the service has not viewed them as being mandatory. In addition, there is no formal agreement on what items should be bought at national, regional or local level, and no agreed criteria for determining these items. The Working Group on Procurement[19] recognised this and provided general guidance (see Appendix 4). The Working Group also proposed new arrangements for future product selection. For national contracts, user input to product selection is achieved through Commodity Advisory Panels that are appointed by SHS from nominations by trusts. However, seven audit reports (28%) indicate that users are ambivalent about using products secured by

SHS, preferring to seek local solutions, especially if they can secure a better deal for their own trust. Barriers to using national contracts also relate to concerns about the loss of trust autonomy and lack of responsiveness to local needs. These issues need to be addressed so that centrally negotiated contracts are used when agreed criteria suggest it is most appropriate to do so and so that the long-term needs of NHSS as a whole are best served.

Most trust chief executives recognise the potential for partnership working and 26 (93%) of trusts have signed up to SAP (see appendix 5 for its draft objectives and efficiency improvement aims). However, this group is made up of operational supplies specialists who will need sustained high-level support and authority to deliver the changes required.

Performance reporting

Given the high level of expenditure on supplies, NHS boards should be monitoring high-level performance. Most do not yet have the information needed to do this effectively. As a starting point, Audit Scotland used a minimum data set proposed by the Working Group on Procurement (see appendix 2), and then reviewed with trusts whether the information is available:

- thirteen trusts (52%) currently have no routine performance measurement or monitoring information
- eight (32%) have access to some of the PIs
- only three (12%) indicated they could provide all of the PIs.

Recognising that many of these original PIs will only comment on the relative efficiency of any service as it is presently configured rather than offering insights into progress towards goals, we have worked with SAP to produce a revised set of PIs. This is currently out for consultation[20] with NHSS. Once agreed, these will form the basis for much of our follow up study. It is vital that the development of performance information is led and co-ordinated at national level, since benchmarking requires robust data and consistent definitions. Trusts have recognised this and have been reluctant to risk wasting time and money by working in isolation.

The Working Group on Procurement recommended that the future development of PIs should be the responsibility of a proposed National Procurement Management Board (NPMB), but the ME rejected this recommendation. Instead the ME proposed that a group would be established to develop and set targets for the trusts relating to the percentage of products purchased nationally, product standardisation and product range. This group never met and no progress was made on this front mainly due to the disruption caused by trust reconfiguration.

Despite previous efforts, no benchmarking initiative between trusts has so far been successful and the main barriers appear to be:

- the wide range of different service combinations and of service delivery practice
- several facets of cost and other data are hidden or difficult to tease out because of definitions and interpretation
- current availability of data in trust systems.[21]

Notwithstanding these challenges, trusts and SHS are expected to develop management systems that enable monitoring against the proposed PIs. They will also have to take into account any requirements from the Scottish Executive Performance Assessment Framework.

Managing trust expenditure on supplies

Expenditure is an important aspect of management information. An analysis of expenditure should provide vital data on the use of supplies, in terms of both spending departments and products. Reports should clearly identify who is spending, how much, on what and with whom. Trusts (through supplies or procurement managers) should have access to this information to identify where there is scope for better value for money; for example through a review of contracting points, product rationalisation, market testing, long-term contract negotiation, and usage management. However, previous studies have failed to be able to analyse expenditure in this way and have had to rely on estimates.

Trusts seek to control supplies expenditure through their routine budgeting systems but at one trust even this information was inadequate, raising questions about accountability. Financial information is unlikely to be sufficiently detailed to support effective supplies management, or to allow potential problems to be identified and investigated. Managers need a combination of financial and usage information in a user-friendly format. The lack of this basic management information also means that it is not possible to ascertain whether savings or other targets are realistic or have been achieved. Only three trust boards (12%) receive sufficiently detailed reports to monitor supplies expenditure.

At operational ward or department level, even where budget reports are provided, users want to see financial information matched by usage information. They also want more timely information, produced with their needs in mind rather than those of the finance or procurement specialists.

Recommendations

Using the good practice guidelines outlined in Appendix 3, trust boards need to put in place:

- *a supplies strategy which is aligned with the local NHSS environmental, human resource and health and safety policies and which sets out how the supplies strategy will link to and support the corporate objectives*
- *accountability arrangements for supplies management which are clear, up to date and robust*
- *arrangements to ensure that expenditure on negotiable goods and services are influenced by the procurement function*
- *staff development arrangements to ensure that staff are suitably qualified*
- *systems to evaluate the opportunities for procuring on a regional or national basis which maximise the combined purchasing power of NHSS*
- *effective user involvement, including in product selection*
- *a reporting framework for supplies that meets the needs of users, supported by adequate information systems.*

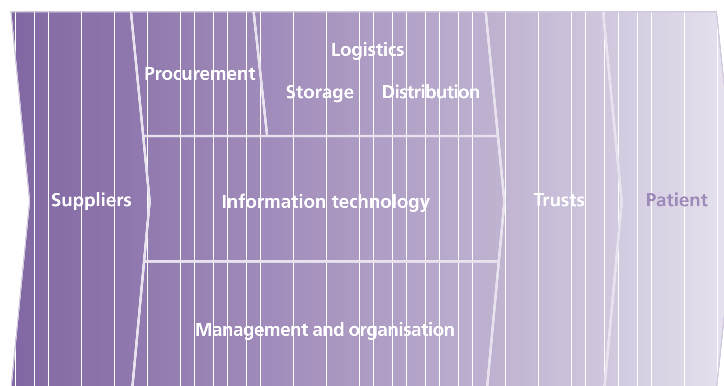
Trusts should also participate in the consultation process initiated by SAP and Audit Scotland to agree a set of PIs to be used in future to manage and monitor performance. In addition, NHSS should ensure that management information systems are developed and implemented in a consistent way, so that performance monitoring is possible and the results are acted upon. This requires a strategic view of local supplies systems as well as those systems (eg, finance, laboratories and theatre) that should interface with them. Trusts should take full account of the implications of the national e-procurement initiative when introducing local systems. In developing a national procurement strategy SEHD should consider agreeing criteria for determining which goods and services should be contracted for at national, regional and local levels and should ensure that national contracts are being used when appropriate. As previously indicated, SAP is already working in some of these areas. Whoever is given ultimate responsibility for overseeing progress on a national basis, needs to be given the status and authority to drive through the changes required to end the fragmented approach to procurement in NHSS.

The supply chain

The supply chain

A simple definition of a supply chain is 'the process of supplies provision from the original point of manufacture to the final point of use'. The supply chain process is regarded as a "demand pull" system and may be shown as:

Exhibit 2: Supply chain process



Source: Trust Chief Executive's Group: Supplies within the Scottish Health Service, March 1997

There are a number of steps between supplier and the end user. Processes such as indenting, ordering, delivery, storage, invoice reconciliation and payment all represent additional cost and are often paper intensive. Value chain analysis and process costing are required to ensure that the elements in the supply chain add value that outweighs their costs.

Although the diagram applies generally to the concept of a supplies chain process, trusts manage their supplies functions in a variety of ways. For example, trusts may elect to receive supplies in the following ways:

- two or more trusts acting together with longer term plans to develop centralisation of purchasing, uniformity of requisitioning and the reduction in the number of ordering points
- direct delivery of certain commodity groups (eg, stationery, provisions and medical disposable items)
- a centralised supplies function serving several trusts with one or more major stores locations
- removal or reduction of the stockholding element from supplies chain management – trusts and suppliers agree systems and logistics for direct delivery
- specialist storage of high cost items
- storage or warehousing with next day delivery commitments over a range of commodity groups.

Trusts need to be able to identify the total unit costs of goods and services at the point of use, regardless of their supplies model. This forms the basis for detailed analyses of the supply chain, using PIs and benchmarking. Without this, target setting is undermined since it is not possible to monitor changes, and savings made in one area simply create additional costs or problems elsewhere. Only six trusts (24%) are actively looking at the supply chain in its entirety, although some others have been tackling aspects of it in a drive to reduce costs.

Recommendations

Trust boards need to adopt the good practice guidelines outlined in Appendix 3 so that the supply chain is fully understood and opportunities for improving efficiency can be identified. In particular, in view of the poor state of management information available at present, trusts need to consider whether their current level of investment in supplies systems and the management information systems that should interface with them is adequate.

Procurement processes

The health service, as a major purchaser of goods, will need to take due account of wider central government e-commerce initiatives, as these are likely to fundamentally alter local approaches to procurement.The Scottish Executive's procurement policy manual requires that procurement must be undertaken to the highest ethical standards and that purchasers should be honest, fair and impartial in their dealings with suppliers. This is in line with the Government's set of core values for working with suppliers developed through the Office of Government Commerce to apply across the central government sector[22].

Exhibit 3: The Code of Good Customer Practice

When working with suppliers central government commits itself to four core values: fairness, honesty, efficiency and professionalism:

- **Fairness**. Central government will act fairly towards all suppliers during a competition and towards the successful supplier throughout the business relationship.
- **Honesty**. Central governement will be honest when conducting business with suppliers.
- **Efficiency**. Central government will work towards improving efficiency when awarding contracts and working with suppliers.
- **Professionalism**. Central government will work to a high standard of professionalism when dealing with suppliers.

Source: The Office of Government Commerce, 2001

Ordering, receiving and paying for goods and services are the main processes by which users obtain the goods that they need. These processes therefore need to be effective, and to offer value for money. All the elements of the supply chain are connected; poor management of one part of the process can have adverse effects on the effectiveness or value for money of others. For example, poor control over ordering may ultimately result in additional work for staff involved in the goods received or payments processes.

Process costs vary considerably among trusts in England and Wales[23]. One of the main reasons for this is the variation in the number of orders raised and invoices received. This means that each of these processes should be governed by clearly defined procedures which complement the trust's policies on rationalisation, standardisation and stock management. It has not been possible to provide equivalent Scottish figures. However, SHS is undertaking pilot work with two trusts to develop this information and this needs to be pursued as a matter of priority. Consequently, it will form part of our follow up study.

Ordering

Auditors reported that they were generally satisfied with ordering processes at four (16%) trusts. Elsewhere, the two main issues raised by auditors relate to low value orders, and departments that are able to order direct, thereby by-passing the formal procurement function as previously discussed.

At the time of the audit some trusts had problems aggregating orders because of bringing systems together under trust reconfiguration. Auditors drew attention to three trusts where different systems in place meant that volume discounts might not be being maximised. In addition, most day-to-day manual orders for directly purchased items have similar processing costs, whatever the value of goods ordered. This means that a high number of low value orders will increase process costs at all stages, from ordering through to receipt, distribution and payment to suppliers. Whilst some low value orders are inevitable, auditors reported that low value orders are an issue in a quarter of trusts. For example:

- a sample of non-stock orders at one trust showed that the cost of placing the order was greater than the order value for 19% of orders
- in another trust, 10,000 orders were placed per year, of which 80% were for less than £500
- orders of less than £50 in a third trust accounted for approximately 50% of orders, but only 1% of the value of payments.

This issue should be resolved when e-commerce is introduced fully. In the meantime those responsible for procurement need to ensure that the number of low value orders is minimised.

Receiving

Inefficient arrangements for the receipt and distribution of goods often arise where there are separate procedures for dealing with stock and non-stock supplies. The former are typically delivered once a week to each of the delivery points around the trust, eg, theatres on Monday, one hospital or site on Tuesday, catering on Wednesday and so on. By contrast, deliveries of non-stock items are often unpredictable. This unpredictability means that the people who receive and distribute non-stock supplies are often either under-employed or overwhelmed. Supplies managers should be able to assess whether non-stock items need to be delivered in this ad hoc way, or whether they can be delivered along with the normal scheduled delivery. They should also consider agreeing specific delivery times with suppliers, or going further and using nominated carriers to combine deliveries from a range of suppliers. This can achieve three-fold benefits by rationalising deliveries, reducing overall cost and reducing congestion on site. At least seven trusts have introduced local stock management systems such as materials management, given concerns that many staff were carrying out similar tasks relating to the internal distribution of supplies. Pharmacy, linen, post, meals, medical records and sterile supplies were all being distributed around the trust separately and often with different arrangements for stock and non-stock goods. This distribution work was being carried out by a range of people including suppliers' staff, internal stores' staff and porters. By combining some of these distribution channels, staff time can be saved and congestion reduced. This can be done by:

- integrating the internal distribution of stock and directly purchased goods wherever possible
- controlling the delivery of directly purchased goods into their premises.

Audit reports identified that direct delivery is undertaken in a fifth of trusts, but five auditors identified the need to do more to ensure good systems are in place to:

- match invoice with order and goods supplied documentation to ensure that the contractor has supplied to a specified standard and to accurate quantity
- minimise losses, eg, by tagging goods received until their point of use
- ensure staff are clear about their responsibilities for following up undelivered items.

Auditors reported that almost 40% of trusts had either undertaken or were in the process of undertaking a fundamental review of the supply chain process. However, in a quarter of trusts, auditors indicated that there is still potential to improve value for money by redesigning the trust's distribution systems.

Payment

The main processes involved in payment are:

- matching an invoice to a goods received note, to verify that the goods have been received
- matching the invoice to the original order to confirm details
- making the payment.

Auditors reported general satisfaction or no problems with payments systems at more than half the trusts. However, they drew attention to opportunities to improve value for money at 11 (44%) trusts. In particular, they drew attention to problems in matching invoices with orders and goods received notes that cause delays and higher costs. Auditors found examples of poor practice such as requesting missing paperwork only monthly, leading to late payments, and invoices rejected because of minor differences of only a matter of pence. Late payment can cause the trust to lose out on discounts; waste staff time in answering calls and correspondence; and damage relationships with suppliers. Five trusts (20%) did not have effective systems to allow them to maximise their prompt payment discounts. Whilst the introduction of e-commerce might help, the ability to make prompt payments depends crucially on the co-operation of those receiving the goods and services in assisting with the document matching process.

Delays might also breach Scottish Executive policy on prompt payment that endorses a CBI 30-day payment target unless organisations have negotiated other terms with their suppliers. Given the size and complexity of NHSS, it is likely that most trusts will need to negotiate a period outwith the CBI target. However, auditors drew attention to concerns about this in only three cases.

The combined effect of these problems is to lead to inefficiencies and higher costs. Clearly, there is a cost to each control; the challenge for trusts is to ensure that their procedures balance the costs and risks involved.

Recommendations

Trust boards should ensure that they can demonstrate they achieve the good practice outlined in Appendix 3. In particular, they should be able to identify their process costs in a consistent way for benchmarking purposes and ensure that they have systems in place to address:

- *low value orders*
- *distribution systems, including controls over direct deliveries*
- *prompt payment of invoices.*

Logistics

Logistics is the process of managing the movement and storage of goods and materials from source to the point of use. Logistics are becoming increasingly sophisticated, offering new opportunities for value for money, and trust chief executives suggested that a target should be set for logistics on-costs at 2.5% of turnover[24]. Some trusts have joined together to form local partnerships to purchase supplies and have goods delivered in consortium quantities; others, particularly larger trusts, have developed their own supplies organisations in search of better value.

Stock

It is vital to staff and patients that supplies of the right quality are available in the right place at the right time. However, holding too much stock is undesirable for various reasons:

- stock is expensive to store
- it may become obsolete
- it is vulnerable to damage, deterioration, loss and theft.

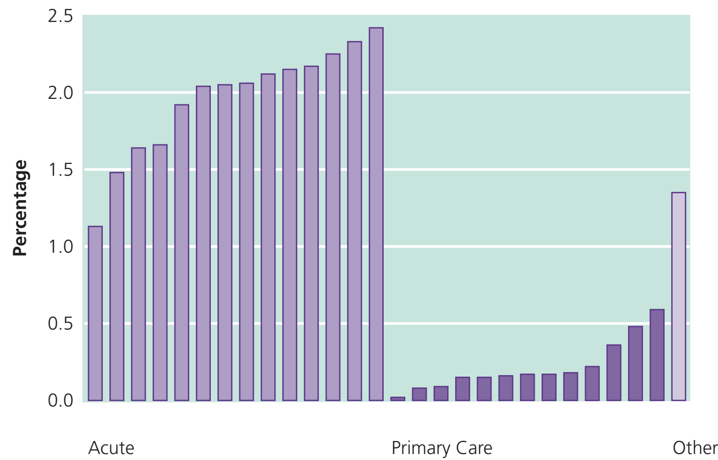
Exhibit 4: The main characteristics of a well managed local stock management system

- Target stock levels are based on an assessment of expected activity as well as data about previous orders.
- Stock levels are kept under close review.
- The system employs barcode technology.
- Introduction of the system is the trigger for the rationalisation of product lines.
- Data from the system are used to compare usage rates between similar wards or departments.
- Opportunities are sought to consider wards or departments in groups to reduce total stock requirements.

Source: Audit Commission, *Goods for your health*, 1996 p43

The Audit Commission[25] noted that in England and Wales there were wide (approximately four-fold) unexplained variations among similar trusts in the extent of their balance sheet stock levels. The data for Scottish trusts in 1999/2000 also highlight significant variances within trust groupings (Exhibit 5). These data must be treated with caution because regional stores may distort the figures for individual trusts and the position is changing because of the opportunities for change following the reconfiguration of trusts. Nevertheless, the data should be investigated further to assess whether they reflect real differences or simply differences in accounting arrangements. The follow up report will examine this at unified health board level.

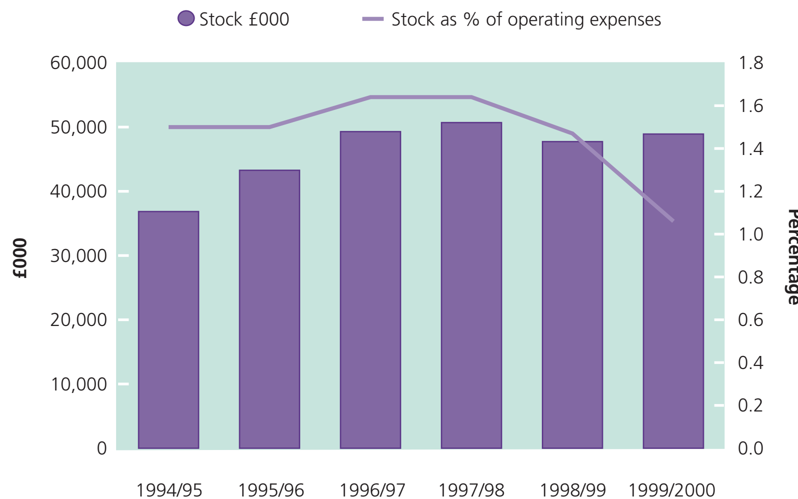
Exhibit 5: Variations in stock as a percentage of operating expenses in Scottish NHS Trusts



Source: Annual Accounts of NHS in Scotland, 1999/2000

Whilst the value of stock rose from approximately £37 million in 1994/95 to almost £49 million in 1999/2000, it dropped from a high of 1.6% of operating expenses to 1.1% (Exhibit 6). This suggests that supplies professionals are beginning to reduce stockholding after NHS trust reconfiguration. Where large stores remain, there can still be considerable scope for rationalising lines; for example one auditor reported that the number of lines held had been reduced from 1,700 to 900. However, more work on benchmarking is required before we are in a position to comment on relative performance.

Exhibit 6: Changes in balance sheet stockholding for Scottish NHS trusts



Source: Summarised accounts of NHS Trusts in Scotland

Staff may create large holdings of stock because they fear that central stocks may run out or items may not be available at short notice. To avoid this, trusts need a ward stock management system that can ensure that users have access to the right level of stock to meet their needs. This should be a comprehensive and systematic framework that helps control the flow of materials to wards and departments. Supplies staff and users work together

to identify the range and quantity of materials used; thereafter, supplies staff take responsibility for maintaining and replenishing materials through checks at predetermined frequencies. This can be further enhanced by the use of bar code technology and automatic data entry processes to reduce paper work and clerical errors. A ward stock management system offers a range of advantages:

- it is user friendly and designed around customer requirements
- ward or department staff are released from stock checking, requisitioning, goods receipt and shelf restocking duties
- costs are reduced through better management of stock levels, stock rotation and expiry dates.

Auditors indicated that materials management and top up systems are in place in wards in at least 11 trusts (44%) although, even within trusts systems differ. One supplies manager expressed the benefits from introducing a materials management system in his trust:

- identification of an individual who has responsibility for controlling stock in wards and theatres
- savings in initial setting up of the system through the removal of excess stock back to stores (estimated at approximately £1,000 per ward)
- savings through eliminating wastage by obsolescence by stock rotation
- savings through tighter control and closer monitoring with less scope for pilfering
- approximately 10% of nursing time freed up from supplies related activities
- inappropriate products are removed and not reordered
- better communication between ward and supplies professionals
- set up costs are self funding and, paradoxically, a reduction in usage is often achieved.

In Scotland, auditors reported that the systems in place are generally popular with users. The only complaint about them was that they are not always sufficiently responsive to changes in levels of activity. In view of this, and given the limited introduction of materials management systems so far, it would appear that there is considerable scope to improve value for money in this area in Scotland.

Usage

In order to make best use of supplies, clinicians and managers need clear guidelines on the use of equipment and consumables, and appropriate information to identify:

- variations in practice
- inappropriate use
- under-utilisation of equipment.

Trust managers should review usage regularly, at least in areas of significant expenditure including catering, radiology, laboratories, continence services and home loan equipment. They should also examine the use of common consumables by similar wards or departments. High levels of usage may be the result of loss, obsolescence, misuse or other factors; but a review of usage enables the causes to be identified and addressed. It is possible that more use could be made of clinical audit findings to explain variations in the use of equipment and consumables by identifying differences in patient types or differences in the use of supplies arising from different methods of treatment.

The two main factors responsible for high comparative expenditure are high prices and high usage. This means that trusts need to have procedures to identify both, and to investigate them and report as required. Usage rates can be optimised and wasteful practices eliminated if managers and end users have good comparative information and act on it. This information will also help managers and clinicians to ensure that supplies are used appropriately, according to their intended purposes. A frequently reported example is that surgeons' gloves should not be used for routine tasks where normal sterile procedure gloves would suffice.

The Audit Commission, in England and Wales, identified[26] unexplained variations in usage of some commonly used consumables between general medical wards at the same trust treating a similar case-mix of patients. Often neither users nor their managers know whether their usage rates are high. Auditors sought to ascertain whether this is also a problem in Scotland but were unable to obtain robust data at most trusts. At present usage data is available at only one fifth of trusts, and in some it is only available on an ad hoc basis. There is also scope to benchmark the use of supplies among similar trusts; this could be especially useful where comparisons within a trust are not possible because of a lack of similar wards or departments. However, benchmarking of usage is not undertaken systematically either within or among trusts, which rely mainly on their financial budgetary control systems to highlight changes in use. Our follow up report will seek to ensure that usage information is being developed and used by managers.

Recommendations

Trust boards should ensure that the good practice guidelines in Appendix 3 are adhered to and that:

- *product lines are minimised*
- *ward stocks are actively managed to maintain optimal levels; consideration should be given to introducing or extending the use of materials management systems which are monitored to ensure they are sufficiently responsive to user needs when activity levels change*
- *usage is actively monitored and managed by means of benchmarking within and among trusts.*

Exploiting IT

Supply chain operations and transactions can be made much more efficient and effective through the use of IT and e-commerce. IT also offers the opportunity to free clinical staff, especially nurses, for more appropriate tasks. In particular, IT can be used to provide:

- links between supplies and finance systems
- supplies management information, with systems reports on usage and expenditure;
  - who buys and uses what supplies
  - the quantities involved
  - bought from whom
  - the price paid to buy the product and to get it to the point of use.

The Audit Commission found[27] that some trusts seeking to integrate supplies management and financial management systems were achieving considerable benefits, including:

- reduced stockholding costs
- reduced process and transaction costs
- better management information and greater management control
- improved levels of customer service
- improved use of staff time.

The Working Group on Procurement endorsed the view that the use and development of electronic trading would contribute to improving procurement and reducing costs. However, previous study reports have commented on the lack of IT in supplies management, particularly the lack of integration between finance and supplies systems. Trust chief executives[28] identified effective, integrated IT systems at both local and national level as being essential for modern methods of supply chain management. However, they found that:

- there were wide variances within NHSS on the number and type of IT systems in use
- none of these systems were compatible with management and, more importantly, finance systems
- information systems need to allow flexibility over the range of commodity groupings and suppliers, so that NHSS is not tied to particular suppliers by virtue of the IT systems in use.

The report of the Working Group on Procurement[29] recognised that one of the barriers to change and improvement had been the lack of good information systems. Consequently, they proposed that the responsibilities of a new NPMB should include the development of an IT strategy. This was seen as complementing individual trust's efforts following the trust chief executives' report in 1997.

The ME[30] did not endorse the Working Group on Procurement's proposals for a NPMB to take forward supplies issues. However, there is a public sector e-procurement initiative[31] that involves NHSS. Trusts have been asked to speak to the Scottish Executive before reaching any decisions on signing up

to an e-procurement system and they are being encouraged to take part in the national initiative rather than pursuing systems on their own.

Auditors found a proliferation of systems in use even within trusts (see Appendix 6). In addition, there are likely to be pharmacy supplies systems in place at most trusts. Pharmacists are also looking towards e-procurement solutions so that electronic prescribing at ward level can trigger the procurement process. Rather than thinking of 28 trusts, it is probably more realistic, therefore, to think of the need to rationalise supplies procedures at some 400 hospital sites across Scotland. Several audit reports highlighted the need to develop a supplies IT strategy to support the business, and all reports indicated that there is considerable scope to improve performance through IT.

The current systems can involve a significant manual element, particularly for non-stock items. Ward requisitioning also tends to be manual, at a heavy cost in clinical staff time. Requisitioning procedures that are paper intensive can also lead to processing delays and increased costs.

Even in those trusts where supplies and financial management systems are in place and integrated across the main hospital sites, problems can still arise. For example, there are instances where each site runs a different version of the same software. This means that they maintain their own supplier databases and order separately, limiting their ability to make savings through combined purchases.

Some of the IT systems in place are old and are not user friendly. For example, data retrieval and the production of management information can be complex and unwieldy, requiring specialist skills. Data held on manual systems are even more time consuming to analyse. At present all management reports are well out of date by the time they are received; instead, users need on-line access to supplies information to support their decision-making. A number of trusts have indicated that they will be replacing systems in the foreseeable future. When these are being replaced, every opportunity must be taken to meet the information needs of all the potential users and to ensure that integration is achieved. In addition, trusts need to exploit the wider potential of e-commerce including, where appropriate, strategies such as 'just in time' ordering and business to business approaches.

Initiatives underway to address these problems include:

- employing supply chain analysts to review business and IT support needs
- piloting and implementing ward stock systems to minimise the burden on nursing staff
- using electronic ordering via fax links with suppliers
- piloting the use of purchasing cards to reduce the number of orders and invoices
- using the intranet to publish guidelines and procedures on purchasing.

As indicated on page 22, the Scottish Executive is currently developing an e-procurement system on behalf of the public sector, including the health service. Six NHS trusts have been selected as pilot sites to develop the process model for NHSS, and some of these are expected to form the initial implementation sites. Although this is being taken forward nationally, trusts also need to undertake preparatory work, for example, to determine:

- the capability of the finance system to integrate with the e-procurement system
- the capacity of the trust's network to cope with the added traffic
- the phasing of the introduction across the trust's suppliers, activities and staff.

Recommendations

Trust boards should ensure that the good practice outlined in Appendix 3 is adopted, and that the trust IT strategy includes proposals to ensure that existing supplies systems are rationalised and the benefits of e-commerce are achieved.

Appendix 1

Advisory panel members

The project team was assisted in the development of this review of supplies management by an advisory panel of professionals from the health service in Scotland. The panel advised us at some or all of the key milestones in the process: the scope of the review, the audit guide and on the draft national report.

Members of the panel are listed below; those who were also members of the short life working group on procurement are marked *. Those marked ** are also members of the Strategic Alliance Partnership.

Mr Steve Atherton (replaced by Paul Pike **), Scottish Healthcare Supplies

Mr George Brechin, Chief Executive, Fife Primary Care NHS Trust

Ms Michele Caldwell *, Chief Pharmacist, Ayrshire and Arran Acute Hospitals NHS Trust

Mr Jim Ferguson, Director of Operations, Grampian University Hospitals NHS Trusts

Mr Frances Gibb *, General Manager, Common Services Agency – now left the service

Mr Steve Glass **, Commodities Manager, Grampian Primary Care Trust

Mr Brian Hennedy *, Supplies Manager, Greater Glasgow Primary Care NHS Trust – now left the service

Mr Ron Heredia **, Trust Supplies Manager, Tayside University Hospitals NHS Trust

Mr David Hird *, General Manager, Forth Valley Health Board

Mr Eric Murray, Facilities Manager, Grampian Primary Care Trust

Mr Steven Oakley, Supplies Controller, Forth Valley Primary Care Trust

Mrs Fiona Ramsay *, Director of Finance, Forth Valley Health Board

Mr John Robertson, Non-executive Director, Borders Acute Hospital Trust

Appendix 2

Working group on procurement: performance indicators

National Level Indicators (SHS)

- Total operating cost
- Value of on-costs
- Number of contracts
- Use of national contracts
- Number of contract lines (number of items)
- Number of complaints
- Time taken to resolve complaints
- Efficiencies and savings (value of cost savings).

Local Level Indicators (trust stores)

Financial
- Total operational costs (full costs) for all departments involved in supplies
- Total value of inventory holding
- Cost per transaction (per order – requisition)
- Average value per purchase order
- Distribution/delivery
  - Number of miles per vehicle
  - Tonnage carried
  - Number of delivery points
  - Vehicle utilisation.

Processes and procedures
- Demand satisfaction rate
  - Time taken from requisition to delivery (stock/non-stock)
  - Off shelf satisfaction rate (warehouse items)
- Number of requisition raised
- Number of purchase orders placed (number of lines).

Inventory
- Number of product lines held in stock
- Number of days stocks held
- Percentage of stock inactive
- Value of write-offs (obsolete, loss etc).

Customer service
- Number of complaints received
- Time taken to resolve complaints
- Number and value of damaged goods/claims and returns.

The Strategic Alliance Partnership and Audit Scotland have been working together to develop a revised set of Performance Indicators. These are currently in draft and the latest version can be found at: http://www.audit-scotland.gov.uk/publications/ppmf.htm

Implementation of the procurement performance measurement framework will be ongoing with key milestones for the initial phase as follows:

Milestone	Date
Accept revised proforma framework status	October 2001
Commence data collection on proforma measures in stage one	October – December 2001
Resolve stage one data collection and reporting issues	January – March 2002
Full implementation of stage one performance measures	April 2002
Agree final content of stage two performance measures	May 2002
Commence data collection on proforma measures in stage two	September – December 2002
Resolve stage two data collection and reporting issues	January – March 2003
Report stage one performance measures for 2002/03	June 2003
Full implementation	April 2004

Appendix 3

Good practice guidelines

Management and organisation issues	✔ Good practice
Strategy	✔ There is an agreed, formal supplies strategy that: ✔ supports the trust's business objectives ✔ determines how the supplies service is to be delivered (eg, in-house / out-sourced) ✔ prioritises the need to invest in supplies management against the demands for other scarce trust resources
Accountability	✔ There is a clear chain of accountability for operating and improving the supplies service ✔ There are adequate skills at all levels across all areas of management of supplies (the Audit Commission referred the 1996 NAHAT report '*Strategic Procurement for the NHS – Working with Suppliers*' which argued that many trusts lacked procurement expertise ✔ Different levels are held to account by a system of reporting and/or performance measurement
Responsibility	✔ Clarity regarding who has been delegated overall responsibility (ideally preferable for a senior executive to have overall responsibility with operational aspects delegated to supplies 'managers') ✔ Board member/director responsibility for supplies management should extend across the trust as a whole (to avoid any possible line management conflict with other directors) ✔ Responsibilities should include those of ensuring that there are adequate skills and expertise throughout the supplies organisation (or access to expertise if function is not managed in-house)
Product selection and standardisation	✔ Product selection/user groups (representing users, clinicians, managers and supplies staff) with roles which may cover: ✔ appraisal of new products ✔ pursuing policies of rationalisation and standardisation ✔ ensuring that lowest costs are obtained commensurate with quality requirements ✔ stock management arrangements ✔ price benchmarking ✔ product utilisation ✔ focal point for suppliers, company representatives, etc
Trust expenditure	✔ Examples of basic data analyses likely to be required are: ✔ detailed breakdown of non-pay expenditure ✔ value of non-stock spending on equipment over £5,000 ✔ expenditure by (say) top 50 suppliers ✔ expenditure (excluding equipment) analysed over main cost centre groups (eg, wards, specialist units, theatres, radiology, laboratories, etc.) ✔ monitoring of expenditure for catering, laundry and linen, estates, etc. (big spending commodities tend not to be found in many other groups) ✔ use/up-take of national contracts

Supply chain	✔ Good practice
	✔ Supply chain models concentrate on partnership purchasing and good housekeeping practices in the supplies environment including standardisation, volume commitment and genuine partnership with suppliers as reflected in eg, longer contract periods ✔ Supply chain costs are analysed by main heads ✔ Supplies expenditure is analysed to identify what is bought, by whom and from which suppliers ✔ Data from analyses are being used where they have most impact

Procurement	✔ Good practice
Ordering	✔ Purchasing cards used ✔ Stock ordering automated ✔ Longer term partnerships with appropriate suppliers are established ✔ Emergency orders are kept to a minimum
Receiving	✔ Integration of internal distribution of stock and directly purchased goods is achieved wherever possibe ✔ Delivery of directly purchased goods into trust premises is controlled ✔ Goods inward and internal deliveries are scheduled
Payment	✔ Periodic monitoring is undertaken to ensure that processes are efficient and provide adequate control over payments ✔ Procedures allow for selective checking and take account of costs and risks ✔ A specified escalation procedure is in place to link documentation ✔ A fast track system is implemented where discounts are available

Logistics	✔ Good practice
Stock	✔ Target levels are set for high value stock items (eg, according to expected usage, critically of supply, delivery capability, storage facilities/costs) ✔ Stock levels are regularly monitored against target levels and usage rates ✔ Avoidance of stockholding wherever possible ✔ Local stocks (ie, held in wards, clinics, departments, etc which may or may not be included in balance sheet stock actively managed/controlled through local/ward stock management systems) ✔ Stock is pooled between wards/departments where appropriate ✔ User satisfaction surveys are undertaken (findings reviewed/acted upon)
Requisitioning	✔ Clarity of policy as to who may requisition ✔ Clear (user friendly) procedures on how to requisition (to differentiate between routine and emergency) ✔ Use of stock catalogues, or customised requisitioning ✔ Monitoring (for volume and origins) and possible bench-marking of requisitions raised

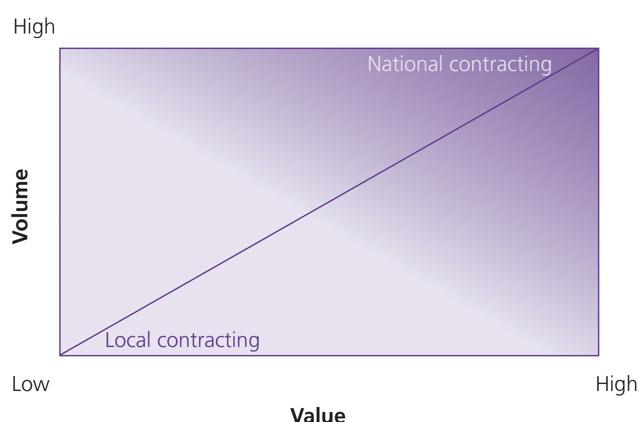
Usage	
	✔ Systems are in place to identify and examine the reasons for significant/unexplained variations in usage levels ✔ Involvement of users/clinicians in monitoring usage rates for common items of significant expenditure ✔ Work with suppliers to benchmark and manage usage patterns ✔ Use of clinical audit and risk management findings to explain variations in use of equipment and consumables ✔ Provision of clear guidelines for use of consumables and equipment ✔ Consideration of pooling/library arrangements as a way of monitoring and improving use of equipment

Exploitation of IT	✔ Good practice
	✔ Automated supplies processes (requisitioning, ordering, receipt and payment) ✔ Ward stock management systems which make good use of bar coding and other automatic data entry processes ✔ Connectivity to other IT systems

Appendix 4

Guidance for determining the appropriate contracting point[32]

1. It has to be recognised that without an overly prescriptive and artificial set of criteria there cannot be a 'yes or no' answer for each decision as to whether an item should be contracted for locally or nationally. Each decision has to be based on a number of factors not all of which will assume equal importance for each item. The illustration below gives a general guideline to the likely point of purchase for most items.



2. Laid over the top of this simple view of the likely contracting point must be the realistic determination of the optimum point for contracting guided by such factors as:
   - geography – where a product is used in only one location or area this will be the optimum point for purchasing
   - specialism – where there are specialist services/facilities delivered by a trust or group of trusts then they should provide a collective approach to the particular item(s)
   - ability/knowledge – where there is a particular individual or trust who is the acknowledged expert in a particular commodity or service, it may be appropriate for them to undertake the contracting activity.

3. The actual point at which items move between the point of purchase would be determined by collaboration between all parties within the service including the expert groups and the NPMB.

4. Even though the actual contracting point may change, an overview of the activity must be maintained by the centre to ensure consistency of approach. All decisions about the optimum contracting point must remain in the best interests of NHSS and best practice must be shared throughout the service. This task would fall naturally to the proposed new professional branch within SHS, should the NPMB determine to proceed with commissioning SHS to undertake this work on its behalf.

Appendix 5

Strategic Alliance Partnership (SAP)

SAP comprises specialist supplies representatives from 26 trusts. Whilst they do not have a formal remit, their objectives and efficiency improvement aims were set out in a presentation in 2000 and are summarised below.

Objectives

- To reduce costs for NHSS
- To review all existing contracts
- To put in place new contracts
- To establish an Alliance Contracts Portfolio
- To establish closer working relationships with suppliers and speak with one voice.

Efficiency improvement aims

- Reducing the price/cost at point of use
- Commitment to volumes/values – better prices
- Rationalisation of products
- Standardisation of products
- Setting up customer focus groups to review products and determine better service levels.

Appendix 6

Current financial and supplies systems within trusts

Trust	Financial System	Supplies/materials management system
Argyll & Clyde Acute Hospitals Trust	Cedar e-financials	Cedar e-financials
Ayrshire & Arran Acute Hospitals	Cedar cfacs (being replaced 2001)	Icsis (being replaced in 2002)
Ayrshire & Arran Primary Care	Cedar cfacs (to be replaced October 2001)	Icsis (being replaced in 2002)
Borders General Hospital	Cedar cfacs v8.3.5	Cedar cfacs v8.3.5
Borders Primary Care NHS Trust	FINIX	None
Dumfries & Galloway Acute Hospitals	Cedar cfacs v8.3	Cedar cfacs v8.3
Dumfries & Galloway Primary Care Trust	Cedar cfacs v8.3	Cedar cfacs v8.3
Fife Acute Hospitals Trust	FINIX	ICSIS v1.9 (to be replaced April 2002)
Fife Primary Care Trust	FINIX	ICSIS v1.9 (to be replaced April 2002)
Forth Valley Acute Hospitals Trust	Cedar cfacs	Cedar cfacs
Forth Valley Primary Care Trust	Cedar cfacs	Cedar cfacs
Greater Glasgow Primary Care Trust	CA Masterpiece 3	Icsis (looking to replace within 24 months)
North Glasgow University Hospitals NHS Trust	Cedar e-financials	Cedar e-financials
South Glasgow University Hospitals Trust	McKeown	McKeown
Grampian Primary Care Trust	Cedar cfacs (due to be replaced April 2003)	Cedar cfacs (due to be replaced April 2003)

Grampian University Hospitals NHS Trust	Cedar cfacs (due to be replaced April 2003)	Cedar cfacs (due to be replaced April 2003)
Highland Acute Hospitals Trust	McKeown	McKeown
Highland Primary Care Trust	McKeown	McKeown
Lanarkshire Acute Hospitals Trust	Cedar cfacs	Cedar cfacs
Lanarkshire Primary Care Trust	Cedar cfacs v7.5.5	Cedar cfacs v7.5.5
Lomond & Argyll Primary Care Trust	Cedar cfacs	Cedar cfacs
Lothian University Hospitals Trust	Cedar cfacs v7.4	Cedar cfacs v7.4
Lothian Primary Care Trust	Cedar cfacs v7.4	Cedar cfacs v7.4
West Lothian Healthcare Trust	Sage Enterprise CS/3	Sage Enterprise CS/3
Renfrewshire & Inverclyde Primary Care Trust	Cedar e-financials	Cedar e-financials
Tayside Primary Care Trust	FINIX	McKeown
Tayside University Hospitals Trust	FINIX	McKeown
Yorkhill Hospital NHS Trust	Meditech HISS	Meditech HISS
State Hospital Carstairs	McKeown	McKeown

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Office of Government Commerce, 2001

End notes

[1] Trust Chief Executive's Group: Supplies within the Scottish Health Service, March 1997

[2] Review of procurement in the NHS in Scotland, final draft report by working group, August 1999

[3] See note 2

[4] See note 1

[5] See note 2

[6] Management Board meeting decision 12/10/99

[7] See note 2 (this estimated figure includes all negotiable goods and services).

[8] The short life working group was set up in early 1999 with a remit to:

- review current procurement practice by the NHS in Scotland covering procurement through Scottish Healthcare Supplies and that carried out directly by the service
- make recommendations for improvements, including improvements in the organisation and management of procurement including the use of IT based systems, training and development of staff and systems to identify and spread best practice.

[9] See note 2

[10] See note 1

[11] See note 6

[12] The latest draft is published on our website: http://www.audit-scotland.gov.uk/publications/ppmf.htm

[13] Office of Government Commerce, The procurement excellence guide: a performance review system for local authority procurement.

[14] See Appendix 1 for the list of members who advised us at key milestones in the study. NB: the Advisory Panel included some members of the Working Group on Procurement in order to coordinate our efforts with those of the ME and the rest of the service. Some of the members are also actively involved in SAP.

[15] NHS Supplies, Developing a Supply Strategy, A handbook for NHS Trusts, October 1999

[16] See note 2

[17] See note 2

[18] NHS MEL(1992)4

[19] See note 2

[20] The latest draft is published on our website:
http://www.audit-scotland.gov.uk/publications/ppmf.htm

[21] See note 2

[22] Office of Government Commerce, Working with suppliers: the code of good customer practice, 2001

[23] Goods for your health, p 21, Audit Commission, 1996

[24] See note 1

[25] Goods for your health, p 41, Audit Commission, 1996

[26] Goods for your health, p 48, Audit Commission, 1996

[27] Goods for your health: Improving supplies management in NHS Trusts, 1996

[28] See note 1

[29] See note 2

[30] NHS(ME) letter, 23/11/99

[31] The award of business is expected imminently

[32] Extract from Supplies within the Scottish Health Service, March 1997

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