House of Commons

Committee of Public Accounts

The procurement of consumables by National Health Service acute and Foundation Trusts

Thirty-fifth Report of Session 2010–12

Report, together with formal minutes, oral and written evidence

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Committee of Public Accounts

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Additional written evidence may be published on the internet only.

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The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

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Summary

The 165 NHS acute and Foundation hospital trusts in England spend over £4.6 billion a year on the procurement of medical supplies and other types of consumable goods, dealing with thousands of supplier companies ranging from large multinational corporations to smaller specialist firms. Each trust controls its own purchasing, in line with the Government's strategy to give NHS organisations increasing freedom to operate independently.

Foundation Trusts, which now account for more than half of hospital trusts, are independent of the Department of Health's control and all trusts are intended to become Foundation Trusts by 2014. Trusts can purchase consumables in various ways: dealing direct with suppliers; through the national supplies organisation, NHS Supply Chain, operated by the private distribution company DHL under a 10-year contract to the NHS Business Services Authority; or via the regional Collaborative Procurement Hubs. They can also choose to join other trusts in collaborative purchasing arrangements for particular localities or types of supplies.

The Department is clearly engaged in improving its procurement systems, and sees the future for NHS procurement as a 'pyramid' structure with national, regional and local procurement of different types of goods, as appropriate to the products and the supplier markets. However, this theoretical model does not reflect the current complex reality, with a profusion of bodies involved in the procurement process. Its effectiveness is open to question in the emerging landscape where Foundation Trusts act independently with no explicit incentive to co-operate. Getting this system right is critical to improving procurement performance in the future. The Department acknowledges that it is accountable for NHS procurement across the system, but it has no control over the actions of the individual trusts who could deliver improvements.

The fragmented system of procurement has produced a great deal of waste, with trusts being charged different prices for the same goods, ordering in inefficient ways and failing to control the range of products which they purchase; for example, the National Audit Office (NAO) found that trusts buy 652 different types of surgical and examination gloves. The NAO has estimated that trusts could save around £500 million annually, 10% of their consumables expenditure, by amalgamating small orders into larger, less frequent ones, rationalising and standardising product choices and striking committed volume deals across multiple trusts. The Department has set a target to achieve procurement savings of £1.2 billion under the Quality, Innovation, Productivity and Prevention (QIPP) programme.

A lack of data has limited progress towards more efficient procurement, and the Department must now address this. The Department plans to require all products sold to the NHS to have standard bar-coding. Bar-coding of products would help trusts to rationalise the range of products they buy and compare prices, providing the data they need to benchmark their performance.

There has not been a culture of efficient procurement in the NHS. The lack of data makes it

difficult for trust boards to challenge managers on the efficiency of procurement and there has not been sufficient control over procurement practices. At a time when all trusts are required to make efficiency savings - 4% in 2011-12 alone - they should seek to achieve as much of these as possible from improvements in procurement. Without such improvements, there is a risk that trusts will make cuts elsewhere, while at the same time continuing to waste money on inefficient procurement.

On the basis of a report by the Comptroller and Auditor General[1] we took evidence from the Department and from Howard Rolfe, Procurement Director of the East of England Collaborative Procurement Hub, on the national and regional procurement systems in the NHS and on trusts' individual procurement practices.

1 C&AG's Report, *The procurement of consumables by NHS acute and Foundation trusts*, HC (2010-12) 705.

Conclusions and recommendations

1. **There is a need for clarity from the Department about how it will deliver the necessary improvements in procurement by NHS hospitals when trusts are independent of its control.** The Department acknowledged, when we recently considered the NHS reform proposals, that it would still be accountable for the performance of the NHS as a whole system. The Department therefore has the responsibility to strengthen trusts' accountability to their boards and to the regulators so that they have the necessary challenge and incentives to secure value for money in procurement. The Department should also strengthen the way hospital procurement is supported by national and regional organisations, so it is easier for trusts to make use of this support and so the benefits of doing so are clearer. The Department should also spell out clearly how it would deal with outstanding debts to suppliers should a Foundation Trust be declared insolvent.

2. **It is not clear how trusts will be motivated to deliver collectively the £1.2 billion savings required from procurement under the Quality, Innovation, Productivity and Prevention (QIPP) programme.** The Department has no control over Foundation Trusts, but has set a savings target which can only be delivered by the trusts themselves. The Department should spell out how the target will be delivered and measured, and who will be accountable for it in the new NHS model.

3. **Information on what products trusts buy and the prices they pay is poor.** We agree with the Department that better information would enable effective benchmarking of products and prices, while increased transparency would help to reduce prices through competition. The Department should require all NHS purchasers and suppliers to make use of a standard, comprehensive product bar-coding system so that price comparisons can easily be made and savings opportunities identified. It should ensure that product bar-coding is in place by April 2014, by which time all trusts are expected to have achieved Foundation Trust status and the NHS reform plans are expected to take full effect.

4. **NHS Supply Chain is not demonstrating its value to the NHS.** In around half of cases, products available through NHS Supply Chain can be more expensive than through other routes, and trusts are not using NHS Supply Chain to the extent that was expected when the contract was set up in 2006. NHS Supply Chain should provide the opportunity for trusts to bulk buy together and so drive down prices, on the basis of their commitment to purchase. Currently, however, NHS Supply Chain purchases only around 5% of the goods it supplies on a 'committed' basis, mainly on purchases of capital equipment. The Department should:

   i) review NHS Supply Chain's operations and if necessary revise its contract to provide the incentives to capture aggregated NHS demand;

   ii) develop plans to make NHS Supply Chain's offer more attractive for trusts; and

iii) assess regularly whether NHS Supply Chain is subject to the right level of competitive pressure and monitor this as other intermediary bodies, such as Collaborative Procurement Hubs, develop, rationalise and reform.

5. **Regional purchasing structures are confused and lack transparency.** The Collaborative Procurement Hubs are undergoing major changes, with some Hubs becoming privatised or merging with others. Hubs are funded by subscriptions from their members, but trusts may not subscribe if they see membership as an unnecessary and unaffordable cost without tangible benefits. The Department does not directly control Hubs but the Department is accountable for the effective functioning of the NHS system as a whole. Given its need to achieve QIPP savings, the Department should work with Foundation Trusts to ensure Hubs add value and avoid duplication.

6. **There is a risk that, faced with the need to make savings, trusts will not identify procurement savings and will instead cut elsewhere.** More efficient procurement has the potential to save money without damaging patient care. Trusts' boards should set aggressive targets for savings from procurement and should require trusts to demonstrate to their boards, staff and patients that they have delivered the optimum savings from procurement, before front-line staff cuts are considered. Information enabling their performance on procurement to be monitored should be a requirement for all Trusts.

1 National and regional procurement systems in the NHS

1. The 165 hospital trusts in England spend over £4.6 billion a year on the procurement of medical supplies and other types of consumable goods, purchased from thousands of supplier companies ranging from large multinational corporations to smaller specialist firms. Spending on consumables accounts for 25% of an average trust's non-pay expenditure. Hospital trusts in England have the freedom to decide what consumables they buy and how they go about doing so.[2]

2. Government policy is that hospital trusts should have freedom to manage their operations with minimal intervention or direction from central government. Foundation Trusts, which now account for more than half of hospital trusts, are independent of the Department of Health's control. All hospital trusts are intended to become Foundation Trusts by 2014.[3] The Department told us that it had extremely limited powers to influence trusts' procurement activity, but it did have responsibility for designing the system within which trusts work and recognised the need to benefit from potential economies of scale.[4]

3. The absence of central control makes the roles of trust boards and regulatory bodies particularly important in promoting efficiencies in procurement. Foundation Trust governors will have increased power and importance in the future, and Monitor (the regulator of Foundation Trusts) will also have greater powers to ask detailed questions about the way trusts are run, in order to set tariff prices.[5] The Department told us that it was working with Monitor to provide training for trust boards, so that they had the skills to challenge trust management effectively.[6]

4. There is a confusing structure of organisations whose role is to encourage collective purchasing across the NHS, which includes NHS Supply Chain, the regional Collaborative Procurement Hubs, trusts' own collaborative purchasing arrangements, Commercial Support Units and a National Procurement Council for the NHS. Trusts can also work with the government-wide purchasing agency Buying Solutions. The Department said these arrangements were in transition and acknowledged the system needed to be simplified.[7] The Department described a three-tiered structure - local, regional and national - or pyramid of organisations involved in the process of procurement appropriate to particular goods being bought.[8]

5. The Department has set a target to achieve £1.2 billion savings from NHS procurement by the end of 2014-15, as part of the £20 billion efficiency savings required under the

2 C&AG's Report, paras 3, 1.1-1.6

3 C&AG's Report, paras 2, 18

4 Qq 1, 15-20, 48

5 Qq 33, 36

6 Qq 33, 37, 43

7 Qq 1, 85

8 Qq 1, 25, 85

Quality, Innovation, Productivity and Prevention (QIPP) programme.[9] However, the Department has no direct control over the actions of the individual trusts on which it relies to deliver these savings.[10] Its strategy is to set up overarching systems, provide information and make tools available which enable Foundation Trusts to achieve the savings.[11] The Department believes that increasing financial pressures, such as the requirement for trusts to deliver a 4% unit cost efficiency gain in 2011-12, will also be an incentive.[12]

6. A lack of good quality, comparable data is restricting progress towards more efficient procurement.[13] Trusts use different financial systems, and different types of product coding which makes it difficult to compare the prices paid and the range of products bought.[14] The Department told us it was producing a tool that trusts would use to extract better information from their procurement systems.[15] In the longer term, the Department planned to require all products purchased by the NHS to have standard bar-coding. It hoped that bar-coding of products would help trusts understand how efficiently they were procuring consumables compared to others and help them rationalise the range of products they bought.[16]

7. In the year to September 2010, NHS Supply Chain's turnover was £1.2 billion, 70% of the expected level of £1.7 billion.[17] The NAO found that, in a sample of 4,300 individual products that trusts purchased from NHS Supply Chain and directly from suppliers, just over half were more expensive when purchased through NHS Supply Chain.[18] The Department acknowledged that NHS Supply Chain's use of framework contracts could encourage 'gaming' whereby some suppliers deliberately offered higher prices to NHS Supply Chain so that they could then undercut these prices and trade directly with trusts.[19] The Department told us that an IT system with real-time pricing could reduce the potential for gaming.[20]

8. NHS Supply Chain has limited scope to aggregate demand from trusts, since trusts can choose whether to use its service and NHS Supply Chain therefore has no guarantee that should it buy in bulk, it would be able to sell large volumes.[21] The Department expects, however, that in future NHS Supply Chain will have a key role in aggregating the requirements of trusts through committed, bulk purchasing.[22] The Department aspires to

9 C&AG's Report, para 16

10 Qq 17-22, 32-34

11 Qq 3, 19-22, 30

12 Q 3

13 Qq 27, 34; C&AG's Report, para 5

14 Qq 31, 34

15 Qq 30, 60

16 Qq 26-27; C&AG's Report, para 16

17 C&AG's Report, para 14

18 C&AG's Report, para 2.17

19 Qq 41, 75-78

20 Qq 41, 63, 78

21 Qq 32, 39, 41; C&AG's Report, paras 2.18, 3.19

22 Qq 22, 31, 38-41, 75

make NHS Supply Chain's offer to Foundation Trusts so attractive that they 'cannot not use it'.[23]

9. Collaborative Procurement Hubs are funded by trusts' voluntary subscriptions and their activities are determined by their members' priorities. [24] Individually, the Hubs report widely varying savings for members, but comparisons are difficult because approaches to calculating savings vary and there is no single performance framework.[25] This makes it difficult for trusts to be informed customers and to know where best procurement value can be found.[26] The Department believes that Hubs should survive or fail on their merits; some are already closing and others moving into the private sector.[27] Mr Rolfe told us that Hub funding could be a struggle, because some trusts could be tempted to save the short-term cost of Hub membership rather than pursue the longer-term savings which membership could offer.[28]

23 Q 22

24 Qq 88-92; C&AG's Report, para 2.9

25 C&AG's Report, para 2.12

26 Qq 94, 85

27 Qq 88, 90-91

28 Q 87

2 Trusts' individual procurement practices

10. There are significant financial pressures on trusts and some hospitals are announcing or considering cuts.[29] Many hospitals are not maximising the efficiencies available in procurement.[30] The Department expects hospital trusts to consider improving procurement to reduce costs, but it has few levers to enforce this and we are concerned that trusts may reduce front-line services without first ensuring that their procurement is as efficient as possible.[31]

11. The Department expects governors and boards of Foundation Trusts to hold trust managers to account for demonstrating that procurement practices are cost-effective and for ensuring that savings are delivered.[32] Mr Rolfe said that there is a lack of data on procurement for trust boards or local populations to hold trusts to account for their performance, for example, to enable comparisons of spend on products with neighbouring trusts.[33] The Department stated that it is working towards increasing the availability and quality of procurement performance information but that it had some way to go.[34]

12. An NAO sample of 61 trusts found they bought 21 different types of A4 paper, 652 different types of surgical and examination glove, 1,751 different cannulas and 260 different administration sets. Some trusts buy as few as 13 varieties of gloves whilst one trust buys 177 different types of glove.[35] The Department acknowledged that there is far too much product variety and that, with the involvement of clinicians, it is perfectly possible to reduce it.[36]

13. Product standardisation combined with volume commitments can produce significant procurement savings. The NAO estimated that if hospital trusts were to amalgamate small, ad hoc orders into larger, less frequent ones, rationalise and standardise product choices and strike committed volume deals across multiple trusts, they could make overall savings of at least £500 million, some 10% of their £4.6 billion spend.[37] The Department said trusts should work together with appropriate intermediary procurement bodies to aggregate demand and provide volume commitments in order to drive down prices.[38]

14. The Department acknowledged that there is a longstanding problem with individuals making their own purchasing decisions without going through their central procurement team. This 'maverick spending' risks poor value from individuals placing small orders in

29 Qq 3, 13-14, 33

30 C&AG's Report, para 17

31 Qq 3, 17-21

32 Qq 33, 37, 43

33 Qq 26-28, 43

34 Qq 1, 33-34

35 Qq 82-83; C&AG's Report, para 9

36 Qq 82-84

37 Q 25; C&AG's Report, para 10

38 Qq 25, 31, 38

isolation.[39] While the Department said that the majority of orders were placed through central procurement teams, there is no central data available to quantify the true extent of maverick spending. The Department told us that most trusts are now focusing attention on this issue.[40]

15. It is important that the NHS not only procures consumables at the right price, but also avoids ordering excess stock, and has systems in place to enable medical staff to locate the items they require. The Department told us that, to address problems of this type, it was important to give clinicians budgetary responsibility that included both clinical and non-clinical activities. The Department cited the example of the 'Productive Ward System', now in place in approximately 70% of wards, where ward sisters and ward managers have improved stock management processes and freed up time for patient care.[41]

16. It is not clear, should a trust become insolvent in future, whether or not outstanding debts to suppliers would be underwritten by the taxpayer. The lack of clarity means that suppliers could factor in a risk premium into their prices, which would not be there if suppliers had certainty over payment. The Department told us that the policy had not yet been finalised in respect of the failure regime that will operate should trusts get into financial difficulties.[42]

39 Q 60

40 Qq 59-64

41 Qq 80-81

42 Qq 52-58

Formal Minutes

Monday 9 May 2011

Rt Hon Margaret Hodge, in the Chair

Mr Stephen Barclay	Mrs Anne McGuire
Dr. Stella Creasy	Austin Mitchell
Matthew Hancock	Nick Smith
Jo Johnson	James Wharton

Draft Report (*The procurement of consumables by National Health Service acute and Foundation Trusts)* proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 16 read and agreed to.

Conclusions and recommendations 1 to 6 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Thirty-fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

Witnesses

Tuesday 15 March 2011

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Oral evidence

Taken before the Committee of Public Accounts

on Tuesday 15 March 2011

Members present:

Rt Hon Margaret Hodge (Chair)

Mr Richard Bacon	Austin Mitchell
Stephen Barclay	Nick Smith
Matthew Hancock	Ian Swales
Joseph Johnson	James Wharton
Mrs Anne McGuire	

Amyas Morse, Comptroller and Auditor General, gave evidence. **Gabrielle Cohen**, Assistant Auditor General, NAO, **Marius Gallaher**, Alternate Treasury Officer of Accounts, NAO, and **Mark Davies**, Director, NAO, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

The Procurement of Consumables by NHS Acute and Foundation Trusts (HC 705)

Examination of Witnesses

Witnesses: **Sir David Nicholson KCB**, Chief Executive, NHS, **Howard Rolfe**, Director of Procurement, East of England NHS Collaborative Procurement Hub, **David Flory CBE**, Deputy NHS Chief Executive, and **Peter Coates CBE**, Commercial Director, gave evidence.

Q1 Chair: Welcome to you all. I also welcome the members of the Commonwealth Parliamentary Association who are here on a delegation to watch how our select committees operate. Welcome back to Sir David, and welcome to the rest of you, and a particular thank you to Howard Rolfe for coming and joining the team for this inquiry. Now, I suppose the obvious first question, to you, Sir David, is that this Report demonstrates that there is potential for a substantial saving if we got smarter in our procurement. You yourselves have included in your plan for saving £20 billion the sum of £1.2 billion on procurement expenditure where you want to save money. The whole reform agenda is about decentralising to Foundation Trusts and presumably GP commissioning consortia. That seems to me to be a conflict of intent. How are you intending to square the circle of more prescription around purchasing and the more decentralised decision-making structure that comes with the NHS reforms?

Sir David Nicholson: You pose the question in exactly the right way. The challenge on this Report, and I would imagine on quite a lot of the Reports that we look at over the next period, is how do you get the benefits of scale that you can get from something like the NHS against the background of an increasingly devolved system? There are two or three things that you need to do. The first is to get the landscape right, and I think we will undoubtedly talk about the landscape in a bit more detail. But however you do the landscape, to us it is very clear that you need a mechanism for people to purchase locally, for all sorts of reasons, not least for sustainability and innovation, but also because there are just some things that it is better to buy locally.

There are some things that you need collective procurement for, at either a regional or sub-regional level. The important thing about all that is getting clinical engagement around some of the decisions that need to be made. So you need to be not too far away from the clinicians when you do it. You need to do some things nationally. Getting that landscape right is essentially what we have been trying to do over the last two or three years or so. We are not quite there yet, but those three elements are really important for us to do that.

The second thing you need to do is essentially have a revolution in the amount of information that is available to people through that: for example, through coding and price comparisons. We will no doubt talk about the information and all that in a bit more detail. Thirdly, you need to create the environment and a culture where people will focus on these sorts of things at local level and make sure this is in the right place. So I think we are trying to do all those things at the moment to deliver the obvious savings that the NAO have identified—and we have identified—that can be made out of procurement.

Q2 Chair: That sounds very theoretical. If you are sitting in an NHS Foundation Trust, how are you going to make sure they do not buy 652 different types of surgical gloves or 71,751 different cannulas? I understand the theoretical framework but we have that in the present structure; I just do not know how it will work if I am sitting running a Foundation Trust or if I am sitting supporting a GP consortium.

Sir David Nicholson: The first thing to say is that this is very difficult to do. We are talking about a whole industry here. We are not talking about an organisation; we are talking about a whole industry. If

you look around the world, there are not many industries that have managed to get procurement across the whole industry in the way that we are trying to describe. This is relatively uncharted territory in industrial terms.

Q3 Chair: But you have put a figure on it. You are expecting £1.2 billion of savings.
Sir David Nicholson: Absolutely, and we need that. There is a variety of ways in which we can get people in the right place to do that. The most obvious one is that the financial pressure on NHS Trusts is now significantly greater than it has been, certainly, over the last 10 years. We are expecting a 4% unit cost efficiency gain for every Foundation Trust, so there is no excuse for Foundation Trusts not looking at procurement as an important mechanism to do that. Indeed, the challenge I would make to any Foundation Trust which has been either announcing or considering announcing losses of jobs in the service is to ask whether they have done everything in relation to procurement to ensure that that is the last possible option that they use. So the financial regime that we are putting in will increasingly force people, I think, towards it. But there are some things that we need to do from the centre. We need to give them information, do the coding right for them and provide them with tools. Again, I think we will talk about those in the session.

Q4 Stephen Barclay: You are implying that it is a new issue that the efficiency savings will drive Foundation Trusts to do this, but we picked up at a previous hearing the value-for-money savings target, where, at the interim stage, the Department has achieved just 20% of its target. There have been previous efficiency targets, so you would have thought this would be happening now. Could I just ask you about the letter that was sent by Jim Easton on 22 February 2011, which just seems, by coincidence, to be 20 days after the NAO published this Report, which flags to chief executives, for example, a price variation of 287% on one item. The lowest unit price was £310; the highest unit price was £1,200. Why wasn't your Department picking that up much sooner?
Sir David Nicholson: It has done, and we have done quite a lot of work over the past three years to get more information and more knowledge into the system through the supply chain, and all the rest of it. So we have been doing it for quite a long time, but the importance, of course, and the focus now is because we have this huge efficiency gain to deliver, we are trying to focus on our attention on that and trying to help people do it.

Q5 Stephen Barclay: It is just a coincidence of timing that this came out 20 days after the NAO Report?
Sir David Nicholson: The NAO Report is a very helpful and useful Report that focuses attention, but our need to drive £1.2 billion out of procurement predates the NAO Report. I think the NAO Report gives us some helpful guidance and reinforcement of some of the things that we are doing, but I am not ashamed to say that the NAO Report has helped us in all this.

Q6 Stephen Barclay: Regarding the 2007–11 figures representing the value-for-money target that the Treasury set you, have you published where you are up to now and what your up-to-date position is?
Sir David Nicholson: On the what, sorry?
Chair: This was the 3% per annum in the 2007 spending review.
Stephen Barclay: The 2007–11—the one at the interim stage you were at 20% of. What is the up-to-date position on that efficiency programme?
David Flory: We have not published an update on where we are at with the 2007–11 figures.

Q7 Stephen Barclay: Will you be publishing an update on that?
David Flory: I think that we will be reporting, clearly, to the Treasury in the way that we do on these numbers, and at some point, towards the end of the period, we will report against that overall number as we have done previously. The timing and form of that, I am afraid, I have not looked at.

Q8 Stephen Barclay: Can we not have a commitment that you will publish where you have got to on that Comprehensive Spending Review challenge?
Sir David Nicholson: I am sure we will. We are bound to publish something. Whatever we do there I guess only reinforces how big this mountain is that we have to climb over the next three years.

Q9 Chair: Getting back to the other matter, it strikes me that two issues arise. I am trying to relate your good intent—you've putting this figure in—but you have got a very different landscape; you've accepted that. Let me ask you a question about tariffs. Does it suggest to you that perhaps the tariffs are too generous and are not, therefore, being effective in driving down the cost on these sorts of procurement issues? Is that a vehicle you could use?
David Flory: In terms of the tariff, each year for the tariff setting process we have refreshed costing information from all providers of NHS service that is used as the reference cost process for the base. We also make an adjustment to tariff price each year, in order to embed in the tariff an efficiency requirement from providers of service.

Q10 Chair: Tariffs are average, though, aren't they? Tariffs reflect an average cost. I am trying to find a way in which you are going to incentivise procurement savings, and one of the mechanisms might be on tariffs. Accepting all the discussion we had previously about the fact that you have to watch that you do not reduce quality in tariffs, is there something here that you are exploring or you might do something around?
David Flory: The adjustment for tariff price each year requires an efficiency gain to be delivered by providers, to be able to deliver service at tariff. As Sir David said, for the year beginning 1 April 2011, that efficiency gain is at 4%, which is higher than we have

set in the tariff process previously. In the current year it is 3.5% and in previous years it has been 3%. In recent years we have stepped up the efficiency requirement on the service.

Q11 Chair: Remind me, do the tariffs cover 60% or 40% of current activity? I cannot remember.
David Flory: They cover about 40%.[1]

Q12 Chair: So therefore, will you be looking to use that as a mechanism? Are you extending that over the other 60%?
David Flory: Yes, and in the operating framework, we set out very clearly for all parts of the service that the 4% efficiency gain that we require as part of the tariff should also be applied to non-tariff services.

Q13 Chair: If people find the efficiency gain by sacking staff, rather than procuring better, what do you do?
Sir David Nicholson: What we are saying is that the challenge to them is that they have to explain to their population, their governors and their boards why they have done it in the way they have done it. That is the mechanism.

Q14 Chair: But will you give them the data to show, for example, *x* trust has done it by saving on procurement, whilst *y* trust has done it by sacking people—doctors and nurses?
Sir David Nicholson: As part of this mechanism, we will publish more and more information.

Q15 Stephen Barclay: But if it was system wide, so a large number of Foundation Trusts are not achieving best value, would accountability for that lie with each of the Foundation Trusts or would it lie with you as the Accounting Officer?
Sir David Nicholson: It would lie with the Foundation Trusts.

Q16 Stephen Barclay: Because that is not the impression that Sir Nicholas Macpherson gave this Committee. He said, "I think he or she"—i.e. the Departmental Accounting Officer—"should be held to account if there is a system-wide problem that is resulting in bad value for money." So if it is systemic and if a number of Foundation Trusts are not achieving value, then you, as the Accounting Officer, should be responsible; whereas the impression you are giving is actually that it is for each Foundation Trust board to be held accountable.
Sir David Nicholson: Sorry, I had misunderstood your question. When you said about a system of Foundation Trusts, I thought you meant a geographic area or a group of them working together. Designing the system is the responsibility of the Department of Health.

Q17 Ian Swales: Can we just tease out this question of accountability a bit more? The Report gives examples, even within Trusts, of bad procurement activity. For example, 177 different types of glove in one particular Trust. It also gives examples of how Trusts within themselves have managed to halve the costs of nurses' uniforms. Suppose they do not do that, where does the power lie? Do you now have the power to go to that Trust that buys 177 gloves and say, "Do something about it?"
Sir David Nicholson: No.
Ian Swales: They are not accountable to you are they?
Chair: You pick up the phone and shout at them.
Sir David Nicholson: Not the Foundation Trusts, no.

Q18 Ian Swales: No. So, Foundation Trusts are effectively arm's length bodies as far as you are concerned?
Sir David Nicholson: Their accountability is different from arm's length bodies. Arm's length bodies are directly accountable to the Department; Foundation Trusts do not have any accountability to the Department in that way.

Q19 Ian Swales: So you have extremely limited powers to influence procurement activity within Foundation Trusts and between Foundation Trusts. Is that not true?
Sir David Nicholson: We do, and that is why designing the system, creating the environment, getting the information systems in the right place and getting the coding right is the sort of thing that we can do.

Q20 Ian Swales: So you are going to try and enable them with some overarching system. Is that what you are saying?
Sir David Nicholson: Yes.

Q21 Chair: And if they do not deliver?
Sir David Nicholson: If they do not deliver on the totality of their financial position—
Chair: So that it all adds up to your £1.2 billion, or thereabouts?
Ian Swales: You are going into this with wishes and hopes, but you do not have the power to go out and make it happen.
Sir David Nicholson: I think it is more than wishes and hopes. I would argue that the alternative, which is often described as the Ukrainian tractor factory bit—the idea that we could do all of this from Whitehall—is nonsense, because we know that this is terribly complicated. There are a million different things that the NHS buys at the moment.

Q22 Ian Swales: You mentioned near the start three levels of purchasing, one of which, you said, was best done nationally. How are you going to get Foundation Trusts to engage with national procurement?
Sir David Nicholson: To make the national offer, largely through the NHS Supply Chain, the best it can possibly be, and to work with the supply chain to ensure that the offer they make to Foundation Trusts is so good that they cannot not use it.

Q23 Ian Swales: Okay, so the NHS buys certain things centrally, and then offers them to the

[1] As a proportion of total PCT allocations, Payment by Results (PbR) activity makes up about a third and as a proportion of average acute trust income PbR activity accounts for around 60%.

Foundation Trusts, who then have the option whether to take them?

Sir David Nicholson: The NHS Supply Chain is run by a private company, and there is a contract that runs through the business service agency, which is an arm's length body of the Department of Health. That contract is for the kind of thing that you described. So, the NHS Supply Chain buys in bulk in the way you described.

Chair: We will come back to the structure towards the end.

Q24 Mr Bacon: May I ask Mr Rolfe a question, because when one thinks of Ukrainian tractor factories, one does not think of Marks & Spencer. You are generally known as a business that finds out what its customers want and is good at supplying it. I know you have now left the company, but I noticed that when you were seconded to the Treasury a few years ago, you led a study on procurement in the NHS on behalf of the health team in the Treasury. Can you just remind us of the conclusions of that study? How much progress has been made from what you set out then, compared with now?

Howard Rolfe: When I undertook the study, there was an organisation called the NHS Supplies Authority, which was both the buyer and also had its own representatives in Trusts. So, there was a bit of poacher and gamekeeper, and we looked to change that model, and from that developed PASA. But going back to the core principle of what I think you are talking about, in terms of collective procurement, progress has been made, as Sir David has indicated, but there remain opportunities. I am sure the Committee will want to tease those out.

Q25 Mr Bacon: I might tease this out a bit, if I could. With your experience, what do you think the NHS could do to enable its buying power to be deployed and leveraged properly, whilst still leaving Trusts operating independently and autonomously?

Howard Rolfe: I fully respect and understand the structure of the NHS, and it is not for me to comment on that.

Mr Bacon: I am not asking you about the structure.

Howard Rolfe: It is very important to bear in mind that they are a series of independent units. So the structure that one could envisage is a pyramid, whereby, as Sir David has indicated, there are national purchases, energy being a very obvious example, there will be local purchases that are appropriate to the individual Trust, and there will be regional purchases. A key word in all this is commitment. If you are able to give commitment to the supplier, you will drive down cost.

Q26 Mr Bacon: Yes, of course, except in the NHS IT programme, of course. I am not joking, because there are volume commitments in there, as Sir David knows only too well, including volume commitments for software that has not been written or has not been finished, and certainly when the commitments were made, it had not been written. But yes, what you have just said ought to be axiomatic. I suppose the question then is: how do you get those commitments from the Trusts?

Howard Rolfe: You need transparency in the system. You were asking earlier about the pressure on the individual Trust and, more so, on the non-executive director, so if you have the transparency, you can understand that a good question for a Trust board would be, "What are your top 10 non-pay spends, and how do those prices compare with the best quartile in your region?"

Q27 Mr Bacon: How many Trust boards do you think ask those questions?

Howard Rolfe: Well, you can imagine.

Mr Bacon: No, I cannot. I am not very imaginative. There are those who think I am, but I am not. I have no imagination and I am asking you to help me out. How many boards do you think can answer those questions, or even ask them?

Howard Rolfe: Not many. The reason is that, unfortunately, it is very difficult to get the data, and the building block of all this is the system that the Department are going to introduce, which is the bar-coding, or the GSI system, because you need to have commonality. If I said prosthesis to one Trust, we won't be comparing apples with apples. So you start with a common system. You can then take that forward and start to be able to benchmark much more effectively.

Q28 Mr Bacon: Lots of companies in the private sector with boards probably would sit round and ask that question, "What are your top 10 items of non-pay spend?" They would probably be able to get some sensible answers and do some sensible benchmarking. They have been doing it for years; for years. The fundamental question to which this Committee likes to know the answer is, what have you done with the money? Sir David, why are we in a position, now, in 2011, where we still cannot answer that question properly?

Sir David Nicholson: Answer which question, sorry?

Mr Bacon: What have you done with the money? Fundamentally, Mr Rolfe said that these boards sit there asking questions, such as, "What are your top 10 items of non-pay spend, and how do they compare with the best quartile in your region?" This Committee likes to know where the money has gone and what it has been spent on. Essentially, what Mr Rolfe was saying is that there is a difficulty around information. He said that the GS1, I think you call it—the proposal for improving the bar-coding—ought to address that. What I am really asking is why here, in 2011, are we thinking about beginning to address it, since this is obviously fundamental and has always been fundamental, whether you are talking five, 10, 12, 15, 20, 25 years ago? These are simple fundamental questions to which you would need to know the answers if you were going to improve your procurement, and we are still not there. Why not?

Sir David Nicholson: I am not quite as negative as Howard about how many people are doing this, because I think there is quite good evidence that more and more people are doing it.

Q29 Mr Bacon: Is there? Where is that evidence?
Sir David Nicholson: Yes. I probably see more of the NHS than anybody in the country because I get around and about, and in most places now people are starting to address this.

Q30 Chair: I have to say to you, you have set the target of £1.2 billion-worth of savings out of this, so that suggests there is a heck of a lot of room for improvement.
Sir David Nicholson: Absolutely. I am not saying that we have solved the problem at all. There are techniques that can be used and organisations that will help people. So, for example, Shared Business Services at the moment have a tool that they can take into organisations and do the kinds of work that Howard just described—get into the data systems and produce a product. We are producing a product from the Department, which will be available in the next week or so. That, again, is a tool that people can use to interrogate their existing systems.

Q31 Mr Bacon: Mr Rolfe talked about the importance of commitments and said that transparency was one of the things that you needed. How are you going to get these commitments and when will you know when you are getting them? How long will it take?
Sir David Nicholson: I won't get the commitments; the NHS Supply Chain and the various organisations we have around the country like Mr Rolfe's will get the commitments. They will get those partly when people understand the scale of the savings that they have to make over the three-year period, but also, it is more to do with the information that they can extract from those systems. Part of the issue about the systems, to be honest with you, is that most are based on financial systems, and there has never been one financial system for the whole NHS. Every organisation makes its own judgment about the kinds of systems that it has. So it has been very difficult.

Q32 Mr Bacon: I just want to press you on this one point. You said, "They will do it because they will see the need for savings, and they will go to the NHS Supply Chain more often than they do at the moment." Not surprisingly, I imagine, they have prejudices about it, because when they go to NHS Supply Chain and look at this list of products, they see at the moment that more than half those products are more expensive through NHS Supply Chain than what they can get themselves. So how is that going to change, and what is your role in making a change? Because at the moment, you seem pretty distanced from this, but presumably I am right in thinking you are accountable for the £1.2 billion, aren't you? Yet you do not seem to have any of these levers, because it is all down there at the Trust level and elsewhere. How are you going to make them use NHS Supply Chain more, when the prices that it offers are so often not competitive?
Sir David Nicholson: Sorry, I should be clear, I am not, in any sense, trying to walk away from my responsibilities either to design the system or to ensure the savings that we make to deliver the totality—
Mr Bacon: I was not saying you were trying to walk away; I was just saying you do not really seem to have the levers.
Sir David Nicholson: No, but what I am saying is that the idea that I can sit in my office in Whitehall and give instructions to thousands of clinicians and thousands of parts of an organisation throughout the country, and tell them what to buy and how to buy it, is simply not credible. What I need to do is design a system, and that is what we are trying to do.

Q33 Nick Smith: Again, on tractors in Ukraine, I want to plough this particular furrow. It is a great book if anyone has not read it. *A Short History of Tractors in Ukrainian* is a lovely book. Mr Nicholson, you talked earlier about local populations having an accountability over money wasted on procurement, and you drew the analogy between jobs lost and money wasted on poor procurement at a local level through local supply chains. How are you going to arm local populations if you think, realistically, they can make that comparison between jobs lost and money poorly spent at a local level? What will enable people interested in health efficiencies at a local level to say, "Stop sacking that nurse, closing that ward, undermining that A&E; save more money on procurement, because it is a lot of money." How would you do that?
Sir David Nicholson: There are a whole series of ways, but there are two ways that I would suggest. First, there is the transparency argument. You publish lots more data in the system, and as we get better at that, that will become clearer and more obvious to local populations. The second issue, particularly, I think, for Foundation Trusts as a cornerstone of the Foundation Trust movement going forward, is the power and importance of governors, and getting education and training for governors to start to ask the right kinds of questions. That seems to me to be a really important part of that equation. In a sense, because governors, as we go forward into the new NHS, will have more power in the system, it seems that focusing our attention on them as a group will be really quite important.

Q34 Nick Smith: Given that there are bags of data out there at the moment, and the difficultly for local people is deciding what data are important, how will you enable local populations to understand what data are important and where real efficiencies and savings can be made at a local level, and allow them to have the read-across to the reduction in services at the local level? Otherwise I suggest you are just putting a whole bunch of information out there which won't be used, and that would be criminal.
Sir David Nicholson: I do not think we have got there yet. At the moment we are trying to get the data clean in a way that you can compare one bit with another, because at the moment we cannot do that, because everything is coded in quite different ways. We are quite a way from getting there, and we are trying to put ourselves in that place, but it is going to take some time.

Q35 Matthew Hancock: I want to continue in this rich seam. Twice a week we have people before us, and when talking about productivity and efficiency, the two things that come up most often are poor data and poor accountability. You have already spoken quite eloquently about what you want to do on data and the need to clean it up and make sure it is matchable. We even have Richard talking about matching, which is quite a feat. But I wanted to concentrate on the accountability and the incentives, because in one of the earlier answers you were describing how you can align a decentralised system with a need to drive improvements in efficiency. In the new NHS, how are the incentive structures for decentralised bodies going to help you do that?
Sir David Nicholson: Before I answer, that is not to say that there is not quite a lot of collective procurement already happening. We have made significant progress, and no doubt we will come on to that, on collective commissioning, so it is possible within the arrangements we have at the moment. But in terms of the system going forward, there are two issues. The first one is that Monitor, the economic regulator, will be responsible for setting the price in future. They will obviously do it in conjunction with the Commissioner, but the actual price will be set.

Q36 Matthew Hancock: That is not price of procuring items; that is the price of the thing that is being done: the output.
Sir David Nicholson: Yes, the hips, the knees, and all that sort of thing. At the moment, as David was saying, each organisation has to produce information for reference cost purposes to set those prices. Monitor has much greater powers in future to ask more detailed questions about the way in which you manage your business in order to make that price. So, Monitor, in future, could—and, I assume, will—ask much more detailed questions about the way in which you procure.

Q37 Matthew Hancock: When you were saying that boards need to ask the right questions and be stronger, that is all very well, so long as the boards have incentives to do the right thing, as well. Just putting a board there won't bring about the right result.
Sir David Nicholson: No. But the first point is that the tariff then, transparently, will be much more focused on the benefits that you can get from procurement, and it will be clear and transparent for everyone to see. I think that is important. It would be useful for the boards to take that—
Matthew Hancock: To hold people's feet to the bar?
Sir David Nicholson: Yes, absolutely. The second issue is the boards themselves, and the development of boards. Together with Monitor, we are offering a whole set of board development opportunities for people to learn and understand how to do all f that.
Matthew Hancock: To give them capability, but not necessarily incentive.
Sir David Nicholson: The incentive is a financial incentive, on the one hand. Sorry, that is absolutely right. That is the financial incentive we want to put into the system.

Q38 Matthew Hancock: You talked about driving down procurement costs of the lower quartile, for instance, as a goal once transparency is achieved. How will the system operate and the incentives be put in place in order also to drive down the lower quartile? Because if you take the letter that we have received with the huge price variations in several items, of course you can get great benefits from driving down the highest unit price—and it is shocking that the differences have been so wide—but you also want to keep driving down the lower quartile point. Otherwise you just settle at a given point. You do not keep generating savings. How are you going to do that?
Peter Coates: NHS Supply Chain operate around continuing improvement in the way they procure. The trick for them is not only to target information to Trusts to allow them to understand what the pricing variation is, but to work with them to aggregate demand and commitment to allow them to drive down the lower quartile prices to the best of industry.

Q39 Matthew Hancock: How are they going to get those commitments, given the decentralised system?
Peter Coates: NHS Supply Chain do centralisation and do commitments at their level. They is a very good example around scanning equipment, where they borrowed money on the market and bought, in advance, a significant number of scanners, and then sold those back to the NHS at a discounted price. So they operate on a national level where it is appropriate. There are also examples at regional levels where it is appropriate to do the aggregation and commitment there.

Q40 Chair: But how do you ensure they pass the benefit on to the taxpayer and the NHS? Obviously, if they can get economies through, they will do so as a supplier, but where is the incentive to pass those benefits through to the taxpayer?
Peter Coates: All the money passing through the DHL and the Supply Chain account is on an open book basis, and audited by the BSA on a regular basis.

Q41 Chair: We will come back to structures, but you have just got to remember that 50% of its products are more expensive, so if I were sitting there I do not know whether I would jump at the opportunity of using them.
Peter Coates: The thing about the way we contract at the moment that is unfortunate is that NHS Supply Chain uses framework contracts; essentially you go to the market and ask them to price on an open book basis for a number of different volumes. The problem with that is that it encourages gaming in the system. Suppliers themselves may often price higher, and then offer discounts back to Trusts so they can trade direct with Trusts. Suppliers who have not tendered go around with the price list and say, "Well, look, if you trade with me, I will give you a 10% discount on this price." It is unfortunately the way we do business.
Chair: So what is your answer?
Peter Coates: My personal view is that I think we should move into different technology and find a technology-based solution to this to allow real-time

pricing to be brought into the NHS as a dynamic purchasing system.

Q42 Mrs McGuire: I wonder if I could just rewind the discussion a few minutes. Earlier, Mr Bacon asked Mr Rolfe whether some of the Foundation Trust boards were asking some of the difficult questions, and you said you did not think there were very many.
Howard Rolfe: It was a specific question about my top 10. What I can give the Committee reassurance about is that boards, and in particular non-execs, will be challenging around cost improvement and service improvement programmes. So we are looking at the totality of savings, and there is a lot of focus on that, but what I am saying is that it is difficult to ask the question about procurement and procuring items, because you cannot necessarily get the true data. That was my point.

Q43 Mrs McGuire: Let me just complete the journey I was on. When Sir David Nicholson was asked a similar question, he said, actually, that you thought that members of boards out there were asking some of the difficult questions. I am just trying to understand what the current experience is. Is it Mr Rolfe's, which was in response to that earlier question, or was it Sir David Nicholson's? Because you said there was evidence that they were actually asking some of these tricky questions about the top 10, etc.
Sir David Nicholson: No.
Mrs McGuire: Is it anecdotal, or is it evidence?
Sir David Nicholson: One person's anecdote is another person's evidence. I spend a lot of time talking to boards and going to visit places, and I cannot remember the last time when I spoke to a senior person in an organisation who said they were not looking at procurement in a very dynamic way. Now, that is what they were saying, because they need to deliver the saving.
Mrs McGuire: You would not expect them to say anything else.
Sir David Nicholson: They could say no, couldn't they? But if you are saying, "Have they got the data to identify the comparison of the top 10?" the answer is, no, they have not. Some of them have. Some of them have used the SBS system to do it and some have used commercial things to do it, but that is a relatively small number. As I say, I cannot think of any board that I have spoken to over the last period that are not looking at procurement as a real opportunity to make savings.
Mark Davies: Just a very quick point here, because we did a survey of all Trusts, NHS and Foundation Trusts, and it is quite interesting that 152 out of the 160 population said that they had set themselves a target for efficiency savings and procurement, which averaged out at £1.6 million per Trust. So, obviously I think it is Sir David's point about the fact that there is a certain focus on procurement that there possibly has not been in the past. But it is a question of how they are going to be able to demonstrate those savings to their boards and to their local populations.

Q44 Ian Swales: Another important question is: do the total targets add up to £1.2 billion?
Mark Davies: It actually adds up to about £250,000,000, but that is in one year.
David Flory: The Trusts are so hungry for the information and are aware of it, the Foundation Trust Network, of which I certainly think the vast majority, if not every single Foundation Trust, is a member, are developing a benchmark in information, recognising that there are some imperfections in the market information about real-time price comparisons. On behalf of the members of that network, they are collectively engaged in developing the benchmark information, so that each and every board can see where they are compared with others, and use that to drive their own improvements.

Q45 Mrs McGuire: Sir David also mentioned that Monitor would be looking at the way that individual Trusts were operating, and obviously looking at some of the detailed information on procurement. What happens, then, if Monitor says, "Well, actually, we do not think this particular Trust or these particular Trusts are actually playing the game in terms of getting value for money." Where does the buck stop on that?
Sir David Nicholson: The buck stops with the Foundation Trusts. What Monitor will use that information for is to set the tariff. So they will be able to identify how much progress they think Trusts are making overall, and then set the tariff in line with what they think is achievable.

Q46 Mrs McGuire: So can I go back to the overriding responsibility of this Committee? Who is accountable for the taxpayer's pound in these circumstances? Is it you?
Sir David Nicholson: I am responsible. I am the Accounting Officer.
Mrs McGuire: Yes, we understand that.
Sir David Nicholson: So in that sense, I am accountable for the totality of the operation of the system. So I am accountable to make sure that £1.2 billion-worth of procurement savings are being made out of whatever system we put in place to make it happen.

Q47 Chair: So we will hold you to account for showing us, by 2014–15, or whenever it is, that you have saved £1.2 billion on procurement? Full stop.
Sir David Nicholson: Hopefully there will be more.
Chair: We will hold you to that.

Q48 Joseph Johnson: I am also a little bit worried about the £1.2 billion target, because on the one hand we are losing the economies of scale, and on the other hand, we are also bringing in a whole new level of risk, in the sense that as we move in to a decentralised environment, there is the increasing possibility that NHS hospitals and Foundation Trusts will be allowed to fail. Now, the prospect of failure is new and that, logically, will lead to suppliers charging something of a risk premium when they are supplying products to a hospital that can potentially be allowed to fail. In your estimation of the £1.2 billion target, have you taken that factor into account?
Sir David Nicholson: We have not taken into account that there will be a large number of hospital failures,

because we do not believe that will be the case. We believe that the system itself and the people who lead these organisations will be successful.

Q49 Mr Bacon: Are you assuming a rate, even if it is not a large one?
Sir David Nicholson: No.
Mr Bacon: You are not assuming any rate at all? You are assuming no failure?
Sir David Nicholson: We are assuming that there needs to be a failure regime, but we want to prevent failure.

Q50 Chair: But you have to plan for failure. We had this argument before.
Sir David Nicholson: Yes, and that is why we have a failure regime. But we are talking about a handful of organisations. If it was a handful of organisations, which is what we think, if at all, it will be, that would not affect the scale of the £1.2 billion savings that we would make.

Q51 Joseph Johnson: So you have applied no discount at all to your estimation of the procurement savings, due to the likelihood that suppliers will be charging a premium to the more financially perilously positioned Trusts and NHS hospitals?
Sir David Nicholson: No, because we think that organisations will increasingly procure collectively.

Q52 Joseph Johnson: There is also, at the same time, as previous hearings have I think established, quite a considerable lack of clarity over the failure regime that you envisage for NHS hospitals that are not going to be in a position to make it to Foundation Trust status by 2014. I would imagine if you are in the supplier community that that will further push up this premium that you are going to be charging hospitals. Do you acknowledge that?
Sir David Nicholson: That has been an issue in none of the supplier conversations I have had.
Peter Coates: I think that in terms of large-scale debt for large-scale investment over a number of years, there will be potential concerns about viability, but when you are talking about, as you might say, baked beans and small items, I think firms will price it as a market as opposed to individually.

Q53 Joseph Johnson: Just to make it more concrete, in the area where my constituency is, South London, the South London Healthcare NHS Trust came quite close to running out of important supplies at various points last year. Now, it was never very clear to me exactly why that was happening. It could be that they were being a bit too clever in their just-in-time procurement and not ordering sufficient quantities of products in time, but there is also the possibility, and certainly that was the suspicion of the local community, that they were having trouble with supply chain due to the fact that they had a very large deficit—I think it is the largest deficit of any Trust in the country—and that this was having an impact on their ability to procure properly. I would like to know if you have any comment on that.
David Flory: Yes, I have. The South London Healthcare NHS Trust is not a Foundation Trust, and therefore is not accountable to the system, and as you say, it has currently the biggest financial deficit.
Chair: I have to say to you, you have got Queen's Hospital here and South London there. Going round the table, we can all collect quite a number of Trusts in difficulties. Mine is bankrupt, in effect.

Q54 Joseph Johnson: Do you have any evidence that South London Healthcare NHS Trust was having to pay over the odds to get supplies, given a lack of confidence in supply chain, and do you think that will worsen given the lack of clarity over the next two or three years over what is going to happen to it?
Mrs McGuire: And when it is effectively an independent business.
David Flory: There is no evidence. Last year, there was evidence that, because of the level of overspend in the Trust, there were, at points in the year, cash flow issues, which were resolved.

Q55 Chair: This is a really important issue. Do you acknowledge that there is an issue here that you guys have to confront and think about?
Sir David Nicholson: About failing hospitals? Yes, absolutely.
Chair: Bankrupt hospitals.

Q56 Mr Bacon: Okay, let me put it really simply. Let's say I am one of the 1,751 cannula manufacturers. Let's imagine there are fewer than that, because some cannula manufacturers make more than one cannula. I am selling my cannulas to a particular NHS Trust. I happen to know about cannulas only because my father-in-law was in hospital recently and they discharged him in rather a hurry. When he got home, his cannula was still in his hand, and I phoned up late at night and the reaction of the nurse in the hospital was, "Oh my God." So I then went up on the website and I looked up NHS advice on the use of cannulas, so I have become, in Jim Slater's "The Zulu Principle" terms, a relative cannula expert, at any rate, in the last few weeks. I know from the Report there are 1,751 different ones that are supplied. Let's say that I am a supplier of cannulas, because following my recent interest I decided it was a good market, and I thought I could do a better price. I go along to a Trust and I sell them some of my cannulas. The Trust gets into not just difficulty but basically hits the buffers and gets into the failure regime, and the Monitor people come in. At this point, am I either an unsecured creditor in the way that somebody who had supplied pick 'n' mix to Woolworths is, or am I going to get paid 100% in full, because I know that the public purse and the taxpayer is standing behind me. Which of the two is it?
Sir David Nicholson: We have not actually finalised the policy in relation to the detail of how the failure regime will operate.
Mr Bacon: This is a fundamental point.
Sir David Nicholson: I know it is a fundamental point, but the conclusion has not been made in relation to that particular bit of policy, as we say.

Q57 Chair: When will it be?
Sir David Nicholson: It has to be made relatively soon, because of the Bill going through Parliament. So as part of that, we need to explain what the system is.

Q58 Mr Bacon: So Mr Johnson is right. In the absence of this clarity, there is going to be a risk premium that suppliers will charge, which would not be there if there were clarity and they knew that they would eventually get paid because they are contracting with the public purse.
Sir David Nicholson: There will be clarity, but not just yet.
Mr Bacon: St Augustine said that about chastity, I think.
Chair: Dear, dear. Thank you for that.

Q59 Stephen Barclay: Can I just ask a really basic question, which is whether all purchasing comes through purchasing teams, or whether individual clinicians are still able to make purchases?
Sir David Nicholson: Howard will be able to answer this, but in most organisations I would guess that some purchasing is still done through clinical teams.

Q60 Stephen Barclay: So this is still some, what I would call maverick spending, where a doctor or nurse on the ward could make purchasing decisions without going through a central team? That is still going on even after all these years?
Sir David Nicholson: Yes.
Stephen Barclay: Okay, and how do you get a handle on how big a problem that is? How are you measuring that?
Sir David Nicholson: That is, in a sense, what the challenge to Trust boards is. We are giving them the tools through Shared Business Services and other organisations to help them get a handle on all that. In fact, this is one of the things that most Trusts—virtually all Trusts now—are focusing their attention on.

Q61 Stephen Barclay: It is a pretty basic thing to have not got right. If we look at paragraph 3.5 on page 24 of the Report, it makes clear the fairly obvious point that the relationship between price and volume is key, and that is varying. Well, it will vary if you allow individuals to place little orders in isolation. It goes on to say that the method of placing the order also affects price. Again, that goes to the heart of who it is. I must confess, Parliament is no better at this. I was amazed, on being elected as an MP, to discover that I buy individual office equipment in isolation, rather than using the economies of scale of Parliament, so Parliament is no better at this. But given the sums involved, it just strikes me as crackers that you are letting people on the wards make individual pricing purchases, rather than putting that through central procurement teams.
Howard Rolfe: I think it would be fair to say that the majority of that maverick spend would be repeat purchases. It is unlikely that they would be buying a new product.
Stephen Barclay: But repeated at a price 280% higher.
Howard Rolfe: There would normally be an agreed price for that Trust on the product with the supplier, so the negotiation would already have been done by the procurement team.

Q62 Stephen Barclay: Sure, so that is embedding past mistakes, isn't it? In other words, if we have overpaid in the past, "Keep ordering guys; do not worry."
Howard Rolfe: There is no suggestion that they have overpaid in the past.

Q63 Stephen Barclay: But this letter on the 22nd makes it clear that the highest unit price is £1,200, when someone else is getting the same item for £310. What you are, in effect, saying is, "You can go on ordering it at £1,200 a go." Well, that's nuts.
Howard Rolfe: Which is exactly why the Department are keen to bring in transparency, and another tool that can be used for that is some form of e-cataloguing system or Amazon-type operation, so that you can order only from your prescribed catalogue, which has all been prescribed. You have total visibility of price on that, and therefore you can do what I referred to when I was questioned earlier in terms of being able to challenge prices compared with other organisations at a senior level.

Q64 Stephen Barclay: But the whole issue of volume, the whole issue of transparency on price and so on means that it makes sense to have an expert team within Trusts, and I do not get any sense from you to what extent you have measured the extent to which clinicians and others within Trusts are placing orders. Do you have any figures that you can share with the Committee for the worst-case scenario is in a Foundation Trust where there are however many people placing orders? What is the worst-case scenario?
Howard Rolfe: Certainly the majority of orders would be placed through the procurement teams.
Stephen Barclay: Have you any figures to back that up?
Chair: It would not be Mr Rolfe who had them.
Sir David Nicholson: Mr Rolfe would have them because he is running one of the Procurement Hubs, so he might have that. But, if you are saying, "Have I got central information that tells me?"
Chair: The answer is no.
Sir David Nicholson: The answer is no.

Q65 Stephen Barclay: One further linked question. The Report also says the method of placing the order can affect the price, with electronic transactions generally offering better prices than traditional paper-based orders. Are you able to provide us with a list of all those Foundation Trusts that still place paper orders? Because, I, as a local MP, would be very interested if my local hospitals were making savings in frontline services, while they were still not maximising the efficiencies on their purchasing. So it would be very helpful, I think, to Parliament, if we could have a list of all the Foundation Trusts that are still using paper-based orders. Is that something you could get a note to us on?

Sir David Nicholson: I have not got that information. I do not know how easy it would be to collect it. We can see.

Stephen Barclay: Is it not a simple email? We had this letter that went out to the chief executives, which your Department sent out; could we not have another letter sent out this week to the same, just saying, "Can you confirm if you still use paper-based orders?"

Sir David Nicholson: No, because we do not collect information like that in the NHS anymore. You have to get a whole set of approvals before you can collect data from the NHS.

Stephen Barclay: So you cannot ask Foundation Trusts whether they still use paper-based orders?

Sir David Nicholson: You can, but you have to go through a process to make it happen.

Q66 Chair: The truth is, on this you believe more in competition that in controlling inputs. Isn't that right?

Sir David Nicholson: I am sorry?

Chair: The basis on which you think you can drive down the cost of procurement, is one of competition rather than controlling inputs. Isn't that right?

Mr Bacon: Mr Coates is nodding. We cannot record nods in the transcript. So, Mr Coates, was that a yes?

Peter Coates: My view is yes. We are trying to bring into the marketplace knowledge and information that allows Trusts to go to the most economic provider of those goods. So yes, competition.

Q67 Chair: But what Steve is pushing for is a control of inputs, which you are rejecting.

Sir David Nicholson: Yes, we are not going to set a system up that will—

Chair: As long as we are clear, we can then take a view as a Committee.

Q68 James Wharton: Mr Rolfe, if you turn to page 27 and figure 10—and this actually builds on the point that Mr Barclay was making—you see very large numbers of orders where the value of the goods ordered was less than the administrative cost of placing the order. You have just said, in response to Mr Barclay, that a lot of the orders that we are talking about may well be repeat purchases, but why aren't these things being bought in larger volumes in a single go, and then kept in a cupboard, rather than ordered however frequently they are currently being ordered, which drives up costs? Is that something that you are alert to from a procurement point of view?

Howard Rolfe: Yes, absolutely. I can go back to my retail experience on this. The Committee will know that modern practice is "just in time." There is absolutely no reason why you have to have huge great warehouses of stock, which incidentally will go out of life and bring on other problems. So it is perfectly legitimate to have a daily routine. That is the way that Supply Chain works. They are delivering on a daily basis from their own warehouses. So it does not necessarily mean that, because there are a lot of orders, that is inefficient. That is a perfectly legitimate way to operate—repeating your order through organisations like Supply Chain.

Q69 James Wharton: So what you are saying is that you believe that this approach is more cost effective than if fewer larger orders were made, because the point of "just in time" is to save money?

Howard Rolfe: Yes, absolutely, but there is a big difference between ordering against a committed framework. Frameworks are fine, but they only take you part of the journey. The key part of the journey is, as I said before, what is the commitment to the supplier? What is the volume? What is the aggregation? But you can perfectly set that up and then order against that particular contract, so I do not think there is any inconsistency there.

Q70 James Wharton: I just want to get to the bottom of this, to understand this. What we are being shown in figure 10, on the face of it, looks like a problem to me. On cannulas, you have 220,300 orders, and 83% of the orders that are made for cannulas are less than £50, while the administrative cost of doing an order is £50. You do not see that there is a problem there?

Howard Rolfe: Inevitably, there has to be an economy of some scale. If you are literally ordering one or two, then that is inefficient and I am not suggesting that that does not happen. But what I am saying is that it is perfectly legitimate to order small volumes on a regular basis. Clearly, it is inconceivable that a hospital should run out of anything that is going to interrupt medical care, but there will be examples where the order has gone below the price.

Now that brings you into another area in terms of how efficient you can be in the ordering process, and Supply Chain obviously now have a mechanised, electronic system, so that has taken a lot of the cost out. You asked a very fair question about whether there is much paper-driven ordering. I suspect there is not a lot, and the question may not be able to be answered, but I do not think there is a lot.

The other aspect, of course, is payment. There are now modules whereby embedded procurement cards are used. Most independent reviews have valued the cost of paying the transaction at about £28 a time. You can do away with quite a lot of that cost by having an embedded procurement card. A number of initiatives are fairly well developed.

Q71 James Wharton: What you say may explain away this figure, but I suspect it does not explain away all of it, and there are some very significant inefficiencies because of orders that are smaller than they should be being placed. Where I am going with this is that the concern that I have—and Sir David, this may be more in your ballpark—is that you are going to provide data so that we can see that a Trust is doing this or this is happening, but it is not a matter, to me, of just telling people that, "You are getting this wrong; there are inefficiencies." One of the big problems and challenges is going to be sharing best practice about how you drive those inefficiencies out and what steps you are going to take. So it is not just local people saying, "We have got all of this data and we can see that you are wasting money," but it is people who are in the profession, and who are working in Trusts across the country, sharing

information and saying, "If you want to save money, this is what you do. If you set up this system, it works; if you set up this system, it does not." How are you going to ensure that information is shared?

Sir David Nicholson: Yes, part of that was referring to what David said earlier. We are working with the Foundation Trust Network to set up both benchmarking and the sharing of best practice across the system as a whole. We think bringing people together under the auspices of the Foundation Trust Network is more appropriate and more likely to get us the result.

Q72 James Wharton: Is that going to mean that you are going to get more directives? Your directives are now going to come from the Foundation Trust Network, rather than from Whitehall? Okay, they may be optional now because you have more freedom, but you are going to get lots and lots of paperwork saying, "This is what you ought to be doing." Or, is it going to be something that is a bit more intelligent than that?

Sir David Nicholson: I hope it will be more dynamic and intelligent than that. Indeed, the Foundation Trusts are committed to making that happen, because they are as conscious of turning into an arm of the Department of Health as anyone else. That is certainly something they do not want to do. So sharing things electronically and using NHS evidence, which is the other opportunity for us across the system to show how things are working, are a couple of ways in which it will happen.

Q73 Chair: What about Any Willing Provider? You have NHS Foundation Trusts that you draw together. They are vaguely public organisations, which are drawn together in the network. We then get to a new world of Any Willing Provider.

Peter Coates: As far as procurement is concerned, one of the things is that we are talking to Supply Chain about extending the remit of the contracts to allow them to tender and to provide to Any Willing Provider, for providing services into the NHS. We are aware that we need to broaden the scope of that.

Chair: Say that again. I am sorry, I just missed that. You will have to speak up. The acoustics are always awful in these rooms.

Peter Coates: We are broadening the range and scope of the Supply Chain contract to allow them to tender and provide goods and services to those who provide service back into the NHS under the Any Willing Provider contract. So those who are Any Willing Providers can buy goods at the same price as NHS providers.

Chair: They can?

Peter Coates: They will be able to.

Q74 Chair: They will be able to, but in your response to James' questioning, you said you have a network, they are going to share information and they will look for best practice. What lever will you have within Any Willing Provider, i.e. not necessarily a traditional Foundation Trust, to ensure they take advantage and help you achieve your £1.2 billion, or don't you care? Do they not care?

Sir David Nicholson: No, we care. It is important, wherever the NHS pound is spent, that people are taking the opportunities that are available to them, hence the work with NHS Supply Chain. To be fair, in all of my experience with Any Willing Providers as people who want to provide service to patients in the NHS, they want to contribute and they want to be involved in this sort of thing. I do not think there will be a problem about them being outside of the system. I think they will want to be part of it.

Q75 Ian Swales: That links directly to something that I wanted to touch on. You said earlier, Sir David, that you expected more collective activity in purchasing. NHS Supply Chain is obviously one of the key ways that happens. It has not had quite the take-up that was expected, based on the figures in the Report, at about 70%. Actually, if you look at paragraph 2.17, which is based on the testing that was done, just over half the products purchased by NHS Supply Chain were more expensive when purchased this way, compared with the same product purchased through other routes. In other words, we are actually talking about a system which just, on average, slightly increases the cost through bulk buying.

Mr Coates, I think, suggested earlier that not everything was as it appeared with that kind of collective activity, and used the expression "gaming the system". At the foot of section 2.18, the very last bullet shows how the National Audit Office have heard stories about how they believe that the system might be being gamed. So DHL is a private company doing this activity. They have done only 70% of the expected activity, and earned about 70% of the profit—69%, actually, is the figure—so it would appear that they are not particularly exposed to volume or performance in this. Can you say more about how you expect bulk-buying to work effectively in the future?

Sir David Nicholson: Yes, I think Peter will maybe say something about that, but I think it is just worth pointing out the other thing, which is that they have almost delivered the savings that were targeted. So although their volumes are not as high and their profits are lower, they are actually producing the level of savings that we put in the business case.

Q76 Ian Swales: Is that administrative savings largely, then? It cannot be product price savings if half the products are more expensive.

Peter Coates: That is the basket of products, but the savings number is audited by the BSA, and it is over a broader range of products than I suspect the NAO looked at. It includes capital, for example, and savings in the flu vaccine programme. The Supply Chain was deliberately set up to allow it to expand into other areas, and my understanding of the NAO's calculation of savings is that it is around what the original contract looked like, and what the savings were against what it originally looked like.

We always knew that the Supply Chain would move into other areas, and we are more interested in how much it is saving across the entire NHS on a range of services, rather than the initial narrow one. We accept, against that narrow business case, that it is below

target. But if you look at all the numbers, it is saving above our projected targets, and is within a whisker of achieving its £1 billion saving over a 10-year period.

Q77 Ian Swales: If I am in an NHS Trust and just over half the time I can go and buy something cheaper from another route, the temptation not to use Supply Chain is obviously there. One can understand why the suppliers might like to play this game, and there is this suggestion that there is actually gaming in the system and the prices you would be offered individually might actually be lower, because they won't want Supply Chain to work, will they? They would much rather divide and rule. That is what suppliers like to do.

Peter Coates: I agree with you. You are absolutely right.

Q78 Ian Swales: So how are we going to beat that?

Peter Coates: As I said earlier, my view is that we need to look at a better technology solution for this and a better IT platform that allows us access to real-time pricing. This is the Amazon.com model, which is gaining more and more acceptance across the system. We need to allow the Trusts to have access to this and to buy all its goods on a day-to-day basis from that kind of site. Now, that requires a change to the procurement regulations, unfortunately, about which we are talking to the OGC. The plan is to do that for 2012.

Q79 Ian Swales: One last question on this. How are you going to avoid that sort of transparency driving prices up, not down? Suppliers are clever people. That is what the suggestion is in 2.18: they are using the information that they have already to drive prices up, not down.

Peter Coates: That is absolutely right. When you have got a fixed point, and it is there for a year in a published catalogue, then you can game around it. But with real-time pricing, it drives it downwards, because if you keep your prices constant, someone is always going to go and undercut you by a penny. There is a constant downward pressure, rather than an upward pressure.

Amyas Morse: I have a couple of comments. One, if I may, just on a point of fact. Our calculation of savings was from information we were given by Supply Chain itself. So it is not something we came up with; we got it from them. I just wanted to ask a more general question, please. There is a combination of effects that are being sought, which I can see, through better information, more collaboration and driving efficiency in that way, and that sounds great. There is also a desire to have competitive pressure between Trusts. How is all that going to work together, do you think? Are those at all contradictory? Can they be brought together in a productive way? I would just be interested to know how you see that working.

Sir David Nicholson: It is perfectly possible for organisations, in any industry, to work in partnership collectively and to compete at the same time if you are operating in a mature way.

Chair: Does Mr Rolfe agree with that?

Howard Rolfe: Yes, I do not have a problem with that. No, I think that is perfectly legitimate.

Chair: I have a bit of a problem, but anyway, go on.

Amyas Morse: I asked the question so that you would elaborate, not because I regard it as a showstopper. I just wanted to hear how you thought those two were going to interact. So, in other words, if at one time you are collaborating with a Trust and getting costs down and sharing quite a lot of information in order to do so, and at the same time, competing for contracts to provide services, you think that will work?

Sir David Nicholson: Do not forget, we do not compete on price; we compete on quality. So there are different dimensions operating there.

Q80 Matthew Hancock: In procurement, not only does price matter but also quantity. So could I ask a bit about what you are doing to ensure that the right amount of stuff is used? Let me put on the table two entirely anecdotal examples. First, stories were reported a few years ago of a senior businessman going into a Foundation Trust and finding boxes and boxes of stuff, no tracking of kit, no management system to know where all the kit was, and clinicians ordering stuff that they needed, of course, to do the operations, without knowing or thinking about what was in the back room. The second is, from personal experience, all I care about is how well my children are when they are in hospital. But you cannot help but notice cupboards full of stuff, and clinicians—who, of course, care about the health of the patients—just not really thinking about how many things are used. What things are being put in place to make sure that the NHS uses the right amount of stuff, and not just gets it at the right price?

Sir David Nicholson: What we are talking about here is bringing together the financial accountability with clinical activity.

Matthew Hancock: Look, I appreciate that it is difficult, and that clinical priorities are critical, but it is still important.

Sir David Nicholson: But this is part of giving clinicians more responsibility for the financial service aspects, as well as just their clinical activities. You will find, in almost all hospitals these days, clinicians taking budgetary responsibility, both for the clinical and non-clinical activities. The best example I can use is the productive ward system, which is in probably 70% of our wards at the moment, where ward sisters and ward managers have taken responsibility for the kinds of things that you have just described. They have completely changed the way in which their ward operates; they have changed the mechanisms by which they store things, and how are easy they are to get at. Part of the problem we had in the past, of course, is that when you had boxes of stuff all around, the ward staff spend a lot of time running around looking for stuff, as opposed to having it in the right place at the right time. As I say, we have had this productive ward system, which has been, I think, remarkably successful. Not only has it improved the way in which the kinds of things you just described have worked in the wards, but it has liberated lots and lots of clinical time to put hands on patients, which was an issue for us. So there are a whole series of productive systems,

such as the productive ward, the productive theatre and the productive community services, which are being rolled out across the country as a whole.

Q81 Matthew Hancock: Does that help you get the management information that you are seeking as well?
Sir David Nicholson: It focuses the attention on the need for it. It does not do it by itself, because the investment in the technology often enables that to happen with regard to the coding arrangements and all that. But it focuses attention on doing it; it does not do it by itself.

Q82 Mrs McGuire: Would it have been clinicians that would have decided in one hospital that they needed 177 varieties of surgical glove?
Sir David Nicholson: Having run many hospitals over many years, although I have to say not for the last 13 or 14 years, so obviously things are much better now, things has moved an enormous amount.
Mrs McGuire: Maybe there has been a massive increase in the range of surgical gloves in that time.
Sir David Nicholson: But the choice of surgical gloves is a very significant issue for surgeons, and you can perfectly see how, in organisations with individual surgeons and their own particular responsibilities, the pressure to increase the number of—
Chair: I cannot buy this argument. It is like housewives and their washing-up gloves.
Sir David Nicholson: No. When you stick a knife in somebody and you are in that intimate relationship with an individual on a table, or whatever, you want everything to be right for yourself. Now, what we know is that if you get clinicians together and you work with them together, they will make sensible decisions about all that.
Mrs McGuire: So that is what has happened in the hospital where they have managed to survive, with that very delicate relationship between the doctor and patient, with 13 different varieties of surgical gloves.
Sir David Nicholson: Yes, it is perfectly possible to do, and we can see it all over the country.
Matthew Hancock: So where are the incentives to go down? If you are a hospital with 177 varieties, where are the incentives in the system, which is the thing you are responsible for, to get that down to 13 varieties, which is doable?
Sir David Nicholson: Because they get it cheaper. They buy them cheaper. They get a price advantage.
Mrs McGuire: You have just said, forgive me, that this is all about the intimate relationship between a clinician—
Chair: And their gloves.
Mrs McGuire: I do not underestimate the importance of that. However, you said a second ago that the reason why one hospital has gone to 13 is, never mind this intimate relationship, to do with price. Frankly, you are all over the place on this one. It is a very good example.
Sir David Nicholson: I did not say any of those things. You asked me whether clinicians would have been involved in deciding on those 177, and I am saying, "Yes, they would have been." Clinicians would be intimately involved in those decisions, because of the kinds of things that I described to you. What I then went on to say is that my experience, and my experience across the NHS, is that when you get clinicians together and you look at all these options, including the price benefits, and you see what it is about the glove that makes the difference, you can very quickly get down to smaller numbers. It is perfectly possible.

Q83 Chair: Can I just ask a question? As a retailer, how do you view this conversation we have just had with 13 versus 177, with all your customers having really intimate ideas about what clothes they want to buy?
Howard Rolfe: Yes, I won't go too far into retail, but it is about customer choice. The important point is the NHS is not Marks & Spencer. Sir David is right that there will be clinical preference, but the key issue is around focus because, clearly, 177 varieties of surgical glove are too many. That is indefensible. But I suspect that it probably was not known within the organisation that they were using that number of different types. It goes back to my very first point, which is that if you have transparency of information and transparency of data and can ask, "Why am I, in my Trust, spending twice as much on surgeon's gloves as they are just down the road?" That will start to drive you down the road in terms of, "I have got too many."

Q84 Mrs McGuire: I should just say, for the point of clarity, that there are not just 177 varieties of surgical gloves; there are 652 varieties of surgical gloves that the NHS currently procures in various orders.
Sir David Nicholson: Yes, and that is far too many.
Mrs McGuire: I am so glad you have said that.
Sir David Nicholson: I am not trying to defend it.

Q85 Chair: Can I move us on a little bit because, Sir David, you said that the way you see this happening is through more collective purchasing in the future. When I read the NAO Report, I got completely muddled about the structures we currently have in place to encourage collective purchasing. Just to go through it, we have NHS Supply Chain, which we have talked about; we have Collaborative Procurement Hubs, which Mr Rolfe supports; we have Trusts with their own in-house teams, some as many as 45; we have Trusts setting up their own collaborative purchasing arrangement—North East Shared Systems Group in the report; we have Buying Solutions, which does Government-wide purchasing; then we have a new thing called Commercial Support Units; and then we have a National Procurement Council. I do not know how much we are spending on all that infrastructure, and I do not know how the hell, if you are in a Trust, you find your way through it.
Sir David Nicholson: There is no doubt that we are in a position now where we are moving from one system to another. There is no doubt about it. We are absolutely in transition around all this at the moment, with the new arrangements being put into the NHS and the new emphasis on competitions and markets and all the rest of it. We are in movement. So we have got some bits that are a hangover from the old system,

and some bits from the new system. Part of my job is to simplify that position as we go forward. But fundamentally, the issue is still that there will be some things that you will buy locally. So you need a mechanism whereby you as an individual organisation can procure locally, and systems and processes to make that happen.

You will also need some things that you need to buy collectively, but not on a national scale; often it will be on a regional or cluster scale. For example, if you want to get a group of clinicians in a particular clinical network to buy the same kinds of things across a number of hospitals. You still will then have a national system. So whichever you do, you need those three levels to make it work. That is what we are focusing our attention on, in a sense: simplifying those three levels.

Q86 Chair: So what are we going to end up with out of this current structure? We will end up with Trusts having their own in-house teams. Are you going to kill off the Procurement Hubs and create Commercial Support Units?

Sir David Nicholson: No, you will have the local arrangements and the middle ranking arrangements.

Q87 Chair: Which are what? What do they do?

Sir David Nicholson: They will be a mixture of Hubs and private-sector organisations. What has been happening across the country is that some of the Hubs have moved into the private sector, or are currently moving into the private sector, and some of the Hubs are closing down. So in a sense you have a market operating in that middle sector, and that will shake out as we go through the next year or so. Then you have a national position, which is NHS Supply Chain. They are the three bits that you will have in the system.

Chair: Mr Rolfe, you are running a Procurement Hub?

Howard Rolfe: Procurement Director at East of England Collaborative Procurement.

Chair: Right, and are you moving in to the private sector?

Howard Rolfe: No.

Chair: can you take us through your thinking?

Howard Rolfe: First, I am quite content with the pyramid structure, and it is absolutely logical that some things are bought nationally. Buying Solutions do a good job on that, and we are not talking about outside health today, but you would logically go across the public sector. Obviously there are aspects of health that touch local government, for example, and there is plenty of work that can be done there. We understand the local purchases. The bit in the middle is complex at the moment, and in my ideal world, it would be a series of regional Collaborative Procurement Hubs that Trusts were encouraged to buy through for items that can be better bought on a volume-committed basis. It would also help rationalisation.

We have, as Sir David has indicated, a number of variations to that now. Leave CSUs out of this; some are going to the private sector. I personally do not think that is helpful. We are a not-for-profit organisation in the East of England. I hope that we deliver good value to our Trusts, but bluntly it is a struggle, because if we are not for profit, we have to be funded by them. So if you were a Trust FD and I was putting in a bill for £90,000, potentially to save you £500,000 or £600,000, you would see that £90,000 as a cost to save this year, because you have a financial struggle. So it is quite difficult to continue the engagement.

There is then the tension between the local procurement teams because, bluntly, we could be jeopardising some of their activity, so they are not necessarily going to encourage us. So, there is conflict within the system. Sadly, we have now conflict between Hubs, in terms of different Hubs trying to take over the business of other Hubs or Trusts in their area. So, this is not an ideal set-up at the moment.

I am a firm believer in the pyramid structure, and I firmly believe that you have to respect the independence of Trusts, but that we could buy in greater volume. As I said earlier, frameworks only take you part of the way; unless the supplier knows that they are going to be buying 50,000 cannulas of one type, you are not going to get the true value.

Q88 Chair: Why is the Department thinking of privatising these regional Hubs?

Sir David Nicholson: The Hubs are membership organisations. They are built up by individual organisations deciding to pay whatever the Hubs require, in order to deliver the service. Our view is that they should stand on their merits or otherwise.

Chair: But why are you going to privatise them?

Sir David Nicholson: If the private sector can offer a better deal for organisations and for Trusts, then they should have the ability to make that choice themselves.

Q89 Chair: There is nothing to stop a private person touting for the business, is there, Mr Rolfe? That is different from saying that you are encouraging privatisation. Are these new Commercial Support Units supposed to be private organisations?

Sir David Nicholson: If I can just put that to one side.

Q90 Chair: Hang on, answer that question first. At the moment, we have regional Hubs, which Mr Rolfe says is your preferred model, although there are problems with it. You come along as the Department and say, "Actually, we want to privatise this lot," in the same way, presumably, as some time in the past—this is not a partisan view—the previous Government decided to privatise NHS Supply Chain.

Sir David Nicholson: We are saying s that it is up to individual organisations and individual Trusts to make the judgment themselves as to who they go with.

Chair: Do you quarrel with that?

Sir David Nicholson: There is a dilemma with it, which I will explain, because it is not straightforward. Generally speaking, what happens is that the business model for most Hubs is that you pay a fee up front, whereas in the private sector you tend to pay per item. Now, individual organisations have to make their judgment about where they go and who they go with. The worry I think that Howard has, and quite rightly, is that Trusts will sometimes say, "We will save the

£80,000," or whatever it is, and end up paying more through the private sector. That is the dilemma, I think, that we have with all that. But the fundamental issue about organisations deciding themselves who they are going to work with collaboratively to make decisions about procurement, seems to us to be the right one. Otherwise you would have to force people to do it.

Q91 Chair: If you want collective purchasing, shouldn't you encourage a model that works, rather than allowing, again, an individual Trust to decide either, "We will go this collective model for which we pay an upfront fee," or, "Actually, we won't do that. We will save the upfront fee and we will just purchase through other means." You are in danger of destroying the model that you have established over the last few years, because you are encouraging the emergence of a different privatised model.

Sir David Nicholson: If the private sector can provide a better service—

Chair: But you are in danger of destroying that model?

Sir David Nicholson: I am not stopping individual Trusts paying their upfront fee.

Chair: You are, because you are encouraging the emergence of a different model, whereby people won't want to pay the upfront fee.

Sir David Nicholson: But that is a business choice that they will make as far as their organisation is concerned.

Q92 Mrs McGuire: Mr Rolfe was saying a few moments ago that, in his opinion, the model is a good model, but the problem is that it is a not-for-profit organisation, which I think, in terms of the bigger society, we should be in favour of. But the difficulty is that the individual Trusts do not look at it as an invest-to-save option. The figures that Mr Rolfe gave were astonishing: £90,000 to save £300,000 or £400,000. So why isn't more being done to encourage Trusts to look at invest to save and to support not-for-profit organisations that can actually deliver a better price, rather than looking at the short term, which is about saving £90,000 in revenue in a year? I just do not understand the logic of this.

Sir David Nicholson: If you had people from Shared Business Services or from some of the private-sector partners that we are working with, they would say exactly the same. They would show you how they can make significant savings for their clients that are as good as anybody else's. The issue is what they are not going to do. We do not have a preferred provider model. We do not have a model whereby we say to NHS organisations, FTs or otherwise, "You should use a particular model." You should be able to choose the model that suits your business and your arrangements and that satisfies you.

Chair: I think we would suggest to you that the pragmatic way forward is to support a structure that already encourages collective purchasing, and you are not following that pragmatic route for some reason.

Q93 Ian Swales: Can I just ask about these procurement organisations? If I imagine myself running one, it must be a fantastic thing to come to work each day having pots and pots of public money to spend on various things. How transparent are these organisations going to be? What levels of control and audit are you going to have? And perhaps a supplementary for Mr Rolfe, do you think Marks & Spencer would ever privatise their purchasing organisation?

Howard Rolfe: No, but as I said repeatedly, the NHS is not Marks & Spencer. You can learn only so much from that.

Ian Swales: Yes, I should have said outsource, sorry. Not privatise; outsource.

Sir David Nicholson: We are talking about an industry here, not an organisation. The NHS is a complete industry.

Chair: It is not. It is a business. It is a business. Marks & Spencer would call themselves an industry, in that sense. It is a business—a complex business, but nevertheless a business.

Q94 Ian Swales: My real question is about control, access and transparency to these organisations that will be spending large amounts of money.

Peter Coates: In this market, we are not encouraging or discouraging any particular provider or models. Simply, we want the Trusts to be able to go to a provider who is best in class in that particular trade, and I think at the end it will be the price that the Trusts pay for the finished product that will determine how Trusts or Hubs or commercial organisations go forward.

We cannot determine or set a structure for these organisations, because, as Sir David said, they are federations of Trusts, normally. Some are choosing to move in to the private sector of their own accord, and we are not pushing them or pulling them in another direction. They are saying that they think they can provide a better service to their clients through that route. Now, it seems to me that therefore, transparency is driven through the contractual relationship between that provider and that Trust.

Chair: Mr Coates, Sir David is going to be accountable to us for this £1.2 billion saving that he says he can find. He is going to be accountable to us. We are going to come back to this issue. Therefore, you ought to have an interest in how you can achieve that, rather than saying, "We cannot do this; we cannot do that," and I think this is the thing we are finding unhelpful.

Ian Swales: Just the last point on this from me. My life has been mostly in the private sector, and the relationships between buyers and suppliers are sometimes legendary in their complexity, the opportunity for fraud and all the rest of it. I am not accusing anybody of anything—DHL, for example—but it is interesting that their prices are actually higher than just going and asking the supplier direct. I think we need to know, given the amounts of money involved, that we are happy about the control mechanisms. That is what we are here to satisfy ourselves about.

Q95 Stephen Barclay: Could I just refresh your memory? At a previous hearing, Sir David, you kindly

offered to provide a note on the cost of the change programme on consultants contracts—question 83 in the transcript—so I would be grateful if you are able to do so. What I wanted to ask about was an issue I have raised with you previously, and I have asked numerous parliamentary questions about, but do not seem to be able to get any answer on, which is, how many special severance payments have been made in each of the last three years by Foundation Trusts? I understand we have approximately 132 Foundation Trusts. What I cannot seem to get is: how many have been made, what the value is, and which Foundation Trusts have made them? When I asked about it previously, I was told that Monitor, perhaps, were responsible for this information. I wrote to Monitor and Monitor said, and I quote, "Monitor does not collect information on what special severance payments have been approved. Our role is to review the quality of business cases submitted to us."

This Committee has repeatedly raised this issue, just to refresh your memory. In 1995, the Public Accounts Committee did a Report on the suspension of a doctor, Dr O'Connell. It took your Department 10 years, until 2005, to get round to producing your guidance. There was a further 2003 National Audit Office Report on the suspension of doctors. There was a 2004 Public Accounts hearing, where Sir Nigel Crisp and Sir Liam Donaldson were questioned, and the Chair of the Committee said, and I quote, "You know this Committee takes a dim view of confidentiality clauses."

Could I ask, please, with the resources at your disposal, whether you might task one of your young, high-flying civil servants to spend a day or two contacting whoever is required on this important issue—because I am sure you share my belief that one is alarmed if gagging clauses and confidential clauses are being paid to clinicians being sacked by Foundation Trusts—in order to get that data for the Committee? Would you undertake to do that for us?

Sir David Nicholson: Do you mean those people who have left Foundation Trusts as a part of a compromise agreement, which includes a gagging clause in it?

Stephen Barclay: The definition used by the Treasury is "special severance payments". How many special severance payments have been made by each Foundation Trust in each of the last three years? What is the value of those payments, so we can get some transparency? Each Foundation Trust has to report it to the Treasury, so they have the data. The Treasury won't provide the information; they say they are unwilling to do so. The Department of Health have hitherto refused to provide the information, and Monitor refuse to provide the information. I would be grateful if you could facilitate getting this information.

David Flory: Yes, for clarity, this is not information that the Department holds and is not disclosing. We do not have the information. I think that for the period up until the point that Hospital Trusts become Foundation Trusts, and within the time periods that you described—

Stephen Barclay: I understand that we can do that, but I am just looking for an undertaking from you. As we touched on earlier, you are the Accounting Officer, and you are responsible in terms of system-wide problems, resulting in bad value for money. It is difficult for me, as a Member of Parliament, to know whether there is a system-wide problem, because I cannot get access to the figures. Regardless of who is responsible in the machine, because we could be here for some time debating that, I am asking whether you, as a Senior Health Official, would undertake to this Committee to provide that data? It is an issue that the Public Accounts Committee has repeatedly raised over many years. Could we have an undertaking from you on that, please?

David Flory: I think we can undertake to seek the data. Chief executives of Foundation Trusts are accounting officers in their own right.

Stephen Barclay: I understand that. They have a duty to report it to the Treasury, so it may be that you negotiate this with the Treasury, or maybe you send an email to each Foundation Trust. If they do not provide it, we will have them lined up outside.

Q96 Mr Bacon: You took the words out of my mouth because, Sir David, one alternative, if you are unable to help Mr Barclay and this Committee, is indeed to line up the 300 Accounting Officers out there in a queue, and we will have them in one by one, and we will ask them the question. It might take all day, and we can wait all day, but I think you would agree that that would not necessarily be a good use of their time, and there is probably a better way of doing it.

I have a personal interest in this, because the guidance that Mr Barclay referred to was produced by your predecessor, Sir Nigel Crisp, who said, at the hearing we had on the National Audit Office Report in 2003—and I remember it—"Yes, well, we are just about to produce some guidance." He then took quite a long time to produce the guidance, and when I finally looked at it, it was two and a half pages long. It said, "No, you really should not have a gagging clause, unless you really want to." That is how I interpreted what I read. So I am interested in both the special severance payments that Mr Barclay has asked about, and the issue of gagging clauses. Because the fundamental point at issue in this Report, *The Management of Suspensions of Clinical Staff in NHS Hospital and Ambulance Trusts in England*, HC: 1143, from November 2003, was this: clinicians were being suspended on full pay, sometimes for many, many months and sometimes for years at a time, when their clinical competence was not in doubt. They were being paid to do nothing when there were people queuing up for heart surgery, etc, because there was a row with the management that dragged on for a long time. Now, I understand that there is employment law and that there are procedures, and that these things do take a bit of time, but it was going way, way beyond that, and that was the burden of this Report. Here we are, eight years later, still not being able to get accurate and adequate information on it.

Sir David Nicholson: You should not construe any of this as a reluctance on my part to give you the information. I want to give you the information; it is whether I have the means to do it.

Q97 Chair: Will you write to us within a week saying whether you can do it?

Sir David Nicholson: I will do everything within my power to make it happen. You are absolutely right that the data should all be in the Treasury, because even Foundation Trusts have to go through the Treasury.
Chair: Sir David, write to us within a week as to what you are actually going to do.
Sir David Nicholson: Yes, okay fine. I am very happy to do that.

Q98 Mr Bacon: That is very kind. I will just point out that this corridor is about 300 yards long, which is about a yard per chief executive, so you could probably get them all on one side. Certainly, if we doubled up, we would fit them in, no problem. I had another question and it is about midwives. You will recall the exchange that we had on midwives. I asked a question based on the Report on productivity. There was a sentence in there about 47,000 nurses, midwives and health visitors, and my question was, "How many of those 47,000 were midwives?" You were unable to give me an answer then, but we then got into an exchange about the shortage of midwives. You said that it was 4,500, and that was indeed roughly the number that the Royal College of Midwives recognised. Subsequently you have corrected that. You have said to the Secretary of State, which was reported, that this was an error, and indeed we had a footnote, subsequently, in the transcript, saying that, "There is no nationally recognised figure for the shortfall in midwives. The campaign is to recruit 4,200 health visitors, not midwives." I just had a couple of questions around that, because you did say that we do not have enough and we do need more midwives. So, first, do you now know and can you now tell me, of those 47,000 extra people who were either nurses, midwives or health visitors, how many of them were midwives?
Sir David Nicholson: No, I am sorry, I have not got that information.
Mr Bacon: Okay, can you get it for the Committee?
Sir David Nicholson: Yes, I can get it.

Q99 Mr Bacon: The second question is: you stand by your sentence that we do need more midwives?
Sir David Nicholson: I think as the birth rate goes up, you need more midwives.

Q100 Mr Bacon: Yes, and indeed, the birth rate went down slightly, by about half of 1%, I think, but it had previously gone up by 17%. Let's not argue about the number for a minute, but we do need more midwives?
Sir David Nicholson: As the birth rate goes up, you need more midwives. Indeed, we have tried to reflect that in the tariff over the last three years or so, where we have boosted the tariff in order to enable that to happen.

Q101 Mr Bacon: And indeed, you said that in your evidence before, that, "We have increased the tariffs significantly greater than inflation generally," etc. So presumably, part of your answer would be that it would be down to the Trusts, depending on, as it were, the demand in their particular area, to hire more midwives and some Trusts will hire more and some will hire less? Roughly speaking, what is your estimate of the shortage of midwives?
Sir David Nicholson: As we sit here at the moment, I have not got that information. We have not done the detailed calculation.

Q102 Mr Bacon: How many midwives are there at the moment?
Sir David Nicholson: As I say, I have not got that information to hand.
Mr Bacon: Okay, well, is it possible that you could write to us with a note with all of those questions from the transcript? Thank you.
Sir David Nicholson: Yes, we can give you that information.
Chair: Good. Thank you very much. We are going to return to this issue, because I think a number of question marks remain in the answers that you gave, but thank you for the openness and straightforwardness in the way in which you answered our questions.

Written evidence from BIVDA

I am writing to you following the recent National Audit Office (NAO) report, *The procurement of consumables by NHS acute and Foundation trusts*, and ahead of the Public Accounts Committee's session on the report.

BIVDA is the national trade association for the manufacturers and distributors of in vitro diagnostic products in the UK. We represent more than 95% of the industry and over a hundred suppliers, of which the majority are SMEs. 70% of clinical decisions are based on the results of laboratory or point of care tests, using IVD products. These are used to diagnose disease and monitor and manage treatment. Increasingly IVDs can be used to predict and prevent onset of disease and they can also help ensure the appropriate and effective use of drugs and other NHS resources.

BIVDA welcomes the focus on improving procurement processes for diagnostics, but is concerned that some of the recommendations outlined in the report do not take in to account the complexity of diagnostic services. The NAO report is right to note that there is "limited data on what is purchased by individual trusts, and there are no practical ways of examining the variation in prices being paid by different trusts". We are keen to ensure

that any attempts to compare prices paid across the NHS take in to account all relevant price factors. We would therefore be keen for the Committee to ask witnesses how they ensure to take these complexities in to account, particularly:

Integrated systems

IVDs in general are complex, integrated analytical systems, comprising reagents, sampling and sample handling devices, analysers, data handling and reporting systems. The interrelated nature of the components of an IVD system makes comparison of the costs of individual parts far more complex than with less integrated supplies. It is important to note, therefore, that the challenges raised in the procurement of IVDs are very different than those raised in the procurement of other consumables such as A4 paper.

Reflecting a range of contracting arrangements

IVDs are supplied under a disparate range of contracting arrangements, which may have a considerable bearing on the price paid. These arrangements vary from simple "one off" local orders, through to "standing orders", to contracts worth tens of millions of pounds. These may be of varying duration—perhaps up to 10 years—and arrangements may be highly tailored to meet the requirements of a particular customer (including their patient population and service and clinical requirements) and often include a variety of ancillary services. The nature of contracting arrangements should therefore be reflected in any cost comparisons that come about as a result of the NAO report.

Use of procurement intermediaries

The use of procurement intermediaries, including NHS Supply Chain, can also affect price, particularly given their requirement to generate revenue through supplier/NHS transactions. The report is right to note that there are a number of factors which influence NHS Supply Chain's prices; including its inability to strike "committed volume" deals with suppliers and that some prices may also include additional services. We believe that clarity is needed as to the benefits to suppliers and customers that is provided by the use of an intermediary, particularly in the procurement of complex items such as IVDs.

Challenges in the tender system

There are a number of areas for potential improvement in the way that tenders are currently run. We are aware of examples of poor tender processes including the use of non-transparent titles or poor notice coding. Some suppliers miss relevant tender opportunities as a result, hampering competition and putting the contracting authority at risk of challenge. A number of usually complex and high value tender processes fail after challenge on award, representing a considerable cost to all concerned. There is also currently little standardisation of process and documentation for large contracts, which can lead to the use of the large professional services companies to advise on what are essentially similar contractual arrangements. Any review of the procurement of consumables by the NHS should also consider improvements that can be made to the tender system.

BIVDA supports the ongoing commitment to ensure choice, competition and innovation in the NHS, and is keen to play its part in any review of procurement for diagnostics to ensure that these principles are taken into account. We are looking to work with all interested parties, including the NAO, to improve the procurement environment for IVDs and ensure that the issues raised here are addressed to bring benefits to both the NHS and to suppliers, including:

- Working with the NHS to ensure that they avoid repeated small orders for the same items.
- Embedding a greater willingness to engage reliably in commitment to volumes to achieve discounts.
- Ensuring that information that is collected on the procurement of IVDs is accurate and fully considers the manner in which they have been procured.
- Improving management of, and information relating to tender processes, including standardisation of information requirements and modes of presentation.
- Clarifying the role of NHS Supply Chain.

I hope that you will be able to address these issues in your evidence session and report, and would be very happy to provide more information if required.

13 March 2011

Written evidence from Department of Health

At the Public Accounts Committee hearing on NHS Trust procurement on 15 March, I was asked about the cost of the change programme on sharing good practice on the Consultants Contract.

The Large Scale Workforce Change Programme was delivered by NHS Employers under a variation to their contract, at a cost of £180,000.

The case studies and the learning from those trusts who took part in the programme were shared with all trusts. The key findings included:

— The majority of trusts on the programme reported that they were implementing the contract more effectively, using it to work together with consultants to agree and make essential changes to impact on the quality and consistency of patient care.

— Where team job planning was used, consultants enjoyed transparency on their activity levels and were using this to improve consistency and access to care in their specialties.

— Consultants had been able to identify the changes needed to support growth and efficiency in their service areas and ensure their services remained attractive to commissioners.

This work demonstrated improvements in effectiveness and, as the trends over time show in the NAO report, the national productivity figures show an improvement in productivity under the new consultant contract when compared with the period prior to the consultant contract.

Some of the case studies included measures, eg related to consultant activity or waiting times. For example:

Weston Area Health NHS Trust developed a new framework for flexible job planning. This included:

— agreeing that time for supporting professional activities (SPAs) would be allocated flexibly with specific duties to benefit both the trust and the consultant. This resulted in some consultants agreeing to have 1.5 programmes activities allocated for SPAs (rather than 2.5) so their direct clinical care contribution increased;

— agreeing a 42 week workload for all specialties with agreement on the number of new and follow-up patients and outpatients, allowing the trust to quantify the number of patients seen in clinics and in timed, clinically related activity; and

— annualised contracts for surgery, and radiologists taking lieu time for on-call work, allowing better targeting of the workforce to address operational issues.

Royal Free Hospital Hampstead NHS Trust used the consultant contract to develop a 24-hour consultant delivered service in paediatrics. A Programmed Activity tariff was worked out for all service demand activities, and informed the agreement of consultant job plans. As a result of the project:

— all job plans were annualised;

— consultants became accountable for using supporting professional activity time to deliver quality improvements;

— patients had consultant delivered care 24 hours a day, 365 days a year;

— in outpatients, all referrals were seen within 10 days compared to waits of eight to 13 weeks prior to the changes;

— in A&E, children spent less time in the department, fewer were admitted to the ward and fewer re-attended; and

— there was an overall increase in patient satisfaction and decreased clinical risk.

County Durham and Darlington NHS Foundation Trust used integrated job planning to maximise theatre capacity. Across three hospital sites, a detailed analysis was made of job plans, theatre schedules and cancellations and working practices. The trust introduced a banking system for unused anaesthetic hours, agreed payments for Waiting List Initiatives to be paid only if banked hours have been used first, and introduced an electronic leave management system. As a result of the project:

— lost working time has been prevented with theatre use increased to 95 per cent capacity;

— commissioned theatre work was better matched to available consultant theatre time;

— the trust was able to determine the workload of each surgeon and the income generated by each operation;

— the trust was able to guarantee a minimum quota of work based on available direct clinical care time; and

— an evaluation of productivity rates by specialty and by individual is discussed at quarterly directorate reviews and is a mandatory part of the appraisal process (with pay progression directly linked to evidence from appraisals).

The Committee raised the issue of special severance payments, with particular reference to their use in NHS Foundation Trusts. As the Committee will be aware, all special severance payments have to be authorised by HM Treasury and we are working with them to assess the number and value of such payments in the last three years, in NHS Foundation Trusts. I shall write to the Committee with details as soon as I can.

The Committee also asked, with reference to the Report on productivity, of the 47,000 nurses, midwives and health visitors being recruited, how many of those were midwives. The figure of 47,000 quoted in the National Audit Office report was the total number of nurses, midwives and health visitors recruited between 2000 and 2004, and of those, the number of midwives was 2,272.

The current number of registered midwives in England is 26,794. While there is a record number of midwives in training at present, the government does not have a specific target for increasing midwife numbers.

28 March 2011

Supplementary written evidence from the Department of Health

SUBJECT: NHS FOUNDATION TRUSTS' SPECIAL SEVERANCE PAYMENTS

In the hearing on NHS Trust Procurement on 15 March, I was asked to provide details of how many special severance payments had been made by each NHS Foundation Trust in each of the last three years and what the value of those payments was.

Further to the hearing, and further to my letter of 28 March, the Clerk to the Committee wrote to Sir Nicholas Macpherson, to clarify the request. This letter said that the data needed to include the value of each special severance payment paid by each trust, the number paid by each trust, and the name of the trust making each payment, for each of the last three years.

The table attached at Annex A shows the number and value of approvals for payments by HM Treasury in respect of NHS Foundation Trusts, arranged by organisation and financial year. It does not show the actual payments, as neither the Department nor HM Treasury records this information.

I trust you will find this information satisfactory.

14 April 2011

Annex A

AMOUNTS AUTHORISED BY HM TREASURY IN RESPECT OF SPECIAL SEVERANCE CASES IN NHS FOUNDATION TRUSTS, 2008–09 TO 2010–11

	2008–09	*2009–10*	*2010–11*
Organisation	*Authorised value (£)*	*Authorised value (£)*	*Authorised value (£)*
2Gether NHS Foundation Trust	0	0	10,000
Airedale NHS Foundation Trust	0	0	8,500
			10,000
			25,000
Alder Hey Children's NHS Foundation Trust	158,726	0	0
	40,000		
Barnsley Hospital NHS Foundation Trust	0	0	8,000
			7,500
			12,410
Basingstoke And North Hampshire NHS Foundation Trust	20,000	5,000	0
	45,000		
Berkshire Healthcare NHS Foundation Trust	0	30,000	95,000
Birmingham Children's Hospital NHS Foundation Trust	0	0	25,000
			1,486
			1,285
			1,450
Birmingham Women's NHS Foundation Trust	0	0	10,000
			3,020
Blackpool, Fylde And Wyre Hospitals NHS Foundation Trust	0	22,798	10,000
Bradford Teaching Hospitals NHS Foundation Trust	0	0	22,663
Burton Hospitals NHS Foundation Trust	0	4,000	3,000
Calderdale And Huddersfield NHS Foundation Trust	0	0	125,000
Calderstones Partnership NHS Foundation Trust	0	0	300
Cambridge University Hospitals NHS Foundation Trust	0	31,175	0
Cambridgeshire And Peterborough NHS Foundation Trust	0	45,000	0
		4,500	
Camden And Islington NHS Foundation Trust	0	0	20,000
			70,000
Central And North West London NHS Foundation Trust	0	8,527	0
Central Manchester University Hospitals NHS Foundation Trust	0	0	150,000
			51,000
			23,253
City Hospitals Sunderland NHS Foundation Trust	0	47,419	0
		15,000	
Clatterbridge Centre For Oncology NHS Foundation Trust	0	0	62,947

Organisation	*2008–09 Authorised value (£)*	*2009–10 Authorised value (£)*	*2010–11 Authorised value (£)*
Countess Of Chester Hospital NHS Foundation Trust	0	37,500	0
		10,000	
County Durham And Darlington NHS Foundation Trust	0	19,000	0
Derby Hospitals NHS Foundation Trust	22,263	14,502	3,500
	1,000		60,000
Dorset County Hospital NHS Foundation Trust	8,000	1,500	10,000
		57,000	
Dorset Healthcare NHS Foundation Trust	0	2,121	2,150
			15,350
			9,351
East London NHS Foundation Trust	24,144	27,500	6,650
	7,125	20,000	30,000
		7,973	12,000
		10,000	
		25,000	
		5,600	
		6,500	
		5,500	
Gateshead Health NHS Foundation Trust	0	17,000	0
		21,960	
Great Western Hospitals NHS Foundation Trust	0	0	20,000
			10,000
Greater Manchester West Mental Health NHS Foundation Trust	30,000	3,000	0
Guy's And St Thomas' NHS Foundation Trust	19,398	0	8,000
			5,000
Hampshire Partnership NHS Foundation Trust	0	0	32,000
			10,000
			54,000
Harrogate And District NHS Foundation Trust	0	0	15,000
Heart Of England NHS Foundation Trust	8,500	25,687	7,000
		32,004	500
		7,500	250
		15,124	58,333
			21,002
Heatherwood And Wexham Park Hospitals NHS Foundation Trust	0	49,500	14,167
Hertfordshire Partnership NHS Foundation Trust	0	950	42,500
		30,000	
Homerton University Hospital NHS Foundation Trust	3,500	0	0
James Paget University Hospitals NHS Foundation Trust	25,000	39,373	3,000
		4,281	
		650	
		8,000	
Kettering General Hospital NHS Foundation Trust	0	0	18,000
			7,000
King's College Hospital NHS Foundation Trust	14,000	10,000	0
		5,000	
		8,000	
		12,000	
Lancashire Care NHS Foundation Trust	5,000	8,000	0
		12,000	
Lancashire Teaching Hospitals NHS Foundation Trust	0	18,000	24,467
		37,000	70,000
		20,000	
Leeds Partnerships NHS Foundation Trust	0	15,000	0
		70,000	
Liverpool Heart And Chest Hospital NHS Trust	0	0	20,076
			37,000
Milton Keynes Hospital NHS Foundation Trust	0	0	1,500
Moorfields Eye Hospital NHS Foundation Trust	65,000	0	0
Norfolk And Norwich University Hospitals NHS Foundation Trust	0	20,000	10,000
		30,945	

Organisation	*2008–09* *Authorised value (£)*	*2009–10* *Authorised value (£)*	*2010–11* *Authorised value (£)*
Norfolk And Waveney Mental Health NHS Foundation Trust	0	10,000	6,000
		10,000	7,000
		17,500	30,000
			5,600
North East London NHS Foundation Trust	8,000	10,497	12,000
			15,000
North Essex Partnership NHS Foundation Trust	1,000	1,400	3,802
		4,250	55,945
		10,920	
		1,632	
		30,000	
Northamptonshire Healthcare NHS Foundation Trust	0	22,400	7,500
Northumbria Healthcare NHS Foundation Trust	0	25,000	0
		10,000	
		2,200	
Oxfordshire And Buckinghamshire Mental Health NHS Foundation Trust	0	30,000	12,500
		10,000	
Oxleas NHS Foundation Trust	0	9,000	10,000
		3,541	22,000
Pennine Care NHS Foundation Trust	11,000	24,000	0
	11,000		
Rotherham, Doncaster And South Humber Mental Health NHS Foundation Trust	0	0	7,500
Royal Berkshire NHS Foundation Trust	0	0	12,000
Royal Bolton Hospital NHS Foundation Trust	6,990	0	0
	2,500		
Royal Devon And Exeter NHS Foundation Trust	0	7,500	0
Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	0	0	0
Salford Royal NHS Foundation Trust	16,500	3,000	0
		1,500	
Sheffield Health & Social Care NHS Foundation Trust	118,000	106,128	0
Sheffield Teaching Hospitals NHS Foundation Trust	25,000	27,962	7,500
	1,500	9,000	3,750
			1,500
			3,000
			4,000
			4,000
Sherwood Forest Hospitals NHS Foundation Trust	1,000	150,000	0
	4,500	170,000	
South London And Maudsley NHS Foundation Trust	1,980	5,340	35,000
		57,000	
South Staffordshire And Shropshire Healthcare NHS Foundation Trust	0	0	90,000
			190,000
			15,000
			35,000
			850
South Tees Hospitals NHS Foundation Trust	0	100,000	15,000
South West Yorkshire Partnership NHS Foundation Trust	0	24,500	0
Surrey And Borders Partnership NHS Foundation Trust	135,000	0	50,381
	25,000		10,500
Sussex Partnership NHS Foundation Trust	0	35,000	25,000
		11,000	
Taunton And Somerset NHS Foundation Trust	5,000	0	0
Tees, Esk And Wear Valleys NHS Foundation Trust	0	48,750	40,000
		20,750	3,000
		62,000	3,000
The Christie NHS Foundation Trust	26,123	0	0
The Dudley Group Of Hospitals NHS Foundation Trust	0	8,000	0
The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	4,500	5,000	59,340
	8,500		
The Royal Orthopaedic Hospital NHS Foundation Trust	0	5,000	5,000

Organisation	*2008–09* *Authorised value (£)*	*2009–10* *Authorised value (£)*	*2010–11* *Authorised value (£)*
The Walton Centre NHS Foundation Trust	0	0	10,416
			17,944
University College London Hospitals NHS Foundation Trust	0	28,119	1,500
		100,000	34,707
		20,000	8,000
		25,000	26,000
			49,750
			5,000
			4,500
			16,000
			10,000
			21,931
University Hospital Birmingham NHS Foundation Trust	0	15,000	0
		14,000	
		3,000	
University Hospital Of South Manchester NHS Foundation Trust	40,000	0	0
University Hospitals Bristol NHS Foundation Trust	15,000	0	0
Warrington And Halton Hospitals NHS Foundation Trust	25,000	4,000	0

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