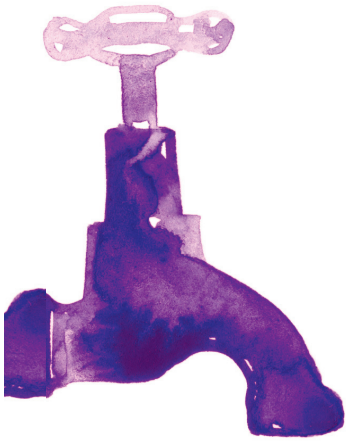

Unlocking the NHS's procurement potential

The year 2013 might go down in history as the most challenging year yet for Britain's National Health Service (NHS). It has seen the introduction and go-live of a fully revamped commissioning structure in which primary care trusts are ceasing to exist, replaced by commissioning groups tasked with procuring key products and services needed at the "front line". This responsibility is expected to result in a steep learning curve for commissioning groups, which to date have had only limited exposure to, and experience of, the commissioning side of healthcare.

The acute care sector is far from being spared these pressures, as ambitious cost reduction targets are being set. The NHS as a whole is required to shave more than £20 billion from its budget before 2015, of which £1.5 billion is procurement-related. These ambitious targets have been fleshed out in various reports published by the National Audit Office (NAO) and Department of Health (DoH), which have identified a sizeable savings potential, mainly stemming from price differentials for products and services procured by different trusts. All reports have come to the same conclusion, namely that the NHS as a whole is not making sufficient use of its leverage and buying power. These findings are supported by the work of other public bodies. For example, the NHS Institute for Innovation and Improvement estimates that the average trust would save £900,000 per year if all trusts paid the lowest prices for consumables across the board – prices currently only available to the largest and best performing NHS trusts.

Because of the different maturity levels of trusts' procurement functions, the new commissioning structure, already a step-change for even the most mature trusts, will be a leap of Olympic proportions for others. The varying stages of maturity are well evidenced, for example, in IT: some trusts have deployed the latest Procure to Pay systems while others are still processing documents manually. The different maturity levels are also seen in the widely differing levels of procurement expertise and resources available.

To leverage their full buying power, trusts will be required both to drastically reduce the variety of products and services being procured and to collaborate. For example, the NAO found that the sample of trusts analysed as part of the study bought 21 different types of A4 paper, 652 types of medical gloves and 1,751 different cannulas. One trust investigated by the NAO procured 177 different types of gloves, precluding any consolidation of demand and negating the chance of getting better prices.

Procurement hubs were initially thought to be the key to demand consolidation. The theory was that an alliance of trusts would be able to harness combined buying power and as a result drive down prices. However, while some hubs have been very successful – e.g. the London Procurement Partnership – others have clearly been lagging behind expectations and have dissolved.

The current inefficiencies are aggravated by the fact that trusts are free to procure through a variety of channels, be it NHS Supply Chain, the Government Procurement Service (GPS), procurement hubs or direct purchasing. The option to procure through alternative channels is the main cause of price differentials between trusts and has led to a proliferation of products that are in essence interchangeable: in a centralised, single-channel procurement scenario, serious overlaps and inefficiencies become apparent much more quickly. These overlaps and duplication of effort require costly administrative and operational support, (e.g. staff to process many purchase orders for low-value transactions).

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All these challenges combined are very similar to what the private sector had to deal with 20 years ago. What is substantially different with the procurement challenges the NHS is facing today is the short time-frame in which the "public sector patient" is expected to heal, and the complexity of the task at hand. Private sector procurement functions had decades to achieve the current level of maturity, while the healthcare system as a whole is expected to "up its game" in less than three years. Also, in the private sector buying consortia are still rare and in many industries are regulated by anti-competitive and anti-trust laws, whereas the NHS considers consortia a key ingredient in achieving competitive pricing in the acute care sector.

Private and public sector however do have something in common: the challenge of the "do more with less" dilemma. They must deliver year-on-year savings with reduced staff, while improving the overall satisfaction of customers, patients and stakeholders as set out by the NHS's QIPP (Quality, Productivity and Prevention) programme. QIPP's main goal is to improve clinical pathways and service delivery, by introducing concepts well known in the private sector such as process re-engineering, lean methodologies (which optimise a sequence of activities while improving quality of output) and Six Sigma.

Quantifying the immediate opportunity

As with most service-related industries, the biggest cost block in healthcare delivery is pay- and salary- related, and the DoH recognised early on that savings through headcount reduction are not a viable short-term option if patient safety and satisfaction as laid out in QIPP are to be improved over time. Nevertheless, the opportunity for non-pay spend remains sizeable: such spend on products and services amounts to an annual expenditure of £20.6 billion,[1] typically accounting for around 30% of the operating costs of an acute trust (or 17% of the total annual NHS budget). This £20.6 billion includes, however, categories such as drugs and medical supplies, which are directly linked to healthcare delivery and as such tend to be less suitable for an initial spend optimisation project.

The reasons why clinical supplies are less suitable for an initial spend optimisation project are manifold:

~ Information asymmetry: information asymmetry occurs in markets where one party holds better, more accurate or more detailed information than the other party. This information advantage might be used, for example, to negotiate a price with a trust that is significantly different to that agreed with another trust with similar volume, knowing that information about the price spread is not readily available. This is happening particularly often with medical supplies or highly customised healthcare IT software, where specifications and deployment efforts are tailored to clients' particular requirements – and so is the pricing, making a like-for- like price comparison almost impossible. It is true that the DoH has issued a list of top metrics and KPIs to be used by NHS procurement areas to increase transparency and enable benchmarking between trusts – but even this falls far short of the desired full pricing transparency.

~ Oligopolies: oligopolies occur when a handful of vendors command a large chunk of the market, giving them disproportionate leverage and negotiation power. This is essentially what is happening with drugs, which account for £5.5 billion2 (note 2 not found below – JC) of NHS spend every year. Pharma companies justify their premium prices by pointing to their huge R&D spend and uncertain pipeline of new drugs – although a recent UK study actually showed that R&D spend has been on the decline for several years now. Either way, the scope to influence pricing or negotiate special deals for so-called blockbuster drugs is extremely slim and cannot be considered an immediate opportunity.

~ Complexity: non-pay cost reductions should ideally be tackled first in areas and/or categories that will not disrupt care pathways or jeopardise the quality of healthcare delivery overall. Successful projects have been delivered in the area of clinical supplies in the past; however, these projects require close co-operation between clinicians, nurses and other personnel to first scope out the consolidation and demand potential and achieve buy-in from clinical staff, before implementing the project. To achieve buy-in in such situations, procurement solution providers typically run expensive workshops to understand the specific requirements of clinical staff and identify potential opportunities for demand aggregation and/or product consolidation.

1 +2 According to the latest report issued by the DoH (Better Procurement, Better Value, Better Care, August 2013).

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Categories that form part of a more competitive and transparent market are usually much better suited to a first wave of cost optimisation and are more likely to achieve quick wins.

Quick wins build momentum and show the stakeholders involved what is achievable, which in turn translates into stakeholder buy-in, which eventually becomes the main building block for more complex time- and resource-intensive projects. These categories are often referred to as "indirect" or "non-core" categories and typically include stationery, telecoms, facilities management and so on.

If we filter out the aforementioned clinical supplies and drug categories for non-pay spend optimisation projects, we get a spend breakdown for NHS acute care trusts as follows:

~ establishment:[2] £1 billion
~ contract and agency staff: £2.4 billion
~ consultancy services: £0.3 billion
~ premises:[3] £3.3 billion
~ non-clinical supplies and services: £1.3 billion
~ training: £0.3 billion.
Total: £8.6 billion per year

The total budget for the entire NHS in 2013 was £107.6 billion.[4] This budget covered a variety of NHS organisations, such as:

~ 211 clinical commissioning groups (including 43 authorised without conditions)
~ 162 acute trusts (including 100 foundation trusts)
~ 58 mental health trusts (including 41 foundation trusts)
~ 36 community trusts (including 18 aspirant foundation trusts and 18 social enterprises)
~ 11 ambulance trusts (including five foundation trusts)
~ c.10,500 GP practices
~ c.2,300 hospitals in the UK.

Clinical commissioning groups are now overseeing a large chunk of this budget, namely c.£93.7 billion, distributed across primary and secondary care, according to an allocation key. Of this, £63.8 billion is allocated to trusts, foundation trusts and purchases from non-NHS bodies, while the **pure acute care and foundation trust proportion is estimated to be around £58 billion[5] per year.**

Consequently, NHS acute care spend categories that could be tackled fairly quickly – without jeopardising the quality of the healthcare delivery model – comprise 14.8% of the total allocated budget. This is the theoretical scope of the opportunity; however Aquanima's experience is that approximately 30% of this amount is typically locked up in managed services and other long-term contracts and is therefore non-negotiable, leaving c.£6 billion (or 10% of the total budget) as an opportunity. To reiterate: these are non-clinical and non-drug-related products and services with only marginal impact on the quality of care at a trust, but representing a massive lever and opportunity for cost reduction.

How Aquanima can help

Aquanima is a procurement service provider. We have been working since 2001 with leading companies in many sectors, helping them to take control of their indirect spend. Our 300 procurement specialists source some £4 billion annually, achieving sustainable savings for our clients in over 150 categories of indirect spend.

We focus on non-core spend, an area of spend that tends to be placed on the back burner by many organisations but which can have a significant impact on the bottom line. We work with our clients to apply the best tools and processes to improve visibility and control, reduce costs and mitigate supply risk.

2 Establishment includes items such as printing, postage, telephone, advertising and travel expenses.

3 Premises includes all the NHS trusts' utility costs, furniture and other property-related revenue expenditure such as rates, rent and insurance.

4 http://www.nhsconfed.org/priorities/political-engagement/Pages/NHS-statistics.aspx

5 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-allocation-of-health-resources-in-england-kingsfund-apr13.pdf

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We offer a range of solutions, from initial opportunity assessment to execution of strategic sourcing projects and procurement process outsourcing. Our solutions provide flexible access to best-in-class procurement tools and expertise, enabling clients to focus on their core spend and business.

Broadly speaking our solutions fall in the following areas:

~ cost optimisation and strategic sourcing: this involves an initial review of spend to identify and prioritise savings opportunities, after which we execute the strategic sourcing and cost optimisation initiatives identified. We can also support clients in the sourcing of specific categories on a stand-alone basis, executing strategic sourcing projects for one or more categories. In both scenarios, we deploy the expertise of our category specialists, our technology platform and our tested methodologies to deliver the best results for our client.

~ procurement outsourcing (BPO): in this model Aquanima operates end-to-end procurement processes on behalf of the client. This can cover all your spend or a part of your spend – for example a single category, or a specific spend threshold such as tail-end spend.

~ consultancy: optimising spend goes beyond reducing prices. In every organisation there are opportunities for improvement in the procurement area by streamlining processes, exploiting new technologies and improving the organisational structure. Our consultancy services aim to perform a comprehensive optimisation of the procurement function, by which we mean the combination of strategy, processes, structure and technology that supports an organisation's procurement activity. Aquanima combines vast practical experience in spend management with proven methodologies to redesign processes and organisational structures and solid technological capabilities. These skills enable us to quickly understand the needs of our customers, develop customised solutions and implement them successfully.

For more information
To learn more about Aquanima's procurement solutions, please call +44 (0) 1908 349 158, email us on commercial.uk@aquanima.com or visit us on the web at www.aquanima.com.

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