Department of Health

NHS Institute for Innovation and Improvement

Quality, Innovation, Productivity and Prevention

Reducing non-pay spend through procurement

18th July 2011

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How the event works

“This is not your usual conference or workshop, it is a specially designed journey which enables a depth and quality of output that would usually be unachievable in such a short timeframe...”

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A warm welcome

We want to thank each and every one of you for taking the time out of your busy schedules to take part in this important event. We recognise this is a considerable time commitment – but rest assured, you have been invited because we value your skills and experience and think your knowledge will be invaluable in helping shape this essential piece of work.

The event will focus on identifying the design principles and processes that will ensure that our procurement processes deliver consistent and high quality care whilst achieving substantial cost savings.

During the event we would like to work with you in a highly focused and creative way, to shape and inform the development of cross-trust collaboration and decision-making.

We look forward to working hard on this significant task with you over the day – we are sure we will have an enjoyable and productive day!

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What are we hoping to achieve?
Objectives of the event:

- *consider how we can support reductions in non-pay spend across the NHS with the support and commitment of clinical and managerial leaders*
- *consider what we need to do all across the system to achieve an ambitious reduction in non-pay spend while maintaining quality – to drive a procurement strategy that really helps the system*
- *consider how we can support Chief Executives understand and accept their personal accountability to the taxpayer for the public purse – particularly around opportunities identified by the Public Accounts Committee*
- *commit to a clear list of specific core actions – a manifesto for non-pay spend*

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We ask you to…

- Go with the flow
- Have faith in the process
- Take collective responsibility for completing the task in the timescale
- Be fully present for yourself and for others
- Collaborate, support and constructively challenge others
- Put yourself in other people's shoes
- Respect confidentiality! What is said in the room stays in the room!
- Bring and voice your professional perspective – that is why you are here!

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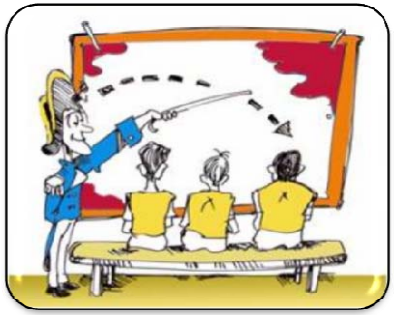
We will work with the “Scan, Focus, Act” model

Scan

- Build foundations for high value discussions
- Engage with emerging trends, leading expert and practices
- Create a common language
- Uncover critical assumptions and issues
- Understand where we are now and get to the same starting point



Focus

- Focus on the most important issues
- Start to create potential solutions
- Evaluate options & clarify expectations
- Uncover and remove barriers to change
- Address the situation in all its complexity

Act

- Create alignment, commitment and intention to act across the group
- Make definitive decisions
- Design all aspects of the solution through focused and creative thinking
- Leave with a clear way forward that we can all act upon

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Approaches to change

Deficit based

- **what is wrong?**
- **solving problems**
- **identifying development and improvement needs**
- **gaps and deficiencies to be filled**

Asset based

- **what is right that we can build on?**
- **exploiting existing assets and resources**
- **“positive deviance”**
- **amplifying what works**

Aim to work from an asset based approach, where we can embrace positive deviance and learn from the best. Aim to find what works already, and amplify it!

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Reducing non-pay spend through procurement

Scene Setting

Jim Easton

National Director for Improvement and Efficiency

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Scene setting: Jim Easton
National Director for Improvement and Efficiency

Key messages:

- Personally committed to supporting this – “if we don’t do it, we’re dead”
- Drive for efficient and effective procurement is an imperative – the current economics are here to stay.
- We need to move to scale, and away from organisations procuring alone.
- The drive for scale needs to come from the ground but with our support
- To work effectively, procurement needs to be built into clinical practice

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Scene setting: Jim Easton
National Director for Improvement and Efficiency

• The design of clinical practice needs to be aligned with procurement practices before we can take next step

• We need to move away from the ‘glamour’ side of purchasing to avoid over specifying equipment and consumables.

• Progress is a necessity so as to reduce the pressure for decreasing pay spend

• Geography does not have to be a barrier to achieving scale – why not scale up with partners across the country and not just regionally.

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Scene setting!

The highest number of examination and surgical glove types identified in one trust was 177

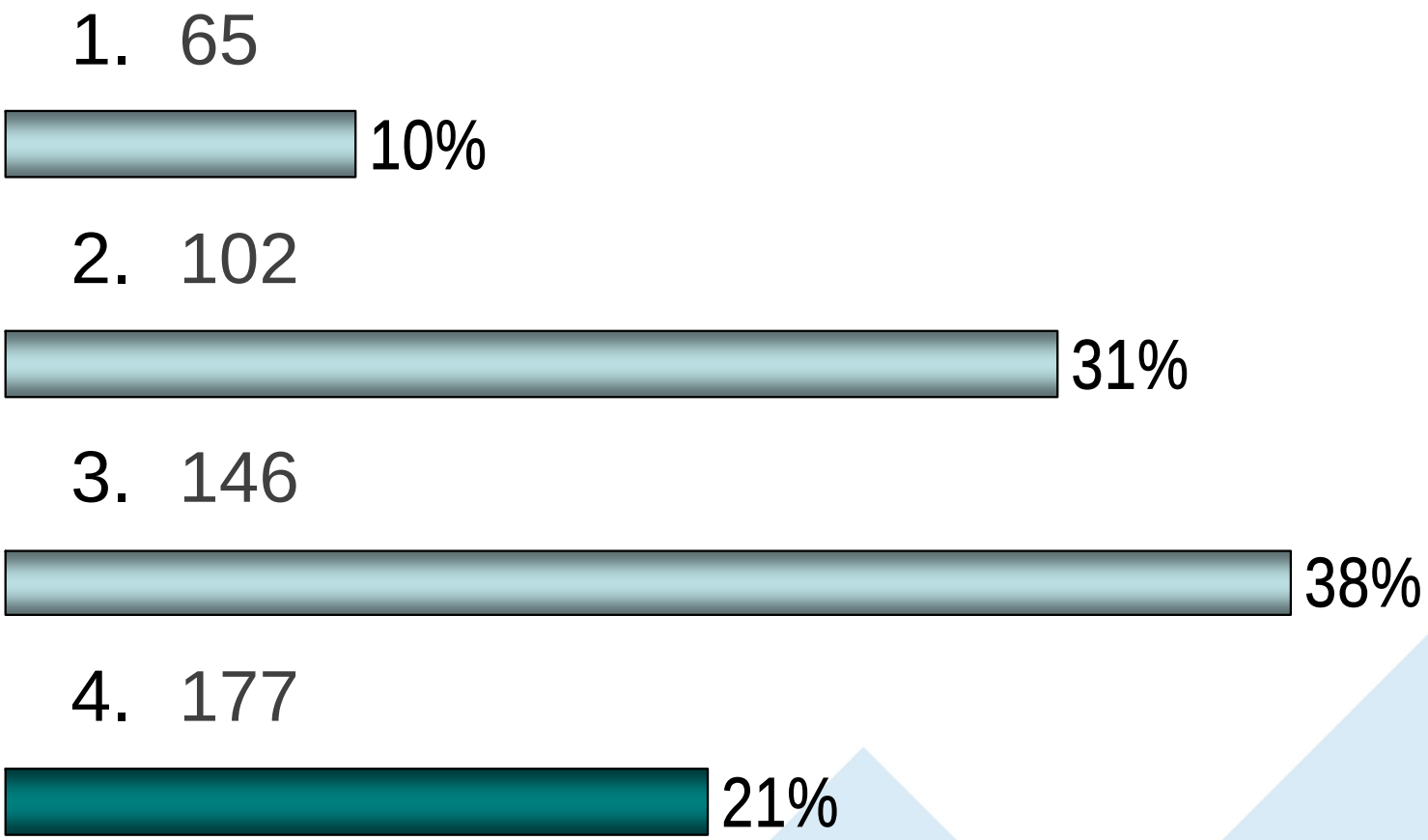
If prices were standardised so that all trusts paid the lowest price paid in the NHS for all consumables, the average trust would save £900k

The percentage of all orders for cannulas less than £50 is 83%

The average annual number of purchase orders issued by a trust for the purchase of paper was 1062

©

What is the highest number of examination and surgical gloves types identified in one trust?



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If prices were standardised so that all trusts paid the lowest price paid in the NHS for all consumables, how much would the average trust save?

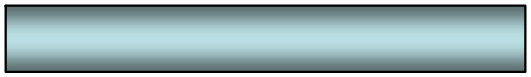
1. 125,000

0%

2. 526,000

11%

3. 753.000



30%

4. 900,000

59%

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What percentage of all orders for cannulas are less than £50? i.e. less than the estimated administration cost to the NHS of processing the purchase order for each transaction.

1. 45%

2. 74%

3. 83%

4. 95%

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What is the average annual number of purchase orders issued by a trust for the purchase of paper?

1. 269

3%

2. 983

14%

3. 1,062

41%

4. 1,652

41%

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Reducing non-pay spend through procurement

A View from Industry

Ninian Wilson

IT Procurement Director, Vodafone

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Scene setting: A View from Industry
Ninian Wilson, IT Procurement Director, Vodafone

Key messages:

• Procurement is a great enabler for taking cost out in the middle impacting on the bottom line

• Use the combined approach of people, process and technology

• Need to consider scale of opportunity for the NHS as a whole – don't throw away the opportunity

• There are fundamental building blocks for transformation in procurement

i. Measurement – find an agreed set of metrics and stick to them. Save money on the balance sheet – cost avoidance doesn't work! Get finance to audit your measures
ii. People – get great people and then train them. Slick negotiation training is key
iii. Process – get it right
iv. Engagement with business – leadership support and staff buy-in secure alignment

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Reducing non-pay spend through procurement

The Scale of the Opportunity

John Warrington
Deputy Director – Policy & Research
Department of Health

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Reducing non-pay spend

Ways to reduce spend

1. Reduce variation
2. Reduce demand
3. Reduce costs to procure
4. Reduce internal supply chain costs/ save clinical time
5. Change the requirement/ specification
6. Reduce prices

Other benefits

Use non-pay spend to drive improvements in quality & efficiency (innovation)

Reduce carbon footprint

Manage risks to supply

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The opportunity

We calculate the NHS could save £1.2bn

Ways to reduce spend

1. Reduce variation
2. Reduce demand
3. Reduce costs to procure
4. Reduce internal supply chain costs/ save clinical time
5. Change the requirement/ specification
6. Reduce prices

Example 1: Variation:
NAO report said huge variation in range of products used. e.g. NHS SC: Exam gloves. If all Trusts used the recommended glove NHS would save £7.4m (£1.2m in this room!)

Example 2: Prices:
NAO report and FTN benchmarking shows significant variation in prices paid (10-30%). If all went to lowest Trusts would save £150m (£900k per Trust)

Example 3: Waste:
One Trust found over £1m of disused stock after sorting out its inventory management

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What needs to be done?

What needs to be done at Trust level?	How?	What needs to be done at system level?
Introduce controls on spending	Price benchmarking	Make NHS SC fit for purpose
Challenge spending requests	Category Mgt	Implement GS1
Better catalogue/ formulary management	More electronic tendering	Support the change mgt process
Reduce waste (inventory/ stock/ flow of goods)	Better use of SC & other partners	Help Trusts with investment decisions (capability/technology/ partners)
Compete requirements/ increase competition	Investment in procurement technology (e-procurement, catalogues, exchanging, sourcing)	Guidance on how best to use partners such as SC
Involve clinicians/manage choice	Improved procurement capability in Trusts	Provide professional leadership
Share pricing with peers	Investment in inventory management systems	Identify opportunities & provide case study evidence
Use collective NHS purchasing muscle	Consider outsourcing/ shared service models	KPIs
	More collaboration and taking collective commitment to markets	
	Win hearts and minds of clinicians in decision-making	
	Implement Trust-wide procurement policy	

Managing Non Pay Spend – a North West Perspective

Catherine Beardshaw

Chief Executive

Aintree University Hospitals NHS FT

Managing Non Pay Spend – a North West Perspective

Catherine Beardshaw, Chief Executive
Aintree University Hospitals NHS FT

Key messages:

• Suppliers are in the business of selling, this is their core business and key priority!

• They currently use their power to divide and conquer us for their own benefit – such as anecdotal evidence of refusal to work with procurement hubs & the courtship of clinicians

• Suppliers have gross profit margins of circa 65% in clinical spend areas (30% in supermarkets)

•Suppliers can be considered a foe, on the basis of their manipulation and fragmentation of the market to maintain high margins

• Variation across the NHS leads to fragmentation

Managing Non Pay Spend – a North West Perspective

Catherine Beardshaw, Chief Executive
Aintree University Hospitals NHS FT

Key messages:

•Know your procurement managers – and check what they're saying!

•Clinical engagement is key – they can respond quickly when engaged in the right way, and their impact is quickly felt

• Need to recognise the risks- such as undercutting and find a way of compensating for this

• More of the same isn't good enough and we have to take a more strategic approach to managing non pay expenditure

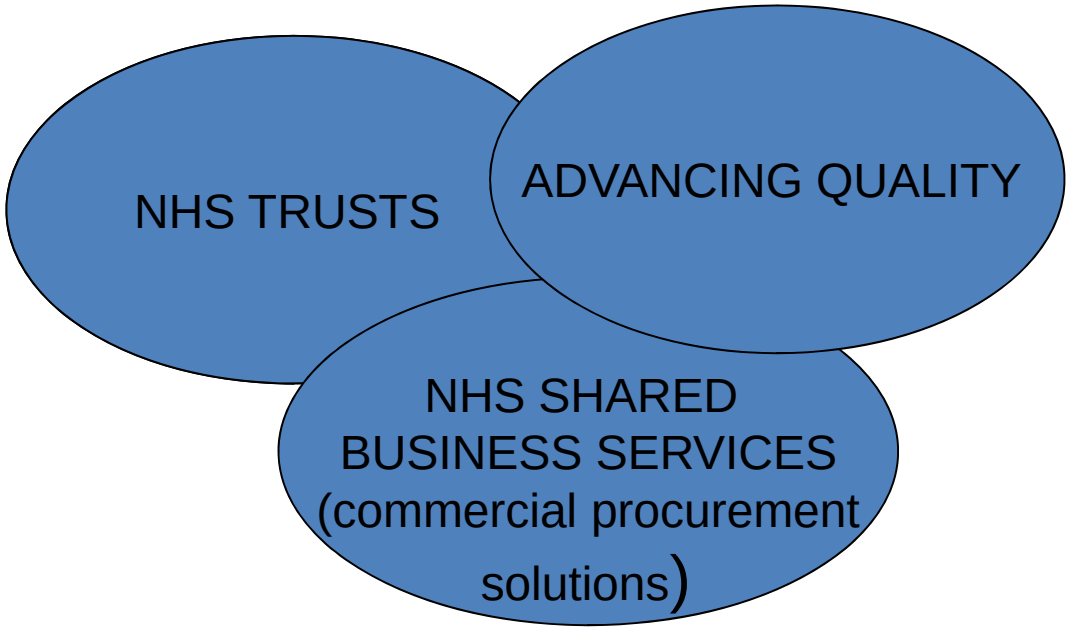
Key slide 1

NHS Approach to Date

- Local tactics
- Dependency on local procurement managers
- Wide variation in terms of our commercial processes
- Little evidence of cross organisational collaborative working
- Raising awareness of the need for a more strategic approach

Key slide 2

North West QIPP Procurement Programme



Key slide 3

Strategic Intent (1)

Implement and comply with the fundamental building blocks of good commercial processes – managing our business

- Clinical engagement at the start of a procurement process
- Rationalisation and standardisation of products and fit for purpose specification
- Collaborative procurements based on commitment
- E-procurement catalogues and solutions to drive compliance
- Purchase to Pay processes to drive financial governance
- Quality data outputs that can be used to inform the next procurement cycle

Key slide 4

Strategic Intent (2)

- Develop the culture and behaviour to eradicate off contract spend
- Stop suppliers getting directly to clinicians
- Work collaboratively across organisations to manage the market to maximise our commercial leverage

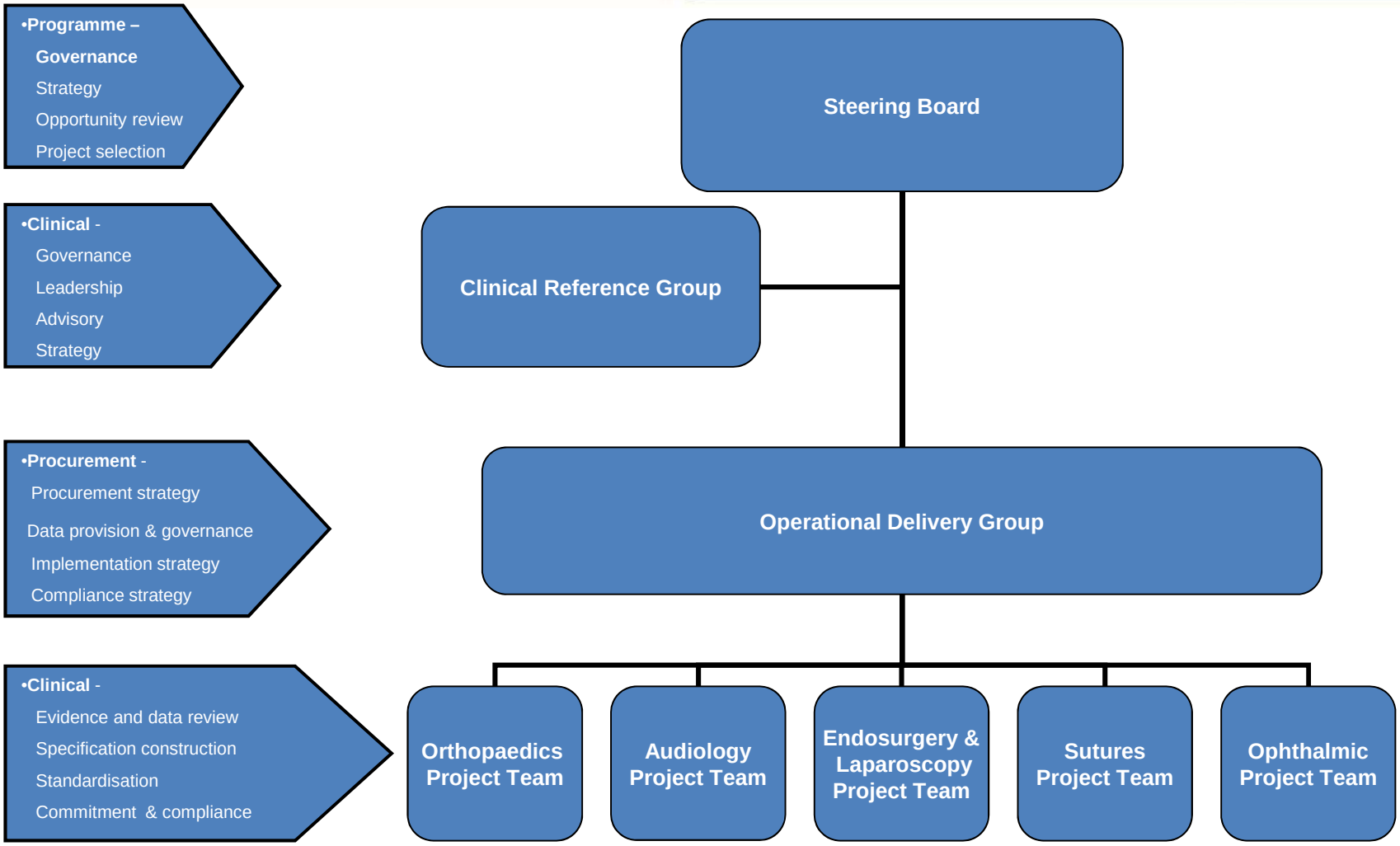
North West Strategic Advantage Programme (SAP)

Key slide 5

Strategic Advantage Programme - The Power of 10

The first wave NW Strategic Advantage Programme consists of 10 Trusts :

- Aintree University Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Royal Bolton Hospital NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- St Helens & Knowsley Teaching Hospitals NHS Trust
- Tameside Hospital NHS Foundation Trust
- Trafford Healthcare NHS Trust
- University Hospitals of South Manchester NHS Foundation Trust
- Withington, Wigan & Leigh NHS Foundation Trust



Strategic Advantage Programme

The Governance Structure – Cohort 1

Key slide 7

Engagement Process

Supplier Briefing Event brought together the key suppliers of each of the category areas selected in the cohort

Value Learning Event brought together all executive, clinical, and procurement representatives from each Trust

Key slide 8

The Clinical Engagement (Value Learning) Event Agreed (1):

- Links between clinical practice, procurement and the cost effective delivery of care
- How we collaborate to deliver clinically led contracting strategies
- The cost v clinical benefits of differing supply scenarios
- The principles of best practice, acceptable outcomes, consolidation and aggregation of product demand and standardisation and rationalisation of products
- Reduction in clinical variation in terms of practice and outcomes was highly desirable

Key slide 9

The Clinical Engagement (Value Learning) Event Agreed (2):

- The importance of using evidence and benchmarking in clinical practice and outcome measures
- To adopt and implement standardised, rationalised supplies
- Utilisation of volume commitment to level pricing
- Commitment to the programme from 10 organisations

Key slide 10

Strategic Advantage Programme

Project team process

Clinical Engagement

- Align key decision makers to project teams
- Key decision makers to represent the wider clinical stakeholders views in their Trust
- To canvas Trust clinical stakeholders input at key decision points
- To act as champion for the Strategic Advantage Programme

Data

- SBS provide cleansed data sets for each Trust
- Summarised expenditure profiles across the 10 Trusts (suppliers & products used)
- Data used to agree the KPI's (level of standardisation & timeline)

Evidence

- Determine evidence requirements and sources
- Engage Evidence consultancy to source, consolidate and summarise the evidence
- Evidence is reviewed to determine and agree attributes associated with key patient outcomes

Specification

- Confirmation of product characteristics and attributes aligned to patient outcomes and clinical consensus
- Specification to be structured and objective (core & desirable)
- Standardised specification delivered to NHS SBS

Procurement

- Confirmation by Trusts of committed volumes
- Market engaged to convey requirement and expected ROI
- SBS facilitate Mini Competition to deliver the savings

Compliance & Implementation

- Generic Implementation and Compliance strategies produced
- Systems, processes and procedures determined in each Trust
- Implementation & compliance strategies tailored for the specific Trust
- Implementation of cohort outcome

Key slide 11

SAP Progress to date

- Established a group of senior leaders across 10 Trusts working on SAP
- Engaged large number of clinicians who are interested in the concept
- Audiology, Ophthalmology & future workstreams progressing towards £1m savings
- Meeting with 25 orthopaedic surgeons from different Trusts
- Market is taking notice of this and are trying to undercut prices to the 10 member Trusts
- Risk pool agreed in principle to alleviate cost pressures on individual Trusts

Risks

- “Jam today” may fragment the Power of 10
- Quality of data
- Losing consultants because of time pressures

Question Time

Hosted by Helen Bevan

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Q&A

Q: How do we move away from cantons to systems?
A: We have no choice but to change. This is a challenge to the leadership, but it needs to be done.

Q: What incentives were offered to clinicians to keep their interest?
A: It's about choice, and the ability to focus on core values. Buy-in comes from commitment not compliance, and as such is on an individual basis. It was about appealing to their core values and letting people have a conversation with one another.

Q: what if the cheapest or the standard model is not best for me?
A: Its agreed that it's hard – and one size will not fit all. Trusts have a long way to go in getting this right.

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Reducing non-pay spend through procurement

Scan – assignment one:

Realising the Opportunity

Table work

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Scan – assignment one:

Scan – Assignment One: Realising the non-pay spend opportunity. It is 2014 ad we have achieved our QIPP goals for procurement. What does good look like?

Task: - exchange views, test reactions, challenge and build the vision for the North West power of ten potential

- create the platform needed for participants to work on focus and act assignments

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Group Feedback – Procurement 2014

• Clinical engagement at all stages of the procurement process (front, middle and end)

• Levers established to incentivise behaviour, such as service line reporting + devolution of budget responsibility to clinicians

•Defined role for the DH to lead on national programmes which may include standardisation of data sets and/or web-based guides on price and product performance

•Collaborative groups leading national categories such as lease cars/energy and regional groups other categories such as clinical areas

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Group Feedback – Procurement 2014

“Better to be involved and in the game than out in the cold”

• Set stretch targets to reduce supplier numbers by 50% and/or non pay spend by 50%

• Performance management baselines needed to be defined and tracked, so that we have transparency of the impact of the work and can demonstrate VFM.

• Learn by doing, do not wait for the perfect solution, but evolve best practice.

• Link to existing work, e.g. technical evaluation by NICE so as to avoid duplication and confusion

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Reducing non-pay spend through procurement

What are the drivers and barriers?

John Warrington
Deputy Director – Policy & Research
Department of Health

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What are the drivers and barriers?

John Warrington

Deputy Director – Policy & Research
Department of Health

Key messages:

- An emotive element to consider: how can boards or trusts justify loosing frontline clinical staff when we don't have a handle on procurement spend?
- QIPP is still at forefront of agenda – procurement needs to feed into this
- data continues to be a restraining force – we cannot compare our current information as we all measure different things in different ways
- The NHS struggles to work in a unified way to drive national change at scale and pace
- We continue to work in competition, rather than collaboration with one another
- Commercial capability restrains us

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Key slide

Desired Situation **Tomorrow**	Current Situation **Today**

Driving Forces

- Economic climate
- Staff cuts unpalatable
- QIPP challenge
- External industry pressures (e.g. US medical device tax)
- NAO and PAC reports
- Central Government approach to procurement
- Better procurement technology

Restraining Forces

- Data
- Leadership
- Lack of accountability
- Commercial capability
- Competing landscape
- Inability to drive national change at scale and pace
- Competition between trusts

Helen Bevan – summary points:

- the example of the power of 10 is based on the commitment that we make to one another
- transformational change is not recognised through compliance in the long term
- leaders who create sustained change do so from a platform of commitment
- what do we need to do to get to this point in the future?

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"You can't impose anything on anyone and expect them to be committed to it."

– Edgar Schein, Professor Emeritus
MIT Sloan School

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Which approach?

Compliance	Commitment
States a minimum performance standard that everyone must achieve	States a collective goal that everyone can aspire to
Uses hierarchy, systems and standard procedures for co-ordination and control	Based on shared goals, values and sense of purpose for co-ordination and control
Threat of penalties/ sanctions/shame creates momentum for delivery	Commitment to a common purpose creates energy for delivery
Based on organisational accountability (“if I don't deliver this, I fail to meet my performance objectives”)	Based on relational commitment (“If I don’t deliver this, I let the group or community and its purpose down”)

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Focus – assignment two:

Driving and Restraining Forces

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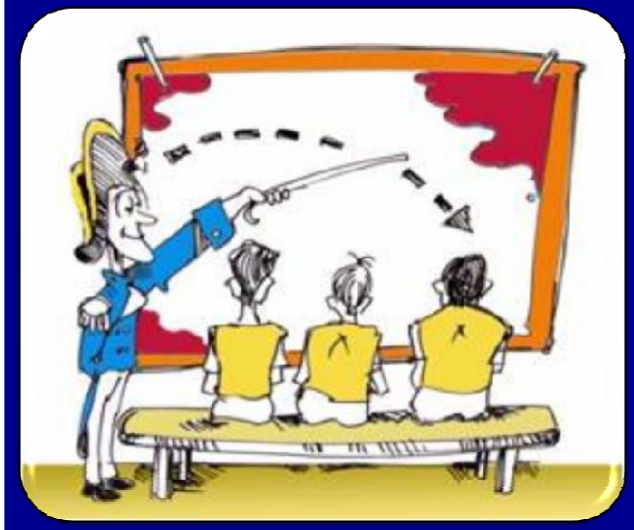
Focus – assignment two:

Assignment two:- Driving and restraining forces



Task: -

To identify what will really drive this work forwards with the energy and commitment needed to make it happen AND what could get in the way, maintain the status quo, and stop it from happening**?**

Scenario One – Orthopedics

Your Trust has 14 surgeons and 6 theatres. In total, the Trust performs approximately 600 hip replacements and 400 knee replacements per year.

An exercise has established that the Surgeons currently use 20 different systems (12 hip and 8 knee systems) which are supplied by 6 different suppliers.

There are significant price variations in the different systems used and procurement has identified savings opportunities from standardisation.

Some clinicians claim better patient outcomes due to the choice of system, but this is unclear and not backed up by evidence.

Having different systems introduces challenges and risk for the theatre team and the staff in the decontamination department, with regard to training and education.

Stock is managed by the Theatre team and the Trust has significant consignment stock as well as having consignment instrumentation on loan from the suppliers (there is no direct charge associated with consignment stock or instrumentation). At year end, the stock value was £800,000 which indicates excessive stockholding.

As inventory is not managed by the materials management team, there is limited usage and price information.

From reviewing the Foundation Trust Network's benchmarking study on orthopaedics, it appears (from the limited information available) that your Trust is paying too much.

The Trust is reluctant to collaborate in sufficient scale to make a difference in its pricing and there is a general mistrust of working with NHS Supply Chain and other partners. The procurement team has been working with NHS Supply Chain to identify savings opportunities and Orthopaedic implants could deliver significant savings from working with other like minded Trusts with NHS Supply Chain.

Q1. What do you need to do as senior executive to address the issues?

Q2. What's stopping success and preventing the issues from being resolved?

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Scenario two – Trust Procurement department

Your Trust is facing financial difficulties and procurement has been recognised as a tool to reducing the scale of the problem. The Finance Director has commissioned a consultancy to conduct a review of procurement and identified a number of opportunities to make significant savings. However, the review highlighted a number of issues that need to be overcome to realise the savings.

- The procurement department has limited data and no meaningful management information to support the analysis.
- Much of the purchasing process is paper based with departments completing paper requisitions for their requirements.
- Staff including clinicians are complaining about the delays in turning requisitions into orders and the subsequent delay in the delivery of goods.
- The procurement department undertakes an excessive amount of single tenders therefore it is unclear if the Trust is paying competitive prices.
- Many departments manage their own stock using clinical / nursing time and there are no electronic catalogues in place to manage products purchased, giving medical staff the freedom to order anything.
- There are lots of invoice queries both from Trust staff and suppliers which is creating an administrative burden in individual departments as well as in procurement and finance. Invoices are being received that do not match the purchase order (if there is a purchase order at all in some cases).
- There is a poor appreciation of key suppliers and products and a lack of understanding of the risks in the supply chain and associated risks to patient care.

The procurement function is not measured and has no KPIs in place that are reported to the Board like other functions.

The Consultants review indicated that the Trusts procurement department did not compare well against its peers – but there is no meaningful MI or benchmarks to validate this.

The report also identified significant opportunities to save money by collaborating with other Trusts

Q1. How can you improve procurement in your Trust?

Q2. You are approached by a third party who offers to undertake procurement on your behalf, addressing the issues – what would you consider / do?

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Focus: assignment two - feedback

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Group feedback – Task 2 Scenario 1 Orthopedics

Restraints:

• Organisational culture – consultants driven by own needs, not necessarily aligned with the Board
• Lack of clear data set/ transparency
• Unclear operational control and leadership
• Trusts are suspicion of collaboration

Drivers:

• Improved patient safety and linked to clinical reputation
• Reduce cost through efficiency
• Develop clinical leadership
• Establish benchmark for improvement and track improvement

Big Idea/ Chairman's Challenge:

Individuals to develop for themselves and their teams challenges which impact on patient safety and reduce costs. Collectively work through issues of safety, effectiveness and affordability

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Group Feedback – Task 2 Scenario 2 Trust Procurement

Constraints:
- Data and lack of KPIs
- Freedom to act
- Accountability

Step 1
- Leadership and setting priorities
-Self certification of performance
- Professional development
- Simplification and process improvement

Step 2
- Identify key suppliers, manage performance and develop KPIs

Step 3
-Set culture and capability of team
- Build systems

Big Idea:
-Leadership to inspire performance

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Focus: assignment two - panel reflections

- Patient safety is key – this is not just about saving money
- Ego must be left at the door
- Deal with blockers head-on
- Create the need for action “the burning platform”
- Utilise tools which we already have – i.e. Productives
- Demonstrate the need for collaboration
- Data, data, data – and accountability for actions
- Change as a management issue
- Incentives through CQUIN
- We cannot always assume that we are in the upper decile for performance, and even if we are – is this good enough?

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Act – assignment three:

Actions to take and commitments to make

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Act – assignment three:

Act – Assignment three: Actions and commitments

Task: - Create 30-day action plans to create momentum for an action area or action theme of your choice

*David Nicholson will be joining us during this assignment

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Jim Easton
Key factors for procurement action planning:

1. Have an approach to change & use it
2. Measurement - how you collect and use – mandate/voluntary
3. Developing people and leadership
4. Target changes to the system
5. Should we create something below national level?

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Action Planning for….

1. core technologies and systems to support procurement nationwide including price comparison
2. to leverage commitment at scale (power of 300)
3. key performance indicators for procurement
4. a transformational change programme for procurement
5. clinically led procurement
6. learning from the best in the NHS and elsewhere

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Action Plan Group 1 – Core Technologies & Systems

1. Standard coding system – compare apples to apples.
2. How – legal mandate with future proofing built in.
3. National data base for procurement - enable comparison on price and product performance.
4. DH to lead and potential seek partners to manage database.

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Action Plan Group 2 – Leveraging Commitment at Scale

1. Short term plans
    1. Conferences on the power of 300 supported by clusters to engage and push on.
    2. Establish price and product performance transparency
    3. Ban on non- disclosure agreements for pricing
    4. Commit volume contracts around specific categories
2. Medium Term (6ths)
    1. Providers look at cost management to drive collaboration
    2. Focus on top 10 spend areas/suppliers to encourage and support contracting

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Action Plan Group 3 - KPI

1. DH to provide support and help but not micro management
2. Establish where individual organisations are
3. Quality Accounts – linking with clinical staff
4. Create a basket of goods for organisation types to establish national benchmarks
5. Service needs to support request to support DH initiatives

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Action Plan Group 4 – Transformational Change

1. Understand current position – base lining
2. Stakeholder analysis - regional/clusters – opportunities and pitfalls
3. Development of a vision of procurement with performance metrics
4. CQUIN to drive change for organisational procurement
5. Create accreditation by peer review – added value via transparency
6. Leadership development programme

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Action Plan Group 5 – Clinically Led Procurement

1. Engage with the entrepreneurial skills of clinicians
2. Use data at patient level reporting – need to understand what clinicians are spending at an individual level.
3. Clinical leadership agendas to be aligned with organisation's
4. Clarify rules of engagement between suppliers and NHS
5. Use legislation – eg bribery act
6. Peer review planning process to hold to account
7. Need to organise ourselves (local / regional / national) with appropriate clinical input to deliver standardisation.

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Action Plan Group 6 – Learning From the Best

1. Develop compare.com idea or develop comparison site - DH to identify potential providers to build.
2. DH to source procurement training
3. Top 10 spend - all present agree to share data to the group and review and determine actions
4. Where is the procurement expertise – NHS / non NHS
5. Benchmark against other industries and countries

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Sir David Nicholson

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Sir David Nicholson

- The work on procurement is fundamentally important
- £1.2bn savings from procurement identified out of QIPP
- If savings are not found here, they will need to be found elsewhere
- Every pound saved through procurement supports keeping a member of staff in post - this will genuinely work towards saving lives
- Lord Darzi found the trick of high performing teams was threefold i) measurement ii) set goals iii) improvement. Transparency is key to this!
- the current profile of procurement is low. How do we raise this? We need to focus on profile within organisations

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Sir David Nicholson

- Communication processes are failing us and deserve improvement
- We understand that newly established organisations want independence – however it's imperative they learn the benefits of collaboration.
- Suppliers want to undermine our efforts – we can't let them.
- We need to establish mechanisms for working together – infrastructure can make this happen.

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Act - assignment three: commitments feedback

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Making commitments

- We commit to specific actions that are measurable
  - not vague promises
  - not just outcomes
- Make commitments as simple as possible (“one specific action”)
- We want to hold people to account to the things that they commit to
- When we do it effectively, commitment is much more effective than compliance
- A definite “no” is always better than a wishy-washy “yes” or “maybe”

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Act - assignment three: closing comments & next steps

Jim Easton:

- An excellent series of action supplied
- Confident that these are practicable
- Our experiences outside of this room will be different – people act interested

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Additional comments

- " this is not me ' not getting over myself' (as per Jim) but some NHS Trusts are good at procurement – even in comparison with the private sector. Plea: 1) listen to them and get them to share policy 2) incentivise them to share support" (Neil Chapman, DoF Leeds)

- How to get CEO on board re: collaboration

✓ Personally addressed letter (name) to CEO

✓ Local data to make relevant

✓ Ask for a response to the issue/data

- If you are going to move on an NHS 'go compare' move quickly. Get it 90% right and not bogged down in coding etc. Get something done and then improve.

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Additional comments, cont.

- 2 areas not covered

1) Capital investments – buildings

Whilst in some areas there is a desire for greater standardisation of specifications to allow a more definitive negotiation for a product; we do have very specific definitive's on buildings through HBN (hosp. Building notices) which may lead us to over spending the requirement for many NHS buildings leading to excess costs. Whilst these aren't mandated Estate professionals find it difficult to identify where moving away from these specs would be appropriate

2) FPIOs

A hard to reach area of NHS spend, but a high cost to NHS budgets. How can we support better procurement with pharmacies to drive value?

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Reducing non-pay spend through procurement

Thank you!

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