



Clinicians who care about procurement

NHE interviews Guy's & St Thomas' NHS Foundation Trust's chief procurement officer **David Lawson** and the trust's clinical procurement champion, consultant transplant surgeon **Mr Geoff Koffman**, who is head of transplantation and deputy medical director.

With a turnover of £1.2bn and more than two million patient contacts a year, Guy's & St Thomas' NHS Foundation Trust (GSTT) is one of the largest foundation trusts in England, with a procurement team dedicated to stamping out wasteful spending while making clinicians' lives easier. Their work is a key part of Guy's and St Thomas' 'Fit for the Future' programme to improve quality, safety and efficiency.

The procurement team of about 60 people, divided between sourcing, systems, and supply chain functions, have a cost improvement target of £12m for this year. The team influence a non-pay spend of about £300m, and so form an important plank of the trust's wider efficiency targets.

Chief procurement officer David Lawson has been at the trust for nearly 14 years, and so has seen how procurement has developed over time. GSTT has been a leading light on many recent advances, and the trust won a European Supply Chain Excellence Award in 2010. It was also responsible for the first large-scale deployment of automated inventory management systems outside of North America, using a cabinet 'vending' system by Omnicell, distributed in the UK by Avanteq. As products from the cabinets are used up, the system automatically re-orders the correct amount of replacement stock each day. The stock is delivered and replaced by the materials management team in a matter of hours.

The trust is now rolling out the system into the remaining areas not captured in the

previous deployment.

Lawson said: "We're also exploring options around online ordering, and looking at a cloud-based system to improve the speed and efficiency of residuals ordered online."

"We're considering restructuring our supply chain team and re-engineering the process to design out non-productive time. We'd have a smaller number of staff providing that materials management service, but at a higher grade."

"That investment would upgrade and professionalise the supply chain function, which can be seen as a 'Cinderella service' – but from a procurement perspective, it's our front line."

Overcoming tensions

Anecdotally, clinicians do not always embrace initiatives coming from their trust's central procurement team, often preferring their old ways of doing things and the flexibility to just place their own orders.

Mr Geoff Koffman, consultant transplant surgeon, head of transplantation and deputy medical director at GSTT, is also a 'procurement champion', helping transform the trust for the better. He did not disagree when NHE suggested that there can be tensions between busy clinicians and those in procurement, saying: "The perception, which may be unfair, is that they [clinicians]

would basically like to order what they want, from whom they want it, and cost isn't really a priority issue for them."

"But we are encouraging them to engage with procurement to bring about efficiencies in the service. We've got an excellent procurement group and my job has been to try to get more engagement with clinicians – not just listening but actually doing something about it."

"In our trust, there's been quite an awakening of interest in this, particularly at a time when we're trying to improve efficiency. We're seeking to provide an equivalent or improved service at a better cost, that's the mantra."

"If people have used certain things for 10 years, they don't want to change. I have sympathy with that, but we're entitled to make them go through an assessment to see if product A is better than product B."

Making stock easy to find and use

Lawson compared NHS supply chain management to an iceberg – a lot of cost is hidden under the surface. "Clinical products, and those in sterile packaging, they're all time-dated. If that inventory is not managed in an efficient way, there's a huge risk of stock having to be thrown away because it's expired."

He continued: "We've deliberately tried to push the inventory as close to the 'point of consumption' as possible. We don't have huge store rooms, we instead have these inventory systems inside the theatres and inside the prep rooms, so there isn't that issue of walking time – of clinical staff walking 10 miles a day just to retrieve inventory."

That's been a "big improvement", Mr Koffman



Mr Geoff Koffman



agreed. “The stock we carry is much more current and relevant; it’s in cabinets and people know where it is. We’re actively dissuading or preventing people from doing individual purchases.”

This policy prevents duplicated or wasted stock, he said, and gradually “rogue purchasing” is being stamped out.

Fragmented supply chains

GSTT specialises in cancer, cardiovascular, dental, dermatology, imaging, children’s, renal, and women’s health services, and is a major centre of transplant surgery. It is the largest provider of elective surgery in the NHS, according to 2011-12 data.

But like at many other trusts, the supply chain for its theatres has traditionally been very fragmented, particularly compared to the wards. The theatres consume more high-value medical

products, and account for more spending than wards (most NHS wards use NHS Supply Chain, a consolidated channel and as such “relatively efficient”, in Lawson’s words). So changes to inventory procurement for the theatres have to be thought through carefully.

Lawson explained: “There are risks if you don’t address that fragmentation: if you put an inventory system into a theatre that has a fragmented supply chain, it can actually end up costing you more money. That is because you’ve got individual delivery charges, and the issue of reliability, where different suppliers will have different lead times.

“Inventory systems normally order things more frequently than someone ordering manually, typically every day, not just every week or month.

“The other aspect, in terms of, say, orthopaedics, vascular, or cardiology, is that having more suppliers on the shelf introduces inefficiency in set-up time. For orthopaedics, we standardised to one supplier. Before then, the theatre staff were spending more time in set-up because they were having to re-learn the instrumentation sets of the various different companies. Now, because they’ve got one supplier, one set of instruments, it’s quicker for them to prep for cases, so they can do more

cases per list than previously.”

He acknowledged that there is “always a risk to manage” in making these changes. “Obviously, if you choose the wrong supplier – one who’s not reliable, or whose performance dips – then you’ve got a dependency and are more exposed. Equally, in terms of consolidating into one brand, there’s a risk if clinical practice changes, or a supplier you decided not to use then introduces a more innovative product with better clinical outcomes. There is a degree of compromise, and it’s about assessing the risk and making an appropriate judgement.”

Consolidation

One of the suppliers chosen as a consolidated supplier was Cook Medical, which Lawson said particularly suited the trust as a major vascular centre.

Cook’s representatives helped with the consolidation, offering lab time, product evaluations and other support.

The trust had invested heavily in overhauling its inventory management systems by that point, and had more confidence in them. This allowed it to take the “brave step” of switching from a consignment model, where the supplier owns the stock and thus the risk of it going out-of-date or staying unused, to buying the stock itself. Although theoretically riskier, this option reduces unit costs, making it a viable option for efficient trusts.

Lawson told us: “That’s achieved a number of
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benefits. We got a very competitive price from Cook, because we were taking the risk around that inventory. But because we had invested in inventory management systems and people, that was an appropriate risk for us to take.

“Not many hospitals have invested in inventory management systems, or their supply chain resource. That’s why other people haven’t done it: because they haven’t got the systems to manage that risk.

“Because we’ve seen Cook as a key supplier, and they see the trust as a key customer, it brings in additional potential investment and support in terms of training and development. We’ve been trying to use the other competencies that other medical device companies have to help the hospital.

“Medical device companies like Cook are manufacturing companies, so have competencies around lean, and lots of good marketing and communications people. Those competencies can be quite valuable to hospitals, which are being assessed and judged on things like patient experience. The other potential strength is data analysis, as one challenge for hospitals is accurate clinical coding and ensuring the case mix is as optimal as possible.”

Big savings

After an initial meeting about improving their relationship in early 2014, Cook worked with GSTT’s supply chain team to ‘cleanse’ the data in its catalogues throughout the spring, helping to ensure error-free ordering via the Smart Store inventory management system. New stock holding levels were then based on historical product usage.

A Cook case study notes: “These efforts reduced clinical frustration and administrative costs and helped to ensure that the right product was in the right place when needed.”

The focus was on the endovascular and interventional radiology clinical areas, with

savings estimated at £250,000 a year.

Mr Koffman said the fragmentation and sheer number of suppliers in the past was “pretty anarchic”. He told NHE: “[Clinicians] have had their favourites, and of course longstanding arrangements often based on mutual benefits.

“They still may not want to change, and they may dig their heels in, but it’s much easier for us now to do it. That’s because we have an excellent procurement team who work with the clinicians to show them the benefits of change.

“Just take the ‘suture story’; we’ve undergone a wholesale change of all our sutures, we’re not alone in the NHS in doing that. But it hasn’t been easy and certain groups are reluctant to change, or they spot a suture that’s not very good and they pick on that as a deal-breaker. So we get the company to come in and show them some more alternatives, and listen to what they’re saying.”

‘The policy was not to speak to suppliers’

Asked about these new and more collaborative relationships with key suppliers – the best of which go far beyond the purely transactional – Lawson said it was important to realise how far things had come.

He said: “When I joined the trust, the policy of the procurement department was not to speak to suppliers – that wasn’t unusual! Procurement teams were very transactional, and all the processes were very manual. Not many teams even had a sourcing function; they had transaction buyers and that was it. Over time, we’ve invested in the sourcing function, and now we’ve invested in the supply chain function.”

The relationship depends on the supplier’s own attitude too – not all want to invest the time and resources in having a collaborative relationship, some just want to sell products; to get the highest unit price they can and be done

with it. Those suppliers run the risk of having their products commoditised though, or even having trusts switch to cheaper competitors offering so-called ‘me too’ products.

“Among the medical device companies, there is a general recognition that if they don’t look at more of a ‘service offering’, they will ultimately get more and more commoditised,” Lawson said.

The next set of savings

Both Lawson and Mr Koffman were keen to stress that there are still procurement savings to be made. Lawson was critical of the incessant focus on unit price in the national debate on hospital procurement, saying it misses important aspects like rebates from suppliers and the benefits of collaborative relationships, and that the data is often inaccurate. In the first edition of the ‘atlas of variation’ for procurement, the trust had the second biggest ‘potential savings’ in the NHS, at nearly £1.2m. But in fact, Lawson said, rebates already secured by GSTT through good procurement practice were actually bigger than the theoretical saving the trust was being told it could achieve.

Mr Koffman wanted to emphasise the balance between clinical and non-clinical items when it comes to procurement savings. He said: “The soft targets seem to be mostly clinical. We’ve saved about £10m [in 2013-14 and so far in 2014-15]. We’ve hit the soft targets, like equipment in operating theatres, sutures, drapes, gloves – the usual chestnuts. We’ve been keen to try to ‘spread the load’, because there’s an awful lot of non-clinical savings to be made as well. It’s important to make sure we don’t just pick on the poor old clinicians all the time. We also want to try to develop a better relationship with the suppliers as well.”

FOR MORE INFORMATION

W: www.guysandstthomas.nhs.uk/our-services/non-clinical-services/procurement
W: www.cookmedical.com/GSTTcasestudy