Comment

NHS procurement and the origins of the NHS PPE crisis

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Introduction

Procurement is seen by many clinicians and NHS managers as a perennial issue. This is currently being illuminated in the public domain by the COVID-19-related personal protective equipment (PPE) shortages. In this article, the authors discuss the current structure of NHS procurement and aims to elucidate the PPE crisis in the UK.

The struggle for centralisation

Recent policies aiming to centralise NHS procurement are designed to increase efficiency. However, they are subject to the success (or lack thereof) of the current procurement model.

Over the last two decades, the imperative of the UK's supply chain management has been one of efficiency. In October 2006, NHS Supply Chain (https://www.supplychain.nhs.uk) was established with the aim of centralising and standardizing NHS procurement services. Savings of up to £1.2–1.5 billion were expected each year through consolidated, centralised procurement, which was intended to reduce fragmentation and inefficiencies within the procurement system (Department of Health and Social Care, 2012; NHS England, 2013).

However, in the first 7–10 years of operation, NHS Supply Chain did not deliver to its full potential. Barriers to efficiency included the wide variation in procurement capability and capacity across different NHS Trusts, poor cost containment and inadequate relationships between healthcare providers and NHS Supply Chain (Carter, 2016; NHS England, 2013). It became apparent that the

procurement landscape needed to be simplified and rationalised, while procurement channels needed to be tailored to the specific needs of NHS clients.

A new operating model came into existence in 2018 which attempted to transform supply chain management by introducing 11 categories, known as ‘towers’, covering medical, capital and non-medical areas of the procurement spend. Each one of these ‘towers’ is facilitated by organisations known as a Category Tower Service Providers, which are contracted to act as intermediaries between the NHS and equipment providers. Some of these Category Tower Service Providers are for-profit firms, while others are collaborations of NHS organisations. For example, the Collaborative Procurement Partnership (https://cpp.nhs.uk) was formed in 2018, comprising four procurement hubs to manage three category towers.

Despite this, in 2019 consolidated procurement by NHS Supply Chain using the Category Tower Service Providers accounted for just 53% of the market share, falling short of the expected 80% (Department of Health and Social Care, 2016). Although transformations have been associated with the new operating model, it has thus become clear that comprehensive centralisation has yet to be achieved.

At present, two other procurement routes exist. The first is collaborative procurement in NHS hubs, which are not-for-profit NHS organisations providing member trusts and publicly funded bodies with strategic purchasing support and specialist knowledge across the entire health economy. These hubs hold framework agreements with suppliers, procuring products both within their towers, but also outside of towers. The second route is through direct expenditure by NHS trusts, which is likely to amount for up to 20% of overall procurement in the NHS. This involves the use of tendering systems that publish procurement notices. For example, Tenders Electronic Daily, a European company, is commonly used. It is evident, therefore, that much NHS procurement is not centralised.

A complex supply chain

The chain of contractual relations with intermediaries and providers within procurement complicates the accountability and efficiency of the supply chain. There are a wide range of actors involved in this supply chain, including multiple forms of intermediary private and public organisations, such as collaborative procurement hubs and Category Tower Service Providers. There are also many NHS organisations on the demand side. This has resulted in a series of complex contractual relationships with varying methods of determining and delivering payment.

There are also implications for increased transaction costs because of the proliferation of contractual relationships. Whereas collaborative hubs and individual organisations use tendering opportunities, NHS Supply Chain has established a chain of contractual relationships with intermediaries and providers. Such relationships add additional costs, such as those associated with reaching agreements, drawing up contracts, monitoring performance against contracts and enforcing compliance with contract terms. These contracts are enacted in the form of framework agreements or dynamic purchasing systems, probably underpinned by third-party electronic catalogues that publish procurement notices on behalf of the NHS. This method of procurement therefore exposes the NHS to the risk of inefficiency, particularly as there are multiple contracts in the supply chain.

The financial side of a new operating model is created on the basis of a commercial arrangement that allows contractors to obtain commercial margins in their supplies or provision of services, which is the way in which NHS Supply Chain has been funded. The Category Tower Service Providers are paid partially on the basis of the amount of savings achieved, but the details of

these contracts are not publicly available. Because of this lack of transparency with contracts, it is not clear how the incentives in them operate.

This contractual structure may not be appropriate to maintain quality and to achieve cost control. This is because, it is fair to conclude, implicit decentralisation has occurred: the new operating model created an additional layer of contractualised governance by using intermediaries. The result of this additional layer is a potential loss of accountability because of the increased distance between supplier and NHS service. It also makes reviewing key decisions in the operation of the NHS Supply Chain, which is heavily dependent on the Category Tower Service Providers, more difficult (Sanchez-Graells, 2018). This decentralization among various intermediaries and independently procuring NHS organisations demonstrates the limits of consolidated, centralised procurement and may be a peril to the sustainability of the national model.

Alternatively, the current model can be viewed as privatised, rather than partially decentralised. A complex web of companies distancing NHS trusts from suppliers is associated with profit-taking; the producers receive their contracts via the Category Tower Service Providers, which are paid to find suppliers, then, finally, the procured products are delivered by another company with a logistics contract (Hall et al, 2020).

Meanwhile, fragmentation takes place because of the horizontal division of the process between multiple Category Tower Service Provider contracts, with the additional complication of outsourcing some of the system to foreign private companies. The problems are particularly stark when there are multiple middlemen and the whole system starts to feed on corrupted outsourcing, cronyism and cartels, as the recent report by Hall et al (2020) argues.

Procurement during the COVID-19 pandemic

Thus far, this article has demonstrated that the pre-COVID-19 procurement picture was complicated, with many actors managing the supplier-customer relations, and with tensions around centralization and decentralisation. During the pandemic, attempts have been made to further centralise NHS procurement, but these have been fruitless because of the misalignments between supply and demand.

COVID-19 has caused an unprecedented demand on the volume and speed of delivery. Severe shortages across all health and social care settings in the UK were reported in March–May 2020 (Foster and Neville, 2020). In response, the Government initially attempted to increase centralisation in relation to PPE procurement. A new dedicated channel, launched at the end of March by NHS Supply Chain, effectively created an independent tower responsible for supplying PPE. The new system for the acute trusts started by operating a ‘push’ model, with essential equipment being issued to NHS trusts based on the expected number of COVID-19 patients they would provide care for. NHS Supply Chain also tasked the Sustainability and Transformation Partnerships (STPs) with facilitating ‘mutual aid’ between trusts and clinical commissioning groups.

Despite these attempts towards greater centralisation, the system has proved to be inadequate and prone to several problems with preparedness, manufacturing, supply and delivery. Drawing on media analysis in particular, the authors identified the five most apparent problems with the PPE supply chain during the pandemic.

First, poor preparedness surfaced when the national pandemic stockpile was found to be ready to supply only around 200 NHS trusts with PPE – enough, perhaps, for an influenza pandemic. Meanwhile, 58 000 NHS providers, GP surgeries, care homes and hospices have required PPE for

COVID-19 (Sasse, 2020). The scale of the stockpile was found to have decreased in value by almost 40% over the past 6 years, while some essential items, such as fluid-repellent gowns and visors, were not included in the stockpile (Foster and Neville, 2020).

Second, logistical problems exacerbated the crisis, particularly in terms of distribution. Unipart Logistics, responsible for NHS Supply Chain logistics operations, was partially blamed for delays, leading to Clipper Logistics and military forces being tasked with local deliveries (Hignett, 2020).

Third, the international supply shortage posed a number of problems. Several countries, including China, implemented export bans, while many shipments to the UK were cancelled or delayed. There were instances of UK orders for PPE being trumped by higher bidders from overseas (Neville and Asgari, 2020) and substandard gowns being shipped. The current procurement landscape has been likened to the 'Wild West', with some manufacturers demanding prices 10 times higher than normal for some items (Carding, 2020).

Fourth, a lack of manufacturers in the UK has meant that domestic production of PPE needed to be 'ramped up'. Meanwhile, confusion and delay occurred as the Government appointed Deloitte Consulting to run UK sourcing efforts, while over 8000 local businesses' offers to help were left largely unanswered (Hall et al, 2020). Lord Deighton, CEO of the London Organising Committee of the Olympic and Paralympic Games in 2012, was eventually appointed to coordinate the end-to-end process of design through to manufacture, termed the 'make' programme. However, successfully expediting the vetting and validating of suppliers and products is still proving challenging. Local donations of PPE and DIY manufacturing in the community are supplementing the national and international efforts, thus decentralisation has also been used to help solve the urgent problems of PPE supply (Hall et al, 2020).

Fifth, there have been mixed messages about parallel sourcing by individual NHS organisations. Many trusts have been procuring their own PPE, as well as other COVID-19 related goods, to supplement 'push' deliveries from NHS Supply Chain. At the beginning of May, the Department of Health and Social Care asked trusts to stop sourcing their own PPE to reduce competition by those trusts with the strongest purchasing departments and largest budgets. However, trusts were allowed to continue working with new, small and local suppliers, which added to the confusion among local organisations (Hignett, 2020).

Conclusions

Supply chain management and procurement are very difficult for a linked network of organisations as complex as the NHS. Centralisation has been a key goal in the NHS, but has only ever been partially achieved. The COVID-19 emergency has shown that under conditions of system stress, agile procurement is vital, and may not be well served by adherence to centralisation or by complicated supply chains.

The narrative around NHS procurement should shift from reducing 'waste' to collaborating and empowering local managers to act in risk management mode during and after health crises. There is a role for STPs, as well as for Integrated Care Systems, in providing a regional forum for procurement coordination. However, in order to do this effectively, such coordination would probably need a statutory footing.

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