

Public Accounts Committee

Oral evidence: NHS Supply Chain and efficiencies in procurement, HC 453

Wednesday 7 February 2024

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[Watch the meeting](#)

Members present: Dame Meg Hillier (Chair); Olivia Blake; Sir Geoffrey Clifton-Brown; Mr Jonathan Djanogly; Mr Mark Francois; Peter Grant; Anne Marie Morris; Sarah Olney.

Abdool Kara, Executive Director, National Audit Office, Ashley McDougall, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1 - 126

Witnesses

I: Shona Dunn, Second Permanent Secretary, Department of Health and Social Care; Amanda Pritchard, Chief Executive Officer, NHS England; Andrew New, Chief Executive Officer, NHS Supply Chain; Julian Kelly, Chief Financial Officer, NHS England; Jacqui Rock, Chief Commercial Officer, NHS England.

Report by the Comptroller and Auditor General
NHS Supply Chain and efficiencies in procurement (HC 390)

Examination of witnesses

Witnesses: Shona Dunn, Amanda Pritchard, Andrew New, Julian Kelly and Jacqui Rock.

Chair: Welcome to the Public Accounts Committee on Wednesday 7 February 2024. Today we are looking at NHS Supply Chain, and in particular at how the NHS overall uses its collective spending power when purchasing medical equipment. Supply Chain was set up to get better value for NHS trusts buying equipment, but currently they buy only 55% of their medical equipment and consumables through it; 45% is bought outside it, although, on the whole, NHS Supply Chain gets the lowest or a lower range of costs. It was set up to secure best value for money, but some trusts are not using it. We want to know why that is, what the barriers for trusts are in using NHS Supply Chain, and where it might not be the best place to purchase goods.

Let me welcome our witnesses. Amanda Pritchard, the chief executive of NHS England, and Shona Dunn, the second permanent secretary to the Department of Health and Social Care, are both frequent flyers at this Committee. They are joined by Julian Kelly, the chief financial officer for NHS England, who is also a regular attender, and by first-time attenders Jacqui Rock, the chief commercial officer for NHS England, and Andrew New, the chief executive of NHS Supply Chain. We welcome them all, particularly our new witnesses.

Before we go into our main session, we want to touch on the announcement that the Secretary of State is making in the House as we sit here, which is on dentistry and on pharmacy changes. I will ask Anne Marie Morris to kick off with dentistry.

Q1 **Anne Marie Morris:** Ms Pritchard, it is clearly very welcome news that we now have a way forward to fight the dentistry challenge, particularly after the pictures that we have seen of the queues at the new practice that opened in Bristol. As I understand it, we are talking about golden hellos of £20,000 in areas where it is much harder to find a dentist, and we are looking at a new mobile service, which is particularly welcome in rural areas, with particular interventions in schools and fluoridation.

Will it work? We tried golden hellos with GPs, and that did not work. How fast can we get the system up and running, particularly the mobile system? Everyone is anxious to see it work.

Amanda Pritchard: We have talked about dentistry a number of times at this Committee; I know that it has been very much on the Committee's mind.



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It is a really important moment that we have been able to publish a dental recovery plan today. I recognise that the Secretary of State is in the middle of giving her statement on it, so the plan has not yet been published; I believe it is coming out later today. In terms of what it covers, all the things you have mentioned are aspects of the plan, but there are some other really important elements as well.

On rapid improvement, the plan includes an incentive payment for new patients, which particularly recognises that it is about immediacy of access. If you have not seen a dentist in the last two years, that is often where people struggle the most. Introducing a £50 incentive payment is one thing we can do straight away.

We also have a number of other things in the plan, such as increasing the minimum price for a unit of dental activity. Colleagues will remember that in the last set of reforms it was increased to £23; it is now going up to £28. The other thing that was previously introduced was more flexibility in how many UDAs would be associated with more complex care. That goes some way towards addressing the concerns that the profession has consistently raised about ensuring that the pricing covers the complexity of care offered.

You have rightly highlighted something that we have all been worried about, which is those parts of the country that are under-served for access, particularly rural coastal communities. I think colleagues will recognise that what we really want for those places is well-established permanent dental facilities, but in the meantime being able to make progress by using some of the more innovative solutions that we have seen in some parts of the country.

Cornwall is one of the areas that are already using mobile vans. They do not have the full functionality that a permanently established dental service has, but they can provide important access none the less. We will now have to go through a procurement process for those units, so it certainly is not a tomorrow thing. The Secretary of State has made it clear that that is something that we will be doing over the coming year, but there are other elements of the plan that can happen much more quickly.

Q2 Anne Marie Morris: Which ones will happen more quickly?

Amanda Pritchard: Things like the incentive payment for new patients, the increase in the minimum value of UDAs, and the golden hellos that you mentioned. Those sorts of thing do not have a lead-in time; they are just about changing how the funding mechanism works.

Q3 Anne Marie Morris: That is helpful. What evidence do you have that it will work? We tried golden hellos before for GPs, and they did not work.

Amanda Pritchard: The evidence on primary care is mixed. In some places they would say that it has been helpful in attracting people to work in parts of the country that have been less well served. It is inevitably about an individual and their personal circumstances. Often it is about where people have trained and the support they get from the oral health



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team. Those will all be factors in whether an individual is willing and chooses to go to work somewhere else. The work that we have done through our chief dental officer and others has suggested that this is a meaningful enough amount of money. For some people it will be the difference that allows them to feel that they would want to go and work in one of those areas, rather than somewhere else.

As with all these things, the important thing is getting on with it, so that we start now. If it proves within the next few months that it has not started to make the difference, our commitment, along with colleagues in the Department, would be to review and see whether there is more we could do.

- Q4 **Chair:** May I pick up on that? One of the challenges is that some people have been waiting a long time to see a dentist, because they have been unable to access one. The queue we saw advertised this week is an example of that. That means that a lot of people might have particularly bad oral hygiene and particular needs. Is there anything to stop a dentist saying, "No, we're not going to take this patient on," because they worry that they will have a highly costly patient? This is an incentive, but what if they say no?

Amanda Pritchard: You are absolutely right. At the moment, the way the dental contracts work means that we are not able to compel an individual dentist to see a particular patient. The idea behind the incentive payment is to make it more attractive to see new patients, but that is also the thinking about raising the minimum value of UDAs and allowing more flexibility. For those patients who require a more complex course of treatment, the reforms to the way the contract works will unlock a higher level of payment for that patient.

Your fundamental point is right: is there a broader set of reforms that we would want to continue to work on, as a next step beyond this plan? We have always said that there was a first set of dental reforms that happened 18 months ago or so.

This is a substantial step in recovery and trying to get the current system to work, as well as introducing the next set of reforms to the dental contract. Hopefully, that does not just speak to an immediate set of challenges. There is a lot in the plan about prevention, children and young people, and trying to get upstream on the prevention side of oral health, as well as dealing with access now. We would all recognise that this is, hopefully, a foundation on which to continue to build and look at what else is needed to support industry.

- Q5 **Chair:** Colleagues from the north-east in particular have raised with me concerns about dentists who have suddenly written to people saying, "You can stay on our list for £10 a month." That is basically a subscription service, before any treatment. Those dentists have decided no longer to provide NHS treatment.

We have NHS treatment deserts. As we saw in Bristol, there was a long queue because people desperately needed a dentist. How is this going to



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help any of that, for those dentists in those areas? Mobile vans are down—how long will the procurement take? It could be a year, couldn't it, before we see a mobile van. Is that really the answer?

Amanda Pritchard: There is a lot in your question. This is a set of measures that is a substantial improvement on where we are now.

Q6 **Chair:** But there could still be deserts, couldn't there? There is nothing to stop there being an NHS desert.

Amanda Pritchard: We are already seeing year-on-year recovery of activity. It has gone up significantly. There was a big dip during the pandemic, and it has come back substantially. Last year was about 30% higher than the year before.

Q7 **Chair:** If I may say so, Ms Pritchard, the pandemic was not the problem for dentists. The pandemic added to problems across the board, but there was a gap in dentistry before the pandemic.

Amanda Pritchard: Indeed. All I am saying is that we have seen year-on-year increases in the level of activity that is undertaken in dentistry. There are clearly gaps. There is no doubt that that is a huge issue for patients, and that is why this plan is so important. It seeks to do a number of things. It seeks to address those areas where there is under-provision. It seeks to make it more attractive for dentists to treat NHS patients, full stop, and particularly to treat new patients. We have to see it alongside the long-term workforce plan, because that is the other really big component of this. Exactly to your point, it is about making sure that we are training enough dentists—and not just dentists, but the oral hygiene team.

Q8 **Chair:** That is all longer-term. We know that it is important—we recognise that—but what about today, here and now? If a dentist has enough private business, even this will not incentivise them suddenly to take an NHS list, will it?

Amanda Pritchard: This will certainly remunerate them at a higher level for doing NHS work than they were remunerated previously. Far be it for me to comment on the local economics of running a practice, but we have been told consistently—Shona might want to talk about this too—that the complexity of the patients coming forward means that there is a need to ensure there is a different level of remuneration for NHS dental care. This plan goes some considerable way towards addressing that and making it more attractive for dentists to see new patients. We have heard very clearly what the real challenges are for patients.

Chair: Absolutely. We hear that in our case loads.

Shona Dunn: Just to add to what Ms Pritchard said, the combination of the new patient payment and the increase in the minimum UDA value is key—it is the core of the plan. We believe that it will drive additional appointments and therefore create the capacity that people are struggling with at the moment.



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- Q9 **Sir Geoffrey Clifton-Brown:** Good afternoon, Ms Pritchard. The dental profession has greeted the Secretary of State's announcement this morning—such as it was—by saying that the increases are not going to cover the cost of each treatment. If that is the case, will the incentive payments work for taking on new patients, or are we going to create a two-tier dental system whereby dentists take on people who have relatively good oral health, but take one look at somebody who needs 10 fillings and decide that they will lose money on them, so there is no incentive to take them on?

Amanda Pritchard: The changes that we made to the UDA remuneration mechanism, to allow people to have more flexibility and basically charge more for more complex patients, were introduced as part of the previous reform, and now the remuneration for each UDA has gone up a bit. Of course, that accumulates quite a lot when you are talking about the most complex end of care.

Shona talked about our premium for new patients. Our best evidence suggests that, while some patients will cost a bit more, some patients will cost a bit less. This should address the challenges that we have been grappling with, jointly with colleagues across the profession. It should ensure we have a fair but reasonable level of remuneration, so dentists do not see NHS work as something they do not want to do. Most dentists do a bit of both: some private work and some NHS work. Some do just one, or just the other.

The change has a range of elements in it, including prevention, accessing treatment and workforce and contract reform. Taken together, they are a really important step forward in trying to address the real challenges that we all recognise in dentistry.

- Q10 **Olivia Blake:** I have a chipped tooth and am struggling to find NHS treatment for it; I had two appointments cancelled, and my practice is no longer NHS. It is very frustrating for patients up and down the country. I am interested in what you are going to do to bring experienced dentists back to the NHS. Commercial dentistry pays so well, and it is not just new dentists we need, but those with experience of complex cases.

Amanda Pritchard: There is always a challenge for dentistry, because cosmetic dentistry in particular is highly remunerative and is not paid for as part of NHS care. I come back to my point about why the long-term workforce plan is so important. The reality at the moment is that until we are training more dentists and allowing other members of the oral health team to work at the top of their licence, we will have a demand and supply problem in some parts of the country.

That is why everything that we are doing in the long-term workforce plan is so important, and why in the short term we hope that these other measures will mean that dentists that have chosen to step out of the NHS will now reconsider coming back in and either rejoining the NHS or, more likely, doing more care on the NHS. As I say, most do a bit of both, and



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we are hoping that this will make it more attractive for people to do more of the NHS work.

Q11 Olivia Blake: When will you review the contracts more fully?

Amanda Pritchard: There has been ongoing engagement for at least two or three years on looking at ways that we could change—

Chair: I think Ms Blake was asking: is this it, or is there going to be more to come on changing the contract?

Amanda Pritchard: This is a big package of change.

Q12 Chair: Is this the final review?

Amanda Pritchard: We want to see how it works, but nothing is ever final. This is a really big set of measures—there is a lot in it, and it is complex—so we certainly would not want to make change before there had been an opportunity to evaluate properly. Equally, there was a clear view that what we needed to do with this plan was really address recovery in the immediate term and put some of the foundational building blocks in place, but absolutely with a view to looking again at what more we could do to strengthen dentistry in the longer term.

Chair: Thank you. We will leave it there for now, but we all have constituents who are very concerned. When they have to have emergency dental treatment, it costs the NHS and the taxpayer more. Many constituents are in that bracket—if they are lucky enough to get that, frankly. Anyway, we will move on to pharmacies.

Q13 Anne Marie Morris: Pharmacy First is a great initiative for pharmacists to be able to prescribe in, I think, seven key areas. What are you doing to monitor the success of the scheme? You have a website; are you tracking how often people are clicking on it to try to find somebody? I am pleased that there are something like 200 in Devon, which is wonderful, but without KPIs and without measuring uptake, we will not know whether or not it has actually worked. How will you evaluate the success of the programme and the uptake, hopefully to incentivise other pharmacies to do likewise?

Amanda Pritchard: Thank you for your support for the initiative. It is a really exciting step in the development of community pharmacy and in the recognition of the highly skilled support that community pharmacists can provide. They have already done a lot to increase a number of things such as blood pressure checks. The initiation of oral contraception is something that we announced just before Christmas. This is the next really big moment. You are right that there are seven key areas.

At the moment, 94% of pharmacies have signed up to be part of the scheme. It was 90% when we announced it and it is still going up, which indicates support from the profession and from the community pharmacy sector for the scheme.



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We will be able to track volumes. There will be a lag time on that, because of the way the data feeds through from the community pharmacy systems into the payment systems, but we will be able to see exactly how much activity is going through the Pharmacy First scheme, and we will be able to report back on that in due course.

- Q14 **Anne Marie Morris:** And will that be divided up into seven key areas, so that you can see not just volume but where the volume is?

Amanda Pritchard: We will certainly be able to see that by geography and by practice. Do you mean by condition?

Chair: By illness.

Amanda Pritchard: I don't know the answer to that, I'm afraid, but we can come back to you on that.

Anne Marie Morris: Thank you. That will be very useful.

- Q15 **Chair:** Briefly, before we move on to the main session, community pharmacies pay business rates, but those based in GP practices do not, so there is a bit of an imbalance there. Is that something that is on your radar, Ms Dunn?

Shona Dunn: We are conscious of it. I will be honest—I don't know whether that is something that we are looking into, but I am more than happy to take that away and find out.

- Q16 **Chair:** Could you, please? If the pharmacy is going to be used more, some have a retail outlet as well, so there is an inequity there that might dissuade. In some areas of the country there are pharmacy deserts or very few pharmacies.

Shona Dunn: To Ms Pritchard's point, the fact that 94% of community pharmacies are now signed up shows that this is a fantastic—

Chair: This is separate from that initiative. This is just the cost of running a pharmacy. They are going to be an increasingly important part of the NHS, which I think we all welcome, as Ms Morris said. That is just a point that I wanted to ask about.

We will now move on to NHS Supply Chain. We will need slightly shorter answers. We are obviously very interested in dentistry and we were happy to indulge on that issue, because we all want to know what is going on in dentistry, but how NHS Supply Chain works is quite a tightly defined issue, so if you could listen to the question and answer it, that would be very helpful. Over to Jonathan Djanogly.

- Q17 **Mr Djanogly:** We will start with the NHS oversight and direction of its supply chain. I refer to paragraph 6 of the NAO Report: "Supply Chain was created as a national body through which NHS organisations could voluntarily make use of their collective purchasing power. There are legal barriers that prevent mandation... Trusts remain largely free to buy directly from suppliers or through other sourcing organisations, outside of



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Supply Chain,” meaning the Supply Chain organisation. Ms Pritchard, why do trusts spend £3.4 billion buying products outside the more cost-effective route of the Supply Chain organisation?

Amanda Pritchard: Do you want me to answer this, or do you want me to hand straight over to—

Mr Djanogly: I would be delighted for Ms Rock to answer the question.

Chair: Your début!

Jacqui Rock: Thank you. Procurement in the NHS is on quite a journey at the moment in terms of some of the actions that I and Mr New have put in place over the past couple of years to really start buying as an NHS community, leveraging that buying power. Hopefully, I will get the chance to explain some of the things we are doing.

Specifically to your question of why trusts are still buying £3.4 billion outside, there are a few reasons. First, when we set up NHS Supply Chain, it was a very deliberate decision to set it up as a voluntary organisation. We wanted to make it so compelling—this is the idea—that trusts would not go elsewhere. It is the same process that the Crown Commercial Service has across the rest of Government. We gave people the freedom, within the public procurement rules—that is really important; they cannot go off to buy however they wish to buy, and still need to be under our Government/taxpayer money procurement rules—to go out and buy elsewhere.

Within our legal capabilities, we cannot mandate foundation trusts to buy through NHS Supply Chain. Again, that was part of the decision to make it voluntary. What is really important now is to come together as a community, with all the different initiatives that we are starting, so that not only is it compelling, but our ICS leads—

Chair: Integrated care systems, to be clear for people.

Jacqui Rock: Yes—apologies.

Q18 **Mr Djanogly:** What is compelling? What do you mean by “compelling”?

Jacqui Rock: What is compelling to buy through Supply Chain? It is all about leveraging market costs and finding those costs at a cheaper price. It is for the greater good, I guess. It is about the logistics that go with this, so it is the service that NHS Supply Chain provides in terms of how you order something and how you get it from the supplier into your hospital every day. It is about that partnership, as we work together on looking at those category interventions and new innovations to bring things forward. That is what should make it a compelling—

Q19 **Mr Djanogly:** I think you are saying that compelling means cheaper and faster. Let us look at cheaper. Ms Rock, when you say the Supply Chain organisation is more cost-effective, can you tell us what the savings would be if the NHS used only Supply Chain?



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Jacqui Rock: So—I am just trying to think of the best way to answer that question. When you buy in bulk, especially when you are buying what NHS Supply Chain buys, which is medical devices and consumables—it is slightly different depending on the categories—you will become a market maker. You will be able to leverage your spend, and therefore be able to push down the prices. Some of the modelling that the NHS Supply Chain team is doing is to model some of those categories to see what the additional savings would be if the £3.4 billion went through Supply Chain.

Q20 **Mr Djanogly:** You cannot actually say how much they would be.

Jacqui Rock: Mr New has some numbers.

Andrew New: Let me point to figure 11 of the National Audit Office Report, where we set out where the opportunities were. A number of elements make that up. Fundamentally, implementing what is available today, we estimate between £60 million and £90 million of opportunity—that is the implementation of today's arrangements, prior to going back to market to secure improved pricing in the future, which then cascades into later years. So figure 11 is probably the most important.

It is also important not just to buy the same product for a lower price but to have a conversation about buying the most appropriate product that will have the best impact on clinical time or patient outcomes—things that may drive different types of efficiencies into the NHS. Those are covered in other lines of the table.

Q21 **Mr Djanogly:** The appropriate product will not always be the cheapest product.

Andrew New: Correct. There are times when the impact on clinical time will be far more valuable to the system than having purely the lowest-cost product, and that varies hugely by category. Some areas are very commoditised activities where the lowest price is hugely important. In other areas, innovation is far more valuable, and therefore driving the right way of caring for a patient is very important.

Q22 **Mr Djanogly:** Do you monitor whether the appropriate product is actually appropriate in terms of the cost?

Andrew New: We implement projects with the trusts to identify the transition that is needed. We do that on a project basis: we might identify an area where sutures may be transferred to glues, which may deliver better outcomes for patients. We would work in partnership with trusts to deliver that, and that unlocks a saving for them.

It is very difficult for us to say remotely, from the centre, that they shouldn't buy a particular product, because we don't know what the exact use case is. Clinical decision making at the point of care is fundamental to delivering exceptional patient care.

Q23 **Mr Djanogly:** Okay, but if £3.4 billion-worth of equipment is being bought outside your system, is the Supply Chain organisation working?



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Andrew New: That is a fantastic question—thank you. The way I would describe it is that, for the capacity and capability that we have today, the teams are working well together to implement opportunities to save money for the NHS and drive better outcomes.

We have moved from 30% or so in 2018 through to what we expect to be around 62% to 65% at the end of this financial year. That is significant growth, but there are a number of operational reasons why we don't want growth to be too quick. We are aware that we are capacity-constrained, particularly in the south of the country, out of Maidstone and Bridgwater specifically; additional volume to be transacted would be challenging to deliver. We need to improve our infrastructure and modernise our technology before we want to see that growth. We very much manage the process through, and we are utilising the capacity to maximise that return investment with each trust. So, although we might have a list of projects that we would like to implement immediately, there is not the capacity to immediately do that.

Equally, there are areas where trusts have existing contract terms in place: they have bundled arrangements, outsourced procurement, or different technology that they have embedded from a capital perspective that needs different types of consumables in order to work. There are a whole host of truly detailed operational reasons why we cannot just move from the position that we are in today to a utopian position in the future.

Q24 **Mr Djanogly:** I get that, but, on the other hand, this has been going for, what, five years, and you still have this huge amount of stuff being bought outside the system. I don't see whether the system is adaptable enough to cope with that.

Andrew New: As it stands, we do not have the ability to move the scale quickly. That is one of the things that we, as an organisation, have identified. To perform to our maximum, we know that we have to be different in the future than we have been in the past.

Q25 **Mr Djanogly:** Okay. The second aspect of the compelling case that Ms Rock was making was faster service. Could you please give me some information on the speed of supply? Do doctors get a shorter service, on the whole, with Supply Chain? Is that something that you measure? Does the size of order make a difference?

Jacqui Rock: I will pass over to Andrew, but the answer is yes, because of the logistics that NHS Supply Chain provides from the point of order to the point of delivery. Of course, there is variation depending on market availability, but we have the proven case that the logistics behind that work. There are trucks that go up and down the country 24 hours a day, delivering these medical devices and consumables to the frontline. Our ordering process and the speed of delivery are measurable and proven.

Do you want to add anything, Andrew?

Andrew New: It is important to say that we work through three delivery channels. One of those is where we stock products within our physical



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network. We hold around 12,000 core products in stock. Those are typically lower-cost items that are consumed on a very regular basis. The delivery service level for those is exceptionally high—in excess of 99.8%, as it stands today—and the number of unavailable products has recently dropped dramatically with the normalisation of supply chains around the world.

Q26 Mr Djanogly: What is “recently”?

Andrew New: In the last six months, there has been a significant improvement in availability. I think we were at 5,500 mid-pandemic, and it has now dropped to around 700, which is equivalent to where it would have been in 2017-18, so we are back to a normal level of change. That typically is regulatory activity, certificates expiring, or something that is quite operational in nature but is manageable by the system.

Where we can stock products, performance is exceptionally high. We hold between five and eight weeks of stock centrally. Therefore surety can be given to the system: those products will always be available. An order received by us on day one normally would be delivered on day three, so it would be a quick response and certainly in line with what is needed locally. Typically, hospitals will hold two or so weeks of those products, so there is quite a lot of resilience in the system.

Q27 Mr Djanogly: How long will it take for them to be delivered to the hospital?

Andrew New: If they are ordered on a Monday, they will typically be delivered on a Wednesday. We have delivery days agreed. In the centre of a town, it might be middle-of-the-night deliveries on certain days. There are some operational constraints.

The more challenging areas are items that we do not stock, where we are reliant on the suppliers’ performance through their own supply chains, and that will be broadly the same whether they are coming through the NHS Supply Chain contracts or directly for trusts. We have a consolidation service, which should be a hugely valuable part of what we do, but we are constrained by space to manage only around £100 million-worth of products through that channel. This is where we receive them and then put them into those consolidated deliveries and send them through—so they are very easy to receive at the other end—or it is on the direct-from-supplier-to-trust basis, where, again, stock holding is typically quite resilient. They tend to be higher-cost items and there tends to be joint expediting management. That is the area in the NAO Report where it talked about 25% of products being 22 days late. Again, in recent times, that has moved to only 8% of products being eight days late. It is still not good enough, but there is material improvement as those supply chains are starting to work together better globally.

Q28 Mr Djanogly: I want to take you through a scenario that I came across. This is from just before covid, so hopefully it has all been resolved by what you are going to tell me. I was speaking to a private company who do consultancy work for trusts. They will go in and advise on supply



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chains and also storage of product in the hospital, and they were telling me of consultants who basically decide that they like something that is not on offer through your organisation and so they just want to buy it themselves, or they could not get it fast enough, and that often when they did buy it, they would buy not just one of the thing but a few of the things, and therefore you would go into the hospital and the cupboards would be packed full of old, out-of-date stock and frankly it was really unimpressive. Are you telling me now that if I went into a hospital, I wouldn't see that any more, or, more productively, what are you proactively doing to stop that happening?

Andrew New: Clinical preference is a fundamental point here. We need to ensure that a range of products is available for clinicians to choose in order to care for a patient. We are not looking to constrain that choice where warranted variation exists, but then we are working with the system to reduce unwarranted variation in product. Individual clinicians do have preferences for individual products, because they have their own evidence for their use across the system. There are 600,000 products currently available through the NHS Supply Chain catalogue and 250,000 outside the catalogue, so we have the vast majority of products covered, in terms of a route to buy them, and frequency of purchasing tends to be low in outliers; 147,000 products are bought in any three-year period, so there is a long tail of one or two purchases. If a clinician asks their local procurement team to go and buy a particular product from a particular manufacturer, they will normally come to us first to assess whether it is available through our channel. If it is not, they will go and buy that product directly, to fulfil the needs of their clinician locally.

We have started working over this year, with the support of NHS England, to implement greater visibility of inventory being held in hospitals. As part of the inventory management implementation programme, where we intend to implement 18 to 20 over the next two years—

Mr Djanogly: This is a standardised—

Andrew New: This is a standardised product that will give us visibility of what stock exists.

Q29 **Mr Djanogly:** At the moment, there are many inventory products, aren't there? So how are you going to standardise them?

Andrew New: We have selected a small number of different products, but to be implemented in the same way. We need resilience across the software side as well as the hardware side of what we do. We have implemented a standard way of working and a standard data model such that, as it is implemented in each one of the, typically, hospital trusts, we will be able to extract the data on what is actually available and utilised, including batch management and dates. So the ability to move products within the system in a more collegiate way will become possible, but the benefits of that won't be seen until 2026-27 as we build this network that can work together.

Q30 **Mr Djanogly:** Will trusts effectively be forced to use the system?



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Andrew New: They are not being forced to use the system, but all of them wish to. We put out a call for interest in the middle of the last financial year and asked who would like to participate. We had over 100 trusts saying, "If we can get this, we would love to." There is absolute appetite, but there are limits to resources to manage that change both locally and centrally, so we have to work it as a programme in a sensible way.

- Q31 **Mr Francois:** Ms Rock, on page 5 of the NAO Report, in paragraph 3, it says that the key objectives for NHS Supply Chain "were, by 2023-24, to deliver £2.4 billion of savings and achieve 80% of relevant NHS spending on medical equipment and consumables (known as 'market share') through Supply Chain." It also says that the organisation "oversees a catalogue of more than 600,000 products" and "has an annual operating budget of £240 million for 2023-24." In layman's English, for every £1 it costs to run NHS Supply Chain, you are hoping to save £10. Is that correct?

Jacqui Rock: That was the original—when we were looking at the market share and the way that we were calculating savings that is documented in the NAO Report.

- Q32 **Mr Francois:** Good, so we are clear on what you are aiming to do. Really, the point of this whole session is to see whether you are doing it. On that basis, how many people does NHS Supply Chain employ?

Andrew New: NHS Supply Chain is a complex organisation and we have a number of service providers that work with us. There is a layer of SCCL—Supply Chain Coordination Ltd—which is the management layer, and then there are a number of procurement service providers that employ individuals to work on our behalf, and our logistics provider and our technology provider. If you look at the entirety of the model, the number is about 4,000.

Mr Francois: Four thousand people.

Andrew New: Four thousand. If you include just the SCCL management layer, including all the procurement of clinical devices and medical technologies, it is around 1,100 people in total.

- Q33 **Mr Francois:** I only ask because I tabled a parliamentary question about a fortnight ago to ask the Secretary of State for Health and Social Care how many full-time and part-time NHS Supply Chain employees you had. The reply that came back yesterday was: "The Department of Health and Social Care has indicated that it will not be possible to answer this question within the usual time period. An answer is being prepared and will be provided as soon as it is available."

Chair: We should have just asked you, Mr New.

Mr Francois: Yes, we should. By the way, I also tabled a question to ask what the salary cost of NHS Supply Chain was, and I got the same answer. I also tabled one to ask how many full-time staff were employed by NHS Supply Chain in the financial years 2020-21, 2021-22 and 2022-23. I got:



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"An answer is being prepared and will be provided as soon as it is available." Well, clearly it should have said in brackets, "After the PAC hearing has taken place."

Chair: Yes, Ms Dunn, it might have been wise for your parliamentary unit to clock that Mr Francois is a member of the PAC.

Mr Francois: Ms Pritchard, please don't play that game again.

Chair: It was not Ms Pritchard; it is Ms Dunn who is at the Department of Health and Social Care.

Mr Francois: Forgive me. Ms Dunn, please don't play that game again.

Shona Dunn: I will take that point back, Mr Francois.

Q34 **Mr Francois:** So it is up to 4,000, all ranks, full-time equivalents, yes?

Andrew New: Yes.

Q35 **Mr Francois:** Thank you very much. In terms of usage, one of the objectives was 80%; I think you, Ms Rock, said that your intention was to provide trusts with a compelling offer. My local acute trust is Mid and South Essex. I have made some inquiries, and they currently source about 25% of their products and consumables by Supply Chain, so they are about 75% uncompelled. There are some trusts in the north of England that procure barely 10% through NHS Supply Chain, so they are 90% uncompelled. Why are those figures so incredibly disappointing when your target is 80%?

Jacqui Rock: There are a few reasons for that, which I will explain. As I said, we have that variation, especially in some of the smaller trusts where they have historically had relationships with suppliers direct and they are continuing on that path because they feel that they get a very direct, personal service from that supplier. Historically, quite often in those trusts they get one-off deals that have been continuing. There could be different levels of on-cost additions and delivery from what they are getting from NHS Supply Chain. Sometimes—

Q36 **Chair:** So there are different levels, and it is cheaper to buy it from their current supplier.

Jacqui Rock: If they have got a one-off deal with them, yes indeed, because they have the right to do that.

Q37 **Chair:** So it is the on-costs from the supply chain that might be adding too much.

Jacqui Rock: Correct. Sometimes, suppliers that they like working with have not been willing or have not met the criteria to be on the SCCL—the NHS Supply Chain sort of catalogue.

Q38 **Mr Francois:** Do you mean that some of those suppliers provide them with a good service, so they want to stay with them?



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Jacqui Rock: Yes, that is sometimes the reason. We have been dipping into the reasons why; we are looking at why there is that sort of non-compliance, and why people are not compelled—

- Q39 **Mr Francois:** You said this tends to be a pattern particularly among some of the smaller trusts. I think Mid and South Essex is the fifth-largest trust by budget in England. They are not a small trust, are they?

Jacqui Rock: No, they are not.

- Q40 **Mr Francois:** I could quote you some other trusts that are extremely large with very small percentages as well. Your thing about it just being the smaller ones that do it this way is not quite right, is it?

Jacqui Rock: Again, we have done the spend comparisons, but it is that culture of how a particular trust has been doing its procurement for many years—

- Q41 **Mr Francois:** You mentioned culture—I am sorry to cut across you, but we never have enough time in these hearings; Ms Pritchard is familiar with this. No disrespect is intended.

When I speak privately to some of the clinical staff in that trust and elsewhere, they basically say that this new system is massively bureaucratic. It takes far longer to get what they need than when they did it the old way. They spend far more time arguing with procurement officials about what they are and are not allowed to buy. A lot of the stuff they want to buy turns up late. Sometimes when there are emergency situations, if they have not got stuff immediately in stock in the hospital and a patient is in a life-or-death situation, they cannot go through NHS Supply Chain because they know that by the time it turns up, bluntly, the patient will have expired. When I speak to clinical staff, I have to tell you that they are deeply cynical about the value of NHS Supply Chain at all.

Jacqui Rock: I am going to ask Mr New to explain it. Some of the potential reasoning for the dissatisfaction with the process—

- Q42 **Mr Francois:** With respect, I have just given you about four. Sorry, Ms Rock, but to save time, I don't need to have the dissatisfaction explained to me. In prep for this, I spent a lot of time talking to clinical staff. These are people who make sick people better—not officials. I have just given you the reasons, so I don't need to be told again what the reasons are. I want to know why.

Andrew New: It is a fantastic question.

Mr Francois: Thank you very much; I'm glad I turned up.

Andrew New: The experience that you have had is different from the experience that I have had. Clearly, that is something that I need to—

Mr Francois: I am just talking to doctors, nurses and clinicians.

Andrew New: And they are the same conversations that I have with those people every week. There is a difference between "Is the thing that



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they want available or not at the point when they need it?" and "Is the NHS Supply Chain doing what it is being asked to do by the local trust?"

I am surprised at the share number being that low. The information I gathered before today suggested it was materially higher, and I wonder whether there is a scope question. I would be delighted to meet with the local trusts to understand where their challenges are. When I met with groups of clinicians in half a dozen or so hospitals in the last two or three months, they generally suggested that the items they are looking to buy are available, and that when they need them, they do arrive. I need to spend some time—

- Q43 **Mr Francois:** I don't want to hog the wicket, but Mid and South Essex trust asked me to ask you one question. In return, I am going to ask you exactly that question: "Are NHS England going to increase the number of frameworks that the NHS trusts are mandating us to use for products and services, and how will trusts be involved in agreeing those specifications?" I have now kept myself honest.

Jacqui Rock: I can absolutely answer that. We launched a new process in summer last year where we looked at all the frameworks available. A framework is a process of where you can buy a predetermined product or service, and there are over 1,200 of them. Quite frankly, there are too many frameworks; some are in competition with each other and there are a lot of different framework hosts. It has been one of my personal objectives to—in my language—get a grip of the frameworks.

We have got our central commercial community, and I have been working with all the chief commercial officers of all the individual trusts to make sure we do this in partnership across the NHS, rather than just from NHS England, down. First, we have reaccredited all framework hosts, and that was launched yesterday on the NHS hub. That means that from 1 April you will not be able to buy off a framework where the host has not been accredited by NHS England. What we have seen as a result is that quite a lot of framework hosts that were sort of on the periphery, or whose frameworks were in competition, have now ceased.

- Q44 **Mr Francois:** You said that you did not want to mandate this, but wanted it to be compelling. Now you are saying that from 1 April you have got to buy from one of those frameworks, or else. That is compelling, isn't it? Sorry—that's forcing people. What is the difference?

Jacqui Rock: Buying from a framework is different from being compelled to use NHS Supply Chain. Anyone can set up a framework, technically speaking—any third company can do that. We are putting in place criteria to make sure they meet the right legal and financial obligations to spend taxpayers' money.

- Q45 **Mr Francois:** So there will still be frameworks via other suppliers?

Jacqui Rock: Yes, absolutely. We have accredited 20 framework hosts.

- Q46 **Chair:** Thank you very much, Mr Francois. I want to ask about the staff numbers, Mr New, before we move on to Anne Marie Morris MP. You



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signed off your accounts in December last year saying that the average number of employees over the year was 686, including 99 agency and temporary staff. However, you gave a different figure to Mr Francois. Can you explain the discrepancy?

Andrew New: Of course.

Q47 **Mr Francois:** It will save us from tabling a lot of parliamentary questions.

Andrew New: We have the SCCL, which is the legal entity, and those numbers relate to the SCCL legal entity. We have a number of service providers who work on a dedicated basis to us, and the total number of 4,000 includes those service providers as well. All the warehouse operatives, for example, are employed through a service provider, and they manage the operational delivery of that activity. This is the difference between the subtlety of the model—

Q48 **Chair:** To be clear, are they private sector employees working to you?

Andrew New: They are private sector employees working to us. However, over the last 12-month period we have transitioned around 600 employees from external procurement bodies into the SCCL layer. The number of 686 is a transitional node between the two. If you bring it up to date today, the number is around 1,100 equivalent in that SCCL layer.

Q49 **Chair:** Thank you; it is helpful to have that made clear. I now call Anne Marie Morris MP, who has a declaration to make.

Q50 **Anne Marie Morris:** I do—you are absolutely right. I am chairman of the all-party parliamentary group on access to medicines and medical devices.

This is an area of particular interest. I have listened with interest to what has been said, and I have to say I think I am as unhappy as the rest of my colleagues. I think it would be helpful first of all for me to understand a little more about what sorts of devices can be included.

Devices are effectively categorised into four groups, subject to risk, and the highest risk are the in vitro diagnostics. On this, you are presumably trying to manage the uptake of the low-risk and medium-risk and not the high-risk—would that be right? Just so I understand what we are talking about in terms of the devices that we are putting up on Supply Chain.

Andrew New: The range would be all those medical devices.

Q51 **Anne Marie Morris:** From all four categories?

Andrew New: Yes, all the way up to implantables and IVDs.

Q52 **Anne Marie Morris:** Okay. Do you measure in each of those categories what the level of uptake from the different trusts is? I am guessing the uptake is going to be lowest in the high-risk ones and highest in the low-risk ones.

Andrew New: We do, and that is not necessarily the case. I will take a very vast generalisation here; we have 200 independent trusts doing this.



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The NHS Supply Chain tends to be the only real route to buy higher cost devices in a consistent way. Therefore, we actually have a higher share in orthopaedics or cardiology-type devices than we do in some of the consumable elements, where they can buy bulk deliveries to be delivered locally.

As I said before, we have this constraint in capacity, which really talks to that consumables element, and therefore we can grow the medical technology end much faster than we can grow the consumables. Over the last five years, medical technologies has gone from £600 million to £1.6 billion as a managed spend, as we have worked with trusts to implement commercial arrangements to manage that area.

Q53 Anne Marie Morris: That leads me to another question. If it is the more complex, higher-risk ones that are getting better take-up, how do we know that they are actually buying the right things? Let me explain.

In talking to cardiologists and others, I have certainly been lobbied regularly on the challenges. For example, with implantable valves in hearts, you need a special size and shape specifically for a child, and those are different. A number of the trusts are simply refusing to stock those, which, to my way of thinking, does not make much sense.

Likewise, catheters—now that is not high risk, but if you have the wrong size catheter, that is not good news and a number of hospitals seem to have a one-size-fits-all approach. It worries me that, in trying to force economies of scale, you may be compromising either the comfort or efficacy of the patient treatment. Does that concern you? Have you actually looked at the buying patterns and whether that is a risk?

Andrew New: I understand the risk. The catalogue currently available for cardiology, for example, has over 90,000 different products that can be used. We do not constrain choice in cardiology products because we recognise the need for a clinician to make that expert choice. We may constrain choice around examination gloves to just a few different manufacturers where we can manage supply and demand in the most appropriate way to drive cost efficiency.

Mr Francois: That is not correct.

Chair: Mr Morris is asking questions and Mr New is giving his own answers. Mr New, carry on.

Andrew New: I do not believe that we have reduced range across those diagnostic or medical technology areas in a way that would promote that activity, but we do not monitor the use of a product from the centre. If a trust were to buy five different catheters and another trust one or two different types, we do not monitor their performance. We are interested in ensuring that we are buying the right product for the right price to make it available for them to then use, based on their own clinical choices.

Q54 Anne Marie Morris: I get that, and that is what worries me. This cannot just be about money. I appreciate that your remit and job title, if you like, is about money, but we are concerned about the patient experience.



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I appreciate that you are going to tell me that it would be very difficult on a trust-by-trust basis to work out how it is used, but none the less there must be patient records and there could be some sort of semi-regular audit. It seems to me that the link between money and patient outcome is mission critical, and I cannot see the measurement between the two.

Andrew New: NHS Supply Chain's responsibility is far broader. It is not just about money, but resilient supply chains, the environment and sustainability. There is a whole range of things that we have to do to support healthcare, and we have to ensure that we have always got available products that are safe for use by clinicians. That choice is in the clinician's hands. I do not know if there is a colleague from NHS England—

Q55 **Chair:** There is a very valid point here: maybe it is the job of the Supply Chain to do one thing, but the impact on the patient is pretty critical.

Amanda Pritchard: I think there is a really important point here, which is what I think Mr New was saying. The job of the Supply Chain is to ensure that the procurement of the catalogue is done according to all the best practice principles that Mr New has explained. It is up to the trusts what they buy. Actually, there is a really important question, but I do not think it is a question to Mr New; it is probably a question to the leadership of a local trust.

Q56 **Chair:** But what about the overarching nature of NHS England?

Amanda Pritchard: If there is a question about what is being bought locally, and if local decisions have been made to constrain choice, usually—in my experience—that will be because there has been a clinically-led process that has reviewed what is being used, and they will have been through a process to agree to call off a smaller catalogue. But I have not personally talked to each trust to work out whether or not that is the process they have been through, and that is what you are describing.

Q57 **Anne Marie Morris:** So what you are telling me is that there is a complete disconnect: there is Supply Chain, which buys the product, and then how it is used is entirely down to the trust. You at the top—NHS England—do not look at the connection between the two.

Amanda Pritchard: We do not constrain local clinical decision making; that is not the role of NHS England. It is up to local trusts and clinical decision making locally as to what they want to buy for their patients. The role of Supply Chain is to make sure that those products bought through it meet the good practice and value for money criteria, and it is right to focus on things like speed of delivery and so on.

Q58 **Anne Marie Morris:** I hear you loud and clear, but my concern remains that, even at the top, there is no connect between the quality, the outcome, the clinical experience and the money—how little we can pay to get what is needed. I am not asking you for more, Ms Pritchard, because I think you have told me all that you can, so let's move to the monitoring process.



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Amanda Pritchard: Except that Mr New did say earlier that, of course, money is not the only criterion used to enrol on to a framework. The quality assessment, which is part of what Supply Chain do, is equally important, if not more important. At times—we can probably give examples of this—local trusts are not choosing the cheapest product. What they are choosing is the right product for their patients.

Anne Marie Morris: We are still beside the point. You are talking about the quality of the product, not the patient outcome. Anyway, I will leave it there.

Chair: Let me bring in Mr Francois briefly.

Q59 **Mr Francois:** Ms Pritchard, what you have just told the Committee is literally true, but what goes on in practice is that trusts game the system. In simple terms, if a consultant uses product A, NHS England reimburses the trust, so there is no net cost to the trust. But if the consultant chooses to use product B, the trust pays for it and is not reimbursed by NHS England.

So what happens in the real world is that if a consultant, based on their clinical expertise, looks at a patient and says, "I need to use product B," the finance department object and the consultant ends up having a shouting match with the medical director of the hospital—while the patient is still waiting to be anaesthetised—about whether or not he can use product B, with the medical director insisting that he use product A because it does not cost the trust any money, as they get reimbursed by NHS England. This happens in NHS hospitals every day of the week, doesn't it?

Amanda Pritchard: I hope that there aren't shouting matches between members of staff every day of the week, because that would worry me for a whole number of different reasons. But you are absolutely right—

Mr Francois: Sorry—this tension happens every day of the week.

Amanda Pritchard: You are absolutely right that there are some specialised high-value products, which have been led by our clinically-led specialised commissioning team. They have been designated through their best practice work as being those that are part of a reimbursement model. There is always the freedom locally to go outside those arrangements.

Q60 **Mr Francois:** For the record, they are called HCTEDs—high-cost tariff-excluded devices. What you said was true: it is ultimately the trusts' decision, but the consultants are put under massive pressure by the trusts' finance departments to use those products, which have no net cost to the trust, rather than something that might be clinically far more suitable, but which the trusts "have" to pay for. That is what goes on, isn't it?

Amanda Pritchard: There is a clinical process that the specialised commissioning teams have been through, which is led by James Palmer, whom you may know as a Committee—a very experienced clinician. His team of clinical experts have, over the years, with support from people



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like Tim Briggs and the Getting It Right First Time team, established a really clear evidence base around what is usual best practice for those highly specialised areas. That is definitely where they have tried to say, "Okay, if we can establish that for the vast majority of clinical cases, this is going to be clinical best practice, we absolutely want to make the link with Supply Chain to make sure that those are the things that are being purchased according to best practice and delivered."

But the important point that you have raised, Mr Francois, is that there must always be a local exception arrangement. Even if it fits 99% of the time, we will always have to have an arrangement for that 1% where there is clinical flexibility to go outside that. So that is absolutely right, but I will take back your challenge. If it is as common as you are suggesting—

Mr Francois: It is.

Amanda Pritchard: That is not my experience, but we should absolutely have a look at that. Perhaps you will allow us to come back to the Committee on that.

- Q61 **Chair:** Indeed. Just to finish off the point that Ms Morris was highlighting, whatever happens in a hospital—you are saying that clinicians have their own freedom within the caveats that we have outlined—do the clinical leads at NHS England at any point look at the clinical outcomes of using different types of products or aids on individual patients, and whether they are any different? Is there any analysis done? You say that trusts do it for themselves, but what about the aggregate? If there is a difference, it is important that we know. It may be that widget A and widget B in many cases are doing exactly the same thing, but widget B costs a lot more. If there is no clinical difference, you can see that that might be an issue. But if there is a clinical difference, who is assessing that aggregately?

Amanda Pritchard: That is part of the conversation we have just had. In these highly specialised areas, that has been part of the work that has been taking place.

- Q62 **Chair:** Are they doing it on a continuous basis so they are getting real-time information about what is being used? Obviously, every patient is different.

Amanda Pritchard: Yes, in certain areas—not in all—but where work has been done particularly through the specialised commissioning teams and the Getting it Right First Time team, they will look at that. Things like the National Joint Registry are part of the evidence base that would allow you to have ongoing continuous monitoring of outcomes, which link back to devices and products as well as broader clinical pathways.

Chair: Thank you. That is helpful to get that clarified.

- Q63 **Anne Marie Morris:** I will be brief. In figure 10, we have Supply Chain's performance against key indicators, and it is not a happy picture because less than half are green. We are going to come on to the overall plan for



transformation and improvement, but as things stand, looking at where you have real challenges, what are you doing to address some of the red areas? We have a real challenge in the “buy smart” category when it comes to capital expenditure and mitigation of on-costs. Those are the two that stand out. What, Ms Pritchard, are you doing to address that red status?

Andrew New: If you do not mind, I would like to pick those ones up. The targets for capital savings were set on a linear basis throughout the year, but the expenditure across the NHS clearly is not in a linear fashion. As it stands, as of the most recent reporting period, I am pleased that we are now ahead of plan and I expect to be towards our stretch target by the end of the financial year, so recovery has happened. The team have worked exceptionally hard to get through a whole host of quotations and things to make sure that we achieve the target, so that one will be green by the end of the year.

That is not necessarily the case on our mitigation of price pressures, so the broader inflation that we are seeing across the supply chain. In accordance with Cabinet Office standards around reviewing contracts to ensure that we don't have excessive challenge for suppliers, we have had to agree a number of changes to their price structures. Some of those are at the end of contracts where they have been retendered, and therefore they have implemented higher pricing in the successor arrangement, and some are partway through a contract with financial distress.

The positive is that the revenue savings target, which is the top line on that page, is a net number of the inflation, so the team are now looking towards achieving our over-perform but not stretch level on our net revenue savings contribution. They have worked exceptionally well with trusts to substitute products that have high inflationary pressures for those that have lower inflationary pressures. As a collective, the teams have done very well this year. I am expecting inflation to finish red, because that is the reality, but the net revenue saving will be green at the end of the year.

Q64 **Anne Marie Morris:** That is very helpful. The red/amber mark is for transformation, which is under your “partner expertly” category under figure 10. The reason why it is red/amber is that there seems to be a failure to have timely delivery of outcomes. We talked a bit about that earlier, but what are the top three things you will do differently to change that—to get timely delivery of outcomes and sort out the transformation process to move it to green?

Andrew New: The two topics are slightly different. The topic from earlier of delivery of product is not impacted by this. This is more, “How fast can we transform the organisation?” We have an ambitious plan that we need to drive very hard to ensure that we grow the capability and capacity and modernise the technology to enable us to do everything we want to do for the NHS. Based on the analytics that have been undertaken, we know that we can create a lot of additional capacity in the NHS by doing a fantastic

job. We also know that we are limited by capacity physically, and by aged technology, which just does not have the flexibility that we need.

We are running seven cornerstone programmes this year in an attempt to accelerate that modernisation. We knew going into this year that they would be exceptionally challenging. We are in the process of opening a new distribution centre in the north-west to replace Runcorn with a site nearby at Gorsey Point. It is approximately three times the size, and resolves the capacity problem for the north of the country. In implementing the new site, there are always going to be challenges around the transition from old to new. We have a number of issues around integrating new technology with old technology, and the team are working through them at the moment. We are already up and running, with the first few trusts delivering out of the new site. That will be concluded by the end of this financial year, and we will have seen the recovery in the right way. We are replacing our core financial systems. For the ERP that runs the trading backwards and forwards of products, we are moving from a product that is no longer in support to a modern, more flexible product. That will go live for our next financial year.

At the time it was reported, it was reported as amber, which meant it needed supervision and management intervention. It has had that from my CFO, and he is now working closely with the team to drive through to completion. We have a project around inventory management implementation, which I discussed earlier, and the benefits that will bring to the system. When we designed the programme, we assumed that we had central funding provided from NHS England and that trusts would not need to undertake individual business cases for the change to happen locally. A number of them have elected to submit additional business cases locally, which has added three to four months to the timeline. That is a lesson we have learned, and as we are now moving forward, we are planning on that being part of the core process. But it means we will not recover inside this financial year—we will now recover next financial year. I expect that programme to be red.

Each of the initiatives we have has its own unique challenges, and with each of them, we are learning lessons as we go. We have a lot of work to do in the future around the modernisation of our technology because, as the NAO report pointed out, we are an operating business delivering 30 million orders a year. We cannot just shut a warehouse, modernise it and reopen it. We have to deliver every day and modernise it at the same time. We are very much changing the wings and the landing gear, and probably the fuel, on an aeroplane that is still in mid-air. It will be challenging into the future.

Anne Marie Morris: Okay—more on that later, but we will leave it there for now.

- Q65 Olivia Blake:** On medical devices and products, does this system make it easier or harder to manage risks related to product recalls, which are quite common in this sector?



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Andrew New: Yes, absolutely. I have a fantastic patient safety team. This year, to date, 27 products have been recalled and 26 of them have been entirely contained. One of them was recalled only last week. That is in triage, and we already have the containment action in place. This system gives us the ability to see exactly who has bought what. The challenge comes at the other end. We know it has been delivered to a trust, but does it still exist? Have they got it in stock? What do they need to do? We have to work collaboratively with them. The benefits of putting the inventory management solution in place are that we will have absolute visibility across both sides and be able to immediately contain any action. There are lots of patient safety benefits that come with the work we are doing, even though I can write a business case primarily around saving money.

Q66 **Chair:** But it will rely on the inventory management being really easily watertight?

Andrew New: Yes.

Q67 **Olivia Blake:** Moving on to the structure, Mr New, is it correct to say that the structure is set up in such a way that senior staff could get paid beyond civil service salaries, while less senior staff could get worse employment conditions than civil servants, given what you have outlined?

Chair: You still have some outsourced services.

Andrew New: I will deal with the separate elements of the organisation. The SCCL layer of the organisation has a separate reward framework that has been approved because we are competing in a very commercial environment—

Q68 **Chair:** Okay. So you can be paid more than the Prime Minister—that is the simple metric, is it?

Andrew New: We have three members of staff who I believe are at that level—

Chair: What I mean is that you have to have a special dispensation for that, and you have that dispensation.

Andrew New: Absolutely. Across our pay bands more broadly, the system is not the same. We do not have final salary pensions; we do not have those kinds of benefits. We have more commercially focused benefits that allow us to compete for those kind of people who will come in and drive the procurement of these products. We have a different reward strategy specifically around attracting and retaining the right mix of people.

In our partner organisations, we don't control the salaries that they offer their employees, because they perform an outcome-based service delivery. Again, therefore, they are competing in their own local markets for activity. However, all of them have ethical obligations in their contracts around national living wage and other provisions, to ensure that they are fair and equitable with their staff.



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A number of our providers, although outsourced, are actually part of broader Government. So, until recently, Crown Commercial Services bought our non-medical products and that has transitioned into an NHS collaborative team that are buying those on our behalf, because they can invest the specific time in that service. Therefore, they are covered by NHS pay arrangements in that group.

Q69 **Olivia Blake:** Why has SCCL not chosen to disclose senior remuneration in its 2022-23 accounts?

Andrew New: The directors' remuneration is disclosed. However, at the time I would have been seconded from the Cabinet Office into the organisation and therefore I wouldn't have been on payroll. There was an agreement after that financial year, so, in the most recent accounts, I have now transitioned into the organisation, because I have to be held to account in the same way as anyone else who is employed by the organisation.

Q70 **Chair:** So that is just a temporary thing?

Andrew New: That is a temporary thing. The chief finance officer left the organisation and has been replaced, and we had a gap. So, just naturally, we have fallen out of line. It is not anything about transparency; it is purely a timing thing.

In our most recent accounts, which we have just signed off, you should find disclosure—

Q71 **Olivia Blake:** That will be in there?

Andrew New: Absolutely.

Olivia Blake: Thank you.

Chair: That is reassuring.

Shona Dunn: Can I just add a point of clarification, Chair? The top-end salaries are subject to the same scrutiny and controls that you would expect them to be subject to in other organisations, and they do come to our Ministers and onwards to the Treasury—

Chair: I think we got that message; it's just that we wanted to be clear about whether there was a dispensation or not. Sarah Olney is waiting patiently.

Q72 **Sarah Olney:** Thank you, Chair. Mr Kelly, it's your turn. The trusts submit data to NHS England—to your finance function—about the suppliers they are using and the spend, but you're not using that data to challenge them on why they are not using Supply Chain. They tell you, for example, that they might have put a third of their spend through Supply Chain and two thirds through other suppliers or an outside supply chain process, but there is no mechanism by which your team can go back to those trusts and say, "Why aren't you using Supply Chain?" Is there a reason you are not doing that?



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Julian Kelly: We are using that data. We clearly provide it back to individual trusts, because there are 200-odd providers, so that they themselves can work out how they can get best value for money. In particular, we focus our effort on challenging those trusts that are struggling most financially. So, we are using the data.

- Q73 **Sarah Olney:** But for those trusts that are struggling financially, is one of your range of measures that they could look at that they should be putting more procurement through Supply Chain?

Julian Kelly: One of the things that we are currently doing is precisely exploring with some of those trusts if they should be putting more of their business through Supply Chain. Where we put providers under legal undertakings, then we can actually require them to do it. Clearly, you want to check that it makes sense from a value for money point of view and that Andrew has the capacity to deliver a good, timely and effective service. But that is something that we are actively doing.

- Q74 **Sarah Olney:** But only where trusts are in financial difficulty?

Julian Kelly: We are focusing our effort, given the resource we have, clearly on those places that are struggling the most financially.

- Q75 **Sarah Olney:** Okay, but is there not more that you could be doing perhaps where there is less financial struggle?

Julian Kelly: Clearly, we provide that data, along with a whole lot of other benchmarking data, so that trusts themselves—clearly, the ones with boards that are responsible for taking decisions—can themselves work out where they can get better value for money.

Chair: Sir Geoffrey Clifton-Brown has a question on the data.

- Q76 **Sir Geoffrey Clifton-Brown:** Mr Kelly, in paragraph 2.11, page 22, the Report states that “55 trusts that do not routinely submit data and are excluded from the market value figure.” How can the targets for purchasing in the contracting chain market be reliable if you do not know what the total market is?

Julian Kelly: I think you said “routinely”. A greater number are submitting, and we are currently working with the trusts that are not routinely submitting. Indeed, we are considering what other actions and levers we might have available to basically require people to submit in a timely fashion.

- Q77 **Sir Geoffrey Clifton-Brown:** How long is that likely to take?

Julian Kelly: We are working out what the levers are in the next few weeks. Getting everyone to do it routinely—clearly, what you really want is people to be doing it on an automatic basis, so that it does not require a lot of manual effort—is often the thing that takes a bit of time to get right.

- Q78 **Chair:** Is it partly IT systems in hospitals?



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Julian Kelly: In some cases the IT systems are set up right, and you can download the data on an automated basis. Now it is just a question of working it through trust by trust.

- Q79 **Sarah Olney:** Sir Geoffrey has slightly stolen my thunder, because I was just about to ask about the 55 trusts, but I have a follow-up question on that. If you are not collecting information, or full information, from all the trusts, how do you know what the full value of potential procurement savings is through Supply Chain? You do not actually have a view of what the current procurement cost is.

Julian Kelly: You can look at it and do some estimation, but that is one of the reasons why we are constantly working on how to improve the data quality and how to get this done on automated, routine basis, so that both we nationally and individual providers locally have a better real-time view. That is why we are doing that improvement work.

- Q80 **Sarah Olney:** Ms Dunn, there was a review by DHSC of the Supply Chain implementation in 2020, and a number of recommendations were made. What has happened to follow up on that review?

Shona Dunn: You are quite right, Ms Olney. That was an important review, which we undertook in advance of enacting the transfer of SCCL from DHSC to NHS England, to make sure that it was still the right thing to do and that we had an up-to-date view of what was strong, what was less strong and what needed to be developed.

There were a number of recommendations in that review, which covered a whole range of issues: thinking about whether the outsourcing model should be developed further by potentially bringing some of those category towers into the organisation, and thinking about the savings model, a single savings model and the representation of savings to trusts, for example.

There are a range of actions like that, most of which I am pretty confident were picked up by Ms Rock and Mr New as the organisation was taken into NHS England and brought into full operation. I think that most of the things that were in that report are now in place, or are shortly to come into place.

- Q81 **Sarah Olney:** Okay, but we are still seeing significant purchasing outside the Supply Chain model, despite action taken as a result of that review. Is that something that remains to be addressed or that you are confident will be addressed in due course?

Shona Dunn: Like most of the panel for the proceedings this morning, I absolutely think that SCCL will continue to see a growth in its market share. There are a range of reasons why decisions were made at each point not to mandate the use of SCCL. I think there is a good logic behind that choice, and there could have been consequences, many of which have come up, if a different choice had been made, which would have been tricky to manage.



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From a DHSC perspective, the ongoing process that the team are going through to improve customer satisfaction and data—which allows the NHS England team to challenge the choices that trusts are making—and the changes that Mr New referred to in terms of systems and ensuring that the service is optimal give me confidence that SCCL will continue to strengthen its position in the market and continue to drive up the efficiencies that we should see as a result.

- Q82 Mr Francois:** If we turn to page 7 of the Report, you will see that paragraph 9 says: “DHSC set Supply Chain a target of making £2.4 billion savings by 2023-24, but the method for calculating this re-counted savings from previous years.” In fact, you have three different methods for calculating the savings, don’t you? As the NAO Report tells us, from April this year—going into the new financial year—you are trying to consolidate that into one standardised method for calculating it, but you have been going for five years and you still can’t agree what the savings are. How do we know that you have actually saved anything at all, Ms Rock?

Jacqui Rock: You are correct; there have been several different savings methodologies, and the different methodologies have been part of the process that NHS Supply Chain has been on. For example, when we had the outsourced category towers, the savings methodology was different. I am not going to go into the details because you have got them all in the Report—

Mr Francois: Did you say the category towers?

Jacqui Rock: When the category towers within NHS Supply Chain were outsourced—

Mr Francois: These are the so-called six towers.

Jacqui Rock: That is correct. We had a particular savings methodology where the external providers of those category towers would do a particular form of savings. When we insourced them, we did much more alignment with the savings methodology to get it much more on track with what the trusts were doing. What we have now done—again, because there are still differences—is align our NHS Supply Chain new savings methodology to a savings methodology that we have actually rolled out across the whole of commercial in the NHS, which means that everybody is going to be looking at their savings, calculating their savings and putting them in the Atamis programme in the same consistent way.

- Q83 Mr Francois:** We have agreed that you are going to move to a standardised method, but, again, paragraph 11 on page 7 says: “Some trusts do not recognise Supply Chain’s in-year savings figures, which causes frustration and mistrust... All the six trusts we spoke with”—that is, trusts the NAO spoke with—“in summer 2023 noted their frustration with the differences in how they and Supply Chain calculate savings.” In layman’s English, you have got three different methods, so not only are you comparing apples with pears, but you are comparing apples with



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pears and oranges. A cynic would say that the reason you are doing that is to obfuscate the fact that you are barely saving any money at all—not that I am cynical.

Julian Kelly: In terms of the method for counting the £2.4 billion—and Andrew, you may want to say some more—it is clear what that method is. It is set out in the NAO—

Mr Francois: Well, there are three different methods.

Julian Kelly: But in terms of calculating the £2.4 billion, the method is set out in the NAO Report, I think in figure 5. That is pretty much that we were paying price X, but we are now, in cash terms, paying price X minus whatever saving we have just done, which is an actual saving for each widget that we are buying. In fact, if you were to include what might have happened due to inflation, that number would be higher, so it is a reasonably prudent method of doing it. Clearly, that is a real saving that is delivered. That method is clear. If you are a trust—and I don't know about all the six trusts or the particular ways they do it, because they have been doing it—

Q84 **Mr Francois:** Mr Kelly, forgive me, but let's cut to the chase. You are the finance director of NHS England, yes?

Julian Kelly: Yes.

Q85 **Mr Francois:** So, over the five years that this organisation has been going, how much money has it saved?

Julian Kelly: It has reduced the cost by that £2.4 billion.

Mr Francois: Over five years?

Julian Kelly: Over the five years. That is the number that is reported. There is a different thing going on with trusts, which is total spend, which is also driven by the total volume of goods they are buying and, basically, "How rich is the product mix? Are they now on average buying more expensive things, because, for example, medical devices have become more complex and therefore more expensive?" What we are trying to do is get a completely consistent approach by which individual trusts are also reporting what they are doing.

Q86 **Mr Francois:** From April, yes. You have given a figure that you reckon you have saved about £2.5 billion over five years. That is the Department's estimate. But I reiterate that in this Report, the NAO says the trusts do not agree with you, and they are the people having to do it at ground level. On that one, perhaps we agree to disagree.

Mr New, you talked about how in cardiology consultants are not forced in any way to choose a product that they don't want to choose, right?

Andrew New: NHS Supply Chain maintains a catalogue with the full range of all the products. Local decision making is local decision making.

Q87 **Mr Francois:** Yes, but—sorry—I come back to the syndrome I mentioned



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before. The military have a phrase that Ms Pritchard has heard me use before, which is “ground truth”. What they mean by that is what really happens on the ground, not what some general puts on a PowerPoint presentation at a château way behind the lines.

The ground truth of this, having spent a lot of time talking to the people who do it day in, day out, is that you have this high-cost tariff-excluded devices list—that applies in cardiology, too; there is a big cardiothoracic centre at Basildon Hospital—and if they use one of those products, it effectively does not cost the trust any money because they get reimbursed, but if they use a different cardiothoracic product that the trust does have to pay for, it does cost the trust money.

What happens in the real world is the finance people lean on the consultants to choose, obviously, to play the system. That goes on in the NHS every single day. In extremis, that results in consultants having shouting matches with medical directors because the medical director becomes the referee. That is true, isn't it?

Andrew New: I don't know if that is true or not. From our perspective, we maintain the broad range of products available, and then local choices are made as to which product they wish to consume, and they have the ability to buy either of them.

- Q88 **Mr Francois:** But there is another point: the cost of some of these things. Often, the NHS is charged way more than it costs to make them. For some of those heart stents, the NHS pays way, way beyond the actual cost of manufacture. If you go to some areas, like brain surgery, it can be a mark-up of 2,000%. Ms Rock, your point about being a market maker doesn't hold. Actually, the suppliers that produce this stuff—you find that they all tend to cost about the same; there is an element of cartel in this in some cases—are the ones making the market, not you. That is right, isn't it, Ms Rock?

Jacqui Rock: I have to challenge a little bit the idea of mark-ups of 2,000%. As commercial professionals, we are constantly looking at and monitoring the marketplace—globally, as well, in terms of what you can buy there.

- Q89 **Mr Francois:** There are some brain stents that retail for £10,000 that cost £500 to make.

Jacqui Rock: The make cost versus what the market cost is—

Mr Francois: No, the market cost is when you add in a gigantic mark-up. That is the whole point.

Jacqui Rock: But we do compare what the NHS pays with the rest of Europe, so by product we are monitoring that and making sure that the NHS is not paying a premium.

- Q90 **Mr Francois:** Ah! It is interesting that you say that, because the same product costs £2,000 in Turkey and £5,000 in Germany. In Britain it costs £10,000. They do not have NHS Supply Chain to contend with. I can get



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you the detailed figures, if you like.

Jacqui Rock: Yes, please do, because I would be very interested to see that.

- Q91 **Mr Francois:** Ms Rock, I have one other thing to put to you—the Chair always keeps us to time. If I had to summarise, NHS Supply Chain is growing like Topsy. When Mr New signed off the annual accounts in December 2023, he signed off that there were 686 staff, 99 of whom were outsourced or contractors. We are told today that the number in all ranks now is 4,000. Five years on, you still cannot demonstrate that you have made real savings to a point where the trusts agree. You still have three different ways of calculating them.

Clinicians who work in the NHS tell you that the new system is slower and less reliable than the old one. It is not a compelling system at all, because some NHS trusts barely use it for anything. In extremis, consultants are leaned on to use devices that they would not otherwise use. Given all that, why don't we just scrap NHS Supply Chain and redeploy those people into the NHS in some other way? If you talk to clinical staff, you will know that any one of them watching this at the moment will be cheering. Why don't we do that?

Shona Dunn: Let me start off and then turn to Mr New. To come to the counterfactual, Mr Francois, if we were sitting here having not put in place mechanisms to aggregate the demand for these products in the NHS, and having not put in place efforts to deal with variation or to leverage the buying power of the NHS, we would be rightly criticised for not having done so. I completely understand all the points you have made today, and I know the team would be extremely pleased to see the specific examples you have picked up, but fundamentally we have a responsibility to you to make sure that the NHS is doing this as well as possible.

- Q92 **Mr Francois:** My point is that you are not leveraging the buying power. If you are talking about brain stents, they all cost around 10 grand from all the different suppliers. There is an element of cartel. There are highly aggressive reps who are trying to flog their particular product to consultants morning, noon and night. You are not actually saving money.

Shona Dunn: There are specific examples that the team can absolutely pick up. There are some other examples that the NAO included in its Report. There will always be cases where there are individual products or individual trusts or individual instances that you could pull out of that type. From my perspective at the Department, looking at the aggregate position and the market share and the savings that can be driven, SCCL is a good idea. To your point about why we don't just scrap it—

- Q93 **Chair:** Just to follow that up, Ms Dunn, I remember years ago GPs were approached by reps and could choose whichever drug they wanted by brand. Over time, the various bodies—now ICSs—have screwed it down so that you have the generic version of a drug rather than the brand version. Does the Department have any understanding or evidence about how much that has saved the NHS?

Shona Dunn: I don't have that data with me, Chair. I don't know whether Julian has—

Julian Kelly: We are saving billions of pounds a year because of that.

Mr Francois: I think that is true. You are talking about the pharmaceutical price regulation scheme—

Julian Kelly: No, no. There is the pharmaceutical price scheme, and that is also getting value to the tune of a billion pounds a year, but in primary care in particular, where drugs are being bought on a generic market outside of the voluntary pricing and access scheme—PPRS, as was—we now do national tenders. We provide all the information so that people can see which are similar drugs with the same outcome and which ones deliver the best value so that people switch to the best value. We are saving hundreds of millions of pounds a year because of that.

Mr Francois: Ms Dunn, I put it to you that if you go into most acute hospitals in the NHS in England and you go down to the canteen and ask the people in scrubs, not the people with clipboards, "What do you really think of NHS Supply Chain?", it will turn your hair white.

Q94 **Chair:** There is a challenge to Ms Pritchard and others to go and do that. Ms Pritchard, did you want to come back in?

Amanda Pritchard: Very quickly, because we need to let Mr New answer, given that he is the chief executive of NHS Supply Chain. I think the story of this really excellent NAO Report was really clear. There are some real challenges in it for us going forward, but actually the conclusions are really clear. You have said to us that there is a real opportunity here. We are already getting at a substantial amount of it. The point of the different way of calculating the savings is to recognise that it is answering slightly different questions. What is it against the original business case? Having been a trust chief executive, as you know, for many years, I know that it is really important that you have the information that makes sense at trust level, but it is okay to look at different things as long as it is absolutely transparent and clear.

The fact that the NAO in figure 2 produced a really simple comparison of pricing also tells a very straightforward story, which says: "In many cases—in fact most—we can see that the supply chain is creating value for money, but it is not the only one." There is further to go on some product lines. No doubt there are better deals that we could get—

Chair: I certainly think we can agree on that.

Amanda Pritchard: And examples are really important. However, I strongly challenge the conclusion that this has been in some way a failed experiment.

Q95 **Chair:** I want to bring in Mr New, because he runs this. It is important that he has some comeback on what has been said.

Andrew New: Clearly I am going to take an opposite point of view.

Mr Francois: I am amazed.

Andrew New: Every hospital in the country is reliant on the services of NHS Supply Chain to operate.

Mr Francois: To some extent. Some trusts use it 10%.

Chair: You have had your say. Let Mr New have his say. Figure 2 is useful.

Andrew New: Let me respond, please. There is a criticality of the service that we offer that must be delivered. We felt that last year, when we had some technology challenges for a few days; every single trust told us that it would have a material impact if we did not resolve the challenges—which, clearly, we did. We are a fundamental part of the establishment. Disbanding it would clearly be a bad idea.

In terms of delivery of the savings, yes, there are three different methodologies, but they are three different methodologies for three different audiences. One looks at the cumulative saving over a period of time—a longitudinal test—and aligns to the business case, and two different methodologies look at in-year management. One has to align to the management of the outsourced service providers—the towers that were referred to earlier—which we must report, record and manage robustly; and one has to be in accordance with the expectations of the trusts.

For the savings that we report to trusts, there are a number of different criteria that we report against. For some of them, they do not feel the benefit themselves. For savings against the centrally commissioned items, where, as you have said, they get fully cost-reimbursed, they do not see any financial benefit; the benefit is returned to NHS England through that programme. So I would not expect them to recognise all the savings.

Some of the mistakes we have made are from an attempt to have excessive transparency, where we have tried to provide two different currencies to explain the story—

Mr Francois: Sorry: excessive transparency?

Andrew New: To explain the story—

Chair: I think Mr New—

Mr Francois: Hang on, Dame Meg. Why didn't anyone answer these parliamentary questions, if you are excessively transparent?

Chair: Mr New is not responsible for that. He is trying to explain what he means. You can come back in after that.

Andrew New: We have provided multiple figures. In reality—and lessons have been learned since 2021, so not recently—we have solely provided the trust-facing Libra-accepted savings, which is the methodology they adopt within the NHS, and have managed the two internally within the

organisation to ensure that we can report across the organisations. It is a responsibility we have to maintain those different savings numbers.

We are now outside that business case period, and we have stepped purely to the NHS saving methodology. We manage the reporting of savings against every single transaction. Across 30 million transactions in a year, we take the last price that was paid and compare it, to absolutely understand that mix.

The point that Julian made is absolutely accurate, which is that the mix is changing dramatically across the NHS. For a period of time, without elective surgery happening, clearly, type A and type B products were being used but not type C and type D. We are now seeing far more of an acceleration towards C and D, which is why we have to maintain an annually rotating baseline. That is how the NHS works, because that works for the NHS to understand the savings.

If you ask an FD, "Have you got a surplus of £1 million this year because of the NHS?", clearly the answer will be no. However, is the value of the intervention that we have created for them £1 million? Absolutely, and I am happy to stand behind those numbers.

Mr Francois: Mr New, all I will say—I am not trying to have the last word—is that there are some people in a hospital in Essex watching this as we speak, and I will spare your blushes and not read out what they have just texted me. Suffice it to say that they are not entirely convinced by your answer. I will just leave it like that.

Chair: Well, people are entitled to their opinion.

Q96 Mr Djanogly: Paragraph 2.17 of the NAO Report addresses customer satisfaction with Supply Chain. It states that, from the quarterly satisfaction survey that you carry out, Supply Chain assessed "overall net customer satisfaction by reporting progress against a target of 66%, but it has only achieved this once in quarter two of 2021-22, when it got 67%. Its scores have been generally decreasing since the end of 2021-22 and in the last quarter of 2022-23 overall satisfaction was 56%." The more recent figures are down to 54%. First, why is customer satisfaction below target? Secondly, why is it decreasing, particularly—in the context of what you said before—when things are meant to be getting better?

Andrew New: Customer satisfaction remains one of our targets and remains something that we report. It is not that it is not a target; it is just the way we manage it within the organisation. It remains a target. The target for this year was to see an improvement in customer satisfaction, because we recognise that it has been declining. Clearly, the interventions we are making need to drive it in a positive way. The message in the organisation was that we need to drive an improvement, and over the last quarter we have seen that improvement start to flow through.

This is a challenging area in statistical terms. We conduct a quarterly survey of 400 people within the NHS—that includes anyone who is involved, whether a clinician, receptionist or a procurement professional—



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to understand their views. We then try to stratify the data to see trends as to what we need to focus on to drive improvement. The things that will drive improvement in customer satisfaction are around ease of ordering activity; availability of data, particularly product data; and the availability of products from across the supply chain. We are aware that, over the last three years, we have moved from a position of having nearly 6,000 unavailable products down to having 700. As I said earlier, that is the historical norm.

The supply chain more generally has been hugely challenged. The NHS trusts' newly formed ICS teams and NHS Supply Chain have worked very well together to look at clinical alternatives to disruption and to look at opportunities to consolidate supplies to ones that are more available across the system. We are expecting to see customer satisfaction start to improve. However, we will fundamentally not see a material improvement until we complete the modernisation of the infrastructure and the modernisation of the technology. At the moment, they hold us back in our ability to deliver the service that the NHS now wants, which is not the same service that it wanted when NHS Supply Chain was designed over 20 years ago.

- Q97 **Mr Djanogly:** Am I getting you right? You are saying that the reason why this is happening is that customers are looking not just at NHS Supply Chain as an organisation, but at the supply chain. In other words, their lack of satisfaction is reflecting the entire market, not just their experience with you.

Andrew New: Correct.

- Q98 **Mr Djanogly:** But is that what it is meant to be?

Andrew New: It is how it has been designed, because the suppliers who supply through Supply Chain are an intrinsic part of the supply chain solution for the NHS. We do not just say: do you like the management layer in the middle who are working on your behalf every day? That is not very interesting if the supply chain as a whole is failing to deliver what they need. For us to know what interventions we need to make to drive the right outcomes from the supply chain, we have to ask a broader question. It has been materially challenging for any supply chain professional over the past four or five years, and I am not at all surprised that there has been frustration around the availability of products.

- Q99 **Mr Djanogly:** Putting it into the context of what you were saying before, in terms of better IT and so forth, when do you expect the turnaround in satisfaction to happen?

Andrew New: We are already delivering some elements. At the end of this financial year—the end of March—we will go live with the new catalogue solution, which is one of the requests that the trusts made. NHS England has supported us in investing in that over the last year. It will roll out during the next 12-month period. That will give a materially improved performance to what is currently an online catalogue that is slow and difficult to use. People will be able to search for products and identify



alternatives, and a new range of capabilities will be deployed. I would expect that to tick into that “easy to work with” measure that we have, and products will be easy to order as we drive the performance into the eDirect channel, which is the channel that provides direct shipment from supplier to trust.

We have already seen a material improvement in the supply performance. It is not good enough yet and we will continue to drive it. Fundamentally, that will involve some technology investment to create greater transparency over the performance of Supply Chain, which is what the trusts are asking us to do. That is part of our business plan for next year, and I would not expect to deploy that until at least the end of the next financial year. That is a complicated system.

Q100 Mr Djanogly: Yes, I can see that. I just wanted to ask a question on this eDirect supply route, which I see is where “eDirect products’ are ordered through Supply Chain but the suppliers deliver the products to customers.” In that regard, the NAO Report notes: “In March 2023, Supply Chain began a three-stage programme to try to improve eDirect.” Why has it taken so long to address the issues with eDirect, and why will it take until March 2025 to improve it?

Andrew New: There has already been a significant improvement across this channel. This came from a meeting I had at the Royal Cornwall. I went to spend time with their teams to understand the impact of the supply chain on their local operations, and they were able to explain to me exactly how this channel was designed to work. It is working in the way it was designed, but they said that it is no longer what they need to run their hospital, particularly as they have enhanced their technology and they now have greater visibility that we cannot support, so we have to modernise at the same pace as they are modernising.

From that point in time, we immediately deployed a team to focus on improving some data cleansing activities—data is a core thread in this because of the systems—to drive the performance across the supplier base, and in some cases make sure the suppliers were aware of the importance of timely delivery. If they relaxed over a period of time, we effectively need to performance-manage them to drive the performance improvements.

As of now, about 8% of orders are not delivered on time. In some cases, that may be understandable. This is the channel that truly bespoke products are designed, developed and sent through, and where consignment stock might exist on site, so the supplier is in charge of when it should be fulfilled, rather than the trust. When orders are delayed, they are delayed by just over a week, whereas previously they had been delayed by nearly a month, so there has already been a material improvement.

Systemising that will require technology to be deployed. In the next 12 months, at the end of the business period we have talked about, all the arrangements with our service providers come to an end. Our technology



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service provider's contract will come to an end, and we will need to replace it with a new provider. We cannot start the material transformation of the technology until new providers are in place.

Q101 Mr Djanogly: I hear what you are saying, Mr New, and it seems positive, but paragraph 2.21 of the NAO Report says: "As early as 2018, Supply Chain was aware of problems with eDirect...Supply Chain data shows that between June 2022 and March 2023, on average more than one quarter...of orders were delivered late, by an average of 22 days". Is that the figure that you say has been cut to 8%?

Andrew New: Yes.

Mr Djanogly: Which is a significant improvement, it has to be said.

Andrew New: But we are not there yet.

Mr Djanogly: You are not there yet.

Andrew New: There is lots of work to be done. Clearly I wasn't in the organisation in 2018, but part of the challenge is that the team immediately moved to deploy a solution to resolve all the issues at the same time. I have already spoken about the challenges of modernising the technology. At each turn, as they tried to understand how to create the ability to do back-order management and various things around the order fulfilment cycle, they found that the legacy technology is not capable of doing it. To make progress, they had to deploy a new order management system, which was deployed just over 12 months ago, and that is now creating the flexibility to put the new technology into it.

The time it has taken is frustrating, and the pandemic in between changed the focus of the organisation somewhat, but they have made progress in breaking some of the core elements of our legacy technology problem. There is still more to do, and it will all be subject to available funding.

Q102 Mr Djanogly: So the 8% figure within a year will be what?

Andrew New: I think this time next year the 8% will be broadly similar, because I do not believe we will have the time to implement the systemic improvements to the technology.

Q103 Mr Djanogly: How long do you need?

Andrew New: This will be subject to the business planning that we are working through at the moment with NHS England. An assessment of the technology and a procurement cycle, which we talked about earlier, may be timely to ensure we have picked the right provider with the right technology to drive this forward. At the time, we said it would take up to 18 months to deploy. That will be 18 months from the point at which we are able to start the project, and we are working on which projects we can deliver next year, based on affordability across the whole programme.

Q104 Chair: When you say "start the project", is that pre or post-procurement?



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Andrew New: In this case, pre-procurement. There are a number of technical assessments going on at the moment, which I will understand more about in the next three months, relating to how much of this solution we can keep at arm's length from the old technology, and purely interface to new. That makes it a much easier and quicker programme to deliver, but I cannot prejudge what the outcomes of those technical assessments will be. But in the next few months I will know, and I am happy to provide correspondence.

Chair: We always like to have timelines to hold you to account next time.

Q105 **Sarah Olney:** I want to talk a bit about transformation and what the NAO Report says about the characteristics of a well-managed transformation programme. The NAO has highlighted concerns about senior staff—sorry, I was looking at you, Mr New, but there has obviously been a change in senior leadership. Do you think that there is enough capacity and resilience to deliver the necessary change?

Andrew New: Since I joined the organisation, we have been through three rounds of those assessments, both in terms of succession planning and of capacity and capability, across the most senior parts of the organisation. We made a choice in summer 2022 to create some new directors who were capable of delivering the operating model activity, particularly the third-party service providers insourcing of the procurement activity, and the re-procurement of those key contracts that support us, to create enough breadth in the leadership team.

At the moment, our focus is still on concluding that activity while we design the transformation programme for the next few years to truly unlock the potential of the NHS Supply Chain. As part of that, there will be a management case, and we have already submitted some thoughts as to how we need to rebalance responsibilities across the executive team, which I do on a regular basis. The scale of the change that we decide we need to undertake will define what level of management supervision it needs, and we will ask for that support at the time.

Q106 **Sarah Olney:** The NAO is highlighting the creation of a chief delivery officer role, and also that there is a bit of a hold-up with getting the appropriate approvals. Ms Pritchard, what are you doing to help speed up the approvals of that new role?

Amanda Pritchard: I think this is now sitting between NHS England and the Department because, as we discussed earlier, if a salary is above a certain level, it has to go through an additional level of checking, assurance and decision making. The NAO has made a fair point, to be honest. Sometimes these things take longer than we would want, but we are certainly committed to working together to try to expedite that.

Shona Dunn: Can I briefly add to that?

Chair: Please do.



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Shona Dunn: We are acutely conscious that, with the SCCL having transitioned to NHS England, there is now a set of NHS England processes and a set of DHSC processes, and we are working together to try to combine those into one set, and to support the organisation with getting those decisions to Ministers as quickly as we can.

Q107 **Sarah Olney:** That sounds very sensible. The other thing that has been highlighted is that the NHS could be doing more to support the Supply Chain. I am particularly interested in a request from Supply Chain to the NHS to support standardisation of pricing for a complex group of products, so that there is not variation through the NHS in how those are priced. Can you tell me a bit more about how that is progressing?

Jacqui Rock: On the standardisation of pricing—give me a second, please. Can you talk to that, Julian?

Chair: Take your time, Ms Rock.

Julian Kelly: We actually discussed some of the issues earlier when we were talking about high-cost devices. That is where you get, in this example, national clinical specialists agreeing a standard specification for the appropriate set of treatments, which we commission. We have put in place arrangements, which were discussed earlier, for that specification—how they are bought and how we fund them. You do get examples where clinicians want to use something different, and the question is: what is the local clinical decision making to ensure that that is appropriate? That is the discussion that we just having earlier.

We have made progress there, but some of the tensions that you get when you try to create some standardisation played out in the conversation that we have just had. It is ensuring that the local clinical decision making is appropriate where exceptions are required. Andrew's team hired a clinical director about two months ago, which gives us the basis to start to look at if there are other areas where we should seek to explore some greater standardisation.

The issues that you have to work through are exactly the same as the issues we were just discussing. It is why it is actually a really difficult area, and why the work is being done more generally to develop the clinical registries, which Ms Pritchard was just discussing. In those, we capture national data about the equality, safety and outcomes of different products to inform clinical, evidence-based judgments and decision makings about what the appropriate set of devices is. It is bringing all those things together, which is a non-trivial task.

Q108 **Sir Geoffrey Clifton-Brown:** Mr New, may I pick up on one or two things you said? On figure 2, I think you said that in every case, your Supply Chain price was cheaper than what could be obtained elsewhere. Is that what you said?

Andrew New: I don't think I did say that—I did not mention figure 2 at all—but you are correct in your assertion. In all those cases, the lowest price is available through NHS Supply Chain. I was particularly frustrated



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about this range, which was selected entirely at random by the NAO. The team reviewed them individually. In a number of areas such as the Spend Comparison Service information, the aggregated data may exclude VAT in some cases and include it in others, but even so, in all those cases the lowest cost for those items is through NHS Supply Chain.

- Q109 **Sir Geoffrey Clifton-Brown:** If you look at figure 2, with a number of the items the lowest price paid by a trust is lower than the price obtained by NHS Supply Chain. I am looking, for example, at “Breathing valve and mouthpiece” and “Insulin delivery devices”. That is just two out of the five that the NAO happened to pick. It means that the trusts can be buying those things cheaper elsewhere. Indeed, as Mr Francois has already advocated, considerable savings could be made.

Andrew New: Specifically on those items, the second item in the figure 2 list has the lowest price because it was excluding VAT, and our price includes VAT; the two are the same, because that actual price was bought through NHS Supply Chain. Insulin delivery devices is an area where a volume-related rebate is given back to the trusts—again, the net number on one side and the gross number on the other. That gets back to the importance of high-quality data.

The final item on the figure 2 list, which is a higher-cost item, a bladder scanner, is a diagnostic item. Although it has a single reference number in the system, it is a configurable item that may or may not include a workstation, additional probes or service contracts, and actually the range of pricing on that is between £6,300 and £11,000, depending on the range chosen, and 93% of them last year were bought through NHS Supply Chain; all the others were bought following a quotation through NHS Supply Chain, even though the order may have been placed locally directly to the supplier. I was particularly frustrated by that.

Sir Geoffrey Clifton-Brown: We have got the picture: you are not comparing apples with apples.

Andrew New: Clearly, however, we have a broad catalogue, and in different places we have different market shares. Suppliers have taken different approaches to pricing they wish to offer. The only way to achieve that point around price standardisation is for us to collaborate as the NHS.

- Q110 **Sir Geoffrey Clifton-Brown:** I have a supplementary question for Ms Pritchard. On that same table, figure 2, taking those two right-hand columns, the NHS Supply Chain price and the highest price paid by a trust, considering that there is quite a difference—look at the total at the bottom—should you not issue guidance to the trusts to say that before they make any purchasing decisions, they should at least consider what their supply chain costs are from buying outside Supply Chain, and compare them with Supply Chain?

Amanda Pritchard: What Mr New has just said is important, because it is a constant piece of work to keep going for the lowest prices and to keep checking. As Mr Francois said, I absolutely believe that there will be examples out there of where Supply Chain does not currently have the

absolute best prices. That is why the professionals are employed to keep doing the work that they are doing.

In terms of achieving, which is of course the correct point here, volume will drive better deals. As we have discussed in this Committee, NHS Supply Chain was set up as a voluntary participation model, and we have a whole range of local arrangements in place in trusts at the moment, from outsourced arrangements to long-term contracts and so on. Even if we had the power, which we do not, we could not flip to a mandatory solution. It is, however, absolutely right that as well as supporting the work of NHS Supply Chain, we are now leaning in with local organisations to encourage trusts to use Supply Chain where there is capacity to do so.

The other important point that Mr New has made is that because the transformation work is going on and there are some physical capacity constraints, we have to work at the pace that Supply Chain can respond to. Mr Kelly mentioned earlier two things that are important on this. One is the use of the data; Ms Olney, you raised that earlier. It is particularly valuable where trusts are in financial difficulty, because it can be really helpful, along with a range of other benchmarking data, in allowing trusts to look at where they have opportunities. Clearly, we would encourage them strongly to use this as an opportunity to switch if it makes sense.

Q111 Sir Geoffrey Clifton-Brown: We are getting quite long-winded answers to quite simple questions. May I take you to paragraph 2.18 on page 26 and follow up on Mr Djanogly's question, Mr New? This is about customer satisfaction. You originally had a target of 66%. You then reduced it to 56%, but you couldn't even meet the reduced, 56% target. It is now 54%. A particular line in that paragraph says: "Overall net customer satisfaction shows a general long-term declining trend from its peak". That must fill you with some anxiety, mustn't it?

Andrew New: I think it says that there is a recognition of the work we need to do. When we discussed with the National Audit Office team the work that we believe we need to complete to achieve our potential, we approached that by saying, "There is a long list of things we need to do to improve as an organisation, but we recognise that it is critical we continue to do all the things we do today, and more, to support the NHS." Our change programme may have a number of big things that need to be delivered to create the capacity and to modernise the technology, but there are a whole host of activities that we are undertaking every day to engage and listen to the NHS in a different way, to drive up customer satisfaction, because that will align to a greater market share and greater market share will give us the power to improve commercial arrangements and therefore see a benefit to the NHS.

In the most recent survey, the performance actually has gone above the target and is back at 57.6%. I am not going to suggest that that is green shoots—I would like to see a number of quarters—but as I have said before, the general challenge in the supply chain and the number of unavailable products will have made this a hugely difficult task for anyone working in a trust, and therefore—

Sir Geoffrey Clifton-Brown: I appreciate the difficulties.

Andrew New: I have seen that indicator improve. My expectation, on a lagging basis, is that we will now see customer satisfaction improve. That will only be told by us completing our quarterly surveys with the NHS.

Q112 **Sir Geoffrey Clifton-Brown:** Well, of course, but I put it to you that if Amazon had a customer satisfaction target of 54%, it wouldn't be in business.

Mr Francois: No, it wouldn't.

Andrew New: Our target this year is to improve on the net position that we achieved at the end of last year—which we are doing—because we recognise that a number of things we would need to do in the NHS to drive up the activity are being done in the year. If you take the underlying data—because it is a net score—approximately 4% of the trusts feel that they would score us between one and four out of 10. There are then 63% who would say that we are at eight and above, and then the balance sit in the middle. We take the number of negative responses from the number of positive responses.

Frankly, achieving an eight or above is a pretty impressive performance. If you take our average score on a pure numerical basis, we are now at 7.8. If you go back three or four years, the average was around 7.9. There is no material difference. What is happening is that we are seeing people go from an eight out of 10 to a seven out of 10. I would like to see the sixes and sevens out of 10 become eights out of 10, but that will require us to make more products available, have better infrastructure and better technology, and work with the NHS as a partner to drive value for them.

Sir Geoffrey Clifton-Brown: Right, Ms Pritchard, let's try to get something out of this hearing. I really would have liked a bit more humility in all of this hearing.

Mr Francois: Me, too.

Q113 **Sir Geoffrey Clifton-Brown:** I have to say, as a long-term Committee member, that there is no humility about how badly this organisation is performing. I don't blame you, Mr New, necessarily, because you have not been there very long, but when we have you back in a year or two's time, we will certainly be expecting considerable improvements.

Ms Pritchard, may I take you to paragraph 3.9 as to how you might help this organisation? Basically, what that paragraph is saying is that if the transformation programme is to be fully successful, the organisation needs £240 million plus a reserve of £8 million. There is then a worrying bit at the end: "NHSE acknowledged that this would delay implementing the eCommerce system, which would have an operational and financial impact of £100 million against the £500 million target by 2026. While NHSE is clear that transformation is needed, it told us it must balance that with the funding needs of other areas of the NHS."

Mr New has been making out throughout this hearing that he needs funds



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to fund this transformational programme. If those figures are right, there are considerable financial gains from him getting those funds to make that transformation. Why can he not make a business case to you and have you give him those funds so that he can make that transformation in full?

Amanda Pritchard: I am conscious that you want me to be brief. I have heard that message very clearly, and I apologise if you feel that we have been insufficiently balanced in this hearing. We certainly recognise that there is a long way for SCCL to go, but equally we want to give credit to Mr New for the work that he has done over the last two years, which is the same period that NHSE has had responsibility for the company. We have seen some real recovery in there.

There is a lot further to go, and this is an important part of that. We are in constant discussion with SCCL and NHS Supply Chain about what the balance is and how much flexibility we have on funding. You will know—because we have been in front of this Committee many times before talking about other things that are also justified investments, such as tech and digital, and capital and estate—that all our budgets are agreed with Government, and we have to weigh up collectively what the respective priorities are. We talked about dental at the beginning of this meeting. There are a lot of calls on NHS funding. What we have sought to do is get the balance right between other competing priorities and giving sufficient resource to Supply Chain to enable it to do the really important work that it does.

Julian Kelly: On the specifics, when we set off this year we had a minimum spend, as is reflected here, but we had agreed with Andrew that we would work with him and that if we could afford it, we would do more, so that we could deliver more of the savings. As it turns out, Andrew's team basically have worked with us so that at the moment we are still targeting the £500 million saving in 2026-27. We have found a way to make sure that we are going for what we thought was the achievable target at the start. Given how tight things are, we have worked it through.

Q114 **Chair:** That is on the record, so we will work that through. I have some quite quick-fire questions. Mr New, we talked about the table in figure 2. I was a bit surprised when you mentioned that one included VAT and one did not, so I have just been checking why the VAT was not reflected. I understand that these figures were provided by you, through the Department, to the NAO.

Andrew New: I believe that they were extracted from the spend comparison service tool, which is where the trusts provide their data on their spend.

Q115 **Chair:** But the VAT point is a bit odd to throw in. It is right that you raise it if it is true, but it is odd and not satisfactory that it is not clear to the NAO that VAT was in the mix.

Shona Dunn: Chair, that is a question that—the Report has been signed off as accurate, and I do not think that anyone is suggesting that the data



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in the Report is not accurate; it is accurate. I think Mr New is referring to something that we should have picked up and discussed with the NAO in advance.

Q116 **Chair:** Yes, it should have been picked up in clearance. Perhaps we can take that offline with the NAO, because if VAT is included in some figures and not in others, that is a substantial difference, which may perhaps explain some of the challenges you had on this.

Mr Kelly, you were very sure about the £2.4 billion of savings, but paragraph 2.4 of the Report—I will not read it all out; you have it all in front of you—lays out in a lot of detail the challenges on calculating that saving about lack of validation. How can you be so sure that £2.4 billion has been saved?

Julian Kelly: Because, on that basis, we were paying price X in 2015-16 and we are now paying price X minus whatever we have saved. That is an absolutely verifiable, validated number. There has been a process, which Andrew and his team worked through, supported by their internal audit, to validate it. I was not here back in 2015-16 or indeed 2018-19, but that is the process that they have worked through.

Q117 **Chair:** Usually I do not like to just quote one sentence out of a paragraph in the Report in this way, but it says: "This accumulation continued to re-count savings made in earlier years and did not take inflation into account." Perhaps you could write to us explaining it really clearly. You are the finance director; you are the money man. We just really need to know, if you make that statement so boldly, that you can back it up, because, as Ms Pritchard and others have acknowledged, there is still some way to go.

Julian Kelly: As I said, it is done on a prudent basis. If you did the counterfactual of if prices had risen in line with inflation, the number would be higher.

Q118 **Chair:** There are questions we have over it, so perhaps you could reclarify that for us in detail.

I just want to check, Mr New, exactly when you will be moving to the new inventory system. Do you know? Do you have a time? We talked about dates earlier. I just want to pin it down so that we can hold you to account on it.

Andrew New: We have a programme working with 18 current trusts. Six of them have gone through their business case process. The other 12 are submitting them at the moment. I am happy to provide a programme with the—

Q119 **Chair:** That will be helpful, because Members across the House, many of whom talk to us before we do these hearings, will be interested to know whether it is happening in their trust. That is something where we can keep an eye on what is happening at our local level. And when are you expecting to be at 80% of market share?



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Andrew New: Physically, we will not be at 80% of market share until we submit our business case this summer to NHS England to seek the broader funding required to build the capacity. We will have to do something different in the south of the country in terms of infrastructure to be able to get there.

Q120 **Chair:** What are the particular issues in the south?

Andrew New: The Maidstone and Bridgwater sites are both fully completed; we could not take on additional work in the southern part of the country.

Q121 **Chair:** So it is basically warehousing.

Andrew New: It is warehousing space—approximately somewhere between 900,000 square feet and 1.1 million square feet.

Q122 **Chair:** Who are you competing with for warehousing space? There are some big shipping containers full of PPE, which is being burned as we speak—sorry, that is old pain for Ms Dunn, but it is true. Who are you competing with for warehouse space?

Andrew New: Not at all. It is purely a question of us making sure that the network design is appropriate and then submitting the business case for approval, at which point we will then find the appropriate site.

Q123 **Chair:** So this is from your JCB background about logistics and so on. It is a logistics issue, is it?

Andrew New: It is a logistics issue.

Q124 **Chair:** Okay. So you have to get the business case and find the warehouses, but there is not a shortage of warehousing.

Andrew New: No.

Q125 **Chair:** So we are not going to see problems in the south of England.

Andrew New: No.

Mr Francois: If it helps, they're building four massive warehouses at a place called Arterial Park in my patch. You can have one of those—and because we're from Essex, we'll do you a deal.

Chair: There's an offer!

Andrew New: There are some very specific location requirements for being able to do this, but it would be lovely if that does work.

Q126 **Chair:** So we have not really got a precise figure on the 80%. I get that it is reliant on other things. When will we see a step change? What is the range of dates? When do you think we will be able to visit our local trust—we reflect a subset of the House of Commons here—and everyone will be saying, "Yes, this is my preferred choice," and you will have a high saturation rate and everyone will be happy with it? When would you like to see that? Which range of years?



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Andrew New: I would like to see it as soon as possible, but it will be subject to that technical assessment as to exactly what infrastructure—and the technology modernisation that I referred to earlier—and how fast that can be done. Then we will go through a business case approval process to ensure we can allocate the funding to it. As a minimum this will take at least three years to do. As a maximum I would hope not much more than three years, but that is the reality.

Chair: And things can happen. We recognise that “events, dear boy, events” can get in the way of things. So it is a minimum of three years. That just gives us an idea of what we need to be aiming at, and when this Committee, or our successor Committee, will be back knocking on your door for you to come and appear in front of us again.

I thank our witnesses very much indeed for their time, especially Ms Rock and Mr New as first-time witnesses. The transcript of this session will be up on the website—thank you to our colleagues at *Hansard*—uncorrected in the next couple of days. We will produce a report on this issue, probably before the Easter recess, which starts on 26 March. Maybe I am being a bit previous—if not, it will be shortly after that.