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TRANSCRIPT OF "FILE ON 4" – "NHS PROCUREMENT"

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CUFFE: With a political storm raging over the latest reform of the Health Service in England, hospitals are facing unprecedented pressure to cut their costs. The Government wants £20 billion worth of savings by 2015, and the National Audit Office has singled out procurement of goods and equipment as an area where money is currently being wasted.

BURNS: You could save about £500 million a year through more efficient and effective purchasing, and that's money that could be spent on frontline services, better patient care, if only trusts could get their act together.

CUFFE: Tonight, why is the NHS in England throwing away so much money when it goes shopping for rubber gloves and knee joints? Are there lessons to be learned from north of the border? And with more change coming, can the Government deliver the savings it's promised?

SIGNATURE TUNE

ACTUALITY IN NHS PROCUREMENT WAREHOUSE

CUFFE: In a vast warehouse off a motorway roundabout in Lanarkshire, men in fluorescent jackets wheel around on electric forklift trucks between stacks that rise two storeys high.

SINCLAIR: We are in Scotland's national distribution centre for the Health Service. This is a warehouse the size of two football pitches, which delivers to at least seventy hospitals in Scotland, with over seven thousand departments, wards and clinics ordering through the same warehouse.

CUFFE: Colin Sinclair, of National Procurement, is spearheading a new, heavily centralised approach to buying. An early move was to choose a national uniform for every health worker in the country. He says the introduction of as much standardisation as possible is crucial to delivering value.

SINCLAIR: One of the key principles of buying nationally is that you get a price that is the same across Scotland, so whether you're in the Highlands or whether you're in one of the central belt cities, the price that the health boards pay will be the same.

CUFFE: And how do you know that that is the best price that's achievable?

SINCLAIR: Because we go through regular processes to establish that that is the best price. We spend a long time understanding the market for a product, talking to our suppliers, and that way we believe we will drive the best price in each product area that we work in.

ACTUALITY OF BABY CRYING

CUFFE: Twenty-six hours old and still adjusting to the world around him, Ewan is one of the latest arrivals at the Ayrshire Maternity Unit in Crosshouse, South West Scotland.

ACTUALITY OF WARD NOISES

CUFFE: The new system of procurement means that the midwives here can concentrate on caring for their mothers and babies without having to worry about checking the store cupboard and chasing round for new supplies.

ROBB: We have a weekly top-up system whereby one of the guys from procurement comes into the theatre and checks our stockroom.

CUFFE: Wilma Robb is in charge of theatre

ROBB: The majority of the things that are frequent use are on what we call our top up list, and he knows the exact amount that we should have as a stock level and will top it up accordingly.

CUFFE: So what sort of things are on that list?

ROBB: Surgical supplies and sundries, oxygen masks, padding for the beds, ... pads, things that we will be using in the theatre. It's quite a long list, but the stock levels have all been agreed and we try to adhere to them.

CUFFE: And then your person from procurement gets it all from one source?

ROBB: Yes. It all comes from the National Procurement Centre, that keeps costs down, so if we are all using the same pack for a spinal anaesthetic then, if it's bought in bulk, then it should be bringing the price down. I think the public would much rather that any monies that are going around are spent on staffing hours to look after the mums, the babies, the patients on the general side than it being wasted spending it on an extra £2 per item for a pack where one that's £2 cheaper will do just exactly the same job.

CUFFE: By streamlining the system for ordering and distributing goods, cutting out the middleman and buying in bulk, NHS Scotland says it has saved £200 million. Health officials from Denmark recently flew in to see how it was done.

CUFFE cont: A satisfying result for the Scottish Government's Cabinet Secretary for Infrastructure and Capital Investment, Alex Neil.

NEIL: We have made a lot of changes in the last three or four years and those changes are paying off for the taxpayer and, most importantly in the Health Service, paying off for the patient, because the patient, at the end of the day, is who matters in terms of procurement, and we are getting a better service, better equipment, better material supply into the Health Service as a result of the changes we've made.

CUFFE: Like Scotland, Wales and Northern Ireland have tried to centralise procurement, but in England things are very different. Earlier this year the National Audit Office looked at the way the NHS in England buys goods and equipment and reported that a combination of inadequate information and fragmented purchasing means hospitals' procurement is poor value for money. The report's author, Mark Davies, says they looked at four products which all trusts buy in bulk – paper, rubber gloves, canulas and other devices for putting fluids and drugs into a patient.

DAVIES: What we found was that in terms of A4 paper, trusts bought twenty-one different types of A4 paper. In terms of rubber gloves, 652 different types. In terms of canulas, somewhere over 1,700 different canulas.

CUFFE: And what are the cost implications of that?

DAVIES: We found over 66,000 products where you can directly compare – this isn't different quality of products, this is exactly the same product – there was a 10% variation in price between one trust and another. If you narrow that down, we found that 5,200 of those products had a price variation of over 50%, so a huge range of prices paid for the same product. If you put all this together, we estimate that there's something like half a billion pounds' worth of savings being lost every year on a spend of £4.5 billion.

CUFFE: The Health Minister in charge of procurement is Simon Burns. He agrees with the National Audit Office that the NHS needs to do better.

BURNS: They have raised some extremely important and valid issues, which have got to be looked at to make sure that we get the trusts to have a more proactive and cost effective way of purchasing their requirements for their hospitals and other NHS facilities.

CUFFE: Because it seems, you know, one trust may be buying 177 different types of glove and some are paying 50% higher than others for the same product.

BURNS: Yes. I mean, it is absolutely crazy. That is why we need to get greater transparency into the system, to get better practice and for them to look more at how they can not only bulk purchase, which will help to bring down costs, but also not have to face buying possibly 177 different items that are the same. It is a crazy system.

CUFFE: So have you set them a particular target?

BURNS: Well, what we are hoping and expecting them to do is to save about £1.2 billion through their purchasing.

CUFFE: And wouldn't a more centralised approach, like they have in Scotland, work better?

BURNS: With Scotland, you're talking about a population that is equivalent to probably one strategic health authority area in England, and so it's easier to have a centralised procurement system because it's a far smaller population that you're dealing with.

CUFFE: But although there is marked difference of scale, the NHS in England does have a national procurement body, the NHS Supply Chain. It was privatised in 2006 and is now owned by the logistics firm, DHL, who have a ten year contract with the Department of Health. But it doesn't have the same grip on the market that its Scottish equivalent has.

ACTUALITY OF LORRY UNLOADING

MAN: Bob, sign for that one please.

BOB: Oh, okay.

CUFFE: About 190 lorries arrive each day at the Royal London Hospital. This one is just unloading goods in front of a towering glass building that's soon to replace the original hospital on the Whitechapel Road. The person in charge of procurement here and at the other three hospitals in the Barts and London NHS Trust is Zoe Greenwell.

GREENWELL: This is the Supply Chain catalogue. It's probably the size of an Argos catalogue – it's about two inches thick, isn't it? So, examination gloves, you have got all sorts of different varieties. You have got latex ones, you've got nitrile ones, you have got vinyl ones, you have got powder-free, you've got powdered, you've got different sizes, so there is lots of choice within the catalogue.

CUFFE: But choice doesn't necessarily equal value, and Zoe Greenwell has gone through the list with clinicians and other trust managers to decide which gloves meet their requirements and are the right price. She then offers a limited selection to the 650 people in the trust authorised to order supplies.

GREENWELL: You have got gloves here, a box of 100, £4.95 for a box of 100 latex gloves. But if you went to a vinyl, you could get a box of 100 for £2.45. We spend over £700,000 a year on examination gloves and we were using over twenty different manufacturers from the Supply Chain catalogue. What we have done now is to move to one supplier choice, and we will be saving this year £320,000 on just standardising to a better value product, removing the choice, and for ourselves, we will mask those items off, so that if a clinician wants to go in and order a different type of examination glove, then they can't - they can only see the one we want them to use.

CUFFE: As well as selecting her products, Zoe Greenwell has to decide how to go about buying them – and here again there's a bewildering amount of choice. In the last five years, numerous regional and local organisations have set themselves

CUFFE cont: up as middle-men between hospital and supplier, some run by the NHS, some private companies, others just networks of neighbouring trusts. In fact she spends only £14 million of her £329 million budget with the NHS Supply Chain.

GREENWELL: We can use Supply Chain, we can go collaborative via the London Procurement Programme, we can collaborate with other collaboratives - for example up in the north west or East Anglia or the Midlands. We can use national contracts.

CUFFE: But how do you know which of those systems to use when you're buying – whether to go to a regional hub, the London Procurement programme, NHS Supply Chain, how do you know which to use?

GREENWELL: It is generally through going to the market and looking at the price that is submitted by those suppliers at the time that the tender is run. The market changes all the time so we can only work with suppliers with the market at the time in getting the best value.

SMITH: The procurement landscape in the NHS at the moment is a mess, its confused, it's confusing and it's unstructured.

CUFFE: Peter Smith advises key Government departments on their procurement and runs his own consultancy firm. He's lived and breathed procurement for the past 25 years and he believes that the number of organisations competing for business makes it harder for English trusts to spend their money wisely.

SMITH: If we go back in time to when NHS Supply Chain and the regional commercial hubs were created, the intention was these groups would work together. What's happened instead is you've seen actual competition between these bodies, so the hubs, because of the way they were funded, had to try and make money, and one of the ways they've made money is to try and beat the deals that were done nationally by NHS Supply Chain, because they can then make money out of those agreements when they get the hospitals to use them. So the competition between procurement organisations may be healthy in some cases, but it's created this confusion. And not just confusion, it's created a situation where you could certainly argue in some spend areas, where the Health Service

SMITH cont: would do better by having a coordinated approach, that's just not happening because you've got lots of people competing to be the procurement arm of the hospital almost.

CUFFE: But presumably the introduction of competition into the system is to drive down prices?

SMITH: But it's where the competition is. The competition in the system needs to be between different suppliers of knee joints. I don't think it should probably be between different groups of people who want to be the people who buy the knee joints.

CUFFE: And the competition is getting fiercer, as a number of American and European companies see an opening in the market and take over existing regional procurement hubs. It makes it all the more difficult for trusts to know exactly what's being offered and who provides best value. And Mark Davies of the National Audit Office says it's definitely had a detrimental effect on the NHS Supply Chain.

DAVIES: The NHS does not have to use Supply Chain and Supply Chain in a way has to sing for its supper in terms of being able to provide the services that trusts require at a price that trusts are prepared to buy at. What we found in our research was that there was a perception that actually Supply Chain's goods and services were more expensive than what they themselves as trusts could achieve. What we found was it was broadly half and half – 50% of the time Supply Chain's costs were higher and broadly 50% of the time they were lower. Supply Chain hasn't achieved the levels of turnover that it was expected to achieve across the NHS. For example, just a year ago, their turnover was something in the region of £1.2 billion as opposed to a predicted level of £1.7 billion. So they haven't achieved the market penetration that they had hoped to at this point.

CUFFE: The Public Accounts Committee has criticised the NHS Supply Chain for failing to demonstrate its value to the NHS. After taking evidence in May, members recommended a review of its operation. They said the Department of Health should develop plans to make its service more attractive for trusts, and should assess whether

CUFFE cont: it's subject to the right level of competitive pressure. Nick Gerrard, Chief Executive Officer of the NHS Supply Chain, says it's already making changes.

GERRARD: We have made a considerable amount of investment in the business, improving infrastructure and IT and investing in capability, and the commercial returns that we're achieving now are broadly in line with our expectations.

CUFFE: But you do have a problem, don't you, because as the NAO identified, a lot of trusts don't come to you because they find your prices more expensive than those they can get elsewhere.

GERRARD: Our product pricing includes, naturally, the price of the goods that are supplied, but also we enable the hospital to have fewer deliveries and also very efficient back office service. And when we take all of those into account, we believe we offer the NHS a very good value service and most trusts within the NHS do work with NHS Supply Chain.

CUFFE: Well you give obviously a very positive picture of your achievement, but that's not the impression that the National Audit Office give in their report, nor is it the impression that MPs at the Public Accounts Committee had.

GERRARD: Well, we believe our prices are competitive and it is important that when you compare prices you consider everything that's included in the total acquisition cost of a product, but the points that the NAO report makes around needing to consolidate volume to drive value in the marketplace are absolutely spot-on.

CUFFE: There's another obstacle, though, on the path to achieving the necessary volume of contracts. All doctors want a say in what to buy, especially when it comes to sophisticated pieces of equipment - like those knee joints - and sometimes they bypass the Supply Chain and go direct to suppliers.

BROWN: There's always a compromise between driving down costs and quality, and the cheapest component isn't necessarily the best component for the job, so there's a balance to be made.

CUFFE: Andrew Brown is an orthopaedic surgeon working for the University of Leicester Hospitals Trust, which has one of the largest orthopaedic centres in the country. The same knee joint can cost £1,400 or £2,500 depending on who's buying and how.

BROWN: We get paid exactly the same amount for each patient that has a knee replacement, whether they have a prosthesis that cost £1,400 or £2,000. And obviously the more expensive the prosthesis, the less likely is the trust to break even on that operation on that patient. And if we are paying over the odds for our prostheses, we will make a loss on those operations, which means the trust as a whole will make a loss in that area.

CUFFE: How can you be sure that the price that you've got, which you think is the best price, is really the best price?

BROWN: It's traditionally very difficult to compare prices between trusts and hospitals around the country. Each hospital tends to treat those negotiations with the companies as confidential to themselves and not share that information widely.

CUFFE: The NAO says there needs to be far greater transparency about the prices being paid to suppliers by individual trusts. It's something the Government is trying to address by introducing a standard barcode for products which will enable hospitals to compare like for like. But in the meantime, there's really no way of knowing whether they're paying the right price or over the odds for a pair of gloves or a new knee.

ACTUALITY WITH DOCTOR AND PATIENT

DOCTOR: How are you getting on?

PATIENT: Fine, thank you. Much better than I expected. It's a lot more comfortable, and today's been a big progress because I've gone from being bed-bound to being on a frame, and hopefully I shall be going home tomorrow, so yes ...

CUFFE: This 65 year old fell walker hopes to get many more years of climbing out of his new knee. The University of Leicester Hospitals Trust, which carried out the replacement, has a real dilemma. Struggling financially with an £8 million deficit, it could either cut staff, reduce the treatments it offers or find other cost savings. To see if it could buy expensive items more cheaply, it entered a partnership with other local hospitals, forming the East Midlands Procurement Hub. The hub promised 'cash releasing savings for reinvestment in front line services'. But in terms of the orthopaedic budget, Andrew Brown discovered it would do no such thing.

BROWN: We entered into that and it became apparent that it was actually going to cost us more to carry on down that line. It was going to cost us an extra £100,000 a year to procure our prostheses via the hub rather than carrying on doing it ourselves, because we'd already achieved very low costs locally with our suppliers. What it seemed to end up with was an average cost across what people were paying at the moment, which meant that there was always going to be losers within the system.

CUFFE: But if the hub had been doing its job properly, wouldn't it have looked at the price that you were getting your knees for and negotiated a similar price for all the other members of the hub?

BROWN: That would be what my expectation would be, that the hub should look at the lowest price currently being paid and bring everyone to that lowest price, because unless the companies are selling at a loss to ourselves, there's no reason why everyone else shouldn't be buying things for the same price as we do.

CUFFE: Not surprisingly perhaps, the East Midlands procurement hub has now folded. The National Audit Office found evidence that where trusts come together to buy a specific product, they can achieve savings of up to 30%. But in practice, it says trusts, hubs and the NHS Supply Chain are frequently establishing new contracts which overlap and duplicate each other, incurring unnecessary costs. When

CUFFE cont: Mark Davies tried to assess the performance of individual hubs, he was hampered by a lack of information. As far as he could judge, the savings they achieved in the last financial year were hugely variable.

DAVIES: In practice it really hasn't worked very well at all. What we found was that the various different hubs would often be putting in place contracts that duplicated other contracts put in place by other hubs, so there is duplication. Also, in a sense, just confusion. Quite a number of regional hubs, nine or ten regional hubs, you know, all doing the same thing. There is no consistent basis for measuring their performance. They charge a fee to individual trusts, so you have got this sort of vicious circle that individual trusts really don't know whether they're getting value. They think if they go to a hub that they might get a better deal, but they don't really know what a better deal looks like. The hubs may be competing with each other in a not very effective way. And our conclusion in the report - and this was backed up by the Committee of Public Accounts - was that actually there needed to be a rather fundamental rationalisation of the hubs, because too many of them doing the same thing not very effectively.

CUFFE: And yet they persuade trusts to join them on the basis that they will guarantee certain savings in the year?

DAVIES: Absolutely. But you've really got to be an intelligent customer and that's the problem with individual trusts, that they don't have the information to know what good looks like in terms of purchasing.

CUFFE: For the suppliers of medical goods, most of them small to medium size businesses, there are clear advantages to dealing with trusts on a one to one basis, without a middle-man.

ACTUALITY AT ESCHMANNS

MAN: What you're looking at here is the first stage of building the base of an operating table together with a column, so the floor with the wheels being attached to the column, then the platform at the top is being connected with the various electronics, and then it'll be passed on to the next stage.

CUFFE: On an industrial estate in Lancing in West Sussex, the small firm of Eschmanns produces equipment for operating theatres up and down the country. An operating table has about a ten year life and costs £25,000 to £35,000. The state of the art version is the T20, which can be controlled remotely. Managing Director Phil Kennedy has twenty salesmen on the road making contacts with surgeons and other clinical staff.

KENNEDY: If an individual hospital wants to buy a specific product for neurosurgery or orthopaedics or whatever it might be, then often the best value for that individual hospital, buying that specialist piece of equipment is to come and talk to us about what that requirement is, because it isn't necessarily easy to group that requirement together with a group of other hospitals.

CUFFE: But of course in making that relationship with the individuals, in a way you are undermining the whole purpose of a collaborative group.

KENNEDY: I would argue the exact opposite. I think the collaboration with clinicians on the ground who understand what best value is, is extremely important, and if collaborative hubs remove the relationship between the clinician and a supplier who can understand their specific requirements, then I think that you can often find examples of where that doesn't work and that where, you know, maybe price becomes a driver and best value is thrown out of the window. I think you can very easily say just because you group together and bulk buy you'll always get best value. Perhaps if you buy paperclips. I don't think if you buy operating tables.

CUFFE: Phil Kennedy believes he's meeting the changing requirements of the health service and providing extra value. Hospitals who buy his high-spec operating table with its push button controls will get training from his staff and an on-going maintenance service. Good for them and good for business.
And going back to this beautiful T20 operating table, how much profit might Eschmann make on one table?

KENNEDY: All of the profit we make as a medical device manufacturer here is reinvested. We're a growing small/medium sized enterprise and we've ploughed every single penny we've earned back into the development process.

CUFFE: That's not answering the question, of course. I mean, what's your margin?

KENNEDY: You wouldn't me expect to put private business profit margins on public record, but we have to make a business that is profitable. Clearly our shareholders would expect that. We reinvest that, we build jobs and we create wealth in the local community and, you know, all the things you would expect me to say as a supplier are true. Am I going to tell you what our profit margins are on the T20 table? I'm afraid I'm not.

CUFFE: There's an argument that if the procurement system in the NHS is ineffective, the only people that benefit from that are the suppliers.

KENNEDY: Well, I think that's a common misconception. I think there was some research some time ago about the cost of £100 purchase order in the NHS to administer to the order, and it was something like about 7%. Every £100 spent in the NHS, £7 of it is just to administer the order. Now if you went to the boss of Tesco and said, '7% supply chain inefficiencies exist in this organisation,' I think he would have a heart attack, he'd probably have to be treated on one of our operating tables. I mean, but seriously, you know, waste is waste and inefficiency is inefficiency. It doesn't all land back in the hands of, you know, profiteering, evil suppliers. It's the efficient suppliers and the efficient procurement specialists that work together to get cost out of the supply chain, and that's where the prize is for everybody.

CUFFE: But it's a prize that remains elusive for many. And one of the reasons is that in England there is no-one making it happen. Gradually, NHS hospitals are being set free; by 2014 they're all supposed to be Foundation Trusts - independent entities managing their own budgets. The regulatory body, MONITOR, will ensure that they meet standards of financial probity and hospital infection control, but it won't look at procurement. And that's a glaring oversight, according to Mario Varela. He runs the London Procurement Programme, a collaboration between 71 NHS organisations.

VARELA: I believe that that for procurement to be high enough on the agenda then it has to be something that's reported in terms of some sort of key performance indicator. At the moment, part of the key performance indicator is that

VARELA cont: MONITOR collects or any other organisation, there's nothing around procurement, so if there's nothing around procurement then it's not that important, we don't need to measure it and we don't need to report on it.

CUFFE: Isn't that surprising, to say the least, that procurement shouldn't be on the agenda?

VARELA: Well, my view is it should be on the agenda and I think the better organisations do have it on the board agenda. The problem is I don't think that the large majority of them have and, as I said, it may well need some sort of intervention from the point of view that having to be part of some sort of monitoring process for them to actually take that agenda seriously.

CUFFE: From all sides – trusts, procurement businesses and suppliers – there's the same call for direction from the top. In his report for the National Audit Office, Mark Davies says that trusts need to be held to account for their procurement practices, but as things stand now, it's hard to know who they should be accountable to.

DAVIES: Currently you have a sort of a halfway house, because for those hospitals that remain NHS hospitals as opposed to Foundation Trust hospitals it is ultimately the responsibility of the NHS Chief Executive and the Department of Health. For Foundation Trusts the picture is less clear. Because they are self-governing, they are local bodies, but ultimately I think it is a question mark and it is a question mark that the Public Accounts Committee have asked repeatedly this year as to who is going to be responsible for securing those system-wide improvements that need to happen, in terms of procurement efficiency and effectiveness.

CUFFE: So it won't necessarily be the National Health Chief Executive?

DAVIES: Well ultimately by 2014 all Hospital Trusts will be Foundation Trusts. You know, the responsibility will no longer fall to an NHS Chief Executive. But ultimately there is a question mark as to who will be responsible...

CUFFE: What about the Department of Health?

DAVIES: Well that's a very good question and that is a question that is, I think, currently revolving around the corridors of power, frankly.

CUFFE: The man that question's directed to is the Minister responsible for NHS procurement, Simon Burns.

BURNS: There is a fragmented NHS procurement landscape, but you can't lose sight of the fact that the NHS trusts are independent organisations and it is important that they have got the freedom to be able to make the commercial decisions that they believe are right for their community, including the products that they buy. But what we are doing is working with the existing networks to raise awareness of efficient procurement practice. This is something that needs to be recognised at a trust board level and we're developing standards for good procurement so that we can, that they can be understood and brought in throughout the organisation.

CUFFE: Well there is one way of encouraging them to procure better, and that would be to set this as a performance target. And yet the regulatory body for Foundation Trusts, MONITOR, makes no mention of procurement at all.

BURNS: Well, procurement targets in the past have not worked and not been the be all and end all that people have suggested ...

CUFFE: But MONITOR does have other targets. It has targets, for instance, for infection control in hospitals. It has targets for financial probity. Why not for procurement?

BURNS: Because the fact is that, as we've already discussed, the trusts are independent and we believe that instead of having some top-down imposition of a system, that it should be driven from the bottom up, but providing the help and the advice so that they can work with the relevant networks and NHS Supply Chain and others to maximise efficient procurement practices.

CUFFE: But there's more devolution to come.

ACTUALITY IN PARLIAMENT

MAN: We come now to the main business, the Health and Social Care Bill programme motion, to move which I call the Minister of State at the Department of Health, Mr Simon Burns.

BURNS: Thank you, Mr Speaker. I beg to move the motion in the name of my ...

CUFFE: Earlier this month, Simon Burns took the Health and Social Care Bill back to the Commons. The Government's reform will put England's 35,000 general practitioners in charge of most of the £105 billion Health Service budget.

ACTUALITY IN GP SURGERY

RECEPTIONIST: Hi, can I help you at all?

WOMAN: I have an appointment, Cheryl Bisby.

RECEPTIONIST: Cheryl?

WOMAN: Bisby.

RECEPTIONIST: Okay. And is it with a doctor or a nurse?

WOMAN: Doctor, love.

CUFFE: Patients at Edgerley Surgery in Stockport can get some of the services here that they'd normally expect to find in hospital.

GILL: We provide spirometry testing, which is a way of measuring lung function to pick up a smoking-related condition called COPD. We provide

GILL cont: on-site ECG recording and we also provide 24 hour blood pressure monitoring, which means patients have a machine that they wear for 24 hours and it records their blood pressure every thirty minutes in the day and hourly through the night.

CUFFE: Up to now, family GP, Dr Ranjit Gill and his partners have bought most of what they need from one supplier, with his Primary Care Trust providing some high cost items. He's chairman of the Stockport Clinical Commissioning Pathfinder, a committee that already oversees the PCT's £400 million annual budget. But when the Government reforms kick in next year, his commissioning group will be responsible for procurement on a grand scale.

GILL: We'll want to reduce the cost of provision whilst at the same time improving the quality and speed and safety of provision.

CUFFE: You're going to be responsible for bigger budgets. Are GPs really qualified to do procurement well?

GILL: I think the short answer would be, we are entirely unqualified to do procurement well, and I think, you know, we know our limitations, and we know that effective procurement means that we need to employ specialist expertise. I have to say, sometimes specialist expertise does end up costing quite a bit and doesn't always deliver what it says on the tin. We don't want to find ourselves going down this road and then finding ourselves as some large organisations have found in the past – they pay over the odds for some simple cheap piece of equipment. So I think we are mindful of the fact that we're not experts, we need expert support and we will need to look carefully at those who tout their wares in terms of offering us a service about procurement.

CUFFE: Previous experience of GP fund-holding suggests that some doctors will be better at managing their budgets than others. And, with so many local commissioning groups in control, procurement –says consultant Peter Smith - can only become more bewildering.

SMITH: The GP reforms, I think, add another layer of complexity and uncertainty. More buying points – that's people each spending still a lot of money, but less money than the PCTs potentially, and in a more fragmented way, because GPs are interested in their own area, in their own commissioning group, their own surgeries. So again we're losing that opportunity to use the NHS purchasing power and really get the best deals, I think.

CUFFE: What are the potential consequences of this?

SMITH: I think there are value for money risks, that the public purse will end up paying more than it needs to for certain goods and services, and I think there's potential for a lot of confusion. I mean, the one group who I can see without any doubt doing very well out of all these changes are the lawyers, because I think we will see the commissioning groups having to take a lot of legal advice. I think we'll see challenges potentially from hospitals and from private sector providers as this new landscape gets into place.

CUFFE: But the Health Minister, Simon Burns, dismisses the idea that his Government's reform will make the situation worse – he says the procurement spending GP commissioning groups will be responsible for is modest. And overall, while accepting there are problems in the system, he remains convinced that when it comes to delivering the £1.2 billion worth of savings, it's the commissioners and trusts themselves who should be in the driving seat, not the Government.

BURNS: I accept that there have been two House of Commons Committee reports in recent months which have highlighted problems that are going to be addressed, but I don't recognise that there is a wholesale, across the board problem. Yes, there are ways in which we can get greater efficiency, greater effectiveness. Yes, there are ways in which we can save money and cut out some of the wasteful practices that have happened at the moment. But I do not believe that the system is as shambolic as might be being suggested to you by some of the people that you're talking to. I'm not saying everything is perfect, but what I am saying is that we've got to move forward along the lines that we are suggesting, within the ambit that the trusts are independent and we want to see a

BURNS cont: bottom-up system that actually works, is more cost effective, more cost efficient without the heavy hand of the Department of Health, because that in itself would not necessarily be the be all and end all to the problem.

SIGNATURE TUNE