NHS Supply Chain Medical Supplier Board Meeting
BIVDA Offices, London
041016
Meeting Notes

Attendees

- **Chair:** Chris Holmes, Head of Procurement & Customer Value, NHSBSA
- **Secretariat:** Louise Hillcoat, Supplier Stakeholder Manager, NHSBSA

• Sandra Barrow	DH
• Alan Birks	AXREM
• Naomi Chapman	DH
• Mariella Childe	DH
• Ila Dobson	AXREM
• Barbara Fallowfield	BIVDA
• Nicola Harrington	NHS SC
• Mark Hart	NHS SC
• Chris Hill	SDMA
• Ray Hodgkinson	BHTA
• Jason Lavery	NHS SC
• Ann McChesney, P/T	DH
• Michael Pace	
• David Pierpoint	NHS SC
• Edmund Proffitt	BDIA
• Tracy Stewart	AHPMA
• Nishan Sunthares	ABHI
• Paul Surridge	BIHIMA
• Andy Sutcliffe	UTA
• John Warrington, P/T	NHS Improvement
• Paul Webster	DH
• Michael Whitworth, P/T	NHS England

Apologies

• Stephanie Hill	Barema
• Tracey Lloyd	BHTA
• Greg Quinn	UTA
• Tony Reed	BDIA
• Jin Sahota	DH

Meeting Notes

	Item
04/10/1	**Welcome and Introductions led by Chris Holmes**
1.1	Chris Holmes read out Competition Law guidelines to the Board as a Standing item requirement
1.2	The Board members are reminded that, with the exception of commercial in confidence slides, all Key Documents will be produced and posted on the Supplier Board website in full and in line with its Transparency Objective. As all Suppliers will have access to the website, the documents will be produced in such a way that the un-initiated reader will have some understanding of the documents and content, even without having all the background.
04/10/2	**Introductions and apologies, Action update**
2.1	All attendees and guests were welcomed to the BIVDA offices and introductions were shared. Particular welcome to Andy Sutcliffe and Edmund Porritt who attended for the first time.
2.2	All Actions from the July 2016 meeting are now completed.
04/10/3	**Supplier Board Review - Terms of Reference (ToR), Membership, Chair**
3.1	A pre-read had been circulated prior to the meeting. This proposed some minor amendments to the membership, purpose and scope of the supplier board to reflect the change of governance of the Board to NHSBSA and to transition to the future operating model post October 2018. Members were invited to comment. The original ToR were drawn up and subject to legal advice prior to their issue. It is proposed that the revised documentation will also undergo legal scrutiny to ensure compliance with competition law. ABHI asked for an amendment to the wording "Support savings delivery to NHS" as this implied that the Board would not be able to challenge or scrutinise the savings initiatives. Members agreed that this should be changed to "Engage on the delivery of NHS Savings Targets". Crown Commercial Service are now members of the National and Regional Customer Boards, with Will Lain as representative. CCS currently service the NHS in the Office Supplies space, the Supplier Board members agreed that CCS should be invited to attend the Supplier Board on the same terms as NHS Supply Chain currently attend. **Action: Chris Holmes to extend an invitation to Will Laing, CCS to attend the January Board**
3.2	Louise Hillcoat now attends the National and Regional customer boards and has presented an introduction to the Supplier Board, which was met with interest and a request from Customer Board members that the agendas be aligned and a representative of each board sit on the other. A rotational representation was suggested. **Action: Louise Hillcoat and Chris Holmes to explore representation on future Supplier and Customer boards**
3.3	The Supplier Board name has to be changed from NHS Supply Chain Supplier Board as

	this no longer reflects the scope and purpose of the Board. Members questioned "NHS Supplier Board" as this suggested a wider representation, including pharmaceutical and services. **Action: NHSBSA to propose alternative names and ask members to vote**
3.4	AHPMA called for more robust Competition Law guidelines to be included in the ToR. The meeting agreed that an extract from Competition Law should be included at the beginning of the ToR document **Action: Louise Hillcoat to add Competition Law extract to the ToR document**
3.5	The chair acknowledged receipt of a letter from ABHI expressing their preference for an independent chair and will consider its proposal. The letter has been shared with the MedTech forum, via the secretariat, but some members had not seen it. **Action: Louise Hillcoat to share the ABHI letter with all members**
3.6	Amended ToR documentation will be circulated for further comment to all members by end October 2016 **Action: Louise Hillcoat**
3.7	Ray Hodgkinson from BHTA suggested that the board should consider appointing a Vice-Chair which members were in agreement with. **Action: Louise Hillcoat**
04/10/4	**NHS Improvement – Carter programme, Core List**
4.1	John Warrington presented an update on the Carter programme delivery and explained the structure. Members were invited to visit the Single Oversight Framework document, published on 30th September 2016, which outlines NHS Improvement's engagement across the NHS. [Click here to see document]  Trusts have been categorised into four groups, depending on the level of provider support they require. These are: 1. Providers with maximum autonomy 2. Providers offered targeted support 3. Providers receiving mandated support 4. Special measures The majority of trusts are classified as Group 2 and Group 3
4.2	Members heard about how the Weighted Activity Unit (WAU) metrics are being used to ascertain spend and identify best practice within trusts. This has informed the key savings initiatives that are being undertaken by NHSi. Procurement data has been the more difficult to obtain as part of the WAU metrics. A "non-pay spend per WAU" metric has been developed and is now being collected from all trusts on a monthly basis. All trusts are being measured against compliance to stated performance KPIs, including:

	1. Non-pay spend per WAU broken down to clinical supplies spend per 2. WAU and general supplies spend per WAU 3. % of transactions on e-catalogue 4. % of transactions on electronic purchase order (ePO) 5. % spend on contract 6. Inventory turns 7. Standard of Procurement assessment score 8. Performance against Purchase Price Index & Benchmarking tool (PPIB) Trusts are required to conform to these criteria and a more standardised behaviour will be visible to suppliers. Administration costs within trusts (including community and mental health trusts) have been identified as a key savings area. A letter has been sent by Jim Mackay, Chief Executive of NHS Improvement, informing CEOs that administration/back office costs and pathology costs should not exceed 7% of spend. This is forming a key aspect of the STP Procurement Transformation Plan and is being programme managed by consultancies (PA Consulting for back office and LTS consulting for pathology). All trusts are required to produce their Procurement Transformation Plan by the end of October 2016 in line with their Sustainability Transformation Plan (STP) collaborations to reduce back office costs. The PPIB, price benchmarking tool is now recording monthly spend data from trusts by product MPC. The data is recovered from ePO information, which has highlighted some discrepancies and areas for improved data management, removal of duplication and inconsistencies of ePO usage, all of which is being addressed and data improvements have already been made. ABHI questioned what "good" looks like for NHS Improvement. John Warrington confirmed that the non-pay spend per WAU is being used to measure improvements. Michael Pace warned that whilst some suppliers may attempt to bypass the national procurement programmes and negotiate bespoke deals with trusts, this behaviour will be visible and transparent due to the ongoing PPIB and WAU data analysis. Members agreed that this Supplier Board would be a useful forum for sharing best practice in order to deliver the national savings programmes. It was proposed that a representative of NHS Improvement be invited to the January Supplier Board. **Action: Chris Holmes to invite Ian White, NHSi to January Board**
4.3	The Getting It Right First Time (GIRFT) programme led by Tim Briggs has collated data from every trust. The work has produced accurate costs per procedure and patient days within the trauma and orthopaedics categories. The success of this programme has led to a proposal to roll-out to 21 clinical specialities. Each programme is forecast to take 12 months and, if funding granted, a channel lead would be appointed for each workstream.
4.4	The model hospital programme is now live. Trusts have a login to the website and can access their performance measurement against some of the benchmark criteria. The remaining criteria will be live progressively.
4.5	The Secretary of State for Health has endorsed a national programme to rationalise and standardise on the use of products with low clinical impact. This will result in strong encouragement to use a recommended suite of products across all trusts, procured through the current national provider, NHS Supply Chain. A letter was sent on 21st September 2016 by Jeremy Marlow to all trust CEOs, informing them of the core list of products and the expectation on them to purchase this list through NHS SC. So far,

	acceptance of this programme has been good.
4.6	Paul Webster, DH, recognised the role of the Supplier Board to channel questions and feedback on the national programmes, but stressed that it is not a forum for challenging or informing policy as this should be done directly through the DH Supplier Engagement programme. He acknowledged that there is no clear forum for sharing best practice improvement and that the department are looking at how new and innovative ideas can be brought to the fore.
04/10/5	**NHS England Excluded Devices Programme - Michael Whitworth, NHS England**
5.1	Michael Whitworth shared an overview of the programme and highlighted that of the 28 high value products, excluded from tariff, 17 are being procured using the zero cost model through NHS Supply Chain. There are no plans to extend this to all 28 at this time. There has been a rapid growth (8%) in usage of these high cost products and a 4% increase in price. There is a reinvestment target of £60m to ensure optimum use of new technologies, but the growth and price increase are prohibiting the investment. This model regains control of £500m of expenditure and will deliver savings as range rationalisation is ultimately rolled out. The model removes the need for clinicians to become involved in the procurement, which currently distracts them from patient focused activity. 19 trusts are adopting the model and they have returned positive feedback scores relating to its implementation and adoption.
5.2	Suppliers and the supplier associations were praised for their engagement with the programme and the provision of base line spend data. In particular, engagement with ABHI and their support for the cascading and escalation of Q&As was acknowledged by NHS England. **Action: Louise Hillcoat to circulate the Q&A document to all members**
5.3	Engagement with BIHIMA in the audiology categories will be developed. **Action: Paul Surridge, BIHIMA and Michael Whitworth to meet and discuss engagement**
5.4	ABHI members will attend a meeting with NHS England on 18th October to inform about the programme.
5.5	Nishan Sunthares asked for a meeting with NHSBSA ahead of that date to discuss this and the current Cardiology super tender procurement activity that is being undertaken by NHS SC. **Action: Chris Holmes, Mark Hart and Nishan Sunthares to set up meeting/ConCall before 18/10/16**
5.6	Chris Hill, SDMA asked what is the advantage and value to the NHS of the zero cost model. NHS England had identified a need for improved transparency and scope for future rationalisation of products to deliver increased efficiencies. The data is being fed into the NHS Improvement database to inform tariff developments.
04/10/6	**Inform on NHS Supply Chain's Capital Solutions business unit**
6.1	Capital spend is constrained and will continue to be reduced. A recent HSJ article detailed the reduction in Capital and Maintenance spend across the NHS.
6.2	Recent Capital finance solution for MRI, CT and Linacs of £20m was taken up within 5

	weeks and delivered a £3.2m savings. A further £30m has been approved for future procurement. Ila Dobson, AXREM asked whether the success of using the DH fund to deliver tangible savings was likely to be extended into other modalities. Jason Lavery, NHS SC confirmed that there were no current plans to extend beyond the next £30m.
6.3	A total of £70m saving across Capital and Maintenance contracts has been delivered since the start of the DH Capital fund.
6.4	A survey has been sent to all trusts to obtain the age and specification profile of capital equipment in order to establish a timetable for renewal.
6.5	NHS SC have put £40m of spend through multi-trust spend aggregation.
04/10/7	**Inform on NHS Supply Chain's Procurement business units**
7.1	NHS Supply Chain metrics will be circulated as a pre-read to the January minutes and will only be reported on by exception and in response to members' questions. **Action: NHS SC to provide metrics updates two weeks in advance of the next meeting**
7.2	The Supplier Board agenda will focus on current and future priorities in order to provide members with the opportunity to engage and challenge them.
7.3	Core list activity has driven strong unit price savings and uptake has been good across all trusts. Focus is now on the integration with the NHS Improvement recommendations for a mandated Core List in alignment with the outputs of the Clinical Evaluation Team specification work. Nishan Sunthares, ABHI questioned the supply chain resilience when range is rationalised as well as the level of clinical evaluation that has taken place. Nicola Harrington, NHS SC confirmed that suppliers are audited to ensure capacity and capability will support the programme, with contingency planning in place in the event of interruption to supply and to avoid monopolisation of supply chains.
7.4	In line with the Carter recommendations, NHS SC is involved in a programme to remove bespoke pricing and commitment discounts in order to optimise pricing transparency. Members sought clarification that bespoke pricing was not related to bespoke product specifications. It was confirmed that "bespoke" refers to price deals negotiated with an individual trust in return for committed volume and that categories where bespoke products were procured, were not included in this programme. Members highlighted that only a proportion of commitment deals were transacted through NHS SC. The PPIB data will highlight where a bespoke/commitment pricing arrangement has been made with a supplier and greater visibility and transparency will result from this analysis.
7.5	In order to ensure accurate communications with suppliers, NHS SC is updating its contact database. This database is used by the Clinical Evaluation Team as well as the communications teams. To ensure accurate contact details are used, a survey monkey link has been sent to all suppliers for them to complete. Response has been low (121/851) and all members are requested to cascade the link to their members with a request to complete the fields. **Action: Louise Hillcoat to circulate the survey monkey link** **Action: Members to cascade the link to their membership with a request that they complete all fields.**

04/10/8	**Clinical Evaluation Team programme update - Naomi Chapman, Programme Lead**
8.1	Naomi presented an update on the Clinical Evaluation Team programme. Andy Sutcliffe, UTA asked how Urology CET activity, the NHSBSA Trusted Customer and the NHS SC Core List are all linked and whether the community market is within scope of the various initiatives. Naomi confirmed that all the programmes are joined up and are working in collaboration. Community is also included and will be increasingly referenced as the STP footprint shapes the NHS activity.
8.2	Members sought clarification on how the Start Rating is being arrived at for each CET product analysis. They asked whether clinicians had the opportunity to challenge. ABHI questioned whether the analysis could be truly objective. Naomi explained that the process is available to view on the CET website and that the testing is done independently by a team of clinicians, who are recognised as subject matter experts by their peers. There is a portal for clinicians to communicate with the CET via the DH Stakeholder site and via the CET email. **Action: Naomi Chapman to share link to the CET process**
8.3	Ray Hodgkinson, BHTA asked whether the medical device directive, which references product evaluation has been considered. Naomi confirmed that the basis for the evaluation process was aligned to the NICE evaluation criteria and complied with the directive. **Action: Ray Hodgkinson to email a copy of the relevant Bill to Louise Hillcoat for reference and consultation with CET**
8.4	Members asked whether there was a requirement to send proof and certification for product conformity to ISO standards. Naomi responded that this would be beneficial and confirmed that the CET recommended specification will be aligned to the relevant ISO standards.
8.5	Members questioned how the CET work plan is aligned to the NHI Improvement Nationally Contracted Product (NCP) list as detailed in the letter from Jeremy Marlow to Trust Chief Executive Officers. Naomi responded that there will be alignment now that there is full visibility of the NCP programme.
04/10/9	**DH Update – Sandra Barrow**
9.1	Sandra Barrow shared an update of the Pre-acquisition and pre-purchase questionnaires that had been circulated to members as a pre-read. There were no questions from members. She informed the meeting that Crown Commercial Service had issued a selection questionnaire which has replaced the PQQ and is based on the European Directive.
9.2	Sandra acknowledged communications from members and individual suppliers about the lengthening of payment days from NHS Trusts. She confirmed that action was being taken and that members should see an improvement. **Action: Members to contact Sandra Barrow with any concerns regarding payment terms**
04/10/10	**NHS Future Operating Model – Closed Session - Ann McChesney, DH FOM Team**
10.1	Ann presented an update of the Future Operating Model. Members asked for more granular detail about the categories

	Action: Ann McChesney to share presentation detailing constituents of category towers
10.2	AXREM asked why the Capital Tower would be split as in their consultation meetings with the FOM team, they had explained that the constituent products are interdependent. Ann agreed that AXREM should detail their concerns in a document and a meeting to address their members' concerns will be set up. **Action: Ann McChesney, Alan Birks to set up a meeting to discuss Capital Towers 7&8**
10.3	Members asked that an agenda slot be included on the next and subsequent Supplier Boards for updates on the Future Operating Model **Action: Louise Hillcoat to include FOM update on future agendas**
04/10/11	**Any other Business**
11.1	Ray Hodgkinson asked whether the HEALTH SERVICE MEDICAL SUPPLIES (COSTS) BILL had been extended in scope beyond Pharmaceutical Suppliers. Paul Webster said that this bill was introduced to enable the DH to control pharmaceutical pricing only and that pricing policy and information can be viewed at the DH website. https://www.gov.uk/government/publications/health-service-medical-supplies-costs Ray asked members to read the Bill and consider if they thought its scope may be extended to products within their categories. **Action: All Members**
04/10/12	**Items for next meeting**
12.1	National Contracted Products update from NHS Improvement CET Evaluation outputs Future Operating Model update **Action: Members to send suggestions for future agenda items to Louise Hillcoat by December 16th 2016**
12.2	Pre-reads will be issued at least 5 working days prior to the next meeting **Action: Louise Hillcoat**
12.3	Date of next meeting: 18th January Venue Skipton House, London
04/10/13	**Close** Meeting Closed at 15:00