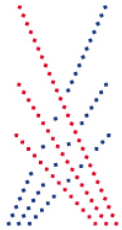

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Analysing the development of an efficient NHS – exploring additional success factors required in the implementation of Lord Carters' efficiency savings in order to share best practice

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Analysing the development of an efficient NHS – exploring additional success factors required in the implementation of Lord Carters' efficiency savings in order to share best practice

Abstract

Aim
To analyse the development and implementation of efficiency in the NHS, by analysing the success of Lord Carter's efficiency savings.

Background

With the current state of the NHS and employees feeling disenchanted along with pressures to perform to higher levels with reduced resources - it has lead to a crisis within the NHS. It is important to identify ways to successfully implement change within the NHS with particular regards towards efficiency savings.

Methodology

A qualitative method was used with semi-structured interviews along with the secondary data in order to triangulate the data. Three trusts formed the case studies with one being more in depth.

Findings
Progress has been made in the implementation of the *Carter challenge*, there is still a lot to do. Staff, patients and to a lesser extent businesses, have been impacted.

Conclusion
Doctors feel extremely demoralised therefore I recommend a HR strategy should be deployed to manage the biggest resource in the NHS.

Word count: 6374

Introduction

The NHS was established in 1948 to provide free medical care at the point of need for patients (NHS, 2015). Whilst the meaning of its mission statement has increased in area and services provided over the years; ranging from acute emergency care to prevention in the form of campaigns for awareness and prevention with vaccinations, to the management of Minor ailments and chronic problems by GPs, followed by treatment by specialists for more serious conditions in hospitals.

There is a national focus on the NHS due to the current political and economic climate (Meehan et al, 2016). Over the years there has been increasing pressure for the NHS to provide high levels of health care with less financial input (Carter, 2016) (Meehan et al. 2016). Due to the economic climate and the number of unemployment and rates of pay behind the rate of inflation, there has been a reduction in funding in real terms (Carter, 2016). Society has demanded that the funds that are provided are not wasted in this time of austerity. With the uncertainty that Brexit brings with unaccounted potential increase in costs on procurement due to new trade deals and import taxes, there is evermore need for savings (Hunt and Wheeler, 2017).

Over the years Lord Carter has provided recommendations for an NHS reform focusing on efficiency savings whilst maintain high standards of care for patients (Matthias and Brown, 2016). Whilst Lord Carter has provided a strategic plan, the NHS trusts and hospitals are required to construct a plan at the local level, following the strategy, and the implementation of it. There is a requirement to identify if there has been success in the implementation of Lord caters efficiency savings and if there is a golden plan of implementation that can be followed across all NHS trusts. With an increase in the cost of life saving drugs NICE is under scrutiny to offer them to patients where the quality of life is also enhanced. Imposing change in a large organisation is often difficult and requires all parties affected to be willing to adapt to the change, and believe it will be for the better (Boak et al., 2015). With the current state of the NHS and employees feeling disenchanted along with pressures to perform to higher levels with reduced resources it has lead to a crisis within the NHS with moral being at its lowest resulting in strikes that have never seen before in the history of the NHS. It is therefore important for this research to identify ways to successfully implement change within the NHS and in particular in regards to efficiency savings.

The overall aim of this research is to analyse the development and implementation of efficacy in the NHS. To analyse the success of the of Lord Carters efficiency savings paying added attention to centralised procurement, and how change can be implemented successfully.

Research questions

To analyse the development of medical procurement efficacy in the NHS; the following questions will be explored:

1. Has the implementation of Lord Carters centralised purchasing system been successful within the NHS?
    a. What does success look like
    b. What factors contributed to the success/failure
2. How have the efficiency changes been implemented

3. What has been the impact to:
    a. Staff
    b. Patients
    c. Business within the medical industry (the suppliers to the NHS)

In order to answer the first question the current stage of implementation of lord caters recommendations needs to be established and in which trusts. Furthermore, a clear definition of what success looks like needs to be explored; as there is a need for efficiency savings whilst providing high levels of care and patient satisfaction.

In contrast, investigating the impact the NHS reforms have had identifying any signs of stifling innovation within healthcare industry, and the effect it has on small and medium enterprises. As it is suggested that real innovation comes from smaller companies and often reduce costs due to new competitive advantage induced by creative destruction (Christensen, 1997; Schumpeter, 1934).

Furthermore it gives rise to a question whether the NHS reform has increased the chances of further privatisation in the wider scale of other services and products purchased by the NHS.

Literature review

NHS reform

Healthcare is considered the most important service people will encounter, as patients become more aware of the financial restraints, it poses ever more challenges for the NHS service design and operations management (Matthias and Brown, 2016). The Government have agreed to increase funding to provide a sustainable NHS providing 120 billion by 2021, however there is still a requirement for efficiency saving with a potential of 5 billion that can be saved from efficient use of staff, medicine and procurement, specifically a 700m procurement savings (Carter, 2016).

Central government has attempted to reform the NHS by major structural changes, and monitoring performance standards and policies, utilising techniques of lean manufacturing, although the implementation is complex (Boak et al., 2015). Matthias and Brown (2016) found Hospitals agree that CEO's own the strategy and the implementation is achieved by engaging with front-line staff. There is a mismatch between politicians, clinical staff, and management demands (Matthias and Brown, 2016). NHS relies on a number of service providers for the delivery of care and it is continuing to increase (Matthias and Brown, 2016). This private - state collaborative working can enable sharing of skills (Matthias and Brown, 2016). There is a high level of concern among public health specialists regarding the NHS reform and implementation (Lamber and Sowden, 2016).

Lord Carter report

Annually the NHS spends £55.6 billion; Lord Carter was tasked with improving efficiency in the NHS. Lord Carters (2016) estimated savings of 5bn due to

unwarranted variation. Lord carter identified inconsistencies in the use of digital procurement catalogues, for example the variety in the NHS procurement is as vast as a 102% difference in price for hip prosthetics from over 20 suppliers to 15 trusts (Carter, 2016).

The Procurement Transformation Programme (PTP) has been formulated to improve the purchasing within the NHS. PTP encompasses; the formulation of a standard NHS catalogue with clear pricing and quality assured, remodelling of the procurement and NHS supply chain at the end of the current contract ending in October 2018, revision and inclusion of new eProcurement technology (Carter, 2016). A number of trusts formed the NHS Southern Procurement Partnership to streamline the number of manufactures and variety of products by 80% for generic products (Carter, 2016). However, minimizing the number of suppliers may reduce competitiveness and in turn result in an increase in price (Grant, 2002).

By September 2017 all trust will be targeted to operate with 80% of transactions via the electronic catalogue. All trusts are expected to have a Hospital Procurement Transformation plan (HPTP) in place to meet the Model hospital benchmarks outlined by lord Carter, improving the NHS procurement by following in the footsteps of the HPTP, used at a national, regional and local level. Collaborations between trusts have been encouraged particularly working with five others.

Furthermore hospital pharmacies within the NHS have a significant variation of 2.5%-71% in time pharmacists spend on clinical services in comparison to infrastructure, an average of 55% of time and 43% of cost on infrastructure. In hospitals there is 6.7 billion spent on medicines, large variation in medicine costs across trusts have been identified and it believed that savings of at least 800m could be made (Carter, 2016).

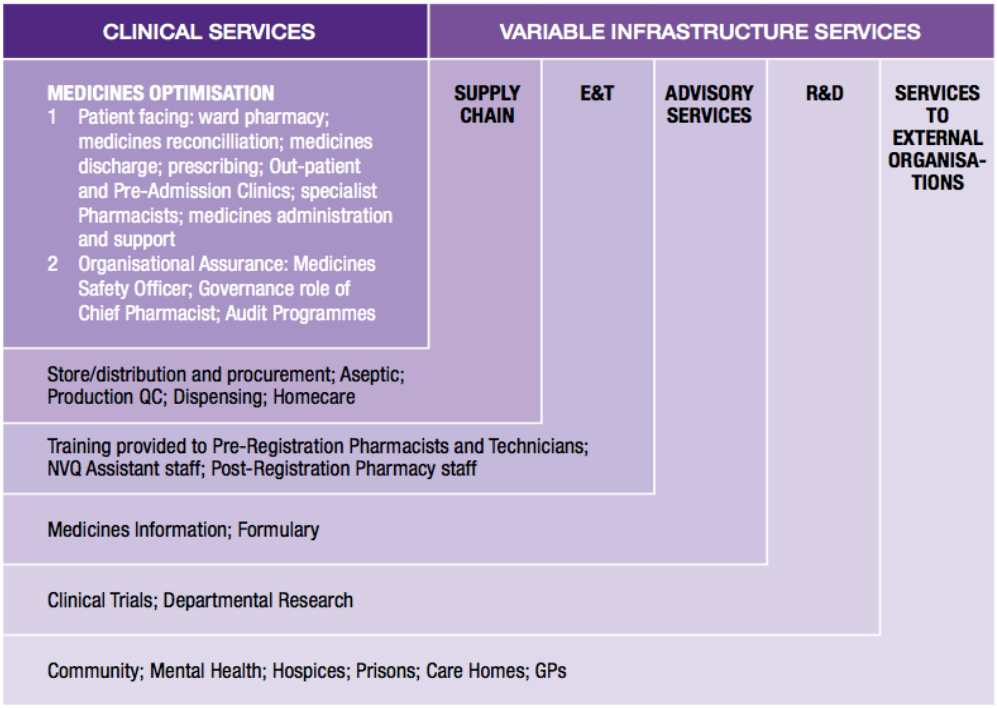

Figure 1. Hospital Pharmacy services shown as clinical or infrastructure. 55% of pharmacy time on average is spent on infrastructure services. (Carter, 2016)

Lord Carter (2016) would like to see the effective use of resources and believes the most important resource is the people working within the NHS. The PTP will include a central reporting system to monitor performance of all trusts. Lord Carter (2016) encourages collaboration on a local and national level, the majority of trusts agreed they would be more efficient if there was a change to clinical service delivery or sharing of support services. Lord Carter states that the same approach should be taken for mental health and community trusts (primary care) and the methodology and tools suggested are transferable (Carter, 2016).

Health services around the world

Lord carter notes there are possible learning's that can be taken from healthcare services around the world (Carter, 2016). For Instance, Lean strategies have been implemented successfully in a number of healthcare strategies such as Hong Kong and the USA (Matthias and Brown, 2016). Matthias and Brown (2016) stated strategies from other countries cannot be copied due to the differences in public and private funding.

Furthermore, the disparities in funding are not discussed in the Carter report. The UK prides itself with having a state funded health service, that is often thought as being the best in the world, therefore it to would be reasonable to expect the funding to match, however the UK is average with a 8% GDP, in tenth place behind Sweden in first place and Germany second, this adds weight to the argument of the NHS being underfunded (OECD, 2016).

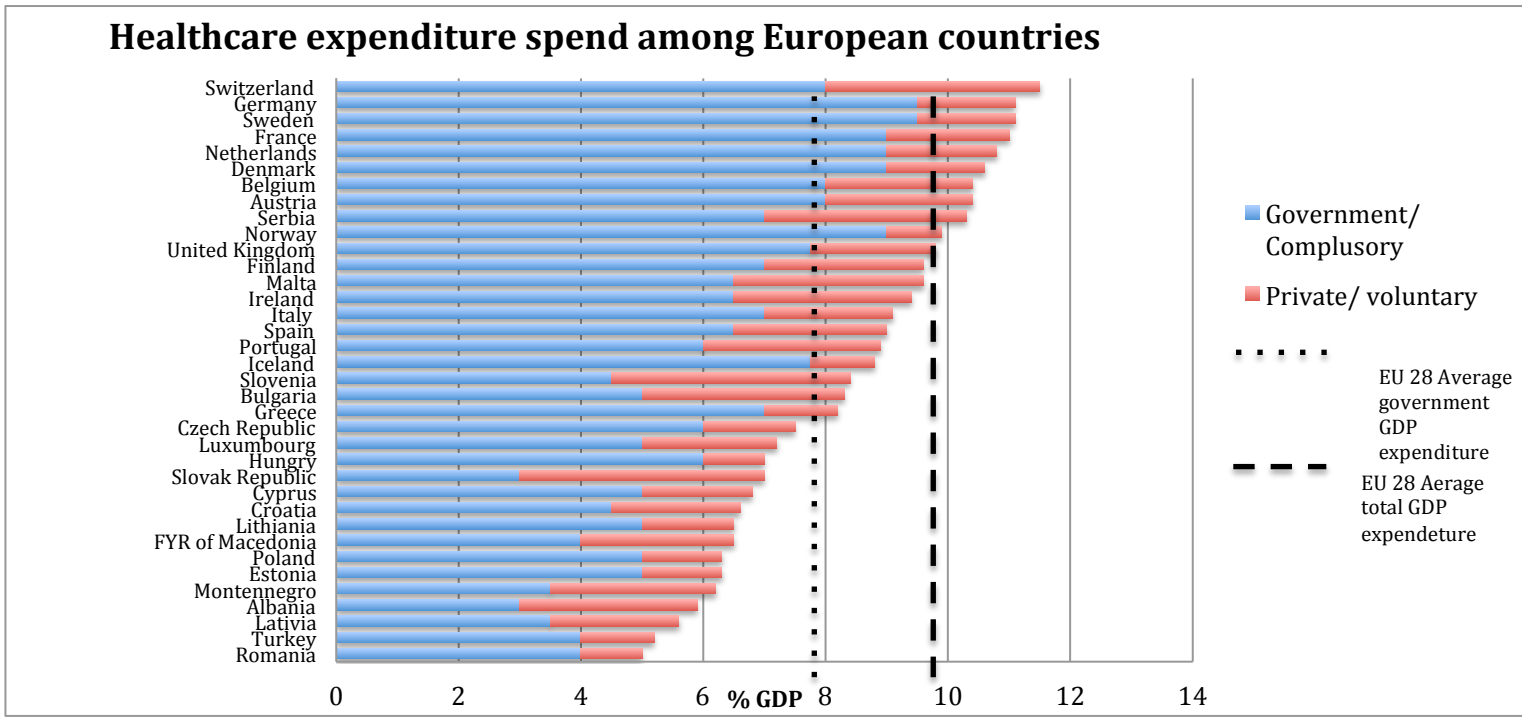

Chart 2.3.1 Healthcare expenditure among European countries, (Author, 2018) adapted from (OECD, 2016).

Healthcare systems over the world have undergone decentralisation in the past 40 years with the assumption to increase efficiency and financial responsiveness (Mauro, Maresso and Guglielmo, 2017). However, since the beginning of the 21st century, European health services in particular are moving back towards recentralisation, albeit

for particular areas where centralisation is seen to be of benefit (Mauro, Maresso and Guglielmo, 2017).

Israel arguably has one of the best national healthcare services in the world however over 70% of the population choose to add the "supplement/complimentary cover (Kaplan, Shahar and Tai, 2017). In contrast, Germany has 90% of its population enrolled in its public health scheme, and the remaining compulsory purchase of private health insurance (Nadash and Cuellar, 2017). However, Nadash and Cuellar (2017) identify the emerging market for long term care insurance supplementary similar to Paris and the USA, in the UK use of means testing and private insurance options "never got a foothold", however this is expected to change.

Procurement strategies

The NHS Supply chain works closely with NHS trust providing healthcare products, including logistics and e-commerce and customer service. Lord Carter (2016) has placed a focus on providing economies of scale by reducing the number of suppliers and lower costs via transparency; the NHS is targeted at achieving a 300m procurement efficiency savings. The Commercial Medicines Unit (CMU) works with NHS medicine procurement managing the contracting process and analysing the amount of money spent particularly in secondary care (Department of Health, 2011).

Meehan et al. (2016) and Lord Carter (2016) agree that savings are to be made in collaborative procurement and increased efficiency in the associated activities, value can be added along the supply chain and not just a focus on economies of scale. Reducing the time required to attend to multiple deliveries throughout the day, this can also be cost effective for suppliers (Meehan et al, 2016). Although Meehan et al (2016) suggest that funding and targets are allocated devoid of suppliers and market intelligence, adding to the NHS funding crisis.

Supply chain management has been of increasing interest to firms for a number of decade's developing into a strategy of its own, it can be argued that purchasing is as important as other strategies within an organisation (Paulraj, Chen and Flynn, 2006). An organisations purchasing strategy should match the companies' business strategy (Drake, Lee and Hussain, 2013). Over the years purchasing has moved towards a relational, centralised global sourcing (Lindgreen, Révész and Glynn, 2009).

SMEs are thought to be at a disadvantage when attempting to provide a service or product to public bodies due to lack of transparency (Georghiou et al., 2014). Loader and Norton (2015) identified the tendering stage and in particular the specifications required to be difficult for SMEs. In addition to contracts being awarded based on low cost rather than the broader picture of value for money (Loader and Norton, 2015). There is also a requisite for specialist knowledge for the application of a meaningful tender (Loader and Norton, 2015). Procurers preferences are often not transparent due to non-linear attributes contributing to bid pricing, it is then open to strategic manipulation due to irrelevant alternatives (Bergman and Lundberg, 2013).

Centralised or decentralised Purchasing

Centralised purchasing often enables an organisation to evoke buying power although, when purchasing decisions are made at the strategic head quarters level, regional employees can resent the decisions imposed on them as they may feel they are inappropriate for the local position in which they are in (Lysons and Farrington, 2012). The NHS is moving towards a more centralised approach for procurement due to the unnecessary variations highlighted in the Lord carter (2016) report. However, due to the large size of the organisation the NHS has taken many years to plan and execute a centralised procurement system, it could be argued that due to the size this would in fact be detrimental (Lysons and Farrington, 2012).

Outsourcing

The decision to outsource and the impact are of great importance to an organisation (Bals and Turkulainen, 2017). Almerida (2017) argues privatisation allows the NHS to clear backlogs and waiting lists without using public investment. Private providers are often more efficient and have increased productivity with the competition and the drive to make a profit, a (financial incentive), however this is then of set by higher salaries and artificial costs or connected contracts to suppliers (Almeida, 2017).

Competition has been important to the NHS as early as the 1990's, as it is believed to increase efficiency, quality and response to consumers (Sanderson, Allen and Osipovic, 2017). Sanderson et al. (2017) highlight the up and coming transatlantic trade agreement between the EU and the United states, which may have an impact on the NHS in terms of the competition laws and regulations that come with the new agreement, however the UK is withdrawing from the EU so it may not affect the NHS, unless the government opt for the agreement.

In France they face similar problems to the UK with rising cost whilst providing "universal access to high quality care", however this differs to the UK as specialist care is provided privately and paid for on a " fee-for-service basis" this autonomy assists in providing an environment conducive to providing high levels of care, however makes it difficult for the government to manage costs (Dumontet et al., 2017).

Implementing change in large organisations

Within the NHS Matthias and Brown (2016) identified that the term 'operations strategy' was not fully understood within the NHS. Operations strategy is important to provide value and service delivery focus on planning to meet demand and leverage resources alone or with partners (Matthias and Brown, 2016). Senior level managers are responsible with recognising all stakeholders whilst developing and implementing processes and understanding content and scope of the operations strategy (Matthias and Brown, 2016). Boak et al (2015) concluded that successful implementation of a new process required shared leadership.

Within the NHS changes tend to be incremental due to the size of the organisation and cultural constraints; it may be difficult to implement a breakthrough change. Strategy is developed top-down whilst improvement initiatives are seen to come from the

bottom in response to targets set centrally. Matthias and Brown (2016) states there is a long-term commitment to sustainable performance improvement in the UK.

Lord Carter (2016) discusses the need to implement change within trusts but does not out line a clear strategy for doing so. There is mention of knowledge workers within the NHS and they should be regarded as assets as apposed to costs, and therefore utilised as such, improving morale and motivation (Carter, 2016).

Carter recommends nine management practice (outlined in figure 2) that should be adopted (Carter, 2016).

Management Practices	Practice Synopsis
Values-based behavioural framework	Developing a **values-based behavioural framework** – agreeing at the very outset the trust's underpinning values, determining their behavioural implications for all occupational groups and roles, and informing any system and process redesign
Patient-centred organisation	Moving towards a **patient-centred organisation** design – ensuring structure, workflow and resource allocation is designed around the patient through each stage of their hospital journey, as opposed to being designed around functional specialisms
Structural improvements	Adopting basic **structural improvements** – ensuring adherence to best practice management spans and layers, consistency of roles, and defining clearly individual accountabilities and decision rights
Leadership strategy	Developing a Board-sponsored **leadership strategy** – based on business need and a clear set of expectations, and encompassing all leaders from Board to frontline; including recruitment, engagement, development, talent management and succession planning
Operational management process	Implementing a comprehensive **operational management process** – a regular and highly disciplined series of Ward to Board management meetings that drive operational performance, cost reduction, increased efficiency and continuous improvement
Dashboards	In tandem with this process, adopting the Model Hospital **dashboards** - a series of upwardly cascading metrics that provide a balanced view of patient, people and financial performance at any given management level of the organisation
Individual performance management system	Instituting an **individual performance management system** – a process for appraising both task and behavioural performance for every individual in the trust, including a range of feedback mechanisms such as 360s, peer review, colleague survey results and actions; linking this to positive and negative consequences including reward, development, career progression
Engagement	Building **engagement** across all occupational groups – harnessing the ideas and viewpoints of everyone in the trust, paying particular attention to clinical engagement and the role of the Clinical Leader
Colleague opinion survey	Repurposing the **colleague opinion survey** – reflecting more appropriately targeted questions and surveying sections of the workforce on a rolling monthly or bi-monthly basis to deliver a more timely pulse of people's views, and using the outcomes as a key metric in all managers' performance appraisals

Figure 2.2 Recommended Management practices

Methodology

To analyse the development of medical procurement efficacy in the NHS, requires specifically answering the question; has the implementation of Lord Carters centralised purchasing system been successful within the NHS and what has been the impact to staff, patients, and businesses working with the NHS? There is currently little to no research done covering this specific area as the implementation of change is over 5 years it is beneficial to see what stage it is at and identify the effects at this current point in time.

Research design

A Case study method was used with semi-structured interviews to obtain primary data. Although 4-10 case studies are recommended to increase validity of results (Eisenhardt, 1989) it is an ambitious target due to the time frame available for the study. Therefore, one trust was studied in more depth along with two others and three businesses to give a more holistic view. This can allow literal and theoretical replication to occur (Yin, 2003), two interview guides were used (see appendix 1). Utilising an explorative approach to attempt to identify subjectivity and provide an in-depth understanding of the participant's beliefs. In addition to an interpretive stance used to analyse the data, due to the complexity of social interactions, responses will be shaped by the researchers assumptions. Thorough exploration of the researchers assumptions, have attempted to identify potential areas of misinterpretation and minimise bias also by piloting the questions that will be used.

A qualitative method was used with semi-structure interviews along with the secondary data obtained via freedom of information requests and asking the participants of the study in order to triangulate the data. Interviews are beneficial in providing an explanation as to why the participants believe a particular result has occurred. The interviews took take place over the phone and in person where possible. Strategic procurement managers (Chief procurement officers) were interviewed along with hospital 'operational' staff (doctors), in addition to community staff (GPs and Psychologist). To add an alternative perspective, interviews from six 'sales representatives' from different sized organisations that supply medical products, medicine and services to the NHS will be included. Ethical precautions were taken to ensure no identifiable data would be presented to protect the participants.

The research strategy used grounded theory to develop theoretical explanations grounded in the data collected (Saunders, Lewis and Thornhill, 2016). Although this method is time consuming it is beneficial in being used with a qualitative research and an abductive approach (Creswell, 2013)(Saunders, Lewis and Thornhill, 2016). Therefore research can be collected and analysed simultaneously using open codes to identify emerging themes, which can then be reorganised identifying relationships between categories, and then further use of selective coding to deduce best practice. Moreover a further benefit of the grounding theory is the use of theoretical sampling whereby core themes and relationships are identified and used until theoretical saturation occurs. A cross sectional study was used due to the nature of the MBA course therefore providing a snap shot of the results (Saunders, Lewis and Thornhill, 2016).

Sampling strategy

Due to the nature of the NHS it may be difficult in obtaining the preferred stratified samples as a result of work load and time restraints therefore a non probability convenience sample was be used to ensure there is enough participants within the allocated time. Participants included members from the NHS involved with the Procurement Transformation Plans at the strategic level (Executives and Management) and the operational level (doctors/ health care professionals (HCP)). In order to identify the impact of the changes on the suppliers to the NHS, businesses were also sampled using the same sampling preferences to analyse views at interactions with NHS procurement.

Using non-probability sampling generalisations can be made from the results although not statistically (Saunders, Lewis and Thornhill, 2012). Purposive sampling is beneficial to answer the research questions; this is beneficial when using small sample sizes seen in case studies. Due to identifying differences in occupation levels homogenous sampling is used to allow focus on these levels with small sample numbers. Heterogeneous sampling was used for the operational level to get a mixture of backgrounds and therapy areas.

Data collection technique

Secondary data was requested and collected from; NHS policy documents, white papers and the freedom of information act. All NHS trusts should have produced a Procurement Transformation Plan this data will identify how trust are performing in terms of success against Lord Carters (2016) parameters in addition to possibly providing information on collaborations that took place.
Primary Data was collected via semi-structured interviews; questions were piloted to ensure the interviewees interpreted the questions presented as intended (Bryman and Bell, 2015). Using a mixture of techniques is ideal to obtain a richness of data that is required to fully explore and provide answers for the research questions (Yin, 2003). In addition, triangulating data enables further exploration to identify if what is documented is in synergy with reality for exemplar; are departments (hospitals/ CCGs) reflecting the suggestions from the proposed reforms. Semi structured interviews are ideal for explanatory and evaluative research in addition to assisting in exploratory research (Saunders, Lewis and Thornhill, 2016).

Primary data was collected from three NHS trusts; Strategic procurement managers, hospital ‘operational’ staff (doctors), in addition to community staff. To further add an alternative perspective, six ‘sales representatives’ from three businesses were being interviewed from different sized organisations supplying medical products, medicine and services to the NHS.

Participants were recruited initially via the freedom of information act then by direct email.

Table 1 Anonymous Identities of NHS Strategic Level Staff Participants

Chief Procurement Officer	NHS Trust
S1	1
S2	2
S3	3

Table 2 Anonymous Identities of NHS Hospital Operational Level Staff Participants

Operational Staff Doctors	NHS Trust
D1	1
D2	1
D3	2
D4	2
D5	3
D6	3

Table 3 Anonymous Identities of NHS Community Operational Level Staff Participants

Operational Staff Community	Occupation	NHS Trust
C1	Psychologist	1
C2	GP	2
C3	GP	3
C4	GP	1

Table 4 Anonymous Identities of Sales staff of businesses selling to the NHS

Business Sales Employee	Industry	Size of organisation
B1	Medical Devices	Small
B2	Medical Devices	Medium
B3	Medical Devises	Large
B4	Services	Large
B5	Pharmaceutical	Medium
B6	Pharmaceutical	Large

Data analysis

The semi-structured interviews were recorded and transcribed whilst collecting data. Selective coding will be used to formulate a theory grounded in the data placing emphasis on the developing the relationships that emerged from the principal categories to give rise to an explanatory theory. These themes were then used with the secondary data triangulation and conclude findings; this was then used to produce a framework (Saunders, Lewis and Thornhill, 2016). The findings are presented using quotations from the interviewees and identified using the codes used for interviewee's identities (see Table 1-4).

Ethical considerations

To ensure the participants remain unidentifiable, any data that was obtained that had the potential to be published at a later date was not included in the results in its raw format. The prospective participants were given a clear brief of the study and informed they could withdraw at any time in addition they were informed of the confidentiality and anonymity that will automatically be given if they choose to partake in the study (Appendix 2). Informed consent was obtained from all participants via participant information sheets (Appendix 3). Permission to record was sought verbally at the beginning/ before the start of each interview, there was no identifiable data recorded as a precaution. The ethical policy was adhered to at all stages of the research and approval was granted from the university prior to data collection (Appendix 5).

Limitations of methodology

Qualitative research is open to influences by the researcher such as there; bias, assumptions, values and own experience .To limit this in the data collection non leading questions was used to reduce the likelihood of influence, in addition to attempt to limiting body language and other cues that can be taken by the participants as signals to hint that what is being alluded is desirable. Yin (2003) states the difficulty of extrapolating case study findings; this is not necessarily a problem for this research study as the aim is to help the NHS, which in itself is a unique organisation.

This research will benefit the government, the NHS and patients as stakeholders of the NHS along with the medical industry, as suppliers to the NHS. Identifying where the implementation of Lord Carters (2016) centralised purchasing system has occurred and where it is yet to be implemented will provide an update of the progress that is being made, whilst in addition to analysing where there been success in the process and implementation in addition to the cost savings. In line with the NHS's common training principle of 'see one, do one, teach one' with analysis of the research findings, key factors can be identified which are linked to success, best practice can be shared (Mason and Strike, 2003). This research paper aims to provide a framework for the implementation of change within the NHS that can be replicated across the country. There is limited academic research in the area; with the recommendations from Lord Carter being relatively new it will be beneficial to identify the progress and areas of best practice. Meehan et al. 2016 concluded, centralisation alone will not result in success therefore there is a need to identify what factors contributes to success.

Results and analysis

Has the implementation of Lord Carters centralised purchasing system been successful?

Lord Carter (2016) proposed by September 2017 all hospital trusts should have 80% of their transactions through the electronic catalogue. Upon looking at documents obtained of the three trusts used as case studies only 2 out 3 achieved this. Although one document claimed the national median was 93%. On further inspection of the documentation from trust 3 it shows there are inclusions of data that may skew the figures as the Carter metric instructions gives criteria of what should be included. For

exemplar the measurement of electronic purchase orders and transactions through the E-catalogue has XML, CVS etc. data also included and had a side note informing this, and that the trust would not have meet this metric if they were not included as per recommended by Lord Carter. It is also worth noting that one trust (Trust 2) had not completed their Procurement Transformation plan, this shows how varied each trust is in terms of their progress in the implementation of these changes, even though the target was to have the plans completed before the study commenced.

In summary, it is too early to tell if the implementation of the centralised purchasing system has been successful, although it is clear that some progress has been made in all the metrics (including the one pertinent to this study the number of transactions via the e catalogue). The E catalogue is available to be used by the trusts included in this paper, however the further work needs to be done to ensure compliance.

Table 5 Results summary from interview data collection

Implementation of change within the NHS	Impact to staff	Impact to patients	Impact to businesses
Consultation Strategic level staff claims that there is in put from all levels of staff. Although they recognise there was no formal input in relation to these changes however they argue there is feedback systems engraved into the system for continuous improvement. The Operational staff (HCP in hospitals and community) both agree that there is a standard process built in for feedback, however they don't feel their opinions are generally accepted as valid, so they don't bother participating in giving any input. It was also mentioned by a few hospital doctors that they do not have time to attend additional steering group meetings, as they are already over stretched.	Strategic staff believe it is difficult to evidence the impact to staff as no feedback has been sought. However, The HCP whilst acknowledging the impacts they feel may not be directly as a result of Lord carters efficiency savings, they are all in agreement that it is as a result of general efficiency savings, and cuts to funding.	S1 claims the impact to patients the standard of care is "difficult to evidence at this stage." When asked what has been the feedback, all procurement staff interviewed stated that no feedback had been sought. However all the HCP agree that there is an impact to patients. D1 stated, "Patients complain that their medications just gets changed, and decision is made somewhere and no one knows how it is happened".	All businesses interviewed (devises, pharmaceutical and services) agreed they had not seen much of the impact in direct relation to the most recent efficiency changes, although they have continued to increase the cost effectiveness and adding value, in terms of added services and working in partnership to help to support the NHS whilst still making a profit. NHS procurement agree that there has not been much change in their actual orders, S1 and S3 Suggests this may be due to an already high compliance. In regards to new products there has not been any change presently however the "new Future Operating Model (replacing NHS Supply Chain) is likely to have more impact regarding new products… and logistics," informed S1.
Communication There is limited communication between strategic staff and HCP.	**Relationship with superiors** The majority of hospital HCP mentioned an unsavoury relationship with their superiors **Morale** All HCP discuss the general mood and low morale experienced by themselves and their colleagues.		**Changing in sales technique** The majority of doctors and suppliers to the NHS agree that over the years there has been a change in regard to the way they sell their products in addition to the reduction in access to HCP partly due to the time restraints.

Shared practice Although at all levels within the organisation there is an understanding and agreement to the benefits of sharing best practices.	**Personal life** All HCP complained about the impact to their personal life due to being over worked and stressed in addition to the unsupported emotional aspects of the role that they have no relief from due to being over worked.		
Strategic alignment/ Clear definitions The use of "Carter metrics NSHi are relying on KPI and the interpretation needs to be the same, therefore definitions and how the data is presented needs to be clear to give an accurate picture" Stated S1. S2 agreed that this should have been a priority earlier to prevent confusion and wasting of time.	**Privatisation** All HCP expressed privatisation negatively and it is not seen to be helpful to the NHS, in addition to the general cynicism and distrust to motives of the government. **Increased inefficiency** All HCP suggest that the cuts have resulted in further inefficiencies and therefore increased cost.		**NHS supports private services** **Profits from efficiency**
Investment Strategic staff and all HCP agree that investment is required to make improvements.	**Salary** All HCP discussed the impact on salaries. The Registrar had a significant reduction in wage, the other Doctors (hospital and GP) maintained their salaries with a pay freeze, in contrast to the community HCP (psychologist). This may be due to the changes in funding for that service; there has been change from NHS to social care for some of the services the department covers. All doctors were unhappy with their pay situation		
	Under staffed Procurement and HCP agree the NHS requires more staff to implement the desired changes. By being under resourced the HCP believe they have an **increased burden of risk**		
	Development opportunities A few HCP commented on the lack of development opportunities, in particular for nurses as a result of services increasingly being outsourced.		
	Reward and recognition All HCP reported a lack of reward and recognition.		

Discussion

Operations strategy is of high importance (Matthias and Brown, 2016). It is difficult to measure the effects of change within the NHS as it consists of inter-related systems (Boak et al., 2015). With change there is often a temporary detrimental effect on services (Boak et al., 2015). In addition, extra funding is required along with long term planning for improvements in efficiency (Mauro, Maresso and Guglielmo, 2017).

Implementing change within the NHS consists of multiple clinical fields; therefore it is a challenge to have distributed leadership (Boak et al., 2015). Managers are required to be proactive within an organisation and they can assist with alternative work within an organisation to add value, such as mentoring other staff (Leopold and Harris, 2009). It is important how leaders are viewed by their followers (Komives and Dugan, 2010). The HCP in this study displayed a lot of mistrust in their leadership, from the government, to the members of management carrying out the strategic changes to improve efficiency. Transformational authentic leadership would be ideal to implement change within the NHS (Komives and Dugan, 2010), it has the added benefit of improving innovation and performance within an organisation (García-Morales, Matías-Reche and Hurtado-Torres, 2008).

Strategic alignment is required at all levels in order for the implementation of change to be successful. In order to aid this it is beneficial to have long deliberation and planning time to fully engage staff and explore alternative options for implementation (Boak et al., 2015). This can be achieved by investing in meetings and seminars, whilst this may impact on time and cost the consequences for not having the desired alignment can result in more wastage of time and money (Besteiro, Souza Pinto and Novaski, 2015) (Rolstadas et al., 2014) (Indelicato, 2015).

Lord Carter (2016) acknowledges it is essential to engage staff, and that a number of staff have not been engaged, NHS improvement has been advised to develop a national people strategy. Lord Carter (2016) identified organisational structures have to be addressed to provide a culture of fair and transparent policies and procedures to achieve this, he recommends a focus on management. It was clear from the results that this 'people strategy' along with a culture of transparency is yet to be deployed.

Carter (2016) recognised the inconsistency in qualified and unqualified service staff resulted in inconsistent quality and cost. This study found that highly qualified clinical staff are replaced by less able and in some areas lower skilled clinical staff. It is recommended that knowledge organisations should reduce their dependency on professional high skilled staff, such as doctors (Soliman and Spooner, 2000). However it is suggested, that can be achieved by recruiting junior professionals as opposed to support workers (Sveiby, 1997) (Thite, 2004). Success is achieved by sharing information, however, the NHS needs to create a culture of sharing for this to be successful (Thite, 2004). There are examples of an attempt to create a sharing culture, however this is not engrained and unsuccessful due to poor communication and slow uptake of change.

Lord Carter found examples of where trusts were collaborating and using economies of scale although it was not utilised to its full potential, due to lack of support from a

national level. Therefore, support and guidance is required from the department of health and NHSi; they have been tasked with making the strategy (Carter, 2016).

The NHS is lacking compared to other sectors with absenteeism, bullying and turnover, staff wellbeing is understood to increase staff productivity (Carter, 2016). There are high rates of sickness of at least 4% in comparison to 2.9% average for the public sector and 1.8% in the private sector (Carter, 2016). This is supported by the general low morale of the feedback obtained in this researching.

Staff retention and recruitment is poor, several different trusts will recruit at the same fair abroad instead of having a central recruitment process which would reduce duplication and therefore cost (Carter, 2016). HR can be further improved with the use of exit interviews and feedback (Carter, 2016). Staff turnover is a problem at all levels, executive posts take a long time to fill and then they only stay in position for an average of 2.5 years and 20% staying for less than a year (Carter, 2016).

HR management most important strategic tool is recruitment, although successful organisations attract and retain their employees by treating them like customers (Sveiby, 1997). It is important in knowledge organisations such as the NHS to identify, reward and develop employees, (Thite, 2004). However, it is evident that this is not being done effectively, if at all within the NHS. There is a need to utilise multiple HR strategies, as the NHS is a large varied organisation with people varying in complexities of their requirements.

Whilst money is not the only way of reimbursing staff, it is however important if there are limitations in other areas such as; developmental opportunities, As mentioned by health care participants partaking in this study, their main motivation is not money it is to help people, however retention and motivation is dependent on the goals and circumstances of the individual employee and should be tailored to the individual (Thite, 2004) (Sveiby, 1997) (Soliman and Spooner, 2000).

Staff morale is continuing to dwindle although staff are loyal and committed, however it is evident that the NHS is at breaking point with scrutiny of their performance and being pressurised to do more with less (Carter, 2016). Mario et al (2017) highlights the potential pitfalls that a top-down approach can have when trying to improve budgetary and operational performance in a decentralised health services. A Shared leadership approach may aid in engaging staff (Boak et al., 2015) (Speechley, 2005).

Businesses providing to the NHS have changed over the years in a number of ways, for example; they have restructured and continue to become increasingly lean and agile, and working with cross-functional shared partnership teams with the NHS (Center for Creative Leadership, 2014) (Speechley, 2005) (West and Sugden, 2011).

Conclusion and Recommendations

This research contributes to the field, as there is limited research in this area and specifically at this time. It provides an insight to the changes and recommendations from the finding of the research. The study highlights areas of concern that need addressing to ensure there is limited damage and the successful implementation of the Lord Carter efficiency changes.

This study used a small sample size due to the nature of a case study; therefore the findings are not statistically significant as achieved with qualitative research. Replication of this study may yield different results with a different sample from the target population. Although this is unlikely due to the consistency in findings reported. However, the NHS is constantly changing and this study truly represents the findings of a snap shot in time. The efficiency savings being implemented are to be completed in 2020, although as mentioned in the report there are continuous changes and often in correlation to other changes, this therefore makes it difficult to truly identify the cause.

The procurement staff driving the transformation admitted that no feedback has been sought from staff or patients regarding these changes, therefore further research could be done to ask staff and patients about the changes they have seen and what impact it has had to them personally. This could be achieved via a mass survey, given the current climate of the NHS I believe there would be a high participation rate, if it was felt their voices would be heard and changes would be for the better, it may be a result of their participation.

Furthermore patient impact could also be researched along with obtaining what the population actually believes should be included in the NHS services along with how much they are willing to contribute. There are suggestions of ring fencing funding and paying an addition amount to save the NHS. The pubic may also have innovative ideas of how the service could be run more efficiently, as it is funded by the population, it can be argued that they should have a say as they are the true investors not the government, and the government should listen to its constituents.

The findings presented display the impact of the current impact to the NHS and the austerity measures. There is a big impact to staff, and patients with some strategic changes to businesses that supply to the NHS. The centralised purchasing system is being implemented at varied rates across the trusts and reports are in the process of being collated by NSHi. There has been progress although the trusts included in this study missed initial deadlines they still believe they are on track to meet the requirements in 2020.

Implementation of change within the NHS has a number of areas in need of improvement. Such as the consultation process, to ensure all members of the trust are on board for change, via communication this aids strategic alignment. Utilising the skills of the front line workers to establish ways to implement change and also have their *buying*, as they will feel valued. There is a requirement to improve ways of sharing best practice. With an under resourced service, staff do not have time to contribute to benefit the wider organisation; this could be achieved thought technology. For example an app where all members of staff have access and are able to contribute to issues in real time. It could then be easily automatically analysed, as that could potentially be an added drain on resources due to the large size of the organisation. This could also help with clear definitions of terms in the proposal included on the app, so there are no misinterpretations from the beginning.

In addition, there is a requirement for a realistic costing of the NHS with a break down of the true cost to run the services. Then an accurate assessment about what services should be included and offered for free can be considered fairly. There is a clear need for the investment of staff, there are a number of posts not filled and the

use of agencies is used resulting in additional costs. The new HR strategy, should include a temporary/casual recruitment agency which is *in house* and the fees are set and controlled and standardised and at the equivalent to permanent staff. The HR strategy can include team building and simple reward and recognition schemes to help create an atmosphere of sharing and reduced stress. Training and development also needs to be addressed in particular for nurses, however this could also included interests that are not immediately apparent to be related to their organisation, as many tangible skills can be developed doing unrelated activities. A focus on work life balance will also help staff be more productive at work.

The impact to staff is questionable, whether it is these specific Lord Carter efficiency savings, or it is more likely to be due to on going changes and cuts in the NHS that have occurred over a number of years. However, HCP feel at risk from litigation as they do not feel they are able to provide the standard of care they have been trained to give. The combination of low morale, being under-staffed, under appreciated, with a low pay to workload ratio has lead to HCP leaving the NHS. Exacerbating the problems highlighted.

There is a general mistrust of the government and a belief that they are underfunding the NHS wilfully to then declare that the NHS is not sustainable and cannot be run by the state resulting in its final complete privatisation. The areas that are already privatised are not thought to be more effective. Unfortunately they are an added pressure on the NHS because they are a hindrance rather than a support tool. The current environment has an increased level of risk caused by human error. Businesses continue to keep up with the changes to the NHS by adapting their sales strategy and offering added value especially increases when the price of the product/services and therefore profits are high.

In conclusion doctors feel extremely demoralised therefore I recommend a HR strategy should be deployed to manage the biggest resource in the NHS.

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Appendix 1: Semi Structured Interview Guides

Questions for interviews

Strategic/ Procurement level and Operational/ HCP

What stage of the implementation of the PTP are you at?

How has the procurement process changed since the implication of PTP?

Has your trust/hospital implemented the centralised purchasing system?

How have these changes been implemented?

What steps were taken to implement the changes?

What involvement did you have in the process?

What input has been obtained from different staff members?

Which staff members were involved and what was/is their role?

What challenges have you faced at each stage (of implementation)?

What do you think has worked well at each stage?

Which factors have enabled the success you have achieved?

What areas require improvement?

What has been the impact on operations?

What has been the impact to finances?

What has been the impact to staffing?

What has been the impact to patients?

What has the feedback been from staff and patients?

What has been the impact on the standards of care?

Can you think of 3 ways how the change has impacted your day-to-day role?

C - Businesses within the NHS supply chain

How has PTP impacted your business?
What has been the impact on operations?

What has been the impact to finances?

What has been the impact to staffing?

What has been the impact to patients?

Have you experienced any changes in the number of orders & frequency?

Have you experienced any barriers to entry of new products?

Have there been any changes in communication?

Have there been any changes to logistics?

Have you identified any notable differences in the implementation of PTP between different NHS Trusts?

Appendix 2: Information Sheet

I am currently conducting a research project as part of the university of London MBA programme.

As previously discussed with your colleague your assistance during this process would be appreciated.

The project aims to assess the implementation and impact of the Lord Carter efficiency savings, in particularly focus at the Procurement Transformation Programme. Any documents or information that can be provided in relation to this would be extremely helpful.

In addition, I'd like to conduct short interviews with the strategic staff that implemented the change. It would also be beneficial to speak with NHS staff (nurses and doctors) in a range of departments that are involved with ordering/ prescribing and who are exposed to the changes, which impacted themselves and/or their patients.

Participation will consist of an interview over the phone or in person depending on availability typically lasting between 30 minutes and 1 hour. All data collected will be anonymous (unidentifiable), held securely and held in accordance to the University (2017) Ethical Policy.

If participates agree to take part they have the right to withdraw any time until 31st December 2017, as analysis will have commenced.

Please return the Participant consent form if you would like to take part.
If you require any further information or clarification please do not hesitate to contact me via email at tn5599c@gre.ac.uk

Appendix 3: Participant Consent Form

To be completed by the participant.

<table>
<tr><td colspan="2">

- I have read the information sheet about this study
- I have had an opportunity to ask questions and discuss this study
- I have received satisfactory answers to all my questions
- I have received enough information about this study
- I understand that I am free to withdraw from this study:
  - At any time (until such date as this will no longer be possible, which I have been told)
  - Without giving a reason for withdrawing
  - (If I am or intend to become, a student at the University of) without affecting my future with the University
- I understand that my research data may be used for a further project in anonymous form, but I am able to opt out of this if I so wish, by ticking her ☐
- I agree to take part in this study

</td></tr>
<tr><td>Signed (participant)</td><td>Date</td></tr>
<tr><td colspan="2">Name in block letters</td></tr>
<tr><td>Signature of researcher</td><td>Date</td></tr>
<tr><td colspan="2">This project is supervised by: Dotun Adebanjo</td></tr>
<tr><td colspan="2">Researcher’s contact details (including telephone number and e-mail address):
Mobile: 07788416378
Email: tn5599c@gre.ac.uk</td></tr>
</table>

Appendix 5: Ethical Approval Form

Business School Application for Ethical Approval for Taught Degrees
June 2012

This form should be completed for any research involving primary data collection conducted by students on taught degrees of the Business School. This procedure particularly aims to minimize ethical issues where the primary data involves human data and includes human beings and their records (such as medical, genetic, financial, personnel, criminal and test results including scholastic achievements). ***Please note that no research may be conducted in the Business School where participants are children.***

A copy of this application will be retained by the School for up to 6 years. The Business School will provide summary information to University's Research Ethics Committee (UREC) and will provide further information to UREC as requested.

1.

Title of project:
Analysing the development of successful medical procurement in the NHS – exploring additional success factors required in the implementation of Lord carters efficiency savings in order to share best practice

2. This Project is:

☐ UG Research linked to Taught Course* ☐ UG Dissertation*
☒ PG Research linked to a Taught Course* ☐ PG Dissertation*

**May require University UREC approval – if this is the case, then a new application using the UREC form will be required.*

PLEASE ENSURE THAT THIS FORM IS APPROVED BEFORE COMMENCING RESEARCH. IF NOT, YOUR RESEARCH MAY BE SUSPENDED WITH IMMEDIATE EFFECT.

3. Principal Investigator(s):

Family Name:	Given Name:	Banner ID:	Programme:

4. Details of the Project

Proposed start date:	01/06/2017	**Probable duration**:	4 months
Brief outline of project *(Describe the objectives and methods. Write approx 150 words in everyday language)*			
Analysis of the implementation of Lord Carter's efficiency savings in NHS procurement, by interviewing members of the NHS to identify additional factors of success. Secondarily interview suppliers to identify areas of concern and impact the changes may have on them and the medical industry particularly for SMEs.			

5. Will the research involve primary data collection?

Yes ☒ No ☐ *(if 'no' go to Question 10)*

Will the research involve human participants?

Yes ☒ No ☐ *(if 'no' go to Question 10)*

6. Could the participants be considered to…

a) be vulnerable? (e.g. mentally ill?) Yes ☐ No ☒

b) feel obliged to take part? (e.g. employees in organisationally sponsored projects)

Yes ☐ No ☒

If the answer to either of these is 'yes', please explain how ethical considerations will be minimised

7. If the research generates data relating to individuals (e.g. interview quotes or unique questionnaire responses), describe the arrangements for maintaining anonymity and confidentiality

A code will be generated to provide anonymity, whilst providing as reference to be able to contact again if additional information is required.

8. Describe the arrangements for storing data and maintaining its security as part of the project.

Identifiable data will be encrypted and stored securely with passwords

It is a requirement of the Data Protection Act 1998 that individuals are aware of how information about them is managed. Tick to confirm participants will be informed of data access and security arrangements. ☒

9. Describe how will participants be informed of the research project's objectives, purpose and Data Protection Act compliance (per question 8) *Please attach a participant information sheet.*

Use of a participant information form, which includes a summary of the research objectives.

10. If the research is going to be conducted within the University or its subsidiaries or partners, which Manager or Officer of the institution has granted access?

11. If there are other relevant issues that have not been mentioned in this form please note them below:

12. Declaration of Principal Investigator:

1. The information contained in this application, is, to the best of my knowledge, complete and correct. I/we have read the Universities Research Ethics Policy and accept responsibility for the conduct of the procedures set out in this application in accordance with it. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.
2. I have discussed the project with my proposed academic supervisor or course leader, and she/he indicates they have approves the planned research.

Signature(s): .....*(please insert an image of your signature)*

email address: …….. Date:…….……

Appendix 6: Semi structured interview transcript: Chief Procurement Officer

Interviewer: Hello thank you for agreeing to take part in my research, Is it ok to record our interview for transcription purposes? Any identifiable information will be removed

S1: That's ok, and yes that's fine

Interviewer: Ok great, before we start do you have any further questions?

S1: No

Interviewer: OK, lets begin. What stage of the implementation of the Procurement transformation plans are you at?

S1: We are currently at the implementation stage, the procurement transformation plan reflects changes we were making in the trust anyway, the adaptation of a new cloud base ordering system. We are working with other trusts that are not doing as well and have created a shared service.

The cloud is due to go live in January 2018, it was referenced in the carter report, other systems are available but the assumption is that it will be used be all trusts. The NHS shared business services are planning to adapt the same system it currently manages 40 + hospitals. It can plug it into any finance system different hospitals are on different finance systems or versions (such as oracle, tegrea, sap) the cloud can overlay any of these systems.

Interviewer: How has the procurement process changed since the implementation of PTP?

S1: When doing his report, Carter found difficulty in measuring performance, as there was an absence of data. Agency spend and procurement is a problem area as no real data to assess and measure performance. NHS improvement (NSHi) are taking forward the implantation of the cater report. They are trying to look at performance measures in place and understand the differences in performance in each trust. So each trust has to submit data against the cater metrics. And obtain this measurement to provide a level of visibility to the auditor NSHi procurement performance, league tables. Adoption of the PBIB price-benchmarking tool gives greater transparency on pricing.
Procurement teams are more accountable for their performance, where they haven't been in the past.

It's also changed by helping other hospitals to push forward to have a grip on there spend and raises awareness of procurement

Interviewer: Has your trust/hospital implemented the centralised purchasing system?

We are on target for January; we wanted it to be implemented earlier in the year.

Interviewer: How have these changes been implemented?

S1: Driving plans forward, "3 year procurement strategy" builds on the transformation plan, as it is not supposed to be a detailed plan, but more of reassurance that we were taking on board the carter recommendations.

Interviewer: What steps were taken to implement the changes?

S1: Clustering consolidating shared services in STP sustainability transformation plans 44 regions in the country London has 5. NHS England requires providers and commissioners to create a plan for their health economy so that it is sustainable in the long term.

Interviewer: What involvement did you have in the process?

S1: Day to day involvement, I am accountable for delivering the changes and improvements that are taken forward and responsible for the plan and procurement strategy.
I believe there should be a focus around on the supply chain to be included, as there is a risk around waste and inventory management and this has been reflected in the final report. People don't appreciate the operational flow of the hospital and amount of consumable items consumed in the hospital. Imagine the clinical supplies everything in a sterile packaging and goes out of date over a number of year's, if not managed can lead to unforeseen wastage.

We have the automated inventory management system; clinical staff access it on theatre and wards, this is a kind of cabinet/vending machine. It processes and controls how materials flow into the hospital, it track and trace systems, and we implement a 'clear deck' meaning everything that gets delivered gets cleared the same day. This process discipline is being exported to the trust we are helping and working closely with.

Interviewer: What input has been obtained from different staff members?

S1: The new ordering system has been driven by clinical teams complaining about past systems. Ordering a product without the picture leaves a risk of ordering the wrong product as they don't recognise the product code. Making process user friendly and slicker has been driven by clinical team and to reduce the risk of error.

Interviewer: Has there been any formal input from staff?

S1: No there has not been any formal consultation, or reflected feedback from key stakeholders.

Interviewer: Which staff members were involved and what was/is their role?
S1: Regarding the cloud it was based on feedback from matrons and nurses on oracle which drove us looking for an alternative. There are existing forums within the hospital to engage with clinical and non-clinical teams already embedded in the organisation, as we are always trying to work out how to improve the service.

Interviewer: What challenges have you faced at each stage (of implementation)?

S1: The Carter context on performance management data quality needs to be correct and definitions consistently applied. The Carter metrics NSHi are relying on KPI and the interpretation needs to be the same, therefore definitions and how the data is presented needs to be clear to give an accurate picture.

Interviewer: What do you think has worked well at each stage?

S1: Visibility of data and the performance management of information is healthy and can identify savings using the price benchmarking tool.

Interviewer: Which factors have enabled the success you have achieved?

S1: As we were already doing work in inventory management we were more mature in this area. Also having a supportive board, senior management support has been helpful.

Interviewer: What areas require improvement?

S1: Clarity early on in definitions, improved alignment on NHSi and DoH commercial team. "The future operating model (FOM)" focuses on replacement of the NHS supply chain national contract and NHSi focuses on how hospital trusts and procurement teams operate on the ground, what is required is a joint up approach that hold these both up what is the future of procurement at a hospital level and how does it fit into FOM and what should procurement be focused on going forward. Still the missing bit is what is the future of procurement at a hospital level, it still requires developing.

Interviewer: What has been the impact on operations?

S1: Increased focus on process control with reporting against Carter Metrics re PO (purchase order) compliance etc. sent to NHSI.

Interviewer: What has been the impact to finances?

S1: Difficult to evidence impact due to number of parallel initiatives alongside Carter, e.g. NHSE zero cost model; NHSI Get it right first time (GIRFT); DH Future Operating Model (FOM)

Interviewer: What has been the impact to staffing?

S1: Establishment of a procurement shared service across NHS trusts we are working with, has enable the procurement function to establish new posts to build capacity.

Interviewer: What has been the impact to patients?

S1: Difficult to evidence at this stage.

Interviewer: What has the feedback been from staff and patients?

S1: It has not been sought, as we have given focus on back-office operational efficiency.

Interviewer: What has been the impact on the standards of care?

S1: It's difficult to evidence at this stage.

Interviewer: Can you think of 3 ways how the change has impacted your day-to-day role?

S1: Greater focus on performance management/ reporting
Improved opportunity for collaborative procurement through use of national price benchmarking tool.
Increased profile of procurement function within the Trust given focus from NHSI/ Trust regulator.

In regards to suppliers to the NHS:

Interviewer: Has there been a change in the number of orders & frequency?

S1: Difficult to evidence at this stage. Our compliance regarding Purchase Orders is already high.

Interviewer: Have you experienced any barriers to entry of new products?

S1: Impact of new Future Operating Model (replacing NHS Supply Chain) is likely to have more impact re new products.

Interviewer: Have there been any changes in communication?

S1: No.

Interviewer: Have there been any changes to logistics?

S1: No. As per above FOM will have greater impact with DH target to increase percentage of spend channelled through NHS Supply Chain from 25% to 80%.

Appendix 7: Semi structured interview transcript: Hospital Doctor

Interviewer: What stage of the implementation of the PTP are you at?
D1: I have no idea

Interviewer: How has the procurement process changed since the implication of PTP?
D1: I haven't noticed any real changes specifically in the procurement procedure

Interviewer: Has your trust/hospital implemented the centralised purchasing system?

D1: I believe so

Interviewer: How have these changes been implemented?
D1: without my knowledge [laughs nervously]

Interviewer: Ok how about we focus on the wider changes that have taken place within the NHS the efficiency savings and the impact they have had.

D1: Ok great

Interviewer: What efficiency changes have you experienced?

D1: Formulary changes are paramount however it is specific to the trust, it does change usually by what is cheapest, sometimes its difficult to understand some change but as a registrar and junior Dr there is no say in it. From a respiratory point of view it's a big problem, it is very difficult, the inhalers each have different devices and are quite tricky to use and the patient has to learn how to use their particular device. Some people just cant use some of it due to arthritis or how you have to time your breath when you press down a button, lots of ways it can go wrong so you shouldn't just change their medication. Research shows that if you change it inappropriately without their consent or properly educating them on their new device they are using, adherence and drug delivery gets worse and people get sick. This research is well established but not taken into account at all. Save a few pennies here and there and it has a direct negative impact on patients for sure.

Patients complain that their medications just gets changed, and decision is made somewhere and no one knows how it is happened. I suppose the NHS is a large organisation and it must be difficult for information to get to front line staff, as people move around a lot as junior doctors.

Some consultants may be involved in the changes; they may believe the consultants are the only ones with the experience to be involved.

Patient comes into hospital prescribe their normal medications if they are available to the hospital, some GPs may have different medications available. E.g. they may have a combination tablet usually but the hospital pharmacy doesn't have that, so give the 2 separate. Whilst in hospital received medication they need, and on discharge they receive 2 weeks plus discharge summary with the description of what they should have when they leave and carry on with a letter to the GP with the drugs they are on

and what they need to continue with. GP usually continues with the recommendation. Sometimes patients come back to clinic possibly because they are seen regularly due to more complex/ specialist requirements the GP may carry on or the hospital will give a short term medication for them to have, but generally the responsibility is in the community.

Interviewer: Has there been a time where there has been a change in the hospital in terms of operations?

D1: Big change to staffing is ridiculous overnight 2 registrars and 5 SHOs to cover all medical and the wards, and it's a very busy hospital. A dishonest Dr had a full time job elsewhere would cover the night do his registrar post and then leave and he got caught. And said the reason why he did it and sleeps through the night is because you don't need that many Drs, they pulled one of the registrar posts as a result. Instead of replacing the dr. it gave management an excuse not to fill the position.
This registrar would have 20 patients "accepted by medicine" and don't know who is sick and not, in the acute medical team it is very difficult and some may need something to happen so a lot of them will be waiting. As everyone had complained they have since reinstated the registrar position and filled it. Its classic example a little piece of information that they can use to justify having less staff or paying less money. Cutting a corner they jump on it but they can have years of people complaining about a dangerous situation and the only solution is to improve staffing and they'll ignore it for as long as possible. They were not trying to refill this post. But then when there is another position available because people don't want to work there because it is understaffed, and dangerous, people don't like to provide substandard care, and don't want to put themselves at risk with how much pressure they are under.

I feel like I am at risk, I don't have the time to evaluate patients they way that I would like to often. You have to then accept there is a higher level of risk, to make sure that every one is seen. So with people not wanting to work in those conditions it then leads to even worse staff levels. Due partly to not making the posts and not enough people to fill the posts, and where there is posts its gotten so bad that people don't want to work there.

I feel it is dangerous to patients all pervasive you accept there is always a certain level of risk inherent, not having enough time to do each thing you have to accept more risk. You may be able to do some of the assessments the more important things like, assessing their cognitive state, listening to their chest, heart and feeling their abdomen. But you may not have time to really assess their respiratory rate properly and look for more signs for other things. You can't go into that extra level of detail, and that is what tweaks the level of risk. If you are prescribing something and have to do it quickly, you then don't have time to look through your prescription to check for any errors. Hopefully you do it right the first time but if you do it 100 times, then there will be human error. Pharmacists are supposed to pick these things up but there is no pharmacist over night, lots of things are prescribed over night, and lots of people are given drugs without a pharmacist or anybody else looking at them, checking them over.

If you don't have time and your worried about someone about to arrest etc. then it is easy to prescribe something that interacts with another drug, because you simply needed a little bit of extra time and less pressure to be able to think about it.

The other common thing, due to time constraints it builds a system of inefficiency. A consultant seeing 30 patients as a standard within 3-4 hrs, because the consultant takes the responsibility of the patient once they have seen them, if they don't have time to thoroughly examine them and take that extra bit of history to get that key pertinent points, what they will often do is send for another test. E.g. abdominal pain and history taken on medical tape not that clear examination not that clear, so they say the patient is probably fine, but lets just do a CT scan to make sure and have a look. If they had an extra 20 mins after examining and speaking to the patient they could say for example it sounds like constipation, lets give you some laxatives and see how you do, come back in 2 hrs they've done a big poo and the pain is gone, then you don't have to order the CT scan. But that doesn't happen because the people need to move too quickly so everything moves slower and the cost goes up and waiting for the CT scan.

Interviewer: What do you think has been the Impact to Business – people working with the NHS?

D1: In my city you see a lot of things done in private hospitals and thy don't deal with the fall out they just send that patient to A&E for the NHS to deal with it, like plastic surgery becoming infected.
Private scans have increased and they are terribly inefficient. If you have a scan its always non specific and doesn't give you an answer, where as if it was done in the NHS hospital you could just call the person up and explain this is the question you need answering because you are part of the same team they get it. Where as the other work that is done by contractors they just tick the boxes and your no further along by the end of it because they haven't answered the questions you wanted answering. So you end up repeating the procedure. It looks fine on numbers and yes they got the scan done but they haven't moved anything forward for the patient. Instead they have slowed it down, which is very frustrating, its definitely a lot more disjointed.

Interviewer: What has been the Impact to staff

D1: Morale is so low it is unbelievable, its not all so low you can still have some fun walking around, however there is definitely a shift, people don't seem to want to work as hard now. There is a big feeling as things become more private people are less happy to go above and beyond. There is the saying that "the NHS is run on good will" and there is a lot of truth in that, 6 years ago when I first started you would stay 1-2 hrs late everyday, but you wouldn't mind because you were working and contributing towards the team and people really valued your contribution. The general attitude now is more of why should I stay late when other people are making profits off of my extra work. Its not just contributing to the NHS which is valued by the government and society, and there isn't enough money but we will dig our heals, work really hard and make it work, now it is we have been battered by the media the government and subsequently some of the public, people are like I'm going to go home then, I've worked really hard for my contracted hours but I am not going to stay even later and miss another meal with my girlfriend or be late again for the cinema. The types of

things we always did before, people got it, as it was just what we did. People now clock out when they are finished.

People are burning out more because they are now walking around pissed off all day feeling undervalued like they have been taken advantage off, staying an extra hour when you know you have really improved a patients level of care and the consultant is really appreciative of that and the patient and government is apologetic that they cant get the extra money but are really appreciative of the work the Drs do, that extra hour isn't such a big deal. But the extra hour in the current climate feels like everyone is angry and pissed off and you turn on the news and it says the NHS is the worst and Jeremy Hunt saying he's not going to pay nurses any more, that is the biggest contributor to people burning out.

This is what I feel is really sad, Drs that have been practicing for 5 years or so are now leaving to do anything else very sad, or they are on long term sick for stress and anxiety. Its difficult to see if that is how it always was. However I did a ward round and had lunch and the consultant was talking about back in his day, I asked all the Drs if they advise people to go into medicine now everyone said no, consultant included…

They will always fill medical school places, a there is a back log, but a big chunk of people that are really good wont apply the competition level will go down, meaning people that may not have been as good Drs are becoming Drs, those that would have been really good will choose and are choosing to do other things. Even Drs have left to do pharmaceutical sales.

The way it is we actually all work for drug companies, Drs that think they prescribe only from well-reasoned evidence based guidelines only and not seeing the way that the decisions that they make are shaped by the people making money around them. It is evidence based but it is only there because drug companies are funding the trials. There are lots of things that are evidence based that we don't do because no one makes money out of it.
For example in respiratory core rehabilitation, exercise is the most effective interventions, and smoking cessation. But the reality no one has access to rehabilitation, and smoking cessations in hospitals is a joke, even though it is the most effective, however they will have an expensive inhaler, no one does a free lunch for cognitive rehab, no one making big money so it is not being pushed, even though the evidence is there supporting it being more effective, it is not getting the funding because that is not how it is actually works.

The things that get priorities, not just saving money its who is saving money, the hospital will try to reduce their readmission rate for example, what they are targeted to do so to get their funding. Public health funding is awful compared to what it should be and the impact is longer than the government's 4-year cycle. It is not a specific hospital that saves money they will pay lip service to it put out the odd promotional material but in terms of putting the proportional amount of money in to what the overall saving is to society is its just doesn't happen.

2 years out of a 5-year programme some things have changed but not a lot and what has changed hasn't been done for the better.

Trying to change things yourself as a front line clinician or clinical staff of any kind there is quite a challenge to get people to allow you to do stuff you have to put forward a really big case. Even to just change a proforma you have to do all of your back ground research etc. and that's probably how it should be done, evidence based, but we are spending hours to make small tweaks but then we get massive changes that come through from the government and the front line staff think it is ridiculous and dangerous. And they just get on and do it anyway.

The government has disempowered people by going into situations and regardless of the evidence is they just do what ever they want any way. Give us the evidence; it makes it difficult to discuss it with them as they have removed logic and evidence from the discussion you then don't know how to argue with them.

Interviewer: How can things be changed for the better?

D1: The main underlying issues are with the government being clearer about what is that they want to do and why they want to do it. There is nothing inherently wrong with the saying they don't think the government should pay for health service, I personally think they should, there is different roles of government within a society and for the people to decide what the role is of government and what is paid for through taxation then that's fine, but we are not having a honest debate. The government is doing things to suggest that is where they are heading; there is such a lack of honesty in the discussion. We should have evidence-based policy in the way that we have evidence based medicine.

To avoid melt down they need to prevent brexit the NHS can not run with no EU nationals as soon as they feel unwelcome they will leave. There is no one to fill the places so that will be key.

The basic thing is the NHS is amazing I've worked in South Africa for a year, Uganda, Cameroon, Tanzania and Mexico and Columbia and visited Italy. The NHS is brilliant and amazing and it gets forgotten by everyone including those that work in it, myself included.

The NHS has massive efficiencies as well as inefficiencies, you have to spend some money to make efficiencies and you don't just squeeze, it leads to more inefficiencies from lack of funding in areas ordering extra scans etc. they are not intending to address this. These are the parts that are difficult to quantify would an individual be more likely to order a scan because they had 6 minutes with a patient as apposed to 10. On the front line however it is clear to see.

If you look at successful new tech companies they value their workers e.g. Google because they know the value in doing so and employees are much more productive.

Interviewer: What does the NHS do currently to show they value their employees?
D1: … Well, my pay has gone down 10K this year, I go around don't have time for lunch if I use the external caterers trolley for a crap coffee I get chastised because it is a Private contractor, and that business has got targets; how may patients to give a coffee to and wash cups etc. If it were NHS run they would give Drs a coffee because they are part of the same team. When private they don't have funding to give NHS coffee, they are contracted to do it for the lowest price they could to still make a profit

they are not the same team. And that is what NHS staff is getting pissed off about and impacts and leads to staff then taking their lunch and not seeing those extra patients. Some hospitals are discounted for lunch /subsidised, but I this is not standardised everywhere.

Appendix 8: Semi structured interview transcript: Community Health Care Professional

Interviewer: How have the efficiency changes impacted your work?
C1: It's difficult to know as there has been cuts all over and has impacted team, the things that have changed in the couple of years I'm not sure if related to Lord Carters report specifically. My team was an NHS team that originally looked after children that get referred to them from social services, social services then said they have some form of mental health therapeutic work that happens in social services anyway so they will stop referring to the looked after children cams or they want control of it. The team got taken over by social services people been around longer recall the team goes back and forth over the years. They merge mental health and social care and then separate it as both doesn't work. It's currently merged. As part of that process they streamlined processes and stop duplication, separate stream of money for children that have been adopted, vs. foster care.

Senior clinicians left and is replaced by entry-level jobs, not sure if due to efficiency but it is a cost savings. They don't cover the same responsibilities but saving at least 10K a year.
Replace certain type of worker with a less trained worker e.g. improving active psychological therapies people who are trained in CBT, gone from an undergrad degree to do a course for a year to provide CBT. The danger is a move towards these cheaper workers that don't have the same kind of in-depth training or breath. I'm trained in different therapeutic models other than CBT, CBT is great but it doesn't do everything.

We are under resourced with a lot of pressure to complete therapeutic work quickly and have a big through put and see client for say 10 sessions and then discharge them.
Waiting lists are increasing, so we are not allowed to work with people for very long, normally 8-12 sessions of CBT, 16 sessions is considered a long time. Luckily my team doesn't work like that, as we are dealing with children with a lot of trauma and difficult attachment histories it's difficult to get them in and out. However, that is the model that general child and adolescent handlers work by.
I for example will have a patient for 5 months, seeing them once a week so they have had about 20 sessions so far one or 2 with an end date soon and others with no end date in sight. The team sometimes works with kids for a year. This sometimes happens in other services but they will have the huge pressure to prevent that from happening.

Whenever there is a consultation process, I thought the point was to get peoples opinions and use that to help guide decision making, but actually what a consultation process is [in the NHS] is they sit down in a room with you and ask you what your opinion is and the decision has already been made. It's a complete waste of everyone's time, it is only held after the decision has been made.

The underlying narrative is we are being pressured to make these cuts so this is where we are

They come to us stating they need to make this change for example restructuring the team, and they will say we are going to have a consultation on this and it happens any

way. Perhaps if you say a tweak it may be incorporated but it would still happen if you don't think the change should happen.

It makes me feel disenchanted, my worry is the overriding direction of the last few years is to cut away at the NHS and to give bits of it to private companies and this is the direction we are heading in and I find it worrying. Me and my colleagues feel that overall in the NHS there are points when you keep your head down and get on with it, do it for a while feeling really over worked and overwhelmed. You stop and it isn't sustainable, none of the changes have resulted in a sustainable way for us to be working, cynically you think is that the point? They underfund and make it unsustainable to say that it isn't working, (therefore) we have to sell of bits of it to private companies.

Interviewer: What is the impact to businesses suppliers to the NHS?
The idea if it's a state run services, the state pays for all of it and the argument is they are run inefficiently and the state wastes money, the idea is that if you sell it of to private companies, they are more business orientated, and have people with that kind of mind set running them, the idea is that they are more efficient and make more efficient use of money overall that should lead to saving for the NHS. But what that whole idea misses out is that a private company is seeking a profit and if the state is paying for that private company to run a service then the state is also generating their profit.

Put a service up for tender a company will quote a lot cheaper so they will be awarded the business, but they then make a mess of it, so it goes out for tender again. In theory you come up with some that does a good job for less money, but this is unlikely to happen.

Private care homes is an example they put money in to marketing, but are run with untrained care staff and a third or half of the people they need to run it.
An NHS run service is set up because the private care homes were doing such a terrible job they had all these old people that were really distressed and showing really challenging behaviour and it was being managed really poorly, because there wasn't enough staff and if there was they were untrained and didn't have a proper understanding and they weren't supported. Managers hiding behind doors working out cost efficiency savings to send to the people above them. There was not savings, if there was it was at the expense of care, so the care home "in reach" team would offer training, free training, to their staff and they were offering support, being there observing interactions with patients and gently directing staff in the things they were doing which might be reinforcing certain difficult behaviours.

They would also work with the managers, point out the staff wasn't supported and can't manage these things and they need to set up Reflective practice groups, you need management supervision and have more staff on board. The advice was adopted in various degrees by different managers, often they couldn't the managers hands were tied so they were leaving, its difficult to make change because the manager would come in and what they were told to do was impossible, so they were over worked, stressed, can't support staff and unable to provide good care so they leave, so they would then have to work with another manager, and the cycle would be repeated – high turn over, low level of staff, not enough well trained staff, the majority of elderly care is run in this way, and they are trying to get a profit to their investors

which they cant deliver at the same time as delivering good patient care. This shows that the NHS is better at running the service than the private company it just doesn't cut corners.

Interviewer: What is the impact to patients
C1: The impact to patients is awful; it is not just the private companies but the NHS also because they are trying to run the services without enough money. What they need is a realistic costing of all services to then make the decision on what services the NHS provides and government pays for. There are patients left in beds for hours at end wondering aimlessly, calling out to people being ignored, patients dehydrated, not being fed. It is difficult and challenging behaviour, its not nice as a member of staff to be hit, you want to support staff, firstly prevent them from being hit, but sometimes it's not avoidable due to their condition being out of it in an unfamiliar place someone coming into their room and undressing them without informing the patient, so staff can be educated to understand this, they are can get stuck in a routine of a job, have 12 patients they need to wash and dress this morning and this patient is holding them up being angry and confused about it.

Private fostering agencies, local authority have a high turnover of social workers, private in theory has better training and support and therapeutically trained support, so NHS staff leave for private so the NHS then has to pay for private places, being inefficient, they may not provide all the services so the fosterers may need training, and the kids that are challenging need therapy and that is then provided by the NHS, to the staff that. So the private company can provide the service at the cheaper price but only with assistance from the NHS. Because they are more expensive the Local Authority is less likely to make permanent placements so kids will be in these placements and you cant give them any certainty about how long they will be there. And that's the main issue, the kids need to know that they wont be moved again and they cant be told that if they are independent placement because the local authority wont commit to that until they have done a number of searches and confirm that no one else can take them. So the lack of stability for the child results in them struggling for longer in need of more therapeutic support. The direction is the increase the amount of privatisation.

So, there is a higher throughput the impact is waiting list of 6-18months, that person is sat around not achieving or thriving. This is a result of understaffing – don't want people sat on awaiting lists and pressure to perform; managers also need to reduce this so the response from staff is to absorb more, take on more cases, and then not be able to prepare as well, or the mount of thinking time in between cases, between sessions, sometimes works out well, but often not settled and centred and in a place to be with the person, which is often the most important thing. And staff an also get compassion fatigue, I keep getting to the point where I cant take anymore trauma, the pressure from the service to hold a certain amount of cases and I just cant have any more of this in my day.

Alternatively you are offering people an abbreviated intervention, which isn't necessarily the worst thing. The old model would be to see someone for ages and absorb ALL their problems, I'm being factitious here its not quite like that but there is something to not seeing people for ever but there is a pressure to push people through. And not do as much as you should or would like to.

Appraisals is the NHS bonus, the manager tells you nice things, on the assumption that you are doing a good job. We go up an increment if you go up a pay scale however there was talk of a pay freeze but I did get a pay rise. But nurses having their bursaries taken away is terrible.

Interviewer: When changes are implemented what worked well?

C1: Hasn't been implemented efficiently it has taken a long time and it's unclear what is happening and poor communication. People don't think about the psychological impact of saying to people we are gong to make this big change that is going to make a big difference to your jobs and we are just going to have these talks behind closed doors which professionals that don't have the time to really think about it so it will take forever for things to happen, and decisions made in a knee jerk way, which is poorly thought through and after they decide to talk it through again so nothing really happens.

Interviewer: What do you think they could do to improve any area we have discussed?
C1: One of the real difficulties is that when we talk about sustainability and what you can and can't fund a lot of that comes from an ideological position rather than an actual financial position, as the government does have money and it chooses to spend it on other things. In terms of sustainability that in some ways is a red herring, the talk about sustainability within the amount of money that they are willing to give it. And it may well be that it is not sustainable with the amount of money they are willing to give it so maybe they should rethink the amount of money they are willing to give it.

In terms of making services as efficient as they can be, people working within the service have a good idea of what is working and what isn't working, therefore can give some ideas on where things can improve. I have never felt in a position where I have been really genuinely consulted on things like the service and how it can be improved, what are the problems and what should be done. There was external consultant (costing money) comes in and went round to different services and looked at their pathways and issues. I didn't see any of the changes as a result of that.

Its difficult for those on the ground to know what the constraints are for managers from further up the chain, they may all be ignored along the chain, looks like decisions are made from the top with little day-to-day knowledge.

The NHS was split to little localised services, there are pros and cons this was reduced during the Blair government with the post code lottery, the idea of a more centralised NHS to reduce that and people could have access to services regardless of where they are living, and those should all be of a high standard. This prevents those in a locality to decide what does the people in my area need, e.g. lots of elderly people need more services for them and less maternity care still need to provide it but less based on the population. Don't think that is done like that at the moment. The Idea of CCGs, good idea in principal, but what doesn't work is making changes to the systems and at the same time cutting the amount of funding you are giving. Changes cost money, some corporations central but decentralised,

Decisions made locally with genuine consultations with teams but not at the same time it needs to be done because we are cutting your funding by a third. It should be

this is what we have we are going to work out how to prioritise and review it after a couple of years.

Interviewer: What is the impact of these efficiency saving on staff?
C1: Impact on staff is they want to help people but cant provide the level of care safely. Not given the support seeing distressing things and not supported,

Clinical psychologists have supervision and other health professions don't, can say what happens and this is how I feel is that normal. Last week I said I don't know if I can do this job long term and she said she plans her holiday's way in advance at certain time intervals. If I do it for too long I get compassion fatigue. That is recognised as a psychologists. As junior Drs with the stress that they have and things they see and have to deal with they don't really recognise the impact on themselves or have a narrative from the people around them saying the job is really hard and you need to look after yourself and you need to look after each other. Which is why you get Drs that want to leave the NHS.

I know a palliative registrar (personally) They didn't have a true concept of the stress thought she could help them in their end of life, regularly the person telling them they are going to die because they haven't accepted and she sees in their eyes when the accept they are going to die.
Huge personal impact and not understood until you are doing it even as a psychologist it is hard to conceptualise the impact. Even physically, I have to have a bath for an hour after work to rid the stress from the body, its difficult to sustain.

The Impact on my personal life is huge, if people call I don't pick up I can't hear problems, and it means I am not the same kind of friend or person that I want to be. I like to be a fun person and I don't really feel like it

Appendix 9: Semi structured interview transcript: Business – Supplier to the NHS

Interviewer: How has PTP impacted your business?
B1: I don't believe it has particularly

Interviewer: What has been the impact on operations?
B1: There hasn't been

Interviewer: What has been the impact to finances?
B1: None so far

Interviewer: What has been the impact to staffing?
B1: There hasn't been any

Interviewer: What has been the impact to patients?
B1: I can't imagine there has been much disturbance to them in relation to our products.

Interviewer: Have you experienced any changes in the number of orders & frequency?
B1: No we haven't

Interviewer: Have you experienced any barriers to entry of new products?
B1: It is always difficult getting a new product on the market I don't believe it has become any more difficult now.

Interviewer: Have there been any changes in communication?
B1: No

Interviewer: Have there been any changes to logistics? No

Interviewer: Have you identified any notable differences in the implementation of PTP between different NHS Trusts?
B1: No we only go through the tendering process and that hasn't changed, not sure if it will in the future.

Appendix 10: Results in depth analysis

Has the implementation of Lord Carters centralised purchasing system been successful?

Lord Carter (2016) proposed by September 2017 all hospital trusts should have 80% of their transactions through the electronic catalogue. Upon looking at documents obtained of the three trusts used as case studies only 2 out 3 achieved this. Although one document claimed the national median was 93%. On further inspection of the documentation from trust 3 it shows there are inclusions of data that may skew the figures as the cater metric instructions gives criteria of what should be included. For exemplar the measurement of electronic purchase orders and transactions through the e catalogue has XML, CVS etc. data also included and had a side note informing this, and that the trust would not have meet this metric if they were not included as per recommended by Lord Carter. It is also worth noting that one trust (Trust 2) had not completed their Procurement Transformation plan, this shows how varied each trust is in terms of their progress in the implementation of these changes, even though the target was to have the plans completed before the study commenced.

In summary, it is too early to tell if the implementation of the centralised purchasing system has been successful, although it is clear that some progress has been made in all the metrics (including the one pertinent to this study the number of transactions via the e catalogue). The E catalogue is available to be used by the trusts included in this paper, however the further work needs to be done to ensure compliance.

S1 explains disparities in progress may be due to changes that were taking place within the trust prior to the initiative.

"We are currently at the implementation stage, the procurement transformation plan reflects changes we were making in the trust anyway"
In regards to the implementation of the centralised purchasing catalogue S1 stated "We are on target for January, we wanted it to be implemented earlier in the year.

S1 further claims their success to be in contribution to them already doing work in inventory management therefore they were more mature in that area. "Also having a supportive board, senior management support has been helpful."

All trusts agreed with S1 "Visibility of data and the performance management of information is healthy and can identify savings using the price benchmarking tool".

However all trusts agree it is difficult to identify the source of the savings and therefore success of Lord carters strategy due to a number of other cost saving tasks that have taken place and some running concurrently. S1 stated it was "difficult to evidence the impact due to number of parallel initiatives alongside Carter, e.g. NHSE zero cost model; NHSI Get it right first time (GIRFT); DH Future Operating Model (FOM)". This was further supported by operation and community HCP; C1 concurred "It's difficult to know as there has been cuts all over and has impacted team, the things that have changed in the couple of years I'm not sure if related to Lord Carters report specifically."

Trust 1s documents explains technology was key in supporting the trust in achieving its targets, as the ordering system continues to be adopted and rolled out across the departments within the trust and across the while NHS there will be a continued increase in results.

Implementation of change within the NHS

Consultation

Strategic level staff claims that there is in put from all levels of staff. Although they recognise there was no formal input in relation to these changes however they argue there is feedback systems engraved into the system for continuous improvement. The Operational staff (HCP in hospitals and community) both agree that there is a standard process built in for feedback, however they don't feel their opinions are generally accepted as valid, so they don't bother participating in giving any input. It was also mentioned by a few hospital doctors that they do not have time to attend additional steering group meetings, as they are already over stretched.

S1 claimed, "The new ordering system has been driven by clinical teams complaining about past systems. Ordering a product without the picture leaves a risk of ordering the wrong product, as they don't recognise the product code. Making process user friendly and slicker has been driven by clinical team and to reduce the risk of error"

However S1 continued "there has not been any formal consultation, or reflected feedback from key stakeholders." S1 then went on to say that the main input was from nurses and matrons which had driven the change, and although there was not a specific consultation on the current changes "There are existing forums within the hospital to engage with clinical and non-clinical teams already embedded in the organisation, as we are always trying to work out how to improve the service."
Nevertheless, D3 agreed that "Steering groups are available to anyone to join but with the pressures and being overstretched and overworked you don't have time to go to these extra meetings. Extra 2 hours on a Friday to sit in a board room as you will then leave an extra 2hrs on top of how late you were originally been leaving"

C1 added "Whenever there is a consultation process…they sit down in a room with you and ask you what your opinion is and the decision has already been made. It's a complete waste of everyone's time, it is only held after the decision has been made." …"I have never felt in a position where I have been really genuinely consulted on things like the service and how it can be improved, what are the problems and what should be done. There was external consultant (costing money) comes in and went round to different services and looked at their pathways and issues. I didn't see any of the changes as a result of that."

C2 "In most cases there is a consultation in the monthly meetings but it is often an informative exercise where they can take on your opinions but what they have planned will still be implemented, whether they will make any adjustments is questionable."

D1 added in support", sometimes its difficult to understand some changes but as a registrar and junior Dr there is no say in it"

D1 continued, “Some consultants may be involved in the changes, they may believe the consultants are the only ones with the experience to be involved”

D1 then added further “Trying to change things yourself as a front line clinician or clinical staff of any kind there is quite a challenge to get people to allow you to do stuff you have to put forward a really big case. Even to just change a proforma you have to do all of your back ground research etc. and that’s probably how it should be done, evidence based, but we are spending hours to make small tweaks but then we get massive changes that come through from the government and the front line staff think it is ridiculous and dangerous. And they just get on and do it anyway”

In contrast D2 has had input in service improvement by implementing the change themselves, D2 believes “there is a need for more people to be involved in service improvement.”

Communication

There is limited communication between strategic staff and HCP.

C1 stated, “Its difficult for those on the ground to know what the constraints are for managers from further up the chain, they may all be ignored along the chain, looks like decisions are made from the top with little day-to-day knowledge”

In agreement D2 explained, “When changes are implemented there is limited discussion and involvement of operational staff with strategic staff. I Thinks it is difficult at all levels; at the very top they are making decisions on limited funding, but they are only doing what they can based on what the government has decided”

D1 added in support “I suppose the NHS is a large organisation and it must be difficult for information to get to front line staff, as people move around a lot as junior doctors.”

C1 concluded that where there is change it “hasn’t been implemented efficiently, it has taken a long time and it’s unclear what is happening” due to “poor communication.

Shared practice

Although at all levels within the organisation there is an understanding and agreement to the benefits of sharing best practices. However
D2 explains “ (I) attempted to be share with other hospitals via a conference, this is a general NHS failing, there is not enough sharing of information as to why and how some trust are able to perform better than others.”
S1 believes the changes will improve the “opportunity for collaborative procurement through use of national price benchmarking tool.”

Strategic alignment/ Clear definitions

The use of "Carter metrics NSHi are relying on KPI and the interpretation needs to be the same, therefore definitions and how the data is presented needs to be clear to give an accurate picture" Stated S1. S2 agreed that this should have been a priority earlier to prevent confusion and wasting of time.

Investment

Strategic staff and all HCP agree that investment is required to make improvements.

D1 stated "The NHS has massive efficiencies as well as inefficiencies, you have to spend some money to make efficiencies and you don't just squeeze, it leads to more inefficiencies from lack of funding in areas (for example) ordering extra scans etc.".
In support, Trust 1 documents support the need for Investment – PTP is focused on improvements with the process and people development. The plan included a business case to scale up systems in inventory management, and they would seek funding as part of an 'invest to save' basis.

C1 commented "what doesn't work is making changes to the systems and at the same time cutting the amount of funding you are giving".

Impact to staff

Strategic staff believe it is difficult to evidence the impact to staff as no feedback has been sought. However, The HCP whilst acknowledging the impacts they feel may not be directly as a result of Lord carters efficiency savings, they are all in agreement that it is as a result of general efficiency savings, and cuts to funding.

Increased risk

D1 explains "I feel like I am at risk, I don't have the time to evaluate patients they way that I would like to often. You have to then accept there is a higher level of risk, to make sure that every one is seen." C1 claims the "Impact on staff is they want to help people but cant provide the level of care safely. (They are) not given the support seeing distressing things and not supported". As a psychologist this is recognised and 'supervision' is given to support them emotionally. This differs to Doctors, where by if they are struggling, they are often met with questioning their suitability to the role, as apposed to the offering of support and acknowledgement that the role is difficult. C1 further explained "staff can also get compassion fatigue, I keep getting to the point where I cant take anymore trauma, the pressure from the service to hold a certain amount of cases and I just cant have any more of this in my day"

Salary

All HCP discussed the impact on salaries. The Registrar had a significant reduction in wage, the other Doctors (hospital and GP) maintained their salaries with a pay freeze, in contrast to the community healthcare professional (psychologist). This may be due to the changes in funding for that service; there has been change from NHS to social care for some of the services the department covers. All doctors were unhappy with their pay situation.

D1 confessed "Well, my pay has gone down 10K this year" moreover "some people didn't get paid for 3 months and the Drs still turned up to work and we were obviously still expected to." Informed D5.
D6 questioned "How can you plan your life, Drs turn up to work because they care about the patients not because it's worth while for them."
D5 claimed with the "new changes you may not even get a pay rise, even though every year you do CPD, have to pay for own exams and they are expensive"
C3 mentioned there was talks of a pay freeze, however they did receive a pay rise as a result of their appraisal.

Nurses have terrible salaries and it is terrible that they have had their bursaries taken away. C3 pondered if the nurse's salaries would be capped at £28,000 if it were a predominantly male role.

Under staffed

Procurement and HCP agree the NHS requires more staff to implement the desired changes.

S1 stated the "establishment of a procurement shared service across NHS trust" … "has enable the procurement function to establish new posts to build capacity." Documents from both trust 1 and 3 support the need to recruit people with the right experience and expertise to improve performance and transformation, with a focus on supply chain and commercial roles from strategic staff, this is in contrast to clinical staff focusing on the need for more clinicians. Strategic staff argues the new role is critically important in supporting front line teams and control inventory risk.

However this will not be seen beneficially to clinical staff, as D6 already believes there is "too much middle management, there are loads of people with well paid jobs and we don't even know what they do, when we do (know what they do) they don't even do their job properly. We have about four people in charge of rotas and they continuously get it wrong, its ridiculous".

D1 believes "to avoid melt down they need to prevent brexit the NHS can not run with no EU nationals as soon as they feel unwelcome they will leave. There is no one to fill the places so that will be key."
D2 added "more pressure on staff at present as they are not hiring new staff, sometimes work load is unmanageable and that is stressful"

D3 explains “Changes to rota, where there would have had slack previously if people were sick there is no one to cover now so the NHS pays high locum rates which isn’t efficient if it has to be done regularly otherwise you stretch already stretched staffs.”

C1 added “senior clinicians left and is replaced by entry level jobs, not sure if due to efficiency but it is a cost savings. They don’t cover the same responsibilities but saving at least 10K a year.”… “The danger is a move towards these cheaper workers that don’t have the same kind of in-depth training or breath.” …” A lot of pressure to complete therapeutic work.”

Similarly C2 stated, there has been “a lot of redundancies with older GP’s and newer GP’s are less likely to take on new roles, there are a lot of vacancies in primary care. Lot of that is due to the cost getting higher and GPs not having enough money to advertise and recruit new staff to fill the vacancies and the stress of the job. If a GP goes off sick, you may not be able to fill the post.”
D1 explained, “…with people not wanting to work in those conditions it then leads to even worse staff levels. Due partly to not making the posts and not enough people to fill the posts, and where there is posts its gotten so bad that people don’t want to work there.”

D3 suggest if they “make working conditions better in terms of providing cover; more people on the ground and not working to 98% capacity it would be much better for moral.”

Morale

All HCP discuss the general mood and low morale experienced by themselves and their colleagues.

C3 sympathises “morale is low even in senior member of staffs, they do as they are told.”

D1 explains “Morale is so low it is unbelievable, its not all so low you can still have some fun walking around, however there is definitely a shift, people don’t seem to want to work as hard now. There is a big feeling as things become more private people are less happy to go above and beyond. There is the saying that “the NHS is run on good will” and there is a lot of truth in that” D6 agrees “The NHS relies on good will, we work hard and are demoralised, and contrary to belief the pay is not great… doctors and nurses and other public service workers are no longer held to high esteem by public, only fire fighters. Possibly due to media and the government austerity so public being squeezed”

Privatisation

All HCP expressed privatisation negatively and it is not seen to be helpful to the NHS, in addition to the general cynicism and distrust to motives of the government.

D1 explained “The general attitude now is more of why should I stay late when other people are making profits off of my extra work. Its not just contributing to the NHS which is valued by the government and society, and there isn’t enough money but we

will dig our heals, work really hard and make it work, now it is we have been battered by the media the government and subsequently some of the public, people are like I'm going to go home then, I've worked really hard for my contracted hours but I am not going to stay even later and miss another meal with my girlfriend or be late again for the cinema"

C1 added "It makes me feel disenchanted, my worry is the overriding direction of the last few years is to cut away at the NHS and to give bits of it to private companies and this is the direction we are heading in"

D1 explains working "the extra hour in the current climate feels like everyone is angry … and you turn on the news and it says the NHS is the worst and Jeremy Hunt saying he's not going to pay nurses any more, that is the biggest contributor to people burning out."

A few doctors further explain that when services are contracted out they are not on the same team as the NHS clinical staff and therefore they do not see the benefit in providing a doctor or nurse with a free coffee even though they have who is rushed off their feet all day and not been able to have lunch.
D1 explains "When private they don't have funding to give NHS coffee, they are contracted to do it for the lowest price they could to still make a profit."

Relationship with superiors

The majority of hospital HCP mentioned an unsavoury relationship with their superiors.

D2 stated the "there is an us versus them attitude and it makes it an unpleasant place to work, I think it is due to the pressure the consultants are under and that has developed this attitude." D1 added if they felt appreciated by the superiors it would make a difference to their morale.

Furthermore it appears to be exacerbated by a lack of support from non clinical staff and management. D5 stated "Middle management never comes on the ward to see what the clinical staff do, if they want to speak to us we are called up to their office and off the ward like they don't have enough work to do and enough patients to see"

Development opportunities

A few HCP commented on the lack of development opportunities, in particular for nurses as a result of services increasingly being outsourced.

C2 stated "Nurses are unhappy with services they used to provide in the community is now outsourced because it is cheaper. Skills wise the nurses would have liked doing and would have further developed them but is now not available to them"

Increased inefficiency

All HCP suggest that the cuts have resulted in further inefficiencies and therefore increased cost. D1 sympathises "these are the parts that are difficult to quantify would an individual be more likely to order a scan because they had 6 minutes with a patient as apposed to 10. On the front line however, it is clear to see."

D1 further explains "due to time constraints it builds a system of inefficiency… because the consultant takes the responsibility of the patient once they have seen them, if they don't have time to thoroughly examine them and take that extra bit of history to get that key pertinent points, what they will often do is send for another test. e.g. (a patient presents with) abdominal pain and a history taken … not that clear (in addition to the) examination not that clear, so they say the patient is probably fine, but lets just do a CT scan to make sure and have a look. If they had an extra 20 minutes after examining and speaking to the patient they could say for example it sounds like constipation, lets give you some laxatives and see how you do. Come back in 2 hours they've done a big poo and the pain is gone, then you don't have to order the CT scan. But that doesn't happen because the people need to move too quickly so everything moves slower and the cost goes up and waiting for the CT scan."

Reward and recognition

All HCP reported a lack of reward and recognition.

D1 mentioned "Some hospitals are discounted for lunch /subsidised, but this is not standardised everywhere" D3 added, "The canteen food is disgusting anyway". Although D3 agrees in thinking there is a need to "Increase moral D3 believes there is no perks working in the NHS as there is no money for it and even if there was D3 doesn't think it would happen. Although there was appreciation when taken out for meals by consultants and drug companies but that has significantly reduced as we don't get lunch breaks and it wouldn't compensate for the extra 2-3 hours we put in everyday, anyway.

C4 explained, "GPs are incentivised to get their funding to essentially do their job"
C1 Joked that appraisals are the NHS bonus, "the manager tells you nice things, on the assumption that you are doing a good job. We go up an increment if you go up a pay scale however there was talk of a pay freeze but I did get a pay rise."

Personal life

All HCP complained about the impact to their personal life de to being over worked and stressed in addition to the unsupported emotional aspects of the role that they have no relief from due to being over worked.

C1 explains, "The Impact on my personal life is huge, if people call I don't pick up I can't hear problems, and it means I am not the same kind of friend or person that I want to be. I like to be a fun person and I don't really feel like it"

D3 states "I can't make plans with friends if do have to cancel them as there is a sick patient and understaffed so no one to look after them after you leave. That is a dent on moral. That is the root."

D1 shared “The basic thing is the NHS is amazing I’ve worked in South Africa for a year, Uganda, Cameroon, Tanzania and Mexico and Columbia and visited Italy. The NHS is brilliant and amazing and it gets forgotten by everyone including those that work in it, myself included.”

Impact to patients

S1 claims the impact to patients the standard of care is "difficult to evidence at this stage." When asked what has been the feedback, all procurement staff interviewed stated that no feedback had been sought. However all the HCP agree that there is an impact to patients. D1 stated, "Patients complain that their medications just gets changed, and decision is made somewhere and no one knows how it is happened". In addition to this the main areas of concern are covered below.

Increased risk

D1 reported "I feel it is dangerous to patients you accept there is always a certain level of risk inherent, not having enough time to do each thing you have to accept more risk. You may be able to do some of the assessments covering the more important things like, assessing their cognitive state, listening to their chest, heart and feeling their abdomen. But you may not have time to really assess their respiratory rate properly and look for more signs for other things. You can't go into that extra level of detail, and that is what tweaks the level of risk. If you are prescribing something and have to do it quickly, you then don't have time to look through your prescription to check for any errors. Hopefully you do it right the first time but if you do it 100 times, then there will be human error. Pharmacists are supposed to pick these things up but there is no pharmacist over night, lots of things are prescribed over night, and lots of people are given drugs without a pharmacist or anybody else looking at them, checking them over.

D1 added **"**If you don't have time and your worried about someone about to arrest etc. then it is easy to prescribe something that interacts with another drug, because you simply needed a little bit of extra time and less pressure to be able to think about it."

C1 stated "There are patients left in beds for hours at end wondering aimlessly, calling out to people being ignored, patients dehydrated, not being fed."

D2 explained "patients are moved through acute admissions, come into A&E there are time limits which can cost the trust a lot of money if patients aren't moved out in a certain time frame. So to over come this they setup a ward to move patients to which was essentially a holding pen to hold them for 6 hours, resulted in an extra ward where patients were staying and not moving on always a bottle neck with the wait for beds, there was not sufficient cover of provision for proper cover Dr and nursing, although they are covered but medical staff spread super thin"

D5" Patient safety could miss things under the time restraints, staffing in hospital is unsafe even in the better hospitals. A paediatric registrar was found guilty for manslaughter, due to shortages with doctor and nurses and then there was a computer failure, she was the responsible Dr at the time of death. The ward was running consistently on a skeleton of resources of staff and when the extra problems occur like a computer problem, or an extra person could be sick, you then can't spread any further and all it takes is one patient to become critical for other patients to then be neglected.

Treatment

C1 “(some children are) more expensive for the Local Authority (to treat, they are then) less likely to make permanent placements so kids will be in these placements and you cant give them any certainty about how long they will be there.” This can result in further psychological issues.

D2 “had a patient in for about 3 weeks waiting for a spinal operation (so they were) regularly getting starved ready for the operation and told she’d have the operation that day, and an emergency would come in and she would get cancelled after about 3 weeks she broke down in tears and there is nothing I could say to comfort her”

C2 explained, “might have to go to A&E extra pressure on that service, or not seen at all and that has the potential to be very dangerous”

C4 claims “In affluent areas your more likely to get a better level of care and services compared to a more deprived area.”

C5 explained “CCG not as efficient as it could be GPs not as autonomous in how they give out their services,”

Impact to businesses

All businesses interviewed (devises, pharmaceutical and services) agreed they had not seen much of the impact in direct relation to the most recent efficiency changes, although they have continued to increase the cost effectiveness and adding value, in terms of added services and working in partnership to help to support the NHS whilst still making a profit. NHS procurement agree that there has not been much change in their actual orders, S1 and S3 Suggests this may be due to an already high compliance.

In regards to new products there has not been any change presently however the “new Future Operating Model (replacing NHS Supply Chain) is likely to have more impact regarding new products… and logistics,” informed S1.

Changing in sales technique

The majority of doctors and suppliers to the NHS agree that over the years there has been a change in regard to the way they sell their products in addition to the reduction in access to HCP partly due to the time restraints.
D5 reported “there is an impact on how reps sell expensive drugs so they emphasis on effectiveness, quicker recovery compared to generics used more cost models, harder job for the, still companies that have monopolised therapy areas”

Profits from efficiency

D1 evaluates “(whilst) Private scans have increased and they are terribly inefficient. If you have a scan its always non specific and doesn’t give you an answer, where as if it was done in the NHS hospital you could just call the person up and explain this is the question you need answering because you are part of the same team, they get it.

Where as the other work that is done by contractors they just tick the boxes and your no further along by the end of it because they haven't answered the questions you wanted answering. So you end up repeating the procedure. It looks fine on numbers and yes they got the scan done but they haven't moved anything forward for the patient. Instead they have slowed it down, which is very frustrating, its definitely a lot more disjointed."

C2 coincided, "ultra sounds in the community/ in surgeries or healthcare centres so that patients can be seen sooner because waiting lists in hospital are longer. However, its not joined up and needs to taken to be interpreted, so you then wait for it to be interpreted, and then deliver the information, if it then needs to be sent on further to specialist it could then take that much longer"

C1 noted, "(a) private company is seeking a profit and if the state is paying for that private company to run a service then the state is also generating their profit. C2 established "Business makes a profit because they run the same service possibly more efficient they can then charge less for the say an ultrasound scan and then do more of them in the allotted time. You can do an ultrasound as an emergency the same day, which in theory is beneficial for the patient"

C2 declared private companies "have leverage being able to undercut the NHS may get the contract provided they can prove they can do the work. CCG vets these companies. Not easier for them they still have to jump through the hoops, local GPs can make their own decisions but within the CCG if they want to provide services to an area they'll need to meet their stringent requirements before they are taken on"

NHS supports private services

C1 explicates "Private care homes is an example they put money in to marketing, but are run with untrained care staff and a third or half of the people they need to run it. An NHS run service is set up because the private care homes were doing such a terrible job they had all these old people that were really distressed and showing really challenging behaviour and it was being managed really poorly, because there wasn't enough staff and if there was they were untrained and didn't have a proper understanding and they weren't supported. Managers hiding behind doors working out cost efficiency savings to send to the people above them. There was no savings, if there was it was at the expense of care, so the care home "in reach" team would offer training, free training, to their staff and they were offering support, being there observing interactions with patients and gently directing staff in the things they were doing which might be reinforcing certain difficult behaviours."C1 concluded "This shows that the NHS is better at running the service than the private company it just doesn't cut corner"

C1 further adds in support "NHS staff leave for private so the NHS then has to pay for private places, being inefficient, they may not provide all the services so the fosterers may need training, and the kids that are challenging need therapy and that is then provided by the NHS, to the staff that. So the private company can provide the service at the cheaper price but only with assistance from the NHS"
C2 added "Some private services nurse services previous provided by district nursing services are now outsourced to the private sectors, although they will refuse parts of the jobs if they feel it is too difficult or not profitable, so they have the option to pick

and choose which can lead to problems as parts of the service is not done and has to be done by the NHS still and therefore not necessarily cost effective”