HFMA briefing
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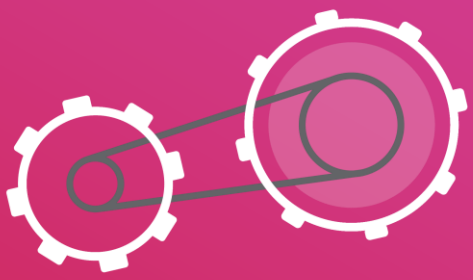
Centralised inventory procurement



High cost devices

Background

NHS England is rolling out a new national, centralised system for purchasing expensive medical devices and implants used in specialised services. Roll out of the system started during 2016/17 and will be completed during 2017/18.

This is one example of centralised procurement which may become more widespread in the NHS as bodies work together on a system-wide basis to deliver efficiencies and improve financial sustainability. This briefing summarises the new arrangements and considers what this means in wider terms for centralised procurement arrangements.

The new arrangement for high cost devices

This new arrangement is a result of the implementation of the Carter review[1]. High cost devices are usually those which are used in the provision of specialised healthcare services (for a full list of devices covered by this arrangement see Appendix 1). Because of their specialised nature, they are excluded from tariff. Previously, each provider sourced and purchased these devices in isolation and were subsequently reimbursed by NHS commissioning organisations for the cost of the device on a pass-through basis.

[1] www.england.nhs.uk/commissioning/spec-services/key-docs/medical-devices/

Historically, there have been regional variations in the amount recharged to NHS commissioners by NHS providers – the device alone or the device and associated peripheries and consumables. Some NHS providers have recharged the full price but there have been other practices in place.

The new system allows providers to order specific high cost devices through NHS Supply Chain from a nationally procured catalogue via an e-procurement system. NHS providers order the devices as they need them and hold them in stock[2] as necessary but NHS Supply Chain pays the supplier invoices and then recharges NHS England directly[3].

NHS England pays for all devices used in English NHS patients – there are recharging arrangements for Welsh, Scottish and Northern Irish patients as well as private and overseas patients.

Any stock (or inventory) held by NHS providers is not reflected on their statement of financial position but is, instead, included on the NHS England statement of financial position. This is reflected in NHS England's 2016/17 accounts which show an increase in inventories for the parent group (NHS England) from £0.15m on 31 March 2016 to £10.59m on 31 March 2017.

Phase 1 of the new arrangement is intended to ensure consistency going forward and is expected to save the NHS more than £60m over its first two years simply by taking advantages of economies of scale and reducing price variations[4]. Phase 2 will involve working with clinicians to improve utilisation of the most effective and best value products as well as reducing unwarranted variation and improving service specifications[5].

Considerations for centralised procurement

As NHS England does not have direct management of the devices once they have been ordered there are many issues that have had to be and still are being considered. This briefing is, in part, intended to allow the lessons learned from the approach to high cost devices to be applied to other centralised procurement arrangements. It is clear that all stakeholders need to work together to achieve the maximum benefits from the new arrangements.

In relation to high cost devices, not all of the issues below have been resolved but they are now being addressed and many of them were pre-existing issues with the old pass through arrangements. The potential benefits to the new model are expected to be wide-ranging. For the first time, for those providers who have migrated across to the new model, NHS England has detailed, consistent information about the products being used, quantities and cost. The future model (phase 2) will provide a governance process for the commissioning of new, innovative devices on a consistent basis across specialised service providers in the NHS in England.

Accounting for stock/ inventories

IAS 2 includes the following definition:

'Inventories are assets:

(a) held for sale in the ordinary course of business;

(b) in the process of production for such sale; or

(c) in the form of materials or supplies to be consumed in the production process or in the rendering of services.'

[2] This briefing uses the words stock and inventory interchangeably.
[3] The new arrangement is the subject of discussion at the HFMA's prescribed specialised services commissioning group. It was discussed at the May 2017 meeting, minutes will be available from the HFMA website (www.hfma.org.uk/our-networks/committees-special-interest-groups/prescribed-specialised-services-commissioning-group/information) once they have been approved.
[4] Specialised commissioning bulletin 22, 10 August 2017
[5] See paragraph 4.2.12 of NHS England's *Commissioning intentions 2017/18 and 2018/19 for prescribed specialised services* - www.england.nhs.uk/wp-content/uploads/2015/12/spec-comm-intent.pdf

IAS 2 does not contain any guidance on accounting for inventories which are bought and accounted for by one body but held and used by another. For this, we need to look at the revenue standards in relation to consignment stock.

IAS 18 *Revenue* does not deal directly with consignment stock but does indicate that there are some circumstances when stock does not necessarily need to be accounted for by the entity which is holding it.

The new accounting standard. IFRS 15 *Revenue from customers* is more useful. Paragraphs B77 and B78 of the application guidance say:

'When an entity delivers a product to another party (such as a dealer or a distributor) for sale to end customers, the entity shall evaluate whether that other party has obtained control of the product at that point in time. A product that has been delivered to another party may be held in a consignment arrangement if that other party has not obtained control of the product. Accordingly, an entity shall not recognise revenue upon delivery of a product to another party if the delivered product is held on consignment.

Indicators that an arrangement is a consignment arrangement include, but are not limited to, the following:

(a) the product is controlled by the entity until a specified event occurs, such as the sale of the product to a customer of the dealer or until a specified period expires;

(b) the entity is able to require the return of the product or transfer the product to a third party (such as another dealer); and

(c) the dealer does not have an unconditional obligation to pay for the product (although it might be required to pay a deposit).'

In this case, the NHS provider body is providing a healthcare service which is being paid for by the commissioner. The provision of that service requires a device which is also purchased and paid for by the commissioner. It can be argued that the provider body is providing a service and does not take control of the stock at any point – it bears none of the risks or rewards of holding it and only orders it to provide a specified service. The stock is therefore accounted for by the commissioning body rather than the provider body.

Control issues to be considered

As this is a new arrangement, the following questions have been raised. They are included in this briefing as issues providers and commissioners of high cost devices should consider but also as questions which need to be asked when any joint procurement system is being devised.

Reimbursement of stock items

- how does NHS England recoup its costs and those of the NHS Supply Chain incurred by managing the central procurement? In the case of high cost devices, a percentage is added to the cost of the device. However, as more items are ordered via the new system, then the percentage reduces.
- how does NHS England identify the devices that have been used in the treatment of patients outside of their jurisdiction so the cost can be appropriately recharged?
- what consumables are required for the devices? Are they included in the centralised purchasing system or not? Are they covered under the excluded device heading or are they 'in tariff'?

Management of physical stock

- what processes can be put in place to ensure that best practice stock management arrangements have been implemented at each provider body?
- what controls can be put in place so that providers do not over-order? What controls are in place to ensure devices are used first in first out basis?
- how is expired and obsolete stock managed? Who bears the cost of write off and how is this information collected and communicated?
- how is damaged stock managed? If an item is delivered to a provider and it is damaged on delivery, how does NHS England know that it has been returned and should not be paid for? If stock is damaged by the provider then how is that managed and who bears the cost?
- high cost devices are sometimes purchased for a particular patient. If the procedure does not go ahead – for example, the patient dies before surgery, there may be no further need for that device by that provider body. What arrangements can be put in place to return items to the supplier or transfer items of stock to other provider bodies that may need them and avoid disposal?

Stock-taking

- what stock taking arrangements need to be put in for the year-end to enable the NHS England accounts to be prepared?
- what arrangements need to be put in place by providers to ensure that the centrally procured stock is not counted with their own purchased stock at the year end? There is a risk of double counting during year-end stock takes.
- what common information do NHS provider bodies hold on items of stock? As there is no single/ common stock control system in place in England, how does NHS England identify the stock that it holds at NHS providers?
- what comfort/ assurance can NHS England obtain that stock is being stored and managed appropriately? Reliance on third party information is an issue which was covered by the HFMA's year-end accounts survey.
- obtaining reliable information on time is critical to the preparation of the annual report and accounts – how can this be achieved without adding pressure to NHS England and provider bodies' finance teams during the year-end period?

Transition to new arrangements

- now, the level of stock on the NHS England statement of financial position is relatively small. However, as these new arrangements develop the amounts may become material. What arrangements do auditors expect to be put in place to ensure that stock is recorded in the correct body's accounts and is not materially misstated? How will these arrangements be tested and by whom? What reliance will NHS England's auditors be able to place on the arrangements implemented in individual provider bodies?
- what is the impact on provider bodies as they withdraw from existing arrangements? Where they have negotiated discounts, will there be an impact on contracts for devices that they are still buying?

Wider value for money considerations

In order to give assurance that NHS trusts maintain a low level of waste NHS England are currently requesting the implementation of patient level records for all devices used. This will ensure that NHS England maintains an accurate record of stock holding for these devices. However, the implementation of this process will add administrative costs to NHS providers whose staff will have to create and maintain these records as well as at NHS England where staff will have to manage,

review and interpret the data supplied. Additional time to discuss this data and its accuracy will almost certainly also be required which will add another cost pressure.

Consideration needs to be given to the wider value for money implications of implementing processes such as these. The change in procurement process is not expected to lead to a change in clinical practice and a decrease in waste. A simpler system requiring NHS providers to record the devices used in non-English and private patients may provide the same level of assurance at a much lower cost.

Best practice in stock management

Good stock management is all about balancing the need to have particular items of stock available to provide healthcare services with the costs of tying up cash in stock sitting on a shelf whilst bearing in mind the costs of ordering and delivery of stock.

The number of places that stock is stored needs to be considered. A single, central store may not be practical if items are needed quickly to provide quality healthcare services and if physical storage space in operating theatres is minimal. However, multiple stores may increase stock levels and costs and run the risk of items being overstocked in one place but understocked in another. Where there are multiple stores, arrangements must be put in place to co-ordinate ordering and stock management.

Reliable systems which are developed with and trusted by clinicians should reduce ‘ad hoc’ arrangements/ stores being held ‘just in case’.

To manage stock effectively, accurate and timely information is needed about how many and when stock items are used. Potentially this means linking procurement, stock control and financial systems together. Clear procedure notes and systems of internal control need to be established. Appendix 2 sets out some of the controls that should be in place in a good stock management system.

Further reading

Yes, we scan – an article on e-procurement in the February issue of Healthcare Finance

www.hfma.org.uk/news/healthcare-finance/feature/yes-we-scan

Ward stock management guide – East Lancashire Hospitals NHS trust

/www.elpd.elht.nhs.uk/images/Ward%20Stock%20Management%20Guide.ppt

The Auditing Practices Board – Practice Note 25 *Attendance at stocktaking* Feb 2011

https://www.frc.org.uk/Our-Work/Publications/APB/PN-25-(Revised)-Attendance-at-Stocktaking.pdf

International accounting standard (ISA) 2 *Inventories*

www.iasplus.com/en-gb/standards/ias/ias2

Appendix 1: high cost devices covered by these new arrangements

According to NHS England[6], the initial implementation will focus on the following 17 categories:

- three-dimensional mapping and linear ablation catheters (complex cardiac ablation)
- aneurysm coils and flow diverters for intracranial aneurysms
- bespoke orthopaedic prostheses
- circular external fixator frames
- bone anchored hearing aids
- carotid, iliac and renal stents
- deep brain, vagal, sacral, spinal cord and occipital nerve stimulators
- endovascular stent graft
- ICD (Implantable Cardioverter-Defibrillator) ICD with CRT (Cardiac Resynchronisation Therapy) capability
- intracranial stents
- intrathecal drug delivery pumps
- maxillofacial bespoke prostheses
- occluder, vascular, appendage and septal devices
- percutaneous valve repair and replacement devices (mitral/pulmonary valve)
- peripheral vascular stents
- radiofrequency, cryotherapy and microwave ablation probes and catheters

[6] www.england.nhs.uk/commissioning/spec-services/key-docs/medical-devices/

Appendix 2: stock controls

The controls which need to be put in place will vary depending on the items of stock that are being considered. In a hospital, there will be various categories of stock:

- low value, frequently used items such as dressings
- low value, infrequently used such as very specific implants
- high value, infrequently used items such as those listed in appendix 1
- high value, frequently used items such as some theatre kits
- drugs and pharmaceuticals which need to be separately managed as access must be limited to qualified staff

The controls listed below will need to be adapted as necessary.

Segregation of duties

Different people should have responsibility for requisitioning, ordering, receiving, using and paying for stock.

Ordering

Stock should only be ordered on receipt of a properly authorised requisition

Minimum levels of stock should be clearly identified and stock should only be re-ordered when that level is about to be reached

Stock should be ordered from an agreed catalogue

New suppliers should be added to the catalogue by authorised personnel

Access to requisitions and ordering systems should be limited to authorised personnel

Receiving stock

Receipt of stock should be reconciled to orders and requisitions on delivery

Stock received should be checked for damage

Any returns should be recorded on the order and the goods received note

Payment of invoices

Invoices should be reconciled to goods received and orders

Invoices should only be paid once they have been authorised as having been received

Invoices must be appropriately authorised by budget holders

Physical controls

Stock should be securely stored – the level of security will depend on the type of stock

Responsibility for security arrangements and custody of keys should be clearly defined

Stock should be marked as NHS property where possible

Access to stock should be limited to authorised individuals

A list of authorised individuals should be maintained and kept up to date – controls should be in place to update the list as staff leave, join and change roles

A list of stores should be maintained and regular checks should be made that these are the only places being used to hold stock

Stock management

The storage location of deliveries should be recorded on receipt

If stock is moved to a different location, that should be recorded

As stock is used/ issues controls should be in place to sign it out of storage – whether it is being used or moved to another storage location

Stock returned to stores should be recorded

Periodic stock takes to reconcile recorded stock to physical stocks should take place at least annually and more frequently for high cost, high turnover items

The oldest items of stock should be used first

Stock should be reviewed periodically for damage and/ or obsolescence

Levels of stock, slow moving and obsolete items should be periodically reviewed

Obsolete stock should be disposed of in accordance with written procedures