IMPROVING RELATIONSHIPS WITHIN THE SCOTTISH NHS SUPPLY CHAIN

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ABSTRACT

The National Health Service (NHS) is a unique organisation which experiences continual change, making the management of the supply chain a particularly challenging area. Key relationships at the two ends of the supply pipelines between NHS buyers and their suppliers and between local NHS supplies managers and their customer base are therefore crucially important. Following the 1990 reforms and the introduction of the NHS internal market, an environment has been created in which managers are generally much more cost conscious and customer orientated. The net effect of these changes has been to raise the profile of the buyer-supplier and Supplies Manager-customer relationships.

A review of the current literature has highlighted aspects of relationships that can be applied to those within the NHS supply chain as well as identifying some conceptual gaps. Initial exploratory surveys of supplies managers, NHS buyers, suppliers and end customers were undertaken with the emerging themes being further investigated through semi-structured interviews. Two relationship review tools were constructed and an action research approach adopted to evaluate the tools which involved Scottish NHS buyers with their suppliers and Scottish Supplies Managers with their end customers.

The experience of the case studies suggest that the tools are a useful way of continually reviewing relationships which is necessary given the dynamic nature of the NHS. The research also suggests that purchasing relationships between NHS buyers and the suppliers currently exist along the whole of the relationship spectrum – from adversarial to partnership type – depending on the influence of particular factors. Both extremes

have a place in the NHS buyer's "relationship portfolio", the challenge is to recognise when and how to adopt a particular type. The research suggests that the tool devised specifically for use by NHS Supplies Managers and their customers assists Supplies Managers in their task of identifying a means of ensuring flexible packages of care are offered to meet the increasing expectations of all customers.

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SECTION ONE

SUPPLY CHAIN MANAGEMENT, BUYER-SUPPLIER RELATIONSHIPS AND CUSTOMER CARE IN RELATION TO NHS SUPPLIES SERVICES

CHAPTER ONE

INTRODUCTION

"The best thing for being sad is to learn something. That is the only thing that never fails. You may grow old and trembling in your anatomies, you may lay awake at night listening to the disorder of your veins, you may miss your only love, you may see the world about you devastated by evil lunatics, or know your honour (has been) trampled in the sewers of baser minds.

There is only one thing for it then - to learn. Learn why the world wags and what wags it. This is the only thing which the mind can never exhaust, never alienate, never be tortured by, never fear or distrust, and never dream of regretting."

T.H. White
US Novelist (1845-1920)

1.0 Purpose of the Research

The central themes of this thesis are to demonstrate that the unique nature of the National Health Service (NHS) as an organisation determines:

- the practices and type of relationships employed in purchasing goods from suppliers;

- the methods used in delivering a Supplies Service[1] to internal customers;

The purpose of this study was two-fold, firstly to identify factors that can be used to shape and adapt the relationship strategy adopted by NHS buyers with their supplier base and secondly to identify factors that affect the way in which NHS Supplies Managers can enhance the delivery of care to their customer base.

Following a review of the relevant literature an action research approach was used whereby an initial exploratory survey was undertaken to identify common themes which were then further investigated in semi-structured interviews. A predominantly qualitative analysis of the data taking account of the literature review, resulted in the construction of two specific relationship review tools. The review tools have subsequently been tested and evaluated in case studies involving both NHS buyers and their supplier base as well as NHS Supplies Managers and their customer base.

[1] NHS Supplies Services are the departments within Health Authorities/Boards or Trust hospitals that have traditionally managed the process of purchasing, storing and distributing goods on behalf of other NHS departments. See Chapter 3 for a detailed historical account of the supplies function in the NHS and an explanation as to current organisational arrangements.

1.1 Context of the Research

1.1.1 Historical Overview of Supply Chain Management

Drucker (1962) argued that physical distribution was one area of business which previously had been neglected but could yet yield significant management results. In the intervening decades, Drucker's plea has been answered by both greater management and academic commitment to the logistics and distribution function. Management focus initially centred upon the transport element of the distribution mix (Wentworth, 1970; Kearney, 1978) but as information technology enabled data to be processed quicker, the emphasis shifted to integrating not only the elements of the distribution mix but to all elements of logistics (Bowersox et al, 1986; McKinnon 1989; Johnson and Wood 1990; Ballou 1992).

Ballou (1992; 4) referred to the 1962 United States Council of Logistics definition of logistics which states:

> "Logistics is the process of planning, implementing and controlling the efficient cost effective flow and storage of raw materials from point of origin to point of consumption for the purpose of conforming to customer requirements".

Whilst this definition is somewhat outdated, written ironically in the same year as Drucker's article, it nevertheless still captures the main tenets of logistics management. The key management trade off is to minimise the total costs involved whilst at the same time ensuring that desired levels of customer service are achieved.

Supply Chain Management (SCM) is the terminology that has subsequently emerged (Christopher, 1992; Christopher 1993) and will be used by the author throughout this thesis.

Some writers argue that there is a simple but significant distinction between logistics and SCM in that logistics concentrates on internal organisational issues, such as inventory and transport management, while SCM also incorporates the crucial external relationships of purchasing and customer service (see Stevens 1989). However, this view was held prior to the emergence of the partnership literature in the early 1990s[2] which has sought to link all the component parts within the supply chain. It also has to be borne in mind that logistics emanate from the fusion of physical distribution management and materials management. There is now a wider acceptance within the academic fraternity that logistics and supply chain management are synonymous terms which include the management of supplier and customer relationships. It is within these two component parts of the supply chain that considerable competitive advantage can be achieved (Porter 1985). There has been a realisation that the optimisation of internal logistics within individual organisations could still leave the supply chain as a whole sub-optimal, thereby promoting the need to improve external linkages. Much of the research into SCM in the United Kingdom (UK) has focused upon the manufacturing sector, notably the automobile industry (Womack et al 1990; Lamming 1993) and the retail sector, particularly the grocery industry (Smith & Sparks 1993; Fernie 1994). There is, however, only preliminary research work relating to the NHS (Rees 1992; Rees 1993; Rees 1994).

1.1.2 Purchasing Relationships with Suppliers

Purchasing's role within an organisation is to manage the process of buying goods from external sources, therefore, the establishment and nurturing of relationships with suppliers is crucial. Traditionally, though, buyer-supplier relationships have been adversarial (Shapiro 1987) based upon short-termism, aggression and price haggling. Sako (1992) argues that business transactions in the Western world are conducted at "arms length". Traditional marketplace economies have consisted of large numbers of suppliers allowing the buyer the opportunity to "jump" between suppliers without having investigated large amounts of time or money in developing relationships. Price would appear to have been the major determinant for the buyer in deciding whether or not to "place the order" with only secondary consideration given to the adherence to delivery schedules and even less to the more qualitative aspects. This approach to suppliers reflects the internal status and position of buyers within their own organisation in what Lamming (1993) describes as a "traditional" model.[3] In this type of model buyers are treated as a clerical ordering function rather than a discipline that can 'add value' in any strategic sense (Cousins 1991).

The process and detail of purchasing will be shown in Chapter 2, Section 2.2 (Dobler et al 1984; Baily & Farmer 1981). The underlying theme of these texts was however based upon an adversarial type relationship with suppliers and the assumption that the predominant market conditions would be such that there would always be a sufficient choice of suppliers for the buyer. This body of literature, whilst essential to the buyer learning his trade, presents a narrow focus. There are obviously a number of different

[2] See Chapter 2, Section 2.2.3 for discussion regarding the partnership literature.
[3] Further discussion of Lamming's traditional model and his models is contained in Chapter 2, Section 2.2.3

approaches to the buyer-supplier relationship, not just the adversarial type promulgated by these texts. At the opposite end of the relationship spectrum the notion of partnerships have emerged as the way forward for the future.

A greater emphasis on cost reduction was brought about by UK market conditions in the 1950s and 1960s which produced increased competition and falling profits. The 1970s shortage of raw materials placed an even greater focus on cost. One element of the subsequent cost management strategy that evolved has been the minimisation of total costs involved in purchasing through the development of stronger links with key suppliers based on longer timescales and trusting-dependancy type partnerships (Carlisle & Parker, 1989; Kanter 1989; Womack et al 1990; Hanan 1992; Cousins 1992; MacBeth and Ferguson 1994; Hines 1994) which shall be explored in some depth in subsequent chapters.

A critical stage before partnerships in the evolution process for purchasing is the acceptance by management of purchasing's strategic role (Carlson 1990; Cammish & Keough 1993; Gaade and Hakanson 1993). Partnerships with suppliers cannot be embarked upon without senior management support and long-term vision as substantial investment and commitment is required which results in only limited short term return. Senior Management must be willing to accept this principle and be prepared to wait for a return on investment.

The partnership philosophy, whilst a significant development in buyer-supplier relationships, cannot be regarded as appropriate for application in all situations. It has been argued that there appears to be a gap between the theory of partnershipping and the reality (New 1994).

The concept of a spectrum of relationships between buyer and supplier (Sako 1992) is very much more acceptable in practice and is seen as the basis for this research. Lamming and Cousins (1994) emphasise the complexity and dynamics of relationships suggesting the need for an organisation to accept and adopt what they label as a Purchasing Relationship Portfolio.

This thesis contends that purchasing relationships between NHS buyers and suppliers currently exist along the whole of the relationship spectrum from adversarial to partnership dependent upon the influence of particular factors. Both extremes have a place in the NHS buyers "relationship portfolio" - the challenge is to recognise when and how to adopt a particular type. NHS Management need to assimilate this concept, be aware of the influential factors, establish practical monitoring measures for control purposes so the chosen purchasing relationship can, if necessary, be adapted to suit changing circumstances.

1.1.3 Customer Care

The concept that customer satisfaction has to be the main strategic influence throughout an organisation has become increasingly accepted throughout the 1980s and 1990s as a means of achieving competitive advantage (Porter 1985; Peters 1987; Schonberger 1990). It is important to define customer care at the outset. Lewis (1995:73) states that:

> "Customer care is concerned with customer satisfaction; putting the customer first, anticipating needs and problems, tailoring products and services to meet needs and establishing customer relationships".

If organisations are to accept a customer centred approach and make this a reality, then senior management has to be committed. Indeed, it is senior management direction that determines the operating procedures within the rest of the organisation. Customer care can be neither merely a management philosophy or a piecemeal approach, but has to become the responsibility of all employees.

A prerequisite of a customer care strategy is the adoption of Total Quality Management (Hutchins 1990: Cook 1992; Morgan & Murgatroyd 1994) where there is a commitment by all to continuously and systematically improve performance.

TQM as a concept can be traced back to early post World War II theorists and practitioners who focused on Japanese manufacturing industry (Deming 1988: Juran 1988). The first stage in establishing a customer care strategy is to carry out a customer audit to determine what level of service the customer actually requires (Christopher & Yallop 1992) rather than what the service provider perceives the customer requires. It is obviously crucial that monitoring mechanisms are put into place, having been agreed with customers, to measure the achievement of customer targets (Donabedian 1980: Parasuraman 1985). Benchmarking performance or "daitotsu"[4] is a monitoring technique employed to gauge performance against an acknowledged market leader.

Organisations have recognised that whilst any level of service is possible (Christopher 1993) not all customers require the same level of service (Sabbath 1987). The need to offer customised packages of care is a necessary flexibility for an organisation to adopt. It is with this principle in mind that successful companies understand the need to stay in

[4] Daitotsu is the Japanese word for benchmarking and has a literal translation of "striving for the best of the best". (Oakland 1989)

close and regular contact with customers. Clear communication between service providers and customers is vital to predict and meet changing requirements (Peters 1987; Oakland 1989).

Every contact between customers and service providers is likely to influence the customers' opinion of the provider and ultimately determine if the experience is to be repeated. Albrecht & Zemke (1985) label each contact as a separate "Service Encounter" which can build or damage trust and confidence between the parties. Both the actual outcome of the encounter and the perception of the process are influential factors on customers' future decision making (Lehtinen & Lehtinen 1982). Perceptions are derived and constructed by a multiplicity of different factors which culminate in the establishment of a culture[5] and can affect the customer-provider relationship. The philosophy of customer care is "not simply concerned with external linkages but needs to apply to internal customers" (Cardwell 1992:17). The approach adopted to internal customers will determine the attitude taken when dealing with external agencies. This thinking re-introduces the main theme of TQM in that responsibility is accepted by all employees in every business dealing whether it be internal or external.

The NHS has not traditionally embraced the philosophy of customers and is unlikely ever to have done so without the introduction of competitive forces through the creation of the internal NHS marketplace[6] in which Trust Hospitals compete for Health Authorities/Boards' business. The NHS and Community Care Act 1990 which created the framework for the marketplace has, as its core objectives, the need to make more

[5] Schein (1983:10) defines culture as "..the pattern of basic assumptions which a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration.

cost effective use of NHS resource and to create a more patient centred, customer focused organisation. An indirect result of the internal marketplace has been to raise the profile of NHS Supplies Service and the concept that they serve internal customers.

This thesis contends that in order for NHS Supplies Services to survive against the threat posed by external competitors, flexible packages of care to meet the increased expectations of all customers must be offered. After having accepted this principle, the management challenge is to determine and understand factors that can inhibit or facilitate their ability to offer increased levels of care within the NHS.

The use of differential service levels may be appropriate in NHS, depending upon the make up of the Supplies Service's customer base.

[6] Further discussion of the NHS internal marketplace is contained in Chapters 2 and 3.

1.2 Structure of the Thesis

The structure of this thesis is shown below in figure 1.

Figure 1.1

Summary of the Structure of the Thesis

SECTION 1 REVIEW OF SUPPLY CHAIN MANAGEMENT, BUYER-SUPPLIER RELATIONSHIPS & CUSTOMER CARE IN RELATION TO NHS SUPPLIES SERVICE	Chapter 1 -	Thesis Introduction
	Chapter 2 -	Principles of Supply Chain Management, Buyer-Supplier Relationships and Customer Care
	Chapter 3 -	The Evolution of the Supplies Service in the NHS
SECTION 2 RESEARCH METHODOLOGY & FINDINGS	Chapter 4 -	Research Methodology
	Chapter 5 -	Research Results (Postal Questionnaires)
	Chapter 6 -	Research Results (Semi-structured Interviews)
SECTION 3 DEVELOPMENT OF PRACTICAL REVIEW TOOLS FOR APPLICATION IN THE NHS SERVICE SUPPLIES	Chapter 7 -	Practical Review Tool for use in NHS Buyer-Supplier relationships
	Chapter 8 -	Practical Review Tool for the delivery of NHS Supplies Customer Care.
	Chapter 9 -	Conclusions to Research

1.2.1 Section 1: Supply Chain Management, Buyer-Supplier Relationships and Customer Care in Relation to NHS Supplies Services.

This section of the thesis outlines the central themes of the research and the boundaries within which the thesis is to be considered. A review of the relevant literature in supply chain management, buyer-supplier relationships and customer care is undertaken to provide a backcloth upon which the results of the empirical studies can be discussed. As Section One in essence is concerned with scene setting, there is also a historical account of the evolution of supply chain management in the NHS.

1.2.2 Section 2: Research Methodology and Findings

This section begins by examining the methodologies employed in reviewing the secondary data and generating primary data. There is a recognition of the limitations and constraints placed upon the research by the chosen methodologies. Finally, this section reports on the results of the empirical data and reviews this information in the light of the literature review.[7]

1.2.3 Section 3: Development of Practical Review Tools for Application in the NHS Supplies Services.

This section builds upon both the literature review and the findings of the primary research to suggest separate programmes of practical measures for buyer-supplier relationships and customer care in NHS Supplies Services. The discussion considers how these programmes can be applied in the "real world" using a small number of case studies as examples. Finally, overall conclusions of the study will be covered, including areas for possible future research.

1.3 Conclusion to the Chapter

This chapter has introduced the central tenets of the thesis, discussed the literature framework being used as the context of the research, and explained the structure.

[7] Data is gathered from postal surveys, semi-structured interviews and case studies. See Chapters 4, 5 and 6 for detail of samples used and a summary of the findings

CHAPTER TWO

PRINCIPLES OF SUPPLY CHAIN MANAGEMENT, BUYER-SUPPLIER RELATIONSHIPS & CUSTOMER CARE

"When you are skinning your customers you should leave some skin on to grow again, so that you can skin them again".

Nikita Khruschev (1894 - 1971)
Soviet Communist Party Leader
(addressing British businessmen)

"Mr Morgan buys his partners: I grow my own".

Andrew Carnegie (1835 - 1918)
US Industrialist/Entrepreneur

2.0 Purpose

The purpose of this chapter is to outline the principles of supply chain management, buyer-supplier relationships and customer care. Each of the three sections in the chapter will critically review the available literature making comparisons to the NHS.[8]

2.1 Principles of Supply Chain Management

2.1.1 Introduction

This section defines supply chain management and examine the main attributes of the supply chain, comparing the theories and models contained in the literature to some of the current practices in NHS Supplies Services.

2.1.2 What is Supply Chain Management?

Supply chain management can be defined as

> "the management task of co-ordinating the component parts of the supply process to facilitate the flow of goods from origin to the point of use. The role of management is to minimise the total cost involved, whilst at the same time ensuring that the desired levels of customer service are achieved." (Bowersox et al 1986 : 5)

The flow of goods can best be visualised as moving through a supply pipeline, passing from one component part of the pipeline to another before finally reaching its destination point - the customer. Rushton (1984) believes that a 'flow society' had been

[8] See Chapter 5 for more detailed analysis of questionnaires and Chapters 7 and 8 for discussion regarding the case studies

created. The management of the components requires an overview as to how each interacts with the others to ensure there is an integrated approach. The best combination of components has to be found in order to ensure the core objective of satisfying customer requirements at the lowest possible cost is achieved.

No one component can be seen in isolation or treated separately from one another, but has to be viewed in respect of its effect both on the total system and the ultimate outcome.

Slater (1994 : 159) describes the supply chain as being,

> "essentially a number of independent activities connected together to transfer goods from their origin to the end user. The key being to integrate all the elements of the supply chain to the single overall objective of minimum cost for a pre-defined service level."

Figure 2.1 shows the supply pipeline with the main component parts identified. Figure 2.2 further develops this picture framework showing what could be entitled as "enablers", both within and outwith an organisation, that surround the supply chain and impact upon its ability to deliver the required level of customer service at the minimum possible total cost.

Figure 2.1

The Supply Pipeline

The Main Component Parts

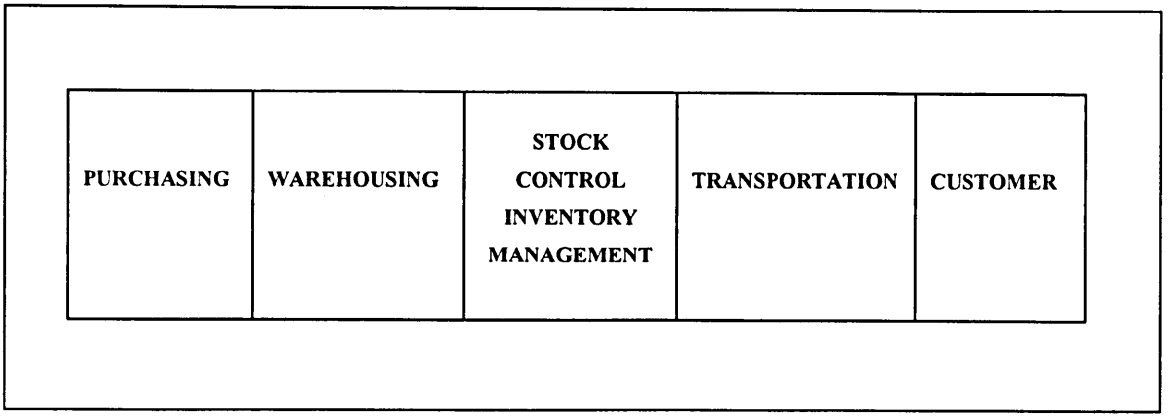
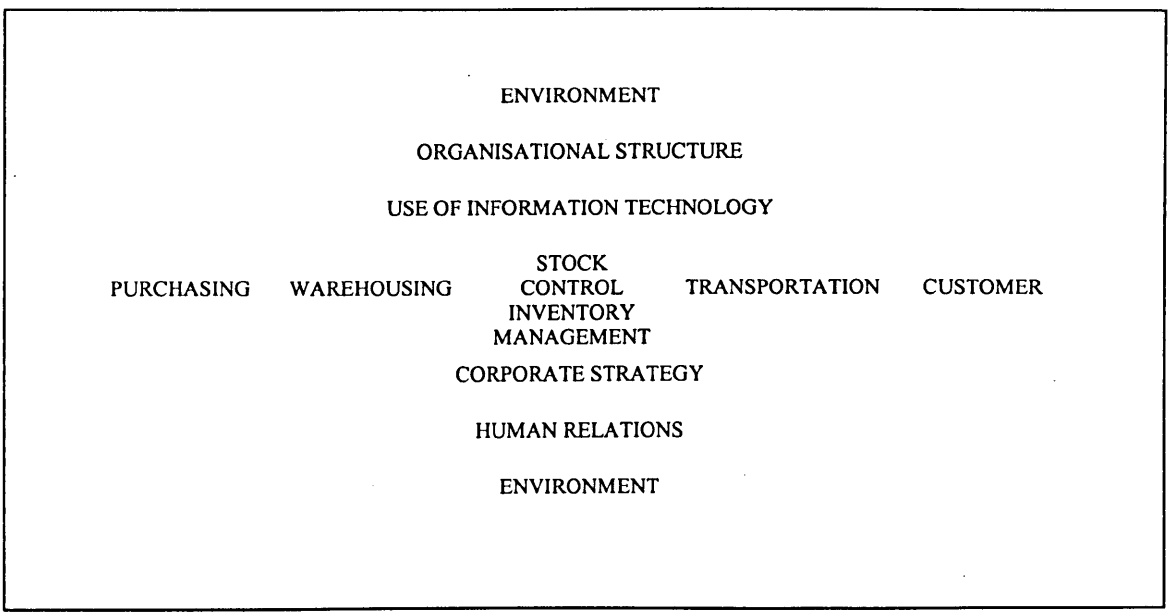


Figure 2.2

The Supply Pipeline

The Main Component Parts and the 'Enablers'

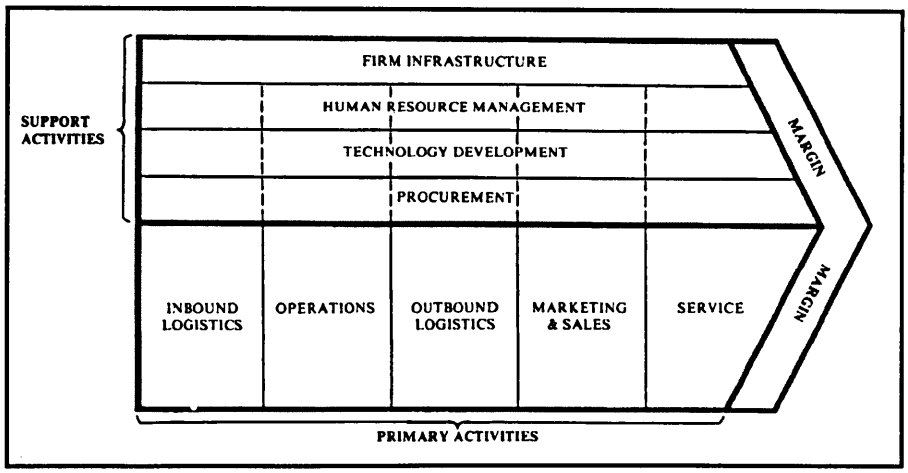


The supply pipeline illustrated in figure 2.2 is derived from previous literature, particularly the work of Porter (1985) and Bowersox et al (1986). The management of the supply chain is, in itself, of little value unless it ultimately creates competitive advantage. Porter (1985) introduced the term 'value chain' where the collection of

activities are performed to design, produce, market, deliver and support its product. Porter's value chain is shown below in figure 2.3.

Figure 2.3

Generic Value Chain



Source: Porter (1985:37)

Porter differentiated between activities of a support and a primary nature, both of which employ purchased inputs, human resources and technology. The value activities create information which should be used to ensure the chain ultimately produces a margin, a profit. Obviously the company with the largest margin has the greatest competitive advantage. Porter (1985 : 38) explains:

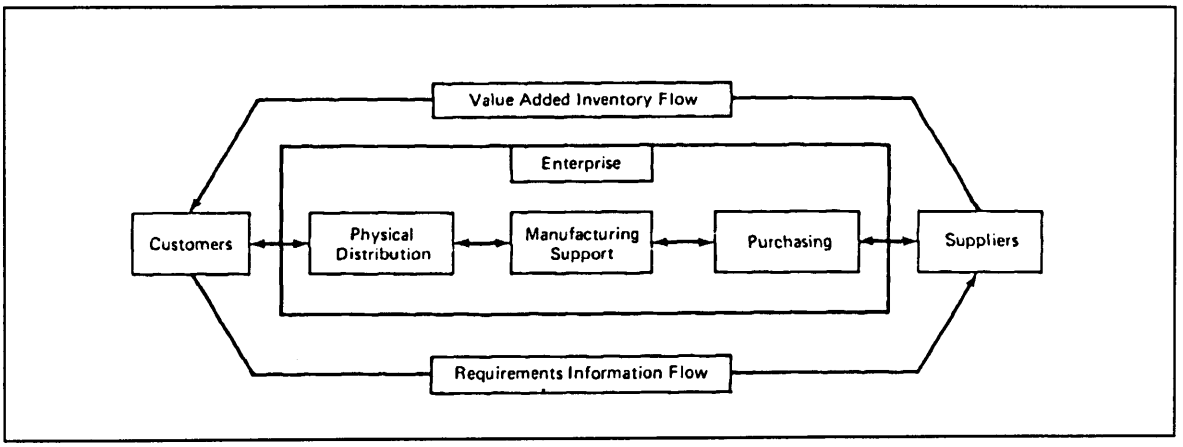
> "The value chain displays total value, and consists of value *activities* and *margins*. Value activities are the physically and technologically distinct activities a firm performs. These are the building blocks by which a firm creates a product valuable to its buyers. Margin is the difference between total value and the collective cost of performing the value activities." (Porter emphasis).

The flow of information as alluded to by Porter is crucial. Information and communication are the life blood of a successful supply chain which, if not available or employed well, will ultimately cause a blockage in the flow. "It is only when the supply of goods is interrupted by, for example, bad weather or industrial disputes, does distribution attract much attention ...." (McKinnon 1989:1). Bowersox et al (1986:18) further emphasised how critical the flow of information is both between customers and suppliers and within the 'enterprise'.

The 'logistics system' proposed by Bowersox is illustrated in figure 2.4, showing the flow of 'requirements information which facilitates inventory flow.

Figure 2.4

Logistics System



Source: Bowersox et al (1986:16)

Bowersox et al (1986:16) state that:

> "Information flows from and about customers in the form of forecasts and orders and is refined through planning into specific manufacturing and purchasing objectives. As materials and products are purchased, a value-added inventory flow is initiated which ultimately results in ownership transfer of finished products to customers".

The definitions and illustrations given of the supply chain are generic in nature and can, at this level of examination, apply to all industries, including the NHS.

The acceptance of the supply chain management concept within the NHS has been, and continues to be a slow process. Although changes in the wider NHS environment post the 1990 reforms have resulted in a greater acceptance of the concept, the full potential benefits of ensuring that supply chain management is afforded strategic management status are still to be realised. NHS Supplies Services have only recently acknowledged the existence of customers and even more recently begun to realise there are now competitors in the marketplace. Rees (1992:18) commented that:

> " Supply chain management in the NHS has traditionally been regarded as the Cinderella service, but now there is widespread realisation that the function can add overall financial and service value. Supply management in the NHS does though require that a professional approach is adopted to the co-ordination of procurement and the management of logistics. There is also a subtle balance to strike between controlling financial expenditure and producing an acceptable service to customers".

2.1.3 Strategic and Integrated Management Approach

Senior management has to recognise that the component parts of the supply chain cannot be managed separately as there is an inter-dependence of the functional areas. Christopher (1993:13) believes that these fundamentals cannot be adopted without strategic senior management direction, stating that:

> ".. the move towards supply chain management points in one direction: the top. Only top management can ensure that conflicting functional objectives along the supply chain are reconciled and balanced; that inventories assume their proper role as a mechanism for dealing with inevitable residual imbalances and finally, that an integrated systems strategy that reduces the vulnerability is developed and implemented .... only top management can be expected to have the perspective to recognise the significance of supply chain management, and only top management can provide the impetus for adopting this new approach".

The results of the author's questionnaires suggest that the lack of supply chain management status within the NHS is attributable to two main factors - the environment and senior management. The changes to the wider environment of the NHS which will be explored in Chapter 3, have, in summary, increased the focus on costs and customers 'per se' which has indirectly helped the profile of the supply chain. Senior management have subsequently responded, motivated predominantly by the possibility of cost reduction, and secondly by the desire to achieve customer service levels.

An integrated management of the supply chain is largely based upon a total systems approach (Johnson & Wood 1990). This approach is concerned with determining the best mix of components to produce the right balance so that costs are minimised whilst the desired service level is achieved. It may be that all component parts are functioning at maximum efficiency but the end result may not be ideal. In fact, it may be that one component is only required to work at 80% efficiency in order to product the desired overall outcome.

Traditionally, there has not been such an overview of all the functions, indeed fierce resistance and functional barriers have been erected within organisations. (Oliver & Weber 1994:61). Departments have considered themselves independent of the workings of other departments, not realising the need to find the "best mix" from each in order that the organisation can satisfy the customer.

Johnson and Wood (1990:10) outline the broad principles of a total systems approach as being:

> "The systems approach to a problem involves not only a reconciliation of the individual importance of the various elements of which it is composed, but an acknowledgement of their interrelationship. Whereas the field specialist concentrates restrictively on his own particular bailiwick, the more versatile systems manager, in his capacity as a generalist, seeks the optimum blend of many of these individual operations in order to fulfil a broader objective".

A holistic and integrated approach to managing the supply chain necessarily cuts across the functions within it. Systems and information flows require horizontal integration in the following ways (Houlihan 1987):

- the management of data capture and flow across the functional boundaries without delay or distortion;
- linking systems in the manufacturing setting for purchasing, production, inventory control, distribution, customer order entry and service;

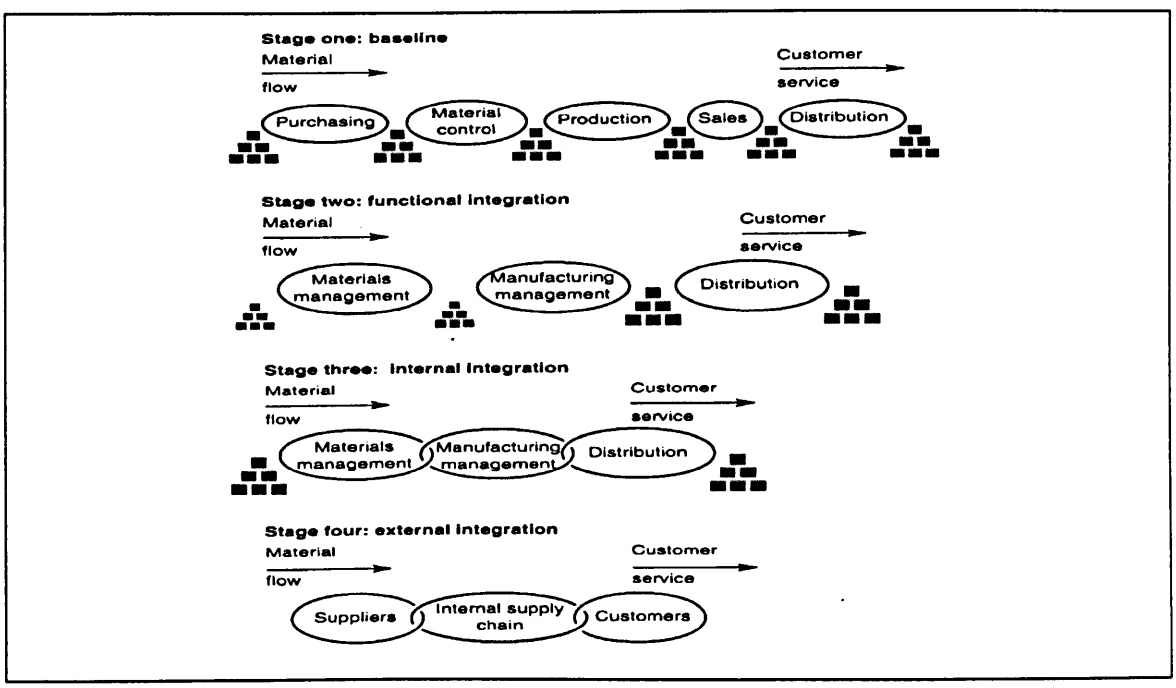
- the shared ownership of information and a high degree of visibility across all functions' plans, allocations and inventories.

Balance is a key word to refer back to when examining supply chain management. In this instance, it is balancing functional objectives and the need to control systems that are required to satisfy the customer.

There is a need for integration not only within the organisation but also with other organisations, especially suppliers. Figure 2.5 suggests that there is an evolution of integration from stage one where all departments are functionally independent through to stage four where there is integration externally in order to add value for the customers and optimise profit and competitive position.

Figure 2.5

Stages in achieving an integrated supply chain



Source: Stevens (1989) in Christopher (1993:15)

2.1.4 Clarification of Customer Requirements

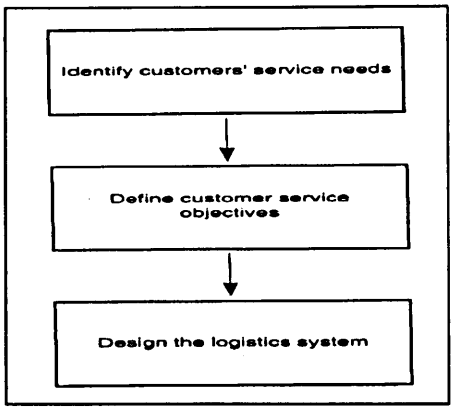
The raison d'être of any business organisation is to satisfy the requirements and expectations of its customer base.[9] A business organisation has firstly to win and subsequently retain customers, both to generate profit and ensure continued survival in a competitive marketplace. A considerable number of organisations assume that they are able to predict their customers' requirements. This is a misplaced assumption as:

- customer service is perceptual;
- no two customers' needs are the same;
- customers need to be continually asked what their changing requirements are rather than the service provider making assumptions.

The identification of customer requirements should dictate the type of supply chain established. Figure 2.6 suggests a simple and logical three stage process.

Figure 2.6

Customer Driven Supply Chains



Source: Christopher (1993:34)

[9] See Section 2.3 Customer Care on Page 81 for a more detailed discussion of the literature

A refinement of this process is to establish the relative importance of those service components to customers and then identify 'clusters' of customers in similar service types. (Christopher 1993:35).

Companies with existing customers do not start with a blank sheet of paper, so the first stage is to audit the requirements of the existing customer base (Bowersox et al 1986; Weeks 1990) before deciding how to re-engineer their service provision to fit. There is a need to accept that when planning service, the process "starts at the end" and customers should be allowed to drive and determine service provision.

There are three main tenets to customer care (Weeks 1990):

- availability;
- service frequency;
- cost.

It is the balance of these three that facilitates effective customer care packages. (Weeks 1990:117) discusses the relationship between inventory management and availability in respect of satisfying the customer, stating that:

> ".. the biggest determinant of inventory is the company availability objective.... once you have worked out what you want to achieve, not only will it drive inventory, it will drive a number of other costs".

Weeks (1990:119) further states: "the second most sensitive determinant of inventory size is probably service frequency".

Supply chain management and marketing are interwoven by the fact that customers are at the end of the marketing channel as well as at the end of the supply pipeline. (Bowersox et al 1986; Christopher 1993; McKinnon 1989). "Customer service is the thread that links the logistics and marketing processes, because in the end, the output of the logistics system is customer service". (Cooper 1988:22).

It is clear that there is a strong overlap between marketing and supply chain management with the common goal of satisfying customer requirements. The NHS, both in terms of supply chain management and marketing was virgin territory up until the introduction of the 1990 reforms as customers and competition were not previously to be found in this environment. NHS Supplies Services did not need to satisfy customers of their worth in obtaining repeat business as there were no real competitive alternatives. The NHS departments simply received, and largely accepted, the standard package available for supplies services. Marginal improvements could be negotiated by departments following a great deal of time and effort, but without the existence of a marketplace, the Supplies Services did not feel the need to be truly customer focused.

There is also a misconception, still widely held, that all customers require the same level and frequency of service. McKinnon (1989:260) highlighted this by pointing out that,

> "..an increasing number of firms are also abandoning the long-accepted principle that all customers should receive a uniform standard of service. Efforts are now being made to tailor the quality of service to the particular wishes of individual customers, in recognition of the fact that some will be prepared to accept a lower quality service in return for larger discounts,

whilst others will pay more for a superior service. In developing a variable service policy, firms must explore individual customer preferences ..."

The notion of recognising individual customer preferences is important to offer a flexible service. It may be that separate supply channels may need to be established for regular customer orders (Ballou 1992:39). Customer preferences can all be accommodated as long as it is profitable to do so. Once more, the questions of balancing components and trade-offs between them are applicable. Any level of service is possible - it all depends upon the cost of providing that level of service and what amount the customer is prepared to pay. The organisation must also determine at what point a particular customer service level becomes unprofitable.

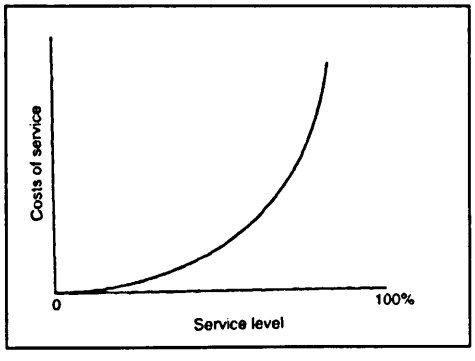
"The challenge to customer service management therefore is firstly to identify the real profitability of customers and secondly to develop strategies for service that will improve the profitability of all customers". (Christopher 1993:39).

The difference between the cost of providing a level of service against the revenue derived from that service will determine profitability.

Figure 2.7 shows a typical curve for the costs of service where the cost rises as service levels increase.

Figure 2.7

The Costs of Service

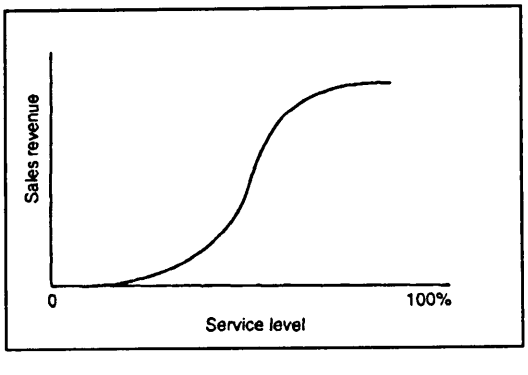


Source: Christopher (1993:40)

Figure 2.8 shows the returns to service in a S-shaped curve which assumes that there is a minimum level of service deemed acceptable and once this level is achieved, increasing returns to service improvements should be achieved.

Figure 2.8

The Returns to Service



Source: Christopher (1993:41)

There will obviously reach a point where diminishing returns set in when "additional expenditure on service does not pay back" (Christopher 1993:41).

A study in 1956 by the Harvard University Graduate School of Business Administration to look at the possible use of air freight as a means of distribution concluded that

decisions as to the mode of transport should be on the basis of total cost. The total cost concept which has become an accepted means of evaluating supply chain management, "takes account of conflicting costs, for example the direct cost of transport and indirect cost of inventory with the best choice occurring where the sum of both direct and indirect costs is at its lowest". (Ballou 1992:41). Total cost analysis is based on a synergistic approach whereby the cost associated with one element of improving customer service may rise but the overall cost decreases (Gattorna 1983:8). This is obviously limited to the holistic and total systems approach previously discussed so that it is not only the best mix of components that has been arrived at, but also the best mix at the lowest total cost, which will satisfy the customer. Lalonde and Zinser (1976:204) state that;

> "Integrated logistics management is based on total cost analysis ..... that is, at a given customer service level, management should minimise the cost...."

The problem for the NHS has largely stemmed from their difficulty in identifying all the true costs involved in the process and consequently informed decision making is difficult. Any changes to the components within the supply chain that have been made to try and produce a better overall outcome have been taking within a "costing darkness" and are practically meaningless as resultant success or failure is hard to measure. A simple summary guide to total cost analysis is suggested in Figure 2.9 which shows three key stages.

Figure 2.9

Key stages in a total cost analysis approach to reviewing the management of the supply chain

Stage 1 -	Identify all true costs - both for individual components and the overall effect.
	⇓
Stage 2 -	Identify the cost of different combinations of components necessary to achieve the required level of customer service.
	⇓
Stage 3 -	Choose the combination with the lowest cost which achieves the required service level.

2.1.5 Performance Measurement

Measurement of the performance of service providers against agreed targets is an essential part of successful supply chain management (Bowersox et al 1986:328). The measurement tools employed need to be agreed between service providers and customers rather than imposed by the service provider.

> "The first key point to make is that the ultimate measuring rod is the customer, hence it is the customer's perceptions of performance that must be paramount". (Christopher 1993:80).

Controlling the supply chain is, though, a complex task with a plethora of information available to the manager. The manager must decide:

- what is to be measured and how?
- when and how often is it to be measured?
- at what stage is corrective action initiated to ensure that actual performance will reflect targeted performance?

The vast majority of what has traditionally been measured by service providers is based on cost. This is useful in itself, but does not "reflect cost-service trade-offs that are so important to include in revenue potential". (Bowersox et al 1986:330). Customer service measures such as inventory availability, speed of delivery, consistency of delivery, order-fill speed and accuracy (Ballou 1992:650) are also relevant but cannot be viewed without reference to associated cost and revenue data.

A large number of reports are generated in the normal course of business operations and the manager must decide which are the relevant ones to be used to track performance. Reports are available at whatever frequency level is required since the advent of information technology. Daily reports, weekly reports, or monthly reports can be used to both monitor actual performance and flag up trends that need to be corrected. Measurements are best undertaken on an exception reporting basis to limit the problems of interpretation and ensure the data is of a manageable size.

Ballou (1992:652) suggests that three key measurement reports are necessary to control the supply chain; - the cost-service statement, the productivity report and the performance chart.

Response time is an area that has increasingly become important to customers during the late 1980s and 1990s. Quick response to customers (Fernie 1990:18) is becoming the accepted norm rather than the exception. Service providers need to be able to offer this as a standard rather than a special.

Bower and Hout (1992) refer to "fast cycle companies" and cite Toyota as an example of these companies who know where in the system compressing time will add the most value to customers. Fast cycle companies are able to distinguish between the main operating sequence, the organisation's central value adding activities from the time consuming support and preparatory steps. This concept which is concerned with a process of continuous review and rapid decisions to respond to changing customer requirements is based upon a United States Air Force method which is known by the acronym OODA (Observation, Orientation, Decision and Action).

In November 1993[10] the author undertook a postal questionnaire survey of Trust Hospital Chief Executives, primarily to determine the criteria applied to assess the performance of Supplies Services in general and specifically to elicit perceptions of the current 'in-house' service (Rees 1994). The Chief Executives were given 11 criteria to rank in terms of importance for assessing the supplies service performance using a Likert scale where 1 is equal to very important and 5 is not very important at all. The

[10] See Chapter 5 for more details

highest ranked criterion was the overall reduction in the cost of service, with the second most important being the reliability of delivery schedules. Criteria relating to response times, although still considered important, were ranked in joint third (immediate response in emergency situations) and eighth (short lead times). As customer expectations increase, it may be that if a similar survey were repeated, response time criteria would be ranked higher.

The growth in competition within markets had made companies realise that simply monitoring their own performance is of little value and what is required is a comparative evaluation against the best in the industry. Christopher (1993:80) describes this process as "competitive benchmarking" and defines this as "the continuous measurement of the company's products, services, processes and practices against the standards of best competitors and other companies who are recognised as leaders".

The aim of benchmarking is to act as a stimulus to the organisation to identify areas within their operation that need improved so that they themselves can become the best. Camp (1989) identified a number of benefits a company derives from benchmarking which include:

- enabled the best practice from any industry incorporated into the processes of the benchmarked function;
- can provide stimulation and motivation to the professionals where creativity is required to perform and implement benchmark findings;

- breaks down ingrained reluctance of operations to change. It has been found that people are more receptive to new ideas and their creative adoption when these ideas did not necessarily originate in their own industry;
- may also identify technological breakthrough that would not have been recognised and thus not applied in one's own organisation or industry.

Benchmarking should incorporate not only those functions internal to the organisation but also the performance of external suppliers, in respect of key areas such as on time delivery and quality conformance. The emphasis should be on assessing their contribution to reducing the total delivered cost and increasing end user customer service.

2.1.6 Supporting Organisational Structure

Organisational structure is a supporting mechanism, an enabler, to effective management.

> "Management is the process of getting things done through others employed by the enterprise. An integral part of management is personnel motivation. The fundamental responsibility of top management is to create an environment within which each operating executive has maximum opportunity to achieve corporate objectives. To this end, organisation structure is a vital part of management." (Bowersox et al 1986:303).

The organisational structure of the management of the supply chain has to facilitate the achievement of customer requirements. The management of the functional components within the supply chain need to be integrated, as has been discussed, therefore an appropriate structure to support this needs to be designed (Coyle & Bardi 1992).

A key question is whether or not functional components are allowed to integrate through a loose matrix team working structure. In this instance, cross functional co-operation and working together to satisfy customer requirements ultimately depends upon the willingness and attitude of all staff. This cross functional team working approach can be augmented by the appointment of a manager with ultimate responsibility for the supply chain, either with line management of all those involved or without direct line management. In the case of the manager with direct management control, the functional barriers are formally removed, so that a of specialists is created under the management of a supply chain "generalist". Where no direct line management authority is given to the manager, the process of control is necessarily through personal influence and persuasion.

Successful companies appreciate that the purpose of business is to create "profitable outputs" and it is outputs rather than inputs that dictate how organisations should be structured. Christopher (1993:189) argued that functional boundaries impede process management;

> "the process of satisfying customer demand begins with inbound supply and continues through manufacturing or assembly operations and onwards by way of distribution to the customer. Logically the ideal way to manage this process is as an entity, not by fragmenting it into watertight sections."

In large organisations where separate business units exist, such as the NHS, the questions of control and organisational structure extends to the debate as to whether a centralised or decentralised structure is more effective (Johnson & Wood 1990). Both forms of structure offer some advantages and have some disadvantages. A centralised structure more easily permits control by the issue of directives in terms of action and the type of monitoring mechanisms to be used. Decentralised structures should, in theory, set frameworks within which the autonomous business units function and report.

The NHS Supplies Service in England is a centralist structure with the NHS Supplies Authority[11] being corporately responsible for delivering a service to all customers who buy their services. There is a direct line management responsibility from the national headquarters to the six divisions from where policy and strategy emanate and to whom divisional monitoring data is submitted. Van der Hoops (1992:262) supports this centralist structure of supply chain management stating that:

> "... to achieve an effective logistics system, both from a cost and service perspective, centralised control is necessary to manage and mesh the converging and diverging material flows".

In contrast to England, the NHS Supplies Service in Scotland is based on a decentralised model with autonomous supplies organisations delivering a service on a geographic basis. These local organisations predominantly offer only warehousing and distribution services. There is also a centralised contracting function that negotiates

[11] Refer to Chapters 3 and 4 for more detailed discussion on the NHS Supplies Authorities in England and Scotland

Scottish[12] wide contracts which, under Scottish Office edict, the units around the country are instructed to buy from. This is arguably as strong a form of central control as exists in England in respect of purchasing, although it is plainly different from an organisational structure perspective.

2.1.7 Impact of the Wider Environment

Figure 2.2 suggests that the environment can act as an enabler in facilitating the flow of goods through the supply chain. Equally the impact of the wider environment can be an inhibitor to this objective. Socio, political and economic factors can all affect the supply chain and will combine in different mixes, depending upon the organisation and its wider operating environment. Organisations cannot always control such factors but need to be aware of these in order to try to minimise their potential impact. Reforms to the NHS in 1990 were politically driven in the first instance, having been introduced by a Conservative government and designed to create a more free market style environment.

It could be argued that the NHS internal market is a managed market, controlled by the Department of Health and indeed there are various interpretations as to the status of the market. Duncan Nichol, the NHS Chief Executive 1988-1993 labelled the internal market as a 'social market', although definitions of social markets are many and varied. Robinson (1993) discussed the theme of 'contestability' which suggests incumbent firms in a market only need the threat of competition to increase their efficiency and reduce their costs. A real competitive situation is, therefore, not necessary to achieve

[12] Scottish Healthcare Supplies (Contracting Branch) is one of the chosen case studies and is reviewed as the major purchaser of goods in the Scottish NHS.

these objectives. The NHS market could arguably be said to exhibit traits of contestability.

The type of marketplace, the ability and number of meaningful competitors and barriers to entry are all important in shaping the environment. Basically, the competitiveness of the market will influence the urgency organisations attach to the need to satisfy and retain their customers. The management attention afforded to supply chain issues will be determined by the extent to which it is believed costs will be contained and customer satisfaction increased if such a focus is adopted.

The NHS has changed considerably since the impact of the reforms with significant effect on supply chain management. Rees (1994:249) thinks that the "creation of an internal market in the UK's National Health Service (NHS) produced an environment conducive to the acceptance and growth of supply chain management". Rees (1994:251) further comments that:

> "A new culture has emerged, which focuses more than ever before upon the costs of providing healthcare and the concept that those within and outwith the organisation are to be considered customers. The focus of the changes reflect the key aspects of supply chain management - costs and customers - and has provided a basis from which supply chain management is growing in stature".

2.1.8 Summary

This section has outlined the principles of supply chain management and identified five key aspects which are:

- the need to adopt a strategic and integrated management approach;
- the need to clarify what the customer's requirements are;
- the need to establish, in conjunction with customers, the performance measurement tools to be used;
- the need to create an organisational structure that supports the task of managing the supply chain;
- the need to be aware of the impact the wider environment can have upon the organisation and supply chain management.

Effective supply chain management is concerned with the application of the total cost concept combined with a systems approach which is illustrated as a simple five stage process in figure 2.10

Figure 2.10

Five Stages of Effective Supply Chain Management

Stage 1 -	Define customer service level required
	⇓
Stage 2 -	Establish a base level of components and monitor associated costs
	⇓
Stage 3 -	Trade off components and monitor costs
	⇓
Stage 4 -	Arrive at the optimum combination of components to meet the service required at the lowest possible cost
	⇓
Stage 5 -	Establish performance indicators, in conjunction with customer base, to constantly review service provision

Three critical tenets of supply chain management which run throughout both the five stages shown in Figure 2.10 and the five key aspects discussed in this section are:

- the speed of availability;
- the reliability of the product and its delivery schedule;
- the minimisation of total costs involved so as to maximise revenues.

This section has also contrasted the principles of supply chain management to the practices in the NHS Supplies Service, a theme which will be further developed and substantiated in subsequent chapters both by empirical evidence and case studies. It is suggested that the literature, whilst relevant to the NHS, is applicable only to a limited degree as the NHS presents such a unique set of circumstances, as summarised in Table 2.1.

Table 2.1

Unique Characteristics of SCM in the NHS

• acceptance of SCM as a concept in the NHS is a slow process as traditionally SCM has been seen as a "Cinderella" service;
• there continues to be problems identifying all of the true costs within NHS supply chains, although cost transparency appears to be improving;
• it is relatively recently that market forces have been introduced to the NHS environment and these have made a significant impact in heightening the awareness of both costs and customers.

An issue common to NHS Supplies Services and other organisations is that SCM is not yet given a strategic level status.

2.2 Principles of Buyer - Supplier Relationships

2.2.1 Introduction

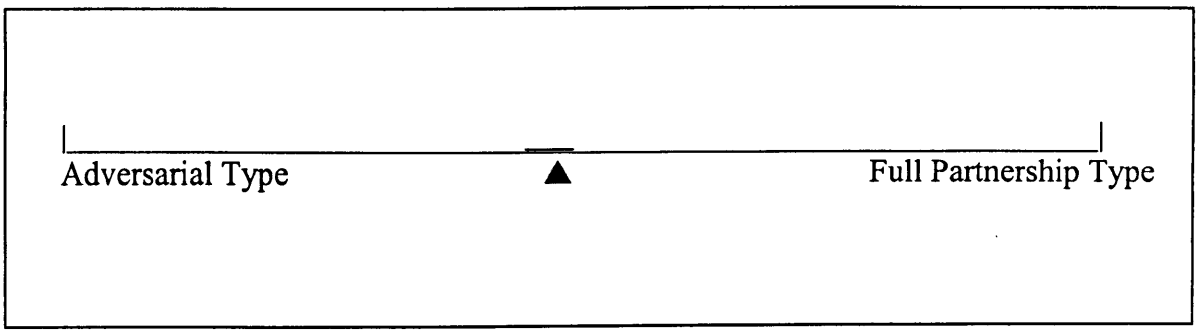
This section considers both extremes of the purchasing relationship spectrum which exists between buyers and suppliers and develops the central argument and contention of the thesis that the NHS presents a unique environment which is only partially explained by the current literature.

2.2.2 Adversarial Type Relationships

The extreme types of the purchasing relationship spectrum are adversarial and partnership, as shown in Figure 2.11.

Figure 2.11

Purchasing Relationship Spectrum



Adversarial type relationships are traditionally those that have existed between buyers and suppliers (Shapiro 1987) and exhibit characteristics such as confrontation, aggression and mistrust, as well as being short term in nature (Gaade & Hakansson 1993:3). This type of relationship results in business transactions being undertaken at 'arms length' (Sako 1992) with both parties being suspicious of the other's next move.

Inevitably this type of relationship is not sustainable in the long term and whilst one party may feel that it temporarily has the upper hand by becoming the 'senior partner', ultimately neither party will be able to derive as much competitive advantage as would

be possible if both were working to develop a mutually beneficial relationship. Adversarial relationships are, in many ways, the easy option, as they "make it easy for people to complain, to throw stones, to withdraw, without having to play any role in improving the situation" (Kanter 1989:145).

The buyer involved in adversarial type relationships will be constantly "fire fighting" and "looking over his shoulder" nervously, jumping from one supplier to the next to minimise the effects of the supplier who under performs. Sporadic multiple sourcing is as much a symptom of the buyer's fear of supplier failure as any planned move to improve the sources of supply, by managing the competition. A seemingly non-stop series of competitive bids will be used by the buyer to constantly test the market and drive prices down. Kanter (1989:118) argued that the "adversarial model had long dominated purchasing ... the goal was to minimise price by maintaining a large vendor base, frequently shifting the mix of purchases from each vendor[13] and operating through short term formal contracts with frequent rebidding". Competitive bids which are an acceptable and valuable form of comparing proposals from different suppliers should be used by a buyer in the context of a balanced purchasing strategy, rather than as a strategy in itself.

The supplier in this type of relationship is likely to feel constantly tense and insecure. It is not surprising that the predominant feeling of both parties is to protect their self interest "it is particularly clear in business dealings between firms that self-interest ... is a prime motive for doing most things ... everyone tries to satisfy the particular need which is most pressing at the time ... that is in their self-interest" (Carlisle and Parker 1989:17). Suppliers may also feel that their self worth is being attacked by buyers who

repeatedly attempt to drive prices down to a level where the suppliers make very little, if any, profit. As Carlisle and Parker (1989:19) point out:

> "It is this challenge to individual or corporate self-worth which tends to inject adversarial conditions into so much of the negotiation done ..."

Selective communication is another significant and common characteristic of an ineffective buyer-supplier relationship (Southey 1993). Buyers who are unsure of their partner will be hesitant to offer information to the supplier that is not directly related to the specific individual business transaction in hand. Information regarding long term plans is unlikely to be shared, equally the supplier will be reluctant to offer the buyer detail showing the breakdown of costs if there is a concern that this will simply be used to drive down the price further. The supplier will be unsure whether to share product prototypes or other innovative developments with a buyer who is constantly changing suppliers. The lack of commitment between the buyer and supplier will result in selective communication, perpetuating misunderstandings and building up assumptions that may mean the adversarial relationship at best continues or, at worst, the whole relationship ends completely.

Buyers in an adversarial relationship tend to focus upon price as the major determinant in supplier choice. Deming (1988) who developed fourteen managerial points on quality, believed that price, and price along was not a solid basis upon which to make purchasing decisions. Deming's fourth point recommended that organisations;

[13] Vendor is a US term synonymous with supplier

> "End the practice of awarding business on the basis of price tag alone. Purchasing must be combined with design of product, manufacturing and sales to work with the chosen suppliers" (Carlisle and Parker 1989:7).

It is, however, not surprising that buyers have focused their efforts on price reduction as this has traditionally been the means by which their own performance, and consequently salary levels, have been determined. It is nevertheless true that one of the buyer's prime tasks is to 'reduce input costs' (Quayle 1992:28) but this cannot be an isolated objective and necessarily needs to be contained within the boundaries of a wider purchasing strategy.

NHS buyers have traditionally been price driven which has dictated their whole purchasing strategy. (Court 1993:16). The findings of the author's survey [14] of NHS Supplies Managers undertaken in 1993 by the author suggests that price reductions are still an important part of NHS purchasing strategy.

Price reductions can only result in short term gains as eventually the supplier will be unable to reduce these any further. A level will be reached at which it is not viable for the supplier to sell to the buyer. Quayle (1992:28) states that;

> "Suppliers will 'learn' from the behaviour of an aggressive price-optimising buyer. In the short term they may compete in the classical sense, but over time will likely withdraw from price competition".

[14] For further details, see Chapter 5

The buyer will then be left in a position of having to source an alternative supplier with the associated costs and possible diminution of quality. The buyer and supplier need to change their approach, adopting a new culture to relationships. Any cultural change is difficult, especially when both parties "expect an arm's length, if not adversarial relationship"(Hines 1991:112).

A fundamental change in culture and approach involves risk for both parties as, voluntarily, each is making themselves vulnerable to the other. One party could decide to exploit the opportunity and violate the other party's trust. Kanter (1989:118) states that "the adversarial mode with its paranoid view of the world centres on images of domination and fear of being dominated".

Sako (1992) outlined three levels of trust; contractual trust, goodwill trust and competence trust. The first type of trust relates to the aspects agreed between the parties as part of a contractual agreement, both explicit and implicit. Goodwill trust develops the notion that relationships between the parties have matured to a level where one party will want to perform over and above what is required in the contract. This creates a type of reciprocal indebtedness in so much as the party feels obliged to "return the favour" so that "mutual indebtedness or obligatedness at any time is a normal state of affairs which sustains a relationship" (Sako 1992:10). Competence trust is based upon the parties' belief that the other has the technical and managerial ability to perform the tasks required. Trust, whilst being a fairly nebulous concept and difficult to define, is nevertheless an important part of relationship building as will be discussed again in respect of partnerships. It is clear that trust is not dominant in adversarial type

relationships where one-off, short term business transactions of an opportunistic nature are the norm.

Adversarial relationships do encourage unplanned and haphazard purchasing from suppliers. Buyers' attitudes are influenced by their position and standing with their own organisation. Barry (1992:25) points out that it is "crucial to get your internal relationships operating before you can achieve the most from external ones". Buyers have traditionally been perceived to be order clerks who simply transpose information from requisitions onto order forms, the actual negotiation with suppliers being undertaken by the end user of the goods. Indeed, NHS buyers have traditionally been seen as little more than administrative assistants.

The role and status of purchasing is, though, moving to becoming a more strategic level function. Cousins (1992:33) argues that ".. the role of procurement is moving from a clerical to a much more strategic business function in its own right". Cousins' research suggests that the educational standards of buyers is increasing with a growing proportion of buyers now holding at least first degree qualifications.

The acknowledged purchasing texts of the 1980s in both the United States (Dobler et al 1984) and the United Kingdom (Baily and Farmer 1981) paid scant attention to relationship strategies. The texts were largely concerned with the technical detail and process of purchasing. Whilst useful, they did not explore that relevance of relationships, and this was only referred to in a chapter discussing sourcing, Baily and Farmer (1981:107). This chapter captures both academic thinking and practice at the time in which buyers were encouraged to focus upon the task of constantly squeezing

suppliers for more price discount. Baily and Farmer also refer to the dangers of buyers being forced, by internal pressure, into practices that perpetuate adversarial type relationships with suppliers, such as reciprocal trading. In the case of reciprocal trading the organisation will ask "which are the companies from which we make substantial purchases who could utilise some of our products, but are currently buying elsewhere? This is then followed by 'Can we bring pressure to bear on these organisations to buy from us on the basis that we are good customers of theirs? Or the sales department may simply ask for the help of the purchase department in applying pressure to a possible customer who is a supplier". (Baily and Farmer 1981:121).

The discussion so far has presented the negative aspects of adversarial relationships and has inferred that these types of relationships are not to be pursued by the buyer at any cost. However, an adversarial approach may be the most appropriate strategy on certain occasions, such as a one-off spot purchase where an opportunist approach may produce maximum benefit for the buyer. The qualification to this is that increasingly organisations tend to use a smaller supplier base with which a longer term approach is the most sensible to adopt. The management challenge is to determine when it is appropriate to create partners and recognise that some relationships will be a mixture of the two.

2.2.3 Partnerships

Definition and Characteristics

Partnerships can be defined as ".. a commitment by both customers and suppliers, regardless of size to a long term relationship based on clear, mutually-agreed objectives

to strive for world class capability and competitiveness" (Hornby 1991:2). The key objectives of partnership are as follows:

- to minimise total costs;
- to maximise product and service development;
- to obtain competitive advantage.

Interpretation and definitions of partnerships are many and varied but the Hornby definition, proposed under the banner of the Partnership Sourcing initiative sponsored by the Confederation of British Industry, captures the essence of the partnership philosophy. The main characteristics of partnerships are directly opposite to those of an adversarial type relationship. Partnership-type relationships exhibit co-operation between the parties and a desire to develop trusting, long-term strategic alliances. Open and honest communication exists as each party willingly builds up an inter-dependence upon the other. Supplier relationships can be viewed as "the most susceptible link ... (as) the dependency of a firm on outside sources for materials often leaves it at the mercy of the supplier's performance" (Handfield 1992:2). Handfield suggests that buyers should introduce supplier certification programmes so that there is a 'co-destiny' agreement between the two organisations.

NHS buyers and their suppliers have not traditionally adopted such a co-destiny type approach, but rather have been more adversarial in style. NHS Supplies Services have mainly been motivated by price and adopted opportunistic short term supplier relationships. The changes to the wider NHS environment and the creation of the internal market has been the catalyst for the change in relationships with external suppliers. The internal market where Health Boards/Authorities buy healthcare from

NHS Trust Hospitals[15] under contractual arrangements has produced a new environment and culture. This new environment has indirectly helped NHS Supplies Services to become recognised. NHS Supplies Services have been able to capitalise on the new market place by trying, in some cases, to adopt a new ethos and approach. However, the results of the author's initial survey in 1994[16] suggests that suppliers remain unconvinced that the NHS Supplies Services are any more partnership orientated in their approach to relationships than before the NHS reforms.

Nevertheless, the White Paper "Setting the Standards : A Strategy for Government Procurement" (1995) sets out the Government's stance on public procurement. There is, for the first time in such a government publication, discussion of concepts such as re-engineering, benchmarking and supplier partnerships. This indicates an acceptance at the centre of these concepts and is likely to influence all public bodies such as the NHS. However, the application of this philosophy in the NHS may prove to be problematic. The NHS Supplies Services have a large and diverse supplier base with whom a whole range of relationships necessarily exist along the purchasing relationship spectrum.

The management of the NHS Supplies Service need to grasp the concept of partnership, understand the factors that influence its effective application and decide when to use this strategy.

[15] NHS Trust is a term to describe a hospital or group of hospitals who supply healthcare under contractual agreements to Health Boards/Authorities in their geographic vicinity. The 1990 NHS Community Care Act has enabled Trusts to become legal persona in their own right. Trust Hospitals accept GP patient referrals which mainly come from within their locality and the costs of these services to treat these patients are recovered via the Health Board/Authority contracts.

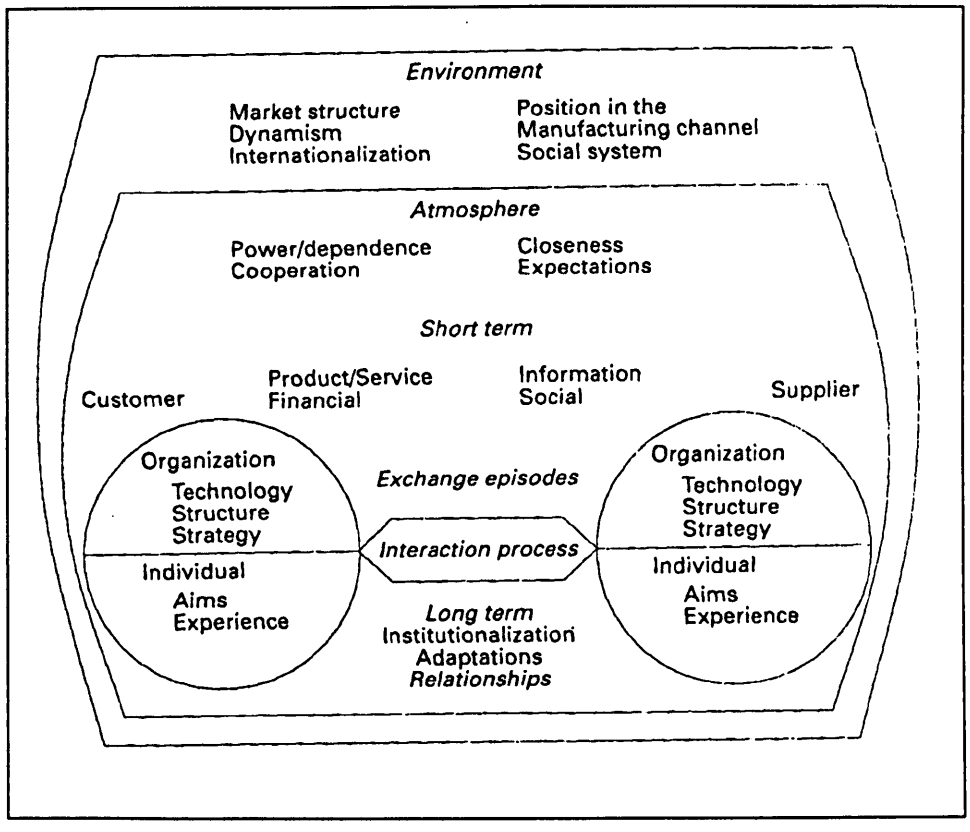
[16] See Chapter 5 for a more detailed description of the results regarding the survey of NHS Supplies Managers and company Chief Executives regarding buyer-supplier relationships.

Emergence of Partnership Models

The evolution of the partnership philosophy can arguably be traced back to Deming's (1988) fourteen points on quality. Deming's thrust in respect of buyer-supplier relationships was that organisations should work more closely with fewer suppliers.

In the late 1970s and early 1980s, an international group of university researchers known as the Industrial Marketing and Purchasing (IMP) Group developed an interaction model (Hakansson 1982), which shows the connections between buyers and suppliers. The IMP research is derived from inter-organisational theory (Van de Ven et al 1975) and new institutional economic theory (Williamson 1975). The interaction model is shown in figure 2.12

Figure 2.12



Source: Hakansson (1982: in Lamming 1993:141)

The model identifies four types of variable which are influential on the behaviour of both buyer and supplier which are;

- the elements of and process of the interaction;
- the participants involved in the interaction;
- the environment in which the interaction takes place;
- the atmosphere affecting and affected by the interaction.

Ford (1978), writing under the auspices of the group, points out that the model recognises both short term interactions, which are labelled "exchange episodes" and long term interactions, labelled as "relationships". Ford suggests that the short term interactions, if repeated, become an accepted part of the relationship and so move, over time, to be the norm.

The IMP model and the four variables is a seminal piece of research on relationships and is helpful when considering the relationships that exist between NHS buyers and their suppliers, particularly the importance placed upon the environment. However, the IMP model does not consider the practical issues of how to manage and measure the process. Research focusing upon NHS Supplies Services' relationships with suppliers needs to produce practical output in order to continue to enhance the credibility of the function both within the NHS and externally with suppliers.

The research based upon the Japanese automobile industry of Womack et al (1990) and Lamming (1987;1993) is derived from the findings of the IMP work. Womack et al, who identified some of the key traits of the Japanese automobile industry from a purchasing and supply perspective, introduced the term 'lean production' to describe how the Japanese automobile companies used value analysis to achieve cost reductions.

The major difference between the Japanese and Western systems is seen as being one of culture. The traditional Western approach to negotiations and decisions is to focus on price. Womack et al contend that this needs to be changed so that costs are analysed by both parties within the framework of a long term agreement. Womack et al conclude, however, that there is a changing culture emerging in the relationships in the West between car assemblers and suppliers which is promoting longer term contracts and lower costs.

Lamming (1987) proposes four models of buyer-supplier relationships which he originally saw as sequential in development. The models are as follows:

- Traditional;
- Stress;
- Resolved;
- Partnership.

Lamming's revised thinking can be summarised as firstly the development of another model, Lean Supply (Lamming 1993), secondly that the models did not necessarily need to evolve in a chronological stage by stage order, and finally that a Purchasing Relationship Portfolio (Lamming & Cousins 1994) will necessarily always exist for organisations. It is appropriate to discuss Lamming's work, considering its relevance to the NHS Supplies Service' buyer-supplier relationships.

Lamming's traditional model corresponds to the discussion regarding adversarial relationships. The model is characterised by the buyer constantly driving the price down and continually sourcing new suppliers from the marketplace. NHS buyers, pre

the 1990 reforms, also exhibited these traits and can be placed within this traditional model. The model is summarised by Lamming (1993:159) such that,

> ".. the traditional model provides a picture of haphazard purchasing, dealing in an inefficient manner with poor information, in a buoyant market, with little real competition requiring it to improve. The threat of re-sourcing was outweighed by the stability of the old boy network and lack of real alternatives for buyers".

Lamming argues that the traditional model is likely to have continued but for the economic pressures in the 1960s that affected the marketplace within which the buyer supplier relationship existed. The oil crises and labour problems in the 1970s produced stress[17] for both parties as companies fought to survive. This shock to the environment can be compared to that which the NHS experienced following the 1990 reforms. As costs were forced down within the NHS generally, the ramifications were felt all the way through the organisation and "out" to suppliers. The focus in the stress model is very much price, "the buyer had not only to win in price negotiations, but having won, to squeeze a little more out of the supplier to achieve a further saving" (Lamming 1993:160). Suppliers, in order to win business, are prepared to bid for contracts at levels which will barely cover their costs, let alone produce a profit. Eventually this will result in the less competitive suppliers being forced out of existence.

Buyers in the stress model are able to negotiate with increasingly vulnerable suppliers to demand that a breakdown of manufacturing costs is made available. This could be a positive development for both sides if the information is used in the context of a long term relationship, to review how costs can be contained and on the assurance that

[17] Stress was later substituted in Lamming's research by the word pressure (Lamming 1993:175).

subsequent increases in profit are shared. However, if the buyer decides to exploit the supplier and drive down prices to unrealistic levels with no guarantee of any share of resultant profit, then the opening of communication channels can only be regarded as a negative step.

Buyers and the suppliers that survived the stress period began to realise the "importance of relationships as opposed to individual deals" (Lamming 1993:163). This period of the early to mid-eighties in the automobile industry was described by Lamming as producing the resolved model. Resolution of the problems of the stress model is conveyed, however, as Lamming (1993:176) states;

> "The term resolved may be seen to suggest a removal of the problems caused by the stress model. This was, of course, not the case. The title is chosen, however, to reflect not simply the resolution of the stress, but also the apparent belief on the part of the assemblers (customers) at the line, that this was all that was necessary".

Nevertheless, the attention of both parties began to focus upon the length of agreements, the quality of products with the parallel emergence of TQM, jointly agreed cost reduction initiatives and the involvement of suppliers in the design stage.

There are suggestions that some of the NHS buyer and supplier relationships are in a resolved type model according to the author's 1993 survey of company executives.[18] An example is that suppliers are holding inventory and delivery to NHS warehouses and direct to hospital ward level in an apparent, rather than a real Just-in-Time

[18] See Chapter 5 for a more detailed discussion.

arrangement.[19] The result is that distributors hold stock specifically for particular NHS organisations so that whilst the NHS stock holding costs are reduced, the real cost of holding the stock remains in the supply chain, simply transferred one stage back.

The resolved model does at least introduce some concepts that are required to be in place for a partnership to develop. The resolved model introduces willingness, commitment and, in general terms, requires the adoption of a new cultural approach. Lamming (1993:170) points out that partnerships are demanding;

> ".. it is necessary for the supplier to use all available resources - including the abilities of other suppliers. Thus co-operation is essential for the partnership model supplier, both with other suppliers (including competitors) and with customers (buyers). This naturally poses challenges for customers : co-operating with suppliers is the reverse of many features of the traditional (adversarial) relationships".

Buyers in a partnership obviously still need to be assured that the price paid is competitive and the quality of goods supplied are to specification. Open channels of communication must exist but on much more of a reciprocal basis, "...efficient information exchange is of fundamental importance to the success of the partnership model" (Lamming 1993:170).

NHS buyers have traditionally been reluctant to share all of their information with suppliers as in the game of negotiation information is power. The ability to 'get one up' on the supplier has been the prevailing attitude. However, certain elements of the

[19] Apparent Just-in-Time" is defined as "the tactical transfer of the inventory from assembler to the supplier" Lamming (1993:164). Lamming saw three variations to Just-in-Time, which were: a) apparent just-in-time; b) in-line warehouses; c) the milkround or ex-works delivery system.

partnership philosophy do appear to exist within some of the NHS Supplies Service relationships with suppliers.

NHS Supplies Managers, like other practitioners and, indeed, academic researchers (New 1994) have questioned the practical application of the partnership model. The NHS has an enormous range of suppliers and it is not appropriate to foster partnership type relationships with all of these organisations. A sensible approach may be to prioritise the suppliers by criteria such as value and importance to key customers so that a manageable number are identified to receive partnership style development.[20]

Lamming's additional model, lean supply, is a theoretical extension of the partnership model. The buyer in the partnership relationship is still seen to be the owner of both the value and supply chains whilst the supplier is merely accommodated within them. The power involved in the relationship is an important concept[21] and if mis-managed, will destroy the partnership. Lamming (1993:239) states;

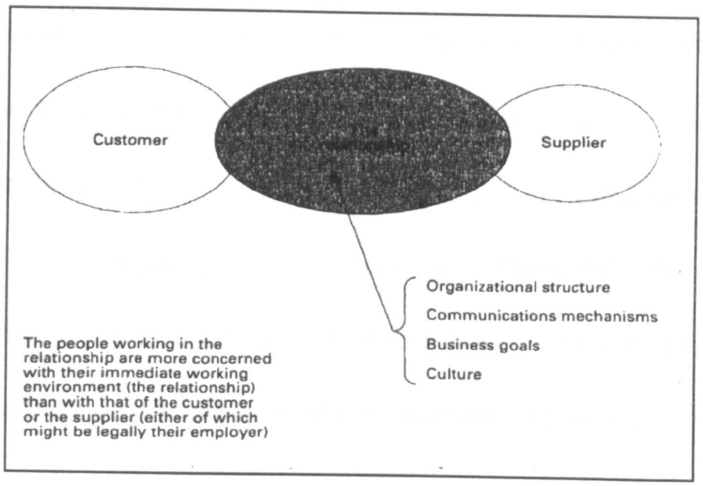
> "This is where lean supply goes beyond partnership ... lean supply, then, emerges as the state of business in which there is a dynamic competition and collaboration of **equals** in the supply chain, aimed at adding value at minimum total cost, whilst maximising end-customer service and product quality". (my emphasis).

Lean supply requires a quasi-firm to be established between the two partners, such is the strength of the collaborators. This quasi-firm becomes so accepted that it begins to be viewed as having its own resource base, image, equipment and premises. Figure 2.13 illustrates the creation of a quasi-firm between buyer and supplier.

[20] See Chapter 7 for further discussion of suggested practical measures for NHS buyer-supplier relationships.
[21] Power is discussed within this section, page 72.

Figure 2.13

The creation of a quasi-firm between buyer and supplier.



Source: Lamming (1993:242)

This concept accepts the supplier as being part of the internal stakeholder group of the organisation, the "fifth constituency"[22] (Kanter 1985; 1989).

Criticism of the lean supply model is similar to that levelled at partnership. In essence, it is difficult to apply in practice as in the measurement of achievement. How does a buyer know where the relationship with a supplier qualifies to be called a partnership? When should the relationship be enhanced, and how, to the level of lean supply?

Lamming originally labelled the partnership model "the Japanese model", reflecting the birthplace of the philosophy. The tenets of sub-contracting that exist in Japan can be traced back to how companies developed in the East after the Second World War. Organisations established tiers of suppliers, the first tier then subcontracted to the second tier, and so on. Hines (1994:52) discussed network sourcing, commenting that,

> ".. the basic starting point for this relationship is not only that the customer (buyer) firm is focused on the consumer requirement, but that it ensures that

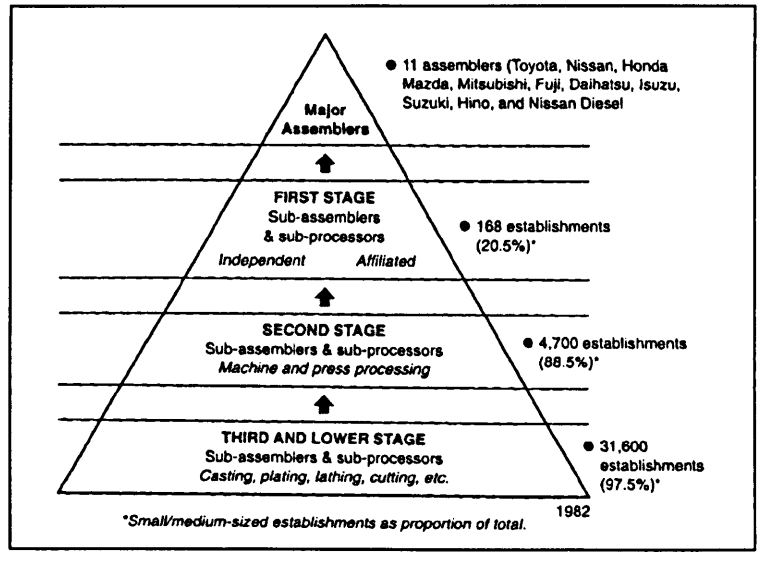
[22] Kanter's four other constituencies are: customers, employees, communities and society.

its suppliers also have this total quality focus. Hence the strategies that the customer (buyer) forms to supply the consumers must be translated back through the direct and indirect supplier network. These strategies will involve what to subcontract, where to locate and even how many people to commit. This can only be done through an extremely close communication mechanism within a group which closely associates with the same aims. This type of supplier network co-ordination is largely achieved through the *kyoryoko kai* (or supplier association) mechanism." (Hines emphasis)

Buyers involved in network sourcing tend to have reduced their supplier base prior to establishing stronger links. A pyramid of suppliers does, however, exist with an increasing number of suppliers further down into the network. Figure 2.14 shows Toyota's pyramid system in the automotive industry which illustrates this point.

Figure 2.14

Toyota's Pyramid Supply System in the Automotive Industry



Source: Shimokawa (1985) in Hines (1994:66)

There is a misconception that the Japanese approach favours single sourcing as a means of developing longer term relationships. It may be that a single source is adopted for a limited period, but that a Japanese buyer will maintain two or three other suppliers over this period to ensure continued competition. Womack et al (1990:153) comments that "in fact, as we saw, Japanese long term relationships do not depend on a single sourcing, but on contract framework that encourages co-operation". Co-operation is likely to include the reduction of costs through joint planning and design. Nishiguchi (1994:124-127) emphasises the importance of communication in this whole process, describing how Japanese firms involve the supplier at the design stage and set clear targets in respect of pricing and completion times.

One of the first supplier associations was developed in 1939 by Toyota who developed long term relationships to the advantage of both themselves and their suppliers. All of the parties involved have become, and remain, competitive - growing together.

> "Growth requires a partner ... in growth partnering, each major customer powers your growth. The power of your customers can be applies co-operatively with you so that your objectives can be the same. Each of you works to grow the other's business". (Hanan 1992:xiv).

Toyota refer to seven guiding principles as shown in figure 2.15 which have facilitated growth and reflect their commitment to developing relationships.

Figure 2.15

Toyota's Seven Guiding Principles

- Customer first;
- Competition and co-operation within our industry and community;
- Respect for the value of people;
- Mutual trust between employees and management;
- Challenge and Courage;
- Applied Creativity;
- Cost Consciousness.

Source: Hines (1994:5)

Network sourcing is then a powerful means of unlocking supplier abilities and increasing competitiveness. However, Hines' research concludes that network sourcing as a model is not typical in industries and sectors throughout Japan. Also other research such as Burt and Doyle (1994) suggests that family tiering of suppliers is not an absolutely essential ingredient to forming alliances in the West as partnership type relationships have succeeded outside of the networking model. Networking sourcing as a model to create strategic alliances is appropriate to consider when reviewing NHS Supplies Services' relationships with suppliers but it needs to be adapted to reflect the circumstances of the various marketplaces NHS buyers operate within.

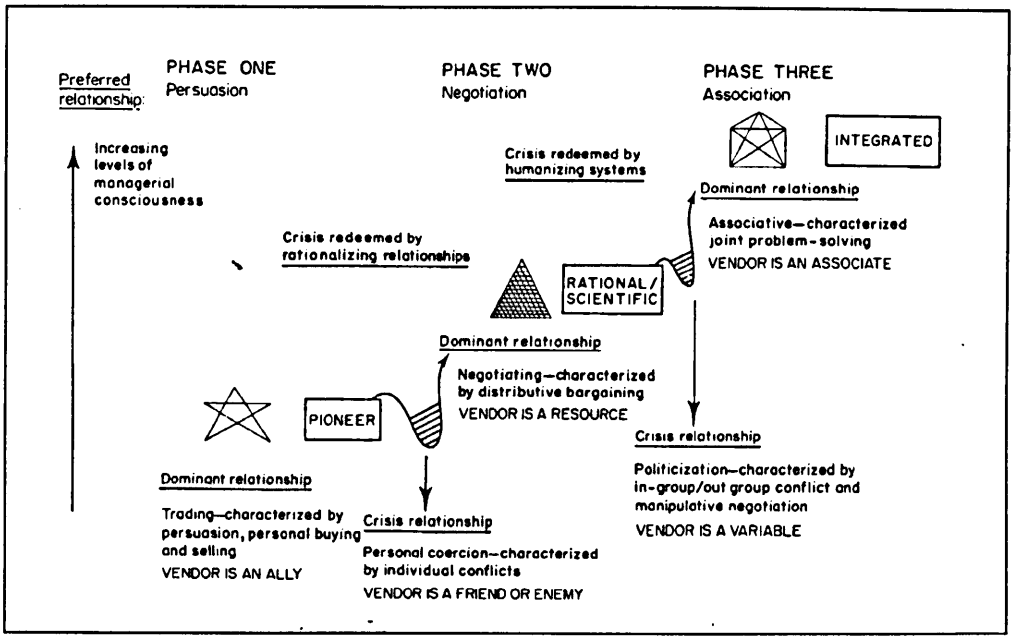
Western business culture is built around ideals of individualism, competition, specialisation and fragmentation so it is therefore difficult to break the mould. There requires an attitudinal change of both parties in the relationship to develop an interdependent and integrated approach. Carlisle and Parker (1989) focused on the

need for both parties to categorically state their commitment to each other and accept responsibility for each other. The traditional ethos and importance of the ritual of negotiation is devalued by Carlisle and Parker (1989:30-40) who believe a long term relationship goes beyond such a one-off confrontation.

Carlisle and Parker (1989:64) discuss three distinct phases than an organisation moves through, which are pioneer, rational/scientific and integrated. Figure 2.16 illustrates the phases and identifies the types of vendor (supplier) to buyer relationships that exist in each.

Figure 2.16

Three Phases of Organisational Development and Buyer Supplier Relationships



Source: Carlisle and Parker (1989:88)

Negotiations with supplier can be used to facilitate both organisations moving to the integrated phase where trust and association is created. Carlisle and Parker (1989:83) comment that,

> ". the active relationship between supplier and purchase becomes one of "association", characterised by the ability to conduct joint problem solving exercises on a whole variety of issues, but all ultimately designed to maximise consumer satisfaction".

In this model, the negotiation process is used not as an opportunity to be hostile to the supplier, but to determine what kind of relationship is required and therefore how integrated the association needs to be. Carlisle and Parker (1989:84) believe that,

> ".. the supplier should increasingly be seen as a voluntary member of the customer (buyer) family. The buyers, then, should be seen as a prime resource to the supplier with responsibility for ensuring that all customer disciplines can and do play their part to cause this associative relationship to recognise and deal with the needs of both parties".

Negotiations should also be used to develop an internal awareness of the importance of the buyer-supplier relationship (Carlisle and Parker 1989:89). Medical clinicians are a crucial internal group that have to work with NHS Supplies Service buyers. Clinicians are influential in determining the product choice, particularly within the medical and surgical commodity group. This involvement needs to be managed by the Supplies Managers in a diplomatic and skilful manner, especially if a clinician's choice of product is more expensive than the one recommended by the Supplies Service. The suppliers to the NHS need to be clear who their customer is and who is the real decision maker so that only one point of contact and access into the system is used. Buyers need

to engage suppliers, having firstly secured a mandate[23] (Carlisle and Parker 1989:151) from internal customers whose demands are conveyed to suppliers. It would appear that the NHS structure can precipitate constant confusion as to who is the contact point which does not create the correct basis upon which to build a relationship. Clinical input is vital, as is input from all other customers, but it has to be controlled and regulated.

Carlisle and Parker identify the strength of increased communication and joint problem solving in the integrated phase. The involvement of end customers and suppliers with the buyer is recommended by the establishment of mandate teams. The mandate teams help to develop strength and perpetuate the greater relationship. However Carlisle and Parker do recognise that mandate teams will move through group development stages and are likely to come to an end point. The parties must be able to accept this concept and voluntarily leave the relationship at an appropriate juncture.

Carlisle and Parker (1989:163) refer to the boiling frog syndrome[24] as an analogy to dissolving group development. It is debatable as to whether this also applies to relationships, as the Japanese type model argues that buyer-supplier relationships are necessarily long term (Hines 1994:96) although interpretations of long term may vary.

Changes in approach and attitude by the buyer to the establishment of relationships, as alluded to by Carlisle and Parker, are a theme of the final model to be reviewed. MacBeth and Ferguson (1994:156-160) under the banner of their Supply Chain

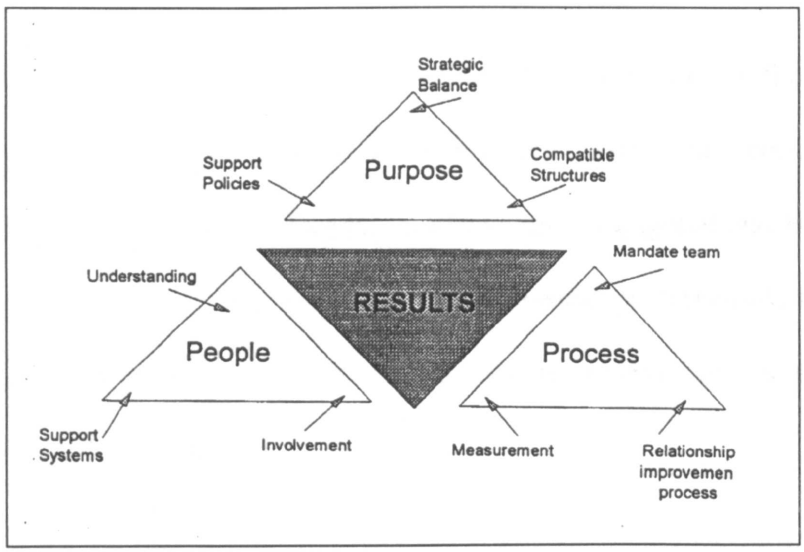
[23] Carlisle and Parker (1989:151) discuss the benefits of establishing "mandate teams... to achieving a creative, buyer-supplier relationship which generates competitive advantage for both parties". Mandate Teams would involve end customers, buyers and suppliers.

[24] "Boiling Frog Syndrome - it is a physiological fact that the frog has a great ability to adapt to the ever-changing temperature of its watery environment. It is also a fact that it does not like extreme temperatures and if dropped into a pan of boiling water, will jump out immediately, little the worse for its experience. It is said to be equally true that a frog placed in a pan of cold water which is slowly brought to the boil will make heroic efforts to adjust to the bad situation, but will die when the water boils without having thought to jump out (Carlisle and Parker 1989:163).

Management Group (SCMG)[25] People, Process and Purpose discuss how such developments can only occur within a framework, labelled RAP-3.

Figure 2.17

RAP-3 Framework



Source: MacBeth and Ferguson (1994:157)

The RAP model as shown in figure 2.17 suggests that results are produced following cross-functional and cross-organisational teams. The teams concentrate on the purpose, the process involved and the people undertaking the actions when deciding how to enhance relationships. This model is similar to others discussed in that it highlights the need for an integrated approach.

A Strategic Issue

A prerequisite to the establishment of partnership type relations is that management accept that purchasing and associated buyer-supplier interactions should be viewed

[25] SCMG is an approach devised by MacBeth & Ferguson that uses twenty four questions to consider how the management of buyer-supplier relationships can be transformed. This approach has been marketed and sold commercially by the authors (SCMG Ltd).

from a strategic[26] perspective. 'An attitudinal change is required by senior management to enable purchasing as a function to be placed on the strategic agenda which would boost long term competitiveness as well as short term profitability' (Cammish and Keough 1993:30).

Senior management input is required to ensure that everyone in the organisation understands the rationale and means by which purchasing can contribute to the achievement and maintenance of competitive advantage. Rajagopal and Bernard (1994) argue that it is as much the responsibility of purchasing professionals themselves to manipulate their position to be more strategic. This is achieved by focusing upon the following four internal areas:

- resources and capabilities;
- organisational structure and control mechanisms;
- organisational culture;
- top management commitment

Purchasing professionals have to be capable of promoting their own work and value before they can be given the opportunity to prove themselves.

[26] a) "Strategic decisions are those that determine the overall direction of an enterprise and its ultimate viability in light of the predictable, and unpredictable, and the unknown changes that may occur in its most important surrounding environments". (Mintzberg & Quinn 1991:5).
b) Strategic decisions exhibit the following characteristics:
- are concerned with scope of an organisation's activities
- match activities of an organisation
- have major resource implications
- affect operational decisions
- are affected by those who have the power in the organisation
- affect long term direction
- are complex in nature
- (Johnson & Scholes 1988:5-8)

In order that purchasing can become strategic, the role of the buyer has to move from simply being the ordering point to the controller of a multi-disciplinary task force which seeks potential new suppliers, evaluates the performance of existing suppliers and acts as a commercial agent for internal departments. Cammish and Keough (1993) identify five key initiatives that are likely to help purchasing move into a more strategic function:

- the establishment of a new purchasing leadership group;
- shifting the focus of the purchasing function to include tasks that have a strategic impact;
- develop and upgrade the existing staff;
- integrate purchasing staff with the staff in the rest of the organisation;
- motivate new and appropriate measures of performance.

Kanter (1989:150) argues that purchasing staff need to be given and be able to accept a new role stating that:

> "Instead of using the purchasing staff as an opportunity to promote less sophisticated clerical personnel, the department seeks people who can effectively take more complete business responsibility for their decisions, represent the company in strategy discussions with partners ...."

Gaade and Hakansson (1993) identified the three strategic roles for purchasing as being rationalisation, developmental and structural. Rationalisation is the need for day to day activities to be reviewed so that less costly suppliers are used. Developmental is longer

term in nature where the buyer and multi-disciplinary team colleagues are actively involved in developing products with suppliers. The final stage is structural which suggests the need for organisations to be aware that the purchasing decisions affect the wider marketplace. Gaade and Hakansson conclude that an increased dependence on selected suppliers is desirable overall in respect of both rationalisation and development models in order to build up openness, mutual trust and long term partnership type relationships.

It is important that purchasing monitors its performance and benchmark against industry leaders. Butler (1995) suggests that measurement in itself can be described as a tool in the overall process of strategic control. Harland (1995) examines measurement in the context of the shift to longer term partnership type buyer-supplier relationships and identifies the need for measurement techniques to reflect the fact that both parties should try to understand each other and exactly what is being performed in the relationship. Harland's research concludes that parties need to identify sources of misperception in the relationship and suggests a "mismatch tool" to do this. The misperceptions that exist between two parties are a reason why relationships do not develop. Assuming this to be the case, the way forward is to firstly identify the gaps between the two parties' perceptions and secondly, close the gaps.

A key aspect of accepting and evaluating purchasing professionals to a strategic status is their performance when given the opportunity. The selection of suppliers with whom to develop strategic alliances is an important aspect in this process. White (1993) suggests that there is little evidence that organisations attempt to categorise components into a hierarchy of strategic importance, therefore it is not surprising that in general,

organisations have not focused sufficiently on those components that are strategically critical.

NHS Supplies Services are unlikely to be able to create effective and sustainable partnership type relationships with all of their array of suppliers, if indeed this was considered desirable. The categorisation of commodity groups in order of strategic criticality is a practical measure that may derive benefits.[27]

The Role of Information Technology

NHS buyers have traditionally spent long hours of price negotiations with suppliers when operating in an 'information vacuum'. Decisions have been taken based on soft data, incomplete data and sometimes no data. The primary source of data has been the suppliers themselves quoting annual usage of a particular product which, whilst useful, is somewhat suspect unless validated by the buyers themselves. The introduction of computerised information systems from the early 1980s has provided the NHS buyers with an invaluable source of knowledge of products and quantities. Information technology has revolutionised the decision making process for NHS buyers from ill-informed to well-informed status. The problems for the NHS buyers are now much more welcome, namely ensuring that the endless data can be distilled into a manageable form to be constructively supplied to buyer-supplier negotiations. The use of Electronic Data Interchange (EDI) in developing buyer-supplier relationships is of particular significance.

[27] See Chapter 7 for discussion of practical measures to develop relationships between NHS buyers and their suppliers.

EDI was defined by Clifton (1989:61) as "... the intercompany computer to computer interchange of business documents in standard formats". However, EDI is much more than this definition, accurate though it may be. EDI has a strategic significance for the two parties who use this form of technology. The need for the buyer and supplier to open different lines of communication within their respective organisations simply to install the computers has the spin-off benefit of promoting stronger links between the two. Emmelhainz's (1988) extensive US based study indicates the EDI implementation is frequently driven by "the desire to obtain a competitive advantage". Buyers and suppliers regard the technology, not as a means in itself, but as a means to an end and as a long term investment.

Rogers et al (1992) argued that IT, and particularly EDI, profoundly change business practice. EDI enabled trading parties to respond quicker and more flexibly to the changing needs of the more demanding customer base. Rogers et al (1992:16) suggest that:

> "The EDI linkage provides a connection which creates a closeness between the service supplier and its customers ... shortens the pipeline and facilitates communication flows between firms supplying and the ultimate customer."

Interestingly, the research undertaken by Rogers et al, which is predominantly based around warehousing companies, concludes that those companies using EDI are able to offer more in the way of services than those companies without EDI.

Allen et al (1992) conclude from studying the US Motor Carrier industry, that the establishment of EDI between members or links in the supply chain, has become increasingly important and has been encouraged by the adoption of such concepts of just-in-time production buying, partnershipping and supply chain management. Allen et al conclude that the decision to implement EDI appears to be either customer driven or marketing driven.

Sheombar (1992) whilst recognising the benefits that EDI presents, argues that in order for EDI to have any lasting benefit, then the current ways of working have to be redesigned. EDI's greatest contribution can be made in facilitating an enhanced level of co-ordination, both internally and with external parties. Sheombar believes that in order for EDI to be effective it has to cut across functional and company boundaries. This in itself is a new approach to management that is enabled by the use of EDI. The use of EDI and the adoption of partnership type relationships to complement one another as the growth of partnerships emphasises co-ordination which is facilitated by EDI. The need to synchronise actions between partners requires a greater and quicker flow of information, to lead the way for the flow of goods which is made possible through EDI.

EDI's benefits are seemingly unquestionable, however there do still appear to be delays in its widespread implementation. The author's 1993 survey[28] of NHS Supplies managers and executives of suppliers included questions relating to EDI. Approximately only half of the NHS Supplies Managers who responded stated that they used EDI whilst suppliers felt that EDI was not used on such a widespread scale as is popularly thought within the NHS itself. The extent of the use of EDI also appeared

[28] See Chapter 5 for details.

limited as the majority of respondents were using the system for ordering, but not for the transfer of payment.

The need to manage communication effectively cannot be stressed enough (Gaade & Hakansson 1993:143-14; Lamming 1993:148). Lamming identifies two levels of communication, the first relating to the integrity of the information exchanged and the second to the use of technology in building the relationship.

> "At the second level, data transfer between companies has taken on a new meaning in the 1908s with the advent of EDI .... thus a measure of a relationship might be the extent to which the parties have invested in compatible technology for transmission and reception of data". (Lamming 1993:148).

Gaade and Hakansson believe that information and communication performs three important roles in a purchasing organisation which are:

- co-ordinating;
- controlling;
- learning.

Information content is categorised as falling into three main areas: commercial, technical and administrative. Plainly, both the purpose and content can vary, demonstrating the complexity of communication. Information exchange is not simply between the buyer and supplier, the buyer also needs to communicate easily and quickly

with internal colleagues. Hakansson and Gaade (1993;145) commenting upon a survey of purchasing organisations, suggest that:

> "In-house communication took more time than external communication and the relative importance of different types of communication varied greatly."

Power

The use of power, which is a determinant in shaping the buyer-supplier relationship, occurs due to the shared need that both parties have for the resources each one has to offer the other. Weber (1968:926) defined power, "in general, we understand by power the chance of a man or a number of men to realise their own will in a social action even against the resistance of others who are participating in the action." Power as a concept is discussed extensively in psychology literature from the point of view of inter-personal power involved in individual relationships (French & Raven 1969) and also intra-organisational literature (Etzioni 1961). However, power within the context of purchasing that occurs between organisations has received little in the way of research focus (Lush 1976; Porter 1980; Gaski 1984).

Porter (1980) describes how the buyer and supplier are in a competitive situation and use bargaining power to manipulate the relationship to meet their own objectives. Porter suggests that the buyer's organisation will use its power to ultimately acquire the supplier's organisation as a means of integration. This model is based very much upon the ethos contained in Lamming's traditional model where adversarial type relationships exist and there is an unequal distribution of power, resulting in unequal partners in the relationship.

Ramsey (1995) views purchasing power from both a potential and actual basis. "In essence, the key theme being that it is the potential ability of one to overcome the resistance of another ..... this issue of potentiality can be applied in a commercial setting". (Ramsey 1995:128). Purchasing power can be seen as the potential capacity of a buyer to produce intended changes in a supplier's product specification that both create a closer match between that specification which will increase the supplier's, but not the buyer's costs. Potential power in a purchasing sense is distinguished from actual purchasing power which is the ability to produce real changes in a supplier's specification and incur increased supplier, but not buyer costs.

Ramsey suggests there is a direct correlation between power and dependency, with power being a function of dependence, whereby the greater party A's dependence, then the greater party B's power in the relationship. Ramsey argues that anything that increases the buyer's need to buy from a specific supplier or that reduces the buyer's freedom tends to increase the buyer's dependence whilst at the same time, reduces the buyer's power. The converse of this is when aspects of the relationship increase the supplier's need or desire to obtain money from specific buyers or that reduces the supplier's customer freedom, tends to increase the supplier's dependence on the buyer.

The balance of power in a relationship may not be equal, but the party in a position of strength should not further their own ends, but rather secure the future stability of the relationship. This links back to the concept of trust being established between the two partners, so that one party does not exploit the other. Ramsey argues that the potential

power within a relationship stems from the attractiveness and availability of resources to the other.

In terms of attractiveness, it is plain to see that if this model is followed through that the perceptions of both parties have about each other and the products/services involved are crucial. In respect of availability, the key aspect is the ability of both parties to obtain from, or supply to alternative sources. Ramsey views the most influential factor in this respect to be the type of marketplace.

A spectrum of market structures exists such as monopsony where the market is comprised of only one purchaser, and monopoly where there is only one supplier. It may be, as in the case of the NHS, that there is a range of marketplaces in which buyers will find themselves, and there is a need, therefore, for a flexible approach once the particular marketplace has been identified.

It is also possible for a bilateral monopoly market structure to exist, where a monopsony buyer interacts with a monopoly supplier. However, probably the most common type of market structure that is created is one where a small number of organisations supply a single buyer. This particular structure which consists of oligopoly suppliers and a monopsony buyer is relatively unknown in the academic literature. The principle point is to recognise that the market structure influences the buyer-supplier power balance and the possibility of partnership type relationship being created.

Kanter (1989) describes how buyers and suppliers become partners through a process which *pools* resources, creates *allies* to exploit opportunities and *links* systems (PALS). In order for both parties to become PALS, there needs to be a real change in the way business is undertaken and how power is employed in the relationship. Kanter (1989:141) also points out that changes to internal relationships are necessary, stating that "... the development of formal alliances with 'external' parties also changes internal roles, relationships and power dynamics for the organisations entering into them".

Partnerships are not concerned with one party temporarily agreeing to give the other party power, "to bequeath something voluntarily in order to win co-operation ... which is something that can be withdrawn at will .... such a paternalistic attitude can undermine the core of the partnership effort and its potential future" (Kanter 1989:141). In short, a real re-distribution of power is required in partnerships, rather than a token effort.

Implementation Problems

Partnerships are neither easy to achieve, not quickly established, with both parties taking time to develop the type of trusting interdependency required. There will always be problems moving such an abstract concept into reality as well as maintaining this, once it has been achieved. Business partners experience constantly changing circumstances which will impact on the stability of the relationship. A multiplicity of factors can affect the subtle balance of the buyer-supplier relationship which need to be identified and monitored. The type and nature of decisions[29] taken by partners at each

[29] Interestingly, the Greek for "decision point" translates in English to "crisis". (Carlisle and Parker 1989:152).

crucial stage in the development and subsequent maintenance, of the relationship are of vital importance. Kanter (1989:160) recognises that:

> "... the fragility of interorganisational alliances stems from a set of common 'dealbusters' - vulnerabilities that threaten the relationship. Partnerships are dynamic entities, even more so than single corporations, because of the complexity of the interests forming them."

Kanter identified twelve common dealbusters,[30] four of which are of specific significance to the NHS Supplies Service. The first factor is where there is a strategic shift by one or both of the parties involved, "any strategic shift in the strategy of the organisations forming an alliance is a potential threat to the relationship (Kanter 1989:16). Suppliers to the NHS are more likely to withdraw from partnerships with NHS buyers than vice versa, as NHS buyers will usually have a continuing need for a product or a similar product, once they have commenced buying. There will, however, be instances when the NHS buyer wants to move from one source of supply to another, but usually following a documented period of deterioration with the existing supplier. There may also be occasions where technological innovation renders certain products obsolete, therefore ending the need to purchase them. This would not normally be a reason to finish a relationship as the partners, if functioning effectively, will be identifying such planned changes well in advance.

Uneven levels of commitment are an inevitable part of relationships which re-emphasises the correlation between power and dependency. Organisations entering into partnerships have obvious differences which largely determine their degree of power and dependency in relation to the other party. There are many small organisations for

whom the whole or vast majority of their income is derived from NHS business. These suppliers are then totally dependent upon the NHS buyer who becomes the more powerful of the two parties. This is likely to influence both parties' level of commitment to the relationship. Kanter (1989:161) suggests that:

> "The vulnerability of alliances to strategic shifts simply points to another source of fragility; differences in the commitment of the partners to their joint activity. For one partner, the alliance may be central to its business, but for the other, it may simply be a peripheral activity".

Adversarial type relationships tend to exhibit a lack of trust where both parties "expect the other side to attack or not to keep to the agreement, so they feel they should be their retaliation in first" (Carlisle and Parker 1989:53). Partnerships are based on trust, but trusting another party is a major decision which should not be taken without serious consideration. Kanter (1989:164) suggests that "sometimes parties to an alliance are naive in trusting their partners too soon, before a solid basis for trust is established". Traditionally NHS relationships have been characterised by extensive contract documentation which has been designed to be able to address worst case scenarios. This approach does appear to be changing somewhat as contract documentation becomes more streamlined, reflecting the growing trend towards partnership type relationships.

[30] Kanter's (1989:160-172) deal busters are: strategic shifts, uneven levels of commitment, power imbalances (a) resources, (b) information, imbalances of benefits, premature trust, conflicting loyalties, under management, hedging on resource allocation, conflicts over scope, insufficient integration and absence of common framework and internal corporate politics.

Nevertheless, NHS buyers still need to retain sufficient protection, only allowing "looser" contracts to evolve over time with their more trusted suppliers. It would be folly on the part of the buyer to prematurely trust suppliers who may then take the opportunity to exploit the buyer. Equally the buyer does not want to operate under the old adversarial maxim of 'caveat emptor' (buyer beware) so a balance between the two has to be struck.

The fourth of Kanter's dealbusters to highlight in respect of NHS Supplies Services is internal corporate politics. Kanter (1989:171) suggests that:

> ".. they (partnerships) also fall prey to the enemy of all innovation - the politics within each of their member organisations. The issue can range from someone feeling that the partnership threatens his or her territory, to the partnership's chief sponsors losing (internal) power."

As already alluded to, the NHS buyer has a vast array of customers and 'masters' to satisfy, some of which are obviously more important and powerful than others. The internal conflicts and 'battles' between disciplines within a Trust hospital, such as between accountant and medical consultants, may cause an agreed stance, which the buyer has adopted with a supplier, to be changed during the course of a negotiation or relationship. NHS buyers need to be wary at all times that they are acting upon information and adopting a stance which their customer has the capacity to authorise.

The management of these problems requires the NHS buyer, indeed buyers in any organisation, to constantly make decisions which will facilitate the establishment, or continuation of partnership type relationships with suppliers. Decision making theory as a generic type is a wide ranging and interesting subject. So, too, is strategic decision making in a commercial setting. Decision making in a competitive environment (Porter 1980: 120-123, Farmer 1981:50-57) has been the traditional focus.

Specific research to investigate NHS buyers' decision making would be worthy, for although not considered critical to this thesis, it is appropriate to recognise the importance of this area and indicate its potential impact upon the buyer-supplier relationships.

2.2.4 Summary

This section has described the complexity[31] of buyer-supplier relationships and, in particular, has contrasted the adversarial and partnership types. Christopher (1993:4) suggests that:

> "the traditional relationship between a buyer and a supplier was a pretty tenuous one. It was an argument, basically, between a sales person and a buyer."

In contrast, Cousins (1992:33) advocates the adoption of a partnership approach which he defines as:

[31] Gaade and Hakansson (1993:63-77) outline six characteristics of buyer-supplier relationships, one of which is complexity. The others are: relationships to be seen as investments, adaptations, reciprocal trust, power and dependence, and conflict and co-operation.

"..... entering into a long term agreement between buyer and supplier, the sharing of risks and rewards, of technology and innovation, leading to the ultimate creation of synergy and competitive advantage."

NHS buyers' relationships with suppliers necessarily occur across the whole relationship spectrum from adversarial to partnership. Lamming (1993:242-243) recommends that different levels of relationships should be adopted:

"... for each supplier, the customer (buyer) would have a planned development of the relationship, based upon the practical limits of performance, the scope for improvement, useful life and so on..... This leads to the idea of a portfolio of relationships on the part of the customer (buyer). This is a strategic plan *to operate differing levels of developed relationships with various suppliers*. The relationships interrelate and support one another on a continually reviewable basis. Thus, a critically important supplier might be part of a fully developed lean supply relationship, providing technological solutions through collaboration etc., whilst a source of commodity items might be run on a more arm's length basis - still with excellent service, but without the need for such intimate working practices." *(my emphasis).*

The discussion in this sub-section has developed the argument that the literature review, whilst providing a sound conceptual basis from which to consider NHS buyer-supplier relationships, does not sufficiently take account of the unique nature of the NHS. The unique characteristics in respect of buyer to supplier relationships are summarised in Table 2.2;

Table 2.2

Unique Characteristics of NHS Supplies Service in respect of buyer to supplier relationships

- It is only since the reforms that an environment conducive for the growth of partnership type relationships has been created in the NHS;
- NHS Supplies Services have both a large and diverse supplier base as well as a large and diverse customer base. The establishment of meaningful internal relationships affects the buyer's ability to create partnership type relationships.
- The accepted models which describe partnership type relationships are largely based upon the manufacturing sector and are not always applicable to the NHS Supplies service.

The issues which are common to the NHS Supplies Service and other service providers are; the need to have a portfolio of relationship types, that traditionally buyers are more comfortable with adversarial type relationships, the use of EDI is not widespread, purchasing is not afforded a strategic status and finally the balance of power and dependency varies depending upon the parties involved.

Subsequent chapters will build upon the existing literature, adapting specific concepts to develop a programme of practical measures which will help NHS Supplies Management to determine which type of relationship to adopt, when to adopt it, as well as heightening awareness of the factors that can influence relationships with suppliers.

2.3 Principles of Customer Care

2.3.1 Definition

The importance of satisfying the customer, which has become increasingly accepted through the 1980s and early 1990s across all industries and sectors, appears to be

penetrating public sector management thinking. Traditionally, the NHS, both in general and specifically within the NHS Supplies Services have not embraced the concept of customer care. However, the introduction of competitive forces, albeit in a managed market setting, has served to raise the profile of customer care, both generally and for Supplies Services. Cardwell (1992:74) suggests that the adoption of a customer focused strategy is a vital developmental step all organisations have to take as,

> ".. success in the future can only be as a result of customer satisfaction through quality - of product, of service, of environment and of people."

There are many definitions of customer care and customer service which are qualitative in nature.[32] Lalonde and Zinser (1976:203-207) however suggest a framework which is based upon three models - the first where customer service is seen as an activity, the second in terms of performance levels and finally as a management philosophy that allows a working definition of customer service to be developed. Bowersox et al (1986:93), building upon these models, suggest that

> "The broad definition of customer service must balance elements from all three models. First, the enterprise must adopt an overall customer-oriented philosophy. This means that the management must direct resources to identify and meet customers' needs. This philosophy must be instilled throughout the enterprise. Since it is difficult to measure performance against a management philosophy, the second task is to define specific measures for evaluating performance. Specific measures are usually quantative in nature..... the final task requires that the customer service

[32] a) See definition given in Chapter 1, Section 1.2.3
b) Customer care and customer service are regarded as synonyms in this thesis

managers be provided (with) the human resources and information necessary to effectively process customer orders and provide necessary information."

It is helpful to consider both the more qualitative and practical definitions of customer care together.

The NHS Supplies Authority[33] (SA) in England, created 1 October 1991, appears to recognise the importance of defining its interpretation of customer service. The mission statement contained in its initial market brochure states:

"NHS Supplies works within the NHS to provide a reliable, responsible and forward looking service that guarantees its customers the best value for money on the goods and services they need to deliver health care".
NHS Supplies Marketing Brochure (1992:1).

The marketing brochure refers throughout to customers and the need to satisfy their requirements which demonstrates the NHS SA's intention, if nothing else, to be customer focussed. Terry Hunt, the National Director of NHS SA states that, "NHS Supplies is customer led .... giving total supply services to customers within their boundaries" (Miller 1993:14). However, these commendable intentions need to be translated into actual day to day practices and compared against the customer's perception of the service they actually receive. In July 1993, the NHS Trust Federation, whose membership of the time covered 80% of all Trusts, published a report entitled "Improving the NHS Supplies Service" which, although containing some positive

[33] See Chapter 3 for further discussion of NHS Supplies Authority in England

comments, is generally negative and critical of the NHS Supplies Service. The report, which is written by an organisation representing the customer base, suggests that the customer's perception is somewhat different to that of the service provider.

Up until July 1993, the NHS SA enjoyed the status of monopoly supplier[34] position as the customer base did not have the right to decide whether to use NHS SA or obtain such purchasing, warehousing and distribution services from an alternative source. The NHS Trust Federation report highlighted the point suggesting that the NHS SA abused their status in the marketplace by adopting a "take it or leave it" attitude with its customers. Also, due to the absence of competition, the Trust Federation suggested that the cost of providing the service was excessive. The ethos of the report is encapsulated by the following statement:

> "... the new NHS Supplies Authority shows some early signs of becoming a national bureacracy, imposing its will rather than being accountable to local customer wishes through market mechanisms and choice". NHS Trust Federation Report (1993:14)

In November 1993 and February 1994, the author issued a postal questionnaire survey [35] to English and Scottish Trust Hospital Chief Executives . Unsurprisingly the vast majority of respondents to both surveys thought that the Trusts should decide from whom they obtained Supplies Services. Nearly two thirds of respondents to both questionnaires perceived that the NHS Supplies Service needed to be improved in order to retain its customer base.

[34] From 1 July 1993, Trusts were given the authority and the right to decide from whom they obtained their Supplies Services, See Chapter 3.

In contrast, the NHS SA conducted its own survey of existing customers during the summer of 1993, concluding that their customers rated them highly (on a scale of 1-5 where 1 is low, 5 is high, the NHS SA obtained an average of 4).

The discussion in this section has highlighted the need for both customers and service providers to understand what is meant by customer care.

2.3.2 A Strategic Issue

The need to make customer care the main strategic driver of an organisation is necessary simply for survival in increasingly fierce competitive marketplaces. The ultimate sanction a customer has is to remove business from the provider organisation and buy from an alternative source. "Customers are poised to fly like a nervous flock of geese in a grain field" (Schonberger 1990:34). The objective should be to build a chain of customers which links people at all levels in the organisation directly or indirectly to the marketplace[36]. Another significant factor is that customers increasingly expect more from their chosen service providers and as such, customer care programmes necessarily need to be devised and monitored at a strategic level by senior management.

NHS Supplies Services are relatively inexperienced at devising, implementing and monitoring customer care strategies. Up until the impact of the 1990 reforms, NHS Supplies Services did not have any customers, only users of the services they provided. Consequently senior supplies management was unconcerned whether customer care

[35] See Chapter 4 for more detail,

percolated throughout their organisation or not. After all, their view was that they were a monopoly supplier with no competition and the 'users' could not go elsewhere for the service anyway. The resultant culture and attitude that prevailed was a "take it or leave it" one. The customer who shouted loudest was likely to get the best service but probably only as a one-of improvement, rather than a sustainable change in practice. Furthermore, the users did not regard themselves as customers who could legitimately complain about service provision and expect the NHS Supplies Service to respond to their individual requirements. A blanket type of service was provided which did not allow for anything other than "the standard" provision. The culture within NHS Supplies Services neither tolerated or responded to requests for individual packages of customer care.

Apart from the Supplies Authority in England, there are signs emerging from other parts of the Supplies Services across the NHS that demonstrate the adoption of a more strategic level acceptance of the customer care philosophy. The Scottish Healthcare Supplies[37] (SHS) organisation produced a promotional document in 1995 which has a customer focus throughout. SHS senior management claim to be a 'customer friendly' organisation who undertake "on-going consultation with clients in order to create a cultural affinity so that a flexible and responsive approach is possible." The contracting branch of SHS states that "our customers' needs are our aims and caring is our commitment".

[36] Schonberger's concept of a customer chain is an extension to Porter's value chain analysis. See Chapter 2, Section 2.1.2.

[37] Scottish Healthcare Supplies was formed April 1995 and previously known as the Supplies Division. SHS is part of the Common Services Agency which is part of the Scottish Office (NHS in Scotland). Scottish Healthcare Supplies negotiates central contracts for use by the Scottish NHS and also provides technical/scientific services. See Chapters 3, 5 & 6 for more details.

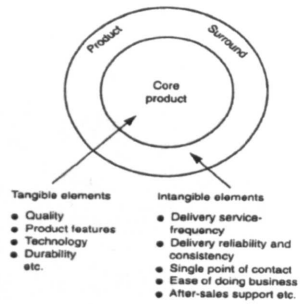
Senior management attention is vital to ensure customer care is afforded a strategic status. Peters (1987:70) suggested that management needed to be obsessed with quality, not just on a one-off basis, but consistently, "persisting through program doldrums" (1989:72). A philosophy is unlikely to become part of an organisation's culture unless the service is valued and seen by others to be valued by the leaders. Cook (1992:49) highlights this point, stating that:

> "Senior managers, therefore, need to be seen to visibly support the service programme if employees are to recognise its importance. If senior managers say 'do this' and employees see them applying other rules to suit their own needs and circumstances, it is hardly surprising when employees do not take service (customer care) seriously".

The central tenets of adopting customer care as a strategic issue are simply: win new customers and retain customers. Competition is such that organisation cannot afford to focus exclusively upon their product features but will need to augment these with added value services. Christopher (1993:31) suggests that customer care services should be used to augment the core product as a means of differentiating from competitors, see figure 2.18. The main intangible benefit centres around availability of the product to the customer as customers increasingly want the product immediately following request.

Figure 2.18

Using service to augment the core product



Source: Christopher (1993:31)

After winning customers, it is crucial to retain them. Christopher (1993:33) discusses 'relationship marketing' which is based on the premise that organisations "should consciously strive to develop marketing strategies to maintain and strengthen customer loyalty". Customers are satisfied with the care they receive to the extent that they do not even consider an alternative service provider.

Schonberger (1990:1-16) describes an approach to strategy that places customers at its centre which is summarised:

- recognition that we all have customers;
- there is a need to reduce flow time through supply chains;
- there are customers inside as well as outside the organisation;
- there is an acceptance that customers are both fickle and demanding - those that are loyal are only so because their needs are consistently satisfied.

Strategy must be planned to deliver to the customer even better quality at lower cost with even quicker response times and greater flexibility. Flow time in the customer

chain is increasingly becoming of paramount importance with quick response seen as customer standard rather than a special requirement.

NHS Supplies Service customers are now expecting "special" treatment all the time from their service providers. Flexible packages of care are required by all of the customer base. All NHS Supplies Services have a common difficulty which is to satisfy their large number of customers, all of whom have very specific requirements, most of which are different and some even conflicting. A possible solution may be to prioritise customers and focus on certain key customers who receive preferential packages.[38] The composition and nature of the customer base will be a significant factor as to whether Supplies Services should or should not offer differential service levels. It may be the case that the Supplies Service has only one Trust organisation as a "customer" therefore making it difficult to prioritise individual staff groups within the whole. However, there may be more scope in dealings where a Supplies Service serves more than one organisation and customer. Peters (1987:112-114) refers to the United States textile manufacturer, Milliken, who, in 1985, adopted a strategy called Total Customer Responsiveness (TCR) which helped them identify new market opportunities through closer collaboration with the customers. The need to engage customers in a constant dialogue must be part of NHS Supplies Service customer driven strategy.

Customer care must be interwoven through an organisation's strategy and the message must be conveyed to both external parties and internal employees. To this end, organisations have developed both mission and vision statements. There does appear to be confusion relating to terminology, although a helpful interpretation of the two is that

[38] See Chapter 6 for discussion of programme of measures for customers.

"a mission is a statement of the purpose or task of the organisation while a vision is a statement of where the business is going, its values and beliefs" (Cook 1992:36). It is clear that both mission and vision statements necessarily need to be formulated at senior management level. Senior management input is required to produce action in line with both the acknowledged mission and vision. Figure 2.19 shows how the mission and vision statements can be used as a platform from which senior management can develop an overall service strategy that produces tangible outcomes.

Figure 2.19

Developing a Service Strategy

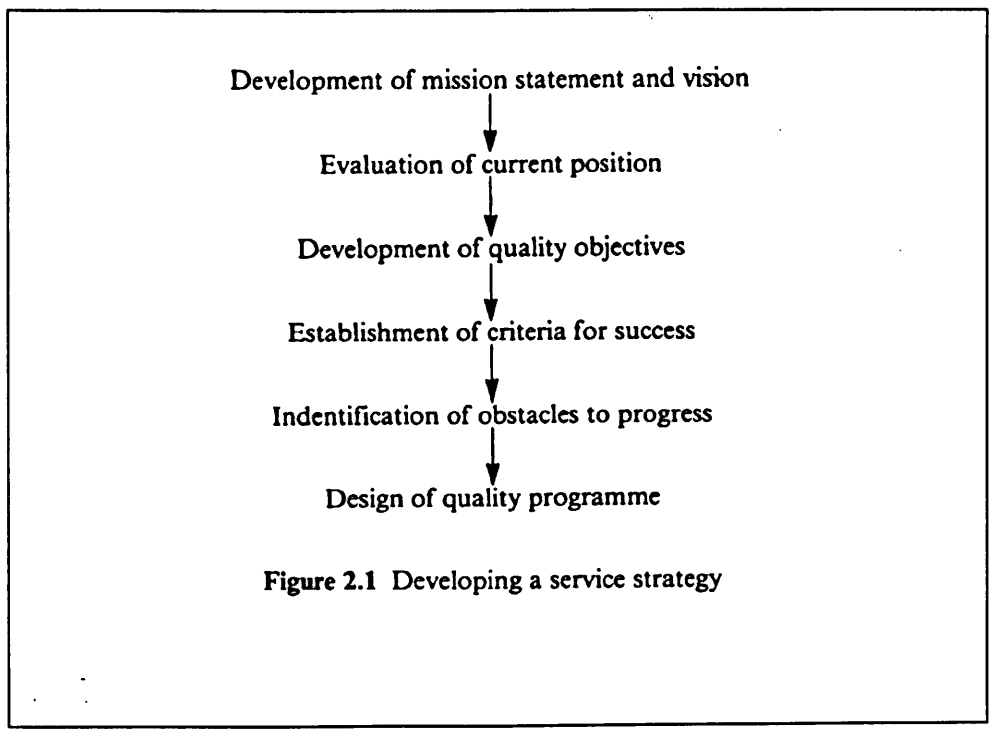


Figure 2.1 Developing a service strategy

Source: Cook (1992:41)

The NHS Trust Federation Report (1993) recommended that in England both the service provider, NHS SA and the customer, the Trusts, needed to reassess their individual stances in respect of their overall relationship. In respect of the NHS SA, the report recommended that improved responsiveness should be an over-riding aim "... the need for a more Trust-customer focus" (NHS Trust Federation Report 1993:13) that is

built into their strategy. The report also made the point that individual customer care packages needed to be made available. The Trusts themselves were urged to view supplies expenditure as an area where savings could possible by derived;

> ".. Trusts should demonstrate, through the business planning process, the importance and strategic significance they attach to the supplies function and the savings and efficiency gains they are able to make". NHS Trust Federation (1993:35).

2.3.3 Total Quality Management

Total Quality Management (TQM) is a competitive strategy where everything an organisation does is perceived through the eyes of its customers from the point of view that the customer is using information to justify continuing to do business with the current organisation or deciding to switch to a competitor. "TQM is a technique, an attitude, concerned with creating an overall impression". (Hutchins 1990:22).

TQM is defined by the American Federal Office of Management and Budget circular (1990) as being:

> "..a total organisational approach for meeting customer needs and expectations that involves all managers and employees in using qualitative methods to improve continuously the organisation's processes, products and services". Milakovich (1990:209).

The key phrases in this definition are "total organisational" and "improve continuously". TQM affects everyone in the organisation and requires everyone to accept quality as their responsibility. TQM strives for the situation when tasks will be performed right at the first time of asking which necessarily involves the commitment of everyone in an organisation. Furthermore, organisations who adopt TQM accept that in order to retain customers, there is always scope for improvement. TQM is therefore "an approach which organisations adopt to improve their performance on a systematic and continuous basis". Cook (1992:69). Clearly the TQM philosophy is based upon the existence of a competitive marketplace and the lack of any competitive forces in the NHS prior to 1990 explains TQM's absence from the NHS up until this time. However, as NHS Supplies Services have begun to focus upon the question of differentiating their service in order to retain customers, TQM is being increasing considered as an appropriate tool for this purpose.

Cook (1992:70) suggests that all TQM initiatives will likely consist of three major elements which are as follows:

- a documented system of defining quality standards whose effectiveness and application can be monitored on a regular basis;
- the creating of organisational processes to ensure that policies, procedures and practices are focused on the customer;
- the monitoring and control of these processes to eliminate waste by doing things right the first time.

The common theme running throughout these elements is monitoring performance to ensure that the customer needs are fulfilled first time of asking with the most efficient

use of resources. Cook also suggests that there are four principle stages required to implement a TQM approach which are as follows;

- the development of a documented quality management;
- the knowledge of the cost of quality;
- the identification of key projects which need to be undertaken to eliminate variations between actual and desired performance;
- the involvement of all employees to ensure continuous improvement.

The knowledge of costs is important to bear in mind as quality enhancements or developments have to be affordable to the organisation and the financial benefits that ultimately occur have to outweigh the implementation costs. Therefore, identifying the true costs is a crucial step in determining if a particular quality initiative should be pursued.

As TQM emanates from Deming's[39] research of post World War II Japanese manufacturing industries, its application to the public sector, particularly the UK NHS is questionable. Morgan and Murgatroyd (1994) suggest five aspects where TQM and the public sector type organisation are incompatible. These are as follows:

a) nature of TQM inhibits applications to public sector.
b) nature of public sector is hostile to TQM
c) cultures of professional groups hostile to TQM
d) public sector customer is a problematic concept

e) public sector much more complicated than manufacturing

One of these five aspects is that TQM is based upon the manufacturing of the same or similar products again and again, whereas a service industry is concerned with agreeing with the customer, a correct service level for a particular individual or group. It is the case that the NHS Supplies Services have a large and diverse customer base who require individual care packages.

It is suggested by Morgan and Murgatroyd that public sector organisations are resistant to change and that real change cannot be affected as "resourcing is disconnected to performance", Morgan and Murgatroyd (1994:31). This would have been relevant to NHS Supplies Services when they were afforded protection as a monopoly supplier, however as their customer base is no longer secured, resourcing is now connected to performance. If a supplier service under performs, the customer can, if it chooses, buy these services elsewhere.

Another of Morgan and Murgatroyd's five aspects suggests that conceptually there may be a problem accepting customer care in a public sector environment. This relates again to the complications presented by different types and wide ranging numbers of customers. Swiss (1992:357) suggests that:

> ".. because Government agencies must serve a wide variety of customers who have widely divergent and even contradictory demands, and because the general public remains a hidden customer, with yet additional, often incompatible demands, Government agencies often have to deliver a service

[39] See also the work of Taguchi; Shingo (both in Deming 1988); Juran (1988) and Crosby (1984).

> or product that reflects an uneasy compromise. In such cases, the (TQM) principle of delighting or satisfying the customers begs too many questions to be a clear or useful goal."

Although the NHS certainly has a complicated customer base, the TQM principles can still be adapted and applied to the NHS Supplies Services setting. TQM can be viewed as providing a generic framework which is flexible enough to incorporate different organisations. It is not, however, possible for a rigid or prescriptive application of a manufacturing type to be applied to the NHS Supplies Service.

The adoption of TQM necessitates a change in organisational culture. Bate (1994:33) describes how cultures can be used as a strategy for either maintenance and continuity or for change and transformation. TQM can be described in these terms as a strategy for transformation so that customers' changing requirements are met, Harvey-Jones (1989:23) has pointed out that success depends upon change, stating that "... unless a company is progressing the whole time, it is, in fact, moving backwards". The NHS Supplies Service has recently experienced both changes in the overall type of marketplace it operates within and the focus given to customers, creating an opportunity for TQM and a new culture to be introduced.

TQM is, however, a difficult concept to maintain once introduced (Whittle et al 1991). Bate (1994:92) comments that;

> ".. this novel way (TQM) of conceiving organisational development is often 'spiked' by the existing culture of the firm; although TQM fundamentally

implies cultural change, what usually happens is that TQM programmes end up adapting to fit the existing culture rather than the other way round. As this happens, they are effectively deprived of their impact and novelty".

The danger for NHS Supplies Services in implementing and managing TQM programmes is that they are 'consumed by' the greater organisational culture already in existence, thus the potential impact of TQM is only marginal. Clearly the TQM philosophy requires to be implemented as part of an overall customer care strategy which is sponsored by senior management.

The implementation of TQM is crucial as the concept is worthless unless it changes actual practices in respect of customer care. The key to effecting this change is the establishment of two way communication channels between service provider and customer.

Oakland (1993:42) suggests that clear statements to staff are important and should include:

- the need for improvement
- the concept of total quality
- individual's responsibilities

Staff must be clear about the organisation's stance in respect of quality so that they can communicate effectively to customers.

2.3.4 Differential Service Levels

It is an acknowledgement that not all customers require the same level of service from their provider. Different customers will obviously have different needs yet organisations consistently assume that changes in service designed to improve quality will be welcomed by all customers. It is crucial that customers' requirements are clarified to avoid a possible waste of resource and management time in arbitrarily increasing an aspect of service when, in fact, the customer may not actually want this. Sabbath (1978:26) stresses this point and states that,

> "... the first step is to banish the costly misconception that all customers seek or need improved service. It is far more likely that current service levels are more than adequate but are poorly defined, it may be that only very few products in a large line need, say a 95% service level, and that 75% is highly satisfactory for all other products".

The initial task is to identify what the customer actually requires and if organisationally possible and economically viable provide this. Individual customers may place different emphasis upon availability (frequency of delivery and timing of delivery), quality of the actual product or cost. However, NHS Supplies Services have traditionally provided one level of service, a rigid delivery schedule, similar quality products and one standard on cost to all customers, regardless of the amount of service they actually use. The threat from potential competitors has been the catalyst for NHS Supplies Services to increasingly consider developing alternatives for particular customers. Also there has been a change in stance for the NHS SA from one where customers were given the option of having to take all the services or nothing at all, to

one where ".. customers can take advantage of as many of these services, however, our preferred approach is to develop partnerships (with customers) over a whole range of activities" NHS Supplies Authority Marketing Brochure (1992:7).

This type of approach necessitates a greater empathy with customers than was previously achieved, to understand their situation and changing circumstance. All organisations are constantly changing, however, in the past five years, the NHS has undergone an exceptional amount of fundamental change. All groups within the NHS have experienced change, none more so than the medical profession. Hunter (1992:20) claims that,

> ".. an understated, yet central aim of the NHS reforms is to get a grip on doctors through the introduction of management principles to a hitherto largely no-go area of professional freedom."

The point here is that the medical fraternity's "fortress" of power has unquestionably been challenged through the introduction of stronger management in the NHS. Medical staff have been encouraged through the introduction of Clinical Directorships, to take a more active role in management, even if there is debate as to how successful this move has been (Best 1993). Clinical practice is also increasingly facing scrutiny, indeed the debate continues regarding the clinical effectiveness of procedures and also more rigorous audit of medical performance are being established (Maynard 1993). In essence, mechanisms are being designed so that the medical staff are accountable for the decisions from both a financial and clinical perspective. The medical staff are experiencing some pressure which NHS Supplies Services need to be aware of so that

they can empathise generally with their customer and understand how this may impact upon their particular relationship.

The medical staff are a key customer of NHS Supplies Service, even if this is not as yet openly and consistently acknowledged by Supplies Services senior management.

The medical staff are the prime users of medical and surgical equipment which is significant expenditure.[40] Therefore the medical staff are a key customer as they influence a significant slice of the overall business for Supplies Services. In short, it is important that the medical staff requirements are continuously satisfied.

Normann (1984) suggests that each service encounter that takes place between the customer and provider moulds the customer's level of satisfaction and Normann terms these encounters as 'moments of truth'[41]. In large service industries, such as the NHS Supplies Service, there will be thousands of moments of truth on a daily basis. Furthermore, Normann suggests that it may be helpful to classify these moments of truth in terms of personality intensity, where the performance of individuals or small groups of people who have a fairly high degree of discretion to influence is a key factor in determining quality and economic performance. The majority of NHS Supplies Services now have specific customer service teams who act as the lead contact for customers. However, it is not only these groups that may interact with customers but also delivery drivers, receptionists and buyers, so all within an organisation must be

[40] FHC SS spend approximately 70% of the total expenditure on medical and surgical products. See Chapter 3, Section 3.3 for more details.
[41] The history of the term 'moment of truth' both as a framework and metaphor is that it was invented by Normann R (1978) 'Development of Strategies for Swedish Service Knowledge', SIAR, Stockholm. The concept was then adopted by Scandinavian Airlines and published in a book by Carlson J 'Moments of Truth'.

customer focused. The customer service teams can be employed to give greatest attention to key customers and proactively management the moments of truth.

2.3.5 Performance Measurement

The usual scenario for the measurement of Supplies Services in the NHS is one where the Supplies Management decide themselves upon the type and extent of information to be sent to customers. The Supplies Service have traditionally assumed the areas that the customers place importance upon rather than engaging the customers in an interactive process to identify what is important. Lewis and Sinhapalin (1991) suggest that the criteria customers think are important are usually different to those which service providers think are important.

A typical NHS Supplies Service will routinely produce basic statistics showing stock turn, stock value, service level in terms of the percentage of stock items issues first time, the value and volume of non-stock orders and number of complaints received. These measures, though very useful, are totally quantative in nature and offer little in the way of qualitative analysis of the service. One of the reasons such statistics continue to be so regularly collected and issued relates to the ease with which such information is available from IT systems. However, this type of information needs to be supplemented by more qualitative type analyses.

Gronroos (1984) discussed the importance of both the technical quality outcome of encounters, in terms of the actual service delivered as well as the functional quality of

the process which includes such "softer" issues as attitudes, behaviour, appearance, accessibility and approachability. Rees (1994:252) comments that

> ".. Gronroos in essence states what appears to be obvious, with the advantage of hindsight, that it is not only the end result, but how the result is achieved and delivered that is important. NHS Supplies Services have traditionally been guilty of poor performance on both of Gronroos' dimensions of care, but particularly on the functional quality of the process".

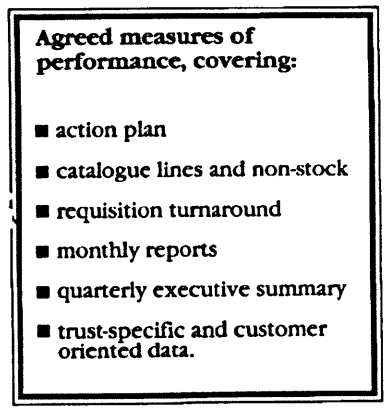
In 1994 the NHS Supplies Authority in England established a series of working parties in conjunction with the NHS Trust Federation to tackle Trusts' supplies issues. One objective was to prepare guidance for Trusts on the tools to measure the performance of a supplies service and the efficiency of local supplies staff. A document issued jointly by both parties entitled "Performance Measures in Service Level Agreements" explores in detail how the service level agreements actually work and illustrates a series of performance indicators (PIs) that can be included. The service level agreement should contain,

> ".. agreed action plans, performance measures and reporting mechanisms to ensure that both parties can monitor progress". NHS Supplies/NHS Trust Federation (1994:2).

This is clearly a significant step that the NHS SA have taken and it is one that appears to have the full support of the customer base. Figure 2.20 summarises the reports available:

Figure 2.20

Summary of Performance Measures available from NHS Supplies Authority



Source: NHS Supplies/NHS Trust Report (1994:2)

The main criticism of these types of reports centre upon the quantative aspect of the data. Parasuraman et al (1985) discuss customers' "zones of tolerance" which are based upon the difference between desired and adequate expectations. The desired level of service is what customers expect to receive and is a blend of what "can" and "should be".

Expectations are complex phenomena, imperfect and subjective judgements which are formed largely through previous experience and word of mouth. Hard data can sometimes hide service gaps and need to be supplemented by sensitive service provider intelligence regarding customer expectations. This type of information can only be derived from regular contact with customers. Lehtinen and Lehtinen (1991) identify the benefits to be derived from quality interaction between service providers and their customers.

NHS SA also provide a quarterly executive summary report targeted at Trust Chief Executive level which "shows key purchasing activity month by month as well as

inflation comparisons and comment on any relevant market changes." NHS SA/Trust Federation (1994:10).

The impact of high performance statistics when presented to customers can be diluted if the service provider is not also nurturing, at every available opportunity, the customer's perception that they are receiving a good service. Each "moment of truth" has to be treated as a golden chance to reinforce customer satisfaction. The success of this type of marketing is, though, difficult to measure.

2.3.6 Summary

In summary, this section has:

- defined customer care and commented that both service providers and customers need to have a common understanding of definitions;

- suggested that senior management need to make customer care a strategic issue;

- discussed the benefits of adopting a TQM approach to customer care;

- suggested that service providers need to recognise that in certain circumstances different customers should receive different levels of service;

- highlighted the need for service providers and customers to agree the types of performance measures to be employed.

The discussion has commented upon the unique nature of the NHS Supplies Service and how this makes comparison to the literature problematic. The unique characteristics in respect of customer care are summarised in Table 2.3.

Table 2.3

Unique Characteristics of NHS Supplies Service in respect of Customer Care

- the concept of customer care is relatively new to the NHS as a whole;
- traditionally there has been a lack of senior management attention to customer care programmes and consequently a poor acceptance that this is a strategic issue;
- the NHS Supplies Services have a large number and a diverse range of customers;
- the NHS Supplies Service may wish to offer different service levels depending on the configuration of the customer base;
- the customer base is multi-disciplinary in composition, all of whom have different needs;
- a large proportion of the customer base is professional staff which makes the adoption of TQM problematic, especially as TQM has largely evolved from manufacturing type industry.

The customer care type issue which is common to the NHS Supplies Service and other service providers is the need to agree performance measures with the customer base prior to implementation.

2.4 Conclusion to Chapter

This chapter has discussed the main principles of supply chain management, buyer-supplier relationships and customer care, drawing out the issues where the application of the literature to the NHS Supplies Service presents difficulties.

The discussion demonstrates the importance of forming a conceptual understanding of both the principles and associated issues to enable a review of current practices in the NHS Supplies Service to be undertaken and subsequently a specific programme of real improvement measures to be developed.

The next chapter will complete the scene section of Section One of the thesis by discussing the evolution of the Supplies Service in the NHS.

CHAPTER THREE

THE EVOLUTION OF THE SUPPLIES SERVICE IN THE NHS

"It's a little bit like coming from being a back room boy to being one of the stars of the show .... centre stage so to speak".

Scottish NHS Supplies Manager
(1995)

"Evolution ..... is a change from an indefinite, incoherent homogeneity, to a definite coherent heterogeneity".

Herbert Spencer
English Philosopher
(1820-1903)

3.0 Purpose

The purpose of this chapter is to complete the scene setting section of the thesis by describing the evolution of the Supplies Service in the NHS and beginning to focus upon two NHS organisations selected as case studies. The organisations are Scottish Healthcare Supplies as the major buyer within the Scottish NHS and Fife Healthcare Supplies Service in respect of their customer care approach.

3.1 Evolution of NHS Supplies Services

3.1.1 General NHS Background

The NHS has undergone constant change, generally Government legislation, since its creation on 5 July 1984, with the most recent radical changes emanating from the Griffiths Report (1983). Griffiths, who was at the time Managing Director and Deputy Chairman of the major retailing company Sainsbury, criticised the lack of general management within the NHS stating that:

> "One of our most immediate observations from a business background is the lack of a clearly defined general management function throughout the NHS. By general management function we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, for implementation and control of performance ... absence of this general management means that there is no driving force ..." (1983:10).

The Griffiths Report recommendations are summarised in Table 3.1:

Table 3.1

Summary of Recommendations contained in Griffiths Report

- Appointment of General Managers on short term, performance related pay contracts designed to inject a business oriented approach into NHS Management;
- the devolution of responsibility to lower levels;
- the involvement and incorporation of the medical staff into the management process
- the introduction of more sophisticated information systems

The Griffiths Report can be argued to have been the catalyst for major legislative reforms imposed upon the NHS in the late 1980s and early 1990s. The issuing of three White Papers; 'Promoting Better Health' (1987); 'Caring for People' and 'Working for Patients' (1989) aimed to change where health promotion and healthcare was provided as well as altering how the services were funded. The emphasis was directed at establishing more community based services with funding managed through a system of contracts between the "purchasers" of healthcare, the Health Boards/Authorities, and the "providers", Trust hospitals. Significantly, the White Paper 'Working for Patients' also laid the foundations for measures to monitor clinical activity and performance, challenging, for the first time, the powerful position of the medical staff. The basis for a more business orientated, cost and customer conscious NHS was established when Parliament passed the NHS and Community Care Act 1990.

As alluded to in the previous chapter, an internal marketplace has been created in the NHS as a result of the changes initiated by the introduction of the 1990 Act. The competitive elements injected have changed relationships within the NHS and also between NHS bodies and external parties. A new culture has emerged which focuses

more than ever before upon the costs of providing health care and the concept that both those within and those who come into contact with the NHS are customers.

The Government, in creating the marketplace, had as its core objectives, the desire to make the NHS more cost effective in the use of its resources and also more orientated to the needs of its customer base - the patients. In short, the reforms have introduced a private sector business type ethos into the Health Service such that there is a need to continually satisfy its customers. However, the internal marketplace is arguably a managed market, as it is still overseen by the Government's Department of Health and in which the competition is not real. It remains to be seen if hospitals will compete against each other to provide certain medical services on the basis of cost, volume and quality. In the event of a hospital consistently losing 'market share' to a competitor, presumably, like any other business, it would cease to function when its operating costs exceed its income. The closure of hospitals due to true market forces is not a likely outcome, however, as this would not be politically acceptable to the Department of Health in its role as guardian of the market.[1]

The Chief Executive of the NHS Management Executive from 1988 - 1993, Sir Duncan Nichol, labelled the internal market as a "social market", although definitions of social markets are many and varied. Robinson (1993) discussed the theme of "contestability"[2] which suggests that incumbent firms only need the threat of competition to increase their efficiency and reduce their costs, therefore a real competitive situation is not

[1] Since this thesis was written, the new Labour Government, elected in May 1997, has indicated that it will review the future of the NHS internal marketplace and intends to produce a White Paper by November 1997.

[2]Contestability is a term and concept firstly highlighted by the work of UK economist Baumol

necessary to achieve these objectives. The concept of contestability may best be used to describe the NHS internal market.

New et al (1995) argue that the 1990 reforms have had the net effect of decreasing the influence of doctors, increasing management power and introducing an entrepreneurial and cost conscious culture into the NHS. They recognise that the new environment has not only produced significant changes in the relationship between purchasers and providers of healthcare but between all parts of the NHS. However, they perceive the internal marketplace for health care to have inherent conflicts built into the system, indeed they argue that the term 'networks' would better describe the evolving situation rather than the term marketplace.

New et al (1995) argue further that the term marketplace can only be applied where separate organisations of parties interact for commercial exchange and as the relationship between the organisations within the healthcare network was so close prior to the organisational divide that strict commercial decisions are not taken. Nevertheless, whatever the term internal marketplace or network, it remains clear that a new environment has been created within the NHS to the extent that supplies organisations' relationships both with internal customers and suppliers have been transformed. It is also clear that the NHS is a unique environment.

The introduction of Trust hospitals within the NHS can be seen as a means of facilitating decision making at lower levels. Trusts are, however, contrary to the claims of the popular press of the early 1990s still within the NHS and can only exercise their autonomy within certain defined parameters, particularly financial ones. It is clear that

Trust hospitals do not have total freedom to act as a private sector business does, with particular constraints on their capacity to borrow and invest money.

Ham (1992) feels on the whole that the Conservative government did not deliver the promises of freedom it made when first announcing the establishment of Trusts. On the other hand, some Trust Chief Executives interpreted the situation differently, as Brackenbury (1992), the Southend NHS Trust Chief Executive stated:

> "I think we have been given the freedom we expected and have not faced any major interference from the centre....." Brackenbury (1992:24).

In short, whilst Trusts are 'legal personae' in their own right, the constraints on them, particularly the financial ones, suggest a comparison to private sector firms is unfounded. Nevertheless, the net effect of Trust hospitals has been to increase the ability of local managers to make quicker decisions resulting in a more business orientated culture, albeit within a protected environment.

3.1.2 An Historical Review of the NHS Supplies Services Development

Introduction

The development of Supply Chain Management within the NHS in many ways reflects the development of the host organisation. The reactive and uncoordinated approach of Supplies Services mirrors the evolution of the NHS as a whole. The provision of goods and services to hospitals appears to have been an issue that was not consciously planned for and one which just happened. The need for goods to support hospitals is obvious, but less obvious is the need to plan and review how these goods are obtained, stored

and distributed. As the various NHS reforms have taken place with the resultant changes to management style and culture so also have the Supplies Services altered. The most recent reforms, driven partly by the Griffiths Report, have encouraged a greater emphasis on cost. It is interesting to note, however, that the Griffiths Report contained only brief references to costs directly attributable to the purchasing, storage and distribution of goods which is ironic, given Griffiths' role in a major retailing organisation. Nevertheless, the overall change in emphasis within the NHS has produced an environment conducive for an increased profile for Supplies Services. A recognised internal NHS average is that 25% of a Health Board/Authority's expenditure is spent on goods and services. It appears that there is now a growing acceptance and recognition of the importance of the role that Supplies Services in the NHS play in balancing the need to satisfy customer requirements whilst at the same time, contain costs.

It is important with this background in mind to review the chronological order of internal NHS reports and legislative changes which have ultimately resulted in such an increased profile for the Supplies Service in the NHS.

Public Accounts Committee - 1951

It was as early as 1951 that a series of internal NHS reviews began to focus on purchasing practices in the NHS, only three years after the NHS had been created. The philosophy from 1948 to 1951 had been to allow hospitals to purchase goods and services on a totally independent basis regarding themselves as separate entities. The trend to centralise in order to try to maximise the NHS purchasing power began in 1951 when a Government Public Accounts Committee (PAC) was convened to examine the

control of hospital expenditure. The PAC's simple recommendation was that there should be greater group purchasing, however no such changes were implemented.

Hunt Report - 1966

The 1966 Report of the Committee on Hospital Supplies Organisation, chaired by J. F. Hunt, reaffirmed the need for a centralised procurement function in the NHS. The Hunt Report's main recommendations are summarised in Table 3.2:

Table 3.2

Main Recommendations of Hunt Report

- the rationalisation of products held in hospitals;
- the involvement of user departments to rationalise product ranges and also to specify future product purchases;
- creation of a central authority able to enter into contracts;
- formalise the ad hoc joint purchasing arrangements that take place in certain geographic areas of the UK NHS and create Area Supply Units to maximise the purchasing power.

These significant recommendations advocate a centralised control of purchasing, a need for strategic level decision making, a greater customer involvement in product choice and a new organisational structure to support the changes. However, the recommendations were not fully adopted throughout the NHS. It is interesting to note that points 103 and 104 of the Hunt Report recommended a Supply Advisory Committee be set up as a corporate body, established by statute with delegated powers from the Minister of Health. These points were not adopted until 1 October 1991 when the NHS Supplies Authority in England was created, some twenty-five years later!

Although the Hunt Report was influential, the process of change was slow and the level of overall responsibility for Supplies matters was left at the individual hospital level, perpetuating the fragmentation of NHS purchasing and supply.

Salmon Report - 1977

Eleven years later, in 1977, a Working Group chaired by R. Salmon was set up within the remit:

> "to examine present arrangements in the NHS in England for procuring supplies (excluding drugs and other items prescribed under the Family Practitioner Service) and to make recommendations on how to make better use of resources by improving these arrangements, with particular regard to the proposal to set up a Supply Board".

The Salmon Report's recommendations extended further than just purchasing. The report suggested that there was a lack of information throughout the Supplies Service in the NHS, poor means of communication, inadequate staffing to perform the tasks required and a lack of oversight from a corporate body. It was also felt that Supplies issues had not yet been recognised at a strategic level and were subsequently omitted from the Department of Health's planning process. The report highlighted the fact that generally storage facilities in the NHS were inadequate and recommended the establishment of central stores at both Regional and District Health Authority level. In respect of information it was felt that the Supplies Service lacked relevant management information and was, therefore, unable to develop, implement or review policies. The lack of information did not allow for any real performance monitoring to take place.

In terms of purchasing, the evidence collected by the Working Group suggested that the proportion of contractual purchasing could be increased as well as concurring with the findings of the Hunt Report by commenting that the NHS still failed to maximise its purchasing potential. The report called for the Supplies Service to give suppliers commitment to purchasing although recognising the pre-requisites for this were the need to involve the end "users" of products in the specification process and also the need to enhance current information systems.

In essence, the Salmon Report exhibits similarities to the Hunt Report as it promoted a centralised form of control for the management of purchasing, as well as recommending changes to the management of warehousing and distribution. The Salmon Report states that their recommendations would be rendered ineffectual unless they were to be implemented consistently throughout the NHS. The Salmon Report recommends that a central body should be given responsibility for formulating policies and monitoring their implementation. The subsequent creation of the Supply Council in 1978 was a step toward centralised control and which echoed Points 103 and 104 of the Hunt Report. However, the Supply Council was ultimately to suffer from its inability to directly manage Supplies Services in England as its decisions and policies were not binding.

Public Accounts Committee - 1980

In 1980, the PAC report on the Procurement and Storage of Supplies in the NHS recommended that executive power be given to the Health Service Supply Council, particularly to co-ordinate purchasing and information systems. Once again, this recommendation was not implemented.

Simultaneously in the early 1980s, plans were drawn up by Regional Health Authorities (RHA) in England to establish Regional Supplies Departments to executively manage supplies services in the fourteen English Regions. In the mid 1980s, Regional Distribution Centres (RDCs) were established which were large[3] centralised warehouses built and owned by the RHAs. The RDCs were radical reactions to the philosophy of the time that large centralised storage facilities were the most cost effective means of managing inventory. RDCs were established in Alfreton Park serving Trent RHA, Normanton for Yorkshire RHA, Runcorn for Mersey RHA, Kings Norton in Birmingham for West Midlands RHA and also one in the London area for South East Thames. These RDCs, which were modelled on the storage and distribution systems of supermarket retailers, were exclusive to England. Although both Wales and Scotland did establish central warehouses, they were on a considerably smaller scale.

The concept of a centralised warehouse and the consolidation of stock means that in theory there should be both a one-off reduction in inventory levels, and the elimination of all other stock holding points. The centralised control of stock should then allow for lower overall stocks to be held on a recurring basis at lower costs, whilst still satisfying the same level of customer demand. However, it is important to note that the process was largely mis-managed in the English NHS and the huge number of stockholding points in hospitals were not eliminated as RDCs came on stream. The net effect was that the RDCs were "filled" up with new stock yet the existing stock had not been eliminated. This factor, together with high start up costs and significant running costs, meant the predicted return on investment for RDCs was not realised. The result was that the costs of these establishments exceeded the benefits available to customers. Indeed, the English Health Service's decision to create RDCs has dictated future

[3] Large in this instance being defined as a minimum of 100,000 sq.ft.

storage and distribution policy and become a millstone around the newly formed NHS Supplies Authority's neck. It is significant to note that NHS inventory policy was to increase stock held and create larger storage facilities when, at the same time, the policy in other industries was most definitely toward cutting back on inventory and stockholding. In 1993 the NHS Supplies Authority in England, which had adopted six divisional structures based on geographic areas began to consider the future viability of the RDCs, eg. the newly created Central Division of the Supplies Authority covering both the old Trent and West Midlands Regional Supplies areas had two RDCs, one in Alfreton Park and one in Kings Norton, Birmingham.

Establishment of National Procurement Directorate - 1986

In 1986 the Supply Council was replaced by the National Procurement Directorate (NPD) following a further PAC report which stressed the need for greater co-ordination in purchasing and the rationalisation of storage arrangements, even though at the time the RDCs were being established in some Regions. The NPD was again to lack the executive management control necessary to implement the policies it devised. Although the policies were drawn up with Regional Supplies Managers, there was no line management to Regional Supplies Managers from the NPD, therefore implementation was not performed in a consistent fashion.

In November 1986 the NPD produced at "15 point plan" for development of the purchasing and supply function in the NHS which was implemented in part by only some of the regions (see Appendix 1 for details).

One of the "15 points" called for the development of a long term national warehouse, distribution and logistics strategy for all supplies and as a result a National Warehousing and Distribution Group was convened. One of the Group's initial decisions was to appoint Binder Hamlyn Management Consultants to join them to promote strategic thinking in the review process.

Binder Hamlyn Report - 1987

The Binder Hamlyn Group's first input was to convince the Group that the original terms of reference needed to be widened to include the total flow of materials from the point of origin to the point of use. This made the remit innovative in that it was one of developing a strategy for Supply Chain Management in the NHS and can be argued as being the first such review of NHS Supplies Services.

Binder Hamlyn listed the main elements of logistics as being service to users, procurement, inventories, storage/distribution and management. The reference to "users" was the first indication in such a high profile national report of the need to treat user departments as customers.

The two principal themes that emerged from the review are discussed below:

> ***"There should be a National Supplies function regionally managed to provide agreed services at the lowest cost."*** Binder Hamlyn Report (1987:2)

This recommendation did not concur with the Hunt and Salmon's call for a Corporate National Structure to oversee Supplies, but left the management at regional level. This

may have been the Group's considered view, but a view which may have been tainted by the fact that five of the fourteen Regional Supplies Managers were members of the seven strong working group.

> ***"The critical factor is the recognition of the fundamental importance of the end user as the force which should influence the structure of the logistics chain."***
> Binder Hamlyn Report (1987:2).

This implied a need for the adoption of a customer culture, placing the customer at the centre of all planning. The Binder Hamlyn Report recommended that the supplies function should manage the total flow of materials concentrating on procurement negotiations and improved delivery to users resulting in the interpretation/co-ordination of procurement and physical distribution functions. The report recognised that the supply pipeline should be shortened to cut costs and reduce management problems. Also it was recognised that traditional supplies functions such as inventory holding, transport, materials handling and warehousing should be minimised and maximum reliance placed on proven suppliers, and third party distributors.

The emphasis of these recommendations was towards a more cost conscious, customer orientated supplies service that focuses both on relationships with internal customers and suppliers. The report can be said to have shown considerable foresight in addressing the issues and recognising the need to control the total flow of materials. It is, however, ironic that at the very time RDCs were being established, demanding considerable management time and effort, the report recommended that input to such functions should be limited. This could be cited as an example where agreed policy at a

national level was diluted at regional level due to the fact that there was no line managed structure in existence.

The Binder Hamlyn Report also suggested how the NHS Supplies Service should develop in the future. The main points in this section, summarised in Table 3.3, reflect the conceptions and key issues identified above:

Table 3.3

Summary of Binder Hamlyn's Future Vision of NHS Supplies Service

- move toward a national co-ordination of the supply chain;
- team work with clinical professional staff;
- partnerships with suppliers;
- full use of information technology;
- minimal inventory levels.

It is curious that the main report's recommendations did not state that a national structure was the best way forward and yet the section which offered the future vision did. It may be that in this instance, the internal politics of the NHS, which have to be recognised as a recurring factor, had inhibited clear management decisions. It is also notable that there was an acceptance of the need to cultivate effective internal relations with particular reference to clinical staff. As discussed in the previous chapter, there cannot be partnerships developed with suppliers unless the NHS buyer has a mandate from key customers such as the medical staff.

The call for partnerships with supplies in the future is also important. The accepted attitude of NHS buyers has been an adversarial approach and such an immense cultural change, if accepted as the way forward, would take time to be introduced.

Inventory control is also identified as a key issue. Centralisation suggests that in order to control inventory, all stocks should be "bought in" and can then be controlled from the centre. There are obvious benefits in this general philosophy, but the creation of RDCs appears only to have added to stocks housed in one facility and has not addressed the costs associated with the flow from origin to point of consumption.

Supply Chain Management had hitherto not been regarded at a strategic level in the NHS and there had been little call from within the organisation for this status to be afforded to the management of the flow of materials. The Binder Hamlyn Report at least identified the need for top management to recognise and support the concept. A significant change in culture was also identified in order that customers' needs were placed at the forefront and that partnerships with key suppliers were created. In storage and distribution the report called for suppliers to hold more stocks for the NHS and, where distribution was required, to evaluate the cost and benefits of employing third party distributors.

The Binder Hamlyn Report clearly identified the issues, took an awareness of the environment and recommended a logical course of action. However, implementation of the plan was once again the stumbling block. The requirement for resources to be made available but the inability or unwillingness of either the Regional Health Authorities or the Department of Health to provide additional resources was a major inhibitor of progress. Nevertheless the Binder Hamlyn Report was provocative and pointed the way forward even though there was only marginal implementation of its recommendations.

MMM Consultancy Group Report - 1988

The 1988 MMM Consultancy Group Report on the NHS Procurement and Distribution Strategies recommended that the procurement function should be considered a separate "stand alone" service reporting directly to the NHS Management Board. The recommendation from the MMM Report to concentrate UK level contracting for high value and high volume goods, such as medical consumables and food stuffs in the hands of fewer buyers was further evidence of recognising the need for tighter control in the procurement component of the supply chain. This was the first ever acknowledgement of the benefit to be derived from prioritising purchasing work. The report also acknowledged the need for local Supplies operations to be responsible and adopt a customer service approach.

Evans Report - 1990

In 1990 Eric Evans, a Management Consultant was commissioned by the NHS Procurement Directorate to review national procurement. The final report emphasised the growing acceptance of both costs and customers. Evans' main recommendations called for a national strategic focus which would be best achieved through a "tighter" national structure concentrating on purchasing of Pareto[4] 'A' class items and the creation of a Procurement Agency to negotiate a contract for these items[5], later to be

[4] Pareto, an Italian economist became famous for introducing the 80-20 rule, an example being that 80% of a company's expenditure is concentrated with 20% of their suppliers.

[5] Evans listed the major spend areas which he believed would fall into the 'A' class as being:

- Major building and capital works
- Electro medical equipment
- Drugs
- Medical and Surgical items
- Energy and utilities
- Information Technology
- Food, drinks and catering equipment
- Medical gases
- Rehabilitation products

established as National Procurement Unit of the NHS Supplies Authority.

National Audit Office and Audit Commission Reports - 1991

The National Audit Office (NAO) and Audit Commission (AC) reports, both published in 1991, reviewed the NHS Supplies Services in England and reasserted the need for centralised control. The difference with these reports to those previously produced was that they were published at a time when the wider NHS environment was undergoing considerable change. The NHS internal market in England was beginning to separate purchasers and providers of healthcare highlighting the importance of costs and customers. Accordingly, the NHS as a whole was more likely to act upon, and implement the recommendations contained in the NAO and AC reports as it now fitted with the changes taking place in the wider organisation. On 1 October 1991 the NHS Supplies Authority in England was created as a single line managed organisation to control the provision of supplies to the English Health Service.

It is interesting to reflect that the NAO and AC reports largely repeated the key themes that had emerged in previous reports, which are the need for the Supplies Service to be accepted as a strategic issue, greater central control of purchasing and more focus upon customers. Implementation of the recommendations prior to NAO and AC reports had varied across English regions with consistent application throughout the NHS. This may link back to the fact that the environment did not recognise either the need to contain costs or satisfy customers.

When the Griffiths Report in 1983 introduced costs and customers as topics to NHS management it generated interest in SCM issues. Expenditure in 1991 of £4 billion on

goods and services in the English Health Service, £350 million in Scotland and £150 million in Wales began to receive the level of management attention and recognition that it deserved. The subsequent changes in the marketplace with the creation of competition between health provider units further heightened the potential role for Supplies Services.

Nevertheless, the initial effects of the 1989 Government White Paper "Working for Patients" and the subsequent 1990 Act were not positive for Supplies Services. All previous reports specific to the Supply Chain had demanded greater central control but the White Paper declared that an internal competitive marketplace within the boundaries of the NHS would be created for health care in the United Kingdom. The effects of this on Supplies Services were overlooked as the main focus of the White Paper was directed at the resources used to manage patient care and was paving the way for changes to how health care funding in general would be organised as opposed to concentrating specifically on Supplies Services. It is ironic that the immediate effect of the 1990 Act was to destabilise Supplies Services in the NHS and create competition amongst the Supplies organisations, yet ultimately the 1990 Act can be credited with creating an environment that has allowed the recommendations of the NAO and AC reports to be adopted.

Scottish Perspective

While the Hunt Committee was still active in England during 1965, it was decided that a joint working party of the Scottish Home and Health Department (SHHD) and hospital authority representatives should undertake a review of the supplies organisation in Scotland.

The Working Party produced the **Robertson Report of 1969** which was the first report specific to the supplies function in the NHS in Scotland. The main theme of the report was to call for the establishment of a "strong central authority for supplies in Scotland".

At that time the imminence of the re-organisation of the Scottish Health Service necessitated the postponement of a decision on the location of such an authority, and hospital service representatives accepted, in 1970, a strengthening of existing organisations and the establishment of a Hospital Supplies Steering Committee, whose remit was to keep under review general supplies policy in the hospital service, having regard to Government purchasing policy and plans for the future organisation of the NHS, and to make recommendations to the Secretary of State for Scotland.

The early 1970s saw the reorganisation of the NHS in England and Wales, in Northern Ireland and in Scotland. In England and Wales the Regional Hospital Boards were superseded by Regional Health Authorities, the Hospital Management Committees were abolished, and there were set up, under the Regional Health Authorities, Area Health Authorities and, under them, Health Districts. In Scotland, both the Regional Hospital Boards and the Boards of Management were abolished and in their place, there were set up 15 Health Boards and a Common Services Agency (CSA).

In 1972 the SHHD published a "discussion paper" setting out proposals for the administration of the Supplies function by the CSA and Health Boards. The subsequent SHHD circular clearly stated that an essential aim was to establish, within the CSA, a Supplies Division capable of being the effective central service agency for the Supplies function in Scotland. The circular also suggested that the Health Boards together with

the SHHD and the CSA should review these arrangements in order to determine whether further changes might be appropriate in the longer term.

In 1975 a small working party was set up by the Secretary of State for Social Services which subsequently produced the **Collier Report (1975)**. The remit of the group was to "review existing policy for NHS procurement and to make recommendation as to the most cost effective policy and its implementation, bearing in mind the need to strengthen the home market as a basis for export". This report focused on the need to adopt better procurement policies, particularly in the field of medical equipment. Although the report concentrated upon England it was also relevant to the Scottish Supplies and procurement practices.

Another significant report was produced by an ad hoc **CSA Supplies Division Working Group in 1978**. The remit of the group was "to consider the current levels at which contracts or other purchasing arrangements are made in the Scottish Health Service and to recommend any changes in these levels which it is considered could lead to greater efficiency of procurement in the service". The report focused its recommendations on specific contractual details of foodstuff and general supplies.

In **1980 the Scottish Office Audit Unit** reviewed several Scottish Health Boards and commented on their purchasing and supply arrangements. The main findings called for:

i) greater financial monitoring and control of local purchasing to ensure the most economical was adopted,

ii) a greater flow of information between Health Boards and the CSA

Supplies Division, particularly when estimating levels of required goods for contracts,

iii) increased central purchasing.

This report was focused by a circular from the SHHD to Health Boards in August 1980 suggesting that a review of local supplies and purchasing be undertaken.

Up to this point it is clear that the historical development in Scotland mirrors that of England. There had been a series of reviews which had, all to a lesser or greater extent, called for greater central control but unfortunately little follow up action and implementation had occurred.

The Ironside Report (1984) was a significant milestone in the process of reviewing the Supplies Services in the Scottish Health Service. The report recommended that each of the fifteen Health Boards in Scotland should appoint professional Supplies Managers to co-ordinate services at Board level. The appointment of a Supplies Director in 1985 to lead the Common Services Agency's role of establishing Scottish-wide contracts for commonly used items was an attempt to maximise the £350 million spend of the Scottish Health Service. The relationship in managerial terms of the Supplies Director to the fifteen Supplies Managers at Board level was only advisory as the local organisations were autonomous and free from central control. This resulted in Health Board Supplies Services developing at different rates in key areas such as warehousing, use of information technology, customer service and purchasing.

In the mid 1980s, the Supplies Service in Scotland did not establish large warehouses

similar to the English RDCs. The size of warehouses was dictated as much as anything by the fact that each Health Board had its own supplies service. In fact, the idea of establishing three large warehouses to serve the West, East and North of Scotland had been discussed, but it was felt this would have required similar organisational structures to have been established which was unlikely to be supported by Scottish Health Board General Managers.

The Scottish Health Management Efficiency Group (SCOTMEG) Action Plan on Supplies Strategy in Scotland (1989) attempted to standardise policies in key areas. The specific recommendations related to purchasing, information systems, staff training and warehouse management. The purchasing initiative was toward securing adequate control at both local and national level whilst at unit level, the need to substantially reduce the number of people empowered to place orders against suppliers was identified. At national level, a move towards establishing contracts which committed the Health Service to buy certain quantities of products was recommended to enable more effective negotiation by the CSA Supplies Division Contracts Branch. Although there were three monitoring reports requested by SCOTMEG over a two year period, an uneven development of Supplies Services continued to persist.

The Scottish Health Service Management Executive letter of 16 April 1992 instructed Health Boards that with immediate effect Scottish-wide and UK-wide purchasing contracts were to be considered compulsory rather than optional. This was a means of further maximising purchasing power and simultaneously challenging the previously dominant position of the medical staff in determining which products should be purchased. The issuing of this directive alleviated the pressure on the Scottish Office to

follow the English lead in creating a single line managed organisation for Supplies in Scotland. However, the debate in the Scottish Health Service continued to focus on whether a national structure should be established or if alternative management arrangements should be adopted to achieve the best balance of costs and customers.

The Scottish NHS Supplies Service structure prior to 1 April 1992 is shown in figure 3.1.

Figure 3.1

Scottish NHS Supplies Service Structure (as at 31 March 1992)
Prior to real effects of NHS Internal Market

NHS Management Executive - Scottish Office
|
Scottish Health Service
Common Services Agency - Supplies Division
|

SS Dumfr & Gall	SS Lanark	SS Western Isles	SS Lothian	SS Greater Glasgow	SS Forth Valley	SS Fife	SS Ayr & Arran	SS Borders	SS Tayside	SS Orkney	SS Shetland	SS Grampian	SS Argyll & Clyde	SS Highla

Notes: Health Board Supplies Services with professional responsibility to supplies director at the CSA - CSA offered guidance for overall policy and strategy in purchasing, warehousing and distribution. CSA Negotiating Contracts for common usage items that Health Board Supplies Service had option to participate in or not: CSA funded directly by Scottish Office.

Key: SS - Supplies Service

There were fifteen independent Scottish Health Board Supplies Departments with only a professional reporting line to the Common Services Agency Supplies Division. There was no line accountability to the centre and only monthly meetings between Supplies Managers at Board level and the CSA Supplies Director to discuss, and hopefully agree, common policies in purchasing, warehousing and distribution. The CSA negotiated Scottish wide contracts for common usage items, such as medical and surgical sundries, that the Health Boards could decide to buy from or could decide to negotiation their own "local" contract.

Inevitably this structure produced a degree of duplication of effort in purchasing and resulted in different prices being charged by companies for the supply of the same

goods to different parts of Scotland. The purchasing power of the Scottish NHS was diluted, particularly the effect of the CSA in negotiating contracts on a national scale simply because they were unable to commit the NHS in Scotland of purchasing up to a certain volume. There was also an uncoordinated and inconsistent approach to warehousing and distribution policies adopted throughout Scotland.

The more positive aspects of the structure centre around the responsiveness of there being local services which were able to adapt to the ever changing customer requirements. However, on balance, these positive aspects were probably outweighed by the fragmentation of services, particularly in respect of the dilution of purchasing power. In any case, the concepts of customer service and responsiveness were only just starting to emerge in the wider environment of the Scottish NHS, let alone in the Supplies Service itself. In May 1995, the structure of the Scottish Supplies Service shown in Figure 3.2,

Figure 3.2

Scottish NHS Supplies Service Structure (as at May 1995)
Post Effect of Internal Market

NHS Management Executive - Scottish Office
|
Scottish Health Service
Common Services Agency - Scottish Healthcare Supplies

Forth Valley SS	Trust Led SS in Lanarkshire		Fife SS	Tayside SS	Trust Led SS in Lothian	Trust Led SS in Greater Glasgow	Argyll & Clyde SS
Trust Led SS in Ayrshire & Arran	Grampian SS	Trust Led SS in Highland	Borders SS	Dumfries & Galloway SS	SS Western isles	SS Orkney	SS Shetland

Notes: (i) Individual Trust Hospitals have established their own Supplies Services
(ii) Relationship between Scottish Healthcare Supplies and other SS is on either a Service Level Agreement or contractual basis with the Scientific and Equipping branch, totally fee earning.
(iii) 1 April 1992 - mandatory use of central Common Services Agency contracts imposed by Scottish Office to ensure collective purchasing power not fragmented by creation of internal markets.

Key: SS = Supplies Service

presents a somewhat different picture. It is immediately noticeable that the number of Supplies Managers and Supplies Departments has increased. There are Supplies Departments at Trust Hospital level with the Board wide Supplies Departments.

Individual Trust Hospitals in Scotland have begun to want to control more of the operational tasks that had previously been managed on a regional basis. In Greater Glasgow Health Board, for example, there had been a central Supplies Department, negotiating contracts, linking with the CSA Supplies Division and setting the policy for the supply of goods into Glasgow hospitals. As Trust hospitals have become established in Glasgow, so the Trusts' management have decided to control the supply chain themselves. This scenario has largely been replicated throughout the other regions within the Scottish NHS.

These structural changes may have resulted in further fragmentation of Scottish NHS purchasing power, had the Scottish Office not issued an instruction that central contracts be mandatory. Furthermore, the CSA Supplies Division were given rolling targets to increase the value and volume of expenditure to be covered by the use of central contracts. This measure was designed to ensure that the possible further fragmentation of the purchasing power was not only stopped, but reversed. The CSA Supplies Division was, for the first time, negotiating with companies from a position of some power, being able to commit the Scottish Health Service to certain levels of volume uptake. Obviously this was not wholly welcomed throughout the NHS in Scotland, particularly by Trust Chief Executives. Trusts were, on the one hand, being given an unprecedented level of autonomy from central control with their relationship changing from parental to contractual in respect of Health Boards. However, on the other hand, there was the imposition of a central instruction that limited the type of

products that the Trust could purchase. It is again ironic that the Trust's powers of independence in the internal market which, with some justification, it seems, can be regarded as a managed and false market, were increasing whilst at the same time the Trust's impact in real commercial markets was being restricted and managed for them.

3.2 Case Study Profile - Scottish Healthcare Supplies

Scottish Healthcare Supplies (SHS) is the major purchaser of goods and services on behalf of the Scottish Health Service. This section is intended to give an outline of the purpose and scale of the SHS organisation.

The SHS came into existence on 1 April 1995, having previously been the Supplies Division of the Scottish Health Service Common Services Agency. SHS is comprised of four discrete branches - contracting services, capital equipping services, information support services group (PSSG) and General Practitioner Information System Services (GPASS). The contracting services branch is the focus of the case study as it negotiates contracts on behalf of the NHS in Scotland. In 1995/96 the value of contracts amounted to £195.76 million per annum, as shown in Table 3.4

Table 3.4

Value of Contracts Negotiated by SHS Contracting Services in 1994/95 broken down by generic commodity grouping

Commodity Group	£ million
Food & Drink	28.02
Textiles & General Supplies	19.03
Works & Energy	29.22
Office Equipment, Consumables and Transport	26.69
Medical Related Consumables	29.78
Pharmaceutical Products	30.67
Surgical Products and Allied Materials	12.45
Services for the Disabled	23.40
TOTAL	195.76

In 1995/96 the contracting services branch of the organisation had an annual operating budget of some £1.2m, resulting in an 'on cost' of 0.6%. In May 1995 there were a total of 300 contracts in place covering 70,000 specific items with 600 suppliers on file. As previously highlighted, the central control of purchasing in the NHS in Scotland began in April 1992, at a time when the Trust hospitals were being encouraged to take up greater autonomy to manage their own organisation and 'break' free from various central constraints. However, in the three year period that has followed, a substantial amount of expenditure has been added to the SHS portfolio of contracts. Annually rising targets were set by the Scottish Office so that 50% of all Supplies expenditure was covered by contractual agreement by April 1996.

This obviously means that the local Supplies Services do not have a substantial role to play in negotiating major contracts with suppliers as this task is performed by the SHS contracting services branch which is the main reason why SHS has been chosen as a case study.[6] The purchasing philosophy of the SHS is therefore crucial in determining whether or not the NHS in Scotland is embracing the tenets of partnership purchasing with its supplier base. The length of contracts, quality assurance measures, availability and delivery requirements, as well as links to the huge and varied customer base are all areas that will be discussed in subsequent chapters. Suffice to say that the SHS contracting branch is of significant importance in shaping the types of relationship the NHS in Scotland is perceived to have and actually has with its supplier base.

In January 1995, SCOTMEG issued a Supplies Monitoring Report to determine the value of contracts held by the CSA Supplies Division to undertake a "shopping basket"

[6] See Chapter 4, Section 4.3.3 for discussion of SHS case study

price comparison against other NHS buyers and to undertake a customer satisfaction study. The main findings of the report are summarised in Table 3.5:

Table 3.5

Main Findings of SCOTMEG Supplies Monitoring Report 1995

- 45% of total expenditure was the level of the contracts held and the report recommended that the original target of 50% of total expenditure be achieved by 1 April 1996;
- In respect of "shopping basket" comparison, the report concluded overall the prices to be 2.4% less than any other comparable NHS purchasing organisation;
- The customer satisfaction survey was possibly the most negative aspect of the report concluding that there was evidence of communication breakdown between the central contracting organisation and its end customers, ie. those actually using the products. The communication process was in need of improvement particularly in respect of information to customers regarding the range of products available on central contract;

3.3 Case Study Profile - Fife Healthcare Supplies Service

With effect from 1 April 1993, the region of Fife comprised three NHS Trust Hospital groups: Kirkcaldy Acute Hospitals, Queen Margaret Hospital and Fife Healthcare, all of whom provide healthcare for Fife residents against contractual agreements with Fife Health Board. Fife's resident population of 350,000 is served by sixteen hospitals, see figure 3.3. The hospitals have two main forms of supply pipelines, are managed by Fife Healthcare Supplies Service who provide, at a cost, services to all three Trusts, whilst each Trust manages its own pharmaceutical pipeline. [7]

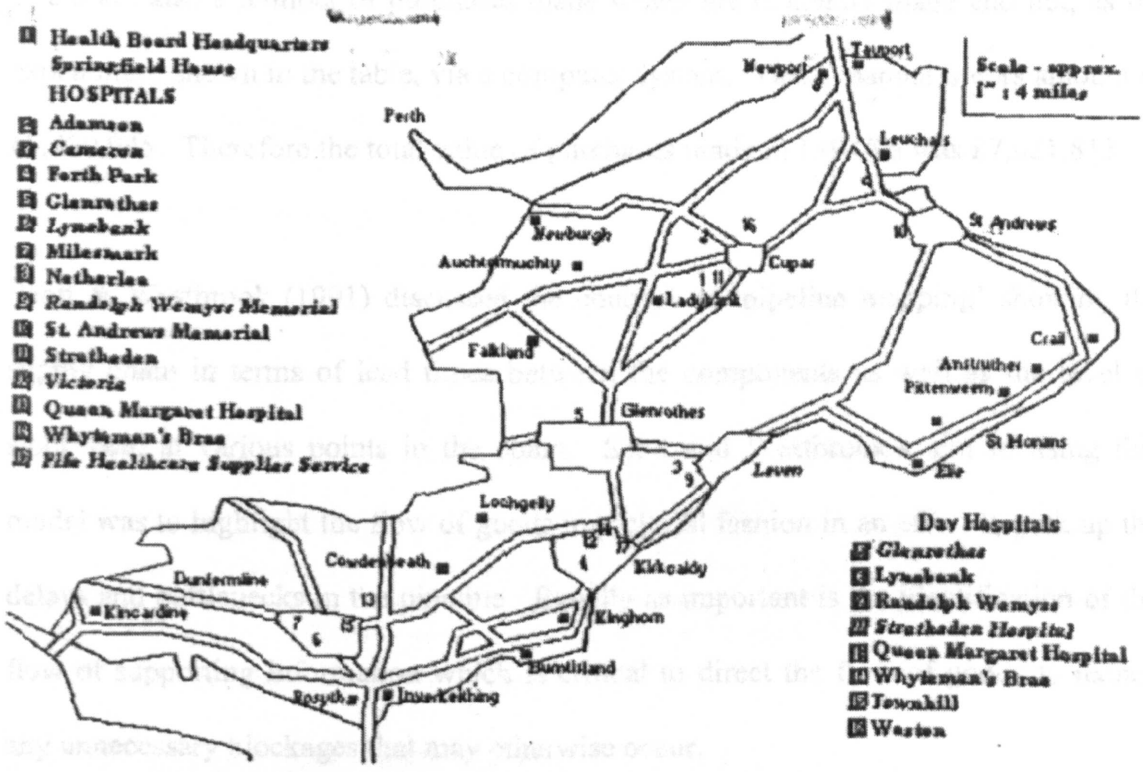
The basic introductory facts about Fife Healthcare Supplies Services (FHC SS) demonstrates that it is a fairly small scale operation. The warehouse is only approximately 1,000 sq. metres, whilst the organisation employs in total, 18 staff with a

total operating cost in 1994/95 of £356,000. Nevertheless, the performance monitoring information produced by FHC SS demonstrates a high level of proficiency and service to its customer base.

Table 3.6 below shows the range of commodities supplied to customers as well as the value of annual expenditure on items purchased as items for stock replenishment which are held in the warehouse, as well as items purchased as non-stock, which are delivered to customers and not held in the warehouse.

Figure 3.3

Map showing Fife Hospitals in relation to Fife Healthcare Supplies Service Warehouse



[7] See Page 166 for discussion of the Pharmaceutical Supply line

Table 3.6

Fife Healthcare Supplies Service
Annual Commodity Expenditure 1994/95

Commodity	Value of issues from the warehouse	Value of Goods purchased as "non-stock"
	£	£
Non Medicated Dressings	723,533	239,003
Medical & Surgical Sundries	881,865	810,983
Surgical Appliances	24,880	89,073
Paramedical Supplies	14,384	53,636
Uniforms	204,789	97,972
Bedding & Linen	87,635	20,052
Cleaning Materials	18,455	20,226
Domestic - Hardware/Crockery	482,988	24,192
Stationery	173,580	243,619
TOTAL	2,612,109	1,588,756

There are also a number of purchases made which are manually made and not, as the expenditure shown in the table, via a computer system. These manual orders amount to £3,420,945. Therefore the total value of purchases made in 1994/95 was £7,621,813.

Scott & Westbrook (1991) discussed the concept of 'pipeline mapping' showing the supply chain in terms of lead times between the components as well as the level of stock held at various points in the chain. Scott and Westbrook's aim in using this model was to highlight the flow of goods in pictorial fashion in an effort to pick up the delays and bottlenecks in the pipeline. Equally as important is the identification of the flow of supporting information which is critical to direct the flow of goods to reduce any unnecessary blockages that may otherwise occur.

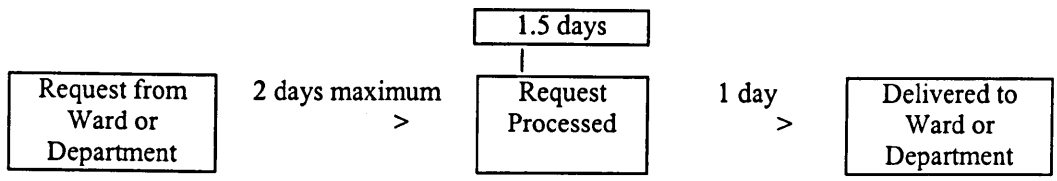
Scott and Westbrook's pipeline mapping model is a useful basis from which to consider the flow of goods and supporting information throughout NHS Supply chains. However, the pipeline model has had to be adapted to the NHS. Figure 3.4 shows two

Fife Healthcare Supplies Service pipelines with the first pipeline being for a medical and surgical consumable issue from the warehouse which has a maximum delay time of 4.5 days. The second is a pipeline for the same product range but relates to an item which is not stocked in the warehouse and shows a range between 9-54 days although the average is 12 days.

Figure 3.4

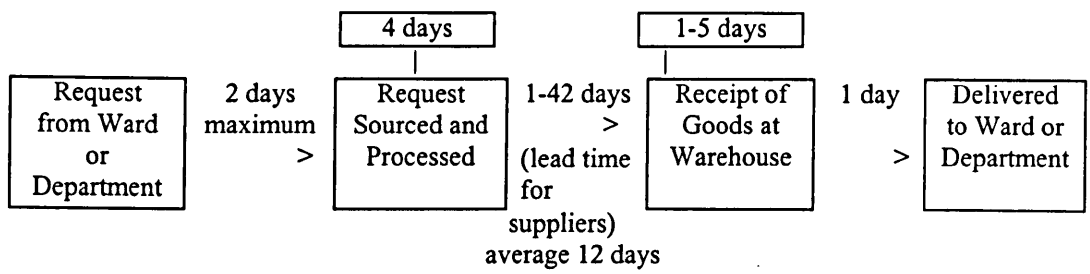
Mapping Fife Healthcare Supplies Pipelines for Medical and Surgical Consumables

1. **Items from the warehouse:**



Notes: Total Pipeline = 4.5 days; assumes no stock out of the product and that purchasing process to replenish stock is ongoing.

2. **Items not stocked in the warehouse:**



Notes: Total range of Pipeline between 9-54 days. Obviously there are items not stored in the warehouse where there are standing arrangements for goods to be delivered direct to wards from supplier on a same or next day delivery basis.

There are also some basic and interesting statistics that present a more detailed view of Fife Healthcare Supplies Service. The operating cost of £356,000 equates to 5.0% as a percentage of the overall value of expenditure which is a competitive on-cost figure and compares favourably to most other warehouse and distribution type organisations.

These costs can be further broken down to show that there is a 3.5% on cost for non stock purchases and a 7.3% on cost for the warehouse and distribution functions within the organisation.

There are some further statistics that place the operation in some perspective; 62.9% of the total expenditure of the goods held in the warehouse in 1994/95 were incurred on medical products. It is not unexpected that an organisation which is managing the supply chain to hospitals will have its main expenditure on medical products, nevertheless it is interesting to see this expenditure in the context of total expenditure.

The Supplies Service in Fife has 465 suppliers on file with 195 suppliers used for medical products. Of these suppliers the top 32 in value terms account for over 50% of the computerised purchasing (£2.2m of a total of £4.1m). Of these the top eight suppliers account for £800,000 of expenditure per year, with the top two suppliers both being medical and surgical wholesalers.

It is significant to note that Fife Healthcare Supplies Service has negotiated three year contracts with the two medical wholesalers, who are direct competitors to each other, in an attempt to establish long term partnership type relationships that will maximise the quality of products supplied, guarantee availability, and reduce the cost of the contract, whilst protecting themselves from potential problems should one of the two under perform. The vast majority of the remaining 'top' suppliers are supplying goods under contract to the Scottish Healthcare Supplies organisation which Fife simply buys from.

Another point worthy of note is that from the middle of 1992 the Supplies Service has been able to monitor both its costs and its performance against agreed customer targets.

This has established an ongoing dialogue to be established with customers that constantly reviews performance and refines the service. The type and range of measurements employed have, in the main, been agreed with customers and implemented by the Supplies Service, such as the service level from stock (meeting requests first time of asking) which achieved 95.5% throughout 1994/95 and the stock turn ratio, which was an average for all commodities 10 throughout 1994/95.

In 1995/96 FHC SS developed their package of performance indicators, in conjunction with their customer base, which is worth exploring in some detail. Table 3.7 shows the summary report of the store's performance produced for the management team of FHC SS. The trends are encouraging showing increasing service levels and stock turns.

Table 3.7

Fife Healthcare Supplies Service (in 1995/96)

Stores Performance

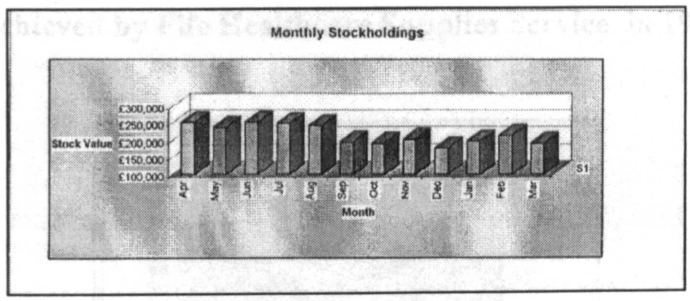
1995/96 Month	Stock Value £	Requests Received	Issues Made	Value of Issues £	Service Level %	Stock Turns
April	252,070	17,551	17,153	228,191	97.73	10.86
May	237,400	21,606	21,113	274,608	97.72	13.88
June	252,520	18,801	18,360	250,622	97.65	11.91
July	249,150	18,820	18,310	245,362	97.29	11.82
August	242,611	20,121	19,577	257,340	97.30	12.73
September	195,610	18,655	17,968	250,841	96.32	15.39
October	191,882	19,826	19,214	254,848	96.91	15.94
November	202,754	19,640	19,116	265,678	97.33	15.72
December	177,693	19,760	18,418	277,677	93.21	18.75
January	198,049	18,196	17,261	250,067	94.86	15.15
February	214,318	19,036	18,287	254,791	96.07	14.27
March	191,971	18,053	17,704	252,592	98.07	15.79
Averages	217,169	19,172	18,540	255,218	96.70	14.35

Source: Fife Healthcare Supplies Service Internal Performance Indicator Package (April 1996)

Figure 3.5 plots the value of stockholding on a monthly basis throughout 1995/96. Again the trend is clearly downward demonstrating that FHC SS had successfully managed to reduce the value of stock whilst simultaneously increasing service levels to customers.

Figure 3.5

Graph showing monthly stockholding in Fife Healthcare Supplies Service Warehouse in 1995/96

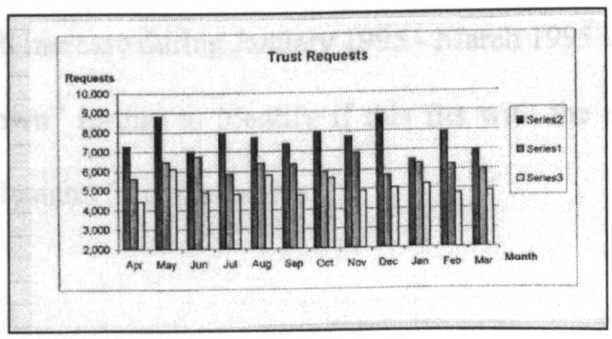


Source: Fife Healthcare Supplies Service Internal Performance Indicator Package (April 1996).

Figure 3.6 plots the requests for items in stock (held in the warehouse) from the three main Trust customers over the 1995/96 period. This is helpful in identifying periods and determining if these need to be planned for in the next financial year.

Figure 3.6

Trust requests for stock items from Fife Healthcare Supplies Service in 1995/96



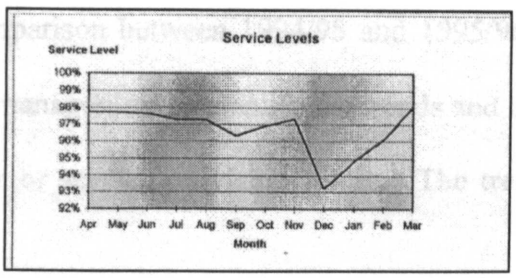
Source: Fife Healthcare Supplies Service Internal Performance Indicator

Package (April 1996)

Figure 3.7 plots the service levels achieved overall for items which are issued at the first time of asking from stock. This is helpful in presenting management with an immediate picture of monthly service level trends. The graph shows a significant fall in service in December 1995 and January 1996 which can be partly explained by the high requests for stock items in December (see Figure 3.6).

Figure 3.7

Service Levels Achieved by Fife Healthcare Supplies Service in 1995/96



Source: Fife Healthcare Supplies Service Internal Performance Indicator Package (April 1996)

Figure 3.8 shows a summary of the numbers and value of orders issued by FHC SS during 1994/5, broken down by stock and non stock orders. The bottom line shows the monthly average which can be used as a basis to compare the figures for each month. This shows an overall increase during January 1995 - March 1995 which will enable the manager to "drill down" further to identify if this fits with the need to buy more to reflect an increased demand from customers.

Table 3.8

Fife Healthcare Supplies Service Order Summary 1994/95

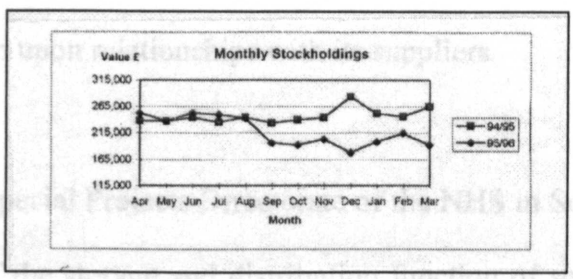
Month	Stk Orders	Stk Lines	Stk Value	Non Stk Orders	Non Stk Lines	Non Stk Value	Total Orders	Total Lines	Total Value
Apr-94	273	492	£209,396	956	2,980	£285,818	1,269	3,472	£495,214
May-94	289	518	£155,193	1,234	3,283	£287,983	1,523	3,801	£443,176
Jun-94	323	582	£398,461	1,195	3,109	£247,350	1,518	3,691	£645,811
Jul-94	262	467	£148,066	1,073	2,801	£298,754	1,335	3,268	£446,822
Aug-94	248	474	£166,326	1,288	3,312	£298,791	1,534	3,786	£465,117
Sep-94	272	508	£155,465	1,175	3,313	£264,346	1,447	3,821	£419,811
Oct-94	276	535	£177,798	1,251	3,376	£314,691	1,530	3,911	£492,489
Nov-94	292	508	£316,314	1,402	3,573	£377,410	1,694	4,082	£695,724
Dec-94	286	522	£224,407	971	2,688	£379,205	1,259	3,210	£603,612
Jan-95	285	503	£238,406	1,338	3,350	£588,303	1,623	3,853	£826,709
Feb-95	364	538	£178,922	1,749	4,542	£1,387,280	2,113	5,080	£1,566,212
Mar-95	363	482	£446,415	1,277	2,802	£771,381	1,640	3,284	£1,216,796
Totals	3,538	6,110	£2,816,181	14,947	39,129	£5,501,312	18,485	45,239	£8,317,493
Averages	295	509	234,682	1,246	3,261	458,443	1,540	3,770	693,124

Source: Fife Healthcare Supplies Service Internal Performance Indicator Package (April 1996)

The final two performance indicators to highlight are shown in Figures 3.8 and 3.9. Figure 3.8 shows a comparison between 1994/95 and 1995/96 monthly stockholding. This is again useful for management to identify the trends and determine if this is likely to affect any manpower or service provision issues. The trend shows a decrease in stockholding.

Figure 3.8

Comparison of monthly stockholding in 1994/95 to 1995/96

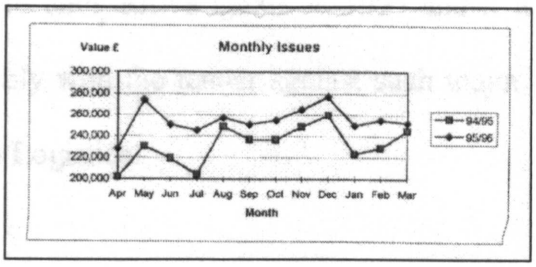


Source: Fife Healthcare Supplies Service Internal Performance Indicator Package (April 1996)

Figure 3.9 graphs the 1994/95 issues against those in 1995/96. This shows an increased level of issues, which could mean FHC SS have performed well in 1995/96 as there has been a reduction in the stock held, whilst using more stock. This is reinforced by the increased trend in service levels.

Figure 3.9

Comparison of Fife Healthcare Supplies Service monthly issues in 1994/95 to 1995/96



Source: Fife Healthcare Supplies Service Internal Performance Indicator Package (April 1996)

It is important to note that Fife Healthcare Supplies Service has changed considerably since 1992 which is largely attributable to the wider changes that have taken place in the NHS in Fife. The new internal market which impacted from 1993 onwards in Fife has created an environment receptive to the types of change the Supply Service was already attempting to implement. The contractual culture within the NHS introduced the concept of "customers" to the Supplies Service and the need to manage and reduce costs focused attention upon relationships with its suppliers.

In January 1995 the Special Projects Directorate of the NHS in Scotland issued a report following a review of the storage and distribution function of seven Scottish Supplies warehouses. The main recommendation contained in the report was that Trust based Supplies organisations offering warehousing and distribution services should be the subject of competitive tendering exercises as had been the case in England and Wales. Interestingly, and arguably, what would be a retrograde step, the report recommended that consideration should be given to closing small warehouses and establishing large warehouses to supply multi-regions in Scotland. This argument was justified on the

basis of bulk buying and the excellence achieved by private sector specialists. Indeed, the report suggested private sector companies may be used to manage such operations. The warehousing and distribution elements of the Fife Healthcare Supplies Service were therefore subject to competitive tender in 1995 and it is significant that the in-house service comfortably won the tender against such major specialist private sector companies such as Exel Logistics.

Fife Pharmacy Supplies Service

Pharmacy supplies is a major area of expenditure for any Health Board or Authority and Fife is no exception to this. The storage and distribution of pharmaceutical products in Fife is not managed by FHC SS and by means of completing this introductory profile, it is important to outline these services.

Fife Pharmacy Supplies Services are split into three distinct organisations operating within and serving the three Fife Trusts. The total value of purchases made in 1994/95 was £3,525,643. Of this, £317,009 was subsequently issued as dispensary issues and the balance as 'normal' pharmacy supplies to wards.

The pipeline mapping for the Pharmacy Service is somewhat different to the supplies service with a system in place that allows wards to deliver requests to the hospital pharmacy which, unlike the Supplies Service, is on the hospital sites. The wards deliver requests once or twice weekly to an agreed schedule which are processed and prepared for collection within 2-5 hours. This service is available from 8am - 5pm Monday to Friday, 8am - 12 noon Saturday, with an emergency 24 hour on call rota. So availability through quick response to customers is certainly a philosophy that has been

adopted by the Pharmacy Services.

The Fife Pharmacy Services do seem to have minimised the distance in the supply chain from the service provider to the ultimate customer. Towill (1992) suggested that the greater the fluctuation in demand due to time delays in communication and supply pipeline the the greater the distortion to planning results in increases in safety stock. If wards in hospitals are convinced that stocks are available within the Pharmacy then the wards themselves will not feel the need to hold stocks. For a true Just In Time (JIT) delivery system to apply, then the Pharmacy must itself balance their requirement of holding sufficient stock at any one time to meet demand whilst at the same time not over stocking. This also requires a fast delivery service from suppliers.

In respect of relations with suppliers, the Pharmacy Services throughout Fife use a total of 320 suppliers. It is estimated that 70% of all purchases are made from national or zonal contracts, zonal being the combined purchasing power of Lothian, Fife, Borders and Forth Valley Pharmacy Services. So the negotiation process with suppliers is not, in the main, handled by the local Pharmacy staff but via the SHS.

3.4 Conclusion to the Chapter

This chapter has described how the changes to the NHS as a whole have created an environment conducive to increasing the profile of Supplies Services. The creation of the internal market for healthcare has heightened the awareness of the need for both cost containment and customer satisfaction. The NHS reforms have promoted a culture in which the constantly recurring, yet previously unimplemented recommendations to the NHS supply chain have occurred. This chapter has also introduced the profile of two organisations selected as case studies, the Scottish Healthcare Supplies and Fife Healthcare Supplies Services.

The developing theme throughout section one of this thesis has been to demonstrate that the NHS as an organisation creates a unique set of circumstances within which the supply chain operates. The NHS is designed to promote healthy lifestyles and subsequently to provide healthcare for those who become ill. The organisation is a collection of many different disciplines, all with their own agenda which are sometimes conflicting. Nevertheless, all of these disciplines require goods and services in order to undertake their function. The Supplies Service has a complex customer base, with some customers having more influence than others in determining the product range to be purchased. The obvious example and one which has already been referred to is medical staff who are the most influential group of decision makers in terms of deciding a particular product to be purchased such as medical and surgical consumables. It is only recently, since the early 1990s, that NHS Supplies Services have started to challenge the medical viewpoint, no more so than in the NHS in Scotland through the introduction of mandatory contracts. This statement should be qualified by noting that up to April 1996 the contentious areas of choice involving strong clinical preferences

had not been addressed by Scottish Healthcare Supplies. Also there are doctors in Scottish hospitals who continue to ignore the central contracting edict and as yet it remains unclear as to the power the SHS possess in the policing of this edict and if punitive action will be taken against offenders.

Similarly, the wide range of products purchased and the diversity of industries from which products are obtained is a unique purchasing challenge. There is a large amount of expenditure undertaken by the NHS from a multiplicity of suppliers. The NHS buyer has firstly to co-ordinate disparate views of the customer base and then to adopt an appropriate strategy with suppliers to obtain the best value for money contract to satisfy the customer base. A spectrum of relationship strategies exist from which the NHS buyer has to choose. Purchasing partnerships , much discussed in the current literature, are but one strategy along the relationship spectrum. There appears to be varying degrees of application of partnerships in practice throughout different parts of the NHS. The factors that facilitate and inhibit the establishment and development of partnerships will be developed in subsequent chapters of this thesis. Suffice to say that the NHS presents a unique environment that has undergone considerable upheaval in a relatively short timescale.

A review of the SCM, buyer-supplier and customer care literature, is a helpful backcloth against which to consider the various models and frameworks that the NHS may fit into. However, particularly when considering the purchasing and customer service "ends" of the supply pipeline there does not appear to be a perfect fit into existing models and frameworks. There is a gap in the literature regarding purchasing and customer care in the NHS, which this research explores. This gap will be addressed

in the two subsequent sections of this thesis. Section Two concentrates on the research methodology and findings whilst Section Three develops a specific programme of measures for practical application in NHS purchasing and customer care. The next chapter reviews the research methodology adopted in this project.

SECTION TWO

RESEARCH METHODOLOGY AND FINDINGS

CHAPTER FOUR

RESEARCH METHODOLOGY

'We never stop investigating. We are never satisfied that we know enough to get by. Every question we answer leads onto another question. This has become the greatest survival trick of our species.'

Desmond Morris (b 1925)
British Anthropologist

4.0 Background

The overall aim of this research is two-fold, firstly to identify factors that can be used to shape and adapt the relationship strategy adopted by NHS buyers with their supplier base, and secondly to identify factors that affect the way in which NHS Supplies Managers can enhance the delivery of care to their customer base.

Following a review of the relevant literature, an action research approach was used whereby an initial exploratory survey was undertaken to identify common themes which were then further investigated by semi-structured interviews. A predominantly qualitative analysis of the data, taking account of the literature review, resulted in the construction of two specific relationship review tools. The review tools have subsequently been tested and evaluated in case studies, involving both NHS buyers and their suppliers as well as NHS Supplies Managers and their customers.

4.1 The Four Paradigms of Management Research

Since the 1970s there has been ongoing debate as to the nature and status of data in management research (see Burrell & Morgan 1979). The recurring questions that have emerged are:-

- What is knowledge?
- What are data?
- What is the status of the data collected in the field of management research?

These questions received a reviewed focus with the relatively recent development in the mid to late 1908s/early 1990s of postmodernism.[8] Indeed, one of the main themes of the 1996 Conference of the British Academy of Management was to review the debate on methodological research issues. There are now four acknowledged research approaches which can be applied to management, the key features of each are outlined in Table 4.1 below:

Table 4.1

Key Features of the Four Research Approaches

	NORMATIVE	INTERPRETIVE	CRITICAL	POSTMODERN
Basic goal	*demonstrate law like reactions among objects*	*display unified culture*	*unmask domination*	*reclaim conflict*
Method	*nomothetic science*	*Ethnography hermeneutics*	*cultural and ideological critique*	*deconstruction, genealogy*
Problems addressed	*inefficiency and disorder*	*meaningless and illegitimacy*	*domination and consent*	*conflict and suppression*
Organisational benefits	*control*	*Commitment*	*participation*	*diversity*
Risks of unreflexivity	*silencing managers for whom they speak*	*Engineering 'meaning' for others*	*offering 'emancipation'*	*focussing all attention of 'researcher'*

Source: Adapated from Hardy and Clegg (1996 : 9.23)

Normative

Normative research methodology is based around the maintenance of the existing social order whose goal it is to establish law like relations between objects based on nomothetic science. Normative research addresses issues of efficiency, order and

[8] See Page 177 in this chapter for further explanation of postmodernism.

control. Positivism, which can be regarded as part of the normative approach, suggests that the social world exists externally and that its properties should be measured through objective methods, rather than being inferred subjectively through sensation, reflection or intuition. The philosophical stance of positivism, which is derived from the work of Comte (1853) makes two assumptions, firstly that reality is external and objective, and secondly that knowledge is only of significance if it is based on observations of this external reality.

Jankowicz (1995 : 90-93) lists the characteristics of positivism as being:

- reliant upon the use of empirical science,
- applied in the form of theories which provide an underpinning to technology,
- when an assertion can be shown definitively to be true or false,
- where truth is recognised in two ways only;
  - i) by seeing that an assertion is consistent with deductions made from it, or,
  - ii) by recognising that it is supported by empirical evidence.

Schön (1983 : 57) reinforces the positivists view stating that;

> "..... the only alternatives are either sheer emotion, which is unreliable, or poetry, which is nice but not to be taken too seriously: anything else is non-sense".

However, the positivists assumption that management research is essentially similar to natural and physical sciences has been consistently challenged on three grounds;

- that there is no single method which generates scientific knowledge in all cases,
- that what may be an appropriate method for researching the natural or physical world may be inappropriate in the social world given the inherent meaningfulness of management action and its contextual nature,
- that knowledge generated is affected by the goals of managers and their validation criteria.

Interpretative

Interpretative approaches are those which,

> " ..... draw on ethnographies to display unified cultures and from an organisational persepective examine the role of commitment, group dynamics and quality of work life, with the prime literature example being Peters and Waterman's 1982 "In Search of Excellence".
> (Hardy and Clegg 1996 : 9.21).

A major criticism of this approach is that the researchers create the interpretation that they perceive fits with their subject rather than determining this objectively.

The interpretative approach encapsulates the phenomenological type of analysis, which emanates from Husserl's research (1946) and contends that social scientists do not view the world objectively as reality is socially constructed rather than objectively

determined. Phenomenologists believe that it is necessary not only to gather facts and measure how other certain patterns occur, but to appreciate the different constructions and meanings that people place upon their experiences.

Critical

The term critical theory can be used to describe the work undertaken predominantly by Alvesson & Wilmott (1992) which,

> "..seeks to unmask domination, critique ideology, and reform the social order"

Critical theorists assume that they are autonomous agents and able to judge what their research subjects' best interests are. However, in this way, critical theorists begin to tell subjects what to feel and how to act. The subject who does not act in this way is seen as being unaware of the cultural norms. The subject,

> ".. who does act must do so according to the strictures laid down by critical theory with scant regard for the costs of such emancipation".
> (Alvesson & Deetz : 1992 :72)

This approach has been criticised (Clifford 1992) for examining a single component of a group's existence and taking this to represent them as a whole, therefore ignoring the complexity and diversity of the whole.

Postmodern

It is appropriate to firstly describe modernism before briefly summarising postmodernism. Modernism is a term, in the organisational context, used to draw attention to the instrumentalisation of people and nature through the use of scientific

and technical knowledge. The results achieved are predictable, based on productivity and technical problem solving approaches which lead to a "good economic and social life".

However, postmodernists, who emerged in the mid-late 1980s/early 1990s see their work as being a response to specific social conditions (see Alvesson and Deetz 1992). Postmodernists argue that whilst contemporary society, as a result of science, industrialisation and communication has developed positive capacities it has also developed dangerous forms of domination. Postmodernists argue that technical or instrumental solutions will not provide lasting remedies and are concerned with "recovering the rational process" by a greater understanding of social, historical and political constructionism.

Postmodern or dialogic approaches as they are also known,

> "..challenge ideas concerning grand theory, the fixity of meaning and the essentialism of the subject .... postmodern approaches seek to claim a space for lost voices by deconstructing and reconstructing meaning, history, traditions and organisations often in ironic, ambivalent playful narrative".
>
> (Hardy and Clegg 1996 : 9.23)

Siedman (1994: 2) defines postmodernism as,

> ".. referring to broad social and cultural patterns or sensibilities that can be analytically distinguished for purposes of highlighting social trend. These themes seem especially visible in the realm of knowledge. Post

> modernism knowledge contests disciplinary boundaries, separation of science, literature and ideology and the division between knowledge and power".

In summary, post modernism is concerned with challenging not only the more traditional approaches to research but also the established ways of interpretation and meaning.

4.2 Action Research - The Fifth Paradigm?

Eden and Huxham (1996 : 527) define action research as being that which

> ".. involves the researcher in working with members of an organisation over a matter which is of genuine concern to them and in which there is an intent by the organisation members to take action based on the intervention."

This type of approach has become increasingly popular amongst researchers, particularly in the field of management research, as a paradigm used to justify the validity of adopting of a range of research outputs. It is also important to note that action research can be seen as being more affiliated with qualitative rather than quantative research, due to its historical evolution. Action research originates from the work undertaken at the Tavistock Institute focussing upon the coal mining industry which gradually led to an exposition of the relationship between investigatory research and its implications for action (Trist and Bamforth, 1951).

Easterby-Smith et al (1993 : 6) reinforce this view, stating that

> ".. management requires both thought and *action*. Not only do most managers feel that research should lead to practical consequences, they are also quite capable of taking action themselves in the light of research results. Thus, research methods either need to incorporate within them the potential for taking action, or need to take account of the practical consequences that will probably ensue". (Easterby Smith emphasis)

Eden and Huxham (1996 : 530-537) suggest that there are fifteen key characteristics of action research, seven of which are applicable to this research project[9] and are shown in Table 4.2 below:

Seven Characteristics of Action Research which are applicable to this research **Table 4.2**

- action research demands an integral involvement by the researcher in an intent to change the organisation. This intent may not succeed, no change may take place as result of the intervention and change may not be as intended.
- must also be possible to discuss the results to inform other contexts, at least to suggest other areas for consideration.
- as well as being applicable to everyday life, action research demands valuing theory with theory elaboration and development as an explicit concern of the research process.
- if tools or models are designed as a result there should also be some explanation related to the theories which informed the design.
- action research will be concerned with a system of emergent theory in which theory develops from a synthesis of that which emerges from the data.
- theory building, as a result of action research, will be incremental moving through a cycle of developing theory from action to reflection to developing theory, from the particular to general in small steps.
- action research requires that the theory development which is of general value is disseminated in such a way as to be of interest to an audience wider than those integrally involved with the action and/or with the research.

Source: Eden & Huxham (1996 : 530-537)

[9] See Section 4.5.4. For further explanation as to the application of action research to this particular project.

4.3 Secondary and Primary Research

It is important to understand the distinction between secondary and primary research both of which are used in this research project. Secondary research which involves reviewing existing data contained in books, published articles in journals and specific organisational literature is the usual method by which the researcher forms a broad picture of the issues and context of the particular research topic. Secondary research can also be said to be beneficial in helping the researcher focus more clearly on the aims and objectives of the project by identifying gaps within the existing literature, given the context of the project[10]

Primary research is the process of gathering original data from which hypotheses and/or thesis can be constructed and subsequently tested.

4.3.1 Methods of Gathering Primary Data

There are basically three methods that can be used to gather primary data which are;

- questionnaires;
- semi-structured interviews;
- case studies.

This research uses each of these at various stages of the project, therefore it is appropriate to outline the three and identify their limitations.

[10] The Secondary Research that has been undertaken for this project has been described in Chapter Two.

Questionnaires

Questionnaires are the main source of gathering large amounts of data which lend themselves to quantitative type analysis. The use of postal questionnaires is particularly popular as this is the most cost-effective method of obtaining substantial amounts of information. There are particular types of questions that can be used, such as those that seek facts as opposed to those that seek opinions. Another distinction in the type of question is between open and closed questions, where a closed question limits the number of responses possible. A type of closed question is where the respondent is asked to rank in order of importance or value a list of attributes or statements. One of the most common forms of this type of closed question is a Likert scale which has been extensively used in the postal questionnaires for this research (see Appendices 2, 5, 6 & 8). This type of question offers both advantages and disadvantages, as Easterby-Smith et al (1993:120) point out,

> "The strength of closed questions is that they are quick to complete and analyse; the weakness is that the data obtained may be very superficial".

This criticism is accepted and is a major reason why the use of questionnaires has been supplemented in this research by interviews and case studies to add a more qualitative approach.

There are, of course, other limitations associated with the use of questionnaires, three of which are summarised in Table 4.3.

Table 4.3

Summary of key limitations of using postal questionnaires

- No opportunity to probe beyond the given answer, to clarify an ambiguous one, to overcome unwillingness to answer a particular question or to appraise the validity or what a respondent said in the light of how it was said,
- As respondents see all the questions as they fill them in, the different answers cannot be treated as independent,
- Cannot be sure that the "right" person answers the questionnaire.

Source: Moser & Kalton (1993:260-261

Semi-Structured Interview

The use of personal interviews is the main medium of gathering qualitative data. Van Maanen defines qualitative methods of data collection as,

> "... an array of interpretative techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world". (1983:19)

Semi-structured or informal interviewing is, however, not easy. Moser and Kalton (1993:289-301) identify four aspects which the interviewer needs to be aware of and try to control, which are;

- interviewer skill;
- interviewer bias;
- consistency of 'depth' throughout interviews;
- difficulty in consistently coding and quantifying material.

Easterby-Smith et al (1993:77) add a further aspect which is the need for the interviewer and interviewee to establish some level of trust and respect to ensure an accurate and honest interview is given. This is not an easy task given that the semi-structured interview may only last a number of hours. Semi-structured interviews were used in this research project as will be discussed in Section 4.5.3 of this Chapter.

Case Studies

The third method to highlight by which primary data can be collected is case studies. Case studies are where the researcher focuses upon particular organisations in an attempt to gain a deeper understanding of the organisation in the context of the research project. Case studies will generate qualitative type data potentially 'rich' in content. However, case studies present their own particular problems, as summarised in Table 4.4.

Table 4.4

Summary of Problems presented by the use of case studies

- Findings are open to influence or biased views and/or different interpretations;
- Very lengthy and unreadable documents are produced;
- There is little basis for scientific generalisation.

Source: Yin (1987:20-22)

These criticisms of case studies are well made and recognised by this research project. In terms of Yin's first criticism, the case studies were not the only method used to gather data and were supplemented by both questionnaires and semi-structured interviews. Also the case studies were used to test the application of the review tools

that were devised as a result of the primary research. The second criticism can be a real problem so the thesis document has been distilled from the large number of notes and manuscripts produced by the researcher as a result of the case studies.

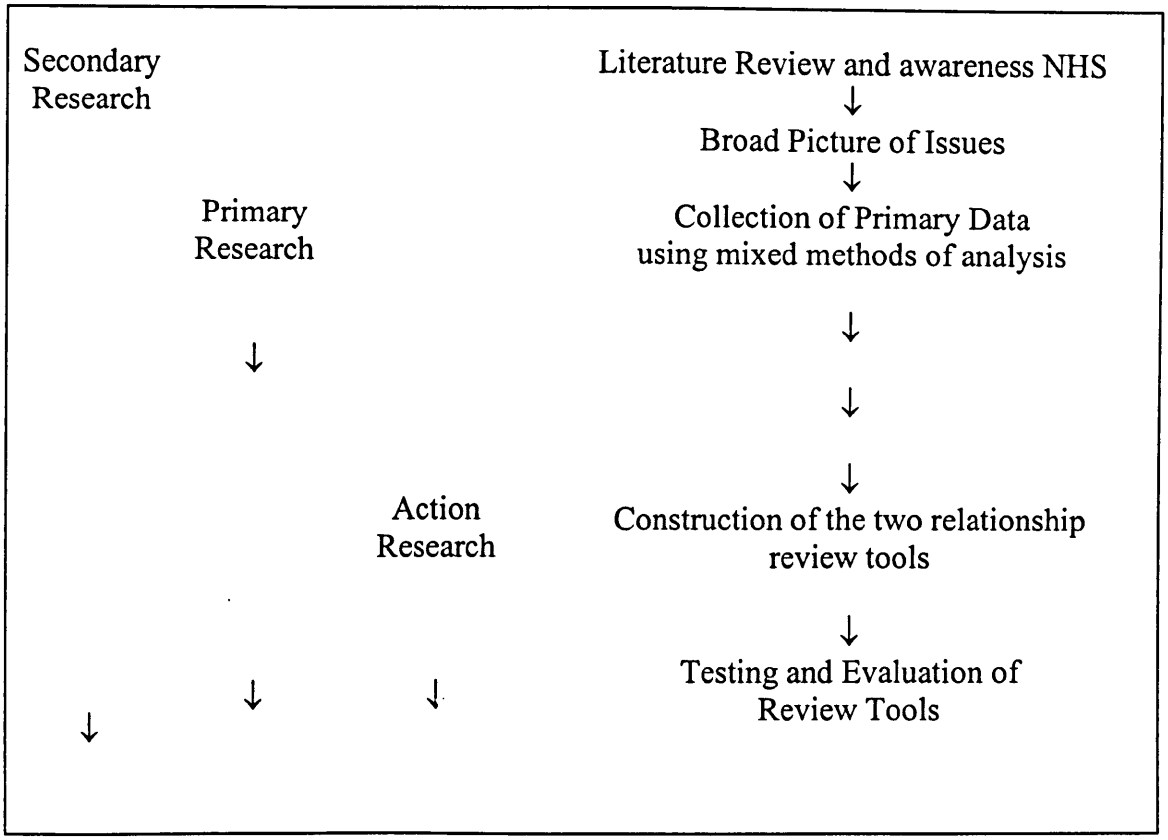
4.4 Outline of Research Project

4.4.1 Overview of Research Project

An overview of the research project is shown in Figure 4.1.

Figure 4.1

Overview of Research Project



This illustrates that the first stage of the project was to perform a review of the relevant literature, as has been performed and described in Chapter 2. This was supplemented in Chapter 3 by an historical review of the NHS Supplies Service which demonstrates that the unique nature of the NHS, the management of the supply chain and the

environment within which it operates are shaped by both Government decisions and subsequent legislation. The researcher was also able to "call on" eight years experience of being an NHS Supplies Manager in both England and Scotland to construct a broad picture in which areas/issues on which to build the research project were identified.

The initial primary data was collected via exploratory surveys (see Kraut 1996) which was analysed using both quantative and qualitative methods. The postal questionnaires were analysed in a quantative way so that issues which required further investigation could be "teased out". The semi-structured interviews were used to gather 'richer' data which could be reviewed in a more qualitative way. Cresswell (1994) states that there are five arguments to support the combination of quantative and qualitative methods which are as follows:

- Triangulation to seek convergence in results and eliminate bias in particular data sources, investigators and methods.
- Complementality to reveal the overlapping and different facets of social phenomena.
- Developmentally, where the first method is used sequentially to inform the second method.
- Initiation, where contradictions and fresh perspectives may emerge.
- Expansion, where mixed methods add scope and breadth to a study.

Kane (1985 : 51) observes that it is possible and perhaps preferable for research projects to include elements of both, commenting;

> ".. if you had to stake your life on which of these methods is likely to represent the most accurate, complete research information, you would

> choose the centre (the overlap) in which you get the information through interviews and questionnaires, reinforced by observation and checked through documentary analysis ... here you are getting not only what people say they do and what you see them doing but also what they are recorded as doing."

The next stage in the research process was to examine the data in the context of the existing literature to construct two specific relationship review tools, testing and evaluating them in real case studies. The case study organisations were willing to participate and prepared to consider change as a result of using the relationship review tools in an action research approach.

Action research requires not only the need to explain 'what' is happening, but also to address 'why' it is happening. (Phillips and Pugh 1987). As management decisions impact on the whole organisation, research that is concerned with shaping action needs to examine situations from a cross-disciplinary approach. Easterby-Smith et al (1993:5) suggest that,

> ".. the practice of management is largely eclectic: managers need to be able to work across technical, cultural and functional boundaries ..".

This research considers Supplies Services' management of relationships with suppliers, as well as the delivery of care to customers within the context of the NHS as a whole, rather than treating the Supplies Services as an isolated function.

It should also be noted that the original research proposal was to compare the implementation of SCM principles in the UK health sector to that of the United States (US), identifying factors which inhibited or facilitated effective implementation. After a short period of reviewing the literature and following a two week study visit to the US, it became clear that the research was overly ambitious. Indeed, it was soon realised that even a comparative analysis of England and Scotland was unrealistic due to the unresponsive nature of English participants. Primary due to the researcher's own work experiences, the next level of focus concentrated upon comparisons between the supplies services in England and Scotland. In order to obtain sufficient detail of the process behind the relationships research exclusively on Scotland which has a unique supplies service.

4.4.2 Initial Primary Data Collection - Postal Questionnaires

The questionnaires were targeted at three groups; NHS Supplies Managers, Trust Hospital Chief Executives as the predominant customer base of Supplies Services and the Executives of companies of key suppliers of goods to the NHS.

NHS Supplies Managers

It was intended that a questionnaire covering a broad range of issues, including purchasing and customer care issues, would be issued to the total population of NHS Supplies Managers in the UK, a census of 275 (as at September 1993). The differences in organisational structure and titles of Supplies Managers dictated to whom the questionnaire would be sent. The NHS Supplies Authority, by far the biggest proportion of the census (87.6%) was to be sent questionnaires to managers at local operational level. The Supplies staff at District Health Authority level being labelled a variety of titles which included: District Supplies Managers, Account Managers and

Customer Service Managers. Wales and Northern Ireland, although their Supplies Services are also organised at a national corporate level, are not so large in size and number, consequently the Supplies Managers at local level are more easily identifiable. In the Scottish Health Service at the time, Board Supplies Services were autonomous and coterminous with Health Boards. The CSA Supplies Division in Scotland was also to be sent questionnaires.

The postal questionnaire was piloted on five randomly selected Supplies Managers from the census. There were a number of amendments made before the finalised questionnaire was issued in September 1993, see Appendix 2.

During the 'piloting' stage, it became apparent that the 'in principle' endorsement that the questionnaire had been given by the NHS Supplies Authority in England was likely to be retracted. One of the Supplies Managers chosen for the pilot questionnaire was based in the South-East Division of the Supplies Authority, and following referral to the Division's Chief Executive, a reply was received which stated that the Division would not participate in either the pilot or final questionnaire. This reduced the number of questionnaires to be issued by 47, from 275 to 228.

The NHS Supplies Authority later confirmed that following further deliberation and consideration of the final version of the questionnaire, they felt unable to issue a supporting letter, which would have helped to increase the return rate, although they "did not have any objection to their managers completing and returning the questionnaire". The reasons given for this change of heart were that the questionnaire

would be time-consuming and similar data had already recently been collected, therefore the NHS Supplies Authority was unlikely to benefit.

228 questionnaires were subsequently issued on 20 September 1993, see Appendix 3 for the distribution list.

Two letters were subsequently received from Central Division Headquarters and North-East Division Headquarters indicating that their managers would not be allowed to complete the questionnaires. These two Divisions accounted for 40% of the figure of 228.

The primary reason given in both cases was that the corporate NHS Supplies Authority policy was not to complete 'market research' questionnaires to outside bodies which contained confidential and proprietary information. After considerable correspondence, and a visit to the NHS Supplies Headquarters, it became evident that the questionnaire was perceived to be market research and therefore no returns at all were likely to be received from the NHS Supplies Authority. It is suggested that the real reasons why the NHS Supplies Authority felt unable to support the participation of their staff in the survey centred around their strong feeling, at the time, of vulnerability in the changing marketplace. There had been some notable criticism of the Authority throughout 1993, particularly the NHS Supplies Federation Report (July 1993) and the Association of British Healthcare Industries (ABHI) Report (October 1993) the draft of which was circulating at the time of the issue of the questionnaire in September 1993. The NHS Supplies Authority having been criticised by both customers and those it was striving to develop into purchasing partners, may have felt sensitive to the release of information it

considered valuable to possible competitors seeking to erode its business base. No assurance of academic confidentiality could comfort the Authority sufficiently to permit its staff to complete the questionnaires. It was disappointing and frustrating from a research perspective that authorisation for the NHS staff to complete the questionnaire was given and then withdrawn.

Notwithstanding this, the research focus had already shifted to Scotland due partly to the high percentage of Scottish Supplies Managers willing to participate and partly due to the fact that the size of the Scottish Supplies function more easily lends itself to being studied in greater depth than its English equivalent. It should be noted that the findings from the survey as still seem to be general to the rest of the NHS supplies function.

The aims of the questionnaire are summarised in Table 4.5 below:

Table 4.5

Summary of the Aims of the NHS Supplies Manager Questionnaire

- to identify what impact the NHS reforms have had upon Supplies Services, particularly the introduction of the competitive marketplace and Trust hospitals,
- to determine what elements Supplies Managers consider as important in setting purchasing policy,
- to determine what benefits EDI is perceived to offer and to gauge the extent of its use,
- to identify the types of performance indicators employed by Supplies Services,
- to determine who Supplies Managers believe their key customers to be and what Supplies Managers believe their role to be.

Trust Chief Executives

In November 1993 a postal questionnaire was issued to 134 Trust Hospital Chief Executives, (see Appendix 4 for the distribution list). It should be noted that the total number of Trusts was constantly increasing so that as many of the total population, known to the author at the time, were issued with questionnaires. The purpose of the questionnaire was primarily to determine the criteria applied to assess the performance of Supplies Services in general and specifically to elicit the Trust Chief Executives' perceptions as to the current 'in house' Supplies Service. A draft questionnaire was piloted to five randomly selected Executives and, following slight amendments, the questionnaire was finalised, see Appendix 5. Of the respondents[11] over 97% were based within the English Health Service.

As the Supplies Managers' survey had concentrated on the Scottish Health Service, it was considered appropriate that a second survey of Trust Chief Executives was undertaken, specifically directed to Scottish Chief Executives, so that comparisons could be made against both the responses of their English counterparts and the Scottish Supplies Managers.

The questionnaire was largely the same as the English version but with three changes. The question asking the respondent to indicate which part of the UK the Trust was located in was irrelevant as the questionnaire was issued exclusively to Scotland. There were two additional questions aimed at drawing out the respondent's perception as to the value of the Common Services Agency's role in contracting for services and goods.

The final questionnaire, see Appendix 6, was issued to a census of the 25 Scottish Trust Chief Executives in February 1994, see Appendix 7 for distribution list. Again, it is acknowledged that the small numbers will not allow for meaningful statistical analysis but will nevertheless present the general thrust of Scottish Chief Executives' opinion on issues.

The aims of the Trust Chief Executive questionnaires are below:

- to seek Trust Chief Executives' views on,
    - Supplies Services performance
    - the cost effectiveness and customer responsiveness of "in house" Supplies Services,
    - the professionalism of Supplies Services

Company Executives

The views of senior executives of companies who supply goods into the NHS are obviously important in helping to form an overall picture, particularly in relation to their perceptions of buyer-supplier relationships. 130 questionnaires were issued in February 1994 to suppliers of the NHS which comprised of a census of the Association of British Health Industries (ABHI) membership, together with an additional 25 companies with whom the Scottish Health Service spend substantial amounts of money, see Appendix 8 for final version and Appendix 9 for distribution list. The ABHI members are predominantly manufacturers and distributors of medical/surgical products. The additional 25 suppliers of the SHS were drawn from all the commodity groupings; energy, medical (including pharmaceutical), hotel services (including food

[11] See Chapter 5 for details of the number of respondents and analysis of the data.

suppliers), textiles and disabled services suppliers. This ensured the questionnaire was distributed to a cross section of suppliers.

The aims of the questionnaire are as follows:

- to identify which groups of NHS staff the supplying companies perceived to be important;
- to assess the scale of the development of EDI;
- to determine how the companies perceive the reforms to have changed the NHS Supplies staff attitudes to buyer-supplier relationships;
- to assess if the companies consider the NHS Supplies Service as a necessary link between end users of products and the commercial world.

Once again, a small pilot questionnaire had been issued prior to the final version being produced.

4.4.3 Second Stage of Primary Data Collection - Semi-Structured Interviews

Following the analysis of the data collected via the postal questionnaires[12] it was decided that the second stage of gathering primary data was to be via semi-structured interviews. The questionnaires were designed to identify the general areas of interest that would require further investigation in the semi-structured interview.

[12] See Chapter 5 for summary analysis of the postal questionnaires

A phenomenological type approach was adopted by the researcher to this stage of the project in that the views and interpretations of the people involved in managing buyer-supplier relationships and the delivery of care to customers were to be explored. Semi-structured interviews were chosen primarily due to the need to produce a 'richer' form of qualitative type data to supplement the initial information derived from the more quantative type analysis of the of the questionnaires.

Buyer-Supplier Interviews

The following three questions were identified as being important in planning all the interviews,

- who was it appropriate to interview?
- what should be the criteria for selection?
- what questions should be asked?

It was also recognised that whilst the buyer-supplier research focused on the Scottish Health Service and their supplier base, the interviews also needed to try to capture views which would be appropriate for other NHS buyers and suppliers.

Buyers

The SHS was chosen as a focus for the research primarily because it is largest and most influential buyer in the Scottish Health Service[13].

[13] See Chapter 3, Section 3.2 for introductory profile of SHS.

The Director of the SHS, together with the Assistant Director, who manage the Contracting Services, were considered key policy making staff to interview. Also, the four Contract Managers responsible for specific commodity groups were selected on the basis that their attitudes and decisions could shape the relationships with the supplier base. Table 4.6 shows the schedule of interviews undertaken.

Table 4.6

Schedule of Scottish Heath Service Staff Interviews

Name	Position	Interview Date(s)
Mr Terry Dunmore	Director - SHS	21 August 1996
Mr John Cowie	Assistant Director - SHS	21 August 1996
Mr Archie McEwan	Contracts Manager - Medical Services Group	21 August 1996
Mr Richard Hemsley	Contracts Manager - Services for the Disabled	21 August 1996
Mr Peter Howat	Contracts Manager - Energy, Works, Office Equipment & Transport Services	21 August 1996
Mr George Young	Assistant Contracts Manager - Hotel Services	21 August 1996

Suppliers

The SHS Contracting Services' annual spend in 1995/96 was £195.6M from a total of 600 suppliers. Of this population, Table 4.7 summarises the percentage spend and percentage of the supplier population of each commodity area.

Table 4.7

Scottish Health Service Percentage of Spend on Commodities in 1995/96

Commodity	Value of Spend £m	% of Total Spend
Food & Drink	28.02	14.31%
Textiles & General Supplies	19.03	9.72%
Works & Energy	29.22	14.93%
Office Equipment, Consumables & Transport	26.69	13.63%
Medical Related Consumables	29.28	15.21%
Pharmaceutical Products	30.67	15.66%
Surgical Products & Allied Materials	12.45	6.35%
Services for the Disabled	23.40	11.95%
Totals	**195.76**	**100%**

Using value as a determinant, it was possible to identify the suppliers which represented at least 25% of the total spend for each commodity grouping. These companies were then selected for interview. This sampling strategy regarding which suppliers to interview is on the basis of critical cases (see Miles and Huberman 1994). Table 4.8 shows the number of interviews broken down by commodity groupings.

Table 4.8

Number of Suppliers to be selected for Interview broken down by Commodity Grouping

Commodity Grouping	Number of Suppliers Selected	Value of Spend £m	% of Overall Spend within Commodity
Food & Drink	2	8.6	30.7%
Textiles & General Supplies	2	4.8	25.22%
Works & Energy	5	22.4	76.86%
Office Equipment, Consumables & Transport	2	6.8	25.47%
Medical Related Consumables	4	11	36.93%
Pharmaceutical Products	3	10.1	32.93%
Surgical Products & Allied Materials	5	6.54	52.53%
Services for the Disabled	5	9.46	40.42%
Totals	**28**	**79.7**	**40.7% total spend**

Table 4.9 shows the interviews that took place with companies from each commodity grouping.

Table 4.9

Interviews with Suppliers broken down within commodity grouping

Commodity Group	Company	Name	Position	Date of Interview
Food & Drink	Brake Brothers Food Service	Mr Chris Milligan	Major Accounts Manager	5 December 96
	Booker Food Service	Mr Joe Foster	Depot Manager	4 December 96
Textiles & General	Kimberley Clark	Mrs Alison Platt	Account Manager	15 November 96
	Fast Aid Products	Mr Eric Robinson	Joint Managing	29 November 96

Commodity Group	Company	Name	Position	Date of Interview
			Director	
Energy and Works	Scottish Hydro Electric plc	Ms Alison Gaubling	Account Manager	22 November 96
	Scottish Power	Mr Bruce Ogilvie	Sales Manager	12 December 96
	BP Oil UK Ltd	Ms Gillian Hughes	Government Sales Manager	27 November 96
	Newey & Eyre Ltd	Mr Jim Morgan	Branch Manager	5 December 96
	Holland House Electricity Co Ltd	Mr A Donnell	No Interview	
Office Equipment, Consumables & Transport	Carlson Wagonlit Travel	Ms Jayne Able	Corporate Sales Manager	20 November 96
	Cochranes Fleet Services	Ms Janet Rendall	Sales Support Manager	21 November 96
Medical Ralated Consumables	Molynlycke Ltd	Mr David Stark	Scottish Sales Manager	28 November 96
	Regent Hospital Products	Mr R Britten	No Interview	
	Becton Dickinson Ltd	Mr Ian Sanderson	Marketing Manager	13 December 96
	Procter & Gamble Ltd	Ms Alison McKelvie	Territory Manager - Patient Care Division	22 December 96
Pharmaceutical Products	AAH Ltd	Mr Robin Raymond	Supply Chain Manager	26 November 96
	Baxter Healthcare	Mr Ian MacDonald	No Interview	
	BOC Gases Ltd	Mr Chris Browning	General Manager	25 November 96
Surgical Products & Allied Materials	Smith & Nephew Healthcare	Mr Peter Steven	Sales/Account Manager	13 December 96
	Southern Syringe Services	Mr T Pidding	No Interview	
	HM & S Ltd	Mr Steve Graham	Operations Manager	9 December 96
	Vernon-Carus	Mr Vince Gatens	Marketing Manager	5 December 96
	Johnson & Johnson Medical	Ms Sandra Humbles	Chief Product Manager	8 November 96
Services for the Disabled	Buchanan Orthotics Ltd	Mr M Currie	No interview	

Commodity Group	Company	Name	Position	Date of Interview
	Johnson & Johnson Orthopaedics Ltd	Mr J Greenaway	No interview	
	A & M Hearing Aids	Mr H Weiss	General Manager	12 December 96
	Howmedica International Ltd	Mr I Cunningham	No interview	
	Hugh Steeper Ltd	Mr D Knight	No interview	

Of the 28 companies approached, 8 declined to be interviewed. The interviews were structured around the interview "prompt sheets" shown in Appendices 10 & 11[14].

Customer Care Interviews

The total population of Trust based Supplies Services in Scotland is 45 (as at May 1995).

A cross section of supplies services in Scotland were chosen representing a range of different sites and geographic areas.

It was also deliberate that Supplies Services were chosen from across Scotland; covering the South of Scotland (Dumfries), the North (Aberdeen), the West (Glasgow), the East (Dundee, Edinburgh & Fife) and the "Central Belt" (Stirling). A maximum variation sampling strategy was employed to select the Supplies Managers to interview (see Miles & Hubermann 1994). Table 4.10 lists those organisations chosen, together with the dates interviewed.

Table 4.10

Interviews with Selected Trust Supplies Services

Name	Position	Organisation	Interview Date(s)
Mr Gerald Ferrie	Supplies Manager	Central Scotland Healthcare NHS Trust, Stirling	5 Sept 1996
Mr Terry Dunthorne	Logistics Manager	Royal Infirmary of Edinburgh NHS Trust	31 July 1996
Mr Ron Heredia	Supplies Manager	Dundee Teaching Hospitals NHS Trust	23 Aug 1996
Mr Mike Hodgetts	Supplies & Purchasing Manager	Yorkhill NHS Trust, Glasgow	18 Sept 1996
Mr Dennis Rowe	Procurement Manager	Edinburgh Healthcare NHS Trust	14 Aug 1996
Mr Matt McElroy Ms Pat Currie Mr Alex Harrower	Supplies Manager Stores Controller Asst Supplies Mgr	Fife Healthcare NHS Trust	25 July 1996
Mr Michael Cambridge	Supplies Manager	Perth & Kinross NHS Trust	8 Aug 1996
Mr Gordon Craig	Materials Manager	Glasgow Royal Infirmary NHS Trust	25 Sept 1996
Mr Brian Hennedy	Supplies Manager	West Glasgow Hospitals University NHS Trust	18 Sept 1996
Mr Jack McIntyre	Procurement Manager	Hairmyres & Stonehouse Hospitals NHS Trust	11 Sept 1996
Mr John Senior	Supplies Manager	Grampian Healthcare NHS Trust	28 Aug 1996
Mr George Crosby	Supplies Services Manager	Dumfries & Galloway Acute & Maternity Hospitals NHS Trust	16 Aug 1996

It was appropriate to also interview the largest customer, in value terms, of each of the selected service providers. Table 4.11 outlines the customers of each that were interviewed.

[14] The prompt sheets were developed from the key points arising from the analysis of the postal questionnaires, see Chapter 5.

Table 4.11

Interviews with Customers of the Supplies Services

Name	Position	Organisation	Customer of	Interview Date(s)
Mr R Anderson	Finance Director	Kirkcaldy Acute Hospitals NHS Trust	Fife Healthcare Supplies Service	27 July 1996
Mr D McPherson	Director of Operational Services	West Glasgow NHS Trust	West Glasgow Trust Supplies Service	31 July 1996
Mrs J Grant	Administrative Service Manager	Aberdeen Royal Hospitals NHS Trust	Grampian Healthcare Supplies Service	28 Aug 1996
Mr I Ritchie	Director of Operations	Perth & Kinross NHS Trust	Perth & Kinross Supplies Service	19 Aug 1996
Mr R Anderson	Finance Director	Royal Infirmary of Edinburgh NHS Trust	Royal Infirmary of Edinburgh Supplies Service	6 Sept 1996
Mr D Patterson	Director of Facilities	Central Scotland NHS Trust	Central Scotland Supplies Service	5 Sept 1996
Mr C McMurray	Business Manager for Medicine	Dundee Teaching Hospitals NHS Trust	Dundee Teaching Hospitals Supplies Service	13 Sept 1996
Ms A Gracie	Charge Nurse - Orthopaedics	Dumfries & Galloway Royal Infirmary NHS Trust	Dumfries & Galloway Royal Infirmary Supplies Service	16 Aug 1996
Mrs N Short	Locality Manager	Edinburgh Healthcare NHS Trust	Edinburgh Healthcare Supplies Services	14 August 1996

It was not possible to interview the representatives of Yorkhill, Glasgow Royal Infirmary and Hairmyres customers. The interviews with both the Trust Supplies Services and their customers were conducted using the interview "prompt sheets" shown in Appendices 12 & 13[15].

4.4.4 Use of Case Studies to test the practical application of the review tools.

The qualitative data derived from the interviews builds on the more quantitative analysis of the questionnaires. This enabled the review tools to be developed both in terms of the management of buyer-supplier relationships and customer care[16].

The case studies were treated as the "test beds" to determine if the review tools devised were appropriate and useful in a "real" setting. It is intended that the review tools although developed via research undertaken in the Scottish Health Service would be applicable throughout the Supplies Service in the NHS.

As SHS is the largest and most influential 'buyer' in Scotland it is an obvious choice around which to test a programme the relationship review tools. BP Oil UK Ltd, Smith & Nephew, Vernon Carus and Proctor and Gamble [17] are all key suppliers to SHS and were selected following consultation with SHS. The overriding reason that these companies were selected centred around SHS's desire to build and develop upon the existing relationships with the companies, viewing this research project as a means of encouraging this. The four companies willingness to participate in the research is perhaps indicative of their 'open' approach and the researcher suggests that they are likely to have been amenable to developing an improved relationship even without the impetus of the project. Table 4.12 below shows the dates the buyer-supplier case studies were undertaken.

[15] The prompt sheets were developed from the key points arising from the analysis of the postal questionnaires. See Chapter 5.

Table 4.12

Buyer-Supplier Case Studies

Case Study	Parties Involved	Date of Case Study
One	BP Oil (Ms. G. Hughes) SHS (Mr. P. Howat)	7 March 1997
Two	Vernon Carus (Mr. V. Gatens) SHS (Mr. J.Cowie. Mr. V. Laing, Mr. G. McIntosh)	12 March 1997
Three	Smith & Nephew (Mr. P. Steven) SHS (Mr. J. Cowie, Mr. V. Laing, Mr. G. McIntosh)	14 March 1997
Four	Proctor & Gamble (Ms. A. McKelvie) SHS (Mr. J. Cowie, Mr. V. Laing, Mr. G. McIntosh)	2 April 1997

FHC Supplies Service was selected to participate in the semi-structured interviews and subsequently act as a case study as the information derived from the interview and the previous experience of the researcher in working with the Fife Healthcare Supplies Manager led the researcher to conclude FHC SS would be an appropriate organisation to test the customer care review tool. FHC SS represents a medium size Scottish Supplies Service in value terms as well as being well developed in terms of information technology, it also has experience in using EDI, and has been through a competitive tendering exercise as well as a fairly high number and range of customers. Also the Supplies Manager of FHC SS has acknowledged to the researcher that, as there is a continual need to enhance the existing customer care practices, they would be interested in acting as a case study for the research project. Furthermore, the Supplies Manager is conscious of their need to attract new customers and recognise that they are now in a competitive marketplace.

[16] See Chapters 7 & 8 for detail of the programmes of practical measures devised as well as discussion as to their application within the case studies.
[17] See Chapter 7 for profile of the companies and the market places.

Kirkcaldy Acute Hospitals NHS Trust was selected to participate with FHC SS primarily on the basis that they are a major customer of Fife Healthcare Supplies Service but that they had also expressed a desire to the researcher to further develop their understanding of Supplies Services, partly due to their need to control supplies costs. Table 4.13 details the date the customer care case study was undertaken.

Table 4.13

Customer Care Case Study

Case Study	Parties Involved	Date of Case Study
One	Fife Healthcare Supplies Service (Mr. M. McElroy) Kirkcaldy Acute Hospital NHS Trust (Mr. R. Anderson)	21 April 1997

4.4.5 Validation

The importance of validating the research has already been discussed in this chapter. It is therefore appropriate to record the process of validation used throughout the course of the research project. The researcher sought feedback from both academics and practitioners at key stages of the project. Table 4.14 outlines both the papers published in journals and presented at conferences.

Table 4.14

Validation Process throughout the course of the research project

Type of Publication	Title of Journal or Conference	Title of Paper	Date
Journal	Government Purchasing	Cinderella Comes of Age: NHS Purchasing & Supply	May 1992
Journal	Purchasing & Supply Management	The Changing Face of Supply Chain Management in the NHS	June 1992
Journal	Purchasing & Supply Management	So Far and Yet So Near - NHS Purchasing & Supply	March 1993
Academic Conference	Second Conference - Purchasing, Supply Education and Research Group (Venue - University of Bath)	Supply Chain Management in the NHS	April 1993
Academic/ Practitioner Conference	Contracting Opportunities in the NHS: The Impact of the Internal Market & EC Procurement Rules on Contract Awards (Venue - University of Birmingham)	The Impact of the Internal Market on the organisational structure and culture of supply chain management within the NHS	February 1994
Academic/ Practitioner Conference	British Academy of Management Conference (Venue - University of Lancaster)	Supply Chain Management in the NHS: Management Response to Legislative Change[18]	August 1994
Journal	European Journal of Purchasing & Supply Management	Impact of the Internal Market on the Organisational structure and culture of supply chain management within the NHS	December 1994
Journal	The International Journal of Logistics Management	Supply Chain Management in the National Health Service[19]	September 1995
Journal	Supply Management	Research to Review Relationships at opposite ends of the NHS Supply Pipeline designed to effect real change	June 1997

[18] Paper submitted jointly with Dr John Fernie, University of Stirling (at the time at University of Abertay Dundee)
[19] See Footnote 11

4.5 Conclusion to the Chapter

This chapter has outlined and justified the selected research methodologies used in this project. The stages of the research have been described from the initial literature review through to devising and testing the tools in practice.

The next chapter of the thesis will discuss the research findings from the postal questionnaires identifying the issues that require more in-depth investigation via semi-structured interviews.

CHAPTER FIVE

RESEARCH RESULTS

(POSTAL QUESTIONNAIRES)

"Discovery consists of seeing what everybody else has seen and thinking what nobody has thought."

Albert Szent- Györgyl
(1893-1989)

Hungarian born - US Biochemist
who discovered the role of Vitamin C

5.0 Purpose

The purpose of this chapter is to identify and interpret the key findings arising from the postal questionnaires. The postal questionnaires were intended to highlight broad areas that need further and more detailed investigation.

Postal questionnaires were issued to the following:

- NHS Supplies Managers
- Trust Chief Executives in both England and Scotland
- Executives of companies who supply goods into the NHS.

5.1 NHS Supplies Managers

5.1.1 Introduction

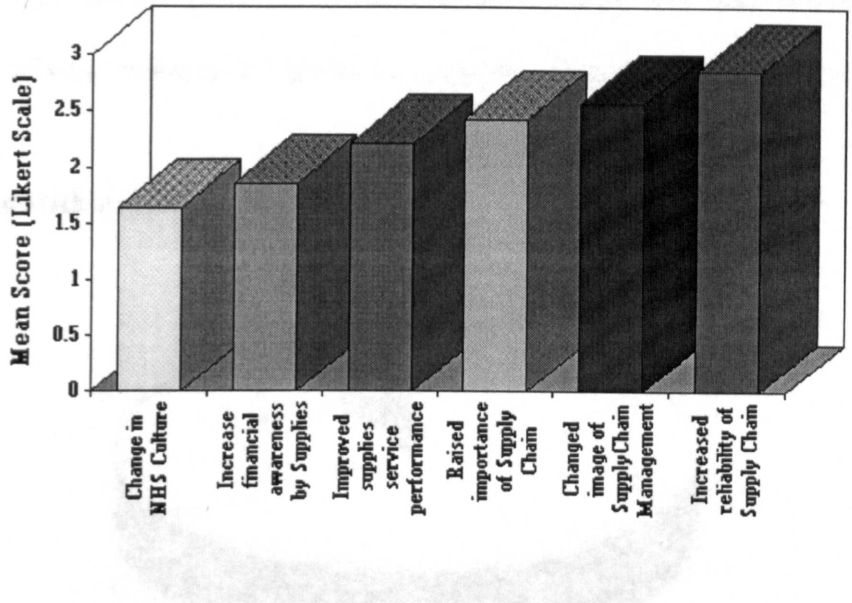
The NHS Supplies Manager questionnaire distribution was limited to Scotland due to the non-co-operation of the NHS Supplies Authority in England. Of the 18 questionnaires issued to Scottish Supplies Managers, 14 were completed and returned. However, it is accepted that this is an extremely small sample of the total Supplies Manager population and the analyses of the responses can only give an indication of the Supplies Managers' views. The data, therefore, has to be interpreted with some caution although it can be said to identify issues of interest which may be applicable to the wider population. The issues flagged up will be further explored in the interview stage of the primary data collection.

The Supplies Manager questionnaire covered a wide range of topics, however, only responses covering the buyer-supplier and customer relationships will be considered.

A general aspect worthy of note emanates from the question in which the Supplies Managers were asked to indicate their strength of agreement with six statements relating to the impact of the 1990 NHS reforms. Figure 5.1 illustrates the mean Likert score for statements. The statement with the lowest bar denotes where the respondents' strength of agreement is greatest so whilst all of the statements received a 'positive' mean score, ie. under 3, the highest is that the reforms have produced "a change in culture within the NHS".

Figure 5.1

Impact of 1990 NHS Reforms



The statement with the greatest strength of agreement is that there is "increased financial awareness of Supplies management" which may indicate that Supplies Managers feel that the reforms have made them more cost conscious. It is interesting that "improved Supplies Service performance against agreed targets" was ranked third in terms of agreement, yet the lowest ranked statement was "increased reliability of the supply chain". So Supplies Managers who responded could be said to be suggesting

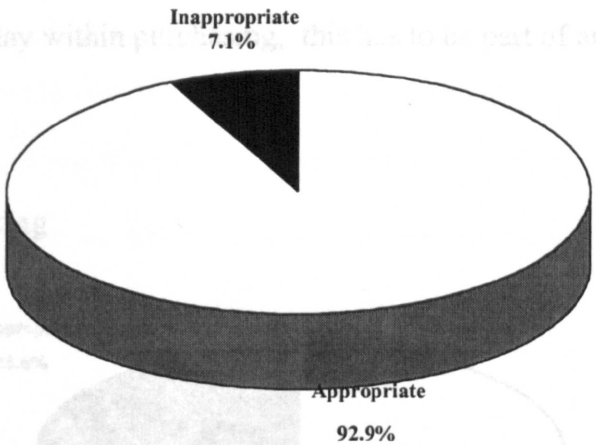
that although performance against targets has improved, this has not necessarily made their services more reliable.

5.1.2 Questions relating to NHS buyer-supplier relationships

The sections of the questionnaire that related to purchasing were designed to obtain Supplies Managers' broad views concerning buyer-supplier relationships and general purchasing issues. Supplies Managers were firstly asked to consider three statements and indicate if these were appropriate or inappropriate in respect of their overall approach to purchasing. Figure 5.2 clearly shows that the Supplies Managers in Scotland thought that co-operation with preferred suppliers was appropriate, although no definition of what constitutes a preferred supplier was given in the questionnaire.

Figure 5.2

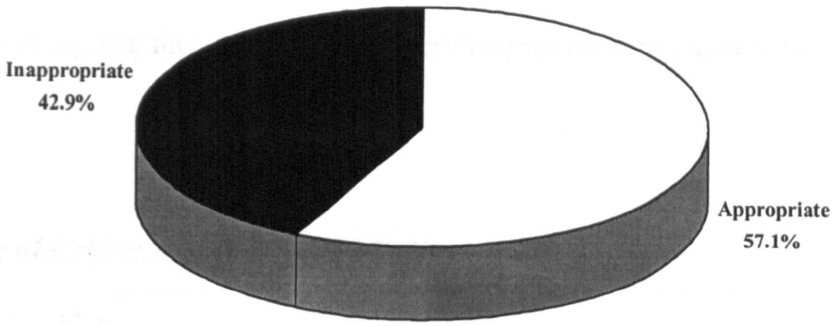
Co-operation with preferred suppliers



Eight of the fourteen Supplies Managers thought it appropriate that a key criteria of their purchasing policy should be the need to enhance the quality of purchased goods as shown in Figure 5.3. However, somewhat surprisingly, six of the fourteen thought it inappropriate.

Figure 5.3

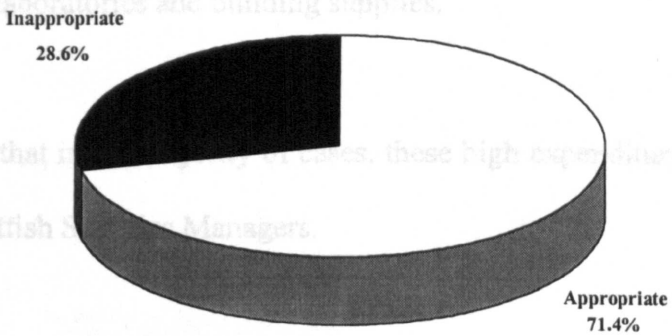
Quality Enhancement of Purchased Goods



Interestingly, ten of the fourteen Supplies Managers thought 'spot purchasing' was an appropriate key criterion to be included in their organisation's purchasing policy, as shown in Figure 5.4. One factor which may partly account for this is that Scottish Supplies Managers appear to operate to a short term horizon and possibly use spot purchasing to obtain "quick" returns from the market place. Whilst spot purchasing does have a role to play within purchasing, this has to be part of an overall strategy.

Figure 5.4

Use of Spot Purchasing

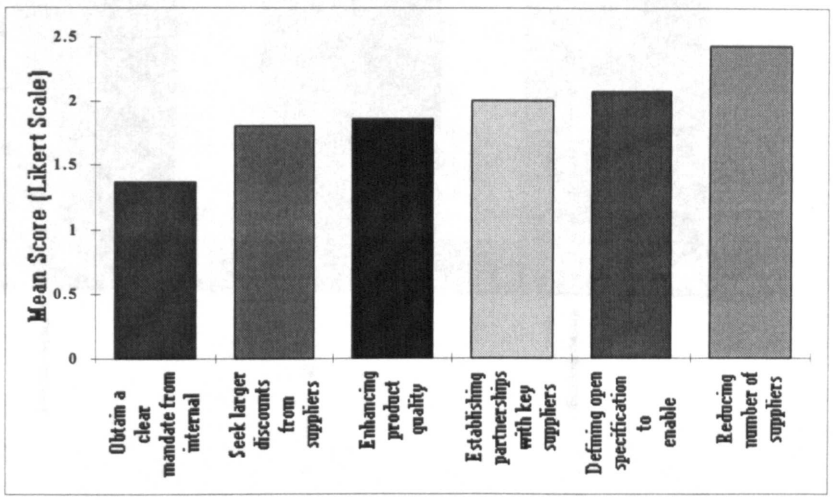


Supplies Managers were also asked to rank the importance of six criteria in respect of their purchasing policy. Figure 5.5 shows the mean scores of the Likert scales of each of the statements. Again, the statement with the lowest bar denotes where the

respondents' strength of agreement is greatest. All six of the criteria were seen to be important, with the highest ranked criterion being 'the need to obtain a clear mandate from internal customers', possibly demonstrating that Scottish Supplies Managers are beginning to recognise their role as one of service providers to customers.

Figure 5.5

Importance of Criteria to Purchasing Policy

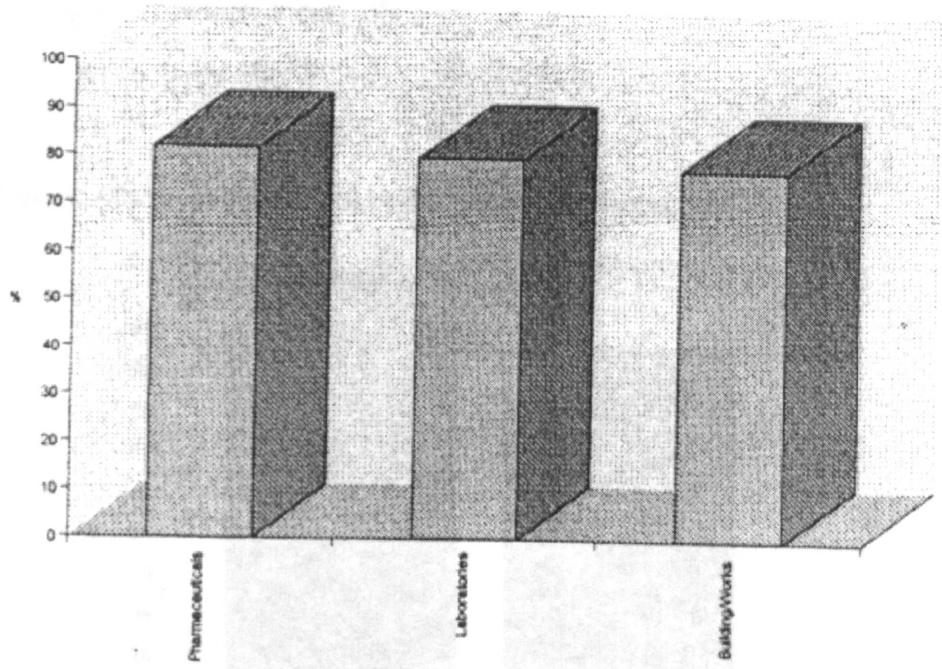


Supplies Managers across the NHS have not traditionally held the responsibility for the total range of products supplied to a hospital. The Scottish Supplies Managers were asked to indicate whether or not they controlled the purchasing in the three areas of pharmaceuticals, laboratories and building supplies.

Figure 5.6 shows that in the majority of cases, these high expenditure areas are outwith the control of Scottish Supplies Managers.

Figure 5.6

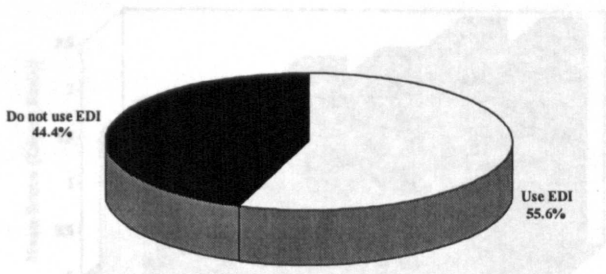
Items outside Scottish Supplies Managers' Control



The use of information technology, particularly Electronic Data Interchange (EDI) was also explored. Figure 5.7 shows that of the nine respondents, five used EDI and four did not.

Figure 5.7

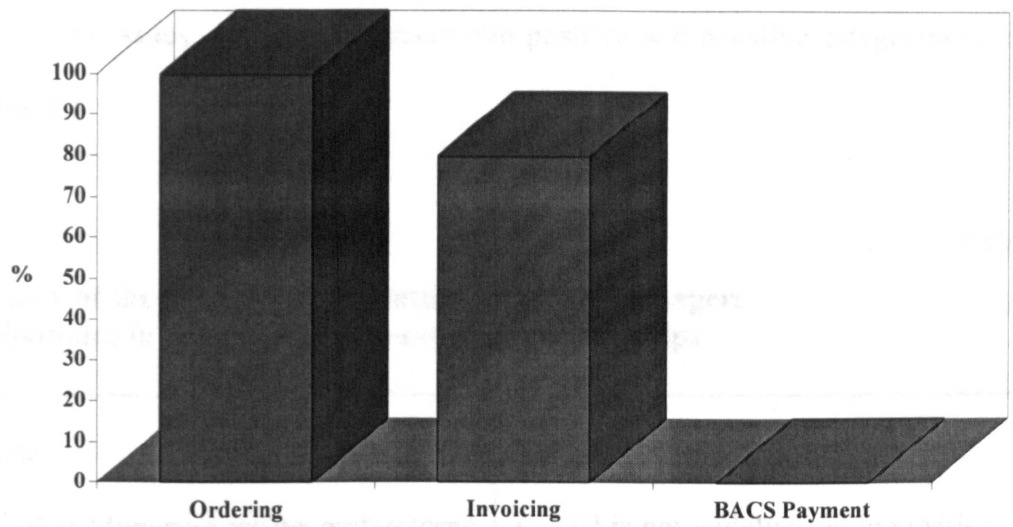
Use of EDI by Scottish Supplies Managers



Of these nine respondents, only five stated that they use EDI as a 'real' means of trading with supplying companies. Figure 5.8 shows that whilst these Supplies Services used EDI for ordering and receipt of invoices, none had completed "the loop" and were paying for goods electronically.

Figure 5.8

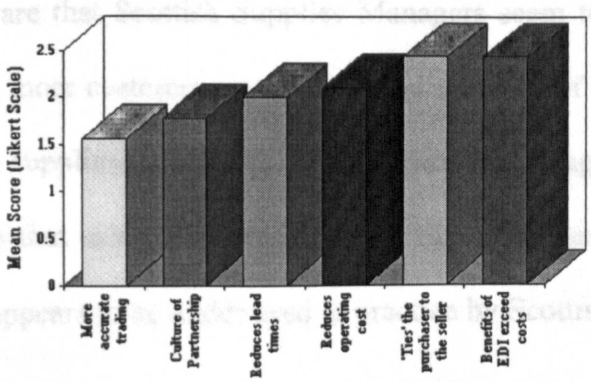
Extent of Use of EDI by Scottish Supplies Managers



All fourteen Scottish Supplies Managers responded positively when asked for an opinion as to their strength of agreement with six statements relating to the benefits of using EDI. The mean score of responses to the Likert scales are shown in Figure 5.9.

Figure 5.9

Scottish Supplies Managers' Benefits associated with EDI



The two highest ranked criteria are the perceived increase in the accuracy of trading and the encouragement of a culture of partnership brought about by using EDI. However, it appears that whilst the Supplies Managers see the potential of EDI, there is still a reluctance to commit to using this in practice.

The findings from the small sample of Scottish Supplies Managers in relation to buyer-supplier type issues can be summarised into positive and negative categories as shown in Table 5.1

Table 5.1

Summary of the findings from Scottish Supplies Managers questionnaire in respect of buyer-supplier relationships

Positive	Negative
• Supplies Managers are becoming more financially aware and customer orientated. • The majority view co-operation with suppliers as appropriate. • The majority recognise potential benefits of using EDI	• EDI is not widely used in practice • There is not widespread acceptance of benefits of adopting partnership type relationships

The positive aspects are that Scottish Supplies Managers seem to have become more financially aware and more customer orientated. The majority of those who responded see co-operation with suppliers as an appropriate means of managing relationships and recognise the benefits that using EDI presents. On the other hand, the more negative aspects are that EDI appears to be under used in practice by Scottish Supplies Managers

and also that there is not a widespread belief in the benefits of adopting partnership type relationships with suppliers.

5.1.3 Questions relating to the delivery of customer care by NHS Supplies Services

The Scottish Supplies Managers were also asked questions relating to customer care. The questions were designed to give some indication as to the level of importance the Supplies Managers place on customer care, who they perceive their customers to be and what are the types of performance indicators they use.

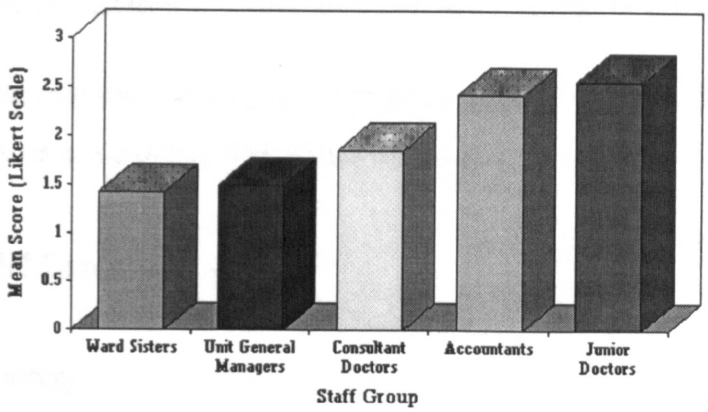
Eight of the fourteen respondents stated that they did have a customer care manager and a discrete customer care team. This does not necessarily mean that the six who do not are any less committed to the concept of customer care. The issue of customer care, the level of resource commitment and the acceptance of the overall philosophy are aspects that will be further discussed in the analysis of the interviews.

Using a Likert scale[1], Supplies Managers were asked to show the degree of importance they attached to five staff groups as customers. Figure 5.10 shows the mean scores which demonstrates that all of the staff groups are considered to be important with Ward Sisters ranked as the most important.

[1] Likert scale used was as follows: 1 = very important; 2=important; 3=average importance; 4=not very important; 5=not important at all.

Figure 5.10

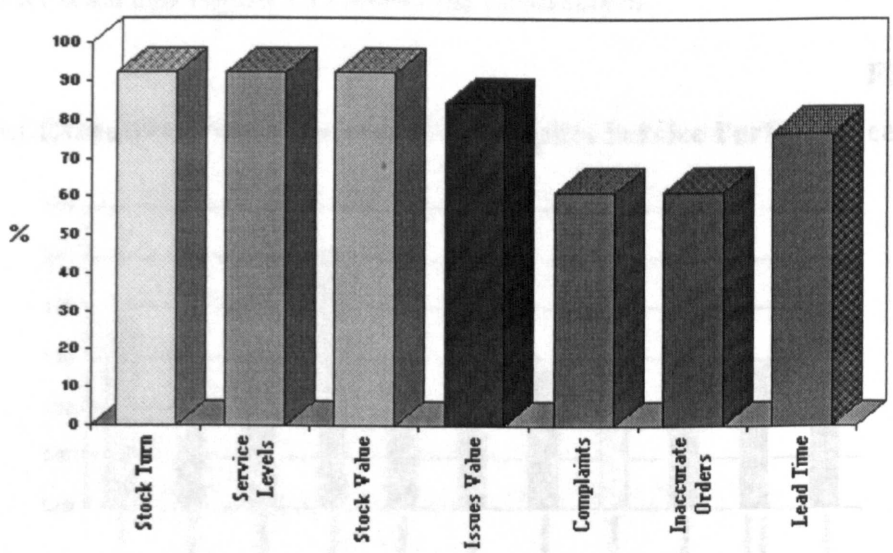
Importance of Staff Groups as Customers of Scottish Supplies Managers



In respect of the use of performance measures, the Supplies Managers were asked to state which of the seven indicators listed they used in practice on a monthly basis. Stock turn ratios, customer services levels and the value of stock were the most popular being used by twelve of the fourteen respondents, as shown in Figure 5.11.

Figure 5.11

Use of Performance Indicators by Scottish Supplies Managers



In summary, the findings from the customer care questions are as follows:

- marginally more Supplies Managers employ Customer Care Managers and have discrete customer care teams than do not;
- Ward Sisters are considered to be the most important customer group;
- stock turn ratios, customer service levels and the value of stock are the most popular performance measures used by Supplies Managers.

5.2 Trust Chief Executives

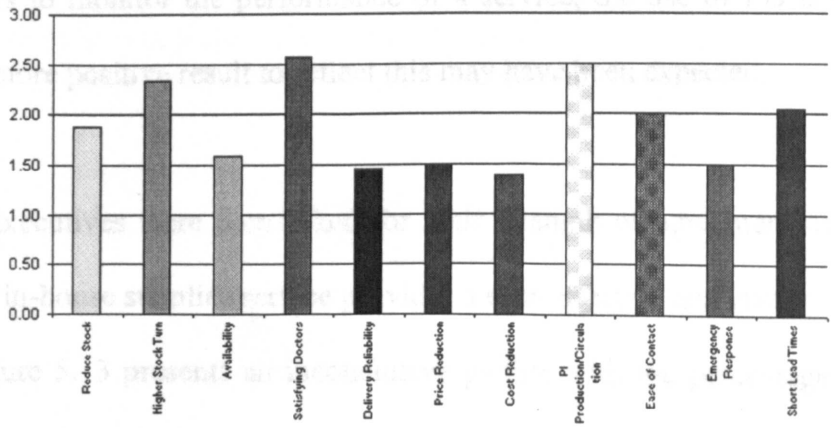
5.2.1 English Survey

The first survey of Trust Hospital Chief Executives concentrated on the Health Services in England. Of the 134 questionnaires issued, 88 were completed and returned (57.5%). As stated in the previous chapters, the survey was designed to determine the criteria applied to assess the general performance of Supplies Services and specifically to elicit perceptions of the current 'in house' supplies service.

The Trust Chief Executives were given eleven criteria to rank in terms of importance using a Likert scale and Figure 5.12 shows the mean scores.

Figure 5.12

Trust Chief Executive criteria for assessing Supplies Service Performance



The criterion ranked highest is the overall reduction in the cost of service with the second most important criterion being the reliability of delivery schedules. The essence of supply chain management could be argued to be captured by this outcome with the balance between costs and customer service highlighted. The joint third criteria are also cost and customer service orientated; cost in respect of 'purchase price reductions' and a customer service criterion in 'immediate response in emergency situations'.

The top four criteria are not surprising and reflect the importance of costs and customers. The mean scores on other criteria are also interesting. A mean score of 2.57 for the "ability to keep the doctors satisfied" did not score as highly as would perhaps have been expected. Does this demonstrate a changing attitude of management towards doctors? Are the management now actually challenging the once sacred position of doctors? Obviously there is only so much that can be inferred from this score, but it is an issue that needs to be explored further in interviews.

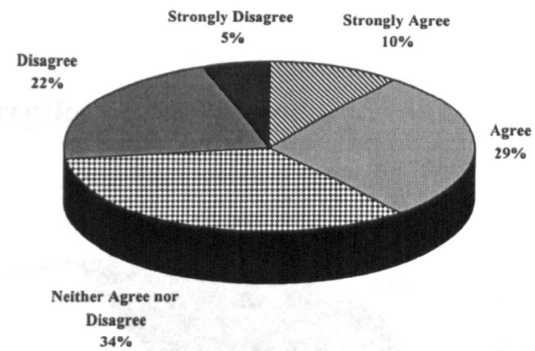
Somewhat surprising also is that the production and circulation of performance indicators (PIs) received a mean score of exactly 2.5, suggesting the customer base is also indifferent to receiving performance indicators. As the literature suggests, in order for customers to monitor the performance of a service, the use of PIs is crucial and, therefore, a more positive result to reflect this may have been expected.

The Chief Executives were then asked for their strength of agreement as to whether their current in-house supplies service provides a cost-effective and customer orientated service. Figure 5.13 presents an inconclusive picture with the percentages split three

ways, with nearly as many disagreeing with the statement as agreeing, and as having no view.

Figure 5.13

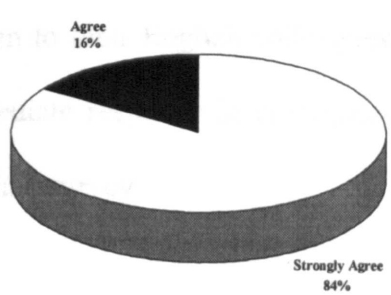
The Current In-House Supplies Service Provides a Cost Effective and Customer Orientated Service



The Trust Chief Executives were asked to indicate their strength of agreement with the statement that NHS Trusts should retain the right to decide from whom they obtain the provision of a Supplies Service. Figure 5.14 shows unequivocally that the Trusts agree with this statement. At the time the NHS Supplies Authority was established in England, this choice was not available and may partly explain the initial adverse reaction that the organisation received from its customer base.

Figure 5.14

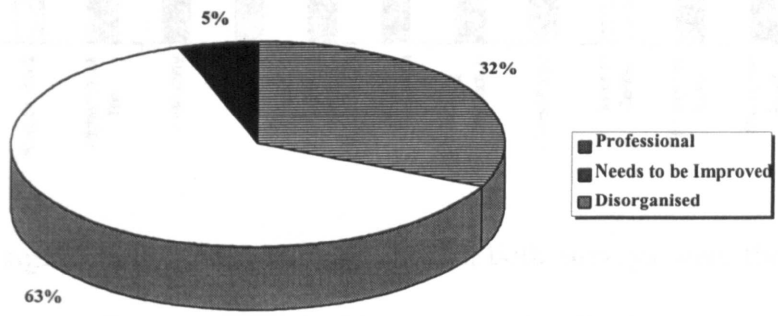
NHS Trusts should retain the right to decide from whom they obtain the provision of a Supplies Service



The final question asked the Chief Executives to indicate which of a possible four statements best fitted with their perception of NHS Supplies. Figure 5.15 shows that nearly two thirds of the respondents perceived that the NHS Supplies Service needed to be improved in order to retain its customer base.

Figure 5.15

Chief Executives' Perception of NHS Supplies



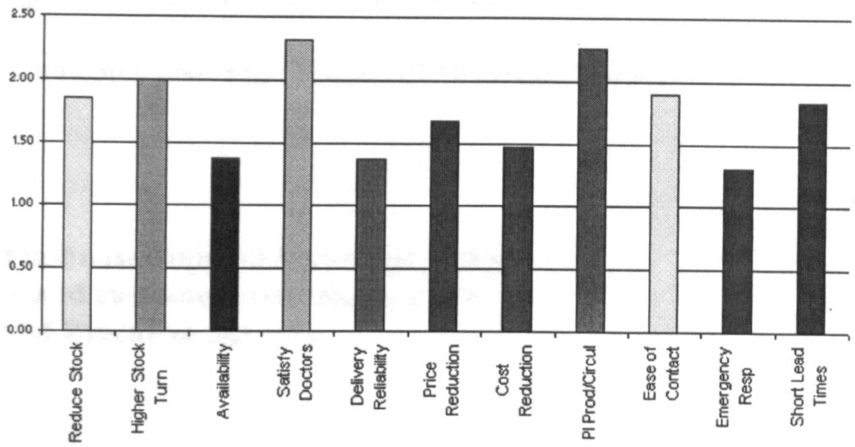
5.2.2 Scottish Survey

A second survey aimed at Supplies Service customers was issued to 25 Scottish Trust Chief Executives[2] in February 1994 with 19 questionnaires (76%) being completed and returned.

The same eleven criteria were given to Scottish Chief Executives to rank in terms of importance as had been given to their English colleagues. Figure 5.16 shows that the highest criteria is the 'immediate response in emergency situations' which had been ranked joint third in the English survey.

Figure 5.16

Trust Chief Executive Criteria for Assessing Supplies Service Performance (Scottish Chief Executive Survey)



Probably more significantly, the top five criteria in both surveys were the same, albeit in a different order. The criteria ranked top two in the English survey; 'the overall reduction in the cost of the service' and 'the reliability of delivery schedules' were ranked fourth and joint second respectively in the Scottish survey. The criteria ranked top three in the Scottish survey were all customer service related issues with the most important cost related criterion being rated fourth. The English Chief Executive rating would seem to lend support to the need to balance costs and customers, but the emphasis in Scotland tends to be more towards customers rather than costs.

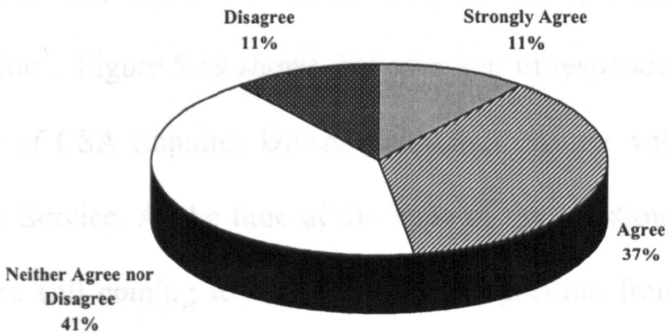
The 'ability to keep doctors satisfied' has the lowest mean score and once more may suggest that the doctors' power base is being eroded somewhat. Also it appears that Scottish Chief Executives are as uncommitted as their English colleagues to receiving performance indicators enabling them to monitor the Supplies Service.

[2] As explained in Chapter 4, this was issued so that comparisons could be made against responses from both their English

Scottish Chief Executives were also asked to indicate their strength of agreement to the statement that the current in house Supplies Service provides a cost effective and customer orientated service. Figure 5.17 shows that nearly half believe the Supplies Service does provide a cost effective and customer orientated service. There is a much more positive outcome than was the case in the English survey.

Figure 5.17

The current in-house Supplies Service provides a cost effective and customer orientated service (Scottish Chief Executive Survey).

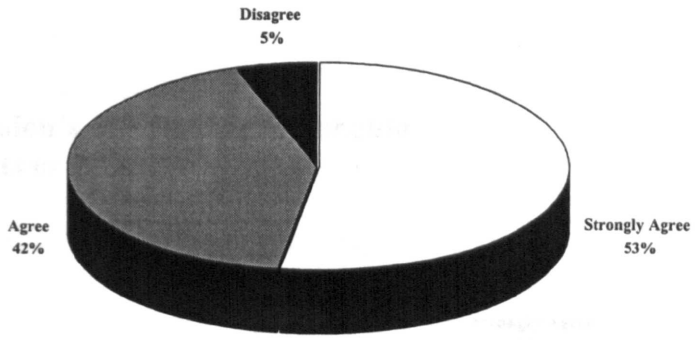


The Chief Executives were asked to indicate their strength of agreement with the statement that NHS Trusts should retain the right to decide from whom to obtain the provision of a Supplies Service. Figure 5.18 shows only a slightly different picture to that obtained from their English colleagues with the vast majority agreeing.

colleagues and Scottish Supplies Managers.

Figure 5.18

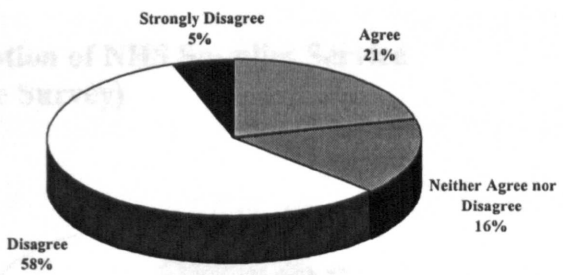
NHS Trusts should retain the right to decide from whom they obtain the provision of a Supplies Service (Scottish Chief Executive Survey)



The Scottish Chief Executives were asked two additional questions relating to the CSA Supplies Division[3]. Figure 5.19 shows that over half of respondents disagreed that the mandatory use of CSA Supplies Division contracts ensures value for money for the Scottish Health Service. At the time of the issue of the questionnaires the Trust Chief Executives were still coming to terms with this imposition from the centre against a backcloth of autonomy in all other ways. This contradiction may partly explain the reaction of Chief Executives.

Figure 5.19

The mandatory use of CSA Supplies Division Contracts ensures value for money for the Scottish Health Service

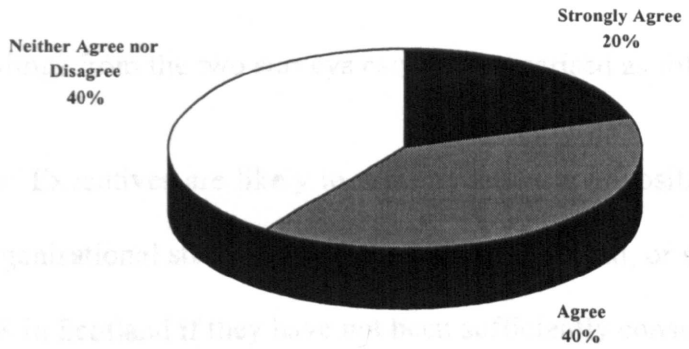


[3] CSA Supplies Division was renamed Scottish Healthcare Supplies in April 1995

Figure 5.20 shows that the majority (60%) of Trust Chief Executives agree that CSA Supplies Division's contracting role should be devolved to Units or Boards. Interestingly no Chief Executive disagreed.

Figure 5.20

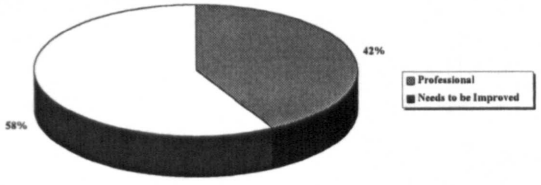
CSA Supplies Division's contracting role should be devolved to Units or Boards



The final question gave the Scottish Trust Chief Executives four statements and asked them which one best fitted with their perceptions of the in-house Supplies Service. Figure 5.21 shows a marginally more encouraging picture than that of the English survey with 42% of Scottish Chief Executives agreeing that the service was professional as opposed to 33% of their English colleagues.

Figure 5.21

Chief Executives' perception of NHS Supplies Service (Scottish Chief Executive Survey)



It is likely that the perception of in house NHS Supplies Services significantly influences whether Chief Executives agree that Trusts should retain the right to decide from whom they obtain the provision of a Supplies Service and to some degree could be said to influence the level of agreement with the statement that the service provides a cost effective and customer orientated service. It appears that if they perceive the NHS Supplies as needing to be improved, then they strongly agree the Trusts should retain the right to decide from whom they obtain their supplies.

The main findings from the two surveys can be summarised as follows:

- Trust Chief Executives are likely to react against the imposition of Supplies issues, be it an organisational structure as in the NHS in England, or mandatory contracts as in the NHS in Scotland if they have not been sufficiently consulted;

- Trust Chief Executives would like to retain the right to choose how they procure a Supplies Service to support their business;

- the rating of criteria used by Trust Hospital Chief Executives for measuring the Supplies Service is largely the same in England as in Scotland. The surveys do suggest, though, that in England the emphasis is slightly more toward cost management then customer satisfaction, whilst in Scotland, this is vice versa.

- Overall, Trust Chief Executives in both England and Scotland believe that the Supplies Service needs to improve in order to retain its customer base.

5.3 Executives of Companies Supplying Goods into the NHS

Of 130 questionnaires issued to suppliers of the NHS, a total of 77 were completed and returned.

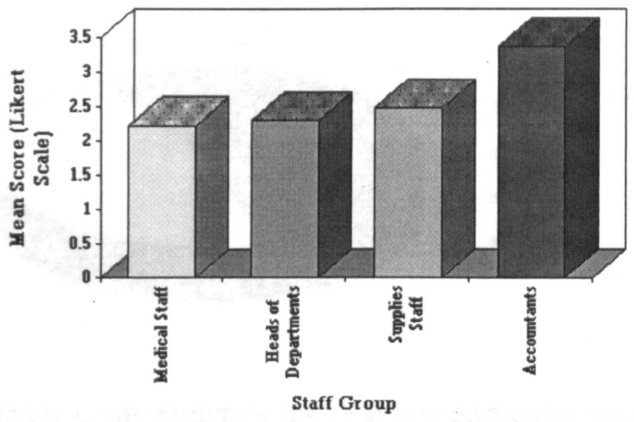
The general questions present a predictable picture of respondents, bearing in mind that the ABHI was the main source of the distribution list, with over half (37/69; 53.6%) stating that their company was involved in supplying medical and surgical consumables. Two thirds (46/69; 65.7%) stated that they have written contracts with the NHS and half of these (23/46; 50%) were up to or over 12 months in duration. In terms of scale of business, over half that answered (34/63; 53.9%) stated that 80% or more of their total business is with the NHS, whilst nearly two thirds (40/63; 63.5%) stated that 50% or more of their total business is with the NHS. The NHS is obviously an extremely important customer to the majority of the companies surveyed.

It is therefore important from the companies' perspective that the type of relationship cultivated with key 'players' within the NHS Supplies Services is positive and partnership orientated, where appropriate. Company executives were asked to indicate how influential they perceived four staff groups to be in the buying decision making process[4]. Figure 5.22 shows that of these four groups, medical staff were considered to be the most influential.

[4] The Likert scale used was 1 = very influential, 2 = influential, 3 = average influence, 4 = not influential, 5 = not influential at all.

Figure 5.22

Influence of staff groups in buying decision making process shown by mean score of Likert scale

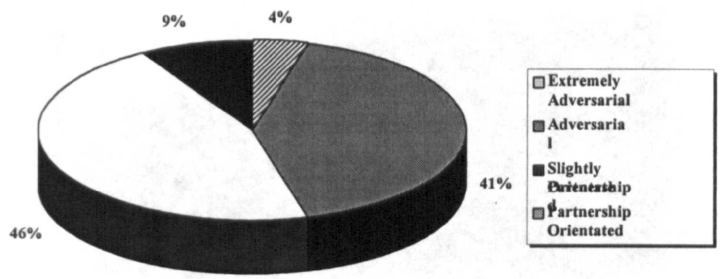


The questionnaire had deliberately not indicated particular product groups and asked respondents to consider altering who they perceived to be most influential for each one. It is a legitimate argument to suggest that one staff group is likely to be more influential than another depending on the product group. It may be significant, although no statistical test has been made, that the medical staff were considered the most important, partly because half of the respondents were from medical and surgical companies. An interesting follow up in the interviews will be to explore which staff groups are perceived to be most influential in particular product groupings.

Company executives were then asked to choose which type of relationship strategy best describes their perception of the management of purchasing by NHS Supplies. Figure 5.23 shows that there is a split between the categories of adversarial and slightly partnership orientated.

Figure 5.23

Description which best fits Company Executives' perception of the management of purchasing by NHS Supplies

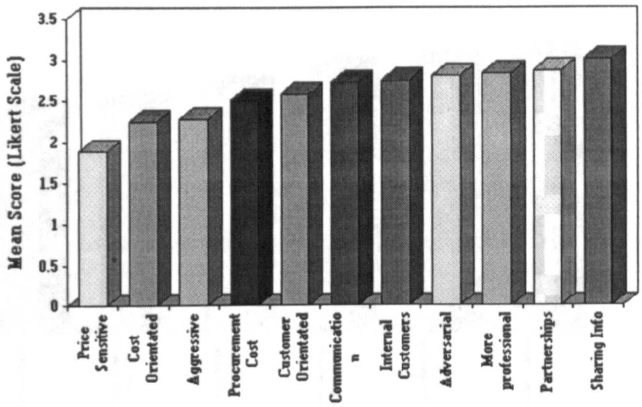


This is obviously a fairly crude indicator taken at one particular moment in time and an issue which needs to be revisited during the interviews. It is important to determine if this view is still held and if so, what are the underlying reasons for company executives maintaining this view. Equally, if the view has changed, why and what factors have caused the shift in thinking.

The company executives were then asked to indicate their strength of agreement as to the effect the NHS reforms have had upon the purchasing policy of the NHS. Figure 5.24 shows the mean scores of the Likert scales with the lowest bar denoting the strongest level of agreement. The criteria ranked top four are cost related with the fifth being customer related. This suggests that the companies perceive the NHS Supplies staff to have become more cost focused in their purchasing and approach to supplies since the NHS reforms.

Figure 5.24

Company executives' perceptions as to the effect of NHS reforms on criteria related to purchasing and supplier relations



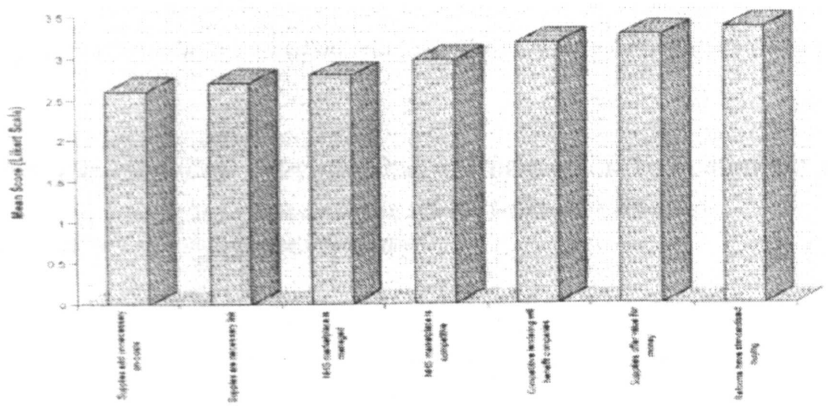
It should also be noted that all of the mean scores, bar one, were below 3, so the question had not clearly identified a specific area that the reforms had been influential in shaping. The company executives perceived all of the criteria had been affected by the reforms, albeit some more so than others. The interviews need to 'tease' out which have been particularly changed and in what ways.

Respondents were then asked questions relating to the scale and use of EDI. The majority of company executives (50/69; 72.4%) had no EDI links to NHS customers, whilst three quarters (46/61; 75.4%) stated that they do not transmit any business via EDI.

Finally, respondents were asked to indicate the strength of agreement with seven general statements in respect of NHS Supplies Services. Figure 5.25 shows the mean scores of the Likert scales with the lowest bar denoting the strongest level of agreement.

Figure 5.25

Company executives' strength of agreement to seven statements



It is not surprising, considering the respondents, that the figure shows that the statement ranked highest was that 'Supplies Services add on necessary on-costs to their sale price from supplies". It is interesting to note that companies appear to be unable to form a definitive opinion as to the status of the evolving NHS marketplace. Company executives may have changed their opinion in the time elapsed between the postal questionnaires and interviews, depending upon their experiences of the market which is an issue to be followed up.

In summary, the postal questionnaires to company executives produced the following key points:

- the NHS is a key customer to those companies who participated in the survey;
- medical staff, supplies staff and departmental heads are considered to be influential in the buying process with medical staff being perceived as marginally the most influential;
- company executives who responded view the Supplies Service as adversarial or only slightly partnership orientated in their approach to supplier relationships;

- company executives perceive that NHS Supplies Services are becoming more cost conscious;

- there is not widespread use of EDI amongst companies supplying goods into the NHS;

- Supplies Services' on-costs that are passed on to customers are seen by company executives as being unnecessary.

5.4 Identification of Issues Requiring More In-Depth Analysis

5.4.1 Introduction

The summary analysis of the postal questionnaires, together with issues that have emerged from the literature review, indicate the general areas of interest within buyer-supplier relationships and the delivery of care from Supplies Services to their customer base which need further explanation. This section will identify and discuss areas that need to be followed up in semi-structured interviews.

It is important to stress again that the central themes of these are to demonstrate that the unique nature of the NHS affect the management of buyer-supplier relationships and the provision of care to customers of Supplies Services. It is equally important to reiterate that the output of the thesis is to develop two programmes of practical measures in the management of these two areas.

5.4.2 Buyer-Supplier Issues

The thesis introduction[5] contends that NHS buyers should 'carry' a relationship portfolio from which they choose an appropriate relationship type to adopt with particular suppliers. Adversarial and partnership type relationships are at the extremes of the spectrum, with lesser degrees of each existing between the two ends. Analysis of the postal questionnaires shows that Supplies Managers do not believe that there is widespread acceptance of the benefits of partnership while Company Executives thought that relationships with the NHS were either adversarial or only slightly partnership in nature. Therefore, an issue to consider further was under what types of circumstances should the NHS buyers adopt partnership type relationships, acknowledging that partnerships are not appropriate in all situations. Burnes and New (1996;21) point out that partnerships may not be for everyone and that indeed there may be a tendency towards a "rose tinted Glasses" syndrome. There is however a need for parties to agree both the definition of partnership and the particular implementation model which will be followed.

Whilst the literature offers definitions of partnership, two parties may interpret the same definition slightly differently, therefore discussion to clarify the exact meaning of the chosen definition should be undertaken. The literature review also demonstrates that there are a number of models of partnership which may or may not be relevant to the particular relationship between the NHS buyer and supplier.

Both parties need to know when their relationship has become a partnership which reiterates the need for both to agree and clarify a definition. Burnes and Whittle (1995)

suggest that a partnership relationship exists where some or all of the characteristics shown in Table 5.2 are present.

Table 5.2

Characteristics of a Partnership Relationship

- long-term commitment;
- both customers (buyers) and suppliers are proactive;
- both parties are integrating key processes and activities;
- common commitment to developing and maintaining close and co-operative relationships;
- Win-Win philosophy operates;
- both parties are committed to continuous improvement

Source: Burnes and Whittle (1995:3)

In order to consider these issues, the research will need firstly to identify common factors that can influence when a partnership should be adopted and secondly how the Scottish NHS presents a unique environment that affects implementation.

A logical extension is the realisation that the supplier base needs to be prioritised. It is unlikely that the SHS, as the lead buyer in the Scottish NHS could, or would, consider establishing partnerships with all of their large and diverse supplier base. Therefore the supplier base needs to be prioritised. The question posed is "what criteria should be used in this process?"

Another issue is the need for partnerships, once established, to be sustained, strengthened and made robust. Organisations in both the public and private sector

[5] See Chapter One, Section 1.2.2

propose to have adopted partnership type relationships with the supplier base when in fact they have not. Hines (1996;11) comments,

> ".. that a large percentage of the UK buyer-supplier partnerships are little more than window dressing ..."

Lamming (1993:171) and Hines (1996:11-15) both highlight the need for parties in a partnership to be prepared to commit substantial time, money and effort to ensure that the relationships established are not just superficial. Partnerships are long term in nature and will inevitably take time to function properly. The role EDI plays in helping to establish and sustain a partnership is a specific issue that also warrants more investigation.

The final issue for further examination focuses upon companies who are attempting to establish partnerships with a number of key NHS buyers. The literature shows that attention has predominantly focused upon the problems faced by the buyer in establishing partnerships. The "difficulties of managing partnerships from the supplier's perspective seems, therefore, to be a much neglected area" Burnes and New (1996:23). Research has tended to look at relationships solely from the view of a single buyer dealing with a multitude of suppliers. Obviously, suppliers may also be faced with a multitude of buyers who each wish to develop a partnership relationship in a slightly different way. Suppliers will face problems in co-ordinating their approaches to different buyers, as Burnes and New point out;

"... clearly the customer (buyer)-supplier relationship under partnership creates many more demands on suppliers than under previous practices".

A summary of the issues to be followed up in semi-structured interviews is shown in Table 5.3.

Table 5.3

Summary of Buyer-Supplier Issues to be Followed up in Semi-Structured Interviews

- How can the definition of partnership be clarified?
- Under what circumstances should NHS buyers adopt partnership type relationships?
- What criteria should be used by buyers to prioritise their supplier base?
- What is the specific role of EDI in establishing and sustaining partnerships in the NHS?
- What are the difficulties from the Suppliers' perspective in managing partnerships within the NHS?

These are the bases from which the interview prompt sheets with the Scottish Health Service buyers and their suppliers have been developed.

5.4.3 Customer Care Issues

The thesis introduction contends[6] that NHS Supplies Services need to offer customers flexible packages of care to meet the increasing requirements of all customers although it is acknowledged that the use of differential service levels may be appropriate, depending upon the configuration of the customer base.

[6] See Chapter One, Section 1.2.3

The literature suggests that organisations should offer differential service levels in order to achieve and maintain competitive advantage. Christopher (1993:25) notes that, "it is customer service that can provide the distinctive difference between one company's offer and that of its competitors". Blanket service levels are no longer acceptable to the ever increasing expectations of the Supplies Service customer base. Analysis of the postal questionnaires suggests that Trusts in both England and Scotland believe that the Supplies Services need to improve if they are to retain their existing customer base, let alone win new customers! However the analysis of this data does not suggest that differential service levels should be adopted as a philosophy by NHS Supplies Services. Nevertheless, it would seem appropriate to explore further in the semi-structured interviews this issue, whilst at the same time considering how customer care can be increased to all customers. Also, there is a need to identify factors which may inhibit the Supplies Services' ability to offer increased service to their customer base.

Assuming differential service levels are considered to be a feasible option, consideration has to be given to the issue that service providers cannot generally offer all customers individual packages of care. Service providers may be able to accommodate some customers with minor changes to their "standard package" but substantially different packages can only be given to key customers. There may, therefore, be a requirement to explore the criteria to apply if the customer base needs to be, or should be prioritised so that only key customers are offered individualised packages of care.

The semi-structured interviews seek to define both key customers and identify the criteria that Supplies Services could apply to prioritise its customer base as well as

highlighting any specific implementation problems. A specific issue for further investigation is whether or not the medical staff are, or should be, afforded higher levels of customer care than other groups of staff.

After having identified the 'what', both in terms of inhibiting factors to the establishment of customised packages of care and criteria used to prioritise the customer base, the next issue is to identify how to limit the impact of inhibiting factors. The role of TWM and benefits of jointly agreeing how to measure performance are specific issues to be followed up.

The final issue centres around customers' perceptions as to the effectiveness of communication with the Supplies Services. The literature demonstrates that communication of a regular and open nature between service providers and customers is vital. Peters (1987:156) recognises that,

> "... in order to determine what the customer wants (the service provider) must be prepared to communicate with the customer".

In order to retain the customer base assumptions as to customer requirement must be tested. Service providers should not assume that they understand customer requirements but must continually re-ask their customer base to ensure service provision is meeting customer expectations. A culture that promotes a learning environment between the two parties must be developed. Customers should be engaged in an ongoing iterative process regarding their changing requirements. Customers may

also be employed as a means of identifying factors that inhibit the implementation of service developments which may have been overlooked by the service providers.

The semi-structured interviews seek to draw out the perceptions of Scottish Trusts as to the measures they believe could be adopted to enhance the process of communication and therefore service provision.

A summary of the issues to be followed up in the semi-structured interviews is shown in Table 5.4.

Table 5.4

Summary of Customer Care Issues to be Followed up in Semi-Structured Interviews

- Under what circumstances is it desirable that NHS Supplies Services in Scotland offer differential service levels to individual customers?
- Assuming it is appropriate, what criteria should be used by NHS Supplies Services to prioritise the customer base?
- How should the NHS Supplies Service develop flexible packages of care to meet the increased requirements?
- What factors inhibit NHS Supplies Services' ability to respond to increased customer expectations?

- What is the role of Total Quality management and performance indicators in NHS Supplies Services' customer care programme?

- What is NHS Supplies Services' customers' perceptions as to the effectiveness of communications?

5.5 Conclusion to Chapter

This chapter has summarised the findings of and identified the issues that require further and more in-depth follow up work.

These issues form the basis for the semi-structured interviews which will be discussed in the next and final chapter of Section 2 of the thesis.

CHAPTER SIX

RESEARCH RESULTS

(SEMI-STRUCTURED INTERVIEWS)

"You know very well that unless you're a scientist, it's much more important for a theory to be shapely than for it to be true."

Christopher Hampton
(b. 1946)
British Playwright

6.0 Purpose

The purpose of this chapter is to identify and describe the research findings arising from the semi-structured interviews. The chapter is divided into two parts, the first covers the issues relating to the NHS buyer-supplier relationship and the other the delivery of customer care by NHS Supplies Managers.

The specific issues/questions investigated are based upon those questions highlighted from the analysis of the postal questionnaires.

6.1 Buyer-Supplier Issues

6.1.1 Background Information

The four lead buyers, as well as the Assistant Director and Director of the Scottish Healthcare Supplies organisation were interviewed to obtain the buyer's perspective in terms of their relationships with suppliers.[1] All of the buyers appeared to be anxious as to their long term future and seemed to be conscious of the need to demonstrate the added value they contribute to the purchasing process which would be lost should the 47 Scottish Trusts decide not to use their services. This anxiety was "hidden" by some of the buyers, although prevalent to some degree in all of their comments.

Since 1994 the SHS have invested time and resources to obtain quality recognition, such as BS 5750 in terms of their processes and procedures, again demonstrating their desire to be seen to be proactive in providing a quality service. The SHS buyers perceive themselves to be a vital link between their customers and the commercial

[1] See Chapter 3, Section 3.1.2 for a profile of the SHS

world of the supplier base. The challenge they face is convincing their customers of the necessity of the role they perform. This type of pressure on the SHS to justify their own position immediately adds tension to the buyer-supplier relationship.

Twenty suppliers were interviewed to obtain their perspective, the breakdown of which is shown in Table 6.1 below.

Key Facts regarding the twenty supplier organisations **Table 6.1**

Supplier	Type of Products/Commodities Supplied to the NHS	Approx. Annual Turnover in 1995/96 £m	Approx. % NHS Business	SHS Contract Value in 1995/96 £m
Johnson & Johnson Medical Division	Medical & Surgical Sundries	60	80%	0.74
Kimberley Clark	Paper Products	3 (in Scotland)	-	-
Cochranes Fleet	Financial Contract Hire (cars as product)	15	-	4.3
Carlson Wagonlit	Corporate Travel	450		3.0
Scottish Hydro	Electricity	-	-	9.0
BOC Gases	Medical Gases	3.75 bn worldwide	6%	2.3
AAH	Pharmaceutical Distributor	1.3 bn	-	4.2
BP Oil	Fuels	40 bn worldwide	-	5.6
Molynckye	Paper Disposables	8 bn worldwide/ 65m in UK	-	5.0
Fast Aid	Polythene bags & incontinence products	4	80%	2.1
Bookers	Delivered wholesale food	35 (in Scotland)	10%	3.5
Brake Brothers	Foodstuffs	400	-	5.5
Ross Electrical	Electrical sundries	-	-	0.36
HM & S	Medical and surgical wholesaler	35	90%	1.3
A&M Hearing	Hearing aids	25	35%	2.8
Scottish Power	Electricity	-	-	7.2
Vernon Carus	Surgical sundries, dressings, and incontinence products	45	40%	3.0
Becton & Dickinson	Medical and surgical sundries, needles and disposables	45	75%	1.5
Smith & Nephew	Medical and surgical sundries	1 bn	75%	1.8
Procter & Gamble	Incontinence & pharmaceuticals	1.5 bn	less than 1%	1.0

The companies interviewed are from all of the commodity ranges that SHS buy from and include the largest single contractor in value terms, Scottish Hydro at £9 million per annum through to Ross Electrical Supplies as one of their smallest contracts at £360,000 per annum. It is also interesting to note that there are some very large companies in terms of worldwide turnover, such as Procter and Gamble (P&G) with a £15 billion turnover, with a relatively small SHS contract which, in the P&G example, is £1 million. The percentage of the SHS contract to the overall turnover is always interesting from the buyer's point of view and helps give an indication as to the relative power and dependency between the two parties.

6.1.2 Partnership Defined

In order that both parties understand the concept that they are trying to achieve, it is important that there is a shared understanding of the definition attached to partnership. The term partnership holds different interpretations for different people and organisations, so unless there is discussion to clarify definitions at the outset, the task of realising this is likely to prove very difficult.

Of the six buyers interviewed, three questioned if a partnership type relationship is applicable at all to the public sector due to the very nature of the environment. The red tape, bureaucracy and need for an audit trail in the NHS were seen to be factors that mitigated against relationships developing beyond normal business formalities. This view was indeed echoed by a number of suppliers who felt that the rules and regulations placed upon the NHS buyers tended to dictate the type of relationships that resulted. The buyers identified other key factors which influence their relationship with suppliers

such as the marketplace and the personal rapport between the lead negotiators. One buyer made the valid point that all relationships needed to be built upon equality commenting that,

> ".. a close relationship is only likely to succeed if the parties are equal .."

However, the same buyer further commented that,

> ".. in most cases they've (the suppliers) have got a hell of a lot more to lose than us should we push them out".

This comment reflects a slightly arrogant approach from the buyer and questions the need to build meaningful, long term relationships with their supplier base. It is also not entirely true, as the figures in Table 6.1 suggest that a significant proportion of the supplier base would continue to survive and grow without their existing SHS business.

All buyers thought that if it was appropriate, both in theory and practice, to have a range of relationship strategies from which to select, depending upon the particular supplier, marketplace and product concerned. One buyer observed that,

> "This game is all about choosing the right supplier to try and develop the relationship with. We tend to concentrate on our high value suppliers first, but it's true that what works for one doesn't always work for another. It's all about horses for courses, don't you think?"

The interviews with the suppliers focused on much the same types of issues as did the buyer interviews. The theme of equality was mentioned again, although there appeared to be a more cynical viewpoint taken as to the difference between theory and practice. One supplier's representative commented that,

> "In theory I suppose it's about giving on equal terms but at the moment we're simply selling products to the SHS and then we try and keep in with them".

The suppliers, like the buyers, acknowledged that partnership is a much used, yet abused term and one supplier reflected this view, stating that,

> ".. partnership is a word that we do bandy around a lot - we think it means developing a working relationship whereby both parties win, ... by dealing with us as a supplier, the customer will get added value and we get more business".

The final comment above is important as a recurring theme from a number of suppliers which highlighted the buyers' inability to accept that suppliers should be allowed to make a profit. There should be no need for buyers to drive down costs to the extent that suppliers make little or no profit as this will ultimately affect both parties. If the relationship is sufficiently trusting such that a transparent open book policy can be adopted in practice, the supplier can show the buyer the profit element in the costing structure. This can be discussed such that the buyer is confident that an element of the

profit is being used to add value to the overall relationship which will, in turn, increase the satisfaction of the buyer and the buyer's customers.

This level of information sharing and trust is only achieved in a fairly well developed and sophisticated relationship and is not characteristic of the vast majority of NHS buyer-supplier interfaces. Nevertheless, the principle of buyers "permitting" their suppliers a reasonable profit margin is one worth reflecting upon.

Suppliers were also united in the view that NHS buyers, in general, tend to be unnecessarily driven by purchase price reductions at the expense of the total costs. This may be partly attributable to the view expressed by the SHS buyers that they are increasingly required to defend their own position which is most easily achieved by referring to financial savings. One supplier, criticising the short termism and narrow mindedness of this approach, commented that,

> "..logistics is all about reducing costs in the chain from the point of origin to the point of delivery .... what the SHS buyers haven't yet grasped is that there's more to this equation than just purchase price".

Another supplier suggested that,

> ".. NHS buyers tend to fall into two broad categories - those who look at price on a piece of paper that's sent to them and those who meet with us to try and understand a lot more about just the price on the piece of paper".

This view was endorsed further by the comments of another supplier who at least offered some initial words of optimism before reverting to the more pessimistic outlook, stating that,

> ".. the more enlightened ones (buyers) at senior level, both in England and Scotland, appear to be more aware of the problems suppliers have .... having said that, they're all conscious of cost ... or should that be purchase price!"

Two of the suppliers interviewed outlined programmes which had initially been designed to train and educate staff internally so they could develop more effective relationships with internal customers. The success of both schemes has resulted in the programmes being 'rolled out' to encapsulate external relationships with both their customers and their buyers. Both of these schemes are based around the premise that increased communication with buyers can only enhance the possibility of strengthening the relationship. A senior representative of one of the companies stressed that,

> ".. we work together with key customers to establish and drive mutually agreed strategy to achieve an overall objective".

Much of this sounds like a quotation from a US MBA textbook and one which bears little truth to the actual situation. However, as the principle is unquestionably laudable, the real success depends entirely on how much is translated into reality.

Apart from the suppliers' concerns regarding the buyers' inability to differentiate between costs and price, the two most commonly referred to issues in the supplier interviews relate to the development of partnership type relationships, were trust and honesty. These are not specific to the NHS environment and will be common throughout any business relationship. However, it would appear that the prescriptive NHS environment limits the opportunities in which the buyers and suppliers can test out each other's trust and honesty and therefore restricts the growth of the relationship.

Returning to the theme of communication, a supplier gave an incisive summation of its importance to the buyer-supplier relationship, although remaining unconvinced of the partnership labelling by stating that,

> "We do try to use this lovely thing called partnership as our umbrella for consultative selling whereby we try to determine our customer's perception to match us up with them. Whatever we choose to call it, it's about matching, adapting and rematching as we go ... which can only be done by constant communication between us both".

In essence, the representative of this supplier seems to be suggesting that labels are unimportant so long as there is an acceptance that there should be an ongoing communication process between the two parties resulting in a shared understanding and direction which can accommodate the constraints presented by the NHS environment.

6.1.3 Is there an ideal time to adopt a partnership?

There is no one set of circumstances that will create the one and only "window of opportunity" in time from which buyers and suppliers can leap to partnership type relationships. It is, however, possible to identify the factors that can influence how a relationship develops so that both buyer and supplier are at least aware of them. It is then a matter of judgement as to the status of their current relationship and its potential for development before deciding what action should be taken in respect of the various factors to mould the future.

Ten factors, shown in Table 6.2, emerged from the interviews as being those which are seen to consistently influence buyer-supplier relationships.

Ten Factors influencing buyer-supplier relationships **Table 6.2**

1. Level of spend with the supplier as a percentage of total spend.
2. Criticality of the product to important end users.
3. Level of trust.
4. Type, frequency and effectiveness of communication.
5. Level of commitment.
6. Willingness to share information.
7. Supplier position in the marketplace.
8. Past performance in quality, cost and delivery.
9. Personality 'fit' of lead negotiators.
10. Use of IT, particularly EDI.

Suppliers suggested that one of their prime concerns was to identify who was the customer they were dealing with at any one time so that they could tailor their approach and adjust the mix of the factors described above. There was a concensus amongst suppliers interviewed that contact with SHS to negotiate the tender required quite a different approach than dealing with Trusts who were more concerned with operational issues. One supplier seemed to have realised the need to differentiate between SHS and Trust relationships, although thought that it was also the supplier's role to act as a facilitating link between the two. This was not altogether altruistic on the part of the supplier who commented,

"In a way, this is a method of positioning ourselves should the Trusts move away from SHS and buy more for themselves. If such a thing happened, we'll be more able to respond and respond quickly to increased purchasing directly by the Trusts .... I suppose you can argue we're hedging our bets and trying to be in between the two to satisfy both the current arrangements and any future ones"..

This flexibility of approach to relationships was practised by another supplier who expounded the virtues of a reactive strategy, albeit within the bounds of certain parameters, stating that,

"We tell them when we've something to say to them and equally they do the same ... time is too precious to be having an airy-fairy chat about what might be and ifs and buts".

This type of view can, of course, be criticised as being short-sighted as the time given to "airy-fairy" chats may mean the identification and resolution of potential problems before they become a reality. This again reinforces the argument that effective communication is likely to result in a stronger relationship bond between buyer and supplier.

One buyer commented that a review of past performance in terms of the supplier's adherence to the quality specification, competitiveness of cost and delivery reliability should be undertaken regularly. The buyer also thought that this type of review should be balanced by the level of commitment the supplier gave to SHS contracts in respect of time, resource and senior management input. The buyer commented,

"I think we'll get more in the long run if we're a touch understanding and sympathetic to suppliers, not soft, but understanding. Anyone can get it wrong to start with so any review of performance needs to be tainted by your own perception of how much effort and commitment the supplier has made to date and is likely to make in the future. Basically I'm more inclined to give people the benefit of the doubt, a chance to keep improving which tends, in the main, to enhance the relationship and produce benefits all round".

In the NHS environment, particularly in an SHS tendering situation, such an approach is not always possible if, for example, an existing contractor submits a tender price that is higher than a competitor's.

6.1.4 Prioritising the Supplier Base

Whilst the SHS buyers expressed a willingness to develop relationships with suppliers, there did not appear to be any set framework to which they worked and given the comments in the previous section, this is not surprising. Indeed, SHS buyers tend to more thoroughly investigate suppliers at the pre-contract award stage and admit that relationship building during the period of the contract is forsaken by comparison. All of the buyers referred in great detail to the EU regulations outlining the criteria dictating how suppliers are initially chosen. There are written procedures and protocols governing the tender process which necessarily leads the buyers to focus their attention at this point in the process. One buyer observed,

"We're particularly rigorous at 'digging out' all the facts about suppliers at the tender stage but have to admit, once the contract has been awarded, our monitoring is perhaps a bit mechanistic and doesn't allow for us to develop the softer aspects of the relationship".

The same buyer was candid in admitting that with limited time and resources the monitoring tended to concentrate on the high value suppliers only, citing the use of the 80/20 pareto rule as a means of determining key suppliers. Value appeared to be the only criteria used to prioritise the supplier base with whom to build stronger relationships.

During the interviews the suppliers consistently highlighted that they, rather than the buyers, initiated schemes and programmes to enhance the relationship. One supplier believed that,

"We're always trying to develop and enhance the existing relationship..... SHS though seem to always be on their guard, always be suspicious of us which tends to restrict how the relationship can naturally develop .... They have to, at some stage, be prepared to open
up, give a bit, sure it's a risk, but that's where the trust comes in I guess ..."

Interestingly, one supplier graded their customers using a formula which takes into account two criteria, one which looks at the current level of spend with the company and a second which tries to estimate the potential future spend. The company would then attempt to learn more about the requirements of that particular customer and remedy any shortfall in service delivery.

6.1.5 The Role of EDI

Both buyers and suppliers appeared to recognise the potential benefits associated with using EDI as a means of communication and acting as a catalyst to improve relationships. However, both were in agreement that these advantages over the manual systems had not yet been realised.

SHS buyers referred to the work undertaken by their organisation to prepare both technically and culturally for the introduction of EDI. However, a combination of

technical and bureaucratic reasons had resulted in a piecemeal implementation of EDI throughout the Scottish Supplies Services. In many ways other forms of electronic communications have started to supersede EDI before it has become fully operational. A buyer captured this brief historical review commenting that,

> "EDI .... much talked about but little action, previously you know this had been seen as the golden end of communications but now it's just another one of many".

The suppliers interviewed agreed with the summation but were anxious to add that they were already, or could in a short space of time, be able to operate EDI should the Scottish NHS want to use this facility. One supplier representative whose organisation was totally functional with EDI and employed the system to perform transactions with its own suppliers stated that,

> "There seemed to have been a false start in using EDI in the Scottish NHS .. they've tinkered with it, trialled it, but as yet not got it up and running in its fullest sense in any part of the country".

The reference to "it's fullest sense" relates to the fact that whilst some Supplies Services have sent orders to suppliers electronically, no organisation has completed the 'loop' by receiving and paying invoices.

EDI appears to be an untapped potential which could be managed to bring buyers and suppliers closer together but as another supplier observed,

> "No-one has yet made a decisive move to use this and we're hanging back, ready to invest, but at the moment it wouldn't be worth our while to commit time and money to this when the Scottish Health Service appears undecided as to its role in the purchasing process."

6.1.6 Changing Attitudes

At first glance, attitudes of both the NHS buyers and their suppliers appear to be changing toward their relationship. The SHS buyers interviewed believed that they were beginning to empathise more with their suppliers than they had previously. The buyers seem to recognise that their role is becoming a link between the end user and the supplier and as one buyer described,

> "Our approach in the past year or so has become one of almost silent facilitator between the end customers and suppliers. This is something of a new role for us and whilst we're still driven and to an extent controlled by some of the external pressures upon us and the need to justify our role we are trying to look at things from the suppliers' viewpoint."

Yet old habits and attitudes die hard and what could be termed as a more suspicious view was put forward by another buyer who stated,

> "... I understand all the new theory but in general I see our relationship with suppliers one where we rub along together. You have to remember

> that they're vultures really, ready to take the NHS pickings ... they can look after themselves and so can we".

So has anything changed in reality after all? Suppliers referred to the impact of the NHS reforms, the introduction of the internal marketplace and with it the concept of balancing costs and customer requirements as being the catalyst for potential attitudinal change. One supplier reflected the thoughts of the majority of colleagues by expressing the view that,

> "Buyers are much more financially focused and have become more powerful within their own organisations ... these people are no longer just storemen - they've gone up in the world to be highly educated and professional people .... The buyers have become more business-like, more concerned with costs and with recognising that they have customers to answer to .... I suppose in a way that's down to the internal marketplace and all that it brings with it".

One issue that was deliberately explored in the interviews with suppliers was the question of whom they perceived their customers to be - is it the SHS, the end user, the Trust management, the patient or a combination of these? Again, there appears to be no one set answer and is largely depended upon which marketplace the company is in and the particular product that is being supplied. The medical and surgical suppliers, be they manufacturers or wholesalers, tended to target opinion leaders at the medical end user level who would then become the internal advocate for the products. Whereas paper disposable suppliers, whose products largely sell on price, see the SHS as their prime

customer. The standard answer to this question was that all of the staff groups identified above are customers and it usually required further discussion during the course of the interview to "tease out" who they see as the prime customer.

One supplier described the importance of understanding that this was a triangular relationship involving the SHS buyer, the supplier and the Trust. The supplier strongly believed that it was as vital that they had as much knowledge of the relationship between the SHS and the Trust as between themselves and the Trust and SHS.

Another supplier viewed this three way relationship within the framework of what was described as a "multi-site account" where the contract is negotiated at the centre with individual sites retaining a degree of discretion. In this model the supplier argued that it is equally as important to treat the centre and individual sites as customers, but recognised that each will be motivated by different types of issues.

The larger multi-national suppliers highlighted the difficulties caused by key NHS buyers in different parts of UK placing them under pressure by presenting them with potentially conflicting demands.[2]

Suffice to say that the NHS environment is a complex and dynamic one which can at times appear somewhat bewildering to suppliers, as one commented,

[2] This is explained in the case studies, see Chapter 7.

> "Ultimately we're working to satisfy the end users, although the whole scene is like trying to find something in very muddy waters .... there are lots of people always dipping in and out of the NHS purchasing pond".

The year on year financial "squeeze" being exerted on the Trusts was acknowledged by SHS buyers as being a major determinant on whether or not the 'bottom line' focused on anything other than financial savings. One buyer admitted that,

> "... yes we talk of quality, service and new innovative approaches to relationships but with the ever mounting financial pressure on Trusts, price is still very important to us, although we really should be looking to compare total costs."

This continued obsession with purchase price can be argued to be partly due to the NHS bureaucracy and partly due to SHS insecurity regarding its own future.

A negative observation from one supplier which suggests that changes in attitudes are yet to happen is that,

> "As ever the NHS buyer seems to want more for less ... that's not partnership is it?"

In summary, the interviews suggest that whilst there is considerable discussion concerning changing attitudes the pressure from within the NHS for continual financial savings appears to be stifling real change. However, there are indicators that there is a

willingness from both the buyers and suppliers to effect change. Improved and more effective communications between buyers and suppliers was again seen to be the route by which such change could be achieved, as one supplier stated,

> "We firmly believe that we have to find ways of working with our customers, there's no point in us dreaming up new schemes unless we've communicated with our customers to determine if this is what they want ... there's no point in going through the motions, we need to be interested in what concerns them and do something about it .... That's when you score".

An equally a positive comment was made by a buyer who stated,

> "We know we have to have better and meaningful relationships with both our customers and our suppliers. The only way to do this properly is to devise more effective communication mechanisms with both. Attitudes are starting to change but this process needs to now be reinforced through stronger communication."

6.2 Customer Care Issues

6.2.1 Background Information

Table 6.3 below provides an overview of the twelve supplies organisations under discussion. This information provides a contextual framework for the subsequent

discussion of the customer care issues and though comments from Supplies Managers' interviews have been anonymised, this is nevertheless a useful backcloth for the reader.

Key Facts of the Twelve Scottish Supplies Services Whose Managers were interviewed **Table 6.3**

Supplies Service	Approximate Value of Annual Spend £M	Oncost Percentage Level (cost of operating as a % of overall expenditure)	Number of Organisational Customers
A	8	5	3 Trusts
B	4	13	1 Trust
C	20	2	1 Trust
D	20	5	5 Trusts
E	8	5	1 Trust
F	6.5	10	3 Trusts
G	14	3.5	2 Trusts (Capital Purchasing for 2 more Trusts)
H	7	3.6	1 Trust
I	16	1.25	1 Trust
J	40	Unknown	1 Trust
K	35	8	2 Trusts (Capital Purchasing for 2 more Trusts)
L	7.5	5.9	2 Trusts

The approximate level of annual spend ranges from £4M (Supplies Service B) to £40M (Supplies Service J). The level of percentage oncost, which is the cost of operating the Supplies Service as a percentage of overall expenditure, ranges between 1.25% and 13%. An acceptable level of oncost, and one which compares to the best in the private sector, is around 5% or under, which is achieved by half of the twelve Supplies Services. Whilst the percentage oncost figures of Supplies Service C (2%) and Supplies Service I (1.25%) appear to be very competitive, their validity may be questionable.

Supplies Service J were unable, or unwilling to give the researcher the oncost level which is in itself of concern as all Supplies Managers should know their oncost percentage and be continually working to reduce it.

Half of the Supplies Services have more than one customer, whilst the other half supply only their host organisation. Supplies Service D supply five trusts, three on the mainland and two islands, while both Supplies Service G and Supplies Service K provide a full service to two trusts and a capital purchasing service to two other Trusts. Supplies Service A and Supplies Service F's costs are recovered from three customers, while Supplies Service L's from two.

6.2.2 Differential Service Levels

It is worth re-stating that above half of the Supplies Services considered have more than one organisational customer, while the other half supply exclusively to their host Trust, ie. the Trust of which they are employees. Furthermore, of the six who have multiple customers, four of them have one predominant customer in that approximately 60% of Supplies Service D's business is with a large Acute Trust, 65% of Supplies Service J's business is with their host Trust, 60% of Supplies Service K's is with their host Trust and 55% of Supplies Service G's is with their host Trust. None of the above Supplies Services claim to be offering or providing any better service to one organisation than another.

Supplies Service A and Supplies Service F, who both have three main organisational customers, do not currently offer any form of differential service to the different

organisations. A's Supplies Manager is convinced that the customers themselves are not interested in obtaining 'special' or better levels of service than other customers. This view is supported by the comments of Supplies Manager K who told the researcher,

> ". . . from a customer perspective, they simply want to be able to ask and get . . . if something goes wrong they expect us to fix it, without hassle or recrimination, which is what we do now."

The same Supplies Manager qualified this by adding,

> ". . . but you know being customer friendly doesn't mean we give into every request, it requires some form of dialogue and strength of approach, we need to challenge them from time to time . . . there needs to be mutual respect."

A's Supplies Manager did however acknowledge the commercial realities of the situation adding that if a customer wanted different or higher levels of service and was prepared to pay for them, then they would be provided.

All Supplies Services in Scotland have a minimum of three hundred individual customers to deal with and only one of the Supplies Managers interviewed gave any suggestion that their individual customers were given preferential or special levels of service. There was, however, universal agreement that differentiation on the basis of medical priority did take place. All confirmed that they had a list of critically important

medical items held in stock as well as procedures to enable rapid response to emergency medical requests for non-stock items.

A limited number of Supplies organisations have written Service Level Agreements (SLAs) with their customer base which specifies the level of service they expect to be provided. It is not surprising that it is those with more than one organisational customer who have SLAs. The Trusts serving only one organisation tend not to have negotiated the levels of service to be provided. One Supplies Manager made the point that he believed SLAs to be,

> ". . . just another means of self defence . . . protecting yourself from the possible threat of competitive tendering, we don't need to do that here, partly because we're supplying a good service and partly because we've only got the one customer and we're part of that organisation anyway."

In general the Supplies Manager interviews seemed to be pointing to the lack of sophistication and development of the internal market place as to the reason why differential service levels are not offered. Although there have been competitive tendering exercises within Scottish Supplies, notable in Ayrshire & Arran and Fife, where both were won by the existing organisation, the tendency has been to continue to use the "in house" supplies services. This may partly be a testimony of the high level of existing customer satisfaction that Supplies Services have achieved across Scotland or partly that Trusts have traditionally addressed other, more obvious, non-core services for competitive tendering, such as laundry, domestics and catering. Nevertheless, Supplies Services in Scotland cannot be complacent as to the level of service they

provide to customers and must be flexible enough to respond to their changing requirements.

The English NHS arena could be argued as being more "real" and commercial. In 1994 the NHS Supplies Authority lost their automatic right to business and Trusts were given the authority to procure a supplies service from any source, although to date the majority of Trusts have chosen to stay with NHS Supplies.

One of the Scottish Supplies Managers interviewed highlighted that another potentially influential factor is when the host Trust is involved in a Private Finance Initiative (PFI). PFIs have become the Government's favoured method of funding "new builds" in the public sector by attracting private sector capital. As part of this particular PFI arrangement the Supplies Manager was aware that the successful company would also assume responsibility for managing non-medical services for the new hospital, including the Supplies Service. In this scenario the Supplies staff would be employed by a profit making organisation with legally binding contracts defining the service levels to be provided to the NHS Trust(s). It is suggested that this type of Supplies organisation would be more likely to respond to a request by a customer to deliver different service levels than an NHS Supplies Service would be.

In summary, the interviews suggest that the vast majority of Scottish Supplies Managers do not currently offer customers differential service levels, simply as customers are not, at present, requesting them. The reasons for this seem to be that most Supplies Services are operating in a fairly protected marketplace where customers who, in many cases, are their host organisation, have not yet identified Supplies as a

function to be market tested. This is not to say that all Supplies Managers are unaware of the threat of future competition or ignorant of the need to respond to customer requests to increase satisfaction levels. It is perhaps significant that the one Supplies Manager, with the experience of serving more than one customer, believes the future security of his organisation lies in,

> ". . . the need to develop our business and generate income from the private sector, that's where we need to be looking and if that means giving different customers different levels of service, then so be it, as long as they're prepared to pay for it . . . . but just now our Trusts don't want this."

6.2.3 Prioritising the Customer Base

The issue of prioritising the customer base assumes that differential service levels will ultimately be introduced into Scottish Supplies Services, therefore the logical extension to this is to ask how such differentiation should be determined. As alluded to in a previous section, one Scottish Supplies Manager claims to be prioritising his customer base already, using two simple criteria; value and influence.

The Supplies Manager in question serves only one organisation with the Supplies Service being part of the host Trust so the prioritisation is to the large number of individual customer points within the Trust. The Supplies Manager stated that customers who controlled a large budgetary expenditure were given preferential treatment in terms of both quality and speed of service, stating that,

> "We don't really publicise it too much but it stands to reason doesn't it, that those customers that spend the most with us need to be well looked after, don't they?"

He went on to say,

> ". . . influential groups of staff such as senior management and the "big players" in the medical set up are also given closer attention . . . . well anyone that can influence our status, our position and our very future needs to be well looked after . . ."

In some ways this is a very pragmatic view and one which is probably being followed by other Scottish Supplies Managers, albeit more covertly. The service dilemma facing Supplies Managers is centred around the question,

> *"do we give an equitable service to all customers or do we differentiate?"*

There are dangers associated with adopting a philosophy which publicly states that all customers receive the same care package yet privately grades customer importance on criteria such as value and influence. The main danger being that customers will, over time, discover the truth and, assuming they have the capacity to do so, take their business elsewhere. However, on the other hand, the fact remains that if key decision makers and influential individuals can be identified, the task of satisfying them is likely

to prove to be in the service providers best interests, more so than satisfying other, lesser influential, customers. Differentiation needs to be sensitively applied, in some cases discretely, so that it does not create feelings that a two or three tier system is in operation, even if this is the case. This may be a tactic Scottish Supplies Managers wish to adopt as customers' demands and expectations rise in the changing marketplace.

6.2.4 Flexible Packages of Customer Care

The safest approach is to develop customer service is to identify practical measures by which all customers can benefit. The interviews identified the following practical techniques that are, to varying degrees, already being used in the Scottish NHS to develop more flexible packages of care for customers:

- Adoption of a customer orientated overall service philosophy,
- Use of specific Customer Care Team,
- Use of both formal and informal communications with customers,
- Developing an effective relationship with the Scottish Healthcare Supplies.

Adoption of a customer orientated overall service philosophy

The size of the Supplies Services varies throughout Scotland as does the nature and type of their customer base. Equally there are significant differences in the overall philosophical approaches adopted to customer care. These approaches can be placed

into two broad categories; those who wish to maintain and improve levels of customer care and those who are, for a number of reasons, not customer orientated.

One Supplies Manager from the pro-service school of thought adopted a text-book like stance to customer care, stating that,

> ". . . we're into total supply for our customers . . . we shouldn't be paying nurses to stock shelves or put away goods, they don't want to know about all that stuff, they just want to be able to get products from a point on the ward when they want to . . . . we see the service to customers as being like a shop from which they buy . . . . the slight difference is we've agreed up front with them the stock list."

Another Supplies Manager shared this type of positive approach to customer care, remarking that customers have to be central to everything the organisation does,

> ". . . our number one goal, the whole reason for us being in existence is to satisfy our customers . . . . I believe all the staff now appreciate this."

The final comment from the Supplies Manager quoted above reflects the crucial importance of all staff being signed up to a service philosophy. The experience and process of a Trust in trying to get a Quality Assurance certificate by the Kings Fund, an independent Government funded health related organisation, helped the Supplies staff to become more customer focused. Supplies staff, like most NHS staff, have found it difficult to make the shift in culture necessary to accept the fact they are now in a

competitive marketplace. Customer care is a new language and a new concept which has not previously been part of their working environment.

One Supplies Manager described at length the practical measures in place designed to satisfy customers without actually referring to the term customer care or customer service. In fact this denial was so strong the Supplies Manager argued that,

> ". . . this philosophy of customer care is the biggest fallacy in management . . . . it's simple, you give them what they want when they want it as long as it's affordable for both you and them."

Although the Supplies Manager's comments may demonstrate an instinctive dislike of "management speak", the final comments relating to costs are salient. There is a cost associated with whatever level of customer care is required and this fact cannot be overlooked. The Supplies Manager at a large Trust commented that,

> ". . . our role is to assist our operating areas to provide healthcare to patients at a level which is economically viable whilst at the same time giving a quality service."

This is a reflection of all the literature discussed in Chapter 2, in so much that supply chain management is about finding the balance between cost reduction/avoidance and satisfying customers. As much as financial considerations cannot be overlooked, they cannot be allowed to dominate decisions at the expense of customer care issues. One Supplies Manager interviewed admitted that his Trust management had turned the

Supplies team into "financial policemen" due to the severe financial pressures on the Trust. The Supplies Manager reflected that,

> "It's gone full circle, we were becoming what you'd call customer focused but now we're more like financial policemen . . . due to the financial constraints on the Trust I suppose . . . after all, any developments must be funded by disinvestments. It's helpful for us and our role, certainly in terms of our profile, but perhaps it's gone too far. I'm not so sure we're what you'd call customer friendly anymore."

Another Supplies Service which did not appear to have embraced the tenets of customer care was one where the Supplies Manager appeared to have a complacent attitude toward customer retention. The Supplies Manager was open in telling the researcher that relationships with customers were occasionally strained, and equally frank to point out that in his opinion the customer base needed him and his warehouse as much as he needed them. The Supplies Manager's views were captured fairly well by his comment that,

> "You know our role is very much to break bulk . . . also we have a unique set up here in that we've no real competition, largely due to our geographic position".

This type of approach is short-term, short-sighted and destined to produce friction between service provider and customer. The Supplies Manager needs to realise that no service organisation can take customers for granted. Customer support is ephemeral

and needs to be won over and over again. Whilst the particular geographic circumstances this Supplies Manager enjoys may present certain advantages, it is likely that customers will not continue to purchase a service should it become unresponsive.

The interviews with Supplies Managers also specifically discussed the question of storage philosophy which is another indicator of how customer care is managed. The use of third party storage and distribution services seems to be regarded by some Scottish Supplies Managers as the method to combine substantial cost reduction and increased customer satisfaction. Two fairly large Supplies organisations have gone as far as to shut all of their warehouses using two medical/surgical wholesalers, one food service company and a printing/stationery firm to supply goods either to a central receipt point or direct to the wards. In theory this sounds as though it could be a positive development although there are two significant concerns which appear to have been overlooked.

The first is cost related as the true costs of managing the "in-house" warehousing were not known prior to closure, therefore no financial comparison could or can be made against the costs of employing a third party. However competitive the costs of the third party operation, no decision to shut the warehouse, which may in fact have been cheaper to run, should have been taken.

The second concern emanates from the customers themselves who, when interviewed by the researcher, commented that they really weren't interested where the stock was held or distributed from but were disappointed that no financial information was available with their goods.

A more financially astute Supplies Manager from another Trust echoed the comments of this customer by stating that,

> "I'm responsible for the cost of the product at the point of use, whatever I do is guided by that and that alone . . . whatever decisions are taken in this area are taken on the basis of cost . . . not whether or not we should continue to have a store, that's totally irrelevant really".

Supplies Managers must adopt a philosophy that marries and balances both cost reduction/avoidance with customer satisfaction. All Scottish Supplies Services need to appreciate the realities of competition and discard any complacent attitudes.

Customer Care Teams

The majority of Supplies Managers interviewed do not have specifically designated Customer Care staff. The most common, and predictable, response is that customer care is the responsibility of all staff, not just one or two nominated individuals. One Supplies Manager claimed that they did not currently have such staff or any plans to appoint any as their operation ran smoothly and customers were satisfied. This is perhaps a slightly arrogant approach and one which ignores the need for a continuous reassessment of customer care delivery.

The Supplies Manager who believed his role had become one of a "financial policeman" informed the researcher that they used to have dedicated customer care staff but these had been removed from the structure as a financial saving measure.

Only two Supplies Managers employed Customer Care staff, with one using them as the first point of contact for all incoming telephone calls. The philosophy is that the two Customer Care managers and their three staff deal with enquiries rather than asking customers to find their way around the Supplies Service to have the problem resolved. This appears to be a commendable use of staff resource but one which was not beyond customer criticism. A customer comment that,

> "One of the customer care managers is head and shoulders above the other, a great fixer. But if you get X you're as well to 'phone back."

This demonstrates the importance that customer care managers are able and efficient or their involvement could have a negative effect.

Another customer from the same hospital stated that,

> "Whilst I applaud the introduction of the customer care managers . . . . it does seem as though they're constantly fire-fighting rather than being terribly proactive."

This is a valid observation acknowledged by the Supplies Manager concerned who believed the balance between fixing problems once they'd arisen and pre-empting them before they'd arisen wasn't correct.

Informal and Formal communications with customers

The need to communicate effectively with customers, be it in a formal or an informal manner, cannot be overstated. This process cannot be regarded as a one-off occurrence which is undertaken and then forgotten about but must rather be treated as an ongoing process. There are many different forms of communication, some will suit one customer but not another, so it's a question of deciding with the individual customer the most appropriate type.

Many of the Supplies Managers interviewed referred to the production of monthly Performance Indicators (PIs) as a formal means of keeping the customers advised of progress. As will be highlighted in section 6.2.5, these PIs are sometimes understood by customers and relate to targets which have been negotiated in service level agreements but in other cases are meaningless to customers.

The use of news bulletins, usually issued bi-monthly, are another way of communicating formally with the customer base. A Supplies Manager who had recently introduced such bulletins at the time of interview expounded their benefits stating that,

> "I believe that these have helped and have proved very useful in changing the attitude of the staff in the Trust to the Supplies Service . . . . although this is very difficult to prove . . ."

This perception was supported by a customer of the same Supplies Service who commented that,

> "It's a million percent better, obviously there's still room for improvement but newsflashes are quick and easy to read, they are definitely useful communications . . ."

Supplies Managers in the NHS have traditionally convened groups of their regular customers meeting either monthly, bi-monthly or quarterly to discuss service delivery and highlight any recurrent problems. This type of forum is still being widely used and it seen as an effective way to involve customers in decisions affecting the running of the Supplies Service.

The Supplies Manager who has become, by his own admission, a financial policeman appears also to have the balance wrong in terms of communicating with finance and customers. This Supplies Manager has three meetings a week with finance colleagues to review every single non-stock requisition submitted by customers. The net effect is that a large proportion of the requisitions are not approved for processing. It is not, therefore, surprising that relationships with customers are strained as this screening of requisitions sends a clear message that the Supplies and Trust management do not believe that the budget holders are capable of managing their own resources.

Customer satisfaction surveys are a further formal technique that are used by Scottish Supplies Managers to monitor and refine their service. Three surveys a year seems to be the maximum both the Supplies Service and their customers can usefully undertake

whilst the vast majority of the Supplies Managers interviewed undertake at least one survey a year. The key to the success of this technique is to act quickly to address the common problem issues identified.

Informal communication techniques can prove to be as, if not more, effective than formal techniques. Personal contact and individual reassurance is preferable to people than receiving a customer survey, participation in a group meeting or being sent a news bulletin.

Every individual enjoys the feeling that they are an important customer and that their service delivery organisation is prepared to listen and adapt to their individual needs. Even if the organisation cannot actually accommodate their exact requirements they may become more satisfied simply due to the fact their views have been listened to.

A Supplies Manager at a large Trust supported the benefit of listening, stating that,

> ". . . we've moved from a demand focused service to a customer focused service, we have listened to our customers and adapted our organisation around this. Whilst we cannot accommodate all of their requirements, just the art of listening goes a long way. We work on the premise that it's our customers' perception that counts whether or not we think it's right."

He went on to add,

> "Actually, it's our experience that customer perception tends to be less demanding than we as the service provider actually thinks it will be . ."

A Trust customer interviewed was unhappy with the fact that representatives of their Supplies Service were not more "visible" on the wards. The customer believed that there was a need for an increased Supplies staff presence at the "sharp end". This type of view further reinforces the argument that customers require a "personal touch" and that each moment of truth[3] with a customer is vitally important.

The most interesting comment came from a nurse who was employed by the Trust as a liaison between professional nursing colleagues and the Supplies Service. It appears that this post-holder had been successful in smoothing and resolving potential problems before they escalated into serious issues. The nurse commented that,

> "I believe I've managed to prevent a lot of unnecessary hassle between the two parties. Also I've helped to point out to the Supplies Staff which pieces of news on products would be important to the nursing staff. . .".

Furthermore, the Liaison Nurse commented that communication between the Supplies Service and their customer base needed to be refined and was assisting in this process. Also that "sharp end" staff valued quick response and the ability to fix problems, commenting that,

[3] See Chapter 2, Section 2.3.4.

> "In many ways, it's not only the communication itself that is important to shape perception . . . . but the ability to fix problems quickly."

A major customer of a Trust Supplies Service supported the argument discussed in Section 6.2.4 that Supplies staff needed to be seen as regularly as possible "on site" stating that,

> "At the moment we've no major criticisms of the service . . . it's better since we've started to see the staff more regularly, both informally and formally."

These comments demonstrate Supplies Managers must find a mechanism to solicit the true views of its customer base on a regular basis. Customers cannot be taken for granted if their continued business is to be given to Supplies Services in Scotland.

The interviews revealed another common theme that Supplies Managers were beginning to recognise that communications with customers, be they formal or informal need to be in easily understandable language rather than technical supplies jargon. This is reflected by the comment of one Supplies Manager who was working to ensure that,

> ".... the whole process was made easier for customers to understand and manage, we have to use customer language, not Supplies language."

Developing an effective relationship with Scottish Healthcare Supplies

A less than obvious way of ensuring that customer requirements are met is to develop an effective relationship with Scottish Healthcare Supplies (SHS). As has been made clear in previous chapters, SHS is the largest single and most influential buying organisation in the Scottish NHS. It should also be borne in mind that the number and range of contracts SHS negotiate is continuing to rise. Therefore, their decisions affect an increasingly large percentage of end users in hospitals who are customers of the local Supplies Service. The local Supplies Managers have to recognise the role of SHS, their relationship to product users and facilitate communication between the two parties. If the local Supplies Manager can communicate their customers preferences and influence SHS contract awards accordingly then their customers will ultimately benefit.

All Supplies Managers interviewed confirmed that they used central contracts, even though some were critical of the terms and conditions negotiated for some products. Two of the interviewees strongly urged the SHS to heed their call for options to be added to contracts, such that separate prices could be quoted for; bulk buys, direct delivery in the standard unit of purchase and direct delivery broken down to the level requested by individual customers. It was felt that this would better reflect the way warehousing and distribution philosophy is heading in the Scottish NHS which is toward the increased involvement of third parties.

Four Supplies Managers were prepared to admit that they use the SHS contracts as a basis for further discussion with suppliers. The justification is summed up by the comments of one Supplies Manager who argued that,

> ". . . . it's the same with all centralised purchasing outfits, it is practically impossible for them to keep their finger on the pulse locally . . . . we tend to use them as a platform for further discussion and negotiation on key, high value products."

One Supplies Manager had co-founded a Purchasing Consortium with ten other similar hospitals in the UK to contract with suppliers for items that SHS had not yet managed to include in central contracts. The Supplies Manager believed that his Consortium was in a stronger negotiating position than SHS, for although it did not control as much expenditure, it was able to give guaranteed volume take up to suppliers and therefore secure more competitive prices. There is no reason why the SHS should not be able to match these prices or obtain from it's own customers commitment to volume take up. Nevertheless the Supplies Manager had lost a sufficient amount of confidence and patience with SHS and set up what in many ways is a duplicate contracting organisation.

A Director from a Trust suggested that the SHS central funding should stop and instead link funding to their performance in respect of satisfying their customer base, the local Trust Supplies Managers. This scenario, where the Trusts pay a management fee to the SHS to cover their costs for arranging the contract, has been replicated in other central services. In this way SHS would "stand or fall" by the quality, as perceived by its customer base of its contracts.

6.2.5 Total Quality Management (TQM) and Performance Indicators (PIs)

The use of TQM and PIs are both positive ways to enhance customer care packages. It is, however, crucial that senior managers believe in their practical application rather than simply their theoretical benefits.

The degree of conceptual understanding of TQM by those Supplies Managers interviewed varied from fully conversant to non-existent. One Supplies Manager was a 'convert' to TQM and had run an extensive series of TQM courses for staff, with the aid of an experienced yet costly management consultant. It was considered to be a worthwhile investment which the Supplies Manager believed had produced tangible results. Another Supplies Manager also held TQM principles in high esteem, claiming that,

> "TQM really governs everything that we do here . . . our whole approach and attitude within the organisation needs to be focused toward the customer . . . everything we do is in support of this . . .".

At the other end of the "convert spectrum" one Supplies Manager, who clearly understood the theory of TQM, dismissed it as rhetoric yet went on to outline that in practice they actually applied it. It is within the bounds of confidentiality to comment that it was the Supplies Manager who claimed customer care to be the biggest fallacy in management whilst in reality adopting its principles!

In respect of PIs, some of the Supplies Managers who use them do not conceptually understand their role in delivering an effective customer care package. All of the Supplies Managers produced some form of PIs, mostly on a monthly basis, which were used for internal Supplies management purposes and circulated to Trust management. However, only seven of those interviewed circulated them widely amongst the customer base. One rather cynical and disappointing comment from a Supplies Manager, which devalues the importance of PIs was that,

> "I don't actually think the liaison managers at the Trusts understand them anyway . . . in any case they've no way of checking them."

However, another Supplies Manager, whilst concurring with his colleague that he didn't believe the customer base understood them, was attempting to work with customers to make the PIs more easily understood. An equally positive approach in this way was reported by a Supplies Manager who had held a series of workshops designed to ensure that only meaningful PIs were produced and circulated, commenting that,

> ". . . these PIs have been very well received by the customers as they've had a big say in what we produce ....and the customers now value this information . . . . also you know, it has increased our credibility with them tenfold."

A Trust Director's comments on PIs, which can be extended to SLAs and customer relationships in general, questions if it is feasible to use these in the NHS due to

annuality of budgets and the need to spend the whole allocation or lose it the following year. He argues that,

> "We have nine months of peace and then three months of absolute war . . . you can't have a robust agreement, targets and monitoring based around this process."

Whilst these comments are a little fatalistic, there is a degree of pragmatism in them which questions if the environment of the NHS allows the application of these concepts in their purest form.

6.3 Conclusion to Chapter

This chapter has selected the most significant comments from the interviews in order to reflect the views of those involved but in the buyer-supplier interface and the customer - NHS Supplies Manager relationship. The chapter acts as a necessary stepping stone in the process of devising review tools for both the NHS buyer-supplier relationship and the delivery of care by NHS Supplies Managers to their customer base.

The next two Chapters will describe the review tools and comment on the experiences of organisations who have trialled the use of the tools.

SECTION THREE

DEVELOPMENT OF PRACTICAL REVIEW TOOLS FOR APPLICATION IN THE NHS SUPPLIES SERVICE

CHAPTER SEVEN

PRACTICAL REVIEW TOOL FOR USE IN THE NHS BUYER-SUPPLIER RELATIONSHIP

"It is the miracle of civilised survival that the human co-operative urge reasserts itself so strongly and so repeatedly. There is so much working against it, and yet it keeps on coming back . We like to think of this as the conquest of bestial weakness by the powers of intellectual altruism, as if ethics and morality were some kind of modern invention. If this were true, it is doubtful if we would be here today to proclaim it. If we did not carry in us the basic biological urge to co-operate with our fellow men, we would never have survived as a species. If our hunting ancestors had really been ruthless, greedy tyrants loaded with 'original sin' the human success story would have petered out long ago".

Desmond Morris (b. 1928)
British Anthropologist

7.0 Purpose

The purpose of this chapter is to describe the buyer-supplier relationship review tool which has been designed following analysis of both the questionnaires and interviews as a simple means of enabling NHS buyers and their suppliers to jointly reflect on their relationship. The chapter also discusses the real experiences of the two organisations who acted as case studies in the practical application of the review tool.

7.1 Design Criteria

7.1.1 Overriding Aim of the Buyer-Supplier Relationship Review Tool

The overriding aim of the buyer-supplier relationship review tool is to provide a quick and easy to use method by which NHS buyers, in conjunction with their supplier base can identify factors that will influence the type of relationship strategy to adopt. The thesis contends[1] that NHS buyers should carry a relationship portfolio from which they choose an appropriate relationship type for particular suppliers. Furthermore, it is contended that buyers need to consider influential factors on an ongoing basis so that strategy can be adapted to suit changing circumstances.

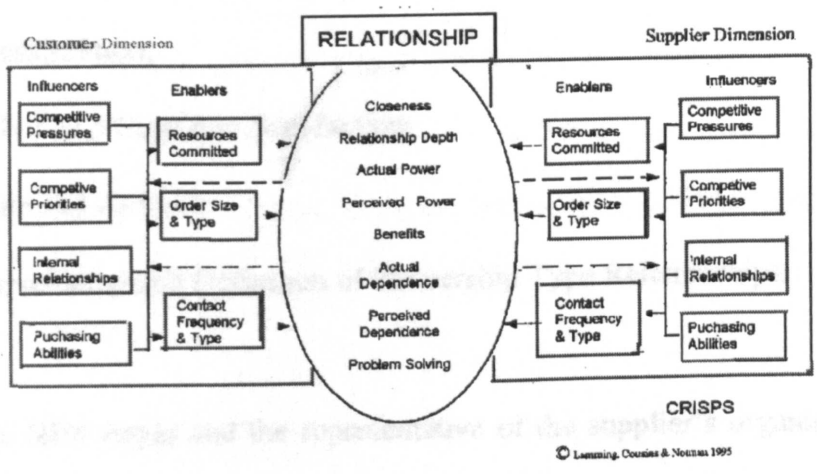
The buyer-supplier relationship review tool has been devised specifically with the NHS environment in mind and whilst the case study organisations are concerned with Scottish buyer-supplier relationships, it is suggested that the application of the review tool can be extended to the NHS throughout the UK. Indeed, the review tool concept could be applied in a commercial setting as a means of continually improving and crystallising dialogue and understanding between buyers and suppliers.

[1] As per the statement regarding the thesis contention in Chapter 1.

Lamming et al (1996) highlight the importance of both parties re-examining their relationship together to jointly improve its performance and potential to add value to each party. Lamming et al, building on both Lamming's (1993) and Cousins (1994) previous work[2], see the relationship as an entity which joins two organisations together for the purpose of a mutually beneficial business transfer. Lamming et al suggest that a Relationship Assessment Programme (RAP), as shown below in Figure 7.1, should be established between buyer and supplier.

Relationship Assessment Programme (RAP) Model **Figure 7.1**

RAP Model



Source: Lamming, Cousins & Notman (1995 : 615)

The RAP is similar to the buyer-supplier relationship review tool as described in Section 7.1.2, in that it aims to clearly identify what factors are influencing the current relationship so

that real progress can be achieved for the benefit of both parties. The buyer-supplier relationship review tool is designed, like the RAP, to help the buyer constantly review the best stance to adopt in terms of the relationship with the supplier.

7.1.2 The Buyer-Supplier Relationship Review Tool

The buyer-supplier relationship review tool, as shown in appendix X is a two part self completion questionnaire. The NHS buyer is asked to complete one part whilst a senior representative from the supplier's organisation is asked to complete the other part. The sections within the questionnaire cover the following areas:

- Current Relationship;
- Degree of Risk Sharing;
- Level of Trust;
- Communication;
- Level of End Customer Satisfaction;
- Culture and Attitude;
- Understanding and Definition of Partnership Type Relationships.

Both the NHS buyer and the representative of the supplier's organisation are then asked to review their answers and identify an action point within each of the seven headings. It is at this point that the two meet, exchanging their suggested action points and using these as a means of generating a meaningful agenda for discussion. It is crucial that the subsequent discussion is managed to produce a jointly agreed way forward to implementation in practice.

[2] See Lamming concept of the creation of a quasi firm as the relationship interface between buyer and supplier, Figure 2.1.3, Chapter 2, Section 2.2.3.

The issues identified in the buyer-supplier relationship review tool are not exhaustive and there may be areas which either party wishes to add to or delete from the questionnaire. The suggested headings emanate from analysis of the questionnaires and the interviews.

7.1.3 Ideal Characteristics of the Parties Proposing to Use the Buyer-Supplier Review Relationship Review Tool

It is essential that both parties have an open mind in respect of changing their relationship even before considering using the review tool. There must be a willingness to change and a recognition that each has something to learn from the other. This process cannot be regarded as a means of simply getting to know more about the other but must be used to effect real change thereafter. The process requires both parties to be honest in reviewing the service delivered or received in order that the joint meeting is worthwhile. It is a potentially painful experience to have their inadequacies exposed by the other party and this has to be sensitively managed such that the discussion produces an agreed corrective action plan. It is important that the final action plan is agreed by both parties so that each has a feeling of ownership which will ensure its successful implementation. The five key ideal characteristics required by both parties are:

- open mindedness;
- honesty;
- empathy;
- willingness to change;
- acceptance of the shared responsibility to implement the agreed plan.

7.2 Case Study Application of the Buyer-Supplier Relationship Review Tool

7.2.1 Introduction

BP Oil UK Ltd, Vernon Carus, Smith & Nephew and Procter and Gamble were the four suppliers selected to re-examine thei existing relationship with SHS using the relationship review tool.

7.2.2 BP Oil UK Ltd - Case Study One

Company Background

BP Co PLC is one of the world's largest petroleum and petrochemical companies which had a worldwide turnover in the first six months of 1996 of £20bn. The company has major operating units in Europe, USA, Australia and parts of Africa, as well as being in the process of expanding into South East Asia, South America and Eastern Europe. The company's main activities can be summarised as:

- exploration and production of crude oil and natural gas
- refining, marketing, supply and transportation
- manufacturing and marketing of petrochemicals

BP Oil UK Ltd is a wholly owned subsidiary of BP Co Plc and operates specifically within the UK and European markets. BP Oil UK Ltd has two marketing and two sales divisions with one of the sales divisions managing government sales. BP Oil UK's contract with Scottish Health Service amounts to £5.6m per annum which equates to approximately 60%-70% of the oil, derv and petrol market in the Scottish Health Service. Furthermore, BP Oil

UK have the only refinement plant in Scotland, which helps them to consolidate their strong market position.

BP Oil UK want, unsurprisingly, to increase their market share and their express wish is to dominate the SHS business. The company would like a longer term contract with SHS - their present contract is renewable annually. SHS, on the other hand, are concerned that the company is becoming too powerful and will be potentially able to dictate the price and general shape of the marketplace. There is also concern that the award of a contract for a period in excess of one year is justifiable and defensible from a public accountability perspective.

Pre-Meeting Points

Both parties appeared to have approached the review in an open, honest and positive manner as indicated by the preferred action points, shown in Table 7.1, which were submitted prior to the joint meeting.

Table 7.1

Pre-Meeting Points submitted by BP Oil & SHS

	BP Oil	SHS
1. Current Relationship	To establish long term supply arrangement	Increase scheduled meetings with energy buyer and with me.
2. Degree of Risk Sharing	Understand buyers risks and seek to reduce/share	Consider present level to be adequate
3. Level of Trust	Continue to be open and involve BP at investigative stage of problems	Increased openness
4. Communication	To agree contact plans outlining expectations for visits	To develop more structured meetings and improve ratio of end customer meetings
5. Level of End Customer Satisfaction	To share customer research with SH and undertake joint visits	As above
6. Culture and Attitude	To introduce/involve BP senior management in meetings with SHS	Find a way of making BP more "acceptable" and not seen as seeking to dominate Scottish scene
7. Understanding and Definition of Partnership type relationships	Explore ways and acceptability of BP being considered the preferred supplier.	Consider to what extent present relationship can be developed without risk to commercial arrangements

Summary of Discussion and Agreed Follow-Up Action

The subsequent discussion which, as with all of the case studies, was facilitated by the research and was as equally forthright. The first and probably the most significant issue highlighted by BP Oil's representative, stated that the company wishes to continue to expand their share of SHS business, Also that the company is seeking a greater level of security from SHS sales through a larger contract.

SHS presented the case from their perspective explaining that their concerns surround one supplier becoming so dominant that other competition in the marketplace is eclipsed. The SHS buyer further commented upon their need as an organisation to demonstrate that public accountability rules are being adhered to in a clear and auditable manner. An extension to the

current one year arrangement would present SHS with obvious added value in order to justify the move to both their customer base and auditors. As the conclusion to this point in the discussion, there did appear to be an increased understanding by both parties of the other's point of view to the extent that the supplier agreed to submit proposals to the buyer detailing the added value possible should the contract award be for longer than a one year period.

The frequency level and effectiveness of communication between the two parties was another important issue that emerged from the discussion. It appeared, for example, that the company were made aware for the first time of the existence of a Scottish Supplies Working Group which is considering the future role of SHS in relation to Trust-based Supplies organisation. Also that the SHS were increasingly under pressure to demonstrate their worth in the supply chain and that these discussions may result in their services moving onto a chargeable basis from 1 April 1998.

BP Oil were reminded that SHS acted on behalf of Trusts in negotiating contracts and that this formed another link in the chain (see Harland's 1996 discussion of NHS supply networks). Trusts example led both parties to agree that more frequent meetings at various levels of the organisation would help the other to empathise and better understand the pressures each faces. BP Oil agreed to propose what they labelled as a 'contact' plan which would include the level and frequency of meetings. It was felt that a meeting to concentrate on strategic issues should be included within the contact plan as well as the opportunity for the supplier to meet the wider adjudicating panel of end customers.

The degree of suppler-end customer contact was a specific issue which re-occurred throughout the discussion. BP asked SHS to endeavour advise them of any premise changes

that would affect their ability to conform to the contract whilst SHS asked that BP notify them of any direct end customer approach for technical support. Again, this simple agreement appeared to be welcomed by both parties in their efforts to make the contract administration operate more smoothly. A further point regarding end customer satisfaction was the SHS buyer's acceptance of BP's offer to share the results of their quarterly customer delivery surveys.

Conclusion to Case Study One

Table 7.2 summarises the main agreed action points resulting from BP Oil and SHS's use of the relationship review tool.

Table 7.2

Agreed Action Points - BP Oil and SHS

1. BP to submit proposals to SHS detailing the added value that would be available should a longer term contract be signed.
2. BP to propose a 'contact plan' detailing the frequency and level of communication with SHS, which will involve a strategic level meeting and contact with the Commodity Advisory Panel.
3. SHS to update BP Oil on the findings of the Scottish Supplies Steering Group.
4. SHS to advise BP Oil of any end customer premise changes.
5. BP Oil to advise SHS of any direct contact by end customers.
6. BP Oil to share with SHS the findings of their quarterly customer delivery surveys.

Both parties appeared to derive benefit from the use of the relationship review tool, as is confirmed by their subsequent comments in letters shown in appendices fifteen and sixteen.

There had, from the buyers' perspective, been an identification of the factors likely to influence the type of relationship strategy to adopt. In this instance the relationship review

tool can be seen as the key to achieving a greater understanding between the buyer and supplier. The supplier has a better awareness as to what type of proposals and the reasons why they are required in order for the development of a closer commercial relationship. The buyer, in this instance, appeared to favour developing an increased collaborative relationship (see Hutton 1995 and Ellis 1996) in order to produce added value for the end customer.

7.2.3 Vernon Carus - Case Study Two

Company Background

Vernon Carus manufacture surgical sundries, surgical dressings and a range of incontinence products in four plans in England. The company's overall turnover in 1996/96 amounted to approximately £45m of which about 50% was NHS business. The SHS business in 1995/96 was approximately £2.5m which represents an increase from the previous year. Vernon Carus has consistently won SHS tenders during the last ten years, although their annual level of business has varied. Vernon Carus are in a highly competitive marketplace with their main competitor in the procedure pack product being the French owned company, Rocialle.

Pre-Meeting Points

The preferred action points submitted by both parties prior to the meeting, as shown in Table 7.3 below, suggest that a reasonable working relationship already exists. Vernon Carus are not as dominant as BP Oil in their particular marketplace but have nevertheless experienced overall growth of Scottish Health Service business during the last few years. Naturally the company wants to consolidate and build upon this position by securing both longer term contracts and a greater volume of sales.

Table 7.3

Pre-Meeting Points submitted by Vernon Carus & SHS

	Vernon Carus	SHS
1. Current Relationship	Opportunity through HCS to talk to key member of User Group Panels – the end customer	Maintain current relationship
2. Degree of Risk Sharing	Volume/packaging costs at end of contract	
3. Level of Trust	"Short termism" particularly at Trust level	Ensure current levels remain
4. Communication	Improved response times to supplier proposals	Maintain current format
5. Level of End Customer Satisfaction	See 1 - current partnership past performance	Ensure end customer satisfaction is maintained
6. Culture and Attitude	Confirmation of improved levels of trust, willingness to share information	Maintain current approach
7. Understanding and Definition of Partnership type relationships	Understanding and agreement in the definition of 'partnership'	Explore further development

As in the case of BP Oil, SHS must make a judgement as to how to maximise the benefits available in the marketplace. The added value to be derived from ensuring that there is competition in the marketplace must be evaluated against the added value offered by one or two suppliers who are awarded increased volumes and longer term business.

Summary of Discussion and Agreed Follow Up Action

As with BP Oil, Vernon Carus requested the opportunity to talk with key members of the Commodity Advisory Panels. SHS acknowledged that such direct communication between the supplier and the end customer may be valuable although they would prefer that such contact is co-ordinated by themselves. SHS agreed to raise this issue with the Commodity Advisory Panel (comprised of key end customers) and advise the supplier of the decision.

During the debate concerning communication it became evident that Vernon Carus were as equally unaware as BP Oil had been of the existence of a Scottish Supplies Steering Group considering the future development of Supplies Services in Scotland. It was agreed that SHS would keep Vernon Carus up to date as to the work of the Group and circulate any reports that are subsequently made available to the public domain.

The next point of the discussion began with Vernon Carus expressing concern that they can be left with packaging and product at the end of contract, although they acknowledged that this is less likely to happen in Scotland than in England. SHS confirmed that their estimations of volume take-up did appear to be reasonably accurate. A senior SHS buyer added that the corporate policy was to move toward firmer volume commitment within a longer term contract framework. This would be welcomed by the supplier who would then be in a position to review their pricing structure with the security of a guaranteed income over a longer period than the existing two year contract. The final issue raised was the suggestion by SHS that each party nominated a senior member of staff to jointly manage a value engineering/analysis programme with a view to identifying measures of reducing the costs in the supply chain.

The final agreed action point was that Vernon Carus would inform SHS of any instance where Trusts approached them to establish Trust based contracts. Vernon Carus had highlighted the fact that they had recently been sent tenders by Trusts for products which are already included in SHS contracts. The company response had been to point out the central SHS contracts already existed for these items. SHS were anxious to learn of such approaches so that they could arrange follow up visits to the Trusts to discuss why they were not prepared to participate in the central contracts.

Conclusion to Case Study Two

The response of both buyer and supplier to the process was again favourable, see Appendices Seventeen and Eighteen.

Table 7.4 below summarises the main agreed action points arising from the meeting:

Table 7.4

Agreed Action Points - Vernon Carus and SHS

1. SHS to ask the Commodity Advisory Panel if they consider it appropriate that Vernon Carus have access to their members and other key end customers.
2. SHS to update Vernon Carus on the findings of the Scottish Supplies Steering Group.
3. SHS to consider, with CAP members, moving toward firmer committed volumes over a long term contract which would in turn allow Vernon Carus to review its pricing structure.
4. Both SHS and Vernon Carus to identify a senior member of staff to initiate the manage a Value Engineering/Analysis programme in order to try to reduce costs in the supply chain.
5. Vernon Carus to advise SHS of any direct approach from Trusts to establish Trust based contracts.

The relationship review tool had identified measures which can further enhance the existing relationship between the SHS and Vernon Carus. There would already appear to be a considerable amount of trust, respect, honesty and collaboration in the relationship, although parties acknowledged that this should never be taken for granted. Both parties realised that a constant review process is required to be in place so that continual improvement can be achieved. The relationship review tool appears to have acted as a catalyst to make both parties re-examine their contribution to the relationship. In summary, it would appear that the SHS buyer should continue to work with Vernon Carus to both consolidate and enhance the already effective relationship.

7.2.3 Smith & Nephew – Case Study Three

Company Background

Smith and Nephew are a large UK owned manufacturer and distributor of medical and surgical sundries with an annual turnover of approximately £1bn. The company is largely dependent on NHS for income with 75% of their business generated by NHS sales. The value of the SHS contract is £1.8m per annum which is an increase from previous years.

Pre-Meeting Points

The desired action points each party submitted prior to the meeting, as shown in Table 7.5 below clearly demonstrate that there are some problem areas within the existing buyer-supplier relationship.

Table 7.5

Pre-Meeting Points submitted by Smith & Nephew & SHS

	Smith & Nephew	SHS
1. Current Relationship	More products listed in each category – let the customer decide	Improve communication and delivery performance
2. Degree of Risk Sharing	We've been around for years and in that time the buyer and customers should be able to trust us.	
3. Level of Trust	SHS should demand clinical evaluations conducted in Scotland before a product is listed.	Improve supplier delivery performance review pricing structure
4. Communication	We could meet them more often and let them know our one year, two year and three year plans for the marketplace.	Increased understanding of each others' aims and objectives.
5. Level of End Customer Satisfaction	We can let the buyer see the results of our customer satisfaction survey.	Improve delivery performance.
6. Culture and Attitude	Who is senior management? I may have met them but I've never been given a business card, and I'm unaware as to who is senior.	More open communication.
7. Understanding and Definition of Partnership type relationships	What are the short term and long term goals of the buyer?	Explore possibility of developing partnership.

The points made by Smith & Nephew indicate a degree of frustration, particularly in respect of the communication process with the Scottish Health Service and with their own inability to secure more business with what they perceive to be high quality products. Ineffective communication is a theme which also runs throughout the SHS pre-meeting points, so too is poor delivery.

On a more positive note, both parties seem to have been prepared to express the issues which give them most cause for concern which suggests that there is a willingness to work together to resolve them.

Summary of Discussion and Agreed Follow Up Action

There were similar issues raised and discussed with Smith & Nephew as there had been with both BP Oil and Vernon Carus. Smith & Nephew's representative asked if there could be hospitals within Scotland designated as trial centres at which all new products had to be evaluated prior to being accepted onto contract. SHS representatives explained that it is the role of the Commodity Advisory Panels to co-ordinate trials and also that adding new items during the contract period would potentially undermine the whole contracting process. The discussion broadened to cover the review of Supplies Services which was being undertaken by the Scottish Steering Group and the potential implications of their recommendations.

The SHS representatives stated that their role and position was being evaluated to determine if their very existence was still required. As highlighted in the previous two case studies the possibility of SHS moving to a fee earning basis was raised. The SHS representatives suggested that in order to secure a future for both buyer and supplier, there needed to be joint working to review and, where possible, eliminate the unnecessary costs currently in the

system. It was again suggested that this review take the form of a Value Analysis/ Engineering exercise managed by sufficiently senior staff of each party to implement change.

SHS representatives repeated the offer made to the two previous suppliers stating that longer term contracts with firmer volume commitment could be negotiated subject to suppliers agreeing to supply at more competitive prices. The meeting between Smith & Nephew and SHS was probably the most rewarding given the initial stance taken by both parties when submitting their pre-meeting points. The discussion and subsequent agreed action took the relationship forward, helping to break down the barriers of suspicion, disrespect and myth.

Poor delivery was a theme which the SHS buyers constantly referred to at the meeting as being a problem for end customers throughout Scotland and specific instances were cited. The company representative acknowledged the problems, suggesting that the recent change of distributors had not been smoothly handled. The company representative explained that there were now more rigorous internal systems in place designed to correct the problems as well as monitor performance more closely.

As ever, the process of communication was discussed at length and consideration given as to the effectiveness of the current arrangements at both a strategic and end customer level. Both parties felt there would be merit is at least one strategic level meeting per year. This debate led into the specific issue of the English NHS Supplies ultimatum to suppliers that unless they signed an agreement guaranteeing one price throughout the NHS in the UK regardless of volume commitment, the supplier would be precluded from English NHS business. In respect of communication with the end customer level, the company offer of sharing their customer satisfaction surveys was welcomed by SHS buyers. It was felt that this type of information

could be used as a means of Smith & Nephew generating an agenda to meet with end customers, particularly those involved in Commodity Advisory Panels.

The benefit of using EDI was an issued that Smith & Nephew had referred to in their self completion questionnaire in which the company had strongly agreed that this would be developed as a means of enhancing communication. This point was also alluded to during the course of the meeting. As a principle, it was acknowledged that measures to enhance communication, such as EDI, would be unable to help improve relationships without a strategic commitment to co-operation and communication in general (see Bungart and Pinnington, 1996).

Another specific issue that arose from the debate which is limited to both communication and the level of understanding each party has of the other relates to organisational structure. Smith & Nephew's representative asked if he could be sent a copy of SHS's organisational chart and would in return be prepared to exchange this for the company chart. It was agreed that this type of knowledge would possibly help both parties to learn more about the other and effect an improved relationship.

The final issue to be agreed during the discussion was that the success of improving the relationship was to be measured predominantly through the number and extent of tangible and practical changes that happened. Whilst it was recognised as important to have an agreed strategic statement that both parties could sign up, the effort and time spent on achieving this should not be at the expense of more practical developments.

Conclusion to Case Study Three

Given the starting point to the meeting and the recent history of the interaction between the two parties, the review tool helped to lay the foundations to significantly improve the relationship between Smith & Nephew and SHS, see Appendices 18 and 19.

Table 7.6 below summarises the main agreed action points arising from the meeting.

Table 7.6

Agreed Action Points – Smith & Nephew and SHS

1. SHS to consider through the Commodity Advisory Panel the suggestion by Smith & Nephew that hospitals within Scotland are designated as 'trial centres' through which all products pass prior to being accepted onto contract.
2. SHS to update Smith & Nephew on the findings of the Scottish Supplies Steering Group.
3. Both SHS and Smith & Nephew to identify a senior member of staff to initiate and manage a Value Engineering/Analysis programme in order to try and reduce costs in the supply chain.
4. Smith & Nephew to submit proposals to SHS detailing the added value that would be available should longer term contracts and firmer volume commitment be possible.
5. Smith & Nephew to continue to improve upon delivery performance.
6. Both parties to consider how more strategic level meetings could be handled.
7. SHS to consider what action to take regarding NHS Supplies 'national' pricing policy.
8. Both parties to exchange organisational charts.
9. The measure of success to improve the relationship is to centre upon tangible change rather than production of joint documents/strategy.

It is vitally important that follow up action is seen to take place to ensure that the process does not lose credibility and equally that each party can trust the other to perform the agreed action. There is an opportunity to develop the relationship having highlighted areas that jointly need to be enhanced.

7.2.5 Procter and Gamble – Case Study Four

Company Background

Procter and Gamble (P&G) is a large US owned multi-national company supplying a wide range of goods and services. In 1966 P&G's annual overall turnover amounted to £15 billion of which the majority was direct retail sales. It is estimated that UK NHS business accounts for less than 1% of total UK sales of which 10% is generated from the Scottish Health Service.

The company supplies a range of pharmaceutical and incontinence products to the NHS, achieving approximately 30-35% of the Scottish NHS business. Molnlycke is currently the dominant force in the Scottish NHS incontinence market with approximately 50-55% of the total business. P&G are obviously keen to increase their level of business by attracting some of Molnlycke's existing customers.

Pre-Meeting Points

A desire to increase and enhance the level of communication is a theme that runs throughout the pre-meeting points of both parties, see Table 7.7 below. The thrust of the P&G points is to call for the establishment of a closer and more open working relationship between themselves, SHS and the end customers.

Table 7.7

Pre-Meeting Points submitted by Procter & Gamble & SHS

	Procter & Gamble	SHS
1. Current Relationship	Scheduled meetings with a clear and set agenda.	Improve process of communication
2. Degree of Risk Sharing	• Initiate a joint strategy document. • Inclusion (and support for) 2.5% settlement discount onto our published price list.	
3. Level of Trust	• Joint training • Sharing of market data and market forecasting. • Joint performance reviews	More open communication regarding developments.
4. Communication	• EDI • Feedback from meetings	Earlier communication regarding proposed changes.
5. Level of End Customer Satisfaction	Joint audit of end user satisfaction	Greater awareness of different customers' needs.
6. Culture & Attitude	Multi-level management meetings, allowing specialists to align. Eg. IT and IT.	Improved understanding of customers' needs.
7. Understanding and definition of Partnership type relationships	Development of published value added service.	Explore the possibility of developing the relationship.

Summary of Discussion and Agreed Follow Up Action

P&G's first suggestion was that there should be a series of scheduled meetings established between themselves and SHS throughout the year. In common with the previous companies, P&G were keen to highlight the potential benefits from meetings at various levels within the organisation, starting with a debate on strategic issues. P&G also echoed their supplier colleagues by asking if they could have access to the members of the relevant Commodity Advisory Panels to either give formal presentations or hold individual 'surgeries' to address specific problems. SHS responded that they were happy to consider a proposed schedule of meetings to enhance the process of communication but that the access to the CAPs would need to be discussed with CAP members.

P&G expressed their desire to devise a strategy statement and subsequently a strategy document that would act as a framework within which the relationship with SHS would develop. P&G referred to their in-house model which reviews objectives, goals, strategy and process (OGSP) in any relationship suggesting that this could be extended to cover external partners. SHS commented that they would be happy to discuss the OGSP model further and asked for more detail.

A specific issue around the payment of invoices was raised and P&G pointed out that the 2.5% settlement discount for early payment was being "missed" by some Scottish Trusts. In England the company reported that this is now built into the price as they are guaranteed by the Supplies distribution centres of payment within the agreed deadline. SHS explained that they are not in control of Trust payments although they would be happy to encourage more timeous payments from the "rogue" Trusts.

P&G made some innovative suggestions under the heading of "trust" within the relationship. The first was to extend an invitation to SHS to send staff on training courses with P&G staff. It was felt that apart from the direct training benefits there would be potential added value through an increased understanding of each other's situation. SHS welcomed this and asked for proposals as well as commenting that it would be preferable from a public accountability perspective if such courses were run by a professional body.

The second suggestion was that SHS buyers be asked to comment on P&G sales staff performance which would then be included in the individual's annual performance review. Furthermore, P&G asked that if this proposal was pursued, it be reciprocal so that P&G sales staff could comment on SHS buyers. SHS representatives commented that such an exchange

of view could be beneficial if managed in a constructive manner, although it was not felt appropriate to include in the SHS staff appraisal process.

SHS asked if P&G could inform them of any planned product changes well in advance of implementation. The discussion broadened with SHS explaining that there was currently a group chaired by a Trust Chief Executive which is reviewing the supplies function in the Scottish Health Service. SHS representatives commented that there are possible changes which may result in the funding of their organisation, specifically that they may become 'fee earning'. In effect SHS will then act like any other business covering its cost from the income derived from customers. This will obviously place greater pressure on SHS to satisfy their customers to ensure that they retain their income stream.

The theme of communication continued with P&G commenting that they are still prepared, as they have been for the past two years, to invest in EDI links with the Scottish Health Service. SHS representatives accepted that EDI had not been widely implemented in the Scottish NHS and suggested that electronic cataloguing and emails may now supersede EDI. This debate led on to links with the end customers and P&G's suggestion that a joint audit of end customer satisfaction be undertaken.

P&G then focused upon the contract award process and asked if they could be informed of any potential loss of business prior to the issuing of letters. SHS representatives explained the requirements of audit and that decisions taken by CAPs are communicated in writing to all tenderers at the same time. SHS intimated that they would be happy to offer unsuccessful tenderers a debriefing. P&G asked if consideration could be given to a system whereby 2 or 3 tenderers are shortlisted and invited to present to CAPs.

Conclusion to Case Study Four

The use of the relationship review tool generated discussion on a range of issues and produced meaningful action, as summarised in Table 7.8:

Table 7.8

Agreed Action Points – Procter & Gamble and SHS

1. P&G to propose a schedule of meetings detailing the level and frequency of meetings. The initial meeting to focus on strategic issues.
2. SHS to discuss P&G's request to have access to members of the relevant Commodity Advisory Panels, either to give formal presentations or to have 'surgeries' to address particular problems on an individual basis.
3. P&G to send SHS a copy of the generic dataset used by both to review the marketplace.
4. P&G to send SHS the generic OGSP model documentation for consideration and possible use within structured meetings.
5. P&G to identify those Trusts who are "slow" payers and SHS to point out the savings that Trusts could achieve if they pay invoices within the settlement deadlines.
6. SHS to consider proposals from P&G to develop joint staff training, subject to such events being facilitated through a third party, preferably a professional body.
7. SHS to consider the proposal that a reciprocal staff appraisal scheme is initiated where buyers are given the opportunity to comment on each other's performance. P&G to send generic documentation relating to this.
8. P&G to keep SHS updated on any planned product changes.
9. SHS to keep P&G informed of the implications arising from the recommendations of the Scottish Supplies Review Group.
10. SHS to consider P&G proposal that the contract award process incorporates the opportunity for shortlisted companies to give presentations to CAPs.
11. P&G and SHS to identify by whom and how a joint audit of end customer satisfaction should be managed.

The feedback from P&G and SHS, see Appendices 20 and 18, demonstrates that both parties felt their relationship was enhanced by the use of the relationship review tool.

7.3 Conclusion to Chapter

The discussion in this chapter has demonstrated that effective relationships are a prerequisite for successful interaction between two parties. Each party has to be able to empathise with the other so that they can reach a common understanding as to how to work together for mutual gain. This principle has firstly to be accepted by senior management before it can permeate throughout an organisation.

John Browne, the Group Chief Executive of BP Co Plc appears to be aware of the importance of relationships and senior management contact, stating

> "our industry depends upon the quality of our relationships... without successful relationships with partners, many of our activities.....would not be possible"
> (BP Annual Report and Accounts 1995:14).

The case studies have shown that the relationship review tool can help an NHS buyer evaluate an existing relationship with a supplier identifying factors that can influence how the relationship currently operates and also how it can develop. The review tool may indicate that increased collaboration is not preferable in every instances and as Hutton (1995) suggested, the potential key to success is determining the balance between collaboration with a supplier and encouraging sufficient competition in the marketplace.

> "Men and women are social animals, but with conflicting demands and passions. They seek association with each other and value the esteem of others, they desire health and autonomy. *They thrive on the stimulus of competition,*

> *they recognise the value of co-operation*, the importance of security and the need for boundaries to individual actions." (Hutton 1995 in Ellis 1995:385 – my emphasis).

An outcome of using the relationship review tool should be that an ongoing review of supplier relationships are started. The NHS is an organisation which strongly exhibits the characteristics of constant change, therefore NHS buyers need to accept that their relationships with suppliers will constantly change. As Fowler observed,

> "....the complexity of the NHS and the political nature of controls exerted over it have led to a climate of changing aims, structures and policies.....within this, the supplies function has changed both as a result of the wider changes and as a result of the gradual awareness of the importance of controlling an expenditure of £4 billion per annum". (Fowler 1996:576).

It is equally important to approach any relationship review with pragmatic expectations as to the level of improvement that can be achieved. Kearney states

> "It is clearly true that many organisations have missed opportunities and incurred needless cost by adopting adversarial and antagonistic positions in their commercial behaviour. The solution to this, however, does not always hinge on developing "partnership" type relationships in which firms (organisations) become encumbered by false expectations". (Kearney 1995:33).

Improving a supplier relationship is not an easy nor a quick process but one which requires the investment of time and resource. On the basis of the case studies, the relationship review tool appears to be a very useful way for the NHS buyer to start this process.

Indeed, Scottish Healthcare Supplies intend to use the review tool to evaluate relationships with their top five suppliers within each commodity area, see Appendix 21.

CHAPTER EIGHT

PRACTICAL REVIEW TOOL FOR THE DELIVERY OF NHS SUPPLIES CUSTOMER CARE

"You can automate the production of cars, but you cannot automate the production of customers".

Walter Reuter (1907-1970)
American Trade Union Leader

8.0 Purpose

The purpose of this chapter is to describe the customer care review tool, which has been designed following analysis of both the questionnaires and interviews as a simple means of enabling the Supplies Managers and their customers to jointly refine how customer care is delivered. The chapter also discusses the real experiences of the two organisations who acted as case studies is the practical application of the customer care review tool.

8.1 Design Criteria

8.1.1 Overriding Aim of the Review Tool

The overriding aim of the review tool is to provide a quick and easy to use method by which Supplies Managers, in conjunction with their customer base, can determine and understand factors that may inhibit their ability to offer increased levels of care to all NHS customers. The thesis contends that in order for NHS Supplies Services to survive against the threat posed by external competitors, flexible packages of care to meet the increased expectations of all customers must be offered. The formulation of this review tool takes account of the unique and constantly changing circumstances of the NHS environment[1]. Whilst the case study organisations are based within the Scottish Health Services, which admittedly has some significant organisational differences to England, Northern Ireland and Wales, it is anticipated that the customer care review tool will also be applicable to English NHS Supplies organisations.

[1] See Table 2.3 in Chapter 2, Section 2.3.7

8.1.2 The Customer Care Review Tool

The customer care review tool, as shown in Appendix 22 is a two part self completion questionnaire and operates along the same lines as the buyer-supplier relationship review tool. The Supplies Manager is asked to complete one part whilst a representative of the customer base is asked to complete the other part. The sections within the questionnaire cover the following areas:

- Clarity of Customer Requirements;
- Customer Care being Central to Planning;
- Flexibility of Approach;
- Use of Customer Care Teams;
- Use of Total Quality Management;
- Use of Performance Indicators;
- Relationship with Scottish Healthcare Supplies.

Both the supplies and customer representatives are then asked to review their answers and identify an action point within each of the seven headings. It is at this point that the two meet, exchanging their suggested action points which generates a meaningful agenda for discussion. It is crucial that the subsequent discussion is managed so that it produces a jointly agreed way forward which is implemented in practice.

The customer care review tool is not meant to be prescriptive and there may be areas that either the Supplies Service or the customer wants to add or delete from the discussion. The suggested headings, which are offered only as a guide, are the common areas of interest as indicated by the findings of the questionnaires and interviews.

However, the use of the review tool should not necessarily be restricted to these issues, there may be areas of the relationship that need to be reviewed other than those proposed within the review tool which, subject to the agreement of both parties, should also be considered. . One of the primary benefits of using this model is to develop better and more effective communication between Supplies Managers and their customer base. Indeed the need to improve communication is a central tenet of the recommendations contained in the 1996 National Audit Office Report on NHS Supplies which is entitled "Goods for Your Health : Improving Supplies Management in NHS Trusts".

8.1.3 Ideal Characteristics of Parties Proposing to Use the Customer Care Review Tool

The same ideal characteristics apply for parties using the customer care review tool as for the buyer-supplier relationship review tool. To reiterate them, the five key ideal characteristics required by both parties when embarking upon the process are:

- open mindedness;
- honesty;
- empathy;
- willingness to change;
- acceptance of the shared responsibility to implement the agreed plan.

8.2 Case Study Application of the Customer Care Review Tool

8.2.1 Introduction

The two organisations who agreed to be case studies for the application of the customer care review tool were Fife Healthcare Supplies Service and Kirkcaldy Acute Hospitals (KAH) NHS Trust. An introductory profile of Fife Healthcare (FHC) Supplies Service has already been outlined in Chapter 3. It is appropriate, therefore, to broadly describe KAH NHS Trust and the relationship with FHC Supplies Service.

8.2.2 General Profile - Kirkcaldy Acute Hospitals NHS Trust

Kirkcaldy Acute Hospitals NHS Trust comprises of two hospital sites, the Victoria Hospital which is a multi-speciality District General Hospital and Forth Park Hospital which provides inpatient Obstetrics and Gynaecology services. The Trust's total income per annum in 1995/96 amount to approximately £40m and employed some 1,200 whole time equivalent staff.

The Trusts states in its Business Plan that it:

> "exists to work closely with other provider hospitals, purchasers of services, General Practitioners and the users of healthcare to improve the health of the people of Fife. It aims to improve the access of the people of Fife to these services in a local setting, wherever possible".
>
> (Kirkcaldy Acute Hospitals Trust 1994:4)

The Trust's strategic objectives, as listed in the same document are:

- to develop patient-focused services within a health promoting hospital;
- to achieve the shift in emphasis from inpatient to day case and outpatient services and joint working with community healthcare services which this will require;
- to provide a positive, high quality and enabling environment in which staff maximise both their individual and team strengths;
- to meet NHS, purchaser and GP objectives;
- to ensure financial viability through
    - the successful negotiation of contracts with purchasers which meet those purchasers' service and quality requirements,
    - operational efficiency and cost effectiveness which is reflected in competitive contract prices.

8.2.3 The existing relationship between Fife Healthcare Supplies Service and Kirkcaldy Acute Hospitals NHS Trust

As part of the drive to cost effectiveness, the Trust has to monitor both its staff and non-staff expenditure. It is estimated that 25% of all costs are related to supplies expenditure which, in KAH's case, are managed for the Trust by four supply departments of which Fife Healthcare Supplies Service is one. Obviously the success of Fife Healthcare Supplies Service in fulfilling this role is crucial for the financial viability of the KAH NHS Trust. The current relationship between the two parties is on the basis of a contractual agreement which specifies the type and quality of services KAH NHS Trust requires and the price it is prepared to pay for them. The current service is very much based around the storage and distribution function, with procurement largely managed by the Scottish Healthcare Supplies central contracts. It is important to be aware of the wider picture to more fully understand the financial

problems Kirkcaldy Acute Hospitals NHS Trust is facing, which places an increased emphasis on the management of the supply chain. KAH needs to reduce its cost base in order to constantly achieve the level of annual savings required by its main purchase, Fife Health Board. This has focused the KAH Trust's attention on all non core activities such as domestics, catering, laundry and general ancillary services. The Trust has initiated a programme of market testing which has resulted in some services being contracted out to third parties in an attempt to reduce overheads. The Supplies Service has been provided by Fife Healthcare Supplies Service, part of the Community Trust in Fife since 1993.

The Supplies Service was previously a Fife Health Board function which all Fife hospitals used without having to pay a fee. The introduction of the internal market, bringing with it the creation of Trust hospitals, saw the Supplies Service being attached to the Community Trust for reasons largely of managerial convenience. The three Trusts in Fife all agreed to continue to use the Supplies Service and pay for a percentage of their operating costs which reflected their proportionate use of the service. Over the past four years contract documents have been developed on an annual basis to formalise this relationship detailing the service levels expected by the customers of the Supplies Service. KAH NHS Trust is a significant customer of the Fife Healthcare Supplies Service and an important source of income. Equally, KAH NHS Trust relies upon the Supplies Service to manage a large percentage of costs on its behalf. In essence, both parties are, to some degree, dependant upon the other and the relationship between the two is crucial. Whilst the contract document is reasonably well developed in terms of financial payment and contains some basic performance indicators in relation to the storage and distribution function, it is less sophisticated or

expansive concerning the "softer" aspects of customer care. This is an area which could potentially be developed to enhance the relationship.

As indicated previously in Chapter 4, both parties recognise the importance of building upon their existing relationship and expressed their willingness to act as case studies with the review tool as a means to making progress to this end.

Following initial discussions with both parties, it became clear to the author that there were aspects of the current relationship between FHC Supplies and KAH which could be improved. There appears to be a gap between the perception of the service KAH believed they should receive and what they actually received. KAH appear to want more than a third party storage and distribution service believing that the Supplies Service has a significant role to play in helping the Trust achieve their savings targets. The Trust seem to think that the Supplies Service are not being proactive in this respect and could contribute a great deal more to aid the Trust's financial recovery. The Trust has suggested that a senior member of the Supplies Service be designated as a dedicated "Account Manager" for KAH Trust.

FHC Supplies Service, on the other hand, gave the impression that they believe they are providing an efficient and effective service which meets their contractual obligations. They appear to be aware of their customer's desires to develop the service, but argued that such developments cannot be progressed as the Trust is not prepared to pay the additional costs. Both the Supplies Service and the Trust made reference to a series of meetings which had been unsuccessful in progressing these issues.

8.2.4 Pre-Meeting Points

The pre-meeting points submitted by both parties, see Table 8.1 below, were strikingly similar.

Table 8.1

Pre-Meeting Points submitted by KAH NHS Trust and FHC Supplies Service

	KAH NHS Trust	FHS Supplies Service
1. Clarity of customer requirement	Set up contract review meetings and customer liaison meetings – joint action.	Set up service review group
2. Customer care being central to planning	Supplies Service to determine a change in communication and attitude to customer	To ensure facility exists to communicate changing service needs.
3. Flexibility of approach	Supplies Service to review how best to meet customers' VFM needs and assist with product choice.	Change from a culture of a rigid financial based service level agreement to a service type.
4. Use of customer care teams	Jointly set up a customer liaison meeting on medical supplies	To implement means of joint working, eg. Task group.
5. Use of Total Quality Management	Supplies Service to review how this might achieve action point 2.	To ascertain a system which will produce benefits.
6. Use of performance indicators	Supplies Service to review information that would be useful to customer	To agree a range of indicators which will be of use to both parties.
7. Relationship with Scottish Healthcare Supplies	Supplies Service to discuss ideas with SHS on how to meet customer needs.	Examine means of heightening the profile of SHS to customers.

Both appeared to recognise that change an attitude and working practices were required to enhance their relationship so that a customer focused approach could be adopted by the Supplies Service. The Supplies Manager demonstrated that he had used the customer care review tool to undertake an hones re-evaluation of the service his organisation provided. The Supplies manager had identified independently from the customer, the shortcomings of the service. It is important that in order to be able to correct gaps in service delivery there is firstly an acknowledgement of the issues. However, it could be argued to be fortuitous that the issues flagged up by the Supplies Service coincided so well with those identified by the Trust. After all, it is the

customer's perceptions of service deficiency that are the key towards restoring them rather than the perceptions of the service provider, as Christopher points out:

> ".. it is important to understand the factors that influence buyer behaviour and, in the context of customer service, which particular elements are seen *by the customer* to be the most important". (1993:36) (My emphasis).

8.2.5 Summary of Discussion

Clarity of Customer Requirement

Both parties agreed that a mechanism should be established to enable the Supplies Service to increase its contact with customers in the Trust. FHC Supplies Manager commented that at the time the service was set up in 1993, there had been considerable customer input and participation in the planning process. However, during the discussion, the Supplies Manager conceded the point that the level of customer involvement had greatly diminished such that there was now very little regular interface between the two parties, apart from at times of crisis. The Supplies Manager recognised that customers' demands are constantly changing and acknowledged the need to continually gather customer opinion. Juran highlights the point in respect of changing customer needs, stating:

> ".. customers' needs do not remain static. There is no such thing as a final list of customer's needs". (1988:57).

Two levels of contact were discussed, one a strategic meeting which would be held quarterly to review the "business" aspects of the service and the other a monthly customer liaison forum to discuss more operational level issues. The question of who

acts as the lead from both sides was debated. In respect of the Supplies Service, it was felt that the vacant Assistant Manager post would have been ideal but delays in recruitment precluded this option from serious consideration in the short term. A combination of the Supplies Manager and the buyer with responsibility for Kirkcaldy Hospitals was discussed and considered to be a more feasible option. This would ensure that there was input from both senior management and the staff member closest to the Kirkcaldy issues. The Trust's Director of Finance commented that the lead input from the Trust for strategic meetings is likely to be drawn from either the Finance or Nursing Directorates, whilst the lead for the customer liaison meetings will likely come from Nursing.

There were two other issues discussed under the general heading of clarity of customer requirements. Firstly, the feasibility of the Supplies Service initiating a newsletter and secondly the issues of an e-mail link being established between the Supplies Service and KAH.

Customer Care being Central to Planning

The concept that customer care has to be central to planning services was accepted by both parties. Furthermore, the Supplies Manager accepted that the current working practice of the Supplies Service did not reflect this. The need for training to help to change the mind set of Supplies staff and to reinforce the customer care message was discussed in detail. However, the stumbling block was the fact that there is insufficient resource within the Supplies budget to cover the level of training required. The Trust's Director of Finance suggested that joint training exercises could be developed and also invited the relevant Supplies staff to meet Trust staff to increase their mutual understanding by face to face contact.

Flexibility of Approach

The Trust's Director of Finance commented that his own sample survey of end customers suggested that the Supplies Service needed to consider implementing a 'Quick Response' (QR) type facility. QR, which is becoming very prevalent in the private sector, means organisations working to provide a rapid response to individual requests. The development of QR for FHC Supplies Service would be offering a quite different service to the current delivery schedules. FHS Supplies Manager felt that the first step would be to try and achieve a combination of the two assuming, of course, that the customer base did actually want QR. This again reiterated the point that service developments are provided only when customers have requested them rather than because the service provider thought that they wanted them. The benefits associated with a customer audit were discussed which would include questions to determine if, and to what extent, QR was wanted.

Use of Performance Indicators

The current performance indicators (PIs) produced and circulated by the Supplies Service appeared to be of little use to the end customers. The Supplies Manager stated that their primary purpose was to allow Supplies management to administer the warehouse bonus scheme. The Trust's Director suggested that two discrete sets of PIs should be produced. The first set for the ongoing financial monitoring of expenditure broken down to Service Departments, produced monthly and circulated to Service Managers. The second set would be intended for senior management who are more likely to be interested in trend analysis of issues such as overall spend and the Supplies ability to deliver levels of service as agreed in the service level agreements. There was also discussion as to the detail the end customers would like so that they could more

effectively manage ward stocks. It was agreed that this type of question should be posed at an early meeting of the Customer Liaison Group so that the customers could themselves decide, as Christopher points out,

> "The importance of this initial step in measuring customer service is that relevant and meaningful measures of customer service are generated by the customers themselves". (1993:36).

The Supplies Manager also referred to the 1996 Audit Commission report and suggested that the set of performance indicators recommended for use by NHS Supplies Service should be re-examined with a view to asking customers if they felt these would be applicable to their situation.

Relationship with Scottish Healthcare Supplies

As already discussed in Chapter 7[2], the performance of SHS as the central contracting body for the Scottish Health Service, has an impact of local Supplies Services' ability to deliver a value for money service to end customers.

FHC Supplies Manager believes that the end customers were unaware of the role of SHS and would, in any case, be unlikely to be interested in hearing about the relationship between SHS and the local supplies organisation. The Supplies Manager suggested that the end customers are only concerned with getting the products they want, not in knowing from whom they get them. Nevertheless, the Supplies Manager did agree to invite the relevant SHS staff to meet a selected number of Trust end customers to discuss the suitability of current contract items, particularly within the medical and surgical commodity area.

The Trust's Director of Finance referred to the possibility that the SHS contracting services may become fee earning from April 1998, in which case he would want the FHS Supplies Manager to advise him whether or not they should continue to be used or an alternative arrangement sought.

8.2.6 Agreed Action

The agreed action points that resulted from the initial meeting, as shown in Table 8.2, demonstrate that progress was achieved in developing the relationship between KAH NHS Trust and FHS Supplies Service. Obviously, these points need to be followed up by both parties in order to implement real change.

Table 8.2

Agreed Action Points – KAH NHS Trust and FHC Supplies Service

1.	Establish a Strategic Supplies Review Group to meet quarterly. The Supplies Manager to lead for the Supplies Service and the Trust to identify a lead, probably from either the Finance or Nursing Directorates.
2.	Establish a monthly Customer Liaison Group to consider operational issues. The Supplies Manager and the Buyer with responsibility for Kirkcaldy to participate. The Trust to identify a lead, probably from the Nursing Directorate.
3.	The Supplies Manager to consider the feasibility in cost and service terms of establishing a Supplies newsletter and e-mail links to KAH.
4.	KAH to determine if customer service training initiatives can be extended to include FHC Supplies staff.
5.	Both parties to consider benefits and practical implications of Trust staff meeting FHC Supplies Service buyer(s).
6.	The Trust's Director of Finance to write to the FHC Trust Director with overall responsibility for the Supplies Service to stress the urgency to recruit a replacement to the post of Assistant Supplies Manager, who would have customer service as part of their remit.
7.	Both parties having agreed that the strategic and operational groups needed clear remits are to detail their thoughts as to what the remits should cover.
8.	The Trust's Director of Finance to consider who should receive senior management performance information.
9.	FHC Supplies Manager to review the PI headings referred to in the 1996 Audit Commission report and make suggestions to the Trust's Director of Finance.
10.	FHC Supplies Manager to speak with the Assistant Director of SHS to devise ways by which SHS's profile could be raised with end customers. One option would be to invite relevant SHS Contracts Managers to give presentations to key Trust staff.

[2] See Chapter 7 for discussion relating to SHS role in NHS Supply Chain

8.3 Conclusion to the Chapter

Understanding customers' real requirements as opposed to those perceived to be required by service providers is the essential first step to an effective customer care relationship. Supplies Service in the NHS cannot afford to take the business of existing customers for granted or they risk losing their customers and their associated income streams. Following the NHS reforms, the introduction of market forces has meant that NHS Trusts can choose between existing Supplies Services and alternative providers. As the thesis contends, the Supplies Services need to offer flexible packages of care to meet the increased expectations of all of their customers in order to survive and grow. As has been demonstrated by the case study, the customer care review tool does provide a mechanism by which an existing relationship between a Supplies Service and a customer can be reviewed and enhanced. The customer care review tool assists both parties in the identification of factors that can potentially inhibit or facilitate the Supplies Services' ability to offer increased levels of care within the NHS.

Both KAH NHS Trust and FHC Supplies Service believe that there were tangible benefits derived from using the customer care review tool, see appendices 23 and 24. KAH's £15m spend per annum on Supplies is managed by three organisations other than FHC Supplies which are their own Pharmacy Department for Drugs, their own Estates Department for Building and Engineering Products and another NHS Trust's Sterilisation Centre for theatre procedure packs. The Trust's Director of Finance intends to use the Customer Care Review Tool to initiate a re-evaluation of the relationship each of these departments has with end customer in order to try to produce a greater value for money and customer orientated service. Similarly, Fife Healthcare

Supplies Manager believes the review tool can be used to re-evaluate the relationship with the two other major NHS Trust customers or the Supplies Service.

The need to constantly clarify customer requirements, testing out assumptions through dialogue with customers, is a process that can be initiated by the customer care review tool. Business winners, be they in the public or private sector, are characterised by having close, effective and dynamic relationships with the customers. Service providers must always stay focused on customers' needs, as Alutto comments,

> "..businesses seen as average and those generally believed to be outstanding tend to be reflected in greater commitment to, and focus on, a clear set of limited (customer) goals. Less successful organisations dissipate similar levels of resources trying to be all things to all people." (Alutto 1991:9).

In other words, the message is to determine and constantly reaffirm what key service components the customer wants and then to deliver these. In the NHS setting, Supplies Services could employ the Customer Care Review Tool as a catalyst to start and also to periodically redo this task.

CHAPTER NINE

RESEARCH CONCLUSIONS

"Progress is impossible without change, and those who cannot change their minds cannot change anything".

George Bernard Shaw
Writer
(1856-1950)

"Sobriety, not subtlety, realism not imagination are the key words to wisdom: the really important facts of life lie scattered openly along its surface, not cunningly secreted in its depths. There is no need, indeed it is a fatal mistake, to deny, as poets, intellectuals, priests and other professional complicators of the world so often do, the obviousness of the obvious".

Geertz
Philosopher
(b.1937)

9.0 Purpose

The purpose of this chapter is to discuss the extent to which the construction of the two review tools has succeeded in addressing the research aims of:

- identifying factors that can be used to shape and adapt the relationship strategy adopted by NHS buyers with their supplier base, and

- identifying factors that affect the way in which NHS Supplies Managers can enhance the delivery of care to their customer base.

The degree to which the thesis contentions[1] have been considered throughout the research will also be discussed.

The mechanism to do this will be to briefly outline each of the key factors that have emerged as a result of this research in respect of both the buyer-supplier and supplies manager-customer relationships. In accordance with the theme of this research, practical action points will be suggested throughout this chapter.

9.1 Key factors affecting the NHS Buyer-Supplier Relationship

It became clear during the course of the research how important it is for both parties involved in an NHS buyer-supplier relationship to define and agree at the outset the type of relationship strategy that they are working within. It appears to be especially

[1] See Section 1.2.2 for the Buyer-Supplier contention and Section 1.2.3, for the Customer Care contention

important that such **clarity of definition** is achieved if the parties are trying to establish a form of partnership. It should also be borne in mind that collaborative or partnership type relationships are neither quick nor easy to set up. Traditionally, NHS buyer-supplier relationships have been adversarial in nature which can, if used selectively, be a useful part of an overall relationship strategy. Equally, partnership type relationships should not be seen as a utopian situation as the adoption of such a strategy is unlikely to be the best solution in all circumstances. It follows that there is **no one set of ideal circumstances** within which a partnership type relationship will flourish and develop. The research suggests that the pragmatic management approach is to be aware of factors that can influence whether or not a programme to enhance the current relationship will produce actual improvement. The thesis contention that both extremes should be included in the buyer's 'armoury' would appear to be borne out by the research. Nevertheless, it does appear that whilst partnership type relationships are the expressed preference of NHS buyers, the reality does not always reflect this. The mix of these factors will be determined by the input and action of both parties but there is no standard recipe for success. Whatever type of relationship strategy is adopted, it must be with the intention of improving performance. Relationships cannot be a means in themselves but must be a means to an end which, from the buyer's perspective, is the enhanced performance of the supplier in satisfying the end customer. Consequently the practical action point to be derived is that the buyer and the supplier should formally agree a statement, clarifying their understanding of what is expected from the relationship. This should be signed by the senior staff of both parties which will help to ensure that there is no ambiguity or difference of opinion regarding the type of strategy to be adopted.

The research draws heavily on the existing buyer-supplier literature and is particularly influenced by Lamming's work in constructing the review tool. There are, as has been shown in the literature review, a number of different models and frameworks that can be generically applied to create closer working relationships between buyers and their suppliers. There are different elements of all of these models that can be said to be relevant to the NHS, particularly where there is a greater emphasis toward change management built into the model. There is, however, no one model that fits perfectly. The unique nature of the **NHS environment** warrants that a varied and flexible approach is adopted as the NHS has such a **multiplicity of suppliers** in different market places which require customised relationship strategies. The relationship tool allows such a flexible approach to be adopted.

An issue which requires further research is how well the NHS buyer empathises with the supplier's dilemma of satisfying more than one key NHS buyer at the same time. The best example being in early 1997 when the English NHS Supplies Organisation tried to impose a national pricing model whereby only one price could be charged in the NHS throughout the UK. This presented, and continues to present suppliers with problems in agreeing lower prices with Scottish, Welsh or Northern Irish buyers even though these buyers may be able to commit to more product volume than their English colleagues.

A strong link between the case studies is the call for increased levels and types of **communication** between NHS buyers and their suppliers. Both strategic and operational interfaces are seen to be crucial to the development and improvement of

relationships. Communication must be regarded as a two way process if it is to produce change, as Krause and Ellram (1997:22) observe:

> ".... when a customer firm (buyer) desires a significant improvement in the capabilities of its supply vase, it must effectively communicate its needs and be willing to participate in the improvement processes".

Both parties should agree a "contact plan" clearly outlining the level and frequency of formal communication links. This can be reviewed and amended as appropriate. It is suggested that there should be at least two strategic level meetings with senior staff during a twelve month period. The frequency of operational level meetings should be agreed between the parties, but should initially be at least quarterly.

Electronic Data Interchange, once seen by NHS buyers as the way to solve accuracy of communication as well as promoting greater collaborative working with suppliers, looks as though it is already been superseded by other electronic forms of communication. The research suggests that EDI has not been used extensively through the NHS although it has been much trialled as discussed. The management of the Supplies Service throughout the NHS should re-evaluate their expectations in respect of utilising EDI. It may be that following such a review it is no longer seen to be appropriate to implement EDI and that more generic electronic communication links should be established with key suppliers.

It has been clearly identified that NHS buyers also require the support and direction of senior management in establishing effective communication links with suppliers. There

is a need to ensure end customers are also included in this loop so that their requirements are placed at the heart of the process. The thesis has described the significant changes that have taken place in the Health Service since the 1990 reforms which have created an environment much more focused on the need to satisfy customers as well as contain costs. It is vital that internal communication links are continually refined so that the buyer has a mechanism by which the customer's changing requirements can be easily updated. This may be in the form of key customer visits, via "complaints hotlines" or customer satisfaction questionnaires. Whatever the forum of data collection, there needs to be an acceptance from senior management that this is of a strategic level importance requiring an appropriate investment of resources.

Information technology is the main medium used to generate and monitor performance indicators relating to suppliers. The **performance monitoring** undertaken by NHS buyers has traditionally concentrated on quantitative measurements and has largely ignored the equally, and arguably, more powerful qualitative issues. The reason for producing performance indicators has to remain in the forefront of buyers' thinking, namely that they are a means of enhancing supplier performance which then in turn helps to satisfy end customer demands. Generally there is a need for NHS buyers-suppliers to communicate more effectively so that both parties' requirements are matched and constantly rematched in order to sustain the relationship.

The types of 'high level' questions that buyers should ask themselves in order to gather "softer" data regarding supplier performance are as follows:

- do the customers appear to be happy with the level of service being delivered by the supplier?

- in instances where there have been problems has the supplier acted quickly to resolve them?

- has the underlying issue been addressed?

- is there evidence that the supplier is constantly looking to realign their service delivery to better match our changing requirements?

These questions are not means to be exhaustive but are designed to give a flavour for the areas the buyer should cover. It should also be borne in mind that subjective analysis is most effective following discussion, preferably face-to-face discussion, with staff from the supplier's organisation. It is obviously important that whatever view taken regarding a supplier is determined by a combination of qualitative and quantitative data. It would be naive to base any opinion on only one type of data which may potentially be misleading.

All successful business relationships, be they within the NHS or not, will exhibit some characteristics of **risk sharing and trust**. It is relevant to note that all parties involved thought that the professionalism of NHS buyers has increased since the 1990 NHS reforms largely due to the heightened need to balance the management of costs and the delivery of customer care. The increased pressure on buyers has forced them to work with their suppliers to create a more trusting and equitable relationship for their mutual

benefit. The more enlightened NHS buyers appear to have realised that key suppliers are no longer to be seen as the enemy, or the 'preying vultures' as one Supplies Manager has described them, but rather as their ally in the joint mission of satisfying the end customer.

As highlighted in the literature review, risk and trust are fairly nebulous concepts open to the interpretation of different parties. The Relationship Review Tool focuses on both issues in an attempt to minimise differences of interpretation. It is crucial that the buyer and supplier are prepared to ask each other "difficult" questions in order to confirm their perceptions. It may be that the buyer believes that the supplier trusts the buyer but this should be challenged rather than assumed. There is a subtle balance to be struck between destabilising the relationship by constantly asking for reassurance and possibly appearing to be insecure against the need to check perceptions.

One practical way of increasing trust and sharing risk is the adoption of **longer term contracts** with key suppliers. However, NHS contracts have been traditionally renewable annually, largely dictated by the annual allocation of funds from the Government's Treasury and together with the buyer's insecurities surrounding adherence to public accountability regulations have resulted in short term contracts. NHS buyers have been reluctant to commit to long term contracts and even where deals have been concluded for up to 3, 4 or even 5 year periods, these have usually been constructed loosely to enable buyers to terminate the arrangement on a yearly basis and incurring only minor financial penalties by so doing. The decision to adopt longer term contracts will be predominantly influenced by the supplier performance to date and the type of market place within which it operates. The issues identified in the literature

review, surrounding the balance of power and dependency between the two parties will also need to be considered.

- All relationships are vulnerable, as identified by Kanter's "dealbusters"[2] whether there is a long term contract in place or not. The signing of a long term contract does not preclude the erosion of trust and confidence between parties, although it does make dissolution of the contract more difficult and may involve significant costs which make the option unattractive. However, the performance of both parties needs to be reassessed on a regular basis which is a process facilitated by the use of the Relationship Review Tool. It is recommended that the frequency with which the Tool is used is left as a 'judgement call' to be made jointly by both parties and is an issue which future research may consider.

9.2 Future research areas: NHS buyer-supplier relationship

The following points indicate areas of future research that could be undertaken;

Follow up the four case studies one year later to assess the extent to which the agreed action points have been implemented and where they have not, identify the reasons why. Furthermore, in the light of these one year reviews, determine how the process could be improved upon and the obstacles overcome or avoided;

[2] Refer to Kanter's "dealbusters" in Chapter 2.

- Extend the use of the NHS buyer-supplier relationship review tool to incorporate more of SHS's suppliers. It would also be appropriate if NHS buyers in England, Northern Ireland and Wales were to consider using the review tool;

- Consider setting up case studies with commercial buyers and their suppliers to examine how applicable the relationship review tool is in the private sector;

- Investigate in greater depth how key suppliers manage the potentially conflicting demands of different NHS buyers and identify the problems that this causes.

- Examine the benefits of using the Relationship Review Tool in a longitudinal study, which would focus on the frequency with which the Tool should be employed.

9.3 Key factors affecting the Supplies Manager-End Customer relationship

The relationship between service providers and their end customers can only be successful if the **customers' requirements are clearly understood** which is a recurring theme that has emerged throughout the research project. Customer expectation and perception must be the main source of Supplies Service planning and it can never be assumed that the Supplies Service knows what the end customers require. The research has confirmed that, like all customers, NHS customers' demands are not static and that a 'final' list of customer demands can never be compiled as it is constantly changing. Wisniewski and Donnelly reinforce this point stating that,

> "Organisations operating in the public sector have also come to realise that not only must they look after the "customers" but they must also take the opportunity to learn from them in terms of both customer expectations and customer perceptions of service".
>
> Wisniewski and Donnelly
>
> (1996:357)

As in the case of the buyer-supplier relationships, the Supplies Service and the customers should jointly devise a statement which encapsulates the type of service to be delivered. This should be signed by senior staff of both parties as an explicit intention that both are committed to working to this goal. The very process of devising this statement, an exercise which could be completed through the use of the customer care tool, is likely to focus both parties' attention as to what is ideally required and what is practically possible.

Customers of NHS Supplies Services have not traditionally questioned the delivery of the service and even when they may have wanted to have been prevented by the deficiencies of the type of **performance indicators** used. The research has demonstrated that the choice of PIs is extremely important and cannot be made without input from the customers themselves. The SERVQUAL model (see Parasuraman 1988) seeks to measure service quality in the public sector where service quality, as perceived by customers, stems from a comparison of what they feel service providers should offer (ie. the customer's expectations) with their perceptions of the performance of firms providing the service. The research has highlighted the need to address the gap between perceived and actual levels of Supplies Service delivery.

The NHS Supplies Services need to ensure that the type of performance indicators employed to measure their service are those valued by the end customer. It is pointless to impose PIs on the customer base if they are not seen to be important by the customers. The PIs must be agreed with the customers before they are implemented. The type and frequency of reporting should form part of the agenda for the meetings between the service provider and recipient. It should also be borne in mind that the customers' requirements for information may change over time and the service provider should be prepared to amend the reports.

As a principal means of understanding the customer **effective communication links must be established** between the Supplies Service and different levels of the customer base. The NHS customer base is complex and varied. Also it is important to realise that expectations of customers have been raised since the 1990 reforms. The research shows that there needs to be both strategic and operational level contact with the customers with the main task of the strategic interaction being to set out and constantly refine the service strategy framework within which operational matters are managed. Berry argues that a service strategy is a prerequisite to effectively "looking after" the customer, stating that

> "A service strategy should incorporate both what is essential to the customer and what will make the customer say 'wow'".
>
> Berry
>
> (1996:7)

It is vital, therefore, that one of the practical action points to be adopted by NHS Supplies Managers is to ensure that there are regular meetings with their key customers. As already mentioned, the meetings should be held at two levels, strategic and operational. The frequency of the meetings can be determined through discussion by both parties. This type of contact with customers should ensure that the Supplies Services are able to constantly refine the type of service that they deliver to the customers.

Communication within an organisation has to be well managed so that 'front line' workers can inform senior management where changes should be made to ensure that there is constant refinement to the strategic framework. This requires listening to both external and internal customers. As the NHS Supplies organisations now face very real competition, listening can no longer regarded as an added extra, as Freemantle (1996:16) observes,

> "...those that do listen effectively will be in a much better position to make improvements and secure a leading competitive edge. Such listening cannot be a peripheral activity of which most employees are unaware, instead it must be an integral part of a company's management approach and thus involve everyone".

Indeed, the research confirms the thesis contention that Supplies Services need to enhance their responsiveness to all customers and improve their service delivery overall if they are to rebuke the growing threat of competition. The customer care review tool presents the Supplies Managers with the facility to review the extent to which the

service delivered is satisfying the customer as well as where and how it should be amended.

The research suggests that **NHS Supplies organisations do not currently offer differential service levels** as the customers have not, to date, requested substantially different levels of service from each other. Only one Scottish Supplies Manager admitted that his strategy was to differentiate customers on value and influence criteria which meant that those who spent more or were perceived to be more influential received a premier service.

As part of the ongoing communication process with customers, which will be enhanced by the use of the Customer Care Review Tool, the benefits of introducing differential service levels to particular customers can be reviewed. If the end customer requests a different level of service to the "standard" then it is a matter of judgement by the Supplies Service as to whether this should be adopted bearing in mind the costs in implementation and the resulting problems of ignoring a customer request.

As a principle, **joint working and collaborative initiatives** have not generally characterised the NHS Supplies Service's relationship with customers. The research has indicated that developments such as joint training days and joint working groups, designed to improve both day-to-day contact and strategic direction, could prove beneficial. The NHS does have a large, multidisciplinary work force who have very different and sometimes conflicting agendas. This results in a very complex customer base for the Supplies Services within the NHS to manage, of which the real influence of senior medical staff is difficult to assess. The role of medical staff is an area that needs

further investigation to determine if their power and influence could be used to the greater advantage of the Supplies Service in balancing cost management whilst satisfying end customer requirements.

9.4 Future research areas - NHS Supplies Service - End Customer Relationship

The following points indicate areas of future research that could be undertaken:

- Follow up the case study one year later to assess the extent to which the agreed action points have been implemented and where they have not, identify the reasons why. Furthermore, in the light of this review, determine how the process could be improved and obstacles overcome or avoided;

- Extend the use of the customer care review tool to the remainder of the customers of Fife Healthcare Supplies Service and also to different Supplies Services throughout the UK and their customers;

- Examine the benefits of using the Customer Care Review Tool in a longitudinal study, which would focus on the frequency with which the tool should be employed.

- Further investigation of differential service levels should be adopted by NHS Supplies Services in the light of increasing competition and, if so, what criteria should be used to differentiate between customers;

- Investigate how the power and influence of senior medical staff can be harnessed to benefit the Supplies Services agenda;

- Consider if the application of the SERVQUAL model to NHS Supplies Service would add value to their relationship with customers;

Given Scottish NHS Trusts' comments regarding the contracting role of Scottish Healthcare Supplies, identify practical methods of improving this relationship.

9.5 Conclusion to the Chapter

The process of reviewing the existing academic literature, gathering the primary data and subsequently constructing the two relationship review tools has enabled appropriate discussion and consideration of the thesis aims and contentions.

This is the only academic research to date which has focused on relationships within the NHS Supplies Service. The research project has given an impetus to debate and knowledge base in the area of relationship management within an NHS setting by devising innovative and original tools with which to review existing relationships.

As an action research project, there has also been a significant contribution in a practical sense and the case studies have clearly demonstrated that the review tools can be and have been used to assess and improve existing NHS buyer-supplier and Supplies Manager-customer relationships.

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APPENDICES

APPENDIX ONE

National Procurement Division

15 Point Plan - November 1986

1. Promote the creation and/or development of regional supplies directorates (or equivalent) in each of the 14 regional health authorities;
2. Strengthen the commercial capability of the national "centres of responsibility";
3. Introduce a greater degree of flexibility and commercial awareness into national and regional tendering and contracting policies and practices;
4. Develop a long-term national warehouse, distribution and logistics strategy for all supplies;
5. Institute an imaginative programme of standardisation/variety reduction in purchased goods, equipment and materials;
6. Introduce an improved national materials classificiation and coding system covering all purchases;
7. Develop a comprehensive national supply chain information system covering (inter alia) vendor quality assurance and performance rating programmes;
8. Establish a comprehensive set of national purchasing and inventory management performance criteria;
9. Create a dynamic career structure in supplies by the introduction of a soundly-based programme of recruitment, training and development of professionally qualified resources;
10. Re-define the research and development need and role in supplies technology;
11. Radically review the manufacturer registration scheme and promote the concepts of "approved suppliers";
12. Examine the impact of new technologies in medical equipment and materials on all supplies activities;
13. Develop optional appraisal techniques in assessing "best buy" opportunities for equipment purchase;
14. Provide practical, commercial and technical support to NHS regions and industry on all supplies issues;
15. Provide greater support to British industry and improve "national added value".

APPENDIX TWO

Postal Questionnaire to NHS Supplies Managers

POSTAL QUESTIONNAIRE TO

NHS SUPPLIES MANAGERS

SUPPLY CHAIN MANAGEMENT

IN

THE NATIONAL HEALTH SERVICE

Issued by:
Clive A Rees
Research Student
Dundee Business School
September 1993

GENERAL INFORMATION *(Please tick appropriate box)*

Q1 Please indicate within which of the following you work?

English Health Service	☐
Welsh Health Service	☐
Scottish Health Service	☐
Northern Irish Health Service	☐

Q2 How many Whole Time Equivalent staff do you manage?

0 - 20	☐
21 - 35	☐
36 - 50	☐
More than 51	☐

Q3 Please indicate the total cost of running your Supplies organisation (including salaries, equipment and overheads) £_____

Please state what value of the Supplies expenditure for which you have:

Q4 Prime responsibility (eg your own budget) £_____

Q5 Shared responsibility (eg working directly for customers under Service level Agreements or equivalent) £_____

Q6 Contributory responsibility (eg working for others not under Service level Agreements or equivalent) £_____

Q7 Remote responsibility (eg as part of a working group or an advisory body) £_____

STRATEGIC NHS ISSUES

Please show the degree of agreement with the following statements. *(Please tick <u>one</u> box only per question)*

		Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q8	The NHS reforms have changed the culture of Supply Chain Management in the NHS.					
Q9	The NHS reforms have resulted in increased financial awareness by Supplies management in the NHS.					
Q10	The NHS reforms have resulted in increased reliability of the Supply Chain in the NHS.					
Q11	The NHS reforms have resulted in improved Supplies Service performance against agreed targets.					
Q12	The NHS reforms have raised the importance of Supply Chain Management in the NHS.					
Q13	The NHS reforms have changed the image of Supply Chain Management in the NHS.					
Q14	The NHS internal market is a real competitive market place.					
Q15	The NHS internal market is a "managed" market place.					

PAGE NUMBERING AS IN THE ORIGINAL THESIS

Q22 Please state the percentage of your expenditure covered by call off contracts which are negotiated on your behalf by other NHS agencies.

	%

Q23 For which of the following Departments do you not control purchasing? *(Please tick appropriate boxes)*

Pharmacy	☐
Laboratories	☐
Building/Works	☐
Other, Please specify _____ _____ _____	☐

In terms of your Purchasing Policy, please indicate the level of importance you attach to each of the following statements: *(Please tick one box per question)*

	Very Important	Important	Average Importance	Not Very Important	Not Important
Q24 Reducing the number of suppliers					
Q25 Establishing partnerships with key suppliers					
Q26 Seeking larger discounts from suppliers					
Q27 Enhancing product quality					
Q28 Obtaining a clear mandate from internal customers covering products/services to buy					
Q29 Defining an open specification to enable the supplier to meet the order					

OPERATIONAL PURCHASING ISSUES

Q30 Which staff group mainly determines the need for a product? *(Please tick one box only)*

Accountants	☐
Doctors	☐
Ward Sisters	☐
Supplies Staff	☐
Heads of Departments	☐
Other, please specify _____ _____	☐

If you ticked 'Doctors' to Q30, please go to Q31.
If you did not tick 'Doctors' to Q30, please go to Q34

Q31 Do Doctors participate in the work of Product Review Committees? *(Please tick appropriate box)*

Yes	☐
No	☐

If you answered Yes to Q31, please go to Q32
If you answered No to Q31, please go to Q33

Q32 Do Doctors succeed in obtaining commodities and equipment of their choice regardless of the associated cost considerations? *(Please tick one box only)*

Always	Mostly	Sometimes	Never

Q41 Does your EDI process include the following.
(Please tick appropriate boxes)

Ordering	☐
Invoicing	☐
BACS payment	☐
Other, please specify _____ _____ _____	☐

Please show the degree of agreement to the following statements:
(Please tick <u>one</u> box per question)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q42 EDI allows for more accurate trading with partners					
Q43 EDI reduces lead times					
Q44 EDI reduces operating cost					
Q45 EDI encourages a culture of partnerships with suppliers					
Q46 EDI "ties" the purchaser to the seller					
Q47 The benefits of EDI exceed the costs					

WAREHOUSE ISSUES

Q48 What are your warehouse costs as a percentage of the annual business throughput? *(Please tick <u>one</u> box only)*

Less than 4%	☐
4 - 6%	☐
7 - 9%	☐
More than 9%	☐

Q49 Please state the number of stockholding points you had five years ago. ____ %

Q50 Please state the number of stockholding points you have currently. ____ %

Q51 Please state the approximate percentage of the value of your total expenditure which was channelled through a central warehouse operation five years ago. ____ %

Q52 Please state the approximate percentage of the value of your total expenditure which is now channelled through a central warehouse operation. ____ %

Q53 Which of the following products ranges do you stock?
(Please tick appropriate boxes)

Medical Consumables	☐
Medical Equipment	☐
Provisions (Foodstuffs)	☐
Cleaning Materials	☐
Printed Forms	☐
Stationery	☐
Other, please specify _____ _____	☐

INVENTORY ISSUES

Q70 Do you use Economic Order Quantity as your main formula to determine stock levels? *(Please tick appropriate box)*

Yes	☐
No	☐
Don't Know	☐

Q71 Please state the approximate value of stock as a percentage of the overall purchase expenditure. ____ %

Q72 What is your overall stock turn target?
(Please tick <u>one</u> box only)

Less than 8	☐
8 - 10	☐
11 - 12	☐
More than 12	☐

Q73 What was your average actual stock turn last year?
(Please tick <u>one</u> box only)

Less than 8	☐
8 - 10	☐
11 - 12	☐
More than 12	☐

Q74 What was your average actual stock turn for medical and surgical products last year? *(Please tick <u>one</u> box only)*

Less than 8	☐
8 - 10	☐
11 - 12	☐
More than 12	☐

Q75 Please state your overall service targets to customers (issues first time on request) ____ %

Q76 Please state your average overall service targets to customers last year. ____ %

Q77 Do you monitor the value and quantity of ward stock levels on a:
(Please tick <u>one</u> box only)

Daily basis	☐
Weekly basis	☐
Monthly basis	☐
Never	☐

In terms of the reasons for holding stock please rank the following in order of importance.

	Very Important	Important	Average Importance	Not Very Important	Not Important
Q78 Accommodate varying demand patterns					
Q79 To benefit from bulk purchase discounts					

The benefits of contracting out the transport operation are:

		Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q92	Greater control					
Q93	Greater flexibility to changing customer demands					
Q94	Enhanced service to the customer base					
Q95	Increased efficiency					
Q96	Clearer knowledge of costs					

INFORMATION TECHNOLOGY ISSUES

Q97 Please state your approximate capital investment into Information Technology as a percentage of your total operating costs during the last three years

	%

The benefits of Information Technology to Supply Chain Management are:
(Please tick <u>one</u> box per question)

		Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q98	More meaningful management reports are produced					
Q99	Better stock levels are maintained					
Q100	Better customer service is enabled					
Q101	Tighter financial control over costs is enabled: both supplier expenditure and stocks					
Q102	Enables better forecasting					
Q103	Reduces lead times from suppliers					
Q104	Others, please specify					

CUSTOMER SERVICE ISSUES

Q105 Do you have a Customer Service Manager?
(Please tick appropriate box)

Yes	☐
No	☐

Q106 Do you have a specific Customer Services Team?
(Please tick appropriate box)

Yes	☐
No	☐

Please show the degree of importance attached to the following staff groups as customers:
(Please tick <u>one</u> box per question)

		Very Important	Important	Average Importance	Not Very Important	Not Important
Q107	Accountants (provision of Management Information)					
Q108	Ward Sisters					
Q109	Junior Doctors					
Q110	Consultant Doctors					
Q111	Unit General Manager					

Thank you for completing this questionnaire. If you would like the survey results, please tick the box ☐ and state your name and address; your anonymity will not be compromised.

Name_____

Address_____

_____

_____

APPENDIX THREE

Distribution List
NHS Supplies Manager Questionnaire

Name	Address
Mr R Fisher	Supplies Manager, Supplies Department, Airedale NHS Trust, Airedale General Hospital, Steeton, Keighley, BD20 6TD
Mr P T Robshaw	Supplies Manager, Supplies Department, Barnsley District General Hospital Trust, Barnsley DGH, Gawber Road, Barnsley, S75 2EP
Mr S Turner	Supplies Manager, Supplies Department, Brandford Community NHS Trust, Leeds Road, Bradford, BD3 9LH
Mr K Seymore	Supplies Manager, Supplies Department, Calderdale Healthcare NHS Trust, Royal Halifax Infirmary, Free School Lane, Halifax, HX1 2YP
Mrs V Archer	Supplies Manager, Supplies Department, Dewsbury District Hospital, Healds Road General Hospital, Dewsbury
Mr I Allcock	Supplies Manager, Supplies Department, Doncaster Royal Infirmary & Montagu Trust, Doncaster Royal Infirmary, Armthorp Road, Doncaster, DN2 5LT
Mr D Hume	Supplies Manager, Supplies Department, Freeman Group of Hospitals NHS Trust, Freeman Road, Newcastle-upon-Tyne, NE7 7DN
Mr J E Charlesworth	Supplies Manager, Supplies Department, Barnsley Comm & Priority Services Trust, Barnsley DGH, Gawber Road, Barnsley, S75 2EP
Mrs G Bailey	Supplies Manager, Supplies Department, Bishop Auckland General Hospital, Bishop Auckland, County Durham, DL14 6AD
Mr S Sherwood	Supplies Manager, Supplies Department, Bradford Hospitals NHS Trust, B Block, 1st Floor, St Luke's Hospital, Little Horton Lane, Bradford, BD5 0NA
Mrs J Ramsey	Supplies Manager, Supplies Department, Darlington Memorial Hospital, Hollyhurst Road, Darlington, DL3 6HX
Mr S Clough	Supplies Manager, Supplies Department, Doncaster Healthcare NHS Trust, St Catherine's Hospital, Tickhill Road, Balby, Doncaster, DN4 8QN
Mr B Spencer	Supplies Manager, Supplies Department, East Yorkshire Hospitals NHS Trust, Castle Hill Hospital, Cottingham, North Humberside, HU16 5JQ
Mrs D Dean	Supplies Manager, Supplies Department, Gateshead Health Authority, Units 3 & 4 Tilley Road, Crowther Industrial Estate, Washington, NE38 0AB
Mr S Sprawka	Supplies Manager, Supplies Department, Grimsby Health, Scartho Road Hospital, Grimsby, DN33 2PY
Mrs D Bell	Supplies Manager, Supplies Department, Hartlepool General Hospital, Hartlepool, TS24 9AH
Mr A Gibson	Supplies Manager, Supplies Department, Leeds Acute Unit, Seacroft Hospital, Leeds, LS14

Name	Address
Mr N Barrass	Supplies Manager, Supplies Department, Newcastle Health Authority, 10-12 North Terrace, Newcastle-upon-Tyne, NE2 4AD
Mr J Mongon	Supplies Manager, Supplies Department, North Derbyshire Unit 1, Scarsdale Hospital, Newbold Road, Chesterfield, Derbyshire, S41 7PF
Mr D Fawcett	Supplies Manager, Supplies Department, North Tees General Hospital, Hardwick, Stockton-on-Tees, TS19 8PE
Mr J Wrigley	Supplies Manager, Supplies Department, Northallerton Health NHS Trust, The Friarage Hospital, Northallerton, DL6 1JG
Mr W Eyre	Supplies Manager, Supplies Department, Harrogate Healthcare NHS Trust, 19 Wetherby Road, Harrogate, HG2 7RH
Mr D Beever	Supplies Manager, Supplies Department, Huddersfield NHS Trust, St Lukes House, Blackmoorfoot Road, Huddersfield, HD4 5HR
Mr T Law	Supplies Manager, Supplies Department, Leeds Comm & Mental Health NHS Trust, Meanwood Hospital, Tongue Lane, Leeds, LS6
Mr S Clough	Supplies Manager, Supplies Department, North Derbyshire HA, Scarsdale Hospital, Newbold Road, Chesterfield, Derbyshire, S41 7PF
Mr M Preston	Supplies Manager, Supplies Department, North Durham Health Authority, Dryburn Hospital, North Road, Durham, DH1 5DW
Mr R E Davidson	Supplies Manager, Supplies Department, North Tyneside HA, Preston Hospital, Preston Road, North Shields, NE29 0LR
Miss R Parkes	Supplies Manager, Supplies Department, Northern General Hospital NHS Trust, Herries Road Stores, Sheffield, S5 7AU
Mrs B Wilson	Supplies Manager, Supplies Department, Northumberland HA, East Cottingwood, Morpeth, Northumberland, NE61 2PD
Mr I Maguire	Supplies Manager, Supplies Department, Pontefract Hospitals Trust, Stanley Royd Hospital, Aberford Road, Wakefield, WF1 4DQ
Mr N Ashforth	Supplies Manager, Supplies Department, Royal Hull Hospitals NHS Trust, Springfield House, Springfield Way, Anlaby, Hull, HUJ10 6RZ
Mr K Eddon	Supplies Manager, Supplies Department, Scarborough & North East Yorks NHS Trust, Scarborough Hospital, Scalby Road, Scarborough, Y012 6QL
Mr K Lawrie	Supplies Manager, Supplies Department, Sheffield Unit 2, Jessop Hospital for Women, Leavygrave Road, Sheffield, S3 7RE
Mr A Taylor	Supplies Manager, Supplies Department, South Tees Acute Hospitals NHS Trust, Sotherby Road, East Middlesbrough Industrial Estate, Middlesbrough, TS3 8BS

Name	Address
Mr D Brown	Supplies Manager, Supplies Department, South Tyneside Healthcare Trust, Units 3 & 4 Tilley Road, Crowther Industrial Estate, Washington, NE38 0AB
Mr K Sheridan	Supplies Manager, Supplies Department, Pinderfields Hospitals Trust, Stanley Royd Hospital, Aberford Road, Wakefield, WF1 4DQ
Mr L Patuzzo	Supplies Manager, Supplies Department, rotherham general Hospitals NHS Trust, Wharfe Court, Oakwood Hall Drive, Rotherham, S65 3AQ
Mr C Shore	Supplies Manager, Supplies Department, royal victoria Infirmary & Associated Hospitals Trust, 10-12 North Terrace, Newcastle-upon-Tyne, NE2 4AD
Mr D Bradley	Supplies Manager, Supplies Department, Scunthorpe Health, Scunthorpe General Hospital, Cliff gardens, Scunthorpe, DN15 7BH
Mr D Cousans	Supplies Manager, Supplies Department, Sheffield Unit 3, Fulwood Hospital, Brookhouse Hill, Sheffield, S10 3TD
Mrs B McCann	Supplies Manager, Supplies Department, South Tees Comm & Mental Health Trust, Sotherby Road, East Middlesbrough Industrial Estate, Middlesbrough, TS3 8BS
Mr P Beeston	Supplies Manager, Supplies Department, St James's University Hospital NHS Trust, Beckett Street, Leeds, LS9 7TF
Mrs A Quigley	Supplies Manager, Supplies Department, Sunderland Health Authority, Units 3 & 4 Tilley Road, Crowther Industrial Estate, Washington, NE38 0AB
Mr A Cooper	Supplies Manager, Supplies Department, Wakefield & Pontefract Comm Health Trust, Stanley Royd Hospital, Aberford Road, Wakefield, WF1 4DQ
Mr I Shepherd	Supplies Manager, Supplies Department, United Leeds Teaching Hospitals NHS Trust, Josephs Well, 4th Floor Suite 16D, Hanover Walk, Westgate, Leeds, LS3 1AN
Mr E J Johnston	Supplies Manager, Supplies Department, York Hospital NHS Trust, York District General Hospital, Wiggington Road, York, YO3 7HE
Daphne Brinkley	Customer Care Manager, NHS Supplies, NTA Division, Orsett Hospital, Rowley Road, Orsett, Essex, RM16 3EU
Peter McNamara	Customer Care Manager, NHS Supplies, NTA Division, Highwood Hospital, Ongar Road, Brentwood, Essex, CM15 9DY
Mike Watkins	Customer Care Manager, NHS Supplies, NTA Division, Middlesex Hospital, Mortimer Street, London, W1 N8AA
Roy Stacey	Customer Care Manager, NHS Supplies, NTA Division,Dominion House, Bartholomew Close, London EC1A 7ED

Name	Address
Annette Featherstone	Customer Care Manager, NHS Supplies, NTA Division, C & W Hospital, 369 Fulham Road, London, SW1D 9HH
Tracey Mann	Customer Care Manager, NHS Supplies, NTA Division, District Office, Union Lane, Rochford, Essex, SS4 1RB
Ian Watson	Customer Care Manager, NHS Supplies, NTA Division, Longthorne Hospital, Leytonstone, London, E11 4HJ
John Whittock	Customer Care Manager, NHS Supplies, NTA Division, c/o Parkside HA, 78 Woodfield Road, Paddington, London W 9
Bob Adams	Customer Care Manager, NHS Supplies, St Andrews Hospital, Devon Road, Bow, London, E3 3NT
Karin Farran	Customer Care Manager, NHS Supplies, NTA Division, Goodmayes Hospital, Barley Lane, Ilford, Essex IG3 8XJ
Mrs E Poulton	Sales & District Manager, Royal Free Hospital, Pond Street, London, NW3 2QG
Stuart Brace	Customer Care Manager, NHS Supplies, NTA Division, The London Hospital, Whitechapel, London, E1 1BB
Andy Middleton	Customer Care Manager, NHS Supplies, NTA Division, St Pancras Hospital, 4 St Pancras Way, London NW1 0PE
Laraine Backshall	Customer Care Manager, NHS Supplies, NTA Division, Whittington Hospital, Highgate Wine, Dartmouth Park Hill, London, N19 5HT
Sean Stokes	Customer Care Manager, NHS Supplies, NTA Division, Hammersmith Hospital, Du Cane Road, London, W12 0HS
Stewart Parker	Customer Care Manager, NHS Supplies, NTA Division, James Paget Hospital, Lowestoft Road, Gorleston, Norfolk, NR31 6LA
David Mustoe	Customer Care Manager, NHS Supplies, NTA Division, The Ipswich Hospital, Heath Road, Ipswich, Suffolk, IP4 5PD
John Bunce	Customer Care Manager, NHS Supplies, NTA Division, Broomfield Court, Pudding Wood Lane, Broomfield, Essex, CM1 5WE
Kevin Everitt	Customer Care Manager, NHS Supplies, NTA Division, Rose Ward, Severats Hospital, Boxted Road, Colchester CD4 5HG
Terry Baxter	Customer Care Manager, NHS Supplies, NTA Division, Hellesdon Hospital, Drayton High Road, Norwich, Norfolk, NH6 5BU
Allan Scholes	Customer Care Manager, NHS Supplies, NTA Division, London Road Hospital, Kings Lynn, Norfolk, PE30 5QD
Bill Jarvis	Customer Care Manager, NHS Supplies, NTA Division, Herts & Essex Hospital, Haymeads Lane, Bishops Stortford, Herts, CM23 5JH
Rachel Hodson-Gibbons	Customer Care Manager, NHS Supplies, NTA Division, West Suffolk HA, Hospital Road, Bury St Edmunds, Suffolk, IP33 3NR

Name	Address
Jim Coltman	Customer Care Manager, NHS Supplies, NTA Division, Fulbourn Hospital, Fulbourn, Cambridge, CB1 5EF
Andrew Rudd	Supplies & Materials Manager, NHS Supplies, NTA Division, Broomfield Court, Pudding Wood Lane, Broomfield, Essex CM1 5WE
Dave Avery	Supplies & Materials Manager, NHS Supplies, NTA Division, Hellesdon Hospital Drayton High Road, Norwich, Norfold, NH6 5BU
Keith Mason	Supplies & Materials Manager, NHS Supplies, NTA Division, The Ipswich Hospital, Health Road, Ipswich, Suffolk, IP4 5PD
Caroline Simpkin	Customer Care Manager, NHS Supplies, NTA Division, Hill End Hospital, Hill End Lane, St Albans, Herts, AL4 0RB
Jon Vickers	Customer Care Manager, NHS Supplies, NTA Division, Ealing HA, Uxbridge Road, Southall, Middlesex, UB1 3HW
Don Knight	Customer Care Manager, NHS Supplies, NTA Division, QE11 Hospital, Howlands, Welwyn Garden City, Herts, AL4 4HQ
Neil Scott	Customer Care Manager, NHS Supplies, NTA Division, Chase Farm Hospital, The Ridgeway, Enfield, EN2 8JL
Maureen Lawrence	Customer Care Manager, NHS Supplies, NTA Division, Harefield Hospital, Hill End Road, Harefield, Middlesex, UB9 6JH
Terry Poole	Customer Care Manager, NHS Supplies, NTA Division, Northwick Park Hospital, Watford Road, Harrow, Middlesex
Annette Davey	Customer Care Manager, NHS Supplies, NTA Division, 85 Tanners End Lane, Edmonton, London, N18 1SB
Bill Baker	Customer Care Manager, NHS Supplies, NTA Division, Royal Lane, Hillingdon, Uxbridge, Middlesex, UB8 3QW
Peter Clarke	Customer Care Manager, NHS Supplies, NTA Division, Mount Vernon Hospital, Rickmansworth Road, Northwood, Middlesex
	Customer Care Manager, NHS Supplies, NTA Division, Lister Hospital, Coreys Hill Lane, Stevenage, Herts SG1 4AB
James Collinson	Customer Care Manager, NHS Supplies, NTA Division, Hill End Hospital, Hill End Lane, St Albans, Herts, AL4 0RB
Sheila Walden	Customer Care Manager, NHS Supplies, NTA Division, Luton & Dunstable Hospital NHS Trust, Lewsey Road, Luton, Beds, LU4 0DZ
Jane Pocklington	Customer Care Manager, NHS Supplies, NTA Division, Watford General Hospital, Vicarage Road, Watford, Herts WD1 8HB
Gilbert York	Customer Care Manager, NHS Supplies, NTA Division, c/o Parkside DC, London, W9 2AZ
Claire McKernan	Customer Care Manager, NHS Supplies, NTA Division, c/o Parkside DC, London, W9 2AZ

Name	Address
Mr J Carvill	Regional Supplies Director, 25-27 Adelaide Street, Belfast, BT2 9FH
Mr S Quinn	Areas Supplies Director (Eastern Board), 77 Bouchar Crescent, Belfast, BT12 6HU
Mr J Evans	Area Supplies Officer (Western Board) Gransha Hospital, Clooney Road, Londonderry, BT47 1YZ
Mr A Hermin	Area Supplies Manager (Northern Board), Clark House, Massereene Hospital, 30 Station Road, Antrim, BT41 4AA
Mr J Milliken	Operational Manager (Supplies & Stores) (Southern Board), Central Purchasing & Supply Department, Tarhill Hospital Complex, Tarhill, Armagh
Mr LL Griffith-Jones	Managing Director - Procurement Group, Welsh Health Common Services Authority, Heron House, 35/43 Newport Road, Cardiff, CF2 1SB
Mr S W Brown	Supplies Manager, Supplies Department, Caerleon House, Mamhilad Park Estate, Pontypool, NP4 0XA
Mr T Candlish	Supplies Manager, Supplies Department, Princess of Wales Hospital, Coity Road, Bridgend, CF31 1UZ
Mr C R Davey	Supplies Manager, Supplies Department, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW
Mr R Frost	Supplies Manager, Supplies Department, 36 Orchard Street, Swansee, SA2 5AQ
Mr L E Petterson	Supplies Manager, Supplies Department, Park Road, Whitchurch, Cardiff, CF4 7YY
Mr S Thomas	Supplies Manager, Supplies Department, St David's Hospital, Carmarthen, SA31 3HB
Mr I G Williams	Supplies Manager, Supplies Department, Colomendy Industrial Estate, Denbigh, LL16 5TA
Miss S J Howells	Support Services Manager, Powys Healthcare NHS Trust, Supplies Department, Felindre Unit, Bronllys Hospital, Bronllys, Brecon, LD3 0LS
Mrs P Owen	Supplies & Materials Manager, Pembrokeshire NHS Trust, Supplies Department, 'White House', Withybush General Hospital, Fishguard Road, Haverfordwest, SA61 2PZ
Mr R G H Heredia	Area Supplies Officer, Tayside Health Board, Ninewells Hospital, Dundee
Mr A Gee	Supplies Officer, Ayrshire & Arran Health Board, Area Distribution Centre, Meadowhead Stores, Unit 3, Dunlop Drive, Meadowhead Industrial Estate, Irvine, KA11 5AU
Mr J Cowie	Assistant Director, Supplies Division, Common Services Agency for the Scottish Health Service, Trinity Park House, South Trinity Road, Edinburgh, EH5 3SH

Name	Address
Mr P R Duncan	Procurement Manager, Grampian Health Board, Area Supplies Department, Central Store, Foresterhill Road, Aberdeen, AB2 5XB
Mr G Tait	Area Supplies Officer, Highland Health Board, Craig Phadrig Hospital, Inverness, IV3 6P
Miss J D Porter	Supplies Officer, Borders Health Board, Huntlyburn, Melrose, Roxburghshire, TD6 9BP
Mr G Crosbie	Supplies Services Manager, Dumfries & Galloway Health Board, Dumfries & Galloway Royal Infirmary, Bankend Road, Dumfries, DG1 4AP
Mr S Oakley	Area Supplies Manager, Forth Valley Health Board, Central Supplies Department, Colquhoun Street, Stirling, FK7 7PX
Mr K E Hague	Assistant Chief Administrative Officer, Orkney Health Board, Health Centre, Kirkwall, Orkney, KW15 1BX
Mr L Groat	Supplies Officer, Shetland Health Board, Montfield Hospital Central Stores, 28 Burgh Road, Lerwick, Shetland, ZE1 0QP
Mr I Neally	Supplies Manager, Western Isles Health Board, 37 South Beach Street, Stornoway, Isle of Lewis, PA87 2BN
Mr J M Moorhouse	Assistant Director, Supplies Division, Common Services Agency for the Scottish Health Service, Savoy Tower, Renfrew Street, Glasgow, G3 2BZ
Mr G T Craig	Supplies Manager, Greater Glasgow Health Board, MacLeod Street, Glasgow, G4 0RA
Mr R L Mason	Area Supplies Officer, Area Supplies Division, Argyll & Clyde Health Board, Royal Alexandra Hospital, Corsebar Road, Paisley, PA2 9PN
Mr J McIntyre	Procurement Officer, Lanarkshire Health Board, MacDougall House, Bellshill Maternity Hospital, North Road, Bellshill, Lanarkshire, ML4 3JN
Mr M McElroy	Area Supplies & Commercial Manager, Fife Health Board, Area Distribution Centre, Unit 7, Midfield Road, Mitchelson Industrial Estate, Kirkcaldy, KY1 3NL
Mel Latham	Territory Manager, New Cross Hospital, Wednesfield Road, Wolverhampton, WV10 0QP
Peter Adams	Territory Manager, East Birmingham Hospital, Bordesley Green East, Birmingham, B9 5ST
Alan Turrell	Territory Manager, Good Hope Hospital, Rectory Road, Sutton Coalfield, B75 7RR
Paul Butterfield	Territory Manager, Queen Elizabeth Hospital, Edgbaston, Birmingham, B15 8TN
Dianne Griffiths	Territory Manager, Childrens Hospital Unit, Ladywood Middleway, Ladywood, Birmingham, B16 8TN
David Coley	Territory Manager, West Heath Hospital, Rednal Road, West Heath, Birmingham, B38 8HR

Name	Address
John Wood	Territory Manager, Dudley Road Hospital, Dudley Road, Winston Green, Birmingham, B18 7QH
Michael Stanton	Territory Manager, Alexandra Hospital, Woodrow Drive, Redditch, Worcs, B98 7UB
Graham Webster	Territory Manager, District Headquarters, 12 Bull Street, Dudley, DY1 2DD
James Wailes	Territory Manager, Kidderminster General Hospital, Bewdley Road, Kidderminster, DY11 6RJ
Kay Smith	Territory Manager, Sandwell District HA, Lyndon, West Bromwich, B71 4HG
Craig Bunnell	Territory Manager, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, SY3 8XQ
Andy Harris	Territory Manager, Princess Royal Hospital, Apley Castle, Telford, Shropshire
Lis Foskett	Territory Manager, Robert Jones & Agnes Hunt Orthopaedic Hospital, Gobowen, Oswestry, SY10 7AG
Richard Cole	Territory Manager, New Cross Hospital, Wednesfield Road, Wolverhampton, WV10 0QP
Chris Spencer	Territory Manager, Burton District Hospital Centre, Belvedere Road, Burton on Trent, Staffordshire, DE13 0RB
Stephanie Watts	Territory Manager, Chelmsley Hospital, Marston Green, Birmingham, B36 7HL
Alan Jones	Territory Manager, Derbyshire Royal Infirmary, Devonshire House, London Road, Derby DD1 2QY
Sue Ord	Territory Manager, Derby City Hospital, Uttoxeter Road, Derby, DE3 3NE
Anne Walker	Territory Manager, Melbourne House, 96 Osmaston Road, Derby
David Painter	Territory Manager, Nottingham City Hospital, Annex 3, Hucknall Road, Nottingham, NG5 1PB
Ian Walker	Territory Manager, Queens Medical Centre, Curie Court, Clifton Boulevard, Nottingham, NG7 2UH
Keith Temple	Territory Manager, General Hospital, Park Row, Nottingham, NG1 6HA
Helen Phoenix	Territory Manager, Ransom Hospital, Southwell Road West, Mansfield, NG21 0ER
Neil Griffiths	Territory Manager, Bassetlaw District General Hospital, Kilton Hill, Worksop, Notts S81 0BD
Terry Bright	Territory Manager, Chelmsley Hospital, Marston Green, Birmingham, B36 7HL
Sydney O'Brien	Territory Manager, Carver Road, Astonfields Industrial Estate, Stafford
Tony Lavelle	Territory Manager, Burton District Hospital, Belvedere Road, Burton on Trent, Staffs, DE13 0RB

Name	Address
Mick O'Brien	Territory Manager, Burton District Hospital, Belvedere Road, Burton on Trent, Staffs, DE13 0RB
Philip Carter	Territory Manager, St Margaret's Hospital, Queslett Road, Great Barr, Birmingham, B43 7EZ
Anthony Duke	Territory Manager, Chelmsley Hospital, Marson Green, Birmingham, B36 7HL
Julie Powell	Territory Manager, NHS Supplies Authority, Central Division
Peter Simmonds	Territory Manager, Services Unit, Grange Lane, Leicester, LE2 7EG
Supplies Manager	North Bedfordshire Supplies, Britannia Place, Bedford, MK42 9DN
Supplies Manager	Hinchingbrooke Hospital, Hinchingbrooke Park, Huntingdon, Cambridgeshire, PE18 8NT
Supplies Manager	Kettering General Hospital, Rothwell Road, Kettering, Northants, NN16 8UZ
Jonathan Wedgbury	(Leicester Royal Infirmary) Territory Manager, Services Unit, Grange Lane, Leicester, LE2 7EG
Mike Baker	(LGH & Community) Beattie House, Leicester General Hospital, Gwendolen Road, Leicester, LE2 7EG
Richard Pitt	(Leicester GGH + MHSU + M/Handicap) Territory Manager, Services Unit, Grange Lane, Leicester, LE2 7EG
Colin Evans	Territory Manager, 1 St Anne's Road, Lincoln, LN2 5RA
Vivienne Kinder	Territory Manager, St George's Hospital, Long Leys Road, Lincoln, LN2 5QY
Mark Barrett	Territory Manager, District Headquarters, Council Offices, Eastgate, Sleaford, Lincs, NG34 7EB
John Lord	Territory Manager, District Headquarters, Council Offices, Eastgate, Sleaford, Lincs, NG34 7EB
Mark Osborne	Territory Manager, Milton Keynes General Hospital, Standing Way, Eaglestone, Milton Keynes, MK6 5LD
Margaret Linnitt	Territory Manager, Northampton General Hospital, Billing Road, Northampton, NN1 5BD
Terry Granger	Territory Manager, Supplies Department, St John's Close, Thorpe Road, Eastlea, Peterborough, PE3 6JW
Mark Higgitt	Territory Manager, Chelmsley Hospital, Marston Green, Birmingham, B36 7HL
Rod Bougourd	Territory Manager, Services Unit, Grange Lane, Leicester, LE2 7EG
Larry Jones	Branch Manager, NHS Supplies Authority, South and West Division, Old Chapel, Horton Road, Gloucester, GL1 3PR
Howard Gaunt	Customer Care Manager (Worcester), NHS Supplies Authority, South & West Division, London Road, Redhill, Worcester, WR5 2JG

Name	Address
Mike Privett	Customer Care Manager (Hereford), NHS Supplies Authority, South & West Division, Hereford County Hospital, Union Walk, Hereford, HR1 2ER
Brian Swinburn	Customer Care Manager (Cheltenham), NHS Supplies Authority, South & West Division, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN
John Wilkinson	Customer Care Manager (Gloucester), NHS Supplies Authority, South & West Division, Old Chapel, Horton Road, Gloucester, GL1 3PR
Steve Lemon	Branch Manager, NHS Supplies Authority, South & West Division, Bumpers Farm Industrial Estate, Chippenham, SN14 6LH
Anne Baldwin	Customer Care Manager (Bath - Acute), NHS Supplies Authority, South & West Division, Royal United Hospital, Combe Park, Bath, BA1 3NG
David Sharp	Customer Care Manager (Frenchay), NHS Supplies Authority, South & West Division, Frenchay Hospital, Bristol, BS16 1LE
Rodney Martin	Customer Care Manager (Gloucester), NHS Supplies Authority, South & West Division, Bumpers Farm Industrial Estate, Chippenham, SN14 6LH
Pam Collins	Customer Care Manager (Taunton), NHS Supplies Authority, South & West Division, Crown Industrial Estate, Priorswood Road, Taunton, TA2 8RT
Robin Smith	Customer Care Manager (Southmead), NHS Supplies Authority, South & West Division, Southmead Hospital, Westbury-on-Trym, Bristol, BS10 5NB
Helen Baker	Customer Care Manager (Bristol), NHS Supplies Authority, South & West Division, 3rd Floor, Manulife House, 10 Marlborough Street, Bristol, BS1 3NU
Joe Walsh	Branch Manager, NHS Supplies Authority, South & West Division, c/o Oxford RHA Commercial Services Agency, 1 Ashville Way, Cowley, Oxford, OX4 5TS
Faye Robinson	Customer Care Manager (John Radcliffe), NHS Supplies Authority, South & West Division, c/o Oxford RHA Commercial Services Agency, 1 Ashville Way, Cowley, Oxford, OX4 5TS
Mrs Wendy Webster	Customer Care Manager (Churchill/Oxford Community), NHS Supplies Authority, South & West Division, Churchill Hospital, Old Road, Headington, Oxford, OX3 7LJ
Barry Goldsmith	Customer Care Manager (Radcliffe Infirmary/Horton), NHS Supplies Authority, South & West Division, c/o Oxford RHA Commercial Services Agency, 1 Ashville Way, Cowley, Oxford, OX4 5TS

Name	Address
Sue Drabble	Customer Care Manager (Aylesbury), NHS Supplies Authority, South & West Division, c/o Oxford RHA Commercial Services Agency, 1 Ashville Way, Cowley, Oxford, OX4 5TS
David Glover	Customer Care Manager (Swindon), NHS Supplies Authority, South & West Division, Finance Building, Princess Margaret Hospital, Swindon, SN1 4JU
Customer Care Manager Amersham/ High Wycombe)	NHS Supplies Authority, South & West Division, c/o Oxford RHA Commercial Services Agency, 1 Ashville Way, Cowley, Oxford, OX4 5TS
Tim Cronin	Branch Manager, NHS Supplies Authority, South & West Division, Supplies Department, St Leonard's Hospital, Ringwood, BH24 2RR
Jill Buss	Customer Care Manager (Dorset West), NHS Supplies Authority, South & West Division, Supplies Department, St Leonard's Hospital, Ringwood, BH24 2RR
Sue Bater	Customer Care Manager (Dorset East), NHS Supplies Authority, South & West Division, Supplies Department, St Leonard's Hospital, Ringwood, BH24 2RR
Chris Fuller	Customer Care Manager (Southampton Community), NHS Supplies Authority, South & West Division, Supplies Department, St Leonard's Hospital, Ringwood, BH24 2RR
Julia Littlefair	Customer Care Manager (Winchester), NHS Supplies Authority, South & West Division, Winchester Health Authority, Queens Road, Winchester, SO22 5HS
Geoff Thomas	Income Generation and Car Schemes Manager, NHS Supplies Manager, South & West Division, Western Hospital, Oakley Road, Southhampton
Rosie Newman	Customer Care Manager (Southampton University), NHS Supplies Authority, South & West Division, Supplies Department, St Leonard's Hospital, Ringwood, BH24 2RR
John Heenan	Customer Care Manager (Salisbury), NHS Supplies Authority, South & West Division, Salisbury General Hospital, Odstock Branch, Salisbury, SP2 8BJ
Peter Boyer	Branch, NHS Supplies Authority, South & Division, Robinson Way, Portsmouth, PO3 5SB
Ralph Gilburd	Customer Care Manager (Portsmouth Acute), NHS Supplies Authority, South & West Division, Robinson Way, Portsmouth, PO3 5SB
Roger Cooper	Customer Care Manager (Portsmouth Community & Isle of Wight), NHS Supplies Authority, South & West Division, Robinson Way, Portsmouth, PO3 5SB
Neil Thornton	Customer Care Manager (Basingstoke), NHS Supplies Authority, South & West Division, Uplands House, Basingstoke General Hospital, Aldermaston Road, Basingstoke, R24 9NA

Name	Address
John McQueen	Customer Care Manager (East Berkshire), NHS Supplies Authority, South & West Division, Berkshire House, 252-256 Kings Road, Reading, RG3 1PB
Rafe Olsen	Customer Care Manager (West Berkshire), NHS Supplies Authority, South & West Division, Berkshire House, 252-256 Kings Road, Reading, RG3 1PB
David Newland	Branch Manager, NHS Supplies Authority, South & West Division, Stanley Way, Cardrew Business Park, Redruth, TR15 1SP
David Moyle	Customer Care Manager (Cornwall), NHS Supplies Authority, South & West Division, Stanley Way, Cardrew Business Park, Redruth, TR15 1SP
Keith Atkinson	Customer Care Manager (Non-Acute, Cornwall), NHS Supplies Authority, South & West Division, Stanley Way, Cardrew Business Park, Redruth, TR15 1SP
Dennis Waterman	Customer Care Manager (Exeter), NHS Supplies Authority, South & West Division, Dean Clarke House, Southernhay East, Exeter, EX1 1NR
Andrew Stilliard	Customer Care Manager (Non-Acute,Exeter), NHS Supplies Authority, South & West Division, Dean Clarke House, Southernhay East, Exeter, EX1 1NR
Lucia Contrino	Customer Care Manager (North Devon), NHS Supplies Authority, South & West Division, North Devon District Hospital, Raleigh Park, Barnstaple, EX31 4JB
Wally Tucker	Customer Care Manager (Exeter), NHS Supplies Authority, South & West Division, Torbay Hospital, Lawes Bridge, Torquay, TQ2 7AA
David Baker	Customer Care Manager (Plymouth), NHS Supplies Authority, South & West Division, St Modwen Road, Parkway Industrial Estate, Plymouth, PL6 8LH
Lianne Jennings	Customer Care Manager (Non-Acute, Plymouth), NHS Supplies Authority, South & West Division, St Modwen Road, Parkway Industrial Estate, Plymouth, PL6 8LH
Mr C Mosby	Blackburn, Hyndburn & Ribble Valley Health Authority, Queens Park Hospital, Haslingden Road, Blackburn, Lancashire, BB2 3HH
Mr T Kershaw	Supplies Manager, Health Care Supplies - North West, Blackpool, Wyre & Fylde Health Authority, Devonshire Road Hospital, Devonshire Road, Blackpool, Lancashire
Mr J Howarth	Supplies Manager, Health Care Supplies - North West, Units 10, 11 & 12, Edgefold Industrial Estate, Plodder Lane, Bolton, BL4 0LW
Mr M Britcliffe	Operations Manager, Health Care Supplies - North West, Burnley, Pendle & Rossendale Health Authority, Burnley General Hospital, Casterton Avenue, Burnley, Lancashire, BB10 2PQ

APPENDIX FOUR

Distribution List - NHS Trust
Chief Executive Questionnaire

NHS Trust	Address
Airedale NHS Trust	Airedale General Hospital, Skipton Road, Steeton, Keighley, West Yorkshire, BD20 6TD
Ashford Hospital NHS Trust	Ashford Hospital, London Road, Ashford, Middlesex, TW15 3AA
Barnet Healthcare NHS Trust	Horizon, Napsbury Hospital, St Albans, Hertsofdshire AL2 1AA
Barnsley District General Hospital NHS Trust	Barnsley District General Hospital, Gawber Road, Barnsley, S75 2EP
Barts NHS Trust	St Bartholomew's at Smithfield, West Smithfield, London EC1A 7BE
Bath and West Community NHS Trust	Ash House, St Martins Hospital, Midford Road, Bath BA2 5RP
Bedford Hospital NHS Trust	Bedford Hospital, Kempston Road, Bedford, MK42 9DJ
Blackpool Victoria Hospital NHS Trust	Whinney Heys Road, Blackpool, FY3 8NR
Bradford Community Health NHS Trust	Leeds Road Hospital, Maudsley Street, Bradford, BD3 9LH
Bradford Hospitals NHS Trust	Bradford Royal Infirmary, Duckworth Lane, Bradford, BD9 6R3
Broadgreen Hospital NHS Trust	Thomas Drive, Liverpool, L14 3LB
Bromley Hospitals NHS Trust	Bromley Health Authority, Farnborough Hospital, Farnborough Common, Orpington, Kent BR6 8ND
Burnley Health Care NHS Trust	Burnley General Hospital, Casterton Avenue, Burnley, Lancashire, BB10 2PQ
Burton Hospitals NHS Trust	Burton Hospital, Belvedere Road, Burton upon Trent, Staffordshire, DE13 0RB
Calderdale Healthcare NHS Trust	Calderdale Health Authority, Royal Halifax Infirmary, Free School Lane, Halifax, HX1 2YP
Central Middlesex Hospital NHS Trust	Acton Lane, Park Royal, London, NW10 7NS
Central Nottinghamshire Healthcare NHS Trust	Southwell Road, Mansfield, Nottinghamshire, NG18 4HH
Chase Farm Hospitals NHS Trust	Chase Hospital, The Ridgeway, Enfield, Middlesex, EN2 8JL
Cheshire Community Healthcare NHS Trust	Headquarters, Barony Road, Nantwich, Cheshire, CW5 5QU
Chorley & South Ribble NHS Trust	Trust Headquarters, Chorley and District Hospital, Preston Road, Chorley, PR7 1PP
Clatterbridge Centre for Oncology NHS Trust	Clatterbridge Hospital, Clatterbridge Road, Bebington, L63 4JY
Cornwall Healthcare Trust	Porthpean Road, St Austell, PL26 6AD
Croydon Community NHS Trust	12-18 Lennard Road, Croydon, Surrey, CR9 2RS

NHS Trust	Address
Derby City General Hospital NHS Trust	Derby City Hospital, Uttoxeter Road, Derby, DE3 3NE
Doncaster Healthcare NHS Trust	St Catherine's Hospital, Tickhill Road, Doncaster, DN4 8QN
Dorset Ambulance Service NHS Trust	Headquarters, Ringwood Road, St leonards, Ringwood, BH24 2SP
Dorset Healthcare NHS Trust	Boscombe Community Hospital, 11 Shelley Road, Bournemouth, BH1 4JQ
Ealing Hospital NHS Trust	Ealing Hospital, Uxbridge Road, Southall, Middlesex, UB1 3HW
East Berkshire Community Health NHS Trust	Frances House, 81 Frances Road, Windsor, Berks, SL4 3AW
East Cheshire NHS Trust	Macclesfield District General Hospital, Victoria Road, Macclesfield, Cheshire, SK10 3BL
East Gloucestershire NHS Trust	Burlington House, Lypiatt Road, Cheltenham, GL50 2QN
East Hertfordshire Health NHS Trust	Queen Elizabeth II Hospital, Howlands, Welwyn Garden City, Hertfordshire, AL7 4HQ
East Somerset NHS Trust	Yeovil District Hospital, Higher Kingston, Yeovil, Somerset, BA21 4AT
East Suffolk Local Health Services NHS Trust	Anglesea Heights, 1Ivry Street, Ipswich, IP1 3QW
East Surrey Hospital and Community Healthcare NHS Trust	East Surrey Hospital, Three Arch Road, Redhill, Surrey, RH1 5RH
Eastbourne & County Healthcare NHS Trust	Bowhill, The Drive, Hellingly, Hailsham, East Sussex, BN27 4EP
Epsom Healthcare NHS Trust	Epsom General Hospital, Dorking Road, Epsom, Surrey, KT18 7EG
Essex Rivers Healthcare NHS Trust	Trust Headquarters, Colchester General Hospital, Turner Road, Colchester, Essex, CO4 5JL
Exeter and District Community Health Services NHS Trust	Dean Clarke House, Southernhay East, Exeter, EX1 1PQ
First Community Health NHS Trust	Mellor House, Corporation Street, Stafford, ST16 3SR
Forest Healthcare NHS Trust	PO Box 13, Claybury Hall, Woodford Green, Essex, IG8 8DB
Fosse Health, Leicerstershire Community NHS Trust	Community Unit 1 Headquarters, Gipsy Lane, Humberstone, leicester, LE5 0TD
Freeman Group of Hospitals NHS Trust	High Heaton, Newcastle-upon-Tyne, NE7 7DN
Frenchay Healthcare Trust	Beckspool Road, Frenchay Common, Bristol, BS16 1ND
Frimley Park Hospital NHS Trust	Frimley Park Hospital, Portsmouth Road, Frimley, Nr Camberley, Surrey, GU16 5UJ
Gateshead Healthcare NHS Trust	3rd Floor Aidan House, tynegate Precinct,

NHS Trust	Address
	Sunderland Road, Gateshead, Tyne and Wear, NE8 3EP
Gateshead Hospitals NHS Trust	Queen Elizabeth Hospital, Sheriff Hill, Gateshead, Tyne & Wear, NE9 6SX
Glenfield Hospital NHS Trust	Groby Road, Leicester, LE3 9QP
Gloucestershire Royal NHS Trust	Great Western Road, Gloucester, GL1 3NN
Greenwich Healthcare NHS Trust	Greenwich Health Authority, Memorial Hospital, Shooters Hill, London, SE18 3RZ
Grimsby Health NHS Trust	District General Hospital, Scartho Road, Grimsby, South Humberside, DN33 2BA
Guy's and Lewisham NHS Trust	Keats House, 24/26 St Thomas Street, London, SE1 9RN
Halton General Hospital NHS Trust	Hospital Way, runcorn, Cheshire, WA7 2DA
Harefield Hospital NHS Trust	Harefield Hospital, Harefield, Middlesex, UB9 6JH
Harrogate Healthcare NHS Trust	Ebor Rise, Cornwall Road, Harrogate, HG1 2PU
Harrow Community Health Services NHS Trust	Siddons House, Roxeth Hill, Harrow, Middlesex, HA2 0JW
Hastings and Rother NHS Trust	St Anne's House, 729 The Ridge, St Leonards on Sea, East Sussex, TN37 7PT
Havering Hospitals NHS Trust	Harold Wood Hospital, Gubbins Lane, Romford, Essex, RM3 0BE
Heatherwood and Wexham Park Hospitals NHS Trust	Wexham Park Hospital, Wexham, Slough, Berkshire, SL2 4HL
Herefordshire Community Health NHS Trust	St Mary's Hospital, Burghill, Hereford, HR4 7RF
Hillingdon Community Health NHS Trust	St Johns, Kingston Lane, Uxbridge, UB8 3PL
Hinchingbrooke Healthcare NHS Trust	Hinchingbrooke Healthcare NHS Trust, Hinchingbrooke Park, Huntingdon, Cambs, PE18 8NT
Homewood NHS Trust	Homewood House, Guildford Road, Chertsey, Surrey, KT16 0QA
Horizon NHS Trust	Harperbury Hospital, Harper Lane, Shenley, Radlett, Herts, WD7 9HQ
Horton General Hospital NHS Trust	Horton General Hospital, Oxford Road, Banbury, Oxfordshire, OX16 9AL
Hounslow & Spelthorne Community & Mental Health NHS Trust	Trust Headquarters, Phoenix Court, 531 Staines Road, Middlesex, TW4 5DP
Huddersfield NHS Trust	Huddersfield Health Authority, St Luke's House, Blackmoorfoot Road, Huddersfield, HD4 5RH
Ipswich Hospital NHS Trust	Ipswich Hospital, Heath Road, Ipswich, IP4 5PD

NHS Trust	Address
Isle of Wight Community Healthcare NHS Trust	Whitecroft, Sandy Lane, Newport, Isle of Wight, PO30 3EB
Kent & Canterbury Hospitals NHS Trust	Kent & Canterbury Hospital, Ethelbert Road, Canterbury, CT1 3NG
King's Healthcare NHS Trust	King's College Hospital, Denmark Hill, London, SE5 9RS
King's Lynn and Wisbech Hospitals NHS Trust	The Queen Elizabeth Hospital, Gayton Road, King's Lynn Norfolk, PE30 4ET
Kingston & District Community NHS Trust	Claremont, 60 St James Road, Surbiton, Surrey, KT6 4QL
Kingston Hospital NHS Trust	Galsworthy Road, Kingston-Upon-Thames, Surrey, KT2 7QB
Lancaster Acute Hospitals NHS Trust	Trust Headquarters, PO Box 15, Lancaster, LA1 3SN
Lancaster Priority Services NHS Trust	PO Box 8, Lancaster Moor Hospital, Quernmore Road, Lancaster, LA1 3JR
Leeds Community & Mental Health Services Teaching NHS Trust	Park House, Meanwood Park Hospital, Tongue Lane, Leeds, LS6 4QB
Leicester General Hospital NHS Trust	Gwendolen Road, Leicester, LE5 4PW
Leicester Royal Infirmary NHS Trust	Infirmary Square, Leicester, LE1 5WW
Lifecare NHS Trust	Coulsdon Road, Caterham, Surrey, CR3 5YA
Lifespan Healthcare Cambridge NHS Trust	Management Offices, Ida Darwin, Cambridge, CB5 5EF
Liverpool Obstetric and Gynaecology Services NHS Trust	Trust Offices, Woman's Hospital, Catharine Street, Liverpool, L8 7NJ
Luton and Dunstable Hospital NHS Trust	Luton and Dunstable Hospital NHS Trust, Lewsey Road, Luton, Bedfordshire, LU4 0DZ
Maidstone Priority Care NHS Trust	The Pagoda, Hermitage Lane, Maidstone, Kent, ME16 9PD
Mayday Healthcare NHS Trust	Mayday University Hospital, Mayday Road, Thornton Health, Surrey, CR7 7YE
Mersey Regional Ambulance Services NHS Trust	Ambulance Headquarters, Elm House, Belmont Grove, Liverpool, L6 4EG
Merton & Sutton Community NHS Trust	Trust Headquarters, Orchard Hill, Queen Mary's Avenue, Carshalton, Surrey, SM5 4NR
Mid-Anglia Community Health NHS Trust	Community Health Unit, Hospital Road, Bury St Edmunds, Suffolk, IP33 3NR
Mid-Cheshire Hospitals Trust	Leighton Hospital, Crewe, CW1 4QJ
Mid-Exssex Community Health NHS Trust	Trust Headquarters, Collingwood Road, Witham, Essex, CM8 2TT
Mid-Essex Hospital Services NHS Trust	Broomfield Court, Pudding Wood Lane, Broomfield, Chelmsford, Essex, CM1 5WE
Mid-Kent Healthcare NHS Trust	Maidstone Hospital, Hermitage Lane, Maidstone, Kent, ME16 9QQ

NHS Trust	Address
Mid-Staffordshire General Hospitals NHS Trust	Stafford District General Hospital, Weston Road, Stafford, ST16 3SA
Milton Keynes General NHS Trust	Milton Keynes General Hospital, Standing Way, Eaglestone, Milton Keynes, MK6 5LD
Newcastle Mental Health Trust	St Nicholas Hospital, Jubilee Road, Gosforth, Newcastle-upon-Tyne, NE3 3XT
North East Essex Mental Health Services NHS Trust	Mental Health Services, Severall Hospital, Boxted Road, Colchester, Essex, CO4 5HG
North Hertfordshire NHS Trust	Lister Hospital, Corey's Mill Lane, Stevenage, Herts, SG1 4AB
North Middlesex Hospital NHS Trust	Sterling Way, London N18 1QX
North Tees Health NHS Trust	North Tees General Hospital (T), Hardwick, Stockton-on-Tees, Cleveland, TS19 8PE
Northern Devon Healthcare	Riversvale, Litchdon Street, Barnstaple, Devon, EX32 8ND
Northern General Hospital NHS Trust	Herries Road, Sheffield, S5 7AU
Nottingham City Hospital NHS Trust	Nottingham City Hospital, Hucknall Road, Nottingham HG5 1PB
Nottingham Community Health NHS Trust	Linden House, 261 Beechdale Road, Aspley, Nottingham NG8 3EY
Nuffield Orthopaedic Centre NHS Trust	Windmill Road, Headington, Oxford, OX3 7LD
Parkside Health NHS Trust	The Medical Centre, Woodfield Road, London W9 3XZ
Plymouth Community Services NHS Trust	Mount Gould Hospital, Mount Gould Road, Plymouth PL4 7QD
Poole Hospital NHS Trust	Poole Hospital, Longfleet Road, Poole, Dorset BH13 2JB
Queens Medical Centre, Nottingham University Hospital NHS Trust	University Hospital, Derby Road, Nottingham NG7 2UH
Rochdale Healthcare NHS Trust	Birch Hill Hospital, Rochdale OL12 9QB
Royal Cornwall Hospital NHS Trust	The Royal Cornwall Hospital Trust, Treliske Hospital, Truro, Cornwall, TR1 3LJ
Royal Liverpool Children's NHS Trust	Eaton Road, Liverpool, L12 2AP
Royal Liverpool University Hospital NHS Trust	Prescot Street, Liverpool L7 8XP
Royal London Hospital and Associated Community Services NHS Trust	Trust Offices, The Royal London Hospital, London E1 1BB
Rugby NHS Trust	Hospital of St Cross, Brockfield House, Rugby CV22 5PX
Sheffield Children's Hospital NHS Trust	Sheffield Childrens Hospital, Western Bank, Sheffield S10 2TH

NHS Trust	Address
South Devon Healthcare NHS Trust	Hengrave House, Torbay Hospital, Torquay TQ2 7AA
South Warwickshire Healthcare NHS Trust	Community Health Offices, Alcester Road, Stratford-upon-Avon, Warwickshire CV37 6PW
Southend Community Care NHS Trust	District Office, Union Lane, Rochford, Essex SS4 1RB
Southend Healthcare NHS Trust	Southend Hospital, Prittlewell Chase, Westcliff on Sea, Essex SS0 0RY
St James's University Hospital NHS Trust	Beckett Street, Leeds, West Yorkshire LS9 7TF
United Bristol Healthcare NHS Trust	Marlborough Street, Bristol BS1 3NU
United Leeds Teaching Hospitals NHS Trust	Trust Headquarters, Leeds General Infirmary, Great George Street, Leeds LS1 3EX
Wakefield and Pontefract Community Health NHS Trust	Fernbank, 3-5 St John's North, Wakefield WF1 3QD
Walsgrave Hospitals NHS Trust	Walsgrave Hospital, Clifford Bridge Road, Walsgrave, Coventry CV2 2DX
Warrington Community Healthcare NHS Trust	Winwick Hospital, Winwick, Warrington WA2 8RR
Wellhouse NHS Trust	Edgware General Hospital, Burnt Oak Broadway, Edgware, Middlesex HA8 0AD
West Dorset General Hospitals NHS Trust	Dorset County Hospital, Prices Street, dorchester DT1 1TS
Wirral Hospital NHS Trust	Arrowe Park Road, Upton, Wirral, Merseyside L49 5PE
York Health Services NHS Trust	Headquarters, Bootham Park, York YO3 7BY
Aberdeen Royal Hospital NHS Trust	Foresterhill House, Ashgrove Road West, Aberdeen AB9 8AQ
Ayrshire & Arran Community Healthcare NHS Trust	1a Hunter's Avenue, Ayr KA8 9DW
Caithness & Sutherland NHS Trust	Cathness General Hospital, Bankhead Road, Wick KW1 5LA
Grampian Healthcare NHS Trust	Westholme, Woodend Hospital, Eday Road, Aberdeen AB2 6LS
Moray Health Services NHS Trust	Maryhill House, 317 High Street, Elgin IV30 1AJ

APPENDIX FIVE

Postal Questionnaire to NHS Trust Chief Executive

Please show the degree of agreement to the following statements: *(Please tick one box only)*

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q18 The current in-house Supplies Service provides a cost effective and customer orientated service					
Q19 NHS Trusts should retain the right to decide from whom they obtain the provision of a Supplies Service.					

Q20 Which of the following statements best fits with your perception of NHS Supplies

(Please tick <u>one</u> box only)

Highly Professional - total satisfaction with service provided.	☐
Professional - scope for improvements in service	☐
Needs to be improved to retain customer base	☐
Disorganised, unprofessional and ineffective	☐
Other, please specify _____ _____	☐

Thank you for completing the questionnaire.

POSTAL QUESTIONNAIRE

TO

NHS TRUST CHIEF EXECUTIVES

CUSTOMER SURVEY

SUPPLY CHAIN MANAGEMENT

IN THE NATIONAL HEALTH SERVICE

Issued by -

Clive A Rees
Research Student
Dundee Institute of Technology

November 1993

Q1 Please indicate in which of the following your Trust is located.
(Please tick appropriate box)

England	☐
Wales	☐
Scotland	☐
Northern Ireland	☐

Q2 What is the approximate size of your budget?
*(Please tick **one** box only)*

0 - £25 million	☐
£26 - £50 million	☐
£51 - £70 million	☐
Over £70 million	☐

Q3 Do you make exclusive use of NHS Supplies?
*(Please tick **one** box only)*

Yes	☐
No	☐

If you answered Yes to Q3, please go to Q4.
If you answered No to Q3, please go to Q6.

Q4 Do you have Service Level Agreements with NHS Supplies?
*(Please tick **one** box only)*

Yes	☐
No	☐

Q5 What proportion of targets in the Service Agreements were achieved by NHS Supplies in 1992/93?
*(Please tick **one** box only)*

100%	☐
75 - 99%	☐
Less than 75%	☐
Other, please specify _____ _____	☐

Q6 If you do not exclusively use NHS Supplies Service, have you
(Please tick appropriate boxes)

Contracted out certain elements, such as transportation/warehousing	☐
Contracted out the whole service	☐
Established your own Supplies Service	☐
Other, please specify _____ _____	☐

Please indicate how important to you the following criteria are in evaluating the performance of the Supplies Service, be it managed by NHS Supplies or the Trust or Health Board (Scotland and Northern Ireland only) *(Please tick **one** box per question)*

	Very Important	Important	Average Importance	Not Very Important	Not Important At All
Q7 Reduction in stock value					
Q8 Increasing stock turn ratios					
Q9 Product availability at the point of use					
Q10 Ability to keep the Doctors satisfied					
Q11 Reliability of delivery schedules					
Q12 Purchase price reductions					
Q13 Overall reduction in the cost of service					
Q14 Regular production and circulation of performance indicators					
Q15 Ease of contact with Supplies Service					
Q16 Immediate response in emergency situations					
Q17 Short lead times					

APPENDIX SIX

Postal Questionnaire to Scottish Trust Chief Executives

Please show the degree of agreement to the following statements: *(Please tick one box only)*

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q17 The current in-house Supplies Service provides a cost effective and customer orientated service					
Q18 NHS Trusts should retain the right to decide from whom they obtain the provision of a Supplies Service.					
Q19 The mandatory use of CSA Supplies Division contracts ensures value for money for Scottish Health Service					
Q20 CSA Supplies Division contracting role should be devolved to Units or Boards					

Q21 Which of the following statements best fits with your perception of in-house NHS Supplies services.

(Please tick <u>one</u> box only)

Highly Professional - total satisfaction with service provided.	☐
Professional - scope for improvements in service	☐
Needs to be improved to retain customer base	☐
Disorganised, unprofessional and ineffective	☐
Other, please specify _____ _____	☐

Thank you for completing the questionnaire.

POSTAL QUESTIONNAIRE

TO

SCOTTISH TRUST CHIEF EXECUTIVES

CUSTOMER SURVEY

SUPPLY CHAIN MANAGEMENT

IN THE SCOTTISH HEALTH SERVICE

Issued by -

Clive A Rees
Research Student
Dundee Business School

February 1994

Q1 What is the approximate size of your budget?
(Please tick <u>one</u> box only)

0 - £25 million	☐
£26 - £50 million	☐
£51 - £70 million	☐
Over £70 million	☐

Q2 Do you make exclusive use of in-house NHS Supplies?
(Please tick <u>one</u> box only)

Yes	☐
No	☐

If you answered Yes to Q2 please go to Q3.
If you answered No to Q2 please go to Q5.

Q3 Do you have Service Level Agreements with in-house NHS Supplies?
(Please tick <u>one</u> box only)

Yes	☐
No	☐

Q4 What proportion of targets in the Service Agreements were achieved by in-house NHS Supplies in 1992/93?
(Please tick <u>one</u> box only)

100%	☐
75 - 99%	☐
Less than 75%	☐
Other, please specify _____ _____	☐

Q5 If you do not exclusively use in-house NHS Supplies Service, have you
(Please tick appropriate boxes)

Contracted out certain elements, such as transportation/warehousing	☐
Contracted out the whole service	☐
Established your own Supplies Service	☐
Other, please specify _____ _____	☐

Please indicate how important to you the following criteria are in evaluating the performance of the Supplies Service. *(Please tick <u>one</u> box per question)*

	Very Important	Important	Average Importance	Not Very Important	Not Important At All
Q6 Reduction in stock value					
Q7 Increasing stock turn ratios					
Q8 Product availability at the point of use					
Q9 Ability to keep the Doctors satisfied					
Q10 Reliability of delivery schedules					
Q11 Purchase price reductions					
Q12 Overall reduction in the cost of service					
Q13 Regular production and circulation of performance indicators					
Q14 Ease of contact with Supplies Service					
Q15 Immediate response in emergency situations					
Q16 Short lead times					

APPENDIX SEVEN

Distribution List - Scottish NHS Trust
Chief Executive Questionnaire

NHS Trust	Address
Dumfries & Galloway Acute & Maternity Hospitals NHS Trust	Dumfries & Galloway Royal Infirmary, Bankend Road, Dumfries DG1 4AP
Dundee Healthcare NHS Trust	Trust Offices, Royal Dundee Liff Hospital, Dundee, Tayside DD2 5NF
Dundee Teaching Hospitals NHS Trust	Ninewells Hospital & Medical School DUNDEE DD1 9SY
East & Midlothian NHS Trust	Edenhall Hospital, Pinkieburn, Musselburgh EG12 7TZ
Edinburgh Healthcare NHS Trust	St Roque, Astley Ainslie Hospital, 133 Grange Loan, Edinburgh, EH9 2HL
Edinburgh Sick Children's NHS Trust	Sciennes Road, Edinburgh EH9 1LF
Falkirk & District Royal Infirmary NHS Trust	Major's Loan, Falkirk FK1 5QE
Fife Healthcare NHS Trust	Cameron House, Cameron Bridge, Leven, Fife KY8 5RG
Glasgow Community & Mental Health Services NHS Trust	Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH
Hairmyres & Stonehouse NHS Trust	Unit Office, Hairmyre Hospital, East Kilbride G75 8RG
Kirkcaldy Acute Hospitals NHS Trust	Headquarters, Hayfield House, Hayfield Road, Kirkcaldy, Fife KY2 5AH
Law Hospital NHS Trust	Carluke ML8 5ER
Monklands & Bellshill Hospitals NHS Trust	Monkscourt Avenue, Airdrie ML6 0JS
North Ayrshire & Arran NHS Trust	Crosshouse Hospital, Crosshouse KA2 0BE
Perth & Kinross Healthcare NHS Trust	Perth Royal Infirmary, Perth PH1 1NX
Queen Margaret Hospital NHS Trust	Whitefield Road, Dunfermline KY12 0SU
Raigmore Hospital NHS Trust	Old Perth Road, Inverness IV2 3UJ
Royal Infirmary of Edinburgh NHS Trust	Lauriston Place, Edinburgh EH3 9YW
Royal Scottish National Hospital and Community NHS Trust	Royal Scottish National Hospital, Old Denny Road, Larbert FK5 4SD
South Ayrshire Hospitals NHS Trust	Ayr Hospital, Dalmellington Road, Ayr, Ayrshire KA6 6DX
Stirling Royal Infirmary NHS Trust	Livilands, Stirling FK8 2AU
The Yorkhill NHS Trust	Dalnier Street, Yorkhill, Glasgow G3 8SJ
West Lothian NHS Trust	St John's Hospital at Howden Howden, West Livingston, West Lothian EH54 6PP
Western General Hospital	Crewe Road, Edinburgh EH4 2XU

APPENDIX EIGHT

Postal Questionnaire to Supplies of

The National Health Service

POSTAL QUESTIONNAIRE TO

SUPPLIERS OF

THE NATIONAL HEALTH SERVICE

Issued by:
Clive A Rees
Research Student
Dundee Business School
February 1994

Q1 Are you -
(Please tick <u>one</u> box only)

Manufacturers	☐
Wholesalers	☐
Combination of Both	☐

Q2 If you are a manufacturer, approximately how much of your business do you -

Supply directly to the NHS	%
Supply via a wholesaler	%

Q3 Please state the products your company predominately supplies to the NHS. *(Please tick appropriate boxes)*

Medical/Surgical Consumables	☐
Medical/Surgical Equipment	☐
Drugs	☐
Provisions	☐
Computer Hardware/Software	☐
Cleaning Materials	☐
Hardware & Crockery	☐
Other, please specify _____ _____ _____	☐

Q4 Do you have a written contract with majority of NHS customers? *(Please tick <u>one</u> box only)*

Yes	☐
No	☐
Don't Know	☐

If you answered Yes to Q4, please go to Question 5.
If you answered No to Q4, please go to Question 6.

Q5 Please state your average period of contract with the NHS

months

Q6 Please state the approximate percentage of your UK business that NHS amounts to

%

Q7 At what levels do you sell into the NHS?
(Please tick appropriate boxes)

Local Hospital	☐
Trust Unit	☐
Divisional (NHS SA)	☐
National	☐
Other, please specify _____ _____ _____	☐

Please indicate how much influence you perceive the following NHS staff groups to have in terms of the "buying" decision making process -
(Please tick <u>one</u> box only per question)

		Very Influential	Influential	Average Influence	Not Influential	Not Influential At All
Q8	Supplies Staff					
Q9	Medical Staff					
Q10	Heads of Departments					
Q11	Accountants					

Please indicate how much importance you place on the following NHS staff groups as customers -
(Please tick <u>one</u> box only perquestion)

		Very Important	Important	Average Importance	Not Important	Not Important At All
Q12	Supplies Staff					
Q13	Medical Staff					
Q14	Heads of Departments					
Q15	Accountants					

		Extremely Adversial	Adversial	Slightly Partnership Orientated	Partnership Orientated
Q16	Which of the following best describes your perception of the management of NHS purchasing? *(Please tick <u>one</u> box only)*				

Please show the degree of agreement to the following statements:

NHS reforms have made Supplies Staff -

		Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q17	More aware total cost of the procurement operation					
Q18	More price sensitive					
Q19	Improve communications with supplies					
Q20	More aggressive in negotiation					
Q21	More willing to share information					
Q22	More orientated toward their internal customer					
Q23	More customer orientated					
Q24	More professional					
Q25	More interested in developing partnership relationships with suppliers					
Q26	Maintained the adversial relationship with suppliers					
Q27	More cost orientated					

Q28 Do you have Electronic Interchange (EDI) links established to
(Please tick <u>one</u> box only)

All NHS customers	☐
Some NHS customers	☐
No NHS customers	☐

Q29 If you have EDI links with customers, at which of the following levels -
(Please tick appropriate boxes)

Local Hospital	☐
Trust	☐
Divisional (NHS SA)	☐
National	☐
Other, please specify _____ _____	☐

Q30 Approximtely what proportion of your NHS business is transmitted via ED links?

	%

Q31 Do you currently market your products directly to Trust hospitals? *(Please tick <u>one</u> box only)*

Yes	☐
No	☐
Other, please specify _____ _____ _____	☐

Please state the degree of agreement to the following statements:
(Please tick <u>one</u> box per question)

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
Q32 Supplies Services are a necessary link between hospitals and suppliers					
Q33 Supplies Services add unnecessary "on costs" to the sale price from Suppliers					
Q34 Supplies Services offer a value for money service to their customers					
Q35 NHS internal market is a real and competitive marketplace					
Q36 NHS internal market is a "managed market"					
Q37 Do you think there will be benefits to your organisation if the management of the Supplies Service is competitively tendered?					
Q38 The recent NHS reforms have standardised the approach to buying					

APPENDIX NINE

Distribution List - Suppliers of the National Health Service Questionnaire

Supplier	Address
Smith Kline Beecham Parmaceuticals plc	Mundells, Welwin Garden City, Herts, AL7 1EY
Phoenix Pharmaceuticals Ltd	Unit 3, Glenvum Works, Upton Street, Gloucester, GL1 4LA
Scott Ltd	Scott House, East Grinstead, West Sussex, RH19 1UR
Howmedica International Ltd	622 Western Avenue, Park Royal, London, W3 0TF
Minolta (UK) Ltd	1 - 3 Tanners Drive, Blakelands North, Milton Keynes, MK14 5BU
Rank Xerox (UK) Ltd	124 - 125 Princes Street, Edinburgh, EH2 4BD
Proctor & Gamble Ltd	PO Box 1EP, Newcastle-upon-Tyne, NE99 1EP
Scottish Hydro Electric plc	South Inch Business Centre, Shore Road, Perth, PH2 8BW
Shell UK Oil	Shell-Mex House, Strand London, WC2R 0DX
Alexander Clark & Son (Produce) Ltd	151 Balmoral Street, Scotstoun, Glasgow, G14 0DX
Vernon Works	Waterford Street, Old Basford, Nottingham, NG6 0DH
Molnlycke Limited	Southfields Road, Dunstable, Bedfordshire, LU6 3EJ
Mobil Gas Marketing (UK) Ltd	Mobil Court, Clements Inn, London WC2A 2EB
Smith & Nephew Medical Ltd	PO Box No 81, Hessle Road, Hull, HU3 2BN
Campbell Prime Meats Ltd	Brocks Way, East Mains Industrial Estate, Broxburn, EH52 5NB
Newey & Eyre Ltd	Donne House, Calthorp Road, Edgsbaston, Birmingham, B15 QX
Alexandra Workwear plc	21 Cliftonhall Road, Newbridge, Edinburgh, EH28 8PW
Baxter Healthcare Ltd	Carnegie Road, Hillington, Glasgow, G52 4NY
Fast Aid Products Ltd	Edderdail House, Clark Street, Paisley, Renfrewshire, PA3 1QS
British Gas plc	Granton House, 4 Marine Drive, Edinburgh
Brake Bros Frozen Foods Ltd	Enterprise House, Godinton Road, Ashford, Kent, TN23 1EU
H W Poole & Son Ltd	Crispin House, New York Road, Leeds, LS2 7PG
Becton Dickinson (UK) Ltd	Between Towns Road, Cowley, Oxford, OX4 3LY

Supplier	Address
Strachans Ltd	54 Windmill Street, Peterhead, AB4 6UE
Ethicon Ltd	Bankhead Avenue, Sighthill, Edinburgh
Unichem plc	Unichem House, Cox Lane, Chessington, Surrey, KT17 1LT
Scottish Power plc	Energy Trading Division, Cathcart House, Spean Street, Glasgow, G44 4BE
Buchanan Orthotics Ltd	60 Woodlands Road, Glasgow, G3 6HA
BOC Ltd	Priestley Centre, 10 Priestley Road, The Surrey Research Park, Guildford, Surrey, GU2 5XY
Abbott Laboratories Ltd	Abbott House, Norden Road, Maidenhead, Berkshire, SL6 4XE
Lederle Laboratories Cyanamid of Great Britain Ltd	154 Fareham Road, Gosport, Hants, PO13 0AS
3M Healthcare Ltd	3M House, Morley Street, Loughborough, Leicestershire, LE11 1EP
Albyn Medical	Bridgend Road Industrial Estate, Dingwall, Ross-shire, IV15 -QF
Allergan Optical	Coronation Road, High Wycombe, Buckinghamshire, HP12 3SH
Amba Medical Ltd	Unit 5, Bonville Trading Estate, Bonville Road, Brislington, Bristol, BS4 5QH
Bard Ltd	Forest House, Brighton Road, Crawley, West Sussex, RH11 9 BP
Baxter Healthcare Ltd	Wallingford Road, Compton, Newbury, Berkshire, RG16 0QW
Bibby Sterilin Ltd	Tilling Drive, Walton, Stone, Staffordshire, ST15 0SA
Biomet Ltd	Waterton Industrial Estate, Bridgend, South Glamorgan, CF31 3YN
Cedata	PO Box 83, Tramways Building, Frederick Road, Salford, M6 6NU
Clement Clarke International	Airmed House, Edinburgh Way, Harlow, Essex, CM20 2ED
Cobe Laboratories Ltd	Pavilion I and Athena 2/3, Olympus Business Park, Quedgeley, Gloucestershire, GL2 6NF
Codman	The Braccans, London Road, Bracknell, Berkshire, RG12 2AT
Convatec Ltd	Harrington House, Milton Road, Ickenham, Uxbridge, Middlesex, UB10 8PU
Critikon	The Braccans, London Road, Bracknell, Berkshire, RG12 2AT
DRG Medical Packaging Supplies Ltd	Carsons Road, Mangotsfield, Bristol, BS17 3LN

Supplier	Address
Daray Lighing Ltd	Commerce Way, Stanbridge Road, Leighton Buzzard, Bedforshire, LU7 8RW
Davis & Geck	Cyanamid House, Fareham Road, Gosport, Hampshire, PO13 0AS
Derma-Lase Ltd	141 St James Road, Glasgow, G4 0LT
Devilbiss Healthcare UK Ltd	'Airlinks', Spitfire Way, Heston, Middlesex, TW5 9NR
The Dubois plc	5 Princewood Road, Corby, Northamptonshire, NN17 2AP
East Healthcare Ltd	Sandy Lane West, Littlemore, Oxford, EX4 5JT
Electro-Medical Supplies (Greenham) Ltd	Wantage, Oxfordshire, OX12 7AD
Eli Lilly & Co	Intec 2, Wade Road, Basingstoke, Hampshire, RG24 0NE
Enak	Redkiln Way, Horsham, Sussex, RH13 5QH
Ethicon	PO Box 408, Bankhead Avenue, Edinburgh, EH11 4HE
Fairs & Exhibitions Ltd	Suite 12, Accurist House, 44 Baker Street, London, W1M 1DH
Femcare	St Peters Street, Nottingham, NG7 3EN
Griffith Micro Science	Cotes Park Estate, Somercotes, Derbyshire, DE55 4NJ
Hawksley & Sons Ltd	Marlborough Road, Lancing, West Sussex, BN15 8TN
Hoskins Healthcare	Upper Trinity Street, Birmingham, B9 4EQ
Howmedica International Ltd	622 Western Avenue, Park Royal, London, W3 0TF
Huntleigh Healthcare	310-312 Dallow Road, Luton, Bedfordshire, LU1 1SS
IBC Legal Studies and Services Ltd	Gilmoora House, 57-61 Mortimer Street, London, W1N 7TD
IBEES	Institute for Biomedical Equipment Evaluation and Services, Redmires Road, Sheffield, S10 4LH
Impra (UK) Ltd	4 De Salis Court, Hampton Lovett, Drotwich, Worcestershire, WR9 0NX
Intervention Ltd	1 Redman Court, Bell Street, Princes Risborough, Buckinghamshire, HP27 0AA
IOLAB	The Braccans, London Road, Bracknell, Berkshire, RG12 2AT
Isotron plc	Moray Road, Elgin Industrial Estate, Swindon, SN2 6DU

Supplier	Address
Johnson & Johnson Medical Ltd	Coronation Road, Ascot, Berkshire, SL5 9EY
Johnson & Johnson Orthopaedics	The Braccans, London Road, Bracknell, Berkshire, RG12 2AT
Keeler Ltd	Clewer Hill Road, Windsor, Berkshire, SL4 4AA
The Kendall Company (UK) Ltd	2 Elmwood, Chineham Business Park, Crockford Lane, Basingstoke, Hampshire, RG24 0WG
Keymed (Medical & Industrial Equipment) Ltd	KeyMed House, Stock Road, Southend-on-Sea, Essex, SS2 5QH
Kimal Scientific Products Ltd	Arundel Road Trading Estate, Uxbridge, Middlesex, UB8 2SA
Kimberly-Clark International Services Corporation	Larkfield, Maidstone, Kent ME20 7PS
Kontron Instruments Ltd	Blackmoor Lane, Croxley Centre, Watford, Hertfordshire WD1 8XQ
Lederle Laboratories - Export Division	Cyanamid House, Fareham Road, Gosport, Hampshire PO13 0AS
MG Electric (Colchester) Ltd	Wyncolls Road, Colchester, Essex, CO4 4HT
Mangar Aids Ltd	Units 1-4 Presteigne Industrial Estate, Presteign, Powys, LD8 2UF, Wales
Marquette Electronics (GB) Ltd	Unit 7, Priestley Road, Worsley, Manchester,M28 5NJ
Martin James Medical Ltd	Albany Park Industrial Estate, Frimley Road, Camberley, Surrey, GU15 2PL
Medelec Ltd	Manor Way, Old Woking, Surrey, GU22 9JU
Medex Medical Inc	St Crispin Way, Hurstwood Enterprise Park, Haslingden, Rossendale, Lancashire BB4 4PW
Mediscus Products Ltd	10 Westminster Road, Wareham, Dorset, BH20 4SP
Molnlycke Ltd	Southfields Road, Dunstable, Bedfordshire, LU6 3EJ
NH Eastwood & Son Ltd	118 East Barnet Road, Barnet, Hertfordshire, EN4 8RE
Nesbit Evans Group	Timber House, Sandford Avenue, Church Stretton, Shropshire, SY6 6DY
Nihon Kohden Europe Ltd	Alfa Tower, Great West Road, Brentford, Middlesex, TW8 9BT
Nomeq	23-24 Thornhill Road, North Moors Moat, Redditch, Worcestershire, B98 9ND
Ohmeda	71 Great North Road, Hatfield, Hertfordshire, AL9 5EN

Supplier	Address
Overseas Medical Supplies Ltd	17 Cumberland Avenue, London, NW10 7RG
Owen Mumford Ltd	Brook Hill, Woodstock, Oxford, OX20 1TU
Oxford Instruments (UK) Ltd	1 Kimber Road, Abingdon, Oxon, OX14 1BZ
Pall Biomedical Ltd	Europa House, Havant Street, Portsmouth, Hampshire, PO1 3PD
Pegasus Airwave Ltd	Pegasus House, Kingscroft Court, Havant, Hampshire, PO9 1LS
Pennine Healthcare Ltd	Pontefract Street, Ascot Drive Industrial Estate, Derby, DE2 8JD
Plasro Plastics Ltd	38 Wates Way, Mitcham, Surrey, CR4 4HR
Prestige Medical	PO Box 154, Off Clarendon Road, Blackburn, Lancashire, BB1 9UG
Protectair Ltd	18-20 Blacklands Way, Abingdon Business Park, Abingdon, Oxon OX14 1DY
Rayner Intraocular Lenses Ltd	1-2 Sackville Trading Estate, Sackville Road, Hove, East Sussex, BN3 7AN
Regent Hospital Products	LRC Products Ltd, North Circular Road, Chingford, London, E4 8QA
Reynolds Medical Ltd	1-2 harforde Court, Hertford, Hertfordshire, SG13 7NW
Robinson Healthcare	Wheatbridge, Chesterfield, Derbyshire S40 1YF
Rusch UK Ltd	PO Box 138, Cressex Industrial Estate, High Wycombe, Buckinghamshire, HP12 3NB
S&W Vickers	Ruxley Corner, Sidcup, Kent, DA14 5BL
SMS Healthcare	Elizabeth House, Harlow, Essex, CM19 5TL
Seton Healthcare Group plc	Tubiton House, Oldham, Greater Manchester, 0LI 3HS
Seward Medical	131 Great Suffolk Street, London, SE1 1PP
Silogic Design Ltd	Enterprise House, 181-189 Garth Road, Morden, Surrey, SM4 4LL
Smith & Nephew Medical Ltd	PO Box 81, Hessle Road, Hull, North Humberside, HU3 2BN
Smiths Industries Medical Systems	765 Finchley Road, London, NW11 8DS
Eschmann Equipment	Peter Road, Lancing, West Sussex, BN15 8TJ
Portex	1-3 High Street, Hythe, Kent, CT21 6JL

APPENDIX TEN

Semi-Structured Interview Prompt Sheet

for NHS Buyers

INTRODUCTORY REMARKS FOR INTERVIEWS

1 Thanks very much for agreeing to see me.

2 As indicated in my letter this interview is part of a doctoral research project I'm undertaking on a part-time basis at the University of Stirling. The research is concerned with Supply Chain Management in the NHS and focusing on two aspects:-

- relationships between NHS buyers and their suppliers;
- Supplies Services approach to customer care.

Obviously today we're concentrating on ..... .

3 The Project so far has reviewed academic literature on Supply Chain Management, purchasing (particularly partnerships) and customer care. The literature mainly emanates from the manufacturing sector and isn't terribly relevant to the public sector NHS. Also, there's a chapter in the thesis which introduces the NHS. A couple of years ago I undertook postal questionnaires to executives of companies supplying the NHS with goods and services, to NHS Supplies Managers and to Trust Chief Executives.

Analysis of the questionnaires suggested that there were points which required to be followed up and investigated further. That's rally the purpose of these interviews . . . to explore the points raised through the questionnaires.

4 This interview will take about 30 - 40 minutes and it'll start with some factual questions then I'll ask for your opinions on issues. I should add that your comments will be analysed in the write up. After all interviews, and I'm seeing 12 Supplies Managers and staff and then 12 Trusts (both management and users). I hope to be in position to devise a checklist of questions which prove useful for

Supplies Managers in the management of customer care and supplier relationships.

OK - we'll kick off unless you've any questions about this introduction.

Semi-Structured Interview Prompt Sheet for NHS buyers

1. Introduction to Research Project

- Outline and aims of doctoral research (including where interviews fit in)
- Researcher background - work and academic experience
- Ask series of questions in following areas:

- Obtain some facts about your organisation

Then ask your opinions on:

- Types of buyer-supplier relationships that are currently in place;
- Changes to buyer-supplier relationship over the last three to five years.

2. Facts about Your Organisation

- What is the value of overall annual turnover?
- How many employees do you have?
- Can you give me the general outline of your organisational structure?
- What is the size of your customer base?
- Are there particular commodity/product (when lead buyers) groups that you don't contract for?
- Do you have a stated and written purchasing policy?
- Has your policy been updated recently?

3. Types of Buyer-Supplier Relationships that are currently in place

- Do you think that you employ a range of relationship strategies with your suppliers?
- How would you define partnerships?
- What criteria do you use to pick partners?
- Is it your aim to develop partnerships whenever possible?
- Do you think that you are currently involved in any partnerships?
- At what stage in the relationship do you consider it appropriate to develop a partnership type relationship? Is there an optimal time?
- How do you manage the process of establishing partnerships?
- What role, if any, does the use of EDI play in this process?
- Do you think partnerships are an effective purchasing strategy?
- What, in your opinion, are the problems establishing and perhaps, more importantly, maintaining partnerships?
- Do you think suppliers face the same difficulties as you in establishing and sustaining partnerships?

4. Changes to Buyer-Supplier relationships over the last three to five years

- Have your attitudes to suppliers changes over the past three to five years?
- What factors to you think have caused these changes?

5. Is there any additional information that you would like to give?

6. If you would like a personal copy of the synopsis of the final thesis, please let me have your name and address.

Semi-Structured Interview Prompt Sheet for NHS Buyers

Organisation Represented: .....

.....

Name of Interviewee: .....

Date of Interview: / /

Designation: .....

Facts about Organisation:

What is the value of your organisation's annual turnover?	
What is the total spend in your commodity area?	
Could you tell me who are your top 10 suppliers by value?	1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 8 ..... 9 ..... 10 .....
What percentage of your spend is accounted for by these suppliers?	
How many employees do you have?	
Can you give me the general outline of your organisational structure?	
What is the size of your customer base?	
Are there particular commodities/products groups that you don't contract for?	
Do you have a stated and written purchasing policy?	
Has your policy been updated recently?	

Opinions:	
Do you think that you employ a range of relationship strategies with your suppliers?	.....
How would you define partnerships?	.....
What criteria do you use to pick partners?	.....

	.....
Is it your aim to develop partnerships whenever possible?	.....
Do you think that you are currently involved in any partnerships?	.....
At what stage in the relationship do you consider it appropriate to develop a partnership type relationship? Is there an optimal time?	.....

	.....
How do you manage the process of establishing partnerships?	.....
What role, if any, does the use of EDI play in this process?	.....
Do you think partnerships are an effective purchasing strategy?	.....

	.....
Do you believe purchasing and supplies is given a strategic status in the SHS?	.....
What, in your opinion, are the problems establishing and perhaps, more importantly, maintaining partnerships?	.....
Do you believe you are in a more powerful position than the supplier? If so why? Do you think there is generally an appropriate split of power between yourself and the supplier?	.....
Do you think suppliers face the same difficulties as you in establishing and sustaining partnerships?	.....

	.....
Have your attitudes to suppliers changed over the past three to five years?	.....
What factors to you think have caused these changes?	.....
Are SHS central contracts still regarded (and 'policed') as mandatory?	.....

	.....
Is there any additional information that you would like to give?	.....

Remarks:

.....

APPENDIX ELEVEN

Semi-Structured Interview Prompt Sheet for Executives of Companies Supplying Goods to the NHS

Semi-Structured Interview Prompt Sheet for Executives of Companies supplying goods to the NHS.

1. Introduction to Research Project

- Outline & aims of doctoral research (including where interviews fit in).
- Researcher background - work and academic experience.
- Ask series of questions in following areas:

- Obtain some facts about your company

Seek your opinions on:

- Types of buyer-supplier relationships that are currently in place;
- Changes to buyer-supplier relationships over the last three to five years.

2. Facts about your Company

- What goods does your company supply to the NHS?
- What is the value of your overall annual turnover?
- What % of this is NHS business?
- What % is SHS business?
- How many employees do you have?
- Can you give me the general outline of your organisational structure?
- What is the size of your customer base?

3. Types of Buyer-Supplier Relationships that are currently in place

- Do you employ a range of relationship strategies with buyers?
- How would you define partnerships?
- Are you proactive in initiating partnerships?
- Is it your aim to develop partnerships wherever possible?
- Do you think that you are currently involved in any partnerships?
- In the majority of cases, is it the buyer or yourselves who seek to establish partnerships?
- How do you manage the process of establishing partnerships?
- What role, if any, does the use of EDI play in this process?
- Do you think partnerships are an effectives business strategy?
- Do you face the problem of conflicting demands from key buyers?
- Who do you perceive your customers in the NHS to be?

4. Changes to Buyer-Supplier Relationships over the past three to five years

- Have your attitudes to NHS buyers changed over the past three to five years?
- What factors do you think have caused this/these change(s)?

- Do you think NHS buyers' attitudes to you have changed over the past three to five years?
- What factors do you think have caused this/these change(s)?

5. Is there any additional information that you would like to give?

6. If you would like a personal copy of the synopsis of the final thesis, please let me have your name and address.

Semi-Structured Interview Prompt Sheet for Executives of Companies Supplying Goods to the NHS	**Organisation Represented:** ....

Name of Interviewee: ..... **Date of Interview:** / /

Designation: .....

Facts about Organisation:

What goods do your company supply to the NHS?	
What is the value of your overall turnover?	
What % of this is NHS business?	
What % is SHS business?	
How many employees do you have?	
Can you give me the general outline of your organisational structure?	
What is the size of your customer base?	

Opinions:

Do you think that you employ a range of relationship strategies with your buyers?	....

/

	.....
How would you define partnerships?	.....
Are you proactive in initiating partnerships?	.....
Is it your aim to develop partnerships whenever possible?	.....

	.....
Do you think that you are currently involved in any partnerships?	.....
In the majority of cases, is it the buyer or yourselves who seek to establish partnerships?	.....
How do you manage the process of establishing partnerships?	.....

	.....
What role, if any, does the use of EDI play in this process?	.....
Do you think partnerships are an effective purchasing strategy?	.....
Do you face the problem of conflicting demands from key buyers?	.....

	.....
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	.....
Who do you perceive your customers in the NHS to be?	.....
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Have your attitudes to NHS buyers changed over the past three to five years?	.....
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	.....
What factors to you think have caused this/these change(s)?	.....
	.....
	.....
	.....
	.....

	.....
Do you think NHS buyer's attitudes to you have changed over the past three to five years?	.....
What factors to you think have caused this/these change(s)?	.....
Is there any additional information that you would like to give?	.....
Remarks:	

APPENDIX TWELVE

Semi-Structured Interview Prompt Sheet for NHS Supplies Managers as Service Providers

Semi-Structured Interview Prompt Sheet for NHS Supplies Managers as Service Providers

1. Introduction to Research Project

- Outline & aims of doctoral research (including where interviews fit in).
- Researcher background - work and academic experience.
- Ask series of questions in two areas:

- Obtain some facts about your organisation

Secondly to seek your view as to your approach as to Customer Care:

2. Facts about your Organisation

- What is the value of your overall annual turnover?
- How many employees do you have?
- Can you give me the general outline of your organisational structure?
- What is the size of your customer base?
- Are there particular commodity groups that you don't supply?

3. Your Approach to Customer Care

- Do you have a customer care team?
- Do you offer differential service levels to customers?
- What are the factors that you think inhibit you from offering individual packages of customer care?
- What do you think are the problems of offering differential service levels?
- How do you define customer care?
- Do you use TQM within customer care management?
- How do you define TQM?
- How do you measure performance?
- How often do you circulate performance indicators to the customer base?
- What do you think are the benefits of circulating information to the customer base?
- How do you think you could improve communication and dialogue with customers?
- Do you prioritise your customer base? (Tease out issues re relationships with medical staff).
- What criteria do you use to prioritise your customer base?
- Have your attitudes to customer care changed over the past three to five years?
- What factors do you think have caused this/these change(s)?

4. Is there any additional information that you would like to give?

5. If you would like a personal copy of the synopsis of the final thesis, please let me have your name and address.

Semi-Structured Interview Prompt Sheet for NHS Supplies Managers as Service Providers	Organisation Represented: ....

Name of Interviewee: ..... **Date of Interview: / /**

Designation: .....

Facts about Organisation:

What is the value of your overall turnover?	
How many employees do you have?	
Can you give me the general outline of your organisational structure?	....
Are there particular commodity groups that you don't supply?	
How many organisational customers do you have?	
How many individual customer points do you have?	
How many NHS customers do you have?	
How many non-NHS customers do you have?	
What % of you income is from NHS customers?	
What % of you income is from non-NHS customers?	

Opinions:	
How do you define customer care?	.....
Is customer care, as a concept understood by all in the organisation?	
Is there a staff customer care manual?	
Should there be?	
Do staff receive ongoing training in customer care?	
Should they?	
Do you have a customer care team?	.....
Do you offer differential service levels to customers?	.....

	.....
Do you think you should?	.....
If Yes, why?	.....
	.....
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	.....
If No, why not?	.....
	.....
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	.....
What do you think are the problems of offering differential service levels?	.....
	.....
	.....
	.....
	.....
What do you think are the factors that you think inhibit you from offering individual packages of customer care?	.....
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	.....
Do you prioritise your customer base? (Tease out issues re relationships with medical staff).	.....
What criteria do you use to prioritise you customer base?	.....
What do you understand by TQM?	.....

	.....
Do you use TQM within customer care management?	.....
How do you measure performance?	.....
How often do you circulate performance indicators to your customer base?	.....

	.....
What do you think are the benefits of circulating information to your customer base?	.....
How do you think you could improve communication and dialogue with customers?	.....
Have your attitudes to customer care changed over the past three to five years? (Tease out part NHS reforms played in this process)	.....

	.....
What factors to you think have caused this/these change(s)?	.....
Is there any additional information that you would like to give?	.....

Remarks:

.....

.....

.....

.....

.....

.....

APPENDIX THIRTEEN

Semi-Structured Interview Prompt Sheet for

NHS Trusts as Customers of NHS Supplies Services

Semi-Structured Interview Prompt Sheet for NHS Trusts as Customers of NHS Supplies Service

1. Introduction to Research Project

- Outline & aims of doctoral research (including where interviews fit in).
- Researcher background - work and academic experience.
- Ask series of questions in two areas:

- Firstly to obtain some facts about your organisation
- Secondly to seek your views regarding the type of relationship you have with the Supplies Service.

2. Facts about your Organisation

- What is the value of your overall annual turnover?
- How many employees do you have?
- Can you give me the general outline of your organisational structure?

3. Type of Relationship with the Supplies Service

- Do you believe that the Supplies Service is customer orientated?
- Do you believe the Supplies Service is responsive to your individual requirements?
- Are there products that you obtain from sources of supply other than in-house supplies services?
- Do you have a written Service Level Agreement in place with your Supplies Service?
- What types of Performance Indicators (PIs) do you receive? What other PIs would you like?
- Other than PIs, what types of communication do you have with Supplies Services?
- What measures do you believe could be taken by Supplies Services to enhance the process of communication?

4. Is there any additional information that you would like to give?

5. If you would like a personal copy of the synopsis of the final thesis, please let me have your name and address.

Semi-Structured Interview Prompt Sheet for NHS Trusts as Customers of NHS Supplies Service	**Organisation Represented:** ....

Name of Interviewee: ..... **Date of Interview:** / /

Designation: .....

Facts about Organisation:

What is your Organisation's Income?	
How many employees do you have?	
Can you give me the general outline of your organisational structure and specifically who has responsibility for supplies?	
From which Supplies organisation(s) do you obtain a service?	
What is your overall spend this the Supplies Service?	
To What level is budgetary responsibility devolved?	
Do you know the level of "on cost" of the Supplies Service?	

Opinions:

Do you believe the Supplies Service is customer orientated?	
What do you think constitutes being customer orientated?	....

/

	.....
Do you believe the Supplies Service is responsive to individual requirements?	.....
	.....
	.....
	.....
In what ways do you think this could be improved?	.....
	.....
	.....
	.....
	.....
	.....
Are there products that you obtain from sources of supply other than in-house supplies services?	.....
	.....
	.....
	.....
	.....
	.....
	.....
	.....
	.....
	.....
	.....
	.....
	.....
What service levels are required?	.....
	.....
	.....
	.....
	.....

	.....
Are there any specific savings targets?	.....
Do you think there should be?	.....
What types of Performance Indicators (PIs) do you receive? What other PIs would you like?	.....
Why can these not be obtained from the Supplies Service?	.....
What action do you take with PIs?	.....
To whom within the Trust are these circulated?	.....

	.....
What are the benefits in circulating?	.....
Other than PIs, what types of communication do you have with Supplies Services?	.....
How often do you/representatives of your organisation meet to review customer care?	.....
Do you think this is sufficient?	.....
What would be the benefits of meeting on a more frequent basis?	.....
What measures do you believe could be taken by Supplies Services to enhance the process of communication?	

	.....
How do you think you could facilitate these being taken?	.....
What changes could Supplies Services make that would enhance your level of satisfaction?	.....
Have you thought about competitively tendering supplies?	.....
Would you be in favour of a corporate National Supplies Service?	.....
Is there any additional information that you would like to give?	.....

	.....
	.....
	.....
	.....
	.....

Remarks:

.....

.....

.....

.....

.....

.....

APPENDIX FOURTEEN

Relationship Review Tool

APPENDIX

INSTRUCTIONS FOR THE SCOTTISH NHS BUYER

ON USING THE

RELATIONSHIP REVIEW TOOL

Firstly, you are asked to complete this short questionnaire which is designed to make you re-examine your current relationship with your supplier. It is intended that a representative from the supplier will, at the same time, complete a similar questionnaire.

At the end of the questionnaire you will be asked to reflect on the answers you have given and identify a suggested action in each of the section headings.

Finally, it is intended that you will discuss the action points generated by yourself and the supplier before jointly arriving at an agreed course of action to improve the existing relationship.

RELATIONSHIP REVIEW TOOL

1. **Current Relationship.**

2. **Degree of Risk Sharing.**

3. **Level of Trust.**

4. **Communication.**

5. **Level of End Customer Satisfaction.**

6. **Culture and Attitude.**

7. **Understanding and definition of partnership type relationships.**

1. Current Relationship

To what extent do you agree that your current relationship with the supplier is effective?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the supplier currently:

- Adheres to delivery schedule:

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- Conforms to quality specification:

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- efficiently and effectively manages administrative arrangements;

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- is financially stable and viable:

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- has sufficient face-to-face contact with you

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

What do you believe are areas within the relationship that the supplier needs to improve?

_____

_____

2. **Degree of Risk Sharing**

Do you agree that the company is in a strong market position.

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

_____

_____

In your opinion which of the following best describes the supplier's current status in the market?

Growth ☐

Decline ☐

Stagnation ☐

Do you agree that there is a sharing of risk in the relationship?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what is the basis of your confidence?

_____

_____

If you disagree, what measures can be taken to increase the level of risk sharing?

_____

_____

3. **Level of Trust**

Do you agree that you can trust the supplier?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

In which apsects of your relationship do you feel vulnerable?

_____

_____

In your opiion, what measures could be taken to increase your level of trust in the supplier?

_____

_____

4. **Communication**

Do you agree that there is real and open communication in the relationship?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

In what ways do you currently communicate with the supplier?

_____

_____

How frequently do you currently communicate with the supplier?

_____

_____

Do you agree that EDI should be developed as a means of enhancing communication?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

In your opinion what other measures could be taken to enhance the method of communication with the supplier?

_____

_____

5. **Level of End Customer Satisfaction**

When did you and/or the supplier last ask the end customers if they were satisfied?

_____

_____

Are you aware of any recurring issues that the end customer is unhappy with?

_____

_____

6. **Culture and Attitude**

Do you agree that there is senior management commitment from the supplier in both time and resources?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the supplier gives your relationship a strategic level of importance?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the supplier is becoming more collaborative and co-operative?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Does the supplier respond effectively to emergency situations?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In your opinion, what practical measures could be taken by the supplier to further demonstrate their commitment to developing the reationship?

_____

_____

7. **Understanding and Definition of Partnership type relationships**

Do you agree that it is appropriate to develop a partnership type relationship with this supplier?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for wanting to do so

High Value Supplier ☐

Criticality of Product to end customer ☐

Willingness of Supplier to develop relationship ☐

Other reasons:

_____

_____

ACTION POINTS

Please review your answers to each section of the questionnaire and identify a suggested action which it is intended you will discuss with the supplier.

1. Current Relationship.

   Action Point is _____

   _____

2. Degree of Risk Sharing.

   Action Point is _____

   _____

3. Level of Trust.

   Action Point is _____

   _____

4. Communiction.

   Action Point is _____

   _____

5. Level of End Customer Satisfaction.

   Action Point is _____

   _____

6. Culture and Attitude.

   Action Point is _____

   _____

7. Understanding and Definition of Partnership type relationships.

   Action Point is

   _____

   _____

APPENDIX

INSTRUCTIONS FOR THE SUPPLIERS OF THE SCOTTISH NHS ON USING THE RELATIONSHIP REVIEW TOOL

Firstly, you are asked to complete this short questionnaire which is designed to make you re-examine your current relationship with your buyer. It is intended that a buyer will, at the same time, complete a similar questionnaire.

At the end of the questionnaire you will be asked to reflect on the answers you have given and identify a suggested action in each of the section headings.

Finally, it is intended that you will discuss the action points generated by yourself and the buyer before jointly arriving at an agreed course of action to improve the existing relationship.

RELATIONSHIP REVIEW TOOL

1. **Current Relationship.**

2. **Degree of Risk Sharing.**

3. **Level of Trust.**

4. **Communication.**

5. **Level of End Customer Satisfaction.**

6. **Culture and Attitude.**

7. **Understanding and definition of partnership type relationships.**

Suppliers Version

1. Current Relationship

To what extent do you agree that your current relationship with the Scottish NHS buyer is effective?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that you as the supplier currently:

- Adheres to delivery schedule:

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- Conforms to quality specification:

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- efficiently and effectively manages administrative arrangements;

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- is financially stable and viable:

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

- has sufficient face-to-face contact with the buyer

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

What do you believe are areas within the relationship that the buyer needs to improve?

_____

_____

2. **Degree of Risk Sharing**

Do you agree that your company is in a strong market position.

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

_____

_____

In your opinion which of the following best describes your current status in the market?

Growth ☐

Decline ☐

Stagnation ☐

Do you agree that there is a sharing of risk in your relationship with the buyer?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what is the basis of your confidence?

_____

_____

If you disagree, what measures can be taken to increase the level of risk sharing?

_____

_____

Do you agree that the relationship is equal?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

3. **Level of Trust**

Do you agree that you can trust the Scottish NHS buyer ?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

In which aspects of your relationship do you feel vulnerable?

_____

_____

In your opinion, what measures could be taken to increase your level of trust in the buyer?

_____

_____

4. **Communication**

Do you agree that there is real and open communication in the relationship?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

In what ways do you currently communicate with the buyer?

_____

_____

How frequently do you currently communicate with the buyer?

_____

_____

Do you agree that EDI should be developed as a means of enhancing communication?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for doing so?

In your opinion what other measures could be taken to enhance the method of communication with the buyer?

_____

_____

5. **Level of End Customer Satisfaction**

When did you and/or the buyer last ask the end customers if they were satisfied?

_____

_____

Are you aware of any recurring issues that the end customer is unhappy with?

_____

_____

6. **Culture and Attitude**

Do you agree that there is senior management commitment from the buyer's organisation in both time and resources?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the buyer gives your relationship a strategic level of importance?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the buyer's organisation is becoming more collaborative and co-operative?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that you as the supplier respond effectively to emergency situations?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In your opinion, what practical measures could be taken by the buyer to further demonstrate their commitment to developing the relationship?

_____

_____

7. **<u>Understanding and Definition of Partnership type relationships</u>**

Do you agree that it is appropriate to develop a partnership type relationship with this buyer?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

If you agree, what are your reasons for wanting to do so

_____

_____

ACTION POINTS

Please review your answers to each section of the questionnaire and identify a suggested action which it is intended you will discuss with the supplier.

1. Current Relationship.

   Action Point is _____

   _____

2. Degree of Risk Sharing.

   Action Point is _____

   _____

3. Level of Trust.

   Action Point is _____

   _____

4. Communication.

   Action Point is _____

   _____

5. Level of End Customer Satisfaction.

   Action Point is _____

   _____

6. Culture and Attitude.

   Action Point is _____

   _____

7. Understanding and Definition of Partnership type relationships.

   Action Point is _____

   _____

APPENDIX FIFTEEN

BP Oil letter regarding their experience of using the relationship review tool

BP OIL

FIFE HEALTH BOARD
LOCALITY MANAGER
CENTRAL FIFE
- 7 MAY 1997
COPIES
ACTION
FILE No.

BP Oil UK Limited
Witan Gate House
500-600 Witan Gate
Milton Keynes
Bucks
MK9 1ES

Switchboard: (01908) 853000

Direct Line:
Direct Fax:

Mr C Rees
Fife Health Board
Springfield House
CUPAR
Fife
KY15 5UP

Your Ref:
Our Ref: 01908 853928
01908 853495

Date: CR/AC
C&I/GH/FIFEHB

6 May 1997

Dear Mr Rees

Feedback on buyer-supplier relationship review tool

I am writing to thank you for involving BP Oil in your research into buyer-supplier relationships. We found the process extremely valuable, the questionnaire and subsequent review meeting acting as a catalyst in the development of our relationship with Scottish Healthcare Supplies. It provided parties with the opportunity to address strategic issues in an open and honest way and to seek ways to improve our future business partnership.

The buyer-supplier relationship review tool encourages those involved to undertake a frank assessment of the business relationship. The questionnaire covers the key areas of the relationship encouraging the supplier and buyer to express their limitations, expectations and aspirations. The review meeting provides the focus for exploring the gaps in understanding as well as an opportunity to build on the strengths in the relationship. The presence of yourself as facilitator at the meeting helped the development of the discussion and ensured all key issues were addressed.

In general BP have a good relationship with Scottish Healthcare Supplies, we meet regularly to review the business performance and address any operational issues. The review process has definitely improved our understanding of the motivation and strategic issues facing Scottish Healthcare Supplies. BP are committed to building on this platform of greater understanding and we have already implemented specific actions identified at the meeting. A further follow up meeting with Peter Howat is planned for 13 May 1997.

In consideration of the potential weaknesses of the relationship review process, I believe it will have greatest value where both are prepared to be open and honest. We recognise that buyers and suppliers are not always encouraged to be open, the value derived may therefore depend on the nature and sensitivity of the relationship.

I would like to thank you again for involving BP in your research project and trust this feed back is useful to you.

May I wish you every success in completing your Masters degree.

Yours sincerely

Gillian Hughes

Gillian Hughes
Public Sector Manager
BP Oil UK Limited

APPENDIX SIXTEEN

SHS Energy Contracts Manager's letter regarding the experience of using the relationship review tool

SCOTTISH HEALTHCARE SUPPLIES

Trinity Park House, South Trinity Road, Edinburgh EH5 3SH. Tel: 0131 552 6255. Fax: 0131 552 6535.

Mr C A Rees
Assistant Director Planning
Fife Health Board
Springfield House
CUPAR
Fife
KY15 5UP

Our Ref:
Your Ref CAR/MR
Date: 19 March 1997
Direct Line: 0131 551 8250

Dear Clive

RELATIONSHIP REVIEW TOOL

Many thanks for your letter of 11 March 1997 and the agreed action plan for BP Oils.

I found the meeting to be most useful and the review tool provided just the right structure to promote open discussion. I intend to utilise again in the future.

Gillian I know found the morning to be most useful and she undoubtedly got more from that one meeting than half a dozen unstructured ones.

All success with your thesis.

Kind regards.

Yours sincerely

Peter E Howat
Contracts Manager

APPENDIX SEVENTEEN

Vernon Carus letter regarding their experience of using the relationship review tool

Vernon-Carus Limited
Penwortham Mills, Preston, Lancashire, England PR1 9SN
Tel 01772-744493 Fax 01772-748754 Telex 677119

vernoncarus

VKG/CM

7 May 1997

Mr Clive Rees
Locality Manager - Central Fife
Fife Health Board
Springfield House
CUPAR
Fife
KY15 5UP

Dear Clive

Thank you for your letter of 11 March and 28 April and must apologise for the delay in replying.

Whilst I found the buyer-supplier relationship review tool a useful exercise, particularly in gaining a common understanding of each others position, it is obviously only a start and more face to face communication and openness is vital if further partnership trust is to develop.

I am perhaps a little more disillusioned than I was following our meeting in Edinburgh, having recently lost two high volume items in the recent Sterile Dressing Pack Contract award.

Decisions, I understand, were passed purely on unit price without consideration or understanding of the possible implications such decisions can cause, both to ourselves and ultimately the end customer. The knock-on effect of "cherry picking" for the remaining tower volume products left on the contract, in terms of lost overhead costs, will be serious indeed.

It would appear short term savings, as discussed at length during our meeting, is still the driving force behind many contractual decisions, if not necessarily by Scottish Health Care Supplies Managers, then certainly by some User Group Panels.

Nevertheless, I believe we must continue the dialogue and hopefully in due course we will get everyone, users and buyers, to think longer term and not have simple knee-jerk reactions to some very questionable prices.

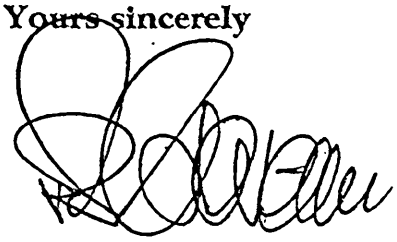
continued ....

Perhaps they will also think of service and quality as well as involvement in joint cost engineering exercises, as promoted by John Cowie, as an alternative way of reducing prices which will have more positive long term benefits.

As I have already stated, I believe the dialogue must continue, but perhaps with a greater degree of urgency than before to ensure the decision making process, as described, becomes a thing of the past.

Kind regards

Yours sincerely



VINCE K GATENS
Market Manager - UK

APPENDIX EIGHTEEN

SHS Medical Consumables Section Manager's letter regarding the experience of using the relationship review tool with Vernon Carus, Smith & Nephew and Procter & Gamble

SCOTTISH HEALTHCARE SUPPLIES

Trinity Park House, South Trinity Road, Edinburgh EH5 3SH. Tel: 0131 552 6255. Fax: 0131 552 6535.

2nd June '97

Clive,

Please find enclosed comments from Graeme and me regarding our supplier meetings.

Hopefully at our next meetings with the companies we will progress some of the points raised

Regards,

Vic

SCOTTISH HEALTHCARE SUPPLIES

SUPPLIER RELATIONSHIP REVIEW

SUMMARY

This was a worthwhile exercise. All participants entered into it with the the correct attitude. All were prepared to speak honestly and openly without trying to score points and to understand each others view point.

At the end of each meeting a number of worthwhile points had been identified which merited further action.

QUESTIONNAIRE

This assisted in providing a structure for the meetings as it identified areas with conflicting viewpoints and helped provide an agenda to follow.

Some of the questions were confusing and were interpreted differently by supplier and buyer. This was identified in the meetings.

MEETINGS

The set agenda helped to keep meetings flowing. All participants were prepared to talk about the areas of conflict and to suggest methods of improvement.

Meetings were conducted in an open and friendly manner and were entirely constructive.

A number of useful points were identified at each meeting which gave areas to be addressed in the future.

A greater understanding of each others problems now exists following the meetings. If used properly and taken forward this should improve relationships for the future to everyone's benefit.

APPENDIX NINETEEN

Smith and Nephew letter regarding their experience of using the relationship review tool

Smith & Nephew Healthcare Limited

Healthcare House
Goulton Street
Hull HU3 4DJ
Telephone: 01482 222200
Telefax: 01482 222211

Smith+Nephew

14 April 1997

Mr Clive Rees
Locality Manager - Central Fife
Springfield House
Cupar
Fife
KY15 5UP

Dear Clive

I would like to take this opportunity to give you some feedback from our meeting with SHS on 14 March 1997.

I felt an excellent two way exchanging of frank views took place which can only benefit both parties. I was pleased that my ideas with regard to a standardised procedure of evaluation of product before tendering met with some interest.

I also took on board all the points they raised with regard to pricing and delivery. We are very aware that this is an issue and are working hard to improve.

We at Smith & Nephew are planning to have a meeting with SHS in the near future to outline the reasons behind our pricing policy and our new product developments.

The meeting in March was useful but I still feel our policy of high quality products which the users in the market place want is of secondary importance to those at SHS.

Thanks for involving me in this exercise and I look forward to hearing from you in the future.

Yours sincerely

PETER STEVEN
REGIONAL SALES MANAGER

APPENDIX TWENTY

Procter and Gamble letter regarding their experience of using the relationship review tool

Procter&Gamble

Procter & Gamble UK
Hygiene Products
P.O. Box 1EE, Gosforth, Newcastle upon Tyne, NE99 1EE
Tel: (0191) 279 2000 Fax: (0191) 279 2282

Mr Clive Rees
Locality Manager
Springfield House
Cupar, Fife
KY 15 5UP

May 9th 1997

Dear Clive,

Feedback regarding the Buyer - Supplier relationship review tool

Firstly , please accept my express apologies for the delay in writing back to you. My mail was held at Head Office whilst I was away on Annual Leave until the end of April.I am now finally catching up. I apologise for any inconvenience caused by this.

Summary of the Relationship Review Tool Meeting at Trinity Park House, 2nd April 1997 between Scottish Healthcare Supplies & Procter & Gamble

Overall Statement :
Dave Newton & myself both felt that the meeting , using the Review Tool , provided a new, interesting and progressive method of reviewing our current relationship with SHS.
It allowed for open & constructive discussion and thus achieved the overall objective through the thorough discussion of the Agreed Action Points.

For further clarification on the above statement, I have divided the process into 3 parts :

Process	Positives	Negatives
1. Pre-work	* Vital part of the review tool * The exchange of pre-work saves valuable time during review session. * Provides a focused framework & platform for active & open discussion. * The exchange also helps to promote a level of trust through sharing of information	* May result in pre-conceived ideas about either participant * Lack of trust between participants may mask the content of the pre-work.

Procter&Gamble

Procter & Gamble UK
Hygiene Products
P.O. Box 1EE, Gosforth, Newcastle upon Tyne, NE99 1EE
Tel: (0191) 279 2000 Fax: (0191) 279 2282

Process	Positives	Negatives
2. Actual Review	* Presence of neutral facilitator was very important to guide participants through the process for the first time. * Allowed acknowledgement & discussion of existing problems in a non-threatening & constructive way * Provides a written document with clear agreed action points * The 2 hour time limit helped to keep the meeting focused & productive.	* Agreed timings must be put on the action points , otherwise the tool will remain an interesting one-off exercise, instead of becoming a dynamic working tool
3. Follow-up based on Action Points	* The Action Points can be divided into different categories : *- Those for immediate action :* eg Current Relationships - regular, scheduled meetings with set agendas to deal with day to day business.Multi-level meetings to become regular eg Risk sharing - initiate a joint strategy document (OGSP?)for use within future meetings eg Level of Trust - more open communications re product developments (which would be addressed in the regular meetings using a forward planner document) *- Those for further discussion & review :* eg Reciprocal performance reviews eg Communication - EDI eg Culture & Attitude - allowing specialists to align eg IT specialists	* Follow up requires commitment from both parties & thus I emphasise the need for timings and ownership for responsibilities.

In conclusion, I felt that the Relationship Review tool, allowed both participants to gain a greater insight into each other's Business & perhaps some of the restrictions within each other's organisations which have at times resulted in conflict and misunderstandings.
It is clear to me that as a result of this exercise, P&G and SHS can work a more effective partnership-relationship, providing that we act on the agreed action points.

h1024W

Procter&Gamble

Procter & Gamble UK
Hygiene Products
P.O. Box 1EE, Gosforth, Newcastle upon Tyne, NE99 1EE
Tel: (0191) 279 2000 Fax: (0191) 279 2282

I hope that my feedback and comments are helpful.Please do not hesitate to contact me directly if you wish to discuss any of the points that I have made.
I look forward to receiving your draft from your thesis.In particular , I will be interested in reading the feedback of the other 3 participants, and if they felt that the Review Tool would be valuable in reviewing and developing long-term relationships with SHS.

My next steps will be to follow up and move forward with SHS and work through our Action Points, and thus benefit from this new and useful work platform.

Best Regards

Miss Alison McKelvie
Territory Manager
Procter & Gamble UK

APPENDIX TWENTY-ONE

SHS Assistant Director's letter indicating the intention to expand the SHS use of the relationship review tool

SCOTTISH HEALTHCARE SUPPLIES

Trinity Park House, South Trinity Road, Edinburgh EH5 3SH. Tel: 0131 552 6255. Fax: 0131 552 6535.

Mr Clive Rees
Locality Manager - Central Fife
Fife Health Board
Springfield House
CUPAR
Fife
KY15 5UP

Our Ref:
Your Ref
Date: 22 May 1997
Direct Line: 0131 551 8118

Dear Clive

RELATIONSHIP REVIEW TOOL

I should like to give you some feedback regarding our recent experience of using your relationship review tool with four of our key suppliers.

Overall, I personally found the experience of using the tool to be interesting and stimulating. At an organisational level I believe the tool has acted as a catalyst for us to review our relationship with the four suppliers.

The tool itself is simple but effective, with the completion of the initial questionnaire only taking about 10 - 15 minutes. However, this process gave us the opportunity to 'stand back' and reflect on our relationship with each supplier. It was helpful to receive the suppliers questionnaire prior to the actual meeting so that we have some knowledge of the issues that they perceived to be important and were able to compare these to our own priorities. The action points that flowed from the meetings have, I believe, given us the basis for improving upon our relationships with these suppliers.

As I indicated over the phone I am considering expanding the use of the tool in order to review the relationships we have with the top five suppliers in each of the commodity areas.

May I thank you for involving SHS in this project from which we have derived considerable benefit.

Good luck with your thesis.

Best regards.

Yours sincerely

J B Cowie
Assistant Director

FIFE HEALTH BOARD
LOCALITY MANAGER
CENTRAL FIFE
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APPENDIX TWENTY-TWO

Customer Care Review Tool

APPENDIX

INSTRUCTIONS FOR SCOTTISH SUPPLIES MANAGER ON USING THE CUSTOMER CARE REVIEW TOOL

Firstly, you are asked to complete this short questionnaire which is designed to make you re-examine your current method delivering customer care. It is intended that a representative of the customer base will, at the same time, complete a similar questionnaire.

At the end of the questionnaire you will be asked to reflect on the answers you have given and identify a suggested action in each of the section headings.

Finally, it is intended that you will discuss the action points generated by yourself and the customer base before jointly arriving at an agreed course of action to improve the delivery of customer care.

REVIEW TOOL

FOR THE DELIVERY OF CUSTOMER CARE

1. Clarity of Customer Requirements.

2. Customer Care being central to planning.

3. Flexibility of approach.

4. Use of Customer Care Teams.

5. Use of Total Quality Management.

6. Use of Performance Indicators.

7. Relationship with Scottish Healthcare Supplies.

Supplies Managers' Version

1. **Clarity of Customer Requirements**

To what extent do you agree that your communications with customers are effective?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that it is appropriate/necessary to improve communications with the customer base?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

What action needs to be taken to improve communication?

_____

_____

How could you develop the use of information technology to enhance customer communication?

_____

_____

What factors are stopping you make these enhancements happen?

_____

_____

2. **Customer Care being central to Planning**

Do you agree that customer care is placed at the centre of your organisational planning?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways do you think you could improve your planning process to ensure customers become the focus?

_____

_____

Do you agree that your service philosophy fits with your customer's requirements?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways does your philosophy need to be refined so that it is more aligned to your customer's requirements?

_____

_____

Do you agree that there is sufficient senior management emphasis given to customer care?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that as customer care is a new concept within NHS Supplies, its adoption is proving difficult?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

How can you facilitate the adoption of the concept?

_____

_____

3. **Flexibility of Approach**

Do you agree that you are able to respond to new requests from customers?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

When did you last ask your customers if they wanted changes to the type of services provided?

_____

_____

Do you agree that you would be willing to change if they did require new services?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that you are currently able and willing to be flexible to new requests from customers?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Would you agree that you would be willing to offer customers differential service levels if they asked for this?

_____

_____

4. **Use of Customer Care Teams**

Do you agree that the use of a specific customer care team is an appropriate tool to enhance customer care delivery?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways can you develop your use of a specific customer care team to strengthen the delivery of care to your customers?

_____

_____

5. **Use of Total Quality Management**

Do you agree that the use of Total Quality Management (TQM) is an appropriate tool to enhance customer care?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways can you develop the use of TQM to strengthen the delivery of care to your customers?

If you accept the premise that TQM is more difficult to apply to professional groups of staff, how can you overcome this?

6. <u>Use of Performance Indicators</u>

How do you believe your use of Performance Indicators (PI's) enhances your ability to care for customers?

What action can you take to refine your use of PI's to ensure that customer requirements are constantly reviewed?

When did you last ask your customers if you are measuring aspects of your service that they value?

7. **Relationship with Scottish Healthcare Supplies**

Do you agree that your relationship with Scottish Healthcare Supplies is effective in communicating your customer's requirements?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

What action can you take to enhance this relationship and bring your customers and Scottish Healthcare Supplies closer together?

_____

_____

ACTION POINTS

Please review your answers to each section of the questionnaire and identify a suggested action which it is intended you will discuss with the Supplies Service representative.

1. Clarity of Customer Requirements.

   Action Point is _____

   _____

2. Customer Care being centinal to Planning.

   Action Point is _____

   _____

3. Flexibility of Approach.

   Action Point is _____

   _____

4. Use of Customer Care Teams.

   Action Point is _____

   _____

5. Use of Total Quality Management.

   Action Point is _____

   _____

6. Use of Performance Indicators.

   Action Point is _____

   _____

7. Relationship with Scottish Healthcare Supplies

   Action Point is _____

   _____

INSTRUCTIONS FOR THE CUSTOMER OF SCOTTISH SUPPLIES SERVICE ON USING THE CUSTOMER CARE REVIEW TOOL

Firstly, you are asked to complete this short questionnaire which is designed to make you re-examine the current method by which you receive customer care from your chosen Supplies Service. It is intended that a representative of the Supplies Service will, at the same time, complete a similar questionnaire.

At the end of the questionnaire you will be asked to reflect on the answers you have given and identify a suggested action in each of the section headings.

Finally, it is intended that you will discuss the action points generated by yourself and the Supplies Service before jointly arriving at an agreed course of action to improve the delivery of customer care.

REVIEW TOOL

FOR THE DELIVERY OF CUSTOMER CARE

1. Clarity of Customer Requirements.

2. Customer Care being centinal to planning.

3. Flexibility of approach.

4. Use of Customer Care Teams.

5. Use of Total Quality Management.

6. Use of Performance Indicators.

7. Relationship with Scottish Healthcare Supplies.

1. **Clarity of Customer Requirements**

To what extent do you agree that the Supplies Service communications with you are effective?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that it is appropriate/necessary to improve communications with your Supplies Service?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

What action needs to be taken to improve communication?

_____

_____

How could the Supplies Service develop the use of information technology to enhance communication with you?

_____

_____

What factors do you think are stopping the Supplies Service making these enhancements happen?

_____

_____

2. **Customer Care being central to Planning**

Do you agree that you as the customer are placed at the centre of the Supplies Service planning?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways do you think the Supplies Service could improve their planning process to ensure customers become the focus?

_____

_____

Do you agree that there is sufficient senior management emphasis given by the Supplies Service to customer care?

_____

_____

Do you agree that the Supplies Service philosophy fits with your customer's requirements?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways do you think that the Supplies Service philosophy need to be refined so that it is more aligned to your requirements?

_____

_____

Do you agree that as customer care is a new concept within NHS Supplies, its adoption is proving difficult?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

3. **Flexibility of Approach**

Do you agree that the Supplies Service is able to respond to new requests from you?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

When did the Supplies Service last ask if they you wanted changes to the type of services provided?

_____

_____

Do you agree that the Supplies Service would be willing to change if you did require new services?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the Supplies Service are currently able and willing to be flexible to new requests from you?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Do you agree that the Supplies Service would offer customers differential service levels if asked?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

4. **Use of Customer Care Teams**

Do you agree that the use of a specific customer care team is an appropriate tool to enhance customer care delivery?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways can the Supplies Service develop their use of a specific customer care team to strengthen the delivery of care to you?

_____

_____

5. **Use of Total Quality Management**

Do you agree that the use of Total Quality Management (TQM) is an appropriate tool to enhance customer care?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

In what ways can the Supplies Service develop their use of TQM to strengthen the delivery of care to you?

_____

_____

If you accept the premise that TQM is more difficult to apply to professional groups of staff, how do you think Supplies Services could overcome this.

---

6. **Use of Performance Indicators**

How do you believe your use of Performance Indicators (PI's) enhances the Supplies Service ability to care for you?

What action can the Supplies Service take to refine their use of PI's to ensure that customer requirements are constantly reviewed?

When did the Supplies Service last ask you if they are measuring aspects of their service that you value?

---

7. **Relationship with Scottish Healthcare Supplies**

Do you agree that 'your' Supplies Service's relationship with Scottish Healthcare Supplies is effective in communicating your requirements?

Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

What action can 'your' Supplies Service take to enhance this relationship and bring you and Scottish Healthcare Supplies closer together?

ACTION POINTS

Please review your answers to each section of the questionnaire and identify a suggested action which it is intended you will discuss with the customer base representative.

1. Clarity of Customer Requirements.

   Action Point is _____

   _____

2. Customer Care being centinal to Planning.

   Action Point is _____

   _____

3. Flexibility of Approach.

   Action Point is _____

   _____

4. Use of Customer Care Teams.

   Action Point is _____

   _____

5. Use of Total Quality Management.

   Action Point is _____

   _____

6. Use of Performance Indicators.

   Action Point is _____

   _____

7. Relationship with Scottish Healthcare Supplies

   Action Point is _____

   _____

APPENDIX TWENTY-THREE

Kirkcaldy Acute Hospitals NHS Trust letter regarding their experience of using the Customer Care Review Tool

DEPARTMENT OF FINANCE & INFORMATION

KIRKCALDY
A C U T E
HOSPITALS
NHS TRUST

Tel 01592 643355

Fax 01592 647041

Our ref: RA/CT/H34 CRSUPTOL.DOC
Your ref:
Enquiries to: Mr R Anderson
Ext: 2051

22 April, 1997

Mr C Rees
Locality Manager - Central Fife
Fife Health Board
Springfield House
Near Cupar
Fife

Dear Clive

CUSTOMER CARE REVIEW TOOL

I refer to our meeting of 21 April 1997 with Matt McElroy. The process of developing a more assured relationship with our Supplies Service on both a business and customer level has been given a tremendous kick-start by the process you have assisted us with. I certainly now feel we have the basis on which to move forward in a more pro-active way to develop a clear understanding of each others requirements. From my viewpoint, the structured customer care tool had a number of areas of potential repetition, but we were able to use these in discussion to re-emphasise points such as the need for improvement in customer communication, and this in itself was useful. One minor point, and that relates to question 3 - flexibility of approach, I think the responsiveness to new requests could be illustrated with reference to changes in the way the service is delivered as an example.

Many thanks for your help in this process. I look forward to receiving further feedback.

Yours sincerely

Robert Anderson

R Anderson
DIRECTOR OF FINANCE

APPENDIX TWENTY-FOUR

Fife Healthcare Supplies Service letter regarding their experience of using the Customer Care Review Tool

fife healthcare
NHS TRUST

SUPPLIES SERVICE
UNIT 7
MIDFIELD ROAD
MITCHELSTON INDUSTRIAL ESTATE
KIRKCALDY
FIFE KY1 3NL

TELEPHONE: 01592 653187
FAX: 01592 653384

REF: MMCE\AA\

FIFE HEALTH BOARD
LOCALITY MANAGER
CENTRAL FIFE
29 MAY 1997
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27 May 1997

Mr Clive Rees
Fife Health Board
Springfield House
Cupar

Dear Clive,

USE OF CUSTOMER CARE REVIEW TOOL

Thank you for your letter of 24 April 1997 and notes summerising the points discussed at our review meeting.

Despite my earlier scepticim, I found the meeting to be useful. It was interesting to find that many of the responses to the topics posed in the review tool were very similar from both customer and provider parties.

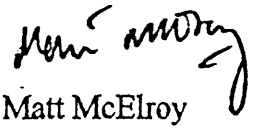
A distinctive feature of the review tool was that it focused participants attention to specific service issues. In the past customer service has been a very ad-hoc function with the tendency being towards reacting to situations when necessary. More often than not the case has been to "impose" a service on the customer, assume satisfaction and leave well alone provided there are not too many complaints.

An important point which surfaced from the exercise was the need to ensure that participants were chosen correctly, being able to demonstrate some commitment with a proactive approach to the subject. This will be of particular importance when appointing members to work together on the action groups as prominently mentioned in the review.

I think the review tool has a future for use in the NHS. Too often NHS officers have aspects of supply chain management added to their remits which will be fairly low on their scale of priorities. When this happens the review tool should provide a focus. A commercial organisation providing a supplies service must attach top priority to customer services because of its direct link to business development, growth in profitability, ability to adapt to market change - hence survival.

I'll finish now because I must be starting to sound like your tutor!

Yours sincerely,



Matt McElroy
Supplies Manager