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MANAGING VENDOR CONTRACTS IN PUBLIC SECTOR I.T.: A CASE STUDY ON THE UK NATIONAL HEALTH SERVICE

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ABSTRACT

The National Programme for Information Technology is the largest civil IT programme worldwide at an estimated cost of £6.2 bn over a ten-year period. Launched in 2002, it provides an opportunity for the IT service industry to develop business models in the UK healthcare sector in which, historically, has seen low investment in IT services. Nearly four years on—and under pressure from government and senior hospital managers to deliver working systems—the relationship between public sector organisations and private sector firms is once again under increasing scrutiny. All the IT systems are late and over-budget with vendors either leaving the programme or re-negotiating their contracts with Connecting for Health, the government agency which runs the National Programme for Information (National Programme).

In this study, we investigate the role of IT vendors in fulfilling the aims and objectives of the National Programme in the context of market, business, managerial, and technical factors. Despite highly publicised large-scale IT outsourcing contracts, many IT vendors are unable to fulfil the rigid terms and conditions of their contracts. Our findings suggest the reasons are complex, but shortcomings in vendor capabilities, contractual terms and conditions, financial pressures and poor governance arrangements have led to slow progress and even resistance to the National Programme.

KEYWORDS: Vendor Management, National Programme, Public Sector, Healthcare IT, NHS

INTRODUCTION

The UK National Health Service (NHS) was set up in 1948 to offer free healthcare at the point of delivery to all citizens. Since then, the NHS has rarely been out of the public eye. The current debate by politicians, the media and citizens is about the allocation of the £70 billion annual NHS public spend (Wanless Report, 2002). The annual spend on computer systems and services by UK government have doubled since 1999, reaching a figure of around £14bn, representing the highest in Europe (NAO, 2004). This increase has been accompanied by the growing use of large external IT service providers, and smaller, more specialised firms (Table 1) who see great potential in developing skills and capabilities in the healthcare sector (Wyatt, 1998). The split between public (in-house) and private (external) markets for IT services now stands at around 55 and 45 per cent respectively.

Yet the history of introducing ICT into the NHS has produced mixed results (NAO, 2004; 2006). From an information intensive organisation with virtually no computers in the 1960s, the NHS now has tens of thousands (Brennan, 2005). One of the first computer systems was the Patient Administration System (PAS) introduced in the 1960s. This was followed by several different systems in the 1970s (laboratory), in the 1980s (management systems), in the 1990s (IT strategy like electronic patient records (EPR), electronic record development and implementation programme (ERDIP) and electronic health records (EHR).

Against a background of relative under-investment in ICT over three decades, the government pledged in 2002 to spend around £6.2 bn¹ on a National Programme for Information Technology (National Programme) to deliver four critical elements:

- 1) NHS Care Records Service
- 2) Electronic Appointment Booking
- 3) Electronic Transmission of Prescriptions, and
- 4) IT Infrastructure and Network.

The key objective of the National Programme is, *'To deliver a 21st century health service that is better for patients, citizens, clinicians and people working in the NHS through the efficient use of information and communication technology'* (Granger, 2004).

As a longitudinal study on the vision and implementation of the National Programme covering the period 2001-2005, this research analyses data collected from 120 interviews with clinicians, hospital managers, IT suppliers and relevant healthcare agencies and groups. Developing a theoretical framework using concepts from outsourcing theory, we present a practical and systematic overview of some key vendor issues, exploring and highlighting management implications where appropriate. By discussing these issues systematically from a management and practical perspective, the paper contributes to the ongoing debate surrounding the apparent slow progress with the National Programme, thus bridging the gap between theory and practice and seeking to offer useful information to colleagues researching on the NHS.

This paper first presents our conceptual framework, which develops ideas from the literature on global IT sourcing. Next, we discuss our methods of data collection and analysis. We then present our research findings from data collected from more than a hundred respondents, including hospital managers, clinicians, and vendors supplying IT services to the NHS. Finally, it draws conclusions from the data and offers ideas and directions for future research in the health sector using vendor management analysis.

CONCEPTUAL FRAMEWORK

Since the early 1980s, the UK NHS has increasingly looked towards the private sector to provide IT services using a range of outsourcing contracts (Currie & Guah, 2007). The success of public sector outsourcing contracts, however, has mixed results, with many high-profiles 'IT failures'

¹ This figure does not represent the whole cost of National Programme and is largely confined to the technical requirements of the various systems.

occurring. These include, Wessex Health Authority, the London Ambulance Service, the Child Support Agency (CSA) and the Passport Office. To avoid such disasters, the UK government developed 'Gateway Reviews' which were intended to monitor and evaluate IT projects at various critical stages in their development (NAO, 2004). While such rational approach reflects the theory espoused in numerous project management textbooks, there appears to be little evidence that this formulaic approach has worked in practice. On the contrary, the IT system introduced in the CSA passed the various Gateway Reviews only to be scrapped in 2006 when it became clear the system was unlikely to work. This led to the restructuring of the CSA.

So against a background of mixed success with public sector IT projects, *how will the National Program for IT apply some of those lessons learned from previous projects to mitigate risk in IT outsourcing contracts?* Our literature review suggests a shortage of work on vendor IT contracts, with the majority of studies focusing upon the client side. However, some of the recent work covers a range of issues that need to be taken into consideration by vendors and clients when negotiating and managing IT outsourcing arrangements. We therefore combine four critical issues relevant for analysing the National Programme.

Supplier Diversity and Capabilities

The Wanless Report (2002) showed that IT spends around £1000 per employee in healthcare compared with around £9000 in financial services. While these statistics invite many questions about validity and relevance, they convinced policy-makers that more investment in healthcare IT was needed. Yet low investment in IT services since the mid-1960s suggests that few IT vendors have developed the appropriate capabilities and skills to serve the needs of complex healthcare organisations. The IT outsourcing market, which has expanded globally over the past twenty years has witnessed heightened activity in financial services, manufacturing and retailing, but not healthcare. The extent to which private sector templates are useful for understanding and application of IT in healthcare is debateable.

The generic outsourcing literature suggests that the IT vendor marketplace has become more diverse in recent years. The generic IT vendors target larger firms and combine a range of IT and management capabilities and skills. More specialist IT vendors target specific industrial sectors (i.e. investment banking, hotel and catering) or applications (i.e. SAP, payroll systems). Feeny, Lacity & Willcocks (2006) identify three potentially critical areas of provider competency listed below:

- Delivery competency: the extent to which the supplier is equipped to deliver service to specification on a sustainable basis.
- Transformation competency: the scope of supplier ability to achieve radical improvements in the quality, cost, and functionality of the outsourced service.
- Relationship competency: the ability of the supplier to work in true partnership with the client, with aligned incentives operating through the life of the contract.

The National Programme incorporates all three of these wide-ranging competencies, as the various IT systems are not only designed for process improvement but also for process and work practice transformation.

Strategic Partnerships

IT outsourcing contracts often euphemistically refer to strategic partnerships, more as an aspiration than a tangible outcome. Lacity and Willcocks (2006) point out the essential elements of a strategic partnership to include sharing risks and rewards, as well as creating synergies from complementary competencies. While the general public is being made to believe that the National Programme encourages strategic partnerships between the NHS and IT vendors (Mohan, 2002), how this is expected to work in practice is still a topic of much debate. One impediment to formulating a strategic partnership is the different working environment of these sectors, with private sector firms attempting to maximise their profits, and public sector NHS organisations focusing upon the needs of their patients. Our findings show that the National Programme is unlikely to close the gap between this divide. The perception that IT vendors are earning high profits from working with the NHS is likely to cause consternation, particularly if the 'cash-strapped' NHS cannot afford to provide front-line patient services.

Procurement Contracts

Most sourcing models show evidence of an inherent adversarial nature in the contract wherein the client covers the costs of all expenditure incurred by the supplier (Lacity & Willcocks, 2006). In the case of the National Programme the procurement of IT services has been shrouded in secrecy and defined as 'commercially sensitive' and 'confidential'. While Connecting for Health advises that it has followed rigorous private sector 'best practices' in the negotiation and signing of the various contracts (Table 2), secondary source data suggests that many problems exist, notably because the 'tight' contracts leave little room for the IT vendors to re-negotiate terms and conditions. Further, the fulfilment of the various deliverables and targets is dependent upon the co-operation of the organisation where the IT work is carried out, which may not be the same as the client organisation.

While the procurement contracts offered by Connecting for Health are tightly coupled and legally binding, IT outsourcing is a commercial relationship, which must satisfy the needs of both client and vendor. IT vendors that are unable to fulfil a commercial contract, either through shareholder pressure (McNulty & Ferlie, 2004) or because of resistance from NHS staff in accepting new IT systems (Currie & Guah, 2007) may decide to terminate a contract. This will lead to negative publicity and possibly legal action.

Governance Systems

The governance systems surrounding healthcare are highly organised and comprise public and private sector organisations employing both regulatory and normative controls over the activities conducted within the field of healthcare services. In the UK, three sets of principal players participate in the governance system (Guah & Currie, 2005):

- i) Governance agencies use their regulatory powers to exercise control over the material-resource environment and the value system.
- ii) The doctor/patient relationship has become highly institutionalised, with the doctor relying on their professional knowledge, expertise and judgement to advise an essentially 'passive' patient about treatment options.
- iii) More recently, patients are advised to exercise their rights to participate in healthcare governance systems. This has been encouraged by the UK government in its aim to

give patients *'more choice'*. A recent example has been where certain drugs have only been available to patients on the grounds of where they live, rather than for medical need. This has occurred because shortfalls in NHS hospital budgets have led some senior executives to refuse drug treatments to patients on the grounds of cost, with the fallout played out in the media as a story about treatment being offered according to a *'post-code lottery'* rather than on medical need (Pollack, 2005; Webster, 2002).

The above concepts are central to our understanding of how the healthcare system adopts and adapts to changes in the material-resource environment and the beliefs, rules and ideas which comprise the value system within which vendors from the private sector must do business.

THE RESEARCH STUDY

Our study on the UK National Health Service began in 2001 at a time of heightened activity in this sector. As far back as 1998, the Department of Health produced a strategy document which committed the NHS to lifelong electronic health records, 'for everyone, with around the clock, on-line access to patient records and information about best clinical practice for all NHS clinicians' (Connecting for Health, 2004). This culminated in the NHS plan in 2000, which outlined a vision of healthcare service designed around the patient and a new delivery system.

By 2001, another report was produced which outlined the information systems needed to deliver the NHS plan and support patient-centered care and services. The following year saw the Wanless Report (2002) published which offered several key recommendations for IT in the NHS. The report advocated an increase in IT investment, stringent, centrally managed national standards for data and IT, and better management of IT implementation in the NHS, including a national programme. Later in 2002, another report was published – *'Delivering 21st Century IT Support for the NHS – A National Strategic Programme'* (Department of Health, 2002). Within it contained the plan for the governance system to create a Ministerial Taskforce and recruitment of a director general for the National Programme for Information Technology. In addition, it set up the Clinical Care Advisory Group, with representatives from many healthcare organisations. The main task for this group was the recommendation to create an NHS Care Record for each patient, with core information held in a national data repository. By October 2002, the National Programme was launched with the appointment of a Director General of NHS IT (Table 1). The purpose was to *'procure, develop and implement modern, integrated IT infrastructure and systems for all NHS organisations in England by 2010'* (Connecting for Health, 2004).

As a longitudinal study on the UK healthcare system, it was imperative that a research method was compatible with our objective to identify and understand the institutional environment of healthcare delivery. More specifically, we were keen to identify and explain the observed changes in the diversity of supplier base, the vendor management issues, and also the governance systems designed to facilitate the introduction of the National Programme. Three broad research questions were developed: 1) How can we identify and delineate the key vendor groups and individual actors which comprise National Service Providers and local service providers (LSPs)? 2) What are the defining business logics prevailing within and across the NHS in relation to the National Programme and change programmes more generally? 3) Who are the key players in

determining the vendors deliver what was promised under the National Programme?

As an exploratory-descriptive study, we selected to interview a variety of individuals working within the organisational field of healthcare. This included, government ministers, professional groups within healthcare, NHS clinicians and administrators, and external IT suppliers involved in the National Programme.

A literature review of the healthcare arena identified a number of studies on policy issues, yet few which systematically and rigorously examined how change management programs were adopted and diffused throughout the healthcare sector. Whereas many studies considered the introduction of a change programme, usually involving IT, within a specific organisational setting (Brown, 2001), there were limited studies that examined vendor management between different constituents in the adoption and diffusion of IT systems (i.e. government agencies, NHS executives, hospital trusts, IT suppliers and patients). Most of the studies were descriptive and lacked an historical dimension. Further, many of the studies on the introduction of medical systems were not supported by a robust theoretical framework, and instead were more narrowly aimed to identify examples of best practice.

Data collection and analysis

Three methods of data collection were adopted. First, the researchers assembled a range of academic, government and industry studies on the healthcare sector. These studies were not restricted to the UK only, but included articles and reports on healthcare services in many countries, regions and locations. This material proved invaluable for understanding some of the societal, economic, political, cultural and technical differences in healthcare nationally and internationally. Second, we attended various trade fairs, conference, workshops and exhibitions on healthcare. Some of these events were focused on general topics (i.e. IT in healthcare, patient services, hospital management and professional best practice), with others more focused upon specific activities (i.e. the National Programme, presentation of the Wanless Report, IT strategy for NHS). These events generated many useful research contacts. Third, we engaged in primary data collection, where 120 interviews were conducted with a range of constituents (i.e. health service professionals and administrators, clinicians, doctors, patients, IT service providers, and politicians).

An open-ended and semi-structured interviews schedule was used to enable interviewees to expand on their answers. This method of data collection was critical for allowing interviewees to raise additional themes, issues and concerns that they felt were important to the research study. Interviews with respondents took place over a three-year period. Most of the interviews lasted around two hours. The interviews at the NHS hospitals were tape-recorded and the tapes were transcribed. Respondents were sent a transcript of the interview to verify it was an acceptable account of what was discussed. Any errors were corrected. Since some of the interview content is politically contentious, many interviewees asked for themselves and their NHS hospitals to retain their anonymity.

The open-ended and semi-structured interviews were conducted during the first four years of the National Programme project implementation, part of which was the negotiation of contracts to

the service providers. Multiple informants were interviewed both within the NHS hospitals and with other constituents. During the first year of interviews, the scope of the study was extended as it was important to elicit data and information from a wider range of respondents engaged in the implementation of the National Programme. These included, IT service firms bidding for public sector IT contracts (Table 1) and doctors in general practice (external to the NHS hospitals). Respondents from IT service firms offered critical insights into the political and procurement processes within the NHS and public sector more generally (see comments by Project Manager of IT Vendor below). GPs offered useful insights about the communication channels underpinning the vendor responsibilities.

Following the first year of interviews, the researchers evaluated the data and refined the semi-structured interview schedule. It was recognized that given the range of constituents involved in the National Programme, the questionnaires needed to be more closely targeted to the professional and personal situation of the individual, as generic questions were less meaningful. The comments and insights from respondents were further compared with the policy documents and reports from government sources.

CASE STUDY: THE NATIONAL PROGRAMME FOR IT

Healthcare in the UK is a highly complex environment with the NHS providing patient services to around 60 million citizens, free at the point of delivery. The NHS was created by a parliamentary act initiated by the Labour government following a national healthcare review after World War II. The current NHS organisation consists of parliament, a secretary of state for health, strategic health authorities, under which NHS trusts, foundation trusts, primary care trusts, care trusts and non-NHS organisations reside. An independent regulator that monitors these organisations reports to parliament.

The past six decades has witnessed the NHS experiencing periods of both stability and change. As a highly institutionalised environment, the NHS has developed a 'public sector ethos' infused with the values of serving the public. Clinicians and healthcare workers have placed these values above issues of finance and cost effectiveness as treatment has been provided based upon medical need rather than ability to pay. Over the years, the NHS has developed many institutionalised mechanisms that make change difficult and often highly controversial, such as the powerful professional bodies which govern the conduct and performance of clinicians (McNulty & Ferlie, 2004). Successive governments have introduced policy documents to modernize the NHS with varying levels of success. One area has been in the use of information and communications technology, as a means to enhance efficiency and performance. Healthcare is an information-rich business with 15% of hospital resources spent on gathering information. Doctors and nurses are estimated to spend up to 25% of their time collecting and using information (Audit Commission, 1995).

The proliferation of new entrants into the healthcare organisational field was a consequence of changing government policies over six decades. During the era of professional dominance, healthcare workers, particularly clinicians, enjoyed a level of freedom to define and structure their working practices. This extended to choices about the types of technology adopted and

diffused across the NHS. As a new era emerged in the 1970s, which embraced managerialism as a way to enhance efficiency and performance, the healthcare system was increasingly inundated with various managerial fads and panaceas, like BPR and change management (Willcocks and Currie, 1997). An outcome of these interventions was that isomorphic structures across the NHS were increasingly threatened, as NHS managers were keen to demonstrate 'best practice' examples through the adoption of the latest management ideas. Implicit in this logic was that the NHS organisations that had not embraced 'new ideas' ran the risk of being labeled as 'against modernization' or, at worst, 'failing institutions'.

Governance Structure for the National Programme

Up till the mid-90, the NHS governance structure for IT was decentralized or division-based, although decisions about organisational-wide IT projects remained centralized at the level of the government and NHS Executive. IT divisions were spread across several regional authorities, with medical functions centrally controlled. This precluded many small IT service firms from gaining a foothold in the NHS, as only their larger counterparts had the political, organisational and technical capacity to deliver large-scale IT work. In the late 1990's, the government increasingly recognized the opportunity to use IT to improve the delivery of service within the NHS. After a series of reviews of NHS IT service delivery, a more integrated and seamless IT organisation was recommended (Department of Health, 2000; Wanless, 2002). An IT Director commented,

'If you compare banking and the NHS, IT systems tend to be standardized in banking but non-standardised in the NHS. IT in the NHS has grown from the bottom up, and this is now creating problems for the National Programme, which is trying to create a uniform approach to IT across the NHS'.

The governance structure for the National Programme operates at three levels with defined reporting lines and links to other groups. At the top level, the Department of Health (DoH) Departmental Management Board (DMB), chaired by the DoH permanent secretary, provides governance. This is the senior decision-making body within the DoH and is the National Programme sponsor. The Senior Responsible Owner (SRO) is the DoH Group Director for Delivery who is a member of the DMB and who chairs the National Programme Board Executive which is an executive sub-group attended by all SROs for individual programmes and work streams. On a day-to-day basis, the management of the National Programme is the responsibility of the operational management team, chaired by the Chief Operating Officer, who reports to the National Programme Board and its Executive, and also chairs the National Supplier Board.

Other agencies involved in auditing and reviewing the National Programme are part of the programme governance structure. These include HM Treasury, the National Audit Office and the Office of Government Commerce, all of which are represented on the National Programme Board. The Cabinet Office Committee, which reviews the ongoing progress of all large-scale IT projects, also plays a role.

The Nationwide Programme is structured around regional clusters following consultation with Strategic Health Authorities. After much discussion, England was split into five geographic

regions - each cluster comprising between five to seven SHAs – to would work together on the procurement and implementation of the National Programme services at local level. Five LSPs deliver applications at a local level. The LSPs work closely with local NHS IT professionals and are overseen by a Regional Implementation Director (RID) from the National Programme. The LSPs ensure that existing local systems are compliant with national standards and that data are able to flow between local and national systems. To do this, the National Programme plans to deliver upgrades or replacements to hardware and software as appropriate and implement core local training for NHS staff. All RIDs lead the implementation process across their individual areas. RIDs manage the National Programme support team and the relationship with the supplier, as well as co-ordinating deployment. A RID is part of the National Programme team and reports to the National Programme implementation director, but is also responsible to the cluster board for delivery. This arrangement, however, created difficulties for the IT vendors as per this observation:

“We believe the National Programme will delivery benefits to both national and local authorities resulting from investment in the provision of technology that will be released through parallel investments in implementation and changes to local working practices.

Although practical value may differ and lead to different conclusions about investment opportunities, the consequence of the local IT infrastructure or lack of past investment in IT, the local priorities for new investment may not align with a national emphasis. We have observed certain instances where the contractual commitments made in relation to the deployment of IT are not always aligned with the timing of local initiatives or other projects developments.

Present government policy offers a mix of centralized initiatives such as the National Programme, alongside devolution of power and responsibility through initiatives such as the delegation of decisions over a very large proportion of NHS funds down to local Primary Care Trusts and the creation of foundation hospitals. Yet this apparent dichotomy is coherent. Greater standardization of some processes will provide greater freedom for others. As an example one of the more extreme examples of the devolution of power - the provision of choice to individual patients to select their care provider - will be dependent on the successful implementation of a common national software application as much as it will through local investments in new facilities and services.” Project Manager of IT Vendor.

The magnitude of the National Programme suggested the need for a formalised governance structure. Yet interviews with a range of respondents identified serious shortcomings:

‘The formal structure is intended to clarify roles and responsibilities which are standard practice in any large-scale IT implementation. However, the current structure is not permanent as the government is planning to reduce strategic health authorities to only nine. This will have significant implications to decision-making structures as many chief executives will either be out of a job or moved to another role. It is very difficult to implement IT change when things keep changing’. IT Director.

The on-going changes in the formal structure of the NHS only exacerbated these problems with two identifiable negative outcomes (Heathfield, Pitty, & Hanka, 1998). First, NHS staff described the situation as ‘change management fatigue’ as they sought to interpret new and revised government policy. Many staff were concerned that structural changes did little to increase efficiency and performance, and instead contributed to low morale. Second, structural changes produced confusion and contradictions, as NHS staff struggled to interpret new institutional logics against existing institutional logics. For example, a Director of ICT at one hospital said,

‘In the past, the hospital was owned by the state. Now that we are part of the private finance initiative (PFI), the buildings are privately owned. If someone wants a new socket in their wall, I can no longer go and fit one in. I have to ask the leaseholders of the building to do this, and the cost is five times as much. This changes relationships within the organisation as everyone is either a provider or purchaser in this internal market’.

The move from a less formal governance structure to one which emphasised market mechanisms through the continuation of policies which set up the ‘internal market’ was not interpreted by NHS staff as a positive outcome. Rather, NHS staff described their working practices as being imbued with the values of service and compassion. To undertake roles and tasks on the basis of cost and efficiency criteria were against these core values. The Director of ICT continued his point,

‘The internal market which started in the 1970s was more about reducing waste and increasing operational efficiency. But now, we have moved towards an external market, where even the buildings and other capital equipment is owned by private firms. The current delays in the National Programme, such as Choose & Book, reflect all the problems of dealing with contractors and sub-contractors. I am not sure that we have become more efficient in this new regime. Personally, I think that NHS staff did a lot of things in the past for which they were never properly rewarded. Nowadays, if the private firms mess up, they still seem to get paid’.

DISCUSSION AND CONCLUSION

This paper has considered the development and early implementation of a large-scale IT-enabled change programme throughout the NHS in England. Using institutional theory as a lens to interpret our data, we consider the changing organisational field of healthcare, the prevailing institutional logics and the governance systems that both encourage and facilitate organisational and technical change.

Our findings highlight the increasingly complex organisational field that comprises the healthcare environment. Such complexity employs what is now described as a ‘kaleidoscopic workforce’ with about one quarter of primary care delivered by agency staff (Gray, 2006) with only the patient seen as a constant within the NHS. Like other initiatives within healthcare, the National Programme is designed and implemented by more than one bureaucracy, which suggests that delineating roles and responsibilities becomes increasingly difficult.

Against a backdrop of continuous change in the NHS, the National Programme is currently halfway through its planned implementation. It is too early to predict whether the National Programme will achieve its overall aims and objectives, but our findings suggest that while the government and media have narrowly focused upon its technical deliverables, a significant challenge is to win the hearts and minds of those who are expected to adopt the various technologies of the National Programme. As a large-scale IT project, the National Programme is consistently missing the original performance targets (Hendy et al, 2005; NAO, 2006). While this is not unusual for IT-enabled projects, the National Programme is not simply about installing new hardware and software, but requires a significant change in the working practices of clinicians and administrators. Politicians describe the National Programme as a knowledge-based programme, where information sharing is a fundamental outcome measure. However, our findings suggest that such a goal is naïve as professional groups such as clinicians and IT firms perceive knowledge as something to be protected and secured, not available for public or competitor consumption.

The current delays and shortcomings of systems such as Choose & Book are not merely confined to technical blips, but extend to poor communication between those who seek to impose this system and the various user groups it is intended to serve. A simple solution is to increase communication between the stakeholders in the form of additional workshops to fuel dialogue about the delivery and implementation of the various aspects of the National Programme. Several initiatives towards achieving this objective are currently being sponsored by Connecting for Health (NAO, 2006). A more fundamental and intransigent problem, however, was highlighted by the various respondents and concerned conflicting institutional logics.

In an era of increased marketisation, privatization and commercialisation (Pollock, 2005), one of the significant challenges facing the National Programme is to reconcile competing institutional logics emanating within an organisational field which has become increasingly fragmented over time. Past logics espousing the virtues of the public sector ethos, professionalism and self-regulation, continue to collide with a private sector ethos, which is sanctioned by government policy and regulation to enhance performance and efficiency within the NHS. But this conflict continues to pose problems as clinicians reconcile competing interests among NHS managers and patients. More recent logics have compounded the problem, as the concept of the internal market has been externalized and now encompasses a new vision for 'patient choice' to enhance the 'public value' of government controlled services (Moore, 1995).

Against these changes, defining the aims and objectives of the National Programme has become increasingly difficult, as conflicting and contradictory logics circulate within the organisational field of healthcare. This is continuously being played out in the media as the high cost of the National Programme is often discussed in the context of a zero-sum game, in that scarce resources could be spent on 'more pressing public needs' such as treatment and drugs, rather than technology. The growing accent upon nurturing a 'patient centred ethos', where citizens play an active role in choosing and managing their own healthcare needs (including access to their own on-line patient records), will serve to generate new logics about the role and purpose of technology.

This research study has addressed a range of broad questions in relation to the National Programme. Using vendor analysis, we recognize our research has many limitations that are germane to this theoretical perspective. Two important limitations are given here. First, our study adopts a conceptually broad analysis using concepts of vendor field, institutional logics and governance systems. Within each LSP arrangement, there are variations in the dominant institutional logics and governance systems. Specific vendors will therefore espouse different priorities and policies pertaining to service delivery policies, healthcare agencies, internal management and administrative structures and even post-implementation support. While our research has not attempted to compare and contrast the major application service providers from which data was collected, future research may seek to identify variations in the material-resource environment and value systems between vendors. Second, another limitation of adopting this type of outsourcing theory perspective is the absence of ‘quality of service’ in the interpretation of our data. In many studies in the healthcare systems, the quality of patient data is emphasized in leading and managing large-scale IT-enabled hospital change programmes. We recognize that although we convey the values, comments and opinions of various respondents, we do not seek to measure or evaluate their impact or role within the Connecting for Health to its vendors. Further research may therefore focus upon the individual role of specific vendors in delivering the aims and objectives of the National Programme for the purposes of comparative analysis of different vendor performance outcomes. This is likely to become increasingly relevant where further fragmentation of healthcare results in highly differentiated healthcare delivery.

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TABLE 1: Original companies that expressed interest in bidding for National Programme in 2002
99 COMPANIES – EXPRESSION OF INTEREST

ASC ComputerSoftware	AME International	CSC	IBM	Hiperworld Cybertech
Avaya UK	Atlantic Global	Anite Public Sector	Centerprise	Hiperworld Cybertech
BDS Solutions	Attenda	Bearing Point Inc	Chameleon Info Mgment Service	Holdcare Consortium
Damovo UK	Bridge Systems	Computerland	Civica Service	Imtech Uk
Fujitsu	Cerner	Corporate Solutions	Communications Advisory Service	Indigo 4 Systems
HP (UK)	CTG Inc	Consulting (UK)	Healthtrio	Infermed
Lason Systems	Information Group (UK)	CSE-Servelec	ISC Computer	InHealth Solutions
Logica	Lockheed Martin	McKesson/Capita	Kingston Comms	Integrated Medical Solutions
Micor Warehouse	Lucent Technologies	MLL Telecon	OE Group (Stone Computers	Loghar
PlexusCare	Omnetica	Pars Technology	Patient First Alliance	Logica
Service & Systems Solutions	Parity Computers	Quest Software UK	Patni Computer Systems	McKesson/Capita
Simon Management	Plato Health Systems	Ramesys (e-Business)	Securicor Info Systems	Northrop Grumman
Southern Alliance	Redstone Communications	SAIC	Serco	Nucletron OSS
Stalis Ltd	Targetfour	Selection Services Plc	Specialist Computer Centres (SCC)	World Class Int.
Telewest	Viglen	Siemens	Wipro Tech.	Steria
Triple G Ltd	Xansa	Silversands	OLM Systems	Torex
Accenture	In4tek	Compuware	Ergo Computing UK	Quask AG
Beaufort Int.	Insight Direct (UK)	SciSys (Commerce & Industry)	Morgan Chambers	Everlogic
BT Syntegra	iSoft	Cap Gemini Ernst & Young	CACI	Kelvin Connect

TABLE 2: Major vendors on the National Programme

MAJOR VENDORS - National Programme			
<ul style="list-style-type: none"> • NASP purchasing & integrating nationally • LSP delivering IT systems & services locally 			
CONTRACTS (DEC-2004)	SERVICE PROVISION	PROVIDER	LENGTH
Care Records Service – NASP	National	British Telecom	10 years
Care Records Service – LSP	North East	CSC	10 years
Care Records Service – LSP	Eastern	Accenture	10 years
Care Records Service – LSP	London	Capital Care Alliance (British Telecom)	10 years
Care Records Service – LSP	North West & West Midlands	CSC	10 years
Care Records Service – LSP	Southern	Fujitsu Alliance	10 years
National Network for the NHS (N3)	National	British Telecom	7 years
Choose and Book	National	Atos Origin	5 years
Contact (email)	National	Cable & Wireless	10 years