Procurement Maturity in Public Healthcare Procurement: An Exploratory Study

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Abstract
This paper reports on the early findings of a study into procurement maturity across four English Trusts in the UK's National Health Service (NHS). Procurement is central to NHS cost cutting initiatives yet the ability to deliver is compromised by the lack of procurement maturity as activities centre almost exclusively on process compliance. Procurement activities were explored via interviews with buyers, clinicians and suppliers. The failure to progress to a higher level of procurement maturity in the NHS is not attributed only to failings at the buyer-seller dyadic interface as standard procurement models would suggest, but to predominantly internal barriers.

Introduction
Improving procurement performance can make a considerable contribution to an organisation's performance (Carr and Pearson, 2002; Sánchez-Rodríguez, Hemsworth and Martínez-Lorente, 2005; Schiele and McCue, 2006). Despite this dominant rhetoric in the academic literature and in professional procurement practice, the strategic maturity of procurement has not been subject to rigorous theoretical and empirical scrutiny (Chen, Paulraj and Lado, 2004). An issue arising from the lack of conceptual development of procurement maturity is that a number of assumptions are made on the ability and freedom of procurement to contribute strategically, and on the level of engagement and acceptance of other stakeholders, internally and externally, of procurement's role.

The preliminary results reported in this paper reveal how procurement teams in the UK's National Health Service (NHS) lack strategic maturity, notably in relation to sourcing and contract management, yet are tasked with delivering ever-increasing cost savings. To illustrate the challenge, the NHS's net deficit for the 2014/15 financial year totalled £671 million (NHS Confederation, 2015) and government commissioned reports identify £1 billion savings targets from improvements in procurement (Carter, 2015). The lack of consideration of procurement maturity when setting targets risks procurement adopting narrow, short-term price-based approaches that damage internal and external relationships. Procurement's journey to maturity requires more nuanced understanding of organisational culture, conflict and resistance than the current development models suggest.

Procurement maturity

Procurement maturity has been defined as "the level of professionalism in the purchasing function" (Rozemeijer, Weele and Weggeman, 2003:7). Maturity models commonly establish auditable, cumulative stages which a procurement function needs to go through in order to achieve a greater level of sophistication, typically from a process orientation through to a strategic value-based contribution (Rozemeijer et al., 2003; Schiele and McCue, 2006). The thematic structure of the development of procurement typically journeys from a tactical to a strategic function. Strategic procurement is widely considered to be the key to provide sustainable competitive advantage at a corporate level (Ellram and Carr, 1994; Carter and Narasimhan, 1996). There is an expectation that procurement and supply management are mainstream value-contributing activities (Ellram and Liu, 2002; Cousins, Lawson and Squire, 2006), beyond the provision of process compliance and cost-saving measures. Yet, claims of procurement's strategic impact lack rigorous theoretical and empirical scrutiny in the literature (Chen et al., 2004) and most procurement research still focuses exclusively on net earnings or bottom line efficiencies and studies focusing on top-growth impact of procurement are limited to notable exceptions (Wagner, 2012). More importantly, despite numerous maturity models and the dominant practitioner narrative of procurement's strategic development, NHS procurement is still viewed as largely inefficient with government-commissioned reports identifying £1 billion of untapped procurement potential (Carter, 2015).

Procurement maturity models have been popular since the early 1980s and typically include a staged sequence of levels that progress from an initial state to maturity. An organisation's current maturity level represents its capabilities in relation to a specific classification or domain (Rosemann, De Bruin and Power, 2006). Maturity models are used to identify as-is situations, guide improvement initiatives to the next stage, and to control progress towards some desired future state. The logical and anticipated phased journey of the models is rooted in the assumption of predictable patterns of organisational evolution and change (Kazanjian and Drazin, 1989; Van de Ven and Poole, 1995). Table 1 identifies the more prominent procurement maturity models (based on 100+ citations), and the stages they include.

Common across all of these maturity models is that procurement grows in maturity from a transactional function that focuses on process, to a strategic function that is aligned with the supply chain. Procurement maturity is viewed as a broad, aggregated concept across dimensions of structures, relationships, processes and systems (Van Weele, 2010). To reach the final strategic stage, procurement must be integrated from the top-down in order to enhance competitive advantage (Foerstl, Hartmann, Wynstra and Moser, 2013). This implies that an organisation's top level of management has placed an emphasis on the strategic importance of procurement and has chosen to invest time and resources into improving the function. A danger in the laddering of predefined procurement maturity is that it can restrict considerations of resource and context (Schweiger, 2015)

Table 1: Stages in prominent procurement maturity models

Authors	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
(Kraljic, 1983)	Purchasing Management	Materials Management	Sourcing Management	Supply Management		
(Reck and Long, 1988)	Passive	Independent	Supportive	Integrative		
(Freeman and Cavinato, 1990)	Buying	Purchasing	Procurement	Supply		
(Keough, 1993)	Serve the factory	Lowest unit cost	Coordinated purchasing	Cross functional purchasing	World Class Supply Manage-ment	
(Van Weele, Rozemeijer and Rietveld, 1998)	Transactiona l orientation	Commercial orientation	Coordinated purchasing	Internal integration	External integra-tion	Value chain orienta-tion
(Cousins et al., 2006)	Celebrity (exclusion)	Undevelope d	Capable	Strategic		
(Paulraj, Chen and Flynn, 2006)	Nascent	Tactical	Strategic			

In the various models (see table 1), maturity is taken as a proxy for strategic impact, yet there are arguably some subtle differences. Maturity relates to the range and scale of activities undertaken (Rozemeijer et al., 2003), while strategic procurement relates to the demonstrable impact of these activities in a competitive context. Strategic resources are valuable, rare, imperfectly imitable and non-substitutable (VRIN) (Barney, 1991). For procurement as an internal service provider, these criteria require others to view it as such. The danger for a low status, immature procurement function is that failure to provide impact perceived as VRIN by stakeholders, decision makers and executives runs the risk of procurement being excluded from strategic plans. This is not to say that strategic procurement activities are not undertaken; rather where they are conducted, and by whom, may be the critical questions.

A positive relationship has been identified between procurement maturity and performance, yet public procurement organisations often lack both systems and indicators to measure and improve on their procurement maturity (Batenburg and Versendaal, 2008; Plomp and Batenburg, 2009). Public sector organisations can be complex, adding to the difficulty of

addressing a single overall procurement strategy (Hesping and Schiele, 2015) or maturity assessment. The profiling of skills and maturity, while advantageous, do not fit well in highly dynamic and complex contexts (Knight, Tu and Preston, 2014). Similarly, the healthcare context may not sufficiently represent the scale of procurement challenges seen in product-oriented and more stable manufacturing contexts (Hesping and Schiele, 2015).

The staging of the maturity models tends to ignore the factors that influence evolution and change. Van Weele et al., (1998) offer the only procurement maturity model that explicitly states the importance of both internal and external integration as separate stages (see table 1). The suggestion here is that to achieve a high level of procurement maturity, organisations should collaborate internally between departments and develop and manage supplier relationships. Empirical research highlights the importance of enablers (comprised of individual employee capabilities, training and talent development, IT system support, and performance tracking and reporting) to act as a catalyst to more mature procurement activities and in developing a strategic alignment between resources, capabilities and competitive advantage evolution (Kerkfeld and Hartmann, 2012).

There is a paucity of empirical research on internal relationships, supplier-focused activity and corporate performance (Zimmermann and Foerstl, 2014). A key assumption made in the literature is that all internal stakeholders buy in to a mature procurement function and that buyers will be empowered to undertake strategic activities. Given that stakeholders may not consider procurement as valuable, rare, imperfectly imitable and non-substitutable (Barney, 1991), particularly if parts of the new strategic role is currently undertaken by them (contract management, sourcing, supplier engagement etc.), then there could be considerable internal resistance to the path to procurement maturity. The gap in internal relationships in the current procurement models is problematic as these may be the key enablers to procurement development.

Methods

This project was funded by the University of Liverpool's Knowledge Exchange scheme. It was conducted with professionals from an NHS regional procurement development organisation. The NHS faces a challenge as many supplier contracts have already been commercially optimised so new approaches are needed to tackle cost. The NHS procurement context is characterised by conflicting pressures of cost-savings, short-term targets, patient safety and legislative-regulations to deliver social impact and the pressure to evidence value for money. Maintaining integrity in decision-making is essential in public sector procurement (Schooner, 2002). The project was initially funded to identify whether value-based procurement is a feasible option in the NHS, in spite of this context. Researching this provided valuable insight into other aspects of procurement in the healthcare sector, including procurement maturity, complexity and conflict. Through the procurement development team, four of the NHS Trusts pledged their involvement to the project. The majority of procurement staff in these Trusts were CIPS trained and thus had good knowledge of procurement as a discipline and how to improve their purchasing function. However, they were experiencing multiple barriers due to the NHS context.

Engaged, qualitative research approaches were needed to build researcher credibility and confidence with multiple stakeholders, as cost savings and value are emotive issues in the healthcare market, particularly in such turbulent times. In NHS procurement, some products have a huge impact on the lives of patients and may be highly specialised. Focus groups were deemed the most appropriate method for data collection, as the Head of Procurement for each

Trust could invite all stakeholders involved in the procurement process for a particular spend category, leading to a comprehensive view of the overall process. During focus groups, participants interact and in doing so reveal more of their own frames of reference on the subject of study (Finch and Lewis, 2003). However, only one Trust was able to co-ordinate a focus group. The rest of the data was gathered using informal interviews with two-three of the stakeholders involved in the process, as these proved easier for the Head of Procurement at each Trust to organise. By interviewing multiple stakeholders at the same time, the researchers were still able to obtain a deeper view than individual interviews would have allowed. Informal group interviews are appropriate for exploratory purposes, particularly when trying to understand a complex social context (Frey and Fontana, 1991). However, participants in each interview worked in similar areas, rendering the researchers unable to obtain multiple viewpoints from across the procurement process as the planned focus groups would have enabled. The fact that focus groups with stakeholders outside of the procurement team were so difficult to organise provides us with valuable insight into the power (or lack) of procurement in the NHS. Clinicians were subsequently interviewed separately to obtain their perspective on, and role in, procurement activities.

To supplement data generation from NHS staff, a supplier event was held in May 2015 at the University with 17 NHS supplier representatives. The emphasis in NHS procurement is heavily focused on cost saving and the researchers were keen to capture the impact that this was having on suppliers. Participants at the supplier event completed two in-depth focus groups, each between 45-60 minutes long to explore their perceptions of procurement within the NHS, their frustrations with the system and how they approach working with this complex organisation. It has been identified that previous studies that only gathered data from procurement staff resulted in homogeneity of responses (Walker, Schotanus, Bakker and Harland, 2013). This multi-stakeholder approach mitigates this risk.

In total, 37 stakeholders took part in the research. The data generated allows for a richer understanding of procurement maturity in the NHS, from multiple stakeholder perspectives. The data arising from all sources has been recorded, transcribed and an initial preliminary analysis has been conducted. At the point of writing, the transcripts have recently been completed and the researchers have begun conducting a full verbatim analysis using NVIVO. As the research is in its early stages, this paper reports on the initial themes identified by the researchers when separately, then collectively, reading over the transcripts. The output of this is a descriptive analysis, using quotes to emphasize key points. The initial findings have then been assessed and reviewed against academic literature to provide an assessment of NHS procurement activities against standard procurement maturity models.

Results and Discussion

The findings demonstrate a lack of procurement maturity in the NHS. Although there are pockets of good practice, committed staff, and a desire to develop procurement, there are also gaps in foundational activities that prevent progression to a higher level of procurement maturity, such as contract management, supplier relationship management and a lack of departmental integration on a strategic level. Indicative procurement maturity stages and activities mapped were drawn from the data gathered from multiple participant perspectives. The use of multiple stakeholders enables a broader consideration of procurement's current value proposition to service users, and where this could/should be developed to drive strategic benefit. Table 2 outlines this potential procurement maturity 'journey' for the NHS, providing an initial developmental framework. The table was developed in conjunction with participants during their interviews/focus groups, where they were asked to identify the common areas of

the staged journey to procurement maturity within the context of the NHS. The rich data collected has been grouped in stages of emerging maturity.

Table 2: Procurement maturity stages in public healthcare procurement

MATURITY LEVEL GOALS	INDICATIVE PROCUREMENT ACTIVITIES
Stage 0	Process compliance; Tendering; Tender analysis and evaluation; Regulatory advice; Limited supplier engagement; Non-volume committed framework agreements; Product/service standardisation; Targets not aligned to market opportunities
Stage 1	Developing cost and value data metrics; Baselining spend profiles; Developing purchasing segmentation strategies; Exploring market drivers for key categories; Exploring internal value drivers for key categories; Target setting; Supplier engagement; Internal stakeholder engagement; Skills assessment; Training.
Stage 2	Data mining; Market intelligence infrastructure; Category management; Value-based contracts; Supply base rationalisation; Supplier evaluation; Identification of potential suppliers; Targeted sourcing strategies; Contract data management;
Stage 3	Volume-committed contracts; Supplier evaluation systems; Data analytics; Integrated stakeholder category management; Pre-market engagement; Value-based commercial contract management and assessments; Smoothing of capacity and demand; Risk management planning; Supplier relationship management; Commercial intelligence to drive sustainable patient outcomes; Contracts aligned to sustainable value; Collaborative long term planning; Co-creation of innovation throughout supply networks; Social capital creation and capture.

In the region under investigation, buyers, clinicians and suppliers largely felt that procurement is stuck at Stage 0 in relation to activities consistently undertaken; the baseline stage for growth in procurement sophistication. The barriers identified from the data are: perceptions of procurement, short-term savings targets, a lack of knowledge of clinical products, and lack of resources.

Barrier 1: Perceptions of procurement

There is widespread acceptance from staff, clinicians and suppliers that procurement activity has improved in recent years, partly as a result of development work and stakeholder engagement. Procurement ensures compliance to EU procurement regulations and this represents the largest percentage of their activity and time. However, the result of this is that too much of their time is spend administering the process rather than enhancing commercial value through market engagement activities or contract and supplier management. Procurement still has a low level of influence within the NHS that limits their ability to provide a more strategic contribution. Working in NHS procurement is perceived as a difficult job, heavily tied up in paperwork, processes and with numerous conflicting pressures. One clinician summed up the views of many when stating *"I can't imagine anyone actually leaves school and says I want to go into NHS procurement"* (Clinician, Interview 2). Structurally, procurement is not

part of a division or a management structure within a department. This places an emphasis on the development of relationships, to ensure that other departments are aware of the supportive role that procurement provide, instead of perceiving them as a hindrance, yet they lack the authority to engage at a senior level.

Despite development work, there is a perception across the user community, and by suppliers, that procurement is still immature in its approach. Immaturity stems from a narrow focus on iterative price reductions that is deemed to restrict innovation, damage relationships and trust, and prevent procurement maturity. In terms of external perceptions of procurement, the suppliers voiced concerns about the current focus on savings (Supplier, Focus Group 2), and the adherence to established frameworks (Supplier, Focus Group 4) as significant barriers to innovation. Many gave examples of procurement being short sighted and price-orientated that resulted in the NHS not getting the most from their products and services. The focus on price alone was deemed by SMEs to be a barrier to entry.

A narrow price focus is a source of great frustration for the NHS suppliers (Supplier, Focus Groups 1, 2 and 4). There were negative attitudes towards suppliers from procurement where there are persistent views that larger suppliers, as corporate private sector organisations, make substantial profit out of the NHS and prices are not optimal. Suppliers voiced frustrations at the lack of long term view of cost, rather than price, and collectively agreed that tenders often include a question about what added value suppliers can bring if they won the contract but stated that this is usually zero-rated and will not be taken into consideration when awarding the contract, making demonstrating added value a pointless activity. They also argued that procurement do not seem to engage with end-users of the product or service and thus lack the knowledge of the elements of quality of that product or service, and fail to manage contracts sufficiently once they are let (Supplier, Focus Group 3).

A lack of trust was clear between buyers and suppliers, stemming in part from both sides' negative perceptions of the other. Suppliers fear suggesting improvements to the NHS as they felt that procurement would exploit these ideas through putting in out to tender, potentially letting it go to their competition, even when they were in-contract. Some suppliers provided examples of this happening to them (Supplier, Focus Group 2) and explained how this saw them revert back to transactional relationships.

Barrier 2: Short-term savings targets

Procurement perceives that internal stakeholders and financial structures in the NHS limit the potential for the department to mature. Procurement maturity models in the literature assume a level of strategic internal integration, which is not the case in the NHS owing to its culture and complexity. The wider political landscape of government policy and targets creates short-term pressures on budgets and targets that are barriers to longer term cost benefit decisions. Annual savings targets do not enable a long-term view.

Procurement recognise that pressures to achieve short term savings are extremely high and life cycle benefits do not bring immediate, or visible, gain which limits the scope for procurement to add value. Buyers are under immense pressure to meet these targets, are not consulted when targets are set, and feel they lack any authority to challenge them. When asked about what would happen if they didn't meet their savings targets, one participant stated *"we don't know, it has never happened, it's not an option"* (Procurement, Interview 1), highlighting the strength of pressure upon them. The lack of empowerment creates conflicts in their professional identity and aspirations to deliver sustainable contributions. The long-term view necessary for

progression in procurement maturity is not feasible without the support of senior finance staff that set the savings targets, which in turn act in response to high-level budget changes and political pressure. Van Weele et al., (1998) identify the importance of internal integration as a stage in procurement maturity, as a precursor to external integration with suppliers. This suggests that without the cooperation of internal departments, NHS procurement will not progress in maturity.

Barrier 3: Lack of knowledge of clinical products

Procurement teams lack market engagement to build, share, manage and act on category-based commercial knowledge within NHS procurement. Failure to undertake any pre-market engagement for major tenders, or to explore price and value drivers within markets limits the ability to embed metrics beyond prices and traditional quality standards. Across regions, teams and categories, there is no data sharing of different approaches, contract mechanisms used or outcomes. There are no formal category management structures and no knowledge-based infrastructure to capture market intelligence.

Spend data may be available but this was not forthcoming from the participants, despite multiple requests. Reasons given for not providing data mainly centred on a lack of time and resources to fill in the spreadsheet provided. The small amount of data that was provided was unsophisticated, unstructured and unlikely to be conducive to better understanding supply markets. This indicates a combination of issues, including a lack of information, poor systems and a culture reluctant to share knowledge. Despite extensive investment in cost data throughout various parts of the NHS there is poor visibility and control of spend throughout the supply chain. Treatment cost data is available to finance but is not used by procurement. The inability to gain, and use, spend and market data raises a number of critical issues around the quality of data available, the lack of strategies for assessing the spend data and driving value from it, and the inability to record meaningful competitive intelligence on markets, suppliers, benchmarks, value-drivers innovation and other relevant trends to support raw spend.

There is an assumption within the procurement teams participating in this research that their service level would improve if they had a wider range of involvement in purchasing, as suggested by the majority of procurement maturity models, notably an earlier involvement and one that extends beyond the tender award. Figure 1 shows how the participants in procurement perceive their level of involvement throughout the standard procurement cycle in the majority of NHS contracts. The involvement represents a typical bell curve with their involvement peaking during the tendering phase. They have very little involvement in the early need identification phase, which is usually undertaken by clinicians, or in the post contract phase, leaving the majority of contracts unmanaged once they have been awarded. Many of the activities that secure a level of procurement maturity commonly take place during the need identification phase (for example, pre-market engagement; data mining; targeted sourcing strategies; developing commercial intelligence) or the post contract phase (for example, contract management; supplier evaluation; supplier relationship management). To develop their maturity, procurement needs to undertake these foundational activities, and critically, service users and suppliers need to allow procurement to undertake these roles.

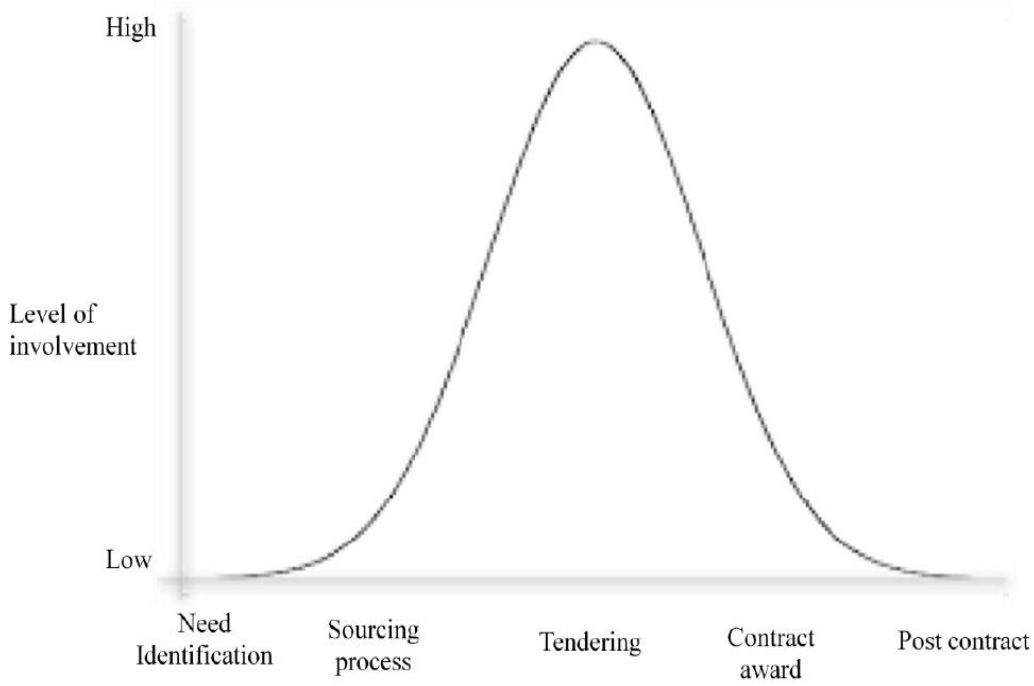

Figure 1: NHS Procurement's involvement in generic procurement cycle

Procurement report that they often get blamed for delaying contracts, particularly when a department has sourced a product themselves rather than involving procurement early in the process (Procurement, Interview 1 and Focus Group 1). However, when pressed on how earlier involvement could enhance the outcomes, procurement tended to focus still on process – early involvement would prevent tenders being delayed, rather than the potential to provide additional service value through market engagement, commercial intelligence, route-to-market, life cycle thinking, or assessment of contract mechanisms.

Market knowledge and early supplier involvement are value-adding activities of a procurement function (Luzzini, Amann, Caniato, Essig and Ronchi, 2015). Negative supplier perceptions and lack of internal engagement create legacy issues to develop in this area as trust can be eroded. Pre-market engagement is minimal at best, partly owing to the technical nature of clinical product areas and the high level of authority from clinicians and national clinical standards groups. Procurement and service users use the lack of clinical knowledge, as a justification not to involve procurement. But clinical expertise are not the only essential aspect of pre-market engagement; it is also necessary to translate market intelligence, risks and opportunities to develop optimal sourcing strategies that enhance value.

There was no evidence of specific, documented procurement or sourcing strategies for different spend areas, or even an overall procurement strategy which is a significant gap especially given the diversity of products and services procured, the level of spend and risk. However, steps have been made in the right direction in some trusts, where category management is being used to allocate resources within procurement. This is a common strategy, used to address the multitude of supply markets that many organisations have to deal with (Luzzini, Caniato, Ronchi and Spina, 2012). Category management enables the procurement lead for a particular division (e.g. surgery, orthopaedics, corporate) to develop their knowledge of the range of products and services in that category. This enables procurement to better link with the clinicians, using the clinicians to develop an appreciation of what value means to them thus

developing a mutually beneficial relationship and moving the function of procurement from purely transactional.

As procurement have low levels of authority and low knowledge, and clinicians are perceived to possess high levels of both, suppliers circumvent procurement. *"They [clinicians] know a lot more about the market and the main players within that market, because we are juggling that many balls, which is really unfortunate"* (Procurement, Interview 1). The social capital invested in these supplier-clinician relationships makes it difficult for procurement to penetrate these knowledge networks. Organisations exist centrally within NHS to assess products and to provide market knowledge but there is little evidence procurement access, share or develop this data to improve the level of sophistication of procurement activities.

Barrier 4: Lack of resources

There is a gap in downstream contract management across the region once contracts are let, which is attributed to a lack of resources. Unlike the need identification phase (see Figure 1), where clinicians conduct many of the essential activities, the post-contract phase is not done within or outside of procurement. Some suppliers have on-going, close working relationships with internal stakeholders at a service level, particularly in clinical areas, but there is no real management of the supplier at an organisation level, covering overall performance, value initiatives, cost improvement targets, risk profiles, financial viability, administrative efficiency, and corporate responsibility. There is no evidence of on-going, robust auditing of supplier promises and opportunities, innovation or sustainability performance identified at the tender/selection stage to ensure tracking of promised savings achieved. Value perceptions across internal stakeholder groups continuously evolve and require on-going effort to prevent natural entropy away from aligned goals of buyers and sellers (Pinnington and Meehan, 2014). The changing priorities across the NHS highlight further the need for contract management to ensure suppliers are provided with consistent messages. The 'let and forget' approach evidenced is unsophisticated in terms of procurement maturity and represents a significant gap where, given the appropriate resources, procurement can improve. Yet, resources were identified as the primary reason for the lack of downstream contract management.

Existing suppliers provided numerous examples of ways in which their products and services could be used more effectively over a longer-term horizon, but still within contract life cycles (Supplier, Focus Group 2 and 3). One supplier had put in a proposal to procurement, estimated to save the NHS 25% on their existing contract, but the change in approach required buyer approval to put through a contract change. The proposal was rejected, not on commercial or services grounds, but owing to lack of procurement resources to manage the change process (Supplier, Focus Group 2). Another supplier identified an issue with their contracted product due to misuse and had suggested training to mitigate this issue but couldn't identify anyone within the NHS to help arrange this training (Supplier, Focus Group 2). Whilst these examples only provide one side of the story, there were enough examples in the focus groups, and a general agreement from all present, to establish a pattern of frustration with the NHS not engaging to get the most of their products post-award. Those experiencing the problems with the product/service within the NHS often do not have the authority to commission the training/investment to mitigate this problem, which is an issue with the complex structure of the NHS.

The contracting environment needs to encourage suppliers and internal stakeholders to engage in the co-development of value-based, cost-effective solutions. Developing supplier relationships through effective contract management facilitates the collection of market

intelligence and ensures savings actually reach the bottom line. Regional procurement places emphasis on direct relationships with suppliers to drive innovation and trust (Klein, 2015), yet there was little evidence that procurement played a role in this. The procurement professionals that participated in this research are keen to develop more formal contract management approaches but do not have the resources to do so. *"It is the aspiration, we would love to be able to properly manage all of the contracts that we have in the department"* (Procurement, Interview 1).

Larger, long-term suppliers tend to be met with quarterly on an informal basis but this is fairly unsophisticated in terms of contract management as there was no mention of measuring performance against the existing contract, nor of the management of smaller contracts. Whilst procurement teams may aspire to this, contract management does not fall under their targets, the main one of which is to make cost savings for the Trust. These savings are recorded at the point when the contract is awarded, so what happens after this point has no impact on procurement's targets. One Trust stated that they do capture the realised savings after the contract has been awarded but do not measure, or manage, any of the softer aspects of value written into the tender or attempt to develop social capital (Procurement, Focus Group 1). Contract management is currently basic and reactive, with buyers usually only evaluating a supplier's performance as a problem occurs.

Conclusions

The preliminary analysis of the results of the study highlight that NHS procurement is suboptimal and is not fulfilling its potential to make a considerable contribution to organisational performance (Carr and Pearson, 2002; Sánchez-Rodríguez et al., 2005; Schiele and McCue, 2006). Table 2 outlines the findings relating to perceived level of procurement maturity as seen by heterogeneous actors involved in this study. Interestingly there is some congruence across the teams on which parameters characterise maturity. What was not clearly evident was what enables the transition between stages, which will be our focus in the future months. The results establish that procurement have both the will and potential skill to develop, however a number of critical factors are preventing procurement maturity. The results highlight four barriers; perceptions of procurement, short-term savings targets, a lack of knowledge of clinical products, and lack of resources. Interestingly, the failure to progress to a higher level of maturity strategically is not attributed only to failings at the buyer-seller dyadic interface, but to predominantly internal barriers. This study challenges the perceived assumption that procurement needs to work with suppliers to develop strategically; our results highlight that internal maturity across user groups is an important precursor.

Critically, the initial results demonstrate the importance of viewing procurement maturity from the perspective of service users. Service users invariably judge procurement value not just on the function's maturity related to the range and scale of activities undertaken (Rozemeijer, Weele and Weggeman, 2003), but on its strategic positioning in relations to offering resources that are valuable, rare, imperfectly imitable and non-substitutable (VRIN) (Barney, 1991). In the NHS context, clinicians and other healthcare professionals predominantly view procurement as a regulatory process, and fail to associate the function with wider potential value propositions. An important contribution from this research highlights that service users do value mature procurement activities, but crucially, do not believe procurement are the right people to fulfil these roles. A key assumption made in the literature is that all internal stakeholders buy in to a mature procurement function and that buyers will be empowered to undertake strategic activities. In this study, many of the more strategically aligned activities, notably market knowledge, developing innovation and supplier relationships, sit with key

decision makers outside of procurement and ownership of these activities can be a source of conflict internally. In healthcare contexts, clinicians have significantly more legitimacy and authority than procurement so there is a risk of dilution of the procurement role. A key question to be asked is whether it matters who completes the activities, providing they drive sustainable and responsible outcomes? Further research on the longitudinal impacts and unintended consequences of dispersed procurement activity is a potential fruitful area of future research.

Mature procurement strategies are invariably linked to an organisation's overall strategy, yet there is little explicit reference to the business environment in the procurement maturity models, and a purely 'staged' view of progression can conceal considerations of resource and context (Schweiger, 2015). The issue of clinicians conducting procurement activity is legitimised in healthcare contexts given the potential risks to patient outcomes, but in less complex, emotive and risky products procurement may hold more authority. The suggestion here is it is critical to contextualise procurement's potential role. In the NHS while there is a gamut of potential activities that can be used to drive sustainable value (see table 2), the post contract activities are deemed more achievable than the pre-market activities given the contextual constraints. Given procurement's large role in the tender process, understanding how contracts perform is an important feedback loop they need to establish and is a more natural extension to their core competence of ensuring compliance and process management. In healthcare, the pre-market engagement is difficult to penetrate owing the technical knowledge barriers and product links to patient outcomes. Despite wanting to extend their current involvement across both sides of the bellcurve (see figure 1) procurement have little to offer of strategic value at the pre-contract phase beyond what is already provided by clinicians.

The wider contribution of this finding is to challenge the assumption in existing procurement maturity models that all organisations will develop procurement in a generic way and across all phases of the procurement cycle. The results of this study highlight the role of other internal stakeholders and how these can create conflicts and battles of authority and legitimacy. There is a paucity of empirical research exploring internal relationships (Zimmermann and Foerstl, 2014) and internal alignment is not prominent in the maturity models. The results of this study highlight the need for further study on the internal alignment of procurement and service users, particularly in complex environments.

From an applied perspective, a number of issues for practice emerge. Surprisingly, given the level of spend, complexity and criticality of sourced products, there were no documented sourcing strategies across the categories explored in this project. From a research perspective this raised problems in evaluation, but at a practitioner level was deemed to be a contributory factor in a short-term price orientation with a 'one-approach for all' system largely adopted, regardless of the product category. Differentiated sourcing strategies are needed with clear documentation to identify stakeholders, decision makers, market trends, spend data, risk profiles, pathway costs, supply chain structures, supplier pricing strategies, potential suppliers, commercial options, supplier performance and contract histories. All of these elements are essential for auditable, evidence-based growth in procurement maturity and sourcing strategies enable the synthesis of economic health data provided from central NHS bodies, technical pathway data and costs provided by clinicians and technical staff, and commercial management data provided by procurement.

Similarly, market intelligence and understanding of indicative costs throughout pathways are foundational activities for the development of commercial sourcing strategies, irrespective of which function provides the data. Market analysis across categories of spend could be

developed regionally allowing for sharing of resource, comparison of commercial approaches, and the development of category intelligence IT infrastructure. Without this, procurement have very little to add to the need identification phase of the procurement process. This phase is reliant on clinicians, who have the specialist knowledge of the products and services they require. Instead of trying to replicate this knowledge, procurement should instead focus on managing contracts and developing intelligent contract management data that can feed into sourcing strategies so that they are better able to support clinicians to deliver sustainable patient outcomes.

The initial analysis of the findings of this study has provided insight into procurement maturity in the NHS. However, further in-depth analysis is required to delve into the context of these barriers, providing further evidence of the frustration and inefficiencies caused by this complex system. NVIVO will be used as a tool to support a verbatim analysis of the data, using the themes identified in this paper as a coding template. The researchers intend to take the descriptive analysis in this paper to the next level by conducting a full thematic analysis and taking an interpretative approach. The preliminary results have shown the barriers to growth in procurement maturity in the NHS. However, the descriptive analysis limits the identification of the frustration and negativity, both internally and externally, resulting from this lack of maturity.

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