**Let and forget: a dilemmas perspective on contract governance in healthcare procurement**

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**Abstract**

There is a lack of contract management in healthcare procurement, despite pressure to cut costs and drive value. Through an in-depth case study, we reframe the ‘problem’ of the paucity of contract management as a decision dilemma to unpick the causes by exploring underlying attitudes of procurement. Resources focus on cost improvement plans; the role contract management plays in ensuring value is delivered is not recognised. A lack of consequence for not managing contracts dilutes the pressure to take responsibility. Attitudes become entrenched and the dilemma of where to focus resources loses its power to induce ‘stop and think’ behaviours.

**Keywords:** Healthcare, decision dilemmas, contract management

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**Introduction**

Healthcare procurement covers purchasing of care (commissioning of healthcare providers) and purchasing for care covering the procurement of clinical and non-clinical goods and services (van Raaij, Schotanus and van der Valk, 2013). This research concerns the latter, purchasing for care. Procurement third-party spend in England on the National Health Service (NHS) totals over £27bn per annum, with goods and services (excluding pharmaceuticals, agency staff, estates and facilities management) accounting for £9bn per annum (Carter, 2016). The NHS is facing severe financial strain and the constraints are amplified as the demand for services have increased significantly over the past decade. To illustrate, latest figures show that in 2015/6, 46% more operations were conducted compared to 2005/6 (10.1 million up from 7.2 million), and hospital admissions rose by 28% to 16.3 million (NHS Digital, 2017). A government-commissioned report into the NHS in England cites a number of procurement problems that collectively cost an estimated £700million per annum; lack of value extracted from contracts, price variations, hidden costs, inefficiencies, poor compliance, lack of cost containment and poor inventory control (Carter, 2016). In this context, creating and extracting value through procurement becomes increasingly necessary (Meehan, Menzies and Michaelides, 2017).

The positive relationship between procurement and organisational performance is well documented (Sánchez-Rodríguez, Hemsworth and Martínez-Lorente, 2005, Schiele and McCue, 2006) and the potential for mainstream value contribution is clear (Cousins, Lawson and Squire, 2006, Ellram and Liu, 2002). Despite its strategic relevance as a policy tool, public procurement is often not aligned to policy initiatives limiting its ability to drive broader societal value (Rolfstam, 2015). Procurement maturity demands a functionally integrated and coordinated activity that contributes to value and firm-level competitive advantage (Foerstl, Hartmann, Wynstra and Moser, 2013), covering structures, relationships, processes and systems (Van Weele, 2010). In the PSM field, gaps still exist in our knowledge of the role and importance of internal relationships, supplier development and corporate performance (Zimmermann and Foerstl, 2014). Contract management is a core activity linking value capture with internal and external relationships. Although not empirically validated, it has been suggested that contract management is classified in the Purchasing and Supply Management (PSM) literature as operational and functional, rather than strategic and organisational in nature (Matopoulos, Bell and Aktas, 2016).

Contracts are legal agreements that detail the work or transaction to be completed and the terms applicable, ranging from standard boilerplate clauses to highly customised, complex terms and outcomes (Schepker, Oh, Martynov and Poppo, 2014). Contract management is a continuous process that systematically ensures the delivery of agreed outcomes, KPIs, service levels, and contract compliance. Procurement, suppliers and other stakeholders work collaboratively through the contract life to ensure appropriate execution of deliverables and to analyse opportunities to improve and drive further value for all parties, increasing the potential for learning. The majority of extant studies focus on contract design and pre-purchase rather than contract delivery (Nullmeier, Wynstra and van Raaij, 2016). The pre-purchase stage of contract negotiation covers the operational terms of the agreement and can set out each party’s value outcomes, relationship expectations, strategic intent, and organisational contributions. Many contracts, particularly those with key suppliers, or in high value/risk spend areas, can be complex and cover long timeframes. Value needs to be considered throughout the life of a contract (Pinnington, Meehan and Scanlon, 2016) as contract outcomes and expectations can change over time and in dynamic, complex environments. The importance of effective, value-focused contract management is often assumed, in practice and in the academic literature, yet in the UK’s NHS the procurement teams lack engagement and influence over this part of the procurement cycle and contracts once let are often not actively managed by procurement (Meehan et al., 2017). This paper aims to explore why this is.

Contract management can eliminate some problems of opportunism in contracting (Brown and Potoski, 2003), and is important for effective governance (van der Valk, Sumo, Dul and Schroeder, 2016). Governance lacks a common definition, but in essence it relates to the agreed norms, rules and behaviour used to manage and guide how performance is sustained and how parties are held accountable for their actions. Two core concepts - steering and shared responsibilities – are implicit in governance. In considering contract management as an issue of governance, the lack of NHS procurement involvement raises important risks, as this can side-line the influencing of commercial issues of value, create gaps in accountability, and fail to create shared buy-in for broader issues involving consequences of economic power, market development, innovation, and network learning.

**Literature review**

*Contract management*

Contracts in business-to-business markets vary enormously. The academic literature around contracts is equally varied, although transaction cost economics (TCE) (Williamson, 1996) is the dominant conceptual framework adopted in many empirical studies (Schepker et al., 2014). TCE is useful as it provides parameters to manage ex-ante incentives in contracting arrangements – dealing with forecasts and the potential for contracts to deliver particular outcomes, and ex-post governance – providing flexibility to manage performance based on actual metrics (Williamson, 1996). Although there are resource costs associated with contract management, these can be small in comparison to the savings achieved through effective supplier motivation (Turner and Simister, 2001). Effective management can counter issues of incomplete contracting (Brown and Potoski, 2003), which most contracts are, as many risks are unforeseen and rationality at the contract formation stage is bounded (Turner, 2004).

Empirical studies of contract management in the PSM literature are grounded in TCE as its constructs are deemed to ‘explain’ contracts (Schepker et al., 2014, Spina, Caniato, Luzzini and Ronchi, 2016). However, prior studies tend to largely focus on the mechanisms for contracting at the start of the process, rather than the on-going performance management of suppliers against the contractual agreements. Implicit in this view is a rational, economic view of markets and contracts that assume a ‘good contract’ will deliver agreed outcomes, a position that can mask behavioural or other factors involved in contract success. Moving to value outcomes is a major challenge in healthcare business-to-business relationships (Porter, 2010). The extant contract literature largely focuses on the assumption that the most efficient choices are made upfront and remain static, in contrast to value-based procurement, which is contextualised, temporal and multifaceted (Meehan et al., 2017). Approaches rooted in narrow cost and control ideologies can limit the potential for adopting longer term value based procurement strategies in healthcare (Meehan et al., 2017). Additional dimensions of contract management are needed (Schepker et al., 2014) to understand not just the outcomes within a contractual agreement, but to unpick and consider the longer term consequences of inter-organisational exchanges on other stakeholders from an ethical perspective (Piercy and Lane, 2007).

*Governance and dilemmas*

The potential for public procurement contracts to be used as a policy tool to achieve societal outcomes (Grandia and Meehan, 2017) and to add wider value to its environment (Telgen, Harland and Knight, 2007) is a common policy theme across Europe, USA, China and Brazil (Lember, Kattel and Kalvet, 2015). While compliance to effective legal regimes can promote accountability and value, contracts need to be effectively managed as the mere presence of a legal or regulatory framework does not guarantee success (Ibrahim, Bawole, Obuobisa-Darko, Abubakar and Kumasey, 2017). Market governance alone is not sufficient to drive changes in suppliers’ commitments (Jiang, 2009).

The suggestion in the public procurement literature is that contracts should go beyond operational performance measurement to engage the supply chain in delivering broader policy outcomes over time. In this role, procurement requires maturity and strategic influence to balance supplier developments, internal relationships, and policy drivers. A buying organisation’s involvement in contract management can co-determine supplier’s performance as they become involved in service design and can reduce operational barriers (Nullmeier et al., 2016). Contractual governance is a term gaining attention in the inter-organisational literature (Benton and Maloni, 2005, Cao and Lumineau, 2015, Schepker et al., 2014, van der Valk et al., 2016), where attention is focused on the interplay of contractual and relational governance. Although these studies centre on governance, the studies are still often rooted in rational decision-making models, and can lack consideration of the complexities of competing demands, heterogeneous drivers and interests, political pressures, and power structures.

In etymological terms, governance refers to steering and guiding, not just control. At its most abstract, conceptual level, governance is concerned with the delicate balance between the state and civil society (Stoker, 1998). In the broader governance literature complexity is taken as a core condition of the environment, particularly related to public sector governance (Schillemans and van Twist, 2016), and the need to reconcile diverse values is recognised (Chen, 2009). A number of ethical dilemmas emerge in the conceptualisation of governance (Stoker, 1998). Even at a basic, operational level, the question of which contracts should be managed raises dilemmas for procurement. The resource implications of managing all contracts actively (Brown and Potoski, 2003) could prevent this approach, particularly if many contracts are only transactional in nature, and resources are severely constrained, as in the NHS. A strategic account management strategy, whereby only key suppliers are managed is common in practice yet also raises ethical issues. Key NHS suppliers are defined in the latest Government-commissioned review (Carter, 2016) by levels of contract spend rather than a supplier's quality, criticality, innovation or value initiatives (Meehan et al., 2017), providing no incentive for suppliers to work collaboratively to reduce spend on contracts. Further, this approach favours the already powerful few, and if contract management improves a supplier’s competitiveness, then it reduces the ability of smaller spend suppliers, typically SMEs, to compete and survive, distorting markets and power in the longer term (Piercy and Lane, 2007).

Tensions emerging when dealing with contract management are not discussed in the PSM literature. For instance, if suppliers, or other stakeholders are found not to be performing against agreed metrics or against the spirit of the contract, or if contract aggregation is considered to be leading to inequities in the supply chain, what should procurement do? Escalation and resolution procedures for operational issues might be contained within the contract documentation. What is less clear is who carries ownership, responsibility and accountability, and who leads this process, particularly in complex cases and for longer-term unintended consequences. Multiple, competing expectations of performance create conflicting legitimacies and dilemmas (Klingner, Nalbandian and Romzek, 2002). Public organisations have been shown to view contracting as a method to reduce responsibilities through passing accountability to suppliers (Brown and Potoski, 2003). Relationships can become increasingly charged in risk shifting activities (Benjamin, Nisim and Segev, 2015), exposing deeper dilemmas and debates on the responsibilities, political role, and ethical implications of contract governance steering by public procurement that goes beyond the provision of efficient and effective goods and services (Steinfeld, McCue and Prier, 2017).

To explore the lack of contract management in the NHS’s purchasing for care (van Raaij et al., 2013), we utilise the concept of decision dilemmas (Bowen, 1987). Dilemmas relate to people’s experience of having to make a choice between mutually exclusive alternatives, where each option creates emotional and personal concerns and challenges that are difficult to reconcile (Ozkaramanli, Desmet and E Özcan, 2016). Decision dilemma theories look at how people make decisions when the results and feedback on performance of actions are unclear. The difficult decisions people must make are usually not about isolated choices but the series of decisions that have consequences to an entire course of action (Staw, 1981). Emotional duality exists in dilemmas when the set of choices available each contain potential benefits and losses.

A diverse range of early psychology theories seeks to explain decision ‘errors’. In the management literature, escalation of commitment (Drummond, 2014, Staw, 1976, Staw, 1981) has been a prominent development in the dilemmas research stream and describes how decision-makers’ fail to disengage from a failing course of action, effectively throwing good money after bad. Decision theories are useful but often do not capture the central nature of why the dilemma is created. This research builds on prior studies that identify a lack of contract management in NHS procurement (Meehan et al., 2017). In this research, we are interested in understanding the nature of dilemma in NHS procurement to address why there is a very low level of contract management, despite the significant pressure to find efficiencies and manage costs. Reframing the ‘problem’ of the lack of contract management as a decision dilemma enables our research to unpick the causes of the issue through exploring the underlying behaviours and attitudes. Our research questions, bounded by the empirical context of the NHS Trust examined, are:

RQ1: What are the resource priorities for NHS procurement?

RQ2: Do NHS procurement professionals see a broad potential of contract management?

RQ3: What are the levels of procurement maturity to manage contracts in an NHS Trust?

**Methods**

This research was conducted using a rich case study with one NHS Trust, in order to develop a deeper understanding of procurement professionals’ attitudes towards contract management. In the UK, an NHS Trust is an independent legal entity that manages hospitals and operates under unique governance arrangements (NHS Choices, 2017). Attitudes are impacted by a multitude of factors such as culture, governance structure, internal and external perceptions of procurement, procurement maturity and leadership, which vary from Trust to Trust. A case study is valuable to explore context, dynamics and emerging issues in PSM (Dubois and Salmi, 2016). The case was selected in conjunction with a procurement development organisation. This particular Trust is excelling in many other aspects of procurement maturity but, crucially, contract management activities remain lacking.

Methods employed included both open interviews and observations. Previous research has attributed the paucity of contract management in the NHS to a lack of resources (Meehan et al., 2017), so the procurement team were observed to identify how their time is used and what activities are prioritised. The ‘real-world’ problem related to the lack of contract management was the starting point for the research, which drove the choice of a case method, and the various appropriate conceptual domains were iteratively explored as the research findings and analysis progressed (Brinberg and McGrath, 1985). Semi-structured and open interviews were conducted with senior procurement professionals from the team.

Participants selected had been at the Trust for 2years+ to enable comment on changing priorities and the culture, and all had roles sufficient to have an understanding of the strategic role of procurement. The researchers also spoke to internal end users including clinicians and non-clinical (e.g. IT) service managers to ascertain their role in ensuring suppliers were meeting contractual obligations. Observation notes were collected throughout and the semi-structured interviews were recorded and transcribed verbatim.

The data were coded and analysed thematically (see Table 1). Two of the researchers coded the data to achieve greater analytical richness (Eisenhardt, 1989). Coding was compared and discussed until consensus was reached, in order to improve the rigor of the analysis (Pemer and Skjølsvik, 2016). From the results, conflicts and accountability emerged as core issues experienced by NHS procurement staff. A serendipitous grounded approach explored conceptual explanations using dilemma theories and a governance lens to explain the lack of contract management. This approach was critical in our learning of the implications of the original research problem, from academic and practitioner perspectives (Dubois and Salmi, 2016).

**Findings and discussion**

The results of our initial thematic analysis (see Table 1) centres on the current position of contract management and attitudes towards it from key stakeholders in the NHS trust. Our discussion centres on the three research questions to evaluate contract management in relation to concepts of decision dilemmas and governance to offer a new, rich insight in the complexity of contract management in the healthcare context.

Table 1: Stakeholders’ views of contract management

|  |  |  |
| --- | --- | --- |
| **Topic** | **Theme** | **Representative Data Examples** |
| Procurement Activities | Cost improvements | *“Generally, I'd say maybe...70- 80% of time is cost improvement plan projects.”*  *“It’s sort of time issues and when mainly our focus at the moment is CIP [Cost Improvement Plans], savings for the trust, it is difficult to dedicate so much time to contract manage all of the contracts awarded.”*  *“We do contract manage where we can but a lot of our time at the moment is cost improvement.”*  *“We are coming to the point, where there isn't much we haven't looked at, to be fair [under CIP]. We have pretty much looked at everything now. So it's difficult to come up with, now, projects that, erm, that is sort of viable and realistic.”* |
| Compliance | *“We are the experts to advise the people out there to say yes, we have a requirement, we've got to do x,y,z, to make a legally compliant procurement”*  *“My personal experience is that compliance doesn't always go hand in hand with cost improvement because we can get much [emphasis] better savings going direct to our supplier.”* |
| Pre-award contract management | *“When I said light focus on contract management, that is, after we have initiated the contract. In the beginning side of the contract, procurement... we will do as much as we can to smooth the contract management process”*  *“We try to manage as much as we can. We cover the information on that by anticipating some problems on the future.... It is about the contract management conflicts we can erase in most of the cases”* |
| Post-award contract management | *“We don’t contract manage the small value contracts. Large value ones, we will have regular contract management meetings with the provider”.*  *“In terms of contract management whenever we can do... delivered the project, it seems to be put to bed then because we don't have the time to go back and monitor it but I think more and more now [emphasis] we have to go back and monitor it because half of that delivery is ensuring that's realistic.* |
| Attitudes towards contract management | Aspiration | *“I think contract management is something that we have been trying to introduce on a more formal basis.”*  *“I'd say it’s something that we are very aware that we need to do.”*  *“I think it's the aspiration. It's what we'd love to do, you know, we'd love to be able to properly manage all of the contracts that we have in the department.”* |
| Discomfort at lack of contract management | *“We have to think about the contract management side of things when we start the process. Some might...some might not..erm..and once we have the contract in place, then we only get limited time.... to manage a contract...”*  *“Contract managing is really key to what we should [emphasis] be doing but again its just having that time because we are so under pressure at times where the amount of projects we've got to deliver because procurement is seen as a ...support function”* |
| Time consuming | *“One of our buyers does contract manage those contracts that he awarded. He probably has quarterly meetings. There have been some performance issues so he has had to have a couple more meetings which has taken up a lot of his time, and a lot of work has come from that.”*  *“It is difficult to dedicate so much time to contract manage all of the contracts awarded. It really is something that we'd need a lot more time and resources to do really.”* |
| Purchasing Triad | End users | *“We ask others to evaluate the quality. The experts; the end users, the clinicians, doctors....so they will evaluate, but we will carry them, contact them to say how we have to do it. So, they will do that and we will support and guide and mentor them to do it.”*  *“The clinicians are so busy, they wouldn't be able to spend enough time, to clearly track the requirement that is a problem in itself.”*  *“The ownership will sit with the end user in conjunction with procurement. They usually do the day to day management of the contract because we are not there on the shop floor, they will do the contract monitoring. We will come in when there is a problem, when there is confusion...a friction.”*  *“Our approach now is focussed upon the end users, making regular meetings with them as well, and that’s key.”* |
| Poor supplier performance | *“We realised that the supplier had bitten off more than they could chew. Supply then started to really take a nose dive.”*  *“The supplier did not inform us that they could provide these pumps anymore. So, we had to very quickly put in another plan to ensure that we got them in from another supplier.”* |
| Distrust of suppliers | *“Our reps policy throughout the Trust, that a supplier isn’t allowed to approach any clinician or anybody really in the trust without first coming through procurement”.*  *“Other trusts may have done tenders and got better prices. There's a whole host of reasons why but at least we have visibility on that now. So pricing now is transparent throughout the NHS... So suppliers are having to be a lot more transparent now in their prices. Which is great. For us.”*  *“These suppliers have been milking us for years when the pound has been really strong, and now they are saying it's got to this, and they are now saying we've got to put prices up. So it's hard really to have sympathy.”* |

*Contract Management Activities*

The most common barrier to contract management cited in the interviews was a perceived lack of resources to deal with the contracts and manage the ongoing actions arising. Participants predominantly defined resources in terms of capacity and staffing levels, rather than expertise and skills. Only limited contract management activities take place and are reserved for large contracts, typically valued in the £millions. For these contracts multidisciplinary teams comprising of procurement, finance, end users, and suppliers meet quarterly to discuss progress against contractual targets yet there was little evidence of a steering governance role to deliver wider value initiatives or health policy outcomes. Contract meetings are chaired by procurement, placing them firmly at the centre of the contract management activity, and providing potential opportunity for linking internal relationships management, supplier development, and organisational performance (Zimmermann and Foerstl, 2014).

An issue identified in the case is that the significant majority of contracts fall below the spend value that would warrant contract management. One participant clarified that despite managing “hundreds” of contracts, they attended “no more than five” contract management meetings a month. The strategic management of contracts based purely on spend has been linked to ethical dilemmas (Piercy and Lane, 2007), particularly if the consequence of inequitable management leads to favouring the already powerful in a market. Although the contract management activity witnessed in this NHS Trust involved a range of different stakeholders, the focus tended towards operational KPI compliance and monitoring, rather than active steering towards longer-term value-based improvements to health outcomes, commercial agreements, or to analyse the consequences of contract arrangements on markets.

*RQ1: What are the resource priorities in NHS procurement?*

The analysis revealed the dominant priority for NHS procurement is to support end users to achieve their Cost Improvement Plans (CIP), set by finance, whilst also ensuring regulatory process compliance at the sourcing stage. Procurement performance is measured on its ability to support departments to meet CIP targets. Contract management is not perceived as a core activity in achieving this. Participants viewed resources in terms of limited capacity and low staffing levels rather than a broader consideration of resources (skills, capabilities, IT etc), and staff resources are focused on pre-award contract activities such as establishing key performance indicators, delivery schedules, etc. For contracts not actively managed, procurement pass the management responsibilities on to the end users, which is perhaps understandable given the clinical nature of some products, although this does not apply to all spend categories. There is a presumption made by procurement that the end users as “experts” will monitor whether the contract terms are being met, although critically this is not followed up by procurement, or even checked to see if these activities are completed. Given the high risk of some of the clinical products end users confirmed that they did actively assess product quality (if not necessarily contract performance), although for non-clinical areas the end users taking responsibility for this could not be identified.

There is an acknowledgement, at least by some procurement staff, of the resource pressures on end users that suggests expecting them to manage contracts, which sits outside of their official roles and responsibilities, is unrealistic. The lack of clear governance structures both inter-organisationally within contracts, and intra-organisationally across the contract management activity creates gaps of accountability. An interesting finding is how procurement positioned, and defended their lack of contract management. Their rationale is rooted in the belief that they sufficiently state the goals of the contract in early stages, which negates the need for procurement to be involved in post-award contract management activities. Procurement also refers to end-users as the experts to further shift responsibility and justify their own lack of contract management.

A clear and consistent message from the findings is that for procurement teams the activities related to securing cost reduction at the contract agreement stage are the priority. However, it was acknowledged frequently that the opportunities for savings are dwindling making CIP goals more difficult to achieve, suggesting a growing need for procurement to think more creatively. Procurement perceives freeing resource for contract management conflicts with their sourcing/contract negotiation priorities. Procurement do not recognise the full potential of contract management to reduce costs, certainly when compared to the potential cost reduction opportunities in contract negotiation. In terms of decision dilemmas, we trace the resultant lack of contract management to these conflicting priorities, as this is where the initial resource dilemma is rooted.

At the heart of the dilemma we find two conflicting paths. Procurement can: 1) use their limited resource to drive for ex-ante CIP savings at the contract negotiation stage, set against 2) use their limited resource to work with suppliers in the longer term through contract management to deliver value potential and identify further improvement areas. This dilemma supports previous studies that confirm the resource implications of contract management (Brown and Potoski, 2003), but our findings importantly highlight the difficulties that people face in resolving this issue. The restricted resource in the NHS (NHS Digital, 2017) prevents them from merely increasing capacity to attend to both activities, heightening the dilemma.

The personal dilemma emerges because CIP savings are only recorded when contracts are agreed and there is no provision for recording additional value beyond the current annual accounting period. From a behavioural perspective, dilemmas often require a prioritisation between conflicting long term considerations and immediate concerns (Hoffman, Baumeister, Förster and Vohs, 2012). Evidence suggests that people weigh present events more heavily than those in the future (Frederick, Loewenstein and O’Donoghue, 2002). Social forces experienced in the environment shape and constrain decision dilemmas. Given the heavily pressurised NHS environment focused on saving money (Carter, 2016, Meehan et al., 2017), peoples’ decision to prioritise sourcing in the short term at the expense of providing resource to manage contracts is perhaps understandable. However, this ‘let and forget’ approach is not compatible with value-based procurement, that moves from efficiency solely based on price, to broader, long term value measures based patient health outcomes achieved per pound spent (Porter and Teisberg, 2006). Short termism can have consequences that damage longer-term value-based approaches (Lindgreen and Wynstra, 2005), potentially further exacerbating the dilemma.

*RQ2: Do NHS procurement professionals see a broad potential of contract management?*

Our findings support the view suggested in the literature that contract management is predominantly viewed as operational rather than strategic (Matopoulos et al., 2016). Contract management and the broader relational concept of contract governance (Benton and Maloni, 2005, Cao and Lumineau, 2015, Schepker et al., 2014, van der Valk et al., 2016), however have strategic potential for assessing suppliers’ performance and contract compliance, capturing agreed value, and identifying additional value sources. Our results show that there is a general recognition that contract management is recognised as important, but the language used by participants reveals that it is seen as a longer-term rather than an immediate priority.

The dilemma stemming from how to best utilise limited resource is indicative of conflicting legitimacies of competing expectations (Klingner et al., 2002). Decision dilemmas create mutually exclusive alternatives with challenges and choices that are difficult to reconcile, which are the hallmarks of a dilemma (Ozkaramanli et al., 2016). The emotional duality of a dilemma was evidenced in the apparent unease amongst participants when discussing the paucity of contract management in the NHS, manifested through broken sentences, unfinished justifications and hesitant responses. The majority of participants acknowledged that contract management is something they “should” be doing, however current resources and time pressures mean it is not possible to manage more than a few contracts each often in a cursory way. Participants were noticeably evasive around their choices, and the dilemmas experienced were palpable. The language used to describe the number of contract management meetings a month [“no more than five”] suggests that this activity is viewed as something to be minimised.

Interestingly, some contradictory rationales for not engaging with contract management emerged from the interviews. Some buyers failed to identify its potential and considered it to be purely as a time-consuming drain on resources. Managing contracts creates more work as, once they are being managed, problems surface which then need dealing with. The consequences that impact a course of action, rather than the need to make standalone choices, increase the decision dilemma (Staw, 1981). Where contract management had taken place, poor supplier performance had been identified that had led to a significantly increased workload for the procurement team thus creating a reticence to engage in this activity in the future for fear of exaggerating resource pressures. This clearly misses the point and creates a vicious cycle of avoidance rather than problem elimination.

Participants did not seem to equate contract management with new value creation, nor with the ex-post value capture of agreed outputs. This is despite examples where contract management had uncovered poor supplier performance that increased operational costs and highlighted that pre-agreed value contributions were not being realised, which could then be addressed. Significant here, is that under the current procurement and finance regime only financial savings are recorded, and only at the point of contract award. This lack of life cycle consideration effectively reduced the motivation to manage contracts at all.

*RQ3: What are the levels of procurement maturity to manage contracts in an NHS Trust?*

When purchasing for care (van Raaij et al., 2013), there is a triad of stakeholders made up of procurement, end users (e.g. clinicians) and suppliers. The introduction of CIP targets imposed on Trust departments has led to an improvement in relationships between procurement and end users, as the interdependence between them has rebalanced. Procurement recognises the importance of good internal relationships and has invested time into strengthening links with end users and elevating its reputation as a support function. Although all stakeholders saw better relationships as a positive progression, procurement were still very much seen as supporting, rather than leading, even on areas of commercial importance. Where there are pockets of contract management on the major spend areas, procurement take a central role, although the sphere of influence tends to be delineated to the contractual boundaries, rather than a broader approach to drive policy initiatives or consider, and respond to, wider market consequences.

Internal relationships are seen as improving and healthy in the Trust, although relationships with suppliers were still problematic in many areas. Evidence of the poor relationship between procurement and suppliers is the frequency with which NHS suppliers circumvent procurement and go straight to end users to sell products or demonstrate innovations, despite policies to protect against this. Given the importance attached to gatekeeping relationships, it is interesting that no reporting to monitor these policy breaches take place, which in itself sends signals to suppliers of the lack of consequence.

There is a high level of distrust of suppliers evident in the data. It is therefore surprising that contract management is not given more of a priority when allocating resources. Contract management can be viewed as a control mechanism between buyers and suppliers, which is arguably a necessity in relationships with little trust (van der Valk et al., 2016). Participants refer to examples where suppliers have performed poorly against contracts but without contract management processes, it is difficult to establish how extensive this is, and even harder to enforce solutions. By focusing resources on pre-award contract management activities, procurement are identifying the ex-ante risks in contracts but then passing the accountability on to the supplier. This assumes suppliers will comply, despite evidence to the contrary. The examples provided of supplier non-performance against agreed contract criteria further add to the emotional element of the dilemma for procurement as it provides contradictory evidence to their position that a good contract is sufficient. Our observations highlighted that rather than engage with, reflect on and discus the consequences and options that the dilemma created, all behaviours we would see in robust governance, procurement instead disengaged with the issue and amplified their defence of lack of contract management.

Despite the pressure to move to value-based procurement in the NHS (Meehan et al., 2017), participants stated that even if procurement were provided with additional resources, there is currently a lack of government-approved, quantifiable measures that could be used to measure supplier performance throughout the contract period. For example, if a supplier’s product reduces length of stay or number of visits to a hospital, how much does this save the NHS? Without these measures, procurement are unable to quantify the long term value of choosing supplier x over supplier y. Participants used this rationale to challenge that contract management is less strategically important for ensuring value is realised as beyond quantitative delivery metrics, value within a contract is not calibrated. The dominant view was that ‘demonstrating’ value through contract management is not recognised, and not within their remit.

**Conclusions and managerial implications**

Our findings support previous studies that contract management was not a priority for NHS procurement (Meehan et al., 2017), despite the drive for long term savings (Carter, 2016). Cost reduction in NHS procurement is their top-down, highly visible and much-pressured target. Crucially however, there is limited, if any, evidence of actual cost reduction from contract negotiations in terms of budget changes and overall spend profile. Rather, an anticipated financial saving is recorded at this stage, regardless of the length of the contract, and it is deemed to have been achieved, despite no monitoring of spend against the contract.

We introduce a novel approach of decision dilemma theory to contract management to expose some central assumptions around procurement maturity. Procurement maturity as presented in the literature centres on the level of internal integration and contribution to organisational value or competitive advantage (Foerstl et al., 2013). Procurement in this case has good integration through CIP activities although their ability to create and capture value is limited, thereby adding to the dilemma. There is evidence that they can, and do, engage in contract management in large contracts, and take a central role in some of these. Maturity here, we argue is not necessarily only about their ability to ‘do’ contract management, it is around the ability to deal with the consequences of contract management. Operationally, the consequences could mean resolving complex and litigious issues of non-compliance and securing value capture. Strategically it might refer more to governance issues around market impacts, power inequities, health outcomes, and influencing social, health and economic policies. Maturity in this sense demands the resolution of resource-based decision dilemmas and appropriate governance across and within stakeholder relationships to provide accountability around the choices made.

Through this study we identify limited resource as an important dimension in decision dilemma theories. This is important contribution and extension to dilemma theories and it has a broader resonance for procurement maturity research and public procurement policy environments. Resource limitations and pressures create mutually exclusive alternatives with challenges and choices that are difficult to reconcile, which are hallmarks of a dilemma (Ozkaramanli et al., 2016). Without resource constraints, procurement could employ additional staff to increase contract management capacity. However, without this option, as is the case in many public organisations, the dilemma is heightened and ethical dualities exposed.

From a governance perspective, complexity and the need to grapple with and reconcile diverse values (Chen, 2009) is taken as a core condition of the environment (Schillemans and van Twist, 2016). Contracts, particularly in economically and socially important industries like healthcare, are enormously consequential, beyond the bounded goods and services purchased. Healthcare procurement, particularly on the scale of the NHS, impacts markets, power dynamics, health outcomes, taxes, opportunity costs, and innovation. Public organisations in particular therefore have ethical obligations to ensure public contracts are effectively governed so that value agreed is captured, deliverables are actioned, and that the spirit of the contract is mutually beneficial, equitable and responsible. Governance in public procurement should however go beyond the operational boundaries of the contract and should consider the potential, the risks, the challenges, and the dilemmas of steering to deliver wider societal and health outcomes. The point here is not that this more strategic governance approach will provide the ‘answers’ to the dilemmas identified, in many instances it will create increasingly complex dilemmas and knock-on effects. The issue is that governance actively engages this critical debates about what organisations ‘ought’ to do, whether diverse values can be reconciled (Chen, 2009), and openly confronts complexity as a core condition (Schillemans and van Twist, 2016). Opening potentially difficult stakeholder dialogues and exploring dilemmas of short and long term decisions can provide valuable space for considered decision-making and provide accountability for actions (Meehan, Touboulic and Walker, 2016). Failure to actively acknowledge the dilemmas, or provide support to consider the choices and consequences risks a reliance on shifting accountability and risk back through the supply chain (Brown and Potoski, 2003), that further damage supply relationships and behaviours (Benjamin et al., 2015)

A final contribution of this research is exposing how procurement deal with the conflicting legitimacies of short and long term actions in a resource constrained environment. A critical conclusion from our research is counter-intuitive. Although dilemmas create cognitive dissonance and emotional tension for procurement staff, we argue that rather than eliminating dilemmas, we should encourage more dilemmas, with the caveat that these are supported by robust inter-organisational, and intra-organisational governance arrangements. Our premise is based on the potential for dilemmas to force reflection on the consequences of our actions and decisions. Time considerations feature heavily in decision dilemmas as the temporally based choices polarise acting against thinking. In a dilemma people are faced between acting now versus reflecting on future impacts of current behaviours. Dilemmas can behave as a ‘slowing down’ mechanism and can often force people to stop and think about their choices as they try to reconcile these polarities. Studies from psychology show that people look at their past experience to deal with dilemmas (Vera, Crossan, Rerup and Werner, 2014). An issue here for NHS procurement, is that a lack of experience in contract management coupled with the outward lack of consequence of not doing these activities dilutes the pressure for taking longer-term contract management responsibility. Over time, patterns of behaviour – in this case neglecting contract management and the associated long-term impacts - become entrenched and the dilemma loses its power to induce stop and think behaviours. Without the dilemma behaviours, procurement inevitably focuses on short-term gains reinforcing, normalising and legitimising actions, and further concealing longer-term losses. As procurement conceptually decouples their actions from consequences, it is unlikely that we will see a movement away from their let and forget approach to post-award contract management.

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