

Change Management – The Price Of Getting It Wrong

UK Healthcare And Pharma Edition — Why Consulting The People Who Use The System Is Not Optional

A Charterhouse Consultants white paper by Bridget Convey, February 2026.

Executive Summary

This paper makes one claim, applied to UK healthcare and pharma specifically. The single most expensive change management failure in British public sector history was not caused by a lack of funding, ambition, or technical talent. It was caused by a change programme designed and imposed from the top, with insufficient consultation of the clinicians and NHS staff who were expected to actually use the system every day. The National Programme for IT, launched in 2002 with Prime Minister Tony Blair present at its announcement, was intended to give every NHS patient a single electronic health record shared seamlessly across the health service. Originally budgeted at £2.3 billion over three years, it was formally dismantled in 2011 having cost more than £10 billion, with total costs including ongoing contractual obligations later estimated above £12 billion. It remains, by most independent assessments, the largest and most expensive civilian IT failure in history.

The Premise: The Gap Is The Danger, Not The Ambition Itself

The National Programme for IT's ambition was not misplaced. A single, shareable electronic patient record across the NHS remains, decades later, a genuinely valuable goal. The failure sat entirely in how the change was governed and executed. Independent analysis identifies a top-down approach as one of the programme's central failures: the system was designed largely at a national level, without adequate consultation or engagement with the clinicians and NHS staff who would actually be using it, producing a mismatch between what the system offered and what frontline healthcare workers actually needed from it. This is precisely the mechanism this paper is built on, applied to a sector where the people affected by poorly governed change are not just staff productivity statistics but patients relying on accurate, available medical records.

The programme's own procurement structure compounded the problem. Large, rigid contracts were signed with major suppliers including Accenture, Fujitsu, and CSC, based on specifications fixed early and unable to adapt as the programme's understanding of the actual requirement evolved. When circumstances changed, and in a project of this scale and duration they inevitably did, changes to those contracts became complex, slow, and enormously costly, directly limiting the programme's ability to adapt. Fujitsu ultimately exited the programme entirely following disputes over scope and cost, leaving a gap in delivery that took years and tens of millions of pounds in legal fees alone to resolve.

What A Decade Of Deferred Correction Actually Cost

The financial numbers alone are extraordinary. Originally forecast at £2.3 billion, later estimates put the total cost above £12 billion once ongoing contractual obligations, legal costs, and the expense of terminating supplier relationships were included, a more than fivefold overrun against the original budget. The programme's own promised benefits never materialised at anything close to the scale projected: by March 2012, the Department of Health reported realised benefits of just £3.7 million, representing barely half of the costs incurred in that period alone, against original projections of £10.7 billion in total benefits over the programme's life. A parliamentary Public Accounts Committee report described the outcome bluntly as evidence of systemic failure in the government's ability to contract for large-scale technology change.

The human and operational cost extended well beyond the balance sheet. Even after the national programme was formally dismantled, individual trust-level failures continued to surface using software originally procured under it: in 2018, a flawed rollout of the Lorenzo patient record system at one NHS trust resulted in 14,600 patient discharge summaries never being sent to GPs, a direct patient safety risk that cost a further £7 million simply to stabilise. Years after the national programme's collapse, independent reporting found roughly 60 percent of London NHS hospital trusts were still operating without basic IT disaster recovery systems in place, a legacy gap in resilience directly traceable to a decade spent managing the fallout of the original programme rather than building the infrastructure it was meant to deliver.

The Evidence: The Same Governance Failure, Repeating At Smaller Scale

Top-Down Design Without User Consultation Remains The Core Risk

Analysis of the programme's failure identifies end users not being adequately involved in the development process as a direct cause of a system with, in one assessment, unprecedented scale and boundless complexity that frontline healthcare professionals struggled to actually use. This is not a uniquely 2002 problem. It is the same change management principle this entire paper series has documented across every sector: a change designed without genuine input from the people who must live with it daily is a change built on an assumption, not evidence, and assumptions of this kind are where the largest and most expensive failures consistently originate.

Fixed Contracts Cannot Absorb Evolving Understanding

The structural lesson from the programme's contracting approach applies directly to current NHS and pharma digital transformation, and to AI adoption specifically. A contract or system specification fixed too early, before genuine clinical and operational input has shaped the requirement, locks an organisation into exactly the rigid, costly-to-change position that made adapting the National Programme for IT so difficult once its assumptions proved wrong. As AI-enabled diagnostic and administrative tools move from pilot into mainstream NHS and pharma deployment, the same discipline, building genuine adaptability and continuous clinical consultation into governance from the outset, determines whether that wave of change succeeds or repeats this paper's central case study at a new scale.

UK Healthcare And Pharma In Three Horizons: The Gap Closes Or It Does Not?

Two Years: 2026 To 2028

What happens everywhere: AI-enabled diagnostic and administrative tools move from pilot programmes into mainstream deployment across NHS trusts and pharma organisations.

- Thrive path. Organisations build continuous, structured clinical and end-user consultation into every phase of a rollout, treating the lesson of the National Programme for IT as a binding design constraint rather than historical trivia.
- Die path. New technology programmes repeat the top-down design pattern that doomed the national programme, and trust-level failures like the 2018 Lorenzo discharge summary incident recur at a new, AI-driven scale.

Five Years: 2028 To 2031

What happens everywhere: the resilience gap left by a decade of managing the national programme's fallout, including trusts still lacking basic disaster recovery capability, comes under renewed pressure as digital dependency deepens.

- Thrive path. Trusts close the legacy resilience gap deliberately, treating disaster recovery capability as foundational infrastructure rather than a cost to be deferred behind newer, more visible technology investment.
- Die path. Trusts continue prioritising visible, headline technology investment over foundational resilience, and the same underlying vulnerability the National Programme's collapse left behind persists two decades later.

Ten Years: 2031 To 2036

What happens everywhere: NHS and pharma organisations that learned the National Programme's central lesson, genuine consultation and adaptable contracting, have a decade of compounding advantage over those that did not.

- Thrive path. Organisations with mature, consultation-led change governance are the ones successfully absorbing the next generation of AI-driven clinical and administrative tools at genuine scale, with adoption rates and outcomes reflecting that maturity directly.
- Die path. Organisations that never internalised the lesson accumulate a second generation of expensive, poorly adopted technology investment, repeating the National Programme's pattern with different suppliers and a different acronym.

What I Am Recommending To Healthcare And Pharma Boards

- Build structured, continuous clinical and end-user consultation into every stage of a technology or process change programme, not a single sign-off gate early in the project.
- Negotiate contracting structures that can genuinely adapt as requirements evolve, rather than fixing specifications early and treating later change as a costly exception, following the specific lesson of the National Programme's rigid supplier contracts.
- Treat foundational resilience, including disaster recovery capability, as a non-negotiable baseline investment, not a line item that competes with more visible technology programmes for funding.

Conclusion

The National Programme for IT remains, more than a decade after its dismantling, the starkest illustration available anywhere in UK public life of what happens when ambition outruns governance. Twelve billion pounds, five times the original budget, delivered a fraction of the promised benefit, not because the underlying goal was wrong, but because the people who would actually use the system were never genuinely consulted, and the contracts underpinning the programme could not adapt once reality diverged from the original plan. As UK healthcare and pharma organisations enter a new wave of AI-driven transformation, the specific mechanism that made this the most expensive IT failure in history has not gone away. It is simply waiting to be repeated, at whatever scale the next generation of change is allowed to reach before genuine consultation and adaptable governance are built in from the start.

Sources: Panorama Consulting, Commonwealth Fund, Museum of Failure, Failure Hackers, Computer Weekly, IT Pro, Henrico Dolting case study analysis, IEEE Spectrum, UK National Audit Office and Public Accounts Committee reporting. All figures current as of mid-2026, verified at time of writing. This is a first draft prepared for internal discussion.