EMCSR: pp-pp, year
ISSN xxxx-xxxx
http://conference.emcsr.net

EMCSR
European Meetings on Cybernetics and Systems Research

Communications, Interactions and the Re-structuring of the English National Health Service

Raul Espejo, World Organization of Systems and Cybernetics,
r.espejo@syncho.org phone: +441522 589252
David Hooper, Chair of North Middlesex University Hospital NHS Trust, d.hooper@mac.com

Abstract: *The National Health Service in England is entangled in a massive and highly controversial restructuring. One of the authors has an in-depth knowledge of this Service and the other is an expert in organizational design. Together they have gone through the key principles underpinning the proposed restructuring. Our purpose with this contribution is highlighting what we consider key systemic and cybernetic aspects of the proposed changes. From a methodological perspective there are different possible definitions of the system-in-focus, and from the management of complexity perspective the study of the restructuring highlights relevant communication and interaction issues necessary to consider in designing this large organization. This paper highlights these two aspects.*

Keywords: National Health Service in England, communications, interactions, organizational design, self-organization, self-regulation

An Overview

In each decade during the past thirty years or so the UK government of the time has engaged in a major reorganization of the National Health Service (NHS). There are two major principles that have remained since the inception of the NHS - firstly that it should be free at the point of delivery, and secondly that it should be universally and equably available to all who are entitled to receive its benefits.

Underlying the perceived need for re-organization are three major factors, the rapid advance of medical technology and the possibilities for therapeutic intervention, the very much raised expectations of the populations about what they demand of the NHS, and the ever increasing costs of healthcare as a proportion of the GDP.

The direction in successive reorganizations has been to construct effective structures for the distribution of scarce resources through the NHS. It is now accepted that there should be a separation of commissioners (purchasers) of healthcare and its providers. The previous Labor government initiated the move towards creating quasi-autonomous Foundation Trust Hospitals that could compete with each other, and to a limited extent compete with the private sector in the provision of hospital services. Foundation Trust Hospitals are replacing the NHS Hospital Trusts controlled by Strategic Health Authorities, which are disappearing in the reforms.

The present Conservative government is attempting to move towards the next step which is to disperse and localize commissioning by devolving decision making to clinical commissioning groups (CCGs) based upon consortia of locally based general practitioners (GPs), and also to facilitate the involvement of the private sector in both provision, and in commissioning support. Additionally it is attempting to give to local authorities throughout the country the responsibility for public health in addition to adult social care, which is already their responsibility.

Alongside this move towards decentralization of both commissioning and provision there are two opposing tendencies. One is the need for the government to ensure that taxpayers' money is being effectively and efficiently spent. This requires the establishing of a central NHS Commissioning Board to establish annually an operating framework to which CCGs will be bound to adhere, and

CC: Creative Commons License, 2011.

two regulatory organizations, the Care Quality Commission to set and inspect quality standards, and Monitor to ensure due diligence and the financial viability of provider organizations, and also to recommend the pricing/tariff structure within which commissioning will occur. In addition NICE (the National Institute for Health and Clinical Excellence) will "license" drugs, therapies and other interventions that can be permitted within the NHS.

The other issue relates to combined arguments about both the fragmentation and privatization of parts of the NHS that could lead to differential and inequitable access to services. Much of this debate has been cast in terms of the privatization of the NHS.

This paper is a first attempt towards a systemic review of the proposed restructuring. It starts by defining a system-in-focus for this review and then it offers a model to study the restructuring's implied management of complexity. The argument is that agreement about these two aspects offers a good platform for discussing the strengths and weaknesses of the proposed changes.

The System-in Focus

Quite naturally the restructuring can be seen from different viewpoints. Systemically, the NHS, with its wide range of resources, is our organizational system. From the perspective of its unfolding of complexity (Espejo, 1989) the restructuring espouses a service with only two structural levels; the national and local. However, it is apparent that this is a gross over simplification; there are hospitals of national, regional and local significance and there are regions of hugely differing complexities between the national and local levels. London in its own right has several layers of complexity.

A number of questions can be asked. Which are the organizational systems within the NHS? Is it not that large national and specialized hospitals need to be considered as embedded organizational systems in their own right? Is it not that a National Commissioning Board cannot possibly allocate directly resources to CCGs in remote regions of the country? Is it not that it needs the amplification of regional commissioning boards, with accountability and discretion to negotiate the allocation of resources at the local level? These are questions that must be considered by those driving the reforms, and most probably they have, but their answers let alone their systemic implications have not been spelled out. The unfolding of complexity of the NHS is an important issue to study and make decisions about political accountability and central-local relationships. We take the government's viewpoint of considering the CCGs as the corner stone of the NHS restructuring, and more specifically we see a GP led Clinical Commissioning Group (CCG) as the system in focus for our inquiries. The restructuring gives to CCGs control of the necessary resources to commission health services for their local population. Each CCG can be seen as a viable system striving to deliver high quality community health services as it co-evolves with people in the community and also with the wide range of providers, themselves striving for their viability. Our reflections are driven by this viewpoint and the communication and complexity management strategies implied by these reforms (Beer, 1972, 1979, 1985, Espejo and Reyes, 2011).

Communication between a CCG and the Community

Health services anywhere are extraordinarily complex and the challenge to achieve good performance is daunting. In tandem with people's increased appreciation of health issues it is natural that pressures on providers increase. In the proposed restructuring GPs assess individual needs and commission the necessary services from providers. Achieving high performance in this relationship is at the core of their complexity management.

Improving the role of GPs as drivers of health services through a wide range of providers is indeed a necessary concern of the restructuring. The outcomes of the interactions between GPs and patients involve much more than these interactions; they need to account for full-fledged communications, which are shaped by the contributions, among others, of a variety of other health and social care professionals, a web of service providers, multiple public health services and politicians. Beyond interactions, most important to these communications, are self-regulating and self-organizing processes, which absorb large chunks of relevant situational complexity (Espejo

CC: Creative Commons License, 2011.

and Reyes, Chapter 4). These processes are governed, among other aspects, by culture, technology, politics and individual and organizational behaviors including competitive markets. These are soft variables that enable and/or block quality interactions to different degrees. By and large we are aware of these variables but a good understanding, and as far as possible a good design of communications between people and GPs can make the difference between a successful and unsuccessful NHS restructuring, that is, between a high performance restructuring, and a fragmented, privilege driven health service. In this short paper we only attempt a brief description of this web of communications; much more work is necessary to unpack its complexity.

Interactions between community people and GPs are asymmetrical. There is a huge imbalance between the large variety of health issues affecting people and the attention that GPs can give to these issues. Each GP may need dealing with thousands of patients, each with their particular health concerns. On the one hand GPs have, in general, more knowledge about these issues than individuals. The challenge is designing GP-patient interactions, and as far as possible communications, in a way that individual needs are met by high quality responses. For instance, public health services are hugely important to reduce the likelihood that people will need personal attention. In that sense they may attenuate demand through people's self-regulation; people take care of their own health. The residual number of cases that need medical attention may require that GPs commission health services from providers. GPs' productivity relate to the balance between these two strategies; in simple terms, the more public health services reduce demand for providers' procedures the better is likely to be GP's productivity.

A consortium of GPs' surgeries constitutes a Clinical Commissioning Group (CCG), hence structurally CCGs are constituted by autonomous surgeries. In general CCGs will have tens of surgeries, which may have different numbers of GPs and healthcare professionals. For instance in Lincolnshire, one of the English counties, 5 CCGs are envisaged for the whole County, each responsible for one to two hundred thousand people. In practice primary care trusts (PCTs) will be replaced by a similar number of CCGs, but now GPs will control their own budgets for commissioning purposes. The commissioning capabilities of CCGs, is unclear, and most likely they will need people today working for PCTs and also private consultancy firms with healthcare knowledge (e.g. Capita, Price Waterhouse...). The key change is the GPs' execution of budgets rather than PCT bureaucrats' taking centralized responsibility. However, a number of organizational factors will affect their performance, such as the functional capabilities of surgeries' and CCGs.

Surgeries' organization within each CCG may vary significantly, some will be highly organized others less so; this is likely to trigger self-organizing processes and therefore GPs performance within CCGs. From a structural perspective the organization of these surgeries is likely to vary widely, from highly sophisticated surgeries, running a significant number of in-house services, to small surgeries relying on external local services to offer similar functions. We may expect a significant degree of self-organization within each CCG; small surgeries may develop alliances with the larger ones, larger surgeries may develop in-house clinical services at the expense of services currently provided by hospitals or private providers. Local structural adjustments will take place in one form or another.

Regarding the provision of services the key players are hospitals; they are being restructured from local trust hospitals to autonomous foundation hospitals. An important aspect is that the NHS Commissioning Board, supported by regional commissioning boards, will recommend tariffs for all procedures. This arrangement will restrict competition. To improve productivity, and therefore the hospitals' competitive position, the organization and cost structures of foundation hospitals will be crucial. Under these pressures agreements with other public and private providers will be necessary. This transformation will allow hospitals to develop alliances with other hospitals and private providers; we may expect a significant degree of self-regulation and self-organization as they drive improvements in their productivity. Success will require enabling cost-effective and fair processes of self-organization as well as a culture of honest self-regulation. These can be seen as major concerns for the future of the restructuring.

CC: Creative Commons License, 2011.

Similarly public and social health services, whether to reduce avoidable demand for healthcare or to support quality of life, have important implications for the interactions between GPs and people in the community. The restructuring makes local authorities responsible and accountable for public and social services budgets within the context of Public Health England. The evolving communications between CCGs and local authorities will influence the productivity and performance of public health and with that the pressures on the GP-patients interactions.

Coda

What are the risks for different stakeholders implied by the restructuring? How is the reform protecting the necessary cohesion of a National Health Service? Will the restructuring lead to unbalanced services between communities? Will the more articulated and skilled in society unbalance the distribution of resources in their favor? How is the restructuring dealing with these questions?

From an internal view of the NHS, what are the main stabilizers to maintain the balanced development of health services across the country? Are the resource allocation formulae of the Commissioning Board flexible enough to cope with regional cultural variability? What's being learned from pilot CCGs? To what extent these pilots have been driven by local self-organization or have been the result of decision and rules coming from the NHS Commissioning Board (e.g. tariffs)? How is the natural mix of sophisticated and less sophisticated surgeries affecting CCG, surgeries and GPs performance?

As already said, a major responsibility of GPs will be commissioning services. For this purpose they will need communicational competences that possibly are beyond their previous experience. They will need to assess the technical competence of providers as well as their legitimacy and authenticity (Habermas, 1979, Espejo 2007). Providers can be public or private hospitals or providers of any other health service; this variety poses significant communicational challenges. We may expect, as an outcome of self-organizing and self-regulating processes, that all kinds of agreements will emerge between public and private hospitals and services. How is it possible to avoid unfair competition and improve cooperation between these services? How is it possible to achieve a healthy cross fertilization of public and private innovation and research and development, avoiding the private use of public resources in their own benefit, undermining the provision of public services? What are necessary regulatory mechanisms to harness self-organization in desirable directions?

To a large degree we expect that these questions are already being investigated. Our concern is answering them, and other related questions, considering the systemic context of interactions between GPs and patients. We argue that these answers should help improving the overall performance of healthcare in the country.

References

Beer, S. (1972). Brain of the Firm. London: Allen Lane The Penguin Press.

Beer, S. (1979). The Heart of Enterprise. Chichester: Wiley.

Beer, S. (1985). Diagnosing the System for Organizations. Chichester: Wiley.

Espejo, R. (1989). The VSM Revisited in The Viable System Model: Interpretations and Applications of Stafford Beer's VSM. R. Espejo and R. Harnden. Chichester: Wiley: 77-100.

Espejo, R. (2007). "The RISCOM Model: dialogues and requisite organization." Kybernetes 36 (3/4): 291-306.

Espejo, R. and A. Reyes (2011). Organizational Systems: Managing Complexity with the Viable System Model. Heidelberg: Springer.

Habermas, J. (1979). Communication and the Evolution of Society. Boston: Beacon Press.

About the Authors

Raul Espejo

is an international expert in organizational cybernetics. His most recent co-authored book "Organizational Systems: Managing Complexity with the Viable System Model", was published by Springer early in 2011. He is co-author of two other books and co-editor of three and has published over a 100 articles in journals and books. In the early 70s, during the

CC: Creative Commons License, 2011.

Allende's government in Chile, he was Operations Director of the CYBERSYN project under the scientific direction of Stafford Beer. Since then until 2003, he worked at the Manchester Business School in the UK, the International Institute for Applied Systems Analysis (IIASA) in Laxenburg, Austria and the universities of Aston and Lincoln in the UK. In 1985 he set up in the Science Park of Aston University Syncho Research (www.syncho.com), from where he has done research in a wide range of institutions worldwide with a focus on social transformation, organisational learning and democratic processes. Currently he is Director-General of the World Organization of Systems and Cybernetics and Director of Syncho Research.

David Hooper

has been Chair of North Middlesex University Hospital NHS Trust (NMUH) since March 2007. Prior to that he was Chair of Basildon and Thurrock University Hospitals from 1996-2007. In 2004 he led the trust through to become one of the first group of ten Foundation Trusts. With the chief executive he is currently steering NMUH to achieve FT status amidst the changes described in this paper.

CC: Creative Commons License, 2011.