A Systems View of NHS reorganisations
- the pain and cost of boldly going where we have been before

In the light of further NHS structural change and further overspend, Professor Eric Wolstenholme (Symmetric SD, Public Sector Consultants) and Liz Wolstenholme (ex DoH and PCT Chair) take a new look at these issues and hypothesise that they might not be entirely unrelated. They argue that the financial unintended consequences of reorganisations often markedly outweigh the intended consequences and there is a strong case for much more stability in health and social care structure.

A brief history of reorganisation of health and social care

Organisations of all types are restructured on a regular basis. However, the scale and frequency of restructuring in the NHS is exceptional. In recent years we have seen the separation of purchasing Health Authorities from providing NHS Trusts and Health Authorities divided to create Primary care Trusts; only to come back together to create sufficient commissioning clout to handle large hospital trusts. GPs have moved into fund holding and seen it dismantled, only to be recreated in practice based commissioning. This is not to mention other structural changes, such as care trusts, children's trusts and the demise of NHS long term care by redefining structural boundaries between health and social care. Often each new wave of reorganisation starting before all the parts of the country had finished implementing the previous wave and certainly before the gains of the change can be fully realised.

Why is health reorganised so often?

The reasons for structural change in the NHS are many and varied and certainly mindful of the public perception of the NHS which can win and lose elections. The operational rationale usually given is that change is necessary to improve services to patients and users, to make services more appropriate and more easily accessed. The financial rationale is to reduce management costs and to increase the percentage of NHS spending going on direct patient care. However, more covert reasons are often associated with establishing and exerting organisational ownership, intent and power by new owners through aggressive leadership styles, such as a new political party in power or new secretary of state. Or simply to break up power cliques, or even just to avoid politically damaging inaction. Particularly relevant is the fact that governments have little influence patient pathways in the NHS and hence organisational change is often the only lever available.

Are there patterns in the way the NHS is reorganised?

There are a limited number of ways in which organisations such as the NHS can be reorganised and these usually come down to either being centralised or decentralised.

Interestingly, the grass is always seen as green on the other side. Whenever an organisation is in centralised mode, there is the nagging thought that it is too far away from the users and that it might be better to decentralise and to move closer to them. Conversely, whenever an organisation is decentralised there is a worry about control and headlines about the lottery of post codes. There is also a tendency for thoughts to turn to economies of scale and the cost savings that could be gained from centralisation.

In systems terms the pattern of behaviour that would be seen by standing back from individual change events in the NHS is that of a cyclic pattern of oscillations between centralisation and decentralisation. Each swing countering the claim of 'haven't we been here before' by claiming that things will be different this time and that we are riding a spiral rather than a circle.

Some unintended consequences of organisational change

'we constantly create the thing we are trying to avoid'

We would really like to believe that reorganisations are well intended, spiralling in a planned direction and beneficial. However, in many cases the improvements are often far out weighted by the disruption and there is little evidence of efficiency gains.

In fact most of the health care that we receive carries on regardless of the changes affecting management, but at a price. Organisational structure, particularly the positioning of boundaries, is inextricably interconnected with the physics of patient pathways and changing organisational boundaries can significantly disrupt, rather than consolidate those pathways. Patients benefit most when pathways and organisational boundaries are in harmony. The more autonomous boundaries patients cross the greater the number of disconnects and duplication of activity. The resultant bottlenecks can seriously affect the achievement of performance targets and stretch managerial resources to the extreme in a search for ways of coping. Many of these measures lead cost escalation that the changes were intended to reduce.

Reorganisation is at best a distraction to non clinical staff and at worse a destroyer of confidence. When organisations decentralise they expand considerably. There follows a desperate search for new managerial talent to fill expanded structures. The creation of PCTs four years age resulted in a quadrupling of service staff, an enormous challenge of where appropriate staff might be found and the escalation of staff costs as parity and shortage combined.

Conversely, when organisations centralise there is the opposite problem. In this case, there exists a surfeit of well paid staff some of whom have been promoted beyond their competence and who need to be 'dealt with'. In such situations the threat of redundancies is high and morale, uncertainty and efficiency are persistently low. The processes of staff reapplying for jobs is also slow and draining. Those left have to adjust to learn new ways of grouping and working, which further reduces productivity. Many PCT staff had only just grown in confidence and competence just in time to be restructured out of a job. The NHS had very high costs and only very short benefits from these people.

Is there a right structure for the NHS

The answer for this clearly lies beyond this paper. However, suffice it to say that the systems comment on this question would be that changing organisational boundaries should never be undertaken on its own for motives more about policies and finance than patient care. Rather, it should be part of a set of balanced interventions aimed at orderly transitions to better, more affordable patient services reflecting best clinical practice and given sufficient a life cycle to maximise the use of public funds and engender the support of all staff. The alternative is that we are for ever locked into a cycle of personal pain, conflict, blame and almost irreversible overspend - such that when new money is given it is largely used to balance books rather than be directed to new patient centred initiatives. It is also quite possible that stability is a greater vote winner than chaos.