Investigating and assisting the practice of healthcare commissioning in the United Kingdom

Nicholas Harrop, Alan Gillies and Trevor Wood-Harper

Accepted to the SIG Prag workshop on IT Artefact Design & Workpractice Improvement, 5 June, 2013, Tilburg, the Netherlands
Abstract

Introduction

The United Kingdom National Health Service (the NHS) is radically restructuring its arrangements for planning, procuring, evaluating healthcare provision (i.e. ‘commissioning’), devolving this responsibility to newly created Clinical Commissioning Groups (CCG’s), composed of local family physicians (GP’s).

GP-led commissioning is a new practice. A Practice Research approach might assist the growth of local expertise, contribute acquired knowledge to the general practice of commissioning and stimulate the development of new theoretical and methodological approaches.

Purpose and aims

To engage with clinical commissioning groups (CCG’s), we aim to provide a preliminary conceptualisation of the problem situation; second, to develop preliminary ideas on a problem solving approach that can be adapted to the landscape of commissioning as it evolves; and, third, to inform our own ongoing programme of research and understanding.

Methodological approach

Synthesise model of intended research from recent literature. Explore multiple perspectives influencing mental models of the problem situation.

Findings

The three forms of perspective explored illustrate social and political considerations which interfere with the rationality of the new practice.

Conclusion: Value and Implications

We offer a model of the ‘physiology’ of practice research applied to commissioning, showing how its interacting parts function as an organic whole.

We make no recommendations on specific healthcare commissioning objectives but we have shown how healthcare commissioning as a problem situation can be described from multiple perspectives and we suggest that the discipline of taking these perspectives on the commissioning situation has the capacity to enrich understanding, comprehensive diagnosis and accurate prognosis for the health economy concerned. We hope to develop this theme in our future projects.

Keywords:

practice research, multiple perspectives, unbounded systems thinking, health services, commissioning, information systems
1 Introduction

The United Kingdom National Health Service (the NHS) has recently embarked on a radical restructuring of its arrangements for planning, procuring, evaluating healthcare provision (i.e. ‘commissioning’). The existing infrastructure has been dissolved and replaced by newly created Clinical Commissioning Groups (CCG’s), composed of local family physicians (GP’s). CCG’s will be accountable to a new NHS Commissioning Board and to local (‘HealthWatch’) bodies. The market for healthcare provision has now been opened to the third and for-profit sectors. Rather than the Secretary of State for Health, CCG’s and their member GP’s will be more exposed than ever to public and political censure when things go wrong in the local health economy.

GP-led commissioning is a new practice, highly visible and having the potential for severe failure. Most GP’s have no experience or expertise in commissioning. The dissolution of existing structures has been associated with a haemorrhage of management capability. Many GP’s feel ill-prepared for their new role. Their learning curve will be steep. It is possible that a Practice Research approach might assist the growth of local expertise, contribute acquired knowledge to general practice of commissioning and stimulate the development of new theoretical and methodological approaches.

2 Purpose, aims and structure of this paper

The purpose of our paper is to prepare ourselves, as researchers, to engage with clinical commissioning groups (CCG’s), seen as practitioners in the accountable commissioning of clinical services.

Our aims are: first, to provide a preliminary conceptualisation of problem situation; second, to develop preliminary ideas on a problem solving approach that can be adapted to the landscape of commissioning as it evolves; and, third, to inform an ongoing programme of research and understanding. In the following, we will outline our research approach and then present a short study to demonstrate its operation. We will reflect on our findings and draw conclusions.

3 Methodological approach

Our approach begins with the models of policy, design and implementation (Goldkuhl 2012 a) and of the anatomy of practice research in context (Goldkuhl, 2011). These are synthesised in figure 1. The research intervention in our case is driven by an interest in the practice of healthcare commissioning, supported by clinical information systems. The form of situational inquiry will integrate the theoretical and empirical activities of the researchers with the operational and development work of commissioning practitioners (Goldkuhl, 2012 b). It will also incorporate the Dialogical Action Research (DAR) approach of Martensson and Lee (2004), shown in figure 2, to bind researchers and the practitioners into a single category of ‘problem owner’ within the mutually constitutive web of problem situation, problem owners and problem solving approach, illustrated in figure 3.
The DAR approach is useful because it explicitly sets out to overcome the problems of knowledge heterogeneity and knowledge contextuality, encountered in discourse between researchers and practitioners.

Figure 1: Locating and characterising the research intervention and target practices. (Lower left: Policy design model. Upper right: anatomy model. Inset: linking theory, operational and development work). Redrawn from Goldkuhl, 2011, 2012a, 2012b)

Figure 2: Dialogical Action Research model (redrawn from Martensson and Lee, 2004 with insight from Goldkuhl, 2012a).
Figure 3: Mental models mediating between problem owners, problem solvers and the problem situation. T,O,P perspectives are explained below.

3.1 Technical (T), Organisational (O) and Personal perspectives

The problem solvers’ mental models of the problem situation are influenced by their authors’ perceptual sensitivities and conceptual blind spots.

Mitroff and Linstone argue (reference) that three archetypal forms of perspective (Technical, Organisational, Personal) emerge from the study of complex human situations. None should be ignored because they offer unique and complementary insights. Their scheme of ‘unbounded systems thinking’ (UBS) ‘sweeps in’ all three within the holistic, Singerian form of ‘Inquiring System’ discussed by Churchman (1971) and Mason & Mitroff (1973); and also explained by Vandenbosch et al. (2001). We summarise the three forms of perspective in table 1.

<table>
<thead>
<tr>
<th><strong>Technical (T) perspective</strong></th>
<th><strong>Organisational (O) perspective</strong></th>
<th><strong>Personal (P) perspective</strong></th>
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</thead>
<tbody>
<tr>
<td>Limited insight from reductive model of structures and events. Focus on plans and products</td>
<td>Seeks coherence with evolving organisational and political context. Focus on process and systemic relationships</td>
<td>Limited political and contextual sensitivity. Intuitive and reactive. Fallible perception of risk. Inability to plan for low-probability / high-impact events. Limited capacity to deal simultaneously with multiple issues. Focus on personal or sectional interest</td>
</tr>
</tbody>
</table>

Table 1: T,O,P perspectives summarised
4 The approach applied to the problem situation

In this section, we present examples of the three perspectives, substantiated by our reading of relevant literature and personal observation from within UK healthcare. Our purpose here in this short paper is neither to propose any specific intervention nor to describe its results. We will now present a series of diagrams and rich pictures (Checkland & Poulter, 2006) to illustrate the application of T,O,P perspectives to the problem situation represented by the practice field of commissioning health care provision.

4.1 T Perspective : limited insight from reductive models

The T perspective is based on pure rationality, reducing complex situations and tasks to simple, nominal activity labels. This perspective provides no information on the social, political and organisational context of the activities to be carried out. Neither does it shed light on the specific, local problems and issues that commissioning must address.

The NHS commissioning cycle (see Quayle, Ashworth & Gillies, 2013), shown in figure 4, provides a succinct summary of the activities that must be accomplished within the commissioning process.

Figure 4: The NHS Commissioning Cycle
Figure 5 populates the policy, design effects model (Goldkuhl, 2012) with the institutional tools of policy implementation. These include the commissioning cycle, the deployment of competition to drive performance, the use of information to monitor and assess performance and the deployment of incentives and penalties (which can operate perversely). It fails to show how these will operate in practice.

**Figure 5:** The policy, design effects model (Goldkuhl, 2012), populated with the institutional tools of policy implementation

### 4.2 O Perspective: social and organisational context of strategic action

The O perspective identifies the social and organisational content of the problem situation, ignored by the T perspective. It can be deployed to identify interacting parties and explores the impact of change upon them.

Figure 6 shows that the local CCG has both local and national accountability. The widening of the provider market will open competition to locally responsive Small to Medium Enterprises (SME’s) but it will also allow the franchising of NHS services to mega-providers (symbolised as ‘SATANIC’ because of public antipathy to the for-profit sector, seen as a means to tax payments intended to support social solidarity into corporate profits). Experienced commissioning managers have deserted their parent organisations, anticipating redundancy. On consequence, GP’s in CCG’s will need management support. By contracting to provide this support to multiple CCG’s, mega-providers could assume *de facto* control over procurement and provision.
Figure 6: change and impact

In any event, GP’s will be driven to modify their established clinical methods, peer relationships and referral habits and to comply with formalised channels (pathways) of referral as well as prescribed, evidence-based clinical methods. The hope for patients is that they can pick and mix from the providers who will best suit their needs and requirements, according to the doctrine of ‘choice’ instead of conforming with the traditionally inflexible form of provision. It is expected that patients’ decisions on choice of provider will be informed by explicit information on treatment outcomes, safety records, operational performance and published reports of their experience by other patients.

The NHS enjoys periods of apparent stability, punctuated by periodic disturbances, either in the form of structural re-organisation or embarrassing failure. At the time of writing, the public and the government are being made aware that hospital emergency departments are in meltdown. The roots of the problem are complex and relate to deficiencies in primary and social care provision; and the inability of gridlocked hospitals to provide beds promptly for emergency patients or to discharge dependent patients promptly into community-based provision. Penalties for hospitals who admit too many patients are exerting a perverse effect on institutions who cannot influence the extraneous factors preventing their performance. CCG’s will be expected collectively to bring about massive efficiency savings and to divert resources from the hospital to the primary care sector. Concerns about hospital acquired infections are being used to support the resource shift and the impact of gridlock on hospital staff is contributing to a recruitment crisis. A recent public inquiry into substantial failings at a major UK hospital has highlighted the dangers from an over-eagerness to report good performance data at the cost of real service quality. Figure 7: describes the overall situation and allows inferences to be drawn and debated, over the processes that commissioning must bring about. An immediately necessary impact of the commissioning cycle must be to unravel the complexity of the situation presented.
4.3 P perspective

The P perspective shown in figure 8 refers to the position of an individual GP in relation to the commissioning process and focuses on conflicts that are neither intentionally designed into the commissioning process nor disclosed fully within the O perspective. The P perspective sheds light criteria deployed by individuals or groups to assess the desirability or the feasibility of their participating in the way the T perspective would require.

Figure 8 places the GP and his P perspective in the context of other P perspectives. Commissioning organisations represent a utilitarian ethos, acting on behalf of the community, for the benefit of the community. On the other hand, the GP must make his patient his first concern and apply an individualist ethic. Patients may be aware of this ethical dilemma and the GP is aware that the CCG and his own patients can bring significant sanctions to bear.

There is a second conflict between the information demands of secondary data users in the CCG and the work and time costs of organising the content of the clinical encounter reliably into the form secondary users, such as performance managers and planners, might inscribe in their definition of information system requirements. This is relevant in the context of high GP workload, restricted financial resource and poor recruitment in general medical practice.
4.4 Commissioning information systems

The most obvious P perspective on IT artefacts is that they must be useful and usable in the clinical workplace; if they are to furnish the data required by secondary users for governance, they must also actively support, rather than impede the actual practices of clinical work. The T perspective taken, on the functionalities and data outputs required from a clinical information system, is influenced by sectional interests associated with the different roles shown in figure 9.
5 Reflections and Learning

In this paper, we have concentrated on commissioning as a social practice rather than a material technology. Orlikowski (2007) considers that the social and the material are “recursively intertwined” and she states that “all practices are always and everywhere socio-material”.

Taking the T perspective alone treats commissioning as a material technology in isolation from its social content, reducing it to a tool, such as the commissioning cycle. In our own paper we have taken the technology out of the black box and the O and P perspectives emphasise the social practice aspect of commissioning, to which the tool is relevant.

The theory of policy, design and effects has provided a useful structure for our research plan and has drawn our attention, in this case, to the problem of implementing a new practice successfully in a difficult social and political environment. The anatomy of practice research in context identifies ‘practice’ as an amorphous entity. We have begun to explore the interplay between the rational and the social and political content of practice.

The deployment of the multiple perspectives approach provides a panorama from which the landscape of policy implementation and practice effects can be structured, anticipated and observed empirically. Awareness of P perspectives suggests a means to diagnose the roots of resistance and disengagement from the proposed practice.

To understand the dynamics of the practice researcher’s engagement with the practice situation, we need a complement to the general, T perspective afforded by the practice research anatomy archetype. It is difficult to provide general models of O and P perspectives on practice research because O and P perspectives are situation- and person-specific, even though they have identifiable general characteristics. Future case studies constructed around these perspectives could inform our ideas on the practical implementation of a decision to commission or undertake a practice research project.

6. Conclusion

We conclude that the model presented in figure 10 offers a systemic whole in which researchers and commissioners, in dialogue with other groups (would-be contributors to change), will construct and incorporate the three forms of mental model we have demonstrated: to identify and characterise the problem situation that requires the local commissioning response. The form of the commissioning response will emerge from the appreciation provided by all three perspectives, given equal consideration during discourse. Figure 10 offers a potentially useful ‘physiology’ of practice research applied to commissioning, showing how its interacting parts function as an organic whole.
We make no recommendations on specific healthcare commissioning objectives but we have shown how healthcare commissioning as a problem situation can be described from multiple perspectives and we suggest that the discipline of taking these perspectives on the commissioning situation has the capacity to enrich understanding, comprehensive diagnosis and accurate prognosis for the health economy concerned. We hope to develop this theme in our future projects.

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