Medical advisory machinery in the reorganised NHS

Report by Joint Working Group on district management arrangements

The working party appointed by the Chief Medical Officer in June 1980 to consider the medical advisory and representative machinery in the light of changes in the NHS structure has now concluded its consideration of arrangements at district level and its report is set out below. The Secretary of State has agreed that the report should be published for comment and comments are invited by the end of March. In the light of those comments, it is hoped that further guidance will be issued in a departmental circular by the middle of 1981. The working party is now considering the machinery at regional level. The membership of the working party is given at p 240.

The Royal Commission recommended that the health departments should consider with the professions concerned the best way of simplifying the present professional advisory committee structure. In its consultative paper on reorganisation, *Patients First*,[1] the Government agreed that "this was necessary in respect of the medical advisory machinery, especially to ensure that the doctor's voice is fully heard by the health authority."

The Government announced that it had set up a working group with the following terms of reference: "In the light of possible changes in the NHS structure, to consider the current arrangements for the involvement of the medical profession in the strategic planning and operational management of the NHS with particular reference to the role of medical advisory and representative committees and to make recommendations." In its introduction the working group stated that in making its recommendations it had borne in mind three principles. (*a*) Guidance should be concentrated on the tasks that committees have to perform and the methods by which they do them; the detailed composition of committees should be left for local decision. (*b*) Guidance should be flexible and should allow for the marked variability between health districts. (*c*) Guidance should ensure that there are as few committees as is consistent with the work to be done.

Chapter 1: The district health authority and its relationship to clinical doctors

THE DISTRICT HEALTH AUTHORITY (DHA)

(1.1) The Government announced in health circular HC(80)8[2] that throughout the NHS in England there should be a pattern of operational authorities similar in the main to existing single district areas. DHAs will generally consist of 16 members, plus a chairman. Membership will include a consultant, a GP, a nurse, a university nominee, a member drawn from the trade union movement, four members appointed by local government, and seven generalist members appointed by RHAs.

(1.2) Members of the new DHAs will have the same role as current members of AHAs—that is, they will be expected to decide on district policies and priorities within the context of national and regional policy; to review and challenge objectives, plans, and priorities submitted by the DMT; to appoint and monitor the performance of chief officers; and to assess the adequacy of services provided.

(1.3) Each district health authority will have at least two medical members, a consultant and a general practitioner. Their contribution to the authority's work will be to bring their understanding of health and disease, and of health services, to bear on the authority's deliberations. They will be chosen for their individual qualities.

(1.4) Doctors appointed to district health authorities could be drawn either from inside or from outside the district. The appointing authority should seek advice on this matter from the profession locally. Regardless of where they work, medical members of an authority do not represent doctors working in the district. Nor will they be the source of formal medical advice to the authority. However, they will be concerned to ensure that professional views have been properly taken into account when decisions are taken. For example, they will wish to assure themselves that the authority has sought advice from the medical members of the district management team. (See paras (1.20) and (1.21).)

(1.5) It is anticipated that the current procedure will continue by which nominations from medical organisations are forwarded to the regional health authority, which then appoints doctors to the district authority from among the nominations which it has received. Organisations which currently put forward nominations include the British Medical Association, royal colleges and faculties, and the Overseas Doctors Association.

(1.6) The medical members, like other members of authorities, are corporately accountable through the RHA to the Secretary of State and these latter bodies have the power of dismissal "in the interests of the NHS," and of non-reappointment.

(1.7) Some districts contain hospitals with a significant undergraduate teaching role.* To enable the authority to make decisions taking due account of the needs of medical education and service to patients, the medical and dental faculties of the relevant university should be appropriately represented.

DISTRICT MANAGEMENT TEAMS

(1.8) The Government has proposed that throughout the NHS in England there should be a pattern of operational authorities similar in the main to existing single district areas. Each authority will have a management team with the same composition as existing area management teams, which consist of four officers of the health authority and two clinical representatives, one being a hospital consultant and the other a general practitioner. Team decisions can only be reached

*The arrangements for the governance of special postgraduate hospitals are under review; any changes may have further implications for health authority membership.

when all members are agreed, at least in the sense that none is opposed to a proposal, though not all may be equally in favour.

(1.9) In a few districts, the consultant and general practitioner membership of management teams has been doubled in order to take account of special local factors. The introduction of the new district health authorities may reduce the number of districts in which it is felt that this is necessary.

(1.10) In districts with one or more major teaching or research institutions representatives of the academic institutions have regularly attended meetings of the management team. This practice has been found to be mutually acceptable and should be continued or introduced if this has not already been done.

(1.11) In many management teams there has been strong pressure for the team to reach consensus and thus have an agreed view to take to the authority. It is obviously desirable that, whenever possible, management teams should act unitedly on the basis of consensus freely reached. However, in some parts of the country, principally in multidistrict areas, the remoteness of the authority, the presence of an area team of officers, and the existence of competing district management teams have all tended to lead to a less desirable philosophy of "agree at all costs." The restructuring exercise heralded by HC(80)8 should remove many of these pressures and in future when acceptable consensus is not readily obtained teams should then be able to take unresolved business to the authority without a feeling that in doing so the team has failed. In doing this it will be possible to demonstrate the extent to which agreement has been reached and where residual difficulties remain, thus giving the authority a clearer sense of the nature of the underlying issues.

CLINICAL REPRESENTATIVES ON MANAGEMENT TEAMS

(1.12) Clinical representatives are accountable as individuals to the group which elected them but this does not prejudice the collective accountability of the management team to the authority. At meetings of the health authority clinical representatives would support recommendations on which they have reached agreement with colleagues on the management team but they will also have a responsibility both to the authority and to their electorate to ensure that the views of medical colleagues are known and understood.

(1.13) It is the right and responsibility of each team member to attend meetings of the authority and to tender advice. An exception to this general rule would be the rare occasion when the authority is discussing the competence or performance of officers of the authority who are members of the management team; there may be other exceptions.

(1.14) Both clinical representatives will comment on all the business of the team, not confining themselves to sectional interests, and it is hoped that on most issues there will be agreement between hospital consultants and GPs. Nevertheless, the working group considers that the team consultant and the team GP should represent hospital and general practice interests respectively. The consultant representative should therefore be elected by a body including all the senior hospital medical staff in the district (district hospital medical staff committee), or, if that body so wishes, by a representative group—for example medical executive committee. The committee responsible for electing the consultant representative must contain representatives of hospital doctors in training. Similarly the general practitioner representative should be appointed by the local medical committee for the family practitioner committee serving the district, or by a committee of general practitioners authorised by the LMC.

(1.15) It is an essential part of the role of a clinical representative to report back to the electorate about actions taken and thus to ensure that there is support for what has been done and what will be done. The clinical representatives should report regularly to the body which elected them. If this body does not consist of all doctors belonging to the group which they represent, consideration should be given to ways in which the whole group of all hospital doctors or all general practitioners in a district can be kept informed.

(1.16) The length of the term of office of clinical representatives should be a matter for local decision. However, it is important that the tenure should be long enough to ensure continuity and to enable good experience of management team problems to be accumulated. The working group recommends that these criteria may best be met by appointment for a term of three years after which the incumbent would be eligible for re-election for one more term.

(1.17) As clinical duties will sometimes necessitate the absence of representatives from management team meetings, each should have a designated deputy, who can attend in his place when necessary. The opportunity to act as a deputy

Membership of Joint Working Group

Sir Henry Yellowlees, Chief Medical Officer, DHSS (Chairman).

Dr Clifford Astley, consultant physician, North Ormesby Hospital, Middlesbrough.

Dr Maurice Burrows, consultant anaesthetist, St Catherine's Hospital, Birkenhead.

Dr John Chisholm, general practitioner, Henley-on-Thames, Oxford.

Dr George Duncan, regional medical officer, East Anglian RHA.

Dr John Evans, deputy chief medical officer, DHSS.

Mr John Fleming, consultant surgeon, West Middlesex Hospital.

Dr Stuart Horner, area medical officer, Croydon AHA.

Professor George Hudson, administrative dean, University of Sheffield Medical School.

Mr James Johnson, senior registrar in surgery, Royal Liverpool Hospital, Liverpool.

Dr John Marks, general practitioner, Elstree, Hertfordshire.

Dr John Nabarro, consultant physician, The Middlesex Hospital.

Mr Frank Pethybridge, regional administrator, North Western RHA.

Mr Sidney Shaw, area administrator, Essex AHA.

Professor Robert Steiner, professor of diagnostic radiology, Hammersmith Hospital.

Alternates

Mr David Bolt, consultant surgeon, West Middlesex Hospital (for Dr Astley).

Professor Derek Wood, dean of Faculty of Medicine, University of Leeds Medical School (for Professor Hudson).

enables a potential team representative to gain useful experience and to acquaint himself with the problems of serving on a management team. Many districts now elect their representatives a year or more before they take office and this makes it possible for the selected doctor to act as a deputy and attend relevant training courses before taking up an appointment. Newly-appointed DMT clinical representatives may require help in understanding the management structure of the NHS, its resource allocation and planning systems, and the key management issues and problems which arise.

(1.18) The effective involvement of clinicians in management teams necessitates the provision of appropriate administrative and secretarial support and relevant, accurate, and timely statistical information on which decisions can be based.

MEDICAL ADVICE TO DISTRICT HEALTH AUTHORITIES

(1.19) Authorities require medical advice of two main types:

(*a*) Specialised advice on the current and future needs of patients and on methods available for treating them from the various individual specialties.

(*b*) General advice based on the broad medical view of priorities and the way in which resources should be allocated.

(1.20) When an authority requires specialist advice it should seek the advice of the medical members of the DMT as to the most appropriate sources. For example, it may be appropriate to seek the view of the relevant regional committee; to approach a local committee; or to seek advice from individual doctors. Whatever the source, the specialist advice should reach the health authority in the context of the comments of the medical members of the DMT.

(1.21) When a broad medical view is required an expression of the general view of doctors in the district should be channelled to the authority through the three medical members of the management team. The way in which the district medical officer obtains the views of doctors working in community medicine and the community services is for local decision, but he must be able to satisfy the authority that he has sought and considered such views. The responsibilities of the consultant and GP members of the team have already been discussed above. (See also para (1.23) below.)

(1.22) The working group sees no need for a specific committee to be set up to integrate or co-ordinate a medical view for the district health authority. Integration can occur by cross-representation between single-discipline committees and by discussion between the three medical members of the management team. Thus representatives from the local medical committee (including the general practitioner member of the management team or his deputy) and the district medical officer must attend the appropriate hospital medical committee. Consultant representatives (including the consultant member of the management team or his deputy) and the district medical officer must attend the local medical committee.

(1.23) In some districts in which there are many doctors and where problems are particularly complex the clinical representatives on the management team may feel the need for more detailed briefing so that intraprofessional difficulties can be sorted out before management team meetings. This could be obtained by holding regular or ad hoc briefing meetings at which attendance varied according to the items to be discussed at the management team meeting.

(1.24) In a single district area (the future structural norm) there is a statutory area medical committee which gives medical advice to the authority, elects clinical representatives to the management team, and helps develop an integrated medical view for presentation to the management team and the health authority. All these functions can be carried out in alternative ways. (See para (1.14), (1.20), (1.21), and (1.22).) The working group therefore takes the view that there is no need for the new district health authorities and the profession to set up district medical committees and recommends accordingly.

Chapter 2: Medical committees in hospitals and medical collaboration at unit level

MEDICAL COMMITTEES

(2.1) The new district health authorities will vary considerably in size both in terms of population and geographical area and in the provision of hospital facilities. The number of hospitals, the type of hospitals, the absence or presence of a teaching function, and the way in which hospitals are grouped to form administrative units will differ and all will be important factors to be considered in setting up medical committees in a district. The committee structure will also have to take into account the number of hospital doctors working in the district. It is likely that a simpler structure will suffice for a rural district with, say, 50 consultants than one which will be required for an inner city district with major undergraduate teaching commitments in which 200 consultants may be working.

(2.2) The working group has noted that many different patterns of hospital medical committee structure currently exist and has come to the conclusion that no set pattern can be laid down centrally for the new districts. Each district must tailor a system to meet its specific needs. However, there are certain functions which need to be covered in all districts and some broad principles which are generally applicable.

(2.3) In each district a committee of senior hospital medical staff is required to form a hospital medical view on priorities and resource allocation, to elect and brief representatives to the district management team and other groups, and to receive reports from representatives. The membership of a district hospital medical committee (DHMC) would include as full members hospital consultants, medical assistants, scientists of consultant status, and representatives of doctors in training. Representatives of the local general practitioners and of community medicine should normally be present. Administrative and nursing interests should be represented. To fulfil its function, the committee should meet regularly and be properly serviced by administrative staff.

(2.4) In a large district with a considerable number of consultants, the district hospital medical committee may become too large for the effective resolution of interspecialty differences and the development of an agreed hospital view. In this situation the DHMC may decide to set up a medical executive committee (MEC) which includes as full members representatives of hospital consultant staff and of other groups of doctors working predominantly in hospital—particularly representatives of doctors in training. A general practitioner, the district medical officer, and representatives of nursing and administrative interests would also be in attendance at meetings. The chairman of a medical executive committee might also serve as the consultant member of the district management team. Whether the consultant member on the team is elected by and thus reports to the medical executive committee or is elected

by the district hospital medical committee is a matter for local decision by the DHMC.

(2.5) A medical executive committee set up by a district hospital medical committee could be composed of chairmen or representatives of specialty divisions (see para (2.12)) or it might be a committee entirely elected by the DHMC. A third alternative would be a combination of the two. It is up to the district hospital medical committee itself to decide which pattern they think is preferable.

THE UNIT

(2.6) In the guidance issued to authorities in Circular HC(80)8 about management arrangements it was recommended that the only level of management below the district health authority should be the administrative unit.

(2.7) Authorities are free to establish as many units of management as they think appropriate. Examples of such units might include:

(*a*) a major hospital or a group of hospitals with complementary functions—for example, a district general hospital;

(*b*) the community services of a district; or

(*c*) services for a particular client group—for example, a psychiatric unit covering both hospital and community services.

(2.8) Each unit will have an identifiable administrator and a nurse, accountable to the district administrator and nursing officer respectively. Associated with these officers will be a representative or representatives of medical staff working in the appropriate unit.

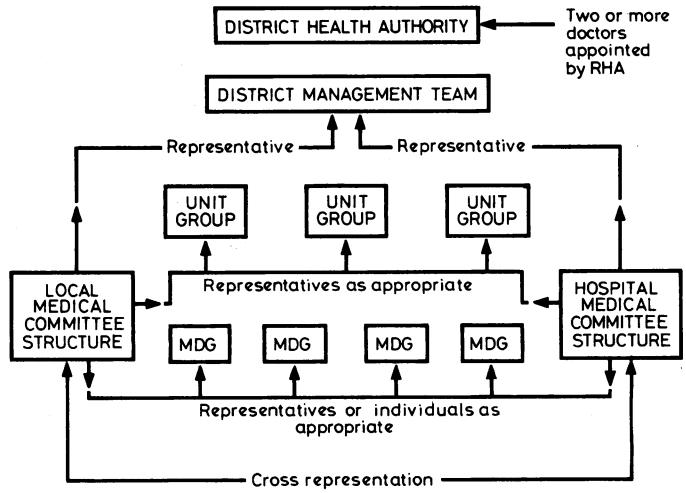
(2.9) Units will differ greatly in size and in the type of work performed. The groups of staff responsible for running the units will therefore work in different ways but no group will operate on a formal basis of consensus as does the district management team. Close collaboration and co-operation will obviously be necessary but disagreement over important matters of mutual concern, if not capable of resolution at unit level, will be referred to the district management team.

(2.10) The medical representative(s) on a unit group should be elected by all the medical staff working in the unit or by an appropriate subset. Thus in a district with one district general hospital unit, the medical representative on the unit group would be a consultant elected either by the district hospital medical committee or by the medical executive committee.

(2.11) In a mental illness or mental handicap unit the medical representative would be elected by colleagues in these specialties. In a unit responsible for community services, general practitioners, clinical medical officers, and hospital consultants may all be involved in providing services, and local arrangements should be made to elect one or more doctors to the unit group. In those units involved with both hospital and community work special consideration must be given to the involvement of a general practitioner.

SPECIALTY DIVISIONS AND MULTIDISCIPLINARY GROUPS

(2.12) In many hospitals it has been useful for doctors to establish specialty (cogwheel) divisions which provide a forum in which doctors working in hospitals are able to co-ordinate their work, to review the service they are providing, and to choose colleagues to represent them on other bodies. Although



The participation of clinical doctors in the management arrangements of the new district health authorities.

specialty divisions or committees are primarily of and for doctors, other disciplines may attend meetings as appropriate. Specialty divisions may report either to a district hospital medical committee or to a medical executive committee. If specialty divisions have been found to serve a useful purpose in any particular district they should be continued.

(2.13) Where a district management team believes that patient care in the district will be improved by setting up a multidisciplinary group to deal with a particular aspect of patient care, this should be done after discussion with the various interests involved. However, it should be realised that these groups take up a lot of time and care should be taken to avoid overlap of functions with those of other bodies. It should be made clear to whom the new group should report and exactly what its function is to be. In particular it is necessary to avoid any overlap of functions between specialty (cogwheel) divisions and multidisciplinary groups.

OTHER DISCIPLINES

(2.14) In accordance with its terms of reference the working group has reported on the involvement of doctors in the strategic planning and operational management of the NHS. However, throughout its discussions it has been conscious that other professions must play their part in providing health authorities with the balanced advice which is needed and that close co-operation between the health professions is essential to the proper running of the Service. The working group has therefore specifically recommended that administrative and nursing interests should be represented at meetings of hospital medical committees (para (2.3)) and at meetings of any medical executive committee that may be formed (para (2.4)). The working group believes that the informal contact between the three medical members of the management team envisaged in para (1.22) above should not always be exclusively medical and that it should include other disciplines when appropriate.

References

[1] Department of Health and Social Security. *Patients first*. London: HMSO, 1979.

[2] Department of Health and Social Security. *Health Service development: structure and management*. HC(80)8. London: DHSS, 1980.