of the district and area teams have come from hospitals and it has taken them most of the year to find out what community services are available in their districts. Thus 90% of the districts' budget remains with the hospital service for the present.

As they find out about the rest of the N.H.S. some hospital people are concluding that resources should go to hospitals rather than local clinics anyway. Alternatively, now that all three branches of the Service are theoretically being administered by one body, the continued separation into three parts is considered to make no sense. The services provided by local clinics and the community staff could be absorbed by the other arms of the Service and be based either in hospitals or with G.P.s.

The financial control of the administrative side of the family practitioner services has now become a matter for the A.H.A. rather than the D.H.S.S. Apart from this there is little difference between the work of the family practitioner committee and the old executive council. There have been few formal contacts between F.P.C.s and A.H.A.s and, though contact at officer level may be close, this in part depends on the individuals having known each other personally in the old system. G.P.s and the other practitioners continue, as agreed, in their independent contractor position and the arrangements for negotiating health centres and alterations in practice conditions with them continue as before. Any major redistribution of resources or services among hospitals, practitioners, and the old community services lie in the future.

The key to shifting the burden of caring for long-stay patients from relatively expensive hospital care to the community has always been the social services. These are still organized by local authorities and so far they are no closer to the Health Service than before reorganization. Joint Consultative Committees, consisting of members of local authorities and area health authorities—whose job it is to advise on collaborative activities—are only just being set up. Few people in the Health Service think that these committees will be able to achieve much through joint planning as the pressure will be mainly on the local authorities to do more. Equally, these committees can do little about day-to-day collaboration as they are at the wrong level in the N.H.S. Operationally the district should have the links with social services and yet there are no formal mechanisms for this, and up to now informal contact has depended on the personalities involved. An additional problem is that social service "districts" do not match those in the Health Service and perhaps more important still is the fact that social services are operating under budgets as constrained as the Health Service.

Planning

A major justification put forward for the structure of the new Service was that it would allow opportunities for broadly based planning to take place. The hope was that such planning would bring about significant changes in the way resources are spent. In fact, the beginning of the D.H.S.S.'s own planning cycle is still a year away and will take some time to develop. Until planning not only occurs but has a visible impact then the elaborate staff structure at each level will seem unnecessarily unwieldy to many within the Service and to some of us without.

[1] *Management Arrangements for the Reorganized National Health Service*, para. 2. 11. London, H.M.S.O., 1971.
[2] *Management Arrangements for the Reorganized National Health Service*, para. 2. 15. London, H.M.S.O., 1971.
[3] *Management Arrangements for the Reorganized National Health Service*, para. 4. 7. London, H.M.S.O., 1971.

Centre for Studies in Social Policy, London
JANET LEWIS, Fellow
S. WEINER, Visiting Fellow

Two Years On—Newcastle Revisited

W. F. WHIMSTER

Two years ago the *B.M.J.* published a series of articles[1-6] about how local medical, nursing, and administration staff expected N.H.S. reorganization to affect Newcastle-upon-Tyne and Gateshead. For this symposium I went and talked to two of the people who had been concerned in those articles—Dr. Andrew Smith, a general practitioner in the Gateshead single-district area, and Dr. Bryan Shaw, then deputy M.O.H. for Newcastle and now Area Medical Officer (A.M.O.) for North Tyneside (also a single-district area). Two other doctors also took part in the discussion: Professor John Walton, Dean of the Faculty of Medicine in Newcastle University, and Dr. David Henley, A.M.O. in Gateshead. In this paper I have briefly summarized their contributions from their three single district areas (including a teaching area) under somewhat arbitrary headings.

M.O.H. to A.M.O.

Though working either in or near their old environments, the former M.O.H.s find themselves doing completely different jobs. But a year later they still spend time directing their old friends (especially in the local authorities) to people who are now doing bits of their old jobs. And, though the main posts in the reorganized N.H.S. have now been filled, the supporting staff in nursing administration and finance are still being appointed. People are still uncertain whether they will get substantive jobs in the new service and morale is low. It is not true that many new posts have been created—but experienced people have retired early, many people have changed jobs, and others have been promoted perhaps too quickly. Gateshead is fortunate in that the central organization of the integrated service is all in one building.

The new A.M.O.s are having to spend time finding out about the hospital side of the service, and have spent little time so far on community services apart from health centres (for which the D.H.S.S. is providing cash). They have found that the plans for their district general hospitals have been delayed—an unhappy result of the coincident economic blizzard. In the teaching area, too, many plans have gone back into the melting pot—particularly the promise by the D.H.S.S. that all the hospitals in the university hospitals group (reorganized three years before reorganization to include all the Newcastle hospitals under the regional board) should be brought up to teaching hospital standard. The new Freeman Road district general hospital was an integral part of the old plan, but has not been financed as such.

Team Working

The A.M.O.s are, of course, key members of their area management teams (the D.M.T.s of single-district areas). No individual member dominated their A.M.T.s because these have emerged as teams, and their regular meetings have been particularly helpful while "working to contract" and other industrial actions have been going on. The A.M.T.s have been in no hurry to set up Health Care Planning Teams—only two have been established in North Tyneside, for family planning and geriatrics, and three teams in Gateshead—because they say that they do not want to raise expectations for schemes which cannot be paid for. Though the A.M.T.s can visit all N.H.S. establishments, including health centres (but not G.P. premises—which are covered by reference to the family practitioner committees), there have been no complaints that they are "snooping." The G.P. member of the A.M.T., who was elected by the local medical committee in North Tyneside, is a well-respected doctor who probably spends two to three sessions a week on the team as well as attending the A.M.C. and A.H.A. and taking part in informal discussions. But one hospital consultant, a

surgeon, has been able to spend only a year on the area management team, largely because of the time commitment that this takes and his consequent absence from clinical duties. At present the clinicians on the team are enthusiastic but their successors may be hard to find; nevertheless, all were agreed that "consensus management" was actually working.

Dr. Smith had no doubt that, as he had predicted, reorganization had given the G.P. a voice. At present he was one of nine doctors practising in accommodation built for three, and a long-awaited health centre had been lost on reorganization. But he had gone to the A.M.T. and put his case; in its turn, the A.M.T. had lobbied the local M.P.s, who had taken the problem to the Minister, who had given the health centre top priority. The G.P.s had been fully consulted about the plans, a better design had been worked out, and building was about to start. Dr. Smith would, however, have accepted any adverse decision from the A.M.T. if other practices or problems had been judged to have priority. What he had had was the chance to state his case. He was a member of the A.H.A. and was convinced that it must decide also on priorities between hospital and community. That was what reorganization was about and why it was working in these areas where this principle was being followed.

Too Many Committees

The dean's diary contained about five times as many functions as he could physically attend. And the same subjects, often trivial, were often discussed by the same people at many of them. The 18 committees that now had to consider a new registrar post was an example.[7] The hospital medical executive committee thrashed out hospital problems and then did it again at the area medical committee, where the G.P. members rarely had anything to add. The Regional Medical Committee and its specialist committees, a sort of super-Cogwheel, could not find a role because the regional manpower committee was doing the same thing. And anyway the area was the statutory body: the region could only advise. In addition, the committee structure was now resurrecting matters which had been disposed of years ago.

Other matters had undergone a three-year delay under the shadow of reorganization. For example, building sites—which had been a regional board responsibility—now came under the A.H.A.(T). This was all very frustrating. Before reorganization the dean had known what was going on in the region and in the hospitals and in the university. Now it was impossible to belong to all the levels. Professor Walton sat on the A.H.A., while the clinical sub-dean sat on the R.M.A. as a university nominee. The Faculty of Medicine was being asked to appoint additional deans so that the increasing load of administrative and committee work could be shared. Professor Walton was also on the M.R.C. and G.M.C., while other senior members of the staff were also heavily involved: the professor of anaesthetics, for example, was chairman of the hospital M.E.C. and chaired the A.M.C., spending over half his time on management. This sort of thing affected teaching, clinical duties, and services—for example, the professor of anaesthetic's duties would last for three years.

Though the three areas were single-district ones, the doctors I talked to doubted whether the region would in future have an effective role: it should be replaced by a committee from the A.H.A.s to talk about the distribution of specialized medical care and facilities throughout the region as a whole.

Local Politics

When the A.H.A.s had been set up, the four local authority representatives had started by behaving politically but this stopped very quickly. The A.H.A.s actually had to run the Service, and these members recognized that the major frustration was lack of finance. In fact, they had offered to help in lobbying for the new district general hospitals, since they knew the political ropes, and were free to go and talk directly to the Secretary of State. The Community Health Council (C.H.C.) was proving to be a forum in which 20 people could talk about health matters with greater freedom. Admittedly, one C.H.C. had passed a resolution condemning fluoridation (though their chairman was a world expert on the subject) and had passed it to the A.H.A.—which had voted against it, incidentally. Nevertheless, the C.H.C. possessed much specialized knowledge, such as from Age Concern and the W.R.V.S. and there was a great eagerness to learn. Relationships between the C.H.C.s and A.H.A.s are still in the exploratory stages.

The joint consultative committees (J.C.C.) between the A.H.A.s and the local authorities were "toothless wonders" at the moment, and true co-ordination took place between officers. The J.C.C. was not a decision-making body—decisions in the local authority sphere being made by the big spending committees, such as social services and education—but it might eventually be able to decide on the nature of the problems, for example, that an old people's home was needed rather than a geriatric hospital.

"We Shall Overcome"

Though not expressed, this sentiment seemed to summarize the forward-looking attitude of these varied, but determined representatives of the medical profession in Newcastle and Gateshead in 1975. The A.H.A.(T) is not easy to understand, and in general I found too many committees, too much confusion, too much "rethinking" with too little money, but no illusions, no ivory towers, and no arrogance towards non-medical health workers. Can they possibly be a representative sample—or indeed is there such a thing?

1 *British Medical Journal*, 1973, 2, 415.
2 *British Medical Journal*, 1973, 2, 478.
3 *British Medical Journal*, 1973, 2, 542.
4 *British Medical Journal*, 1973, 2, 603.
5 *British Medical Journal*, 1973, 2, 654.
6 *British Medical Journal*, 1973, 2, 709.
7 *British Medical Journal*, 1975, 1, 675.

King's College Hospital Medical School, London
W. F. WHIMSTER, M.R.C.P., M.R.C.PATH., Senior Lecturer in Pathology

Discussion

CHAIRMAN: Miss Lewis, could we begin by asking you how D.M.T.s work?

MISS JANET LEWIS[1]: The first year has been spent in running the Service, because of the absence of the planning cycle. The district was envisaged as the cornerstone of management, so it's not surprising that they're less frustrated about their job than the equivalent officials at area level. Even so, there were many complaints about control by the area: priorities put forward by those who knew local conditions—the D.M.T.—were rejected by the area and the region. Otherwise, the districts have retained much independence: some have declined to provide the area with all the statistics asked for, some have resisted visits to hospitals by area authorities (particularly the A.T.O.s), some have made area specialists attend health care planning teams by invitation only.

DR. G. COLEMAN[2]: Our D.M.T. recently analysed its perform-