SUPPLEMENT

NHS reorganisation

Getting down to units

ALAN BUSSEY

Most doctors will now be aware that a further reorganisation of the National Health Service is well under way. What may not have been widely appreciated is how fundamental are some of the changes envisaged and how complex their implementation is proving to be.

The main theme of reorganisation is unexceptionable and disarmingly simple—increased delegation of decision making to levels as near as possible to where the delivery of care occurs. All the structural changes now in progress are intended to serve that aim. Area health authorities (AHAs) have been abolished, member authorities have been created at district level, and new district management teams (DMTs) have been appointed. Attention is now focused on the next "tier" down—units and how they are to be defined and managed.

In the "laid-back" style of government that has become fashionable, the Department of Health and Social Security (DHSS) gave district health authorities (DHAs) little guidance and, therefore, theoretically wide discretion in devising their management structures. They were given a few examples in the relevant circular[1] and left to get on with it within the constraint of management cost limits.

Problems and difficulties

If the widely expressed wish for decentralisation of decision making is to be fulfilled DHAs need to get their units of management right. This task is much more complex than it may seem at first sight and is being completed in difficult circumstances. The first difficulty is time. DHAs began meeting in shadow form late in 1981 and set about appointing their new management teams at the turn of the year. For various reasons many authorities did not complete their teams for several weeks—indeed, some remain incomplete still. Moreover, some of the appointed officers were "running down" area organisations in parallel with "running up" new DHAs and could not devote their whole attention to the latter task until AHAs relinquished their statutory responsibilities on 1 April 1982.

Even without delays in the appointment of officers, whose advice on management structures was essential, authorities faced a daunting timetable. To comply with the requirement that "authorities should aim to have instituted arrangements meeting the Government's requirements no later than 12 months after being established,"[1] it proved necessary for regional health authorities (RHAs) to insist on the proposed management structures of their constituent districts being finalised and submitted by the spring or early summer of 1982. The intention was to enable DHAs to appoint their senior unit managers (unit administrators and directors of nursing services) through the mid-summer and autumn of 1982, leaving time to define and appoint to the lower echelons of unit management before the expiry of the allotted 12 months. This breathless haste has severely limited the time available to DHAs and their management teams for the essential prerequisite to success—thinking through and consulting on the complex questions and fundamental changes necessary.

These problems with time have been compounded by difficulties over lack of experience. Members of many authorities and some DMTs have as yet little experience of working together. In addition, several newly appointed members and, indeed, some DHA chairmen have no previous experience of the NHS. In the longer term the acquisition of these able people will undoubtedly prove a positive advantage by blowing some fresh air through our somewhat stale corridors. In the short term, however, these difficulties have sometimes complicated the immediate task of moving at speed from one fairly complex pattern of organisation to another.

A third group of problems has been associated with the management cost limit applied by the Government. The national target that has been set breaks down into quite widely different levels of cutback between regions. Below regional level the limits applied to DHAs have also varied with different formulae being used by individual RHAs. Furthermore, not only has the management cost ceiling come down on DHAs, but the floor has also come up as staff organisations have persuaded the Whitley Council to grade the new nursing, administrative, and finance posts at higher levels than many existing posts. At the same time, early retirement provisions have been agreed for staff aged over 50. The effect of the management cost ceiling combined with these agreements is likely to be fewer but more highly paid managerial posts, together with a loss of experienced managers. A more immediate effect has been that, because authorities could not finalise management arrangements without firm information on grades and therefore costs, the bargaining necessary in these agreements has put further pressure on the already tight timetable with which DHAs were faced.

Issues and questions

What does all this mean for doctors? Does any of it matter? The short answers are that it is likely to matter and mean a great deal over the next few months and years. There are several issues that are not simply material for arcane administrative games but which will affect patient care and the ability of doctors and others to deliver it.

The first issue is the composition of units in each DHA. Examples of the types of units that may be established are:

(*a*) A large single hospital.

(*b*) The community services of the district.

Maidstone Health Authority, Maidstone, Kent ME16 8JW
ALAN BUSSEY, MRCGP, FFCM, district medical officer

(c) Client-care services—for example, a mental illness hospital with psychiatric community services and possibly the psychiatric unit of a district general hospital. But larger client-care groups may need to be divided into two or more units, provided that there is adequate co-ordination between units.

(d) The maternity services of the district.

(e) An individual hospital, or group of hospitals, with the community services—that is, a "geographical" unit.

(f) A group of smaller hospitals.[1]

The choices facing each district were, therefore, broadly between institutional, geographical, or client group-based units or a mixture of these. But in the indecent haste with which these choices have had to be made it is doubtful whether many DHAs have also been able to formulate even an outline strategy for the development of their services. Consequently, instead of management structures being tailored to serve the authority's aims and objectives the reverse may well be the case. For example, it is possible that some authorities may have accepted an institutionally based set of units somewhat uncritically. Because of lack of time and of members' experience they may not have weighed the undoubted advantages of coherent identifiable hospital management sufficiently against the disadvantages of separation from the community services and primary care—the dilemma of integration that the 1974 reorganisation was intended to solve. When DHAs in this position come to address the problems of reallocation of resources between client groups or between hospital and community services they may find themselves handicapped by too great an emphasis on institution-based management.

A second issue of importance is the role of the DMT vis-à-vis the unit managers. The right relationship should enable the DMT to withdraw from operational management and take up the task of strategic management, which Maxwell[2] rightly points out has all too often been neglected in the past. But defining this relation raises further questions. One question relates to the rules to be applied by the DHA and DMT to the operations of unit management. The unit administrator and director of nursing services will report direct to the district administrator and chief nursing officer respectively. They will be held accountable to their superiors for several functions including certain budgets. What is not clear is how the senior member of the medical staff working in conjunction with them will influence budgeting and other decisions in these circumstances. Will the "troika" operate as a consensus team, or will the director of nursing services or unit administrator, whose job depends on satisfying his or her superior, be taking independent decisions with or without consultation with others?

Again, practices in relation to movement of money between budgets—virement*—require definition. What degree of freedom should unit managers have, say, to raid the nursing budget to buy medical equipment? And, given that almost all DHAs will have to fund any future development of services from savings generated in their own district, what policies are to be adopted over savings? Will a unit be allowed to keep and plough back all, some, or none of its planned savings? If it is to be the latter what incentive is there to save at all?

Yet another set of questions surrounds the planning activities of the DHA, the DMT, and the units. In the past planning has too often been equated with growth. The prospect for most DHAs now is standstill or contraction of real resources. The need for more not less careful planning in these circumstances requires better recognition and an organisational framework to achieve it.

Lastly, any uncertainty remaining over the role of the senior member of the medical staff concerned in unit management will need early resolution. Among the questions that arise in each district are whether sufficient volunteers will be forthcoming; the provision of locum cover and payment or both for this work; the relation of the medical members of unit managements with their constituency, with their counterparts on the DMT, and with the medical advisory machinery; and whether and how general practitioners will participate. It will be interesting to see how many English DHAs adopt the Welsh proposal for the automatic appointment of a general practitioner linkman to hospital units.[3]

All these questions and more have been raised recently by McQuillan,[4] Dyson,[5] and latterly in a King's Fund project paper.[2] None of these still, small voices pretended to have found universally applicable solutions. Nevertheless, I wonder with some anxiety whether their questions have been adequately considered, let alone answered, in each DHA in the helter skelter of the last few months.

*Authorised transference of a surplus to balance a deficit under another head.

References

1 Department of Health and Social Security. *Health service development: structure and management.* HC(80)8. London: DHSS, 1980.
2 King's Fund. *Unit management in context.* Project paper no 31. London: King's Fund Centre, 1982.
3 Welsh Office. *Health service development: medical advice and management.* WHC(82)2. Cardiff: Welsh Office, 1982.
4 McQuillan WJ. Unit management and doctors' participation. *Br Med J* 1981;**283**:802-4.
5 Dyson R. Units of management in reorganised NHS: What choice for senior medical staff? *Br Med J* 1982;**284**:762-4.

Vocational training: three-year mandatory course

The second phase in the introduction of mandatory vocational training for general practice came into operation on 16 August. In order to be admitted to a family practitioner committee list as a principal after that date a doctor must have completed three years' whole-time (or the equivalent part-time) vocational training for general practice or equivalent experience. Since February 1981 trainees have been required to work for one year in general practice before receiving a certificate of prescribed experience from the Joint Committee on Postgraduate Training for General Practice. The prescribed medical experience must be acquired within seven years immediately preceding the date that the would-be GP principal applies for a certificate.

The three-year period may be a special course of training arranged by, or in agreement with, a university in the United Kingdom. In practice these will normally be under the guidance of regional advisors in general practice and general practice subcommittees of regional postgraduate education committees. Doctors may arrange their own training to meet the criteria. A doctor must spend one year as a trainee GP, one year made up of two approved six-month posts in named specialties, and one year in a wider choice of approved jobs.

In brief . . .

SCHMS annual report

The annual report of the Scottish Committee for Hospital Medical Services for the year 1 April 1981 to 31 March 1982 is being sent to senior hospital doctors in Scotland. The report gives a full account of the activities of the SCHMS, which is chaired by Dr I A Davidson, a consultant anaesthetist in Edinburgh. Any doctor who has not received a copy should contact the BMA Scottish Office, 7 Drumsheugh Gardens, Edinburgh EH3 7QP.