Perspectives in NHS Management

Role of health authorities: deceptively simple?

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District and regional health authorities have the deceptively simple task of "managing the health services on behalf of the Secretary of State."¹ Deceptively simple because the massive National Health Service is among the most complex of organisations, perennially subject to budgetary and resource constraints and to professional and public pressures.

Advice from the Department of Health and Social Security acknowledges some of these constraints. District health authority members should "determine policies and priorities" and "devise a sensible formulation and application of policy to local conditions," but only within "national and regional guidelines."² Such advice retains the concept of a national service with equitable access and treatment facilities even though considerable geographical variations remain the reality.

Even the smallest authority is large scale, with a budget of £10 million and more than 1000 staff. Its plant includes hospitals, health centres, offices, stores, and nursing homes. Its services may be dominated by acute hospital expenditure, but it will be under pressure to develop geriatric and psychiatric facilities, community care, and preventive services. There are an awful lot of "priorities" in today's NHS.

The no longer deceptively simple but now rather daunting task of managing this monster falls constitutionally on part timers—the normally 16 district and 18 to 24 regional authority members. Only the (ministerially appointed) chairman is paid—over £7000, to reflect a commitment of about two days a week, though most put more time into the job than this. The rest, expected to devote "some 2-4 days a month, during and outside normal working hours," receive only their expenses, thus retaining the long standing British tradition of voluntary public service.² Members include a consultant, a general practitioner, a nurse, a trades unionist, and a university nominee, as well as four councillors and six generalists from a range of backgrounds.

Local councillors, in particular, often find health authority work difficult because they already have a busy schedule of committee and party meetings and they face an unfamiliar style of government in health authorities, which tend to operate as corporate entities rather than in the politicised adversarial style of local authorities.

The hierarchy of control downwards, from Secretary of State through region to district, is also one of accountability upwards. Subordinate authorities have to respect guidelines from above and work within the resources allocated to them (traditionally seen as money, but in practice including buildings and plant and—since 1983—manpower limits). They are accountable upwards through the planning system, under which quite detailed plans have regularly to be submitted, through budgetary control, and through the new system of regular re-

views, initiated by Mr Norman Fowler in 1982-3. These reviews focus on an analysis of performance indicators of each region and district, and targets are set at meetings of chairmen. The review system is still in its early stages, but its importance is already apparent. Never before have health authorities come under such regular and detailed scrutiny, and the potential for substantially increased central control over regions and for regional control over districts is apparent.

Plans, budgets, and reviews are by no means the only constraints on the freedom of action of health authorities. Pressures vary over time, between issues, and according to personalities. The authority is an amoeba-like body, absorbing pressures from different angles at different times (figure).

Constraints on health authorities.

Some of the constraints

Community health councils, the media, and pressure groups all seek to represent the views of consumers of the NHS, and they cannot easily be ignored. The rights of trades unionists and of professionals to be consulted are enshrined with the NHS administrative system through networks of advisory and consultative committees (such as the medical executive committee), which will be discussed in a later article in this series. In addition, the individual actions of doctors and other professionals—their diagnosis and treatment of a patient—clearly have spending and resource use implications. The largely open ended expenditure of, for example, general practitioners comes out of the total national budget for the NHS and so affects the amounts available for health authority services. Finally, the extent of local authority provision of social services may be a critical factor in determining whether or not community care is feasible: low levels of council provision may help to block beds and thwart community nursing staff.

Government pressure for reduced council spending has made cooperation between health and local authorities hard to achieve.

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Even "joint finance," under which NHS funds can be used to boost council services, has not proved entirely successful because jointly financed projects can be undertaken only when the local authority is prepared to agree to take over the financing after several years, and councillors are reluctant to mortgage their future.

Perhaps the greatest constraint on the freedom of action of the part time authority members is its team of senior officers (the regional team of officers; the district management teams). Constitutionally, this team is not the health authority, but it is appointed to manage the day to day activities of the authority and to advise and make proposals for policy changes and service developments. This gives the authority two roles: policy making and monitoring. A good team will normally give strategic advice that is acceptable to the authority, partly because it will inevitably anticipate the likely reactions to its proposals. But it is clearly "the responsibility of members to review and, where necessary, challenge" recommendations of the team.² Monitoring the officers means assessing the quality of services being provided. The authority will receive information in reports made to it by the officers, through visits, and by setting up working parties, review bodies, etc. In addition, receipt of complaints may also be seen as an aid to monitoring service quality—though admittedly crude in that complainants are clearly not a random sample of users.

Formidable looking agenda

The "model" is now complete and ready to be made operational through a case study. Like most health authorities, Bury has a monthly meeting that lasts about two and a half to three hours. The business to be transacted looks formidable in that the formal agenda characteristically contains 25 to 30 separate items, though a detailed study of one typical agenda shows that these vary in importance. Such a study also highlights the way in which the authority exercises its strategic and monitoring roles and responds to pressures placed on it.

The March 1983 agenda of Bury Health Authority was, as normal, in three parts—public items, at which the press and public were present (in practice few, if any, members of the public attend unless an issue such as abortion law reform is to be discussed); private items that will be in the formal minutes of the meeting; and an epitome of information, also private. The epitome consists of the minutes of various meetings of officers and staff, and is an important aspect of the monitoring role of the authority. In a premeeting session questions may be asked on any aspect of the activities of the district management team, nursing and midwifery committee, management staff committee, major medical committees, and the several health care planning teams responsible for policy advice in areas such as psychiatry, acute service, primary care, and geriatric services. Such questions invariably relate to day to day issues in that any major policy initiatives from this network of bodies would be on the main agenda of the authority.

The 28 items on the formal agenda spanned 116 pages of typescript: the effective member clearly needs to devote an hour or two to preparation for the meeting. Not all 28 items get discussed, for the agenda may be conveniently broken down into four categories, of which the first consists of procedural matters. These covered no fewer than 10 items including the receipt of apologies for absence, approval of minutes of the previous meeting, lists of gifts and donations, date of next meeting, and a statutory resolution to exclude the press and public when the confidential items were reached.

Monitoring, reacting, and making policy

It is the remaining 18 substantive items that were interesting. They may be classified under three heads: monitoring service provision (six), reacting to higher authorities (seven), and

making policy (five). In its monitoring role the authority received routine statistics on bed occupancy and throughput, outpatient attendances and waiting times, day care attendances, and the waiting list for inpatient admission. As a result of an earlier decision the latter gave brief (anonymous) details of cases where the waiting time had exceeded two years. Other monitoring reports included monthly updates on spending levels and the state of the budget, and on any delays to, or changes in estimated costs of, capital schemes. Another report gave changes among senior staff (in medical cases down to registrar level). Finally, written and verbal reports on members' visits were received, and one paragraph summaries of complaints and the action taken were tabled. On visits, the authority breaks into five three member panels and this leads to 30 visits being made each year. In addition, each long stay ward has a member assigned to it who is asked to visit at least monthly. Complaints number around 100 a year, so the typical agenda includes details of about 10, ranging from alleged medical mistreatment to loss of personal items, delays in being attended to, and so on. Justifiable complaints do lead to changes of procedure and improvements in services.

The seven "reacting" items varied in the attention that they received at the meeting. Guidelines from the DHSS on the prevention of harm to patients due to staff disabilities and on developing services for mental illness in old age were, for example, quickly referred to the relevant officers. DHSS press releases were merely noted. Two substantial items did take time, however. Firstly, the authority received a recently completed report from the Health Advisory Service. A preliminary discussion on some of its several dozen recommendations took place, and officers were asked to provide detailed responses at a future meeting. Secondly, the regional review was received and considered.

The 22 page review documents from the regional health authority outlined an action plan of matters on which the Bury Health Authority was expected to respond over the coming months. Several of those matters were important—reducing the number of beds in some specialties, examining unit costs to find so called "efficiency savings," targets for improvements in throughput of hospital beds, for preventive services, and for more intensive use of outpatient clinics and day care facilities, manpower targets, and proposals to develop priority services, such as local facilities for the mentally handicapped. Such pressure has never before been placed on health authorities, and the consequences for medical staff are apparent. Their activities are being placed under increasing scrutiny and, when criticism is implied, this may cause resentment. Presumably, doctors will understand that these new pressures are not of the authority's own making, and that the way forward is to work positively with the district rather than to take a negative stance. After all, authorities have no option but to respond to the review, and it is clear already that penalties could be incurred if the response is not positive: higher authorities have sanctions at their disposal and seem increasingly likely to use them.

Our final category—making policy—embraced five items. Two—a plan for computerisation and a decision about a surplus building—were non-controversial. How best to organise the cervical cytology recall scheme when the central service was discontinued also took little time. The block allocation—how best to spend the £ $\frac{1}{3}$ million given to the authority for small capital items (medical equipment, vehicle replacement, upgrading of wards and dayrooms, and so forth)—took longer. A rolling programme reduced the problem of deciding, and only new items were at issue. The last item of policy was whether to transfer laundry services to a private contractor, not at the DHSS's request (at that time national policy on privatisation was only just getting off the ground) but because of dissatisfaction with the laundry service being provided by neighbouring health authorities (Bury had no laundry of its own).

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of all grades, with a consultant to junior ratio of over 2:1 and a fairly modest reduction (22 to 36) in the number of junior posts needed.

In paediatrics and psychiatry the considerable consultant expansion envisaged, combined with the demands of vocational training for general practice, would result in a need for at least as many junior posts as now exist, but with a distribution shifted towards senior registrar posts. The total number of staff would rise greatly, especially in psychiatry.

The desired consultant expansion in obstetrics and gynaecology would seem to be lower (49%) than in the specialties so far discussed. It would imply a need for junior staff considerably below the existing establishment, even when general practitioner vocational training requirements are taken into account. In fact, the total number of staff available in the specialty on this basis would be 10 to 17 below the present establishment, depending on times spent by doctors in training posts. If 38 to 45 junior posts were made available in the region for trainees from overseas intending to return home there would be a small increase in the regional total of staff in the specialty, and the overall number of junior posts would remain the same. Within this total, however, it would be necessary to establish about 12 additional senior registrar posts to achieve regional self sufficiency.

The most striking positions are in the medical and surgical specialties.

General medicine is aggregated with chest medicine, nephrology, dermatology, neurology, clinical neurophysiology, cardiology, rheumatology, genitourinary medicine, and geriatric medicine because of the common needs for training, particularly at the junior levels. With an expected 49% consultant expansion in these specialties taken together and even allowing for the posts used for general practitioner vocational training a gross "excess" of 87 to 104 junior posts would occur. This is entirely in the senior house officer grade, since the regional "surplus" of about 20 registrars would almost exactly balance the regional "shortage" of senior registrar posts. Various assumptions may be made about how "surplus" senior house officer posts in medicine might be used—for instance, to provide an important element of "general professional training" for doctors wishing to specialise in psychiatry, anaesthetics, radiology, radiotherapy, community medicine, haematology, etc. Such usage would have much to recommend it on educational grounds, and in one way or another a good deal already occurs. It would imply either a need for fewer training posts in the specialties concerned or an increase in the total length of training for those specialties. Even making generous allowance for the development of general professional training along these lines, there would still

seem to be heavy dependence on the senior house officer grade for service rather than for training purposes in the medical specialties. Twenty to 40 senior house officer posts added for general professional training purposes, however, and a similar number of extra senior house officer posts for overseas trainees would still create only a modest growth in the total work force in the medical specialties.

On the surgical side, when general surgery, urology, orthopaedics, accident and emergency, ear, nose, and throat, ophthalmology, neurosurgery, and plastic, paediatric, and cardiothoracic surgery are aggregated, there is an even larger "surplus" of senior house officer posts (146 to 167). This position, with a 52% consultant expansion, would result in a fall in the total number of staff or, alternatively, an opportunity to offer training to 40 to 60 additional juniors from abroad while still achieving a consultant to junior ratio above 1. The aggregation, however, conceals large differences between surgical specialties in existing consultant to junior ratios.

Discussion

Perhaps the most obvious limitation of this study is that it concerns only one region. The concept of regional self sufficiency is necessarily somewhat artificial, but if other regions were to work out plans on a similar basis it should then be possible to construct a total picture and see to what extent the current distribution of senior registrar posts is out of balance with regional needs for recruitment. It is suggested not that movement between regions should be restricted or inhibited, but that a better balance of posts would be in the interests of all concerned.

Second thoughts, and corrections, will no doubt be applied to the suggestions from districts regarding numbers of consultants desired or needed. These requirements for additional consultants were not coupled with an expressed willingness to give up junior staff, except in one case; but in many specialties the indications are that little or no reduction in juniors would actually be appropriate. Individual subspecialties need further analysis in detail.

The calculations in this paper allow for 10% "wastage" at the senior house officer and registrar levels, and 5% at the senior registrar level. This would take some account of doctors who change from one career choice to another, but more transfers than this would require further estimation of how much the flows in different directions were likely to cancel out. Much would depend on the extent to which a change of career made it necessary for the total duration of postgraduate training to be prolonged, and this emphasises the need for further discussion about "general profes-

sional training" as well as tolerance between specialties in the acceptance of extraneous experience.

No detailed consideration has been given to training for overseas doctors, but the differing extent to which they might be accommodated in various specialties can be inferred from the table. In the specialties that have caused the greatest amount of recent discussion about the career structure—medicine, surgery, and obstetrics and gynaecology—the indication from this regional study is that it would be possible to achieve a 50% consultant expansion, with good promotion prospects for trainees and with a consultant to junior ratio greater than 1, while still allowing scope for the acceptance of some trainees from overseas and without increasing the total number of doctors working in the specialty. Further thought would obviously need to be given to more detailed questions, such as how on call rotas might be arranged in these circumstances. In pathology, radiology, paediatrics, and psychiatry there would seem to be no spare capacity to accommodate overseas trainees if a large consultant expansion were to be achieved. This is particularly notable in pathology, where the effect of a low initial ratio of junior staff combines with large consultant demands resulting from increasing separation of the pathology specialties.

The lengths of postgraduate training predicted in these analyses, ranging from eight to nine years in the senior house officer, registrar, and senior registrar grades, do not represent an unreasonable average and might indeed be construed as a slightly pessimistic view of the future.

Recent activities concerned with revenue reductions and manpower targets have temporarily distracted attention, particularly at regional level, from the main theme of service development and its manpower implications. What is now needed is a clear reaffirmation of strategic intentions—particularly in relation to the consultant expansion programme—in order to refocus activity on the adjustment of numbers of training posts, and ratios, and to balance the effects of this against service provision. Ingenuity is also required to unlock some of the available resources from within which the fuel for consultant expansion must be found.

References

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(Accepted 15 May 1984)

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Our study of a typical month's activities has shown the complexity of the NHS and the great range of issues facing health authorities. Though each authority behaves differently in detail, all found the pace hectic in 1983. All experienced increased pressure, through the regional reviews, the specific manpower targets of late summer, and the winter instruction to privatise support services. The pace seems unlikely to slacken in 1984—or beyond. Deceptively simple?

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This is the seventh in the series of articles on NHS administration and management, which started on 28 April.