Perspectives in NHS Management

Professional advice to the National Health Service—the medium or the message?

ALAN BUSSEY

The 1982 reorganisation triggered a reconsideration of ways in which professional advice could best be given to the NHS.^{1,2} The inheritance was a complex, layered set of committees for each profession, which was widely regarded—especially by doctors—as time consuming and ineffective. The intention was, in the words of the then Secretary of State, “that an authority should be able to obtain adequate advice when it needs it and in a suitable form. And, second, the profession concerned should have the absolute right to give advice when necessary, to be consulted on professional matters involving them, and to be satisfied that their advice is appropriately considered.”³ The outcome some two years after reorganisation looks something of a curate’s egg, only partly achieving these aims.

While acknowledging that professional advice from disciplines other than medicine is both required by and provided to authorities, doctors are understandably preoccupied by ways in which *they* may be consulted and may tender advice. They are, if anything, even more concerned over whether their advice is taken. In this connection, the profession has possibly seemed too arrogant in its approach in the past—assuming that medical advice is always more important than advice from others; that all medical advice by its very nature and source is both right and always in the interests of patients; and that for these reasons alone it should never be disregarded.

Many doctors do not see the picture that is presented to authorities and to the public more frequently than is good for the credibility of the profession. Intelligent, dispassionate members of authorities or of the general public are looking for balanced, considered medical views. On many occasions, of course, that is precisely what they get, but on others they are given a confused and confusing mixture. The ingredients are, in varying proportions, good solid technical or professional material; anecdotal evidence and unsubstantiated impressions—“in my clinical experience”; and medicopolitics ranging from national or specialty attitudes through intraregional infighting to local opposition to change. Add to all this a laudable but occasionally ill advised tendency to support doctors in other specialties, not because of the soundness of their case but simply because they are colleagues, and it is perhaps remarkable that medical advice is taken as often as it is.

Part of the problem is the need for the profession to distinguish more clearly than it has done between the content of its advice and the machinery for collation and delivery—between the message and the medium, if you like. With hindsight it may be that, through the 1974 and 1982 reorganisations, too much attention was concentrated on the mechanics and too little on the content.

The machinery

While it is often difficult to disentangle professional advice on medical issues from medicopolitical and negotiating activity, each does have separate machinery. The latter activities are effected through craft committees with representatives negotiating by craft or collectively with the Department of Health and Social Security and the review body. These channels will not be considered further here.

So far as advice on medical issues is concerned, in England this is tendered to the National Health Service at three main levels—national, regional, and district. At national level the Secretary of State has the Chief Medical Officer and his staff of medical officers recruited from a variety of specialties to provide a continuing source of in house advice. Secondly, the DHSS relies on a large number of committees providing expert advice on a wide range of subjects. Some are standing committees while others have a limited life—called together to tackle a particular problem and disbanded after submitting a report. Both kinds of committees contain practising members of relevant specialties selected for their special knowledge, skill, and experience. The distillate of their deliberations frequently forms the basis of government policy or of DHSS guidance to the NHS on a particular medical issue. Still at national level, a further source is, of course, advice that is volunteered rather than commissioned. Examples of this are the series of reports on smoking from the Royal College of Physicians, and the report of the board of science and education of the BMA on nuclear war.⁴

REGIONAL LEVEL

Those aspects of regional health authority work that require medical advice were clearly identified by the joint working group on regional management arrangements.²

These are:

- (a) long term planning of health care services, including the preparation of planning guidelines with particular concern for the ways in which changes in clinical practice affect the distribution of resources;
- (b) the arrangements for supraregional clinical services;
- (c) the need and arrangements for regional and subregional services;
- (d) the allocation of revenue and capital moneys between health authorities;
- (e) setting of priorities for major capital investment in buildings and equipment;
- (f) the deployment of hospital medical and dental manpower, including changes in clinical practice, the development of clinical services, the provision of training, and the maintenance of a career structure;
- (g) the provision of appropriate resources for undergraduate teaching and research;
- (h) the encouragement of clinical and health services research;

Maidstone Health Authority, Preston Hall Hospital, Maidstone ME20 7NJ

ALAN BUSSEY, MRCP, FRCGP, district medical officer

(i) the development of policy for the provision of postgraduate medical and dental education; and

(j) the provision of a careers advisory service for doctors throughout the service.

In the arrangements for providing this advice the same three threads—in house, commissioned, and volunteered advice—are discernible. Each of the 14 regional health authorities has access to in house advice from the regional medical officer and his community physician colleagues on the staff of the authority. In addition, medically qualified members of regional health authorities provide another source that is partly within and partly outside the organisation. The main avenue of external advice is or should be, the regional medical advisory committee supported by the regional manpower committee and the regional postgraduate medical education committee.

The joint working group acknowledged that the structure of these committees was complex and costly. They found that the membership of regional medical advisory committees varied from 25 in one region to 50 in another. Infrastructures also varied greatly, with specialty subcommittees ranging in number from nine to 25; widely different arrangements for including general practitioners; and some differences in representation of districts as opposed to specialties. Recommendations for simplification were made by the joint working group, but information on membership provided by 11 of the 14 English regional medical advisory committees, who replied to an inquiry in late 1983, showed that total membership still ranged from 25 to 45, with the infrastructures remaining complex and variable (J M Forsythe, personal communication).

DISTRICT LEVEL

In formulating proposals for advisory machinery to district health authorities the joint working group identified a requirement for the following two main types of advice¹:

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

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

Experience has shown that this list could usefully be revised and clarified as follows (D A Perkins, personal communication).

(i) Advice regarding the balance and operation of services within the district.

(ii) Advice regarding the main medical priorities for service development (including medical manpower planning) within the district in the long and short term, and the way in which resources should be allocated.

(iii) Advice regarding the coordination of services to patients provided by different sections of the health services, and by other services.

(iv) Specialist advice relating to the development of particular services within the district in the long and short term.

There was also uncertainty in the joint working group report about the precise machinery required to provide this advice at either district or unit level. This was no doubt partly because of wide variations in existing customs and practices between one district and another. Also, while it is again possible to see channels for in house, commissioned, and volunteered advice, the basic framework shared by all districts differs in some important respects from that at regional and national level.

For example, while the district health authority has available in house advice from the district medical officer and other qualified members sitting on the authority, an additional dimension is introduced through the consultant and general practitioner members of the district management team. Further complication is introduced by the presence of a consultant, general practitioner, or, occasionally, community physician on each of the authority's unit management teams. And to complete the mosaic, a district medical committee embracing all specialties exists and attracts formal recognition in many district health

authorities, while in others separate committees for hospital doctors and general practitioners channel advice through their district management team counterpart.

Does it work?

Curiously, for a science based profession, this question does not seem to have been addressed other than in very general terms, relying on the impressions of doctors and, to a lesser degree, those they advise rather than on objective assessment. The structural changes recommended by the joint working group do not seem to have been influenced by any systematic examination of function—for example, the topics and issues that the machinery has processed; the information supplied as well as that needed by both the donors and the recipients of advice; and the kind and quality of decisions taken as a result of it. Fortunately, a study of this kind is now under way supported jointly by the King's Fund and the South East Thames Regional Health Authority (D A Perkins, personal communication).

Some positive aspects as well as some problems are already evident, however. At national level much of the advice given by expert committees is highly valued internationally, let alone nationally. A great deal of the advice volunteered by the medical learned bodies is of equal repute. Moreover, it may well be that advice at this level will be translated into action more effectively now that it is presumably to be given to the Griffiths style health services supervisory board and to its subordinate management board.⁵

At regional level problems still seem to predominate. Conflict frequently exists between in house and external advice and occasionally between the respective advisers. Moreover, while the joint working group made proposals for simplification of regional medical advisory committees largely at the request of the profession, the evidence suggests that many of these committees have changed little in response. No doubt this is partly because specialty and district representatives are unable or unwilling to agree to be represented by others. The danger remains that the purpose, quality, and content of the advice may be lost in the scramble for a place at the microphone.

Nor are the uneasy relationships at regional level solely the fault of the profession. How many regional health authorities have actively sought advice on each relevant topic in the *early or formative stages of policy* as opposed to asking for comments on documents that are virtually a *fait accompli*? How often are specialty subcommittees invited to prepare a strategy themselves rather than provide a token member for a working party? And how often have regional treasurers or regional teams of officers, which contain no clinicians, discussed with clinical representatives the detail of the Resource Allocation Working Party allocations⁶ and their effect on the planning and operation of clinical services before submitting proposals to their regional health authority?

At district level authorities generally have three main sources of advice: medical members of the district health authority—general practitioner, consultant, and university representative; medical members of the district management team—general practitioner, consultant, and district medical officer; and a district medical committee or, where none exists, a constituency of general practitioners and another of consultants. Clearly, when these sources agree on a course of action the district health authority can proceed with confidence. The multiplicity of these sources, however, and the potential for honest disagreement between them is considerable. Here there is a lack of clarity in relation to the different roles of the medical members of district health authorities and district management teams in terms of who should finally guide authority thinking.

In contrast with regional and national levels, the presence at district level of clinicians on management teams does ensure that

continued on page 206

BMA warns clinicians on Griffiths

In a letter to clinical members of district management teams about the government's circular¹ on implementing the NHS management inquiry² the chairmen of the Central Committee for Hospital Medical Services and the General Medical Services Committee have warned that the medical profession must take "swift and positive action to ensure that the interests of clinicians are fully safeguarded."

In their letter Dr M M Burrows and Dr J G Ball state:

"The DHSS circular on the implementation of the proposals of the Griffiths inquiry team is of the greatest significance to the medical profession. The circular was issued on 4 June. It requires health authorities to take action to appoint general managers at regional level without delay, and thereafter at district and unit level, the whole exercise to be complete by the end of 1985.

"It appears that many districts and units may appoint managers at an earlier date than originally envisaged. Your role as a clinical member of the district management team, is of vital importance during the next weeks and months in agreeing the job descriptions for managers at district and unit level and in ensuring that the prospective candidates command the confidence of your colleagues.

"The circular lays great emphasis on the importance of the involvement of clinicians in management and makes clear the primary objective must be to achieve changes at unit level.

"Consultation is now over. The BMA's council executive recognises that with the issue of the circular the government has now committed itself to the concept of general managers

in the NHS. The medical profession must therefore take swift and positive action to ensure that the interests of clinicians are fully safeguarded in the new management structures which are about to be created. Clinicians must be prepared to accept the role of general manager, especially at this level.

"The following resolution of CCHMS has been endorsed by the BMA's annual representative meeting. 'This meeting asks council to consider as a matter of urgency the implications of the health circular concerning the NHS management inquiry and to issue guidance to the profession. In the meantime, doctors are advised to take an active role in the general management function at unit, district, and regional level, pending further guidance from council.'

"A working group set up by the council executive has already started work and negotiations have been opened with the Department of Health and Social Security on the remuneration of clinicians appointed as general managers, and the contractual implications for clinicians taking on management responsibilities including distinction awards, superannuation, and the provision of clinical cover. Further guidance from the BMA will be issued when these negotiations have been completed.

"Meanwhile the following points require your attention as:

"You must be consulted on, and give assent to, the job descriptions for managers at district and unit.

"You must ensure that the prospective manager has the confidence of your clinical colleagues.

"We place great importance upon the continuation of the role of management teams, particularly the district management team. We welcome the emphasis laid by the circular on the fact that the general manager must have 'the ability to command the confidence of the representative members of the management team.'

"We will be seeking further clarification from the DHSS on the definition of the 'general management function.' There must be a clear distinction between management responsibility

at unit, for which there will be accountability to a district general manager, and the clinical role, for which clinicians have professional responsibility as individuals.

"We are concerned over the future role of regional medical officers who at present enjoy the support and confidence of clinicians. Where the regional medical officer is not appointed as general manager, it is feared that the position of the regional medical officer could be undermined. We hope that consultants will preserve the existing valuable relationship between senior medical staff and regional medical officers by insisting that their access to the authority on clinical matters is through the regional medical officer rather than through the general manager."

¹ NHS Management Inquiry. Report. London: DHSS, 1983. (Griffiths report.)

² Department of Health and Social Security. *Health services management. Implementation of the NHS management inquiry report.* London: DHSS, 1984. (HC(84)13.)

"BMA Handbook for Trainee Doctors in General Practice"

The BMA has produced the second edition of the *Handbook for Trainee Doctors in General Practice*, which is being sent free to all trainee general practitioners who are members of the association. The handbook covers all aspects of the terms of service of trainees in the NHS. There are chapters on vocational training regulations, entry into general practice, partnership agreements, maternity leave, postgraduate education, taxation, and house purchase. There is a recommended model trainee contract and explanatory sections on the General Medical Services Committee, the Medical Practices Committee, family practitioner committees, and local medical committees. Health authorities and family practitioner committees may obtain copies of the handbook from the BMA, price £4.

Professional advice to the NHS—continued from page 205

a clinical voice is heard early. But the dilemma of clinicians on these teams may be acute in terms of whether their role and consequently their advice is in house—that is, as part of management—or stems from outside the organisation—that is, from their constituency. Steering between the Scylla of management and financial imperatives and the Charybdis of the views of your consultant or general practitioner colleagues is a perilous, difficult, and time consuming business. Insufficient credit has been given by authorities or colleagues to the 400 or so clinicians who man the consultant and general practitioner posts on district management teams and the much greater number who now serve on unit teams.

When Griffiths comes to pass and general managers are established in units and at district level, further changes will inevitably occur. The essence of the general management function is its generality, and it follows that general managers will require more not less expert advice. This in turn points to a need, not so much for further strengthening of medical advisory machinery but for simplification and clarification of the channels and, crucially, greater clarity of content.

Experience so far suggests that one thing is certain—neither the medium nor the message is right yet. If medical advice is to be effective for both sides we should perhaps reflect that, while "being there" is important, the quality and content of what we say when we are there is no less so.

References

- ¹ Department of Health and Social Security. Medical advisory machinery in the reorganised NHS. Report by joint working group on district management arrangements. *Br Med J* 1981;282:239-42.
- ² Department of Health and Social Security. Medical advisory machinery in the reorganised NHS. Report by joint working party on regional management arrangements. *Br Med J* 1982;284:64-7.
- ³ Department of Health and Social Security. *Professional advisory machinery.* London: DHSS, 1982. (HC(82)1.)
- ⁴ British Medical Association. *The medical effects of nuclear war.* London: Wiley, 1983.
- ⁵ Department of Health and Social Security. *Health Services management. Implementation of the NHS management inquiry report.* London: DHSS, 1984. (HC(84)13.)
- ⁶ Department of Health and Social Security. *Sharing resources for health in England: report of the resource allocation working party.* London: HMSO, 1976.

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