SUPPLEMENT

TALKING POINT

Unit management and doctors’ participation

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The report of the Royal Commission indicated that the job of the hospital administrator at unit and sector level should be expanded. Patients First endorsed this recommendation and emphasised the importance for doctors and nurses to become concerned in management activities. It advised maximum delegation to hospital and community services level. Circular HC(80)8 recommends district health authorities (DHAs) to arrange their services below the district management team (DMT) into units of management.

Range of units

There can be as many units as the authority considers appropriate, but these will be the only tier of management below the DMT. With some exceptions, the units should be smaller than existing sectors and nursing divisions. Examples of the types of units that are to be established include a large hospital or group of smaller hospitals with, in some cases, associated community services, such as those hospitals providing services for special patient care groups—for example, mental illness or mental handicap or those for the elderly or for children. A group of services—for example, hotel or laundry services—might constitute a unit. The numbers and sizes of the units will vary greatly as will the arrangements; if, for instance, there is more than one district general hospital (DGH) in a district one may manage both or alternatively there may be a team for each one, a decision that will be left to each district. For operational management to be effective there will need to be close participation in the day-to-day running of a busy hospital and a degree of commitment to that task that may be difficult to achieve by a team with responsibility for two or more DGHs.

Whether the management team of a DGH also looks after a hospital(s), other than a DGH, in a district will probably depend on the size of the other hospital(s)—that is, number of beds, their relationship to the DGH, and the kind of service provided. One example might be where a separate psychiatric hospital in a district would, as indicated in HC(80)8, be best managed by a separate team, especially if it serves more than one district. Again, if there is a separate hospital for the elderly, for children, for orthopaedics, or for other specialised services, then it may be considered appropriate that each one should have a separate management team, particularly if responsibility for the associated community services is included in the team’s remit.

If a separate hospital exists that does not provide a specialised service, but where there is regular and substantial interchange of patients and medical staff with the DGH, it may be reasonable to ask the same team to manage both hospitals. These decisions are likely to be influenced by the need to balance what is desirable organisationally against what is feasible within the financial constraints imposed by the management costs exercise.

Each unit will be managed by a team comprising an administrator and a nurse, both of appropriate seniority and accountable to the district administrator and district nurse, respectively, together with a senior member of the medical staff. Originally the only guidance available concerning the choice and task of the medical member of the team, whose contribution will be critical in determining its effectiveness, implied that there would be a single doctor as a team member. But the recent reports of the working parties on medical advisory and representative machinery in England and Wales have altered this concept by implying that more than one doctor will be concerned in the work of the team. The Welsh Report considers it unlikely that a single “spokesman” would be able to cover the whole field of medical opinion. The English Report at first refers to medical representatives on a unit group but then favours a single consultant or a unit team for a DGH. Later on it states that “one or more” doctors should be elected to the unit group responsible for community services.

Why a DGH team can apparently function with one doctor while a community services team may need more than one is not made clear in the reports, nor indeed is it made clear why it is thought necessary to have more than one doctor on a unit team. Doctors who are elected representatives of medical staff on teams and committees have special problems, but whether these will be eased by including more than one on unit teams is doubtful. Authorities are unlikely to consider it a sufficient reason for including more than one doctor on a unit team and will doubtless take into account the likelihood of an unfavourable reaction from other disciplines. In any event, a competent medical representative who seeks opinion among his clinical colleagues should be capable of adequately representing medical views. Perhaps the answer lies in adapting the suggestion of identifying “spokesmen” for certain groups who may be consulted at short notice by the “permanent” member of the unit team or who should attend by invitation—an arrangement that could also be extended to representatives from other disciplines.

This small team will have a major task in the management of the new Health Service. Its establishment introduces a new concept; even before 1974 there was no formal recognition of the group secretary, matron, and chairman of the medical advisory or medical staff committee (MAC or MSC) as a team. In addition, the authority and responsibilities of the hospital management committees were much more limited than those of the DHAs. To function effectively, members of the team must have good working relationships and the individual jobs and responsibilities of each, in addition to their corporate responsibility, must be clearly defined and understood.

Unit team

Circular HC(80)8 recommends authorities to ensure maximum delegation of decision making to unit teams. This should include those decisions relating to the unit currently taken by the DMT. The management and co-ordination of the activities of the different parts of the unit will mean a considerable amount of work. It will include the management of resources allocated, and, as staffing costs account...
Implications for the medical profession

The nurse and the administrator will have executive functions and will be personally responsible for the management of certain services and for supervising large numbers of staff, though there is concern that this could result "in unmanageable spans of control." The job of the administrator has been characterised as a "deep" one, and that of the nurse seems to be a "normal" one. But the first medical members of unit teams will be taking on new responsibilities and tasks that have not yet been explored. The medical member will share in the team's corporate responsibility and decision making but his individual responsibilities are not yet clear. Will he, like the administrator and nurse, have any executive functions and will he supervise any staff other than those immediately accountable to him for the care of his own patients? What will be his responsibilities in relation to planning? What will be his function in the medical advisory machinery, and what will be his relationship to other doctors and to other staff?

It seems that his executive responsibilities will be limited and he will not, for example, manage medical staff other than those junior staff immediately responsible to him. He will not, therefore, be in a comparable position to his counterparts in North America, who have moved partly or completely from the clinical sphere to assume managerial functions that include executive responsibilities. In addition, his task will not be made any easier by the fragmentation of the administrative work of doctors that has been so obvious since 1974.

In the preparation of plans he will have certain responsibilities whether or not he chooses to participate actively in the various planning teams. If he is chairman of the MAC or MSC he will retain his existing responsibilities in service planning. As a non-chairman his job is less clear, though he will have an important part to play both as an individual member of his own specialty and also as a member of the unit team. If he is chairman of the MAC or MSC his responsibilities in medical manpower planning are unlikely to change but, even if he is not, he will play an important part because of the team's corporate responsibility for manpower planning for the unit. In medical personnel work, however, as at present, his task is far less clear and needs to be more clearly defined, as his two colleagues on the team will inevitably expect him to take the lead in raising issues on this subject with medical staff.

His function in the medical advisory machinery will depend on whether he is chairman of the MAC or MSC. If he is he will be responsible for ensuring that the advisory machinery operates effectively. He must liaise with the "spokesman" chosen to represent general practitioners and if the committee is unable to offer clear advice it will be his responsibility to advise the unit teams as he considers appropriate. If he is not the chairman he will have to liaise closely with the chairman of this committee and will have to interpret medical advice for the team. Problems may arise between the medical authorities in respect of formal medical advice or when agreement is impossible because the views of the administrator and nurse differ from those of the medical staff.

As to his relationship with other medical staff, the Welsh document refers to the need to select "spokesmen" able to take urgent decisions on their behalf. This probably applies more to members of unit teams than to DMTs. These representatives should seek to involve their colleagues and familiarise themselves with their problems by meeting them regularly and keeping them informed of the problems and decisions of the unit teams. Establishing good working relationships with the other doctors in management teams is equally important in order to avoid, if at all possible, conflicting advice for the different teams.

Relations with non-medical staff will also be important. Doctors, particularly in hospitals, play a key part in establishing the atmosphere and "feel" of a hospital. Those on unit teams both for hospitals and for community services would probably do well to remember that time and energy spent in establishing good relationships with non-medical staff will pay dividends. A particularly sensitive area concerns the relationship with the professions supplementary to medicine. Decisions regarding the management arrangements for these and certain other services are to be left to individual health authorities. Bearing in mind
that functional management above unit level is to cease, it is not clear to whom the heads of these professions are to be accountable. Any suggestion, however, that the medical member of the unit team should manage any of these professions will probably be firmly rejected.

CHOOSING THE MEDICAL REPRESENTATIVE

The choice of a medical representative will play an important part in determining the success of a unit team. It has been recommended that representatives should be chosen by the doctors working in a unit. Whether this is to be done at unit or at district level is a matter for decision within each district as, indeed, is the question of whether hospital and general practice representatives are chosen separately by their respective peers. In some districts, for instance, the chairman of the MAC or MSC may automatically become the medical member of the unit team for a DGH, while in others he may become a member of the DMT.

To ask him, however, to be a member of both teams could mean that he would have insufficient time for his clinical duties. A consultant other than the chairman could be chosen as a member of the unit team, but there is much to be said for the chairman of the MAC or MSC becoming a member of the unit team, while another consultant is chosen as the representative on the DMT. Such a unit team, with its members having a well-recognised and accepted authority in the unit, should prove to be effective. A general practitioner chosen to be a member of the unit team would presumably be elected by the local medical committee or perhaps even the division of general practice. Whichever arrangement is chosen for consultants or general practitioners, the medical member will need to display a considerable degree of commitment in order to provide a balance to the two other members of the team, both of whom will be devoting their energies whole time to carrying out their management responsibilities.

Though the participation of general practitioners in unit teams has been emphasised, the extent to which they are to be concerned in unit teams for hospitals has not been made clear. Activities in hospital units are likely to have an effect on the work of general practitioners as well as of consultants, though this will vary according to the degree of participation. Perhaps the method suggested earlier of identifying a “spokesman” who can be consulted at short notice is a possible solution.

Neither report on advisory machinery contains any useful guidance on the selection of the medical member on the unit team for community services. The English report recommends that “one or more doctors” (consultant, general practitioner, community health doctor) should be elected to a unit team, though election would not seem an appropriate method of selecting a clinical medical officer because of his relationship to the district medical officer. Uncertainty about units for community services tends to reinforce the view that a hospital and the associated community services should be included in the remit of one unit team whenever possible. Conflict between the hospital and the community services may arise less often in such an arrangement, and when it does the motivation to resolve it is likely to be greater. Medical representation should certainly be an easier task, particularly when the arrangement is based on patient care groups.

There are no references to a function for community physicians in unit management in either the English or the Nodder report. The Welsh report differs in making it clear that “a named community physician” must take a particular interest in “a unit team’s activities,” be “involved” in the unit managers’ decisions, and be “available” to attend meetings. It is not clear what is meant by “involved,” but a community physician’s appreciation of the needs of the whole community and his ability to evaluate the current NHS practice should also lead to more effective use of available resources.

Conclusion

The task of unit teams will be challenging. It is likely, therefore, to attract administrators and nurse managers of high calibre and it is hoped that doctors will respond by choosing representatives who have the qualities and the will to make a success of what, for them, is likely to be a difficult but potentially rewarding activity. Acceptance of the job will lead to more doctors becoming concerned in management team decisions and this could have substantial benefits for the NHS. Adequate opportunities for training doctors for this new task should be provided.

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References


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Buying added years

A new booklet, produced by the Superannuation Division of the BMA, urges doctors to purchase added years now. A new scheme, which will be introduced in 1982, will allow members of the NHS Superannuation Scheme to purchase added years at any time before reaching age 59 by periodical contributions of a fixed percentage of superannuable remuneration over the remainder of their service to age 60. Unlike the current scheme where instalments are fixed (based on the salary at the time of purchase), the deductions under the new scheme will increase with future pay rises, making it more expensive in the long run. The new scheme will still allow members to purchase by one lump sum payment but this must be done within the first 12 months of joining the NHS. The booklet, which is available to BMA members from the Secretary of the BMA (please state current membership number), explains, among other things, how many added years may be purchased, the advantage of paying by instalment, and the effects of leaving the NHS before retirement.