Reorganisation à la carte

When this Government announced its intention to streamline the NHS\(^1\) the reorganisation theme could well have been titled à la carte. Freedom of choice with minimum central direction was the declared aim, even to the extent that initially Whitehall did not name a common changeover date, as had been done for the previous reorganisation in 1974.\(^2\) When the House of Commons recently debated and approved the statutory orders for the constitution and boundaries of the 192 district health authorities, which will replace existing area health authorities and districts in England, some MPs were sceptical whether the Government's reorganisation of the Service would fulfil the objectives of a leaner, cheaper, devolved management. As 1 April approaches—now the compulsory changeover day for England and Wales—there are signs that administrators and doctors are picking over the à la carte items with a lack of enthusiasm that in the case of the profession borders on apathy. Yet if doctors do not take a livelier interest local management changes may turn out to be no more than a cosmetic operation on the status quo.

With the four parts of the United Kingdom each plotting their own courses to devolved management\(^3\)-\(^6\) and with DHAs given freedom to set up their own management structures—albeit within general policy guidelines\(^7\) supervised by so far unaltered regional health authorities—doctors may be forgiven if they feel confused about what is happening and when. In welcome contrast to the 1970s' reforms the Government has drastically reduced the amount of official instructions and advice, but for those needing explanations of events there has been no shortage of written and spoken advice. For example, last October the BMJ published a brief article\(^8\) and a report of multidisciplinary discussion\(^9\); the BMA has issued The BMA Division and the New Health Service and is running familiarisation courses for consultants and general practitioners in conjunction with the University of Keele; the University of Hull's Institute for Health has published a useful Guidance for District Health Authority Members, which deserves a wider audience than the local DHA members for whom it was prepared; the nursing organisations have issued a booklet on budgetary arrangements;\(^10\) the Institute of Health Service Administrators has produced a practical guide, Getting it Right; the King's Fund and others have been organising symposiums; and some RHAs are issuing their own information sheets.

England is undergoing the biggest upheaval; in Wales the straightforward translation of area authorities into districts (with only one AHA splitting to form two districts) has limited the disturbance. In Scotland, which plans a changeover date of 1 July 1982, the Scottish Home and Health Department is giving boards a very free hand in deciding their devolved structure; and in Northern Ireland, which also aims to change on 1 July, area boards and the Government are still discussing the pattern of districts to replace the boards' existing districts.

In England and Wales the districts, which will have a management team of six, including two clinicians and a community physician, will be responsible for the planning, development, and management of services. The first major task for districts, which have existed in shadow form for several weeks, is to organise the services into units of management; these will replace existing sectors and nursing divisions and will be set up on a functional or a bricks-and-mortar basis, or, where necessary, a locally appropriate mixture of both. Each unit is to have a triumvirate of an administrator, a director of nursing services, and a senior doctor, and, unlike the district management team, it will not be expected to work on a consensus principle. The Government wants units to have their own budgets—an essential responsibility if they are to operate with any freedom and have the incentive to improve efficiency.

A second major task for districts is how best to organise services that were previously run by areas—for example, supply, works, and pharmaceutical services. During the period of transition, which may well be several months, such services will be left intact and "latched on" to one district. This should give DHAs a breathing space in which to make sensible decisions about this awkward logistic consequence of reorganisation.

In Patients First,\(^11\) which launched this reorganisation, the Government saw the devolution of power to smaller health authorities as the way to make the NHS more responsive to patients' needs, and in general doctors supported this principle. Since then, however, two developments have endangered it. Paradoxically, because DHAs have been given considerable powers, any authority reluctant to pass any of those powers down to units (whether because of administrative inertia or from conviction) can plan a management structure that could make its units impotent. So before approving districts' plans for setting up units regional health authorities will no doubt ensure that the units are viable management entities with an appropriate degree of independence; but doctors, too, should make sure that their opinions on unit management are heard. In a recent BMJ article\(^16\) Professor Roger Dyson, chairman designate of a DHA, has argued the case for units, pointing out to doctors the opportunity these offer for improving the quality and efficiency of patient care. Some administrators and doctors claim that there will be too few good managers to run units and that doctors may shun membership of the triumvirate. Perhaps so, but the initiative of devolved management, particularly if a policy of virement\(^17\)—which allows budget holders to spend locally savings made by improved efficiency—is firmly and fairly applied, deserves a trial before being condemned.

The Secretary of State himself has undermined the objective of devolution by announcing recently that the financial accountability of regional health authorities to the DHSS and of districts to regions is to be tightened.\(^18\) As devolution can be...
meaningful only if it includes the power to budget with reasonable freedom, this decision—prompted largely by criticism from the Public Accounts Committee of inefficient financial controls in the NHS—10—is bound to limit the freedom of local management. Though the Government in announcing its tougher monitoring policy tried to deflect this accusation suspicion is inevitable that the heavy hand of Whitehall will once again stultify local initiatives. Will Conservative ministers have to be persuaded to support their own philosophy that local budgetary freedom can lead to more efficient use of resources?

The Government hoped that reorganisation could be achieved with "minimum turbulence" for staff, but inevitably there have been difficulties, and, among doctors, community physicians have for the second time in a decade had their careers upset. Speaking about England, the Health Minister admitted to MPs that "the price of local flexibility has been uncertainty for many of the staff" and he paid them tribute for continuing the everyday running of the Service while "wondering about their future." Not surprisingly, however, agreement with staff interests about suitable arrangements for the changeover, including redundancy, early retirement, and appointment policies, took longer than the Government had wanted. This has made an already brisk reorganisation timetable so tight that it may handicap proper local planning of the changes. Furthermore, more senior staff took the opportunity to retire early than might have been expected—in some regions over 25% have retired, including experienced community physicians who will be a loss to the NHS.14 The result has been that many shadow DHAs have had to make decisions about management restructuring with an incomplete team of officers, and, inevitably, some have started out short of key people, including district medical officers. Because of these delays at the top the appointment of second-tier management staff has been held up and, as Professor Dyson warned the recent conference of BMA honorary secretaries, it could be October before the staffing of units is complete. Meanwhile, there will be a risk to patient services because of gaps in unit management, and Dyson made the further point that unless the transfer of staff was carefully planned, preferably with a common transfer date, such gaps would be inevitable.

Although this reorganisation is intended to improve patient care and switch 10% of management costs to clinical services, doctors may be worried that too much local autonomy could endanger overall standards of care. This the profession must guard against, but the Secretary of State has already declared that DHAs will be expected to toe the line on overall DHSS priorities.15 The profession has few worries about two Government decisions: one to keep consultants' contracts (with some exceptions) with RHAs; and the other that family practitioner committees are to continue and will be given independent administrative status as soon as the Government can find time for the necessary legislation (meanwhile, interim arrangements have been made).16 Both sections of the profession see these decisions as protecting their independence and clinical freedom. They have not seen eye to eye, however, on medical advisory machinery. While many doctors condemn the present advisory structure as too complex to be effective, GPs are unhappy that district medical committees will not be statutorily imposed in the new advisory structure.17 The Government is leaving it to the profession to set them up and because many consultants are unconvinced about their value many districts could be without a suitable professional forum to thrash out agreed medical advice for the district management teams, which could be disadvantageous to the Service. Doctors will, however, have to resolve this matter locally and the BMA as representing all doctors should play an important part in doing so.

After two reorganisations in 10 years no one in the NHS will be in a hurry to have another one so it is essential to get the structure right this time. Medicine is changing fast, funds for expansion will be small, party politics may intrude even more into the NHS, doctors' relations with other health staff will alter, and patients and their pressure groups are becoming more knowledgeable and articulate. The reformed NHS will have to be able to cope with these pressures. So doctors must ensure, firstly, that the district structure is sufficiently flexible to do so and, secondly, that their opinions from the sharp end of the Service are heard, understood, and acted on.

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