Units of management in reorganised NHS: what choice for senior medical staff?

ROGER DYSON

Professor Roger Dyson is chairman designate of the North Staffordshire DHA.

The new shadow district health authorities are now starting to consider seriously what pattern of units of management to adopt when replacing the post-1974 administrative sectors and nursing divisions. The guidelines were published in the DHSS's circular HC(80)8 *Health Service Development: Structure and Management*. The timetable is very tight; while some regions aimed for the end of February most are seeking completion by the end of April. Many senior medical staff will probably have recently received, or will be about to receive, detailed and sometimes quite radical proposals for change with deadlines so tight that if they draw breath

they may miss their opportunity to contribute to the debate—a debate about decisions that could have important implications for the way in which they do their work. My aim is to outline some of the major issues and choices for medical staff and so help in securing a more effective medical contribution to the final decisions of the DHAs.

DHSS guidelines

The most sensible starting point is the reorganisation circular referred to above: this outlines the task facing authorities in organising health care services below district level.

27. Authorities should arrange their services into units of management, each with an administrator and a director of nursing services, directly accountable to the district administrator and district nursing officer respectively, of appropriate seniority to discharge an individual responsibility in conjunction with a senior member of the medical staff. The unit administrator will carry responsibility for administrative co-ordination at that level on the same principle as the district administrator in paragraph 25.

28. In the main authorities should establish units that are smaller than existing sectors and nursing divisions, although there may be a limited number of exceptions where the sector or division is small enough already. Examples of the types of units that may be established are:

- (a) A large single hospital.
- (b) The community services of the district.
- (c) Client care services, for example a mental illness hospital with psychiatric community services and possibly the psychiatric unit of a district general hospital on the lines described in the report of the Working Group on Organisational and Management Problems of Mental Illness Hospitals. However, 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 (in this case, however, it

may in some circumstances not be necessary to appoint a unit administrator as required by paragraph 27, though there should nevertheless be an administrative point of reference).

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

(f) A group of smaller hospitals.

In other words, no one pattern of units is being prescribed. It is assumed that authorities will determine their unit arrangements in a way most appropriate to the existing health care services and to the health care needs of the population for which they are responsible. This latter point is important because it is clear from the debate in some authorities that the need to create, for instance, a scale 29 post for a particular person is wrongly being allowed to take priority over consideration of the Service. The circular makes clear that generally units will be smaller than existing sectors and nursing divisions, and one way of identifying an authority that may be giving too great a weight to staff grading matters is to check whether the number of units proposed is less than the existing number of sectors and nursing divisions—a formula that would allow staff gradings to be higher.

Six alternative structures

The six alternative unit structures outlined merely encompass two different philosophies of establishing units and also allow for the two different philosophies to coexist within any one authority. Authorities may adopt a bricks-and-mortar approach and base the units on geography so that each major hospital becomes a unit in its own right which may either be responsible for all community services around it or allow for all community services to be part of one unit. This approach also provides for the grouping of smaller hospitals into single units. Alternatively, units can be based on client-care groups as indicated in paragraph 28(c), where a psychiatric unit would be responsible for the long-stay psychiatric hospital, the acute psychiatric wards within the district general hospital, and community psychiatric services. These two approaches are not mutually exclusive unless there is an attempt to subdivide the major acute specialties; the complexities of trying to base units on the major acute specialties that exist side by side in the district general hospital make this an almost impossible choice. The subdivision of acute specialties is most likely to succeed where there are major separate hospitals devoted largely or exclusively to a single specialty—for example, paediatrics.

At a purely mechanical level, the task is quite clear, but, the reader may ask, why is the change taking place at all? Are we just changing structures for the sake of change? If so, should a heavily committed consultant really give time to the frustrating task of trying to influence the outcome? In my view it is essential that senior medical staff make the time to join in this debate: the justification lies in the objectives of the change, which can easily be lost sight of in the struggle to complete the task within the given deadlines.

One unstated assumption behind the present reorganisation is that the financial outlook for the NHS for most of the 1980s is grim. The country is experiencing a major change in the shape and structure of its economy and this is creating pressures that are unhelpful to the NHS. Temporarily at least, the United Kingdom's gross national product is falling, and the real value of State spending on the NHS is therefore hard to

maintain, let alone increase, especially when virtually all other areas of public spending are being cut. Even to maintain the present position of the NHS in real terms implies an upward increase in its proportion of the gross national product. In addition, an aging population has implications for health authorities' spending on the already overstretched geriatric services and on the costs of developing community services.

The fact that this trend is occurring against a background of a declining commitment within the family to caring for the old, the mentally ill, and the mentally handicapped sharpens the problem. Even the fitful local authority support through social service spending is in danger of declining because of the present financial constraints on local authorities. This in turn will put more pressure on the NHS. One further and very important change is the evolution of medical science, which is creating an ever increasing demand by doctors and patients for high-cost medical technology. Somehow, the NHS has to survive these pressures over the next five to six years, and reorganisation can help, provided that the opportunities created at district level and below are recognised and implemented.

There is a theoretical choice about where to put the major emphasis in managing the NHS. At one end of the spectrum are the advocates of very large authorities with territories and populations that allow them to place greatest emphasis on the centralised planning of health care resources; such authorities operate through a system of directives which determine what developments will and will not be allowed in different hospitals and primary care services. At the opposite end of the spectrum lies the small authority, favoured by those who argue that it offers potentially tighter control over the day-to-day operational management of the service.

In the 1960s and early 1970s, when new money was going into the NHS for development, the attractions of the large authority were obvious because of the need to plan as efficiently as possible the take-up of development funds. At such times the ablest talent available to the NHS—and the focus of decision making—tends to move upwards to the larger planning unit, and the 1974 reorganisation substantially facilitated this upward movement.

No large sums for development

Unfortunately, however, the NHS cannot expect large sums of development money either now or in the near future. If any money is to be found to cope with the pressures described and to allow for some modest development it will have to be released locally by increasing the efficiency with which the NHS provides existing services. In these circumstances smaller authorities directing more of their attention to the efficient delivery of services are more appropriate to present needs. The pattern of smaller authorities means that available managerial talent will be drawn nearer to the point of delivery of patient services and thus increase the emphasis on the release of resources through greater efficiency at that point.

If during this final stage of reorganisation a district fudges the issue of devolution to its units by introducing cosmetic rather than real structural changes the opportunity to release resources through improved efficiency will be greatly undermined. I see the key measure of effective devolution to units to be the control of unit budgets. Take the average sector administrator and divisional nursing officer going about their daily and often harassing routine: for them the NHS is singularly devoid of any incentive to tackle the difficult problems associated with improving efficiency. There is in the 1974-model NHS a labyrinthine consultation process that is not only time consuming but can also create any number of apparently insuperable administrative obstacles. If greater efficiency means changes in jobs or working practices the trade unions may react with hostility and sometimes even with threats of industrial action. If the new scheme fails or is only partly successful its detractors—and these will be many—will say

either that the scheme was ill conceived or that its initiators lacked the necessary managerial competence. In these circumstances the temptation to senior staff to confine their tasks to ensuring that their areas of management continue to function with as few difficulties as possible is understandable. In private industry there would be financial incentives for success, less consultation, and more comprehensible arrangements for managerial control. The NHS cannot provide direct financial incentives; it has to rely on the dedication of its staff to improving health care, but it can provide very real incentives of a different type. If the administrative, nursing, and medical members of the triumvirate at unit level know that they can retain any resources they save from planned increases in efficiency in their unit there is a genuine incentive to try to release those resources. If, however, the results of such planned increases in efficiency are either wholly or largely snatched back by the districts the incentive is gone and with it the best opportunity to release resources on a sufficient scale to improve patient care. For this reason the managerial viability of our units and the extent of budgetary devolution to them are vital issues if health care resources are to be efficiently used in the next five years.

Budgetary control at unit level: a challenge

What is meant by the devolution of budgetary control? The authority will have set the overall policy objectives for the district, and no unit, whatever the degree of financial freedom, can expect to use resources in a way that conflicts with that policy framework. If the district has a policy of a growth in the proportion of qualified to non-qualified nursing staff no unit should be able to spend its own resources in a way that reduces the proportion of qualified nursing staff. Should a district, however, have a policy to expand the resources that it commits to its geriatric services this does not mean that resources released through greater efficiency in an acute unit should automatically be taken back to district and redirected towards geriatric care. Such a policy would simply discourage any initiatives in the acute unit. That unit should be free to spend *within the unit* the resources released, provided that the pattern of spending is consistent with the authority's policy for acute services. Furthermore, fortuitous savings—be they one-off or recurring—should also be regarded as belonging either wholly or partly to the district rather than to the unit because that type of saving has not arisen from unit initiatives. Finally, nothing I have said in this paragraph detracts from the responsibility of the authority to plan the development of its services from year to year and encompass within that plan the reduction of services in one unit and their expansion in another. This is clearly the prerogative of the authority, advised by its team of officers.

The prospect of devolution of budgetary control to unit level should offer a challenging and exciting prospect for doctors. It is not just a question of whether the decisions about the use of resources should be taken at district or unit level, it is a question of whether the opportunity should be seized to create additional resources by building in financial incentives at unit level. Viewed in this light, the creation of unit budgets does not detract from the district-based role of the medical executive committee and its chairman: it creates additional opportunities for other consultants to secure access to unit-created funds. For this to happen two things have to be secured. Firstly, units have to be of a size that makes effective management of operational services possible. A unit that is too big in budget and staffing or too scattered across a substantial territory is a less viable entity for achieving improved efficiency than a smaller and more homogeneous unit. Secondly, the authority's policy on budgetary devolution to unit and on virement in the management of unit budgets has to be sufficiently generous to

continued on page 764

UGC cuts: effects on medical education

In January the Secretary of the BMA, Dr John Havard, wrote to the chairman of the University Grants Committee about the effects of the UGC cuts on medical education. Dr Edward Parkes replied on 26 January as follows:

"The university system has had to accept, within a short space of time, a reduction in funding of such severity that some disorder and damage to the system is inevitable. Moreover no provision was made, in the grants made available to the committee, for exempting medical education from the cuts, despite the fact that the Secretary of State for Social Services had reaffirmed the Government's commitment to the target of an entry of 4080 medical students per year.

"The committee therefore felt obliged to make provision for the medical entry to be held at the 1980 level, so that progress toward the target could continue when funds became available. Because of the effect of previous increases in intake, however, this meant catering for about 1000 additional medical students, and provision was made accordingly in the grants of the universities concerned. There was thus a degree of favourable treatment implicit in not actually reducing the intake.

"The committee could not, without unacceptable additional damage to the rest of the system, at the same time continue to maintain the previous level of funding for medical students. It reluctantly decided that on this occasion, clinical medicine must share in the general reduction in the level of funding.

"It was not the committee's intention that

the subject should be disproportionately cut because clinical medical staff on average remain in post for shorter periods than other staff. We fully appreciate the need for key posts to be maintained, in this and other subjects, and are stressing this in our discussions with universities."

Medical manpower and NHS restructuring circulars

The DHSS has drawn the attention of health authorities in circular HC(82)4 to the report of the Social Services Select Committee on Medical Education (Short Report) and the Government's response to it (6 February, p 427). It gives guidance on the implementation of two recommendations of the report—a standstill on senior house officer numbers and a reduction of the present imbalance between numbers of consultants and of doctors in the training grades. It "commends for action, or for consideration," others of the committee's recommendations of particular concern to health authorities.

Another circular (HN(82)9) deals with collaboration between the NHS and local government as a result of the formation of district health authorities. It emphasises the importance of early discussions to ensure that collaboration is maintained during the transition period and to agree on permanent arrangements afterwards.

From the GMSC—continued from page 761

time ago when few young women were entering general practice as principals. Dr Ward wanted maternity leave payment divorced from sickness leave.

Dr J F Milligan referred to the quality of students. Present students and trainees had never been examined to see whether they could undertake responsibility of caring for a patient; they had enjoyed a sheltered life in hospital where responsibility was never given to them; and for many of them vocational training might be viewed as another three years of sheltered existence.

Referring to the suggested annual review of numbers of non-EEC medical graduates being

granted limited registration, Dr Alan Rowe said that he would like to see the numbers of EEC graduates entering general practice in this country included in the review.

Dr Williams said that the vocational training scheme should be monitored to check whether there was a backlog of training opportunities and whether doctors were finding it hard to enter vocational courses or practice. When the Government encouraged people to become consultants it simply established new consultant posts. In the case of general practice, doctors should be encouraged to establish new principal posts, which meant additional annual net remuneration.

Hospital pharmacists

The Guild of Hospital Pharmacists decided to withdraw unpaid emergency services from 1 February (6 February, p 440), and in a written answer in the House of Commons on 18 February Dr Gerard Vaughan announced that the management side of the Pharmaceutical Whitley Council had prepared a draft agreement on payments for emergency duties for hospital pharmacists. This covered provisions for on-call standby and work-done payments. The next step would be discussion in the Whitley Council.

A press statement issued earlier in the month by ASTMS (to which the guild belongs) stated that emergency services had already been withdrawn in several hospitals. In other areas pharmacists were delaying the withdrawal of services to try to negotiate local agreements for emergency duty payments. "These efforts could," ASTMS states, "be doomed to failure, however, as the Department of Health has advised health authorities that it would be illegal to make locally agreed payments to pharmacists for emergency duties. This view is rejected by the union. . . . Although both management and staff sides of the Whitley Council agree that payments should be negotiated, no actual offer has been made, as the Government refuses to provide the necessary funds."

The management side has acknowledged that the working week for hospital pharmacists (39 hours) is longer than for most other comparable groups of NHS staff. A leading article in the *Pharmaceutical Journal* of 27 February (p 233) said that though the management side had agreed to consult health authorities on whether the costs of reducing the working week could be absorbed the management side secretary had pre-empted the answer to the question by stating (1) that an approach to authorities in June 1980 had resulted in a definitive view that a reduction in hours could not be absorbed at nil cost; (2) that because of a number of vacancies in basic grade posts it was unlikely that authorities would wish to contemplate a reduction, however small, in the working week of pharmacists; (3) if one "no cost" agreement were conceded, future demands would be very difficult to resist; (4) a reduction of half an hour per week equated to about 1% of the pay bill; and (5) a "no cost" agreement conceded by the Pharmaceutical Whitley Council might stimulate similar claims across the whole range of conditions of service in others.

Units of management—continued from page 763

create the maximum possible incentive for unit initiatives in the planned release of resources.

Those doctors who are pessimistic about reorganisation are saying that it will be hard to find consultants and GPs prepared to give their time to be part of the triumvirate of management—with a nurse and an administrator—at unit level. These pessimists may be proved right, but if so it will be because doctors have missed the opportunity to ensure effective devolution and have allowed the various institutional pressures that emphasise centralisation at district level to abort some of

the real objectives of reorganisation. Doctors have choices: they can choose to take part in this stage of reorganisation; or not; they can choose to exert their influence in ensuring appropriate unit boundaries, effective devolution, and adequate financial freedom at unit level; and, finally, they may choose whether or not to join the unit triumvirates and work for the most efficient use of resources and so improve patient care. Doctors' clinical experience will be vital to the planning and decision making in the restructured Service. If the medical profession does not play its full part I fear that the post-1982 NHS will use its resources no more efficiently than its predecessors and doctors' and patients' frustrations will worsen.