that in due course they will provide adequate training in paediatrics for general practitioners.

(5) The working party sees no need for general practitioner paediatricians if the previous recommendations were affected.

(6) The working party could not agree with the idea of child health visitors and preferred more health visitors being provided who were adequately trained in child health and who could work in the child health service in collaboration with general practitioners.

(7) The working party disagrees with the appointment of consultant community paediatricians and is of the view that many senior clinical medical officers with some further training could adequately fill much of the role of the suggested consultant community paediatrician.

(8) Furthermore the working party prefers that all consultant paediatricians should extend their interests into the child health ser-

vices in the community as well as in hospital.

(9) The working party strongly resists the creation of the grade child health practitioners. Clinical medical officers and senior clinical medical officers can adequately carry on the developmental paediatric and child welfare clinic work where suitably qualified general practitioners are not available.

(10) The working party agrees in principle that general practitioners should work in the school health service.

(11) It agrees that there is a need for appointment of more school nurses who will collaborate with the school medical officer (general practitioner or clinical medical officer).

(12) The working party appreciates that implementation of many of the Court Report recommendations has serious manpower implications which require careful investigation.

(13) The idea of a district handicap team is accepted, with emphasis on the inclusion of the general practitioner and community nursing staff concerned with the child involved.

(14) The working party agrees that the paediatric and child psychiatric services should provide the specialist child health services for all handicapped children, including the severely mentally retarded.

(15) The working party agrees with the suggestion that the child guidance clinics, psychiatric hospital services, and child psychology services could be integrated with advantage as a child and adolescent psychiatric service.

(16) The Court Committee recommendations on dental care are acceptable to the working party.

These comments were endorsed by the meeting.

TALKING POINT

Medical administration in a multidistrict psychiatric hospital

G E LANGLEY

The Health Service is organised to provide integrated care in a single district, but many psychiatric hospitals are trying to provide a service to more than one. The Royal College of Psychiatrists has offered some advice,¹ as has Cockburn,² and the *BMJ*.³ In the last few years inquiries in 14 mental hospitals have pinpointed the hazards faced by administrators in every psychiatric hospital.

My hospital serves three of the four health care districts in the area health authority. It is administered as a sector and the administration is more akin to a medical executive committee than a "cogwheel" division.⁴ Medical administration is co-ordinated by the chairman of the consultants' committee. There are "cogwheel" divisions of psychiatry in two of the districts but they are weak politically and are concerned mainly with psychiatry in the district general hospital (outpatients, ward consultations, and, in one district, a day hospital). At present there are no DGH psychiatric beds in any district, but one 30-bed ward will open in a peripheral district in 1980. Health care planning teams (mental illness) exist in two of the districts, but despite some planning activity their effectiveness has yet to be tested.

Changes in 1974

Before reorganisation the hospital was a management unit in its own right and the hospital management committee had delegated substantial responsibility to a multidisciplinary group management team for several years. The catchment area had also been subdivided into localities served by clinical teams, and there were liaison committees between the psychiatric and social services at local and county levels. In 1974 district boundaries proved to be almost coterminous with the

existing psychiatric team boundaries but the social service area boundaries were not so happily arranged. Expecting difficulty in co-ordinating psychiatric services centred on a three-district hospital, the joint liaison committee recommended a multidisciplinary area health care planning team (mental illness) incorporating a fourth district served by another psychiatric hospital. This team covered all psychiatric services in the AHA. It operated from April 1974 and has recently become part of the area joint care planning arrangements, remaining as a mental illness subgroup of the area joint care planning committee. This has complicated the management of "pure" NHS issues but it has been agreed that the area medical officer will periodically take "pure" psychiatric matters directly from the subgroup to the area team of officers. The subgroup is multidisciplinary.

After reorganisation the group management team became the sector management team. Until recently it was composed of a sector administrator, a representative of the district finance department, the chairman of the consultants' committee, one other medical representative, and the divisional nursing officer. In the last few months a psychologist, a social worker, and an occupational therapist (all departmental heads in the sector) have been added. Before this development the consultants' committee had invited a representative of clinical psychology, occupational therapy, social work, and administration to alternate meetings so as to foster multidisciplinary discussion. This arrangement has now ceased as it was generally considered that multidisciplinary participation at sector level was the better alternative. All senior registrars attend the consultants' committee.

The reappraisal that led to the above changes also formalised existing ad hoc multidisciplinary teams which co-ordinated

the work of the district oriented clinical teams operating in the hospital. These multidisciplinary team management groups work in the hospital but also look outwards to the provision of psychiatric services in the district. Within the medical consultative machinery there is psychiatric representation on the base district medical committee, the base district medical executive committee, the area medical committee, and no other district medical committees. The system is in many ways similar to that advocated by the Royal College of Psychiatrists.¹

Though the need for district and community-based psychiatric services is accepted, the St Augustine's and Darlington inquiries^{5,6} have shown that the psychiatric services should act as an integrated whole. The hospital is still the principal centre for most patients and needs a sense of identity and purpose. This is shown by the call for the return of the physician superintendent.

Sources of tension

Administrators (including medical administrators) in hospitals and districts are uneasy in their relationship with those in other tiers and other districts because of the fear that when priorities are decided there will be district preference in favour of the base district, or dilution of district effort by patients from other districts. There is no automatic mechanism for consultation between districts and despite a co-ordinating group at area level the districts still retain much autonomy.

Attempts at multidisciplinary (horizontal) management at sector and clinical team (district) level are hampered by vertical line management and the removal of many day-to-day and planning responsibilities from the

sector. Many decisions are now made by district officers. Most of the more senior managers who previously worked in the psychiatric hospitals are now in tiers above and the psychiatric divisions and sectors are staffed with less senior administrators than before.

Financial control rests with district officers or with individual budget holders in the sector. No financial authority is given to the sector multidisciplinary team. Individual budget holders may be either indulgent or parsimonious within their limits without the sector knowing what is happening and demarcation disputes between budget holders are possible.

Responsibilities

Both before and after reorganisation many "cogwheel" committees in the hospital service made serious attempts at multidisciplinary consultation. With the advent of reorganisation local "cogwheel" meetings attracted fewer attenders from related disciplines, in part because of the pressure of other meetings and also, one suspects, from loyalty to line management. The intention to integrate thus led, at least in the "cogwheel" setting, to an increased tendency to compartmentalisation. The local decision to enlarge the sector management team referred to above was taken in the hope of countering this tendency. Subsequent "cogwheel" meetings were purely medical unless other disciplines were specifically invited. Consultants in a psychiatric sector have allegiance to their own sector committees and to those of their health care district. The sector medical committee plays an important part in maintaining the medical integrity of the psychiatric hospital, but it does not easily relate to the district general hospital "cogwheel" system in any of the three districts concerned.

In the base district the committee cannot properly be a division of psychiatry if its members also bear allegiance to other (peripheral) districts. Furthermore, the medical executive and district medical committees of the base district are not in practice likely to be seriously concerned with medical matters in the psychiatric hospital that relate to other districts—for example, bids for new medical appointments. Individual consultants try to participate in both hospital and district management arrangements and therefore have a double commitment to administration compared with their single district colleagues. If they are "modern" and believe in the district concept they will, perhaps because they have a sense of weakness, apply their effort in the district. This may detract from their interest in the hospital. In the event of severe frustration they may, of course, withdraw from both spheres to the detriment of the medical influence in administration.

For everyone engaged in multidisciplinary work there is a tendency to abrogate personal responsibility for difficult decisions—the "collusion of anonymity" in psychodynamic terms.⁷ It is wrong for too much authority to be vested in one man, and individuals should not normally overthrow collective decisions unless their authority to do so is clearly defined. On the other hand, it is not right for individuals to deny personal responsibility and remain inactive unless supported by a group or policy decision. Such behaviour would be the death of initiative,

innovation, and enthusiasm. The remedy lies in full and free discussion and the availability of sufficient time and resources to operate the system.

Inevitably, there must be some conflicts between those in the Service who identify with the patients in need, notably the doctors and nurses, and those who provide the resources to meet this need, principally the managers. Doctors sometimes wear a manager's hat (as a "cogwheel" chairman) and managers directly serve patients' needs—for example, catering. In times of change and financial stringency these tensions can lead to polarisation rather than unity. The organisation of a multidistrict psychiatric hospital enhances this tendency to move apart.¹ The danger will remain until district psychiatric services are self-supporting or until a firm, integrating force is applied at area level.

Communication

A psychiatrist does not have to preach about the value of good communication. The purpose of multidisciplinary and participative management is to bring in all concerned with making decisions. In the case of medical administration it is the medical committee (at whatever level) that is the body politic, the job of the chairman (particularly in a hospital setting) being sometimes one of leadership but more often one of sounding, synthesis, and facilitation. All members must be as well informed as the chairman. This is taxing on the reading ability of the members and even more so on the work load of medical and general administrators whose duty it is to supply the information.

The introduction of team management groups as a second tier in the sector has brought decision taking to the "coal face" but has aggravated the problem of distributing appropriate information to all concerned. Briefing the committee at the meeting does not allow individual members sufficient time to do their homework before decisions are taken. Not only does information, advice, requests for comment, etc, come from the tiers above, but those at the coal face need to obtain local operational statistics, to plan for local developments, to arrange rotas, and to deal with all the small day-to-day matters that make for the smooth running of an organisation. In the present mood of "we have too many administrators" it is not easy for hospital medical staff to find adequate secretarial and administrative assistance in carrying out their administrative tasks. The vortex that has taken many established staff upwards into district and area organisations has aggravated the problem. The need for an adequate medical information system was noted in the first "cogwheel" report, but provision is still rudimentary. Every psychiatric hospital should be able to produce operational statistics, even to the details of a consultant's personal work load, together with an annual cross-section of the hospital population, including day patients.

Conclusion

We must maintain a sense of cohesion within the traditional psychiatric hospitals until they are totally replaced by district-

based services. The divisive and complex nature of the work in a psychiatric hospital serving several districts should be recognised by giving such institutions additional clinical and administrative resources. Well-informed and well-integrated multidisciplinary teams at both sector and clinical team levels would go a long way to meet these requirements. Furthermore, we shall require mental illness planning groups at area authority level with some ability to influence decisions at area and in the districts.

¹ Royal College of Psychiatrists, *News and Notes*, March 1976, p 3.

² Cockburn, J J, *British Medical Journal*, 1976, 2, 929.

³ *British Medical Journal*, 1976, 1, 736.

⁴ Ministry of Health, *First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals*. London, HMSO, 1967.

⁵ South-east Thames Regional Health Authority, *Report of the Committee of Inquiry, St Augustine's Hospital, Chatham, Canterbury, Kent*, March 1976.

⁶ Northern Regional Health Authority, *Report of the Committee of Inquiry*, April 1976.

⁷ Balint, M, *The doctor, his Patient and the Illness*. London, Pitman Medical, 1957.

Exe Vale Hospital, Exeter

G E LANGLEY, FRCP, MRCPsych, consultant psychiatrist

In brief . . .

Management "standstill" extended

The "standstill" in management costs during 1976-7 has been carried forward into the period 1977-8 to 1979-80. Circular HC(77)10 explains that it is the Secretary of State's intention that by the end of 1979-80 all regions would have achieved a national reduction of 5% from the level of management costs at 31 March 1976. RHAs will have maximum flexibility in deciding how to achieve the required reduction and will be responsible for agreeing objectives for individual areas. The Secretary of State is opposed to a general structural reorganisation but is prepared to consider proposals for the merger of existing health districts or for the establishment of single-district areas. In the interests of economy and efficiency in the delivery of services it might be possible to split multi-district areas into smaller single-district areas.

Scottish planning

The Scottish Health Service Planning Council consists of health board chairmen and representatives from Scottish universities and the Home and Health Department. Much of its work is done by programme planning groups—on mental disorder, care of the elderly, cardiac surgery, child health, and cancer and these are reported on in the 1976 annual report. A working party on health priorities has looked at the maternity and child health services and the services for the elderly, and it is now making a study of the acute hospital services. The council concludes its report by emphasising the opportunity which NHS reorganisation offered for effective planning on an integrated basis.