

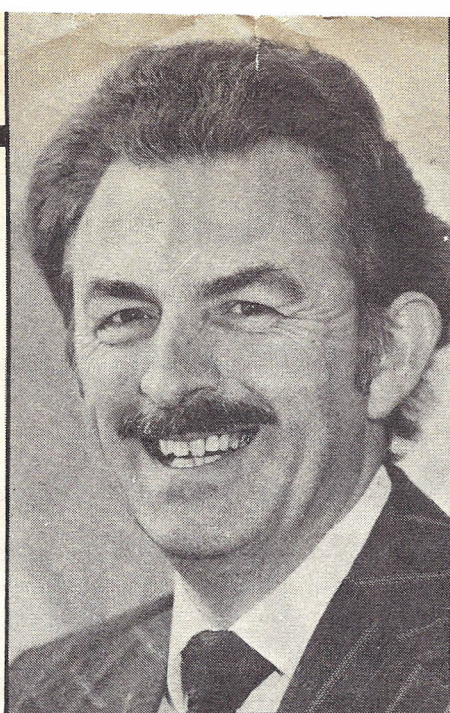
THE Labour Government, when it came to power in 1974, had many senior officers in the Health Service worried about their future. Mrs Barbara Castle made it very clear that she believed the new Service was not planned to produce the most effective system of health care. Nearly all the most senior staff had been appointed to "shadow authorities" awaiting the appointed day. In the event, the new Government decided that the reorganisation had gone too far to alter the structure at that stage. It was, therefore allowed to go ahead with all the reservations that had been expressed.

Within two or three years the Conservative Party in opposition was beginning to express disquiet about the management of the Health Service. Already the government of the day had started to place "management cost" ceilings on health authorities. Several senior officers at that time had what must have been the unique experience of hearing from Parliament how over-managed they were, yet, on personal visits to local health services, both the Secretary of State and Minister of Health praised them for doing a great job against overwhelming odds!

In the months leading up to the general election last year, the Conservative Party made it clear that a reorganisation of the Health Service was to be in its manifesto.

I have mentioned these events at length because I still meet people who say that politics should be taken out of Health Service matters. It is obvious that "health" is the bread and butter of politics, particularly as it takes so much of the finance raised by general taxation, and at the same time affects the lives of so many people. So what is now proposed is to reorganise the reorganised Health Service. The most major proposal to the majority of people will be the abolition of area health authorities. Smaller district health authorities will replace them.

The consultative document – a slim publication of 24 pages – sets out four concerns: too many tiers; too many administrators in all disciplines; failure to take quick decisions; money wasted. What it does not spell out in sufficient detail is, if a tier of administration is abolished what happens to those officers displaced? The retirement and natural wastage rate is insufficient to create the vacancies needed, yet there is not a word about any arrangements for early



Rejig of a rejigged Health Service

Anthony Carr, Area Nursing Officer for Newcastle on Tyne, looks at the effects on staff of the proposals for reorganising the NHS again – particularly the abolition of areas, and the new posts at hospital and community level.

retirement or protection of staff, apart from the normal Whitley Council regulations. In his introduction the Secretary of State, Patrick Jenkin, says: "We must never forget that it is people, not organisations, who have the care and cure of patients in their charge."

A second proposal, that is extremely attractive to me, is the establishment at hospital and community level of a senior nurse and administrator. It is even proposed that Whitley Councils be asked to consider these changes. Unfortunately, what is not disclosed is whether or not these are open-competition posts. What is the position of existing divisional nursing officers who do not obtain these new posts?

The only mention of second-in-line posts is the statement that the area nurse (child health) may be required to cover the boundaries of more than one district health authority (DHA). Are the other area nurses and administrative second-in-line staff to be absorbed into the new

hospital or community posts?

More questions are raised than answered by these proposed changes. I believe it is not enough to say that this will be decided through the consultative procedure. The damage to morale will already have taken place.

Although it would have created a lot of detail to spell out the position of staff, I believe the Government has missed the opportunity to carry the great majority of staff with them with any confidence or expectation. In consequence, it would not surprise me if the trades unions insist on a national "crawl" for the senior posts available in this new reorganisation. If this happened, a standstill in development of proper management systems could be expected for up to three years, as senior staff learned to work with their new colleagues.

The regions will have the task of coping with the changes proposed and they, themselves, may wish to instigate many of the changes. This is a major task for them, and many of their other tasks may have to be set aside.

There are many other changes proposed which cannot be included here, but one of the most important is that London is to be brought into these new arrangements – the London post-graduate hospitals were excluded from the reorganisation in 1974. It is proposed that the interests of the DHSS, the four Thames RHAs, the Post-Graduate Boards of Governors, the University of London, the University Grants Committee, the Greater London Council and the London Boroughs Association, be brought together through an advisory group representation of their interests under an independent chairman.

The London teaching hospitals still have a major influence on teaching of medical and nursing students, research, development and treatment. Because their influence on the provinces is great, this working group is of immense importance. The work will be difficult but they must come forward with the right series of solutions; I recommend all nurses to obtain a copy of the consultative paper *Patients First*, read it, and let their views be known by the end of April 1980.

One last thought. if you are a person likely to be affected by these changes, do not become too depressed. Experience has taught me that proposals of the nature I have described rarely turn out to be as bad as first thought.

You may even enjoy this experience – in retrospect of course □