LEADER

Reorganisation — the government's blueprint

The Government's proposals to reorganise the NHS were published in a Health Circular at the end of July. The DHSS received over 3,500 comments following publication of the consultative document 'Patients First' and a summary will be published later. The circular contains sufficient guidance to regional health authorities and to the new district health authorities to commence and carry through changes in structure and management organisation.

The major change will be the abolition of area health authorities and the institution of one or more district health authorities to replace them. Each DHA will be responsible for the planning, development and management in its district, subject to national and regional strategic guidelines. From the information given it appears that many of the existing districts and single district areas may become the new DHAs. Population limits of between 150,000 to 500,000 are normally proposed. The aim of establishing DHAs is to find the "smallest geographical areas within which . . . integrated planning, provision and development of primary care and other community health services together with services normally associated with a district general hospital" can take place. Also, but not necessarily, these should include services for the elderly, mentally ill and the mentally handicapped. There is a complete absence of mention of the need to maintain and develop active health education programmes as one way ultimately to improve the health of the nation.

The second major proposal is related to the appointment of staff. Each new DHA, in shadow form, will appoint its district management team. Apart from posts at the new unit level a DHA does not necessarily need to make any appointment at district level. Local discussions in each district should prove interesting. Is there, for instance, to be established a personnel department or planning department with its attendant administrative nursing and medical staff? All professions could feel apprehensive about these debates, especially those staff already holding second-in-line posts at area level. The circular does indicate that nearly all the activity relating to works, catering, personnel, and the more traditional sector services of catering, domestic services and medical records will be co-ordinated by unit administrators. There is encouragement given to the idea that specialist officers could either be appointed on a two-district basis and shared between the two authorities or appointed to a unit position and at the same time offer specialist advice to the other units in the district.

At unit level it is expected that a unit administrator and a nurse known as 'director of nursing' should be appointed. Somewhat surprisingly the nursing divisions should, it is said, be smaller than existing divisions. Examples are given regarding the organisation of units. Recognition is given to what nurses regard as functional divisions, that is midwifery and psychiatric services. In psychiatry both community and hospital services, together with the acute unit in a a general hospital, are regarded as a unit. Likewise, the midwifery services are seen as a complete unit. The latter service is the only one where the demand of a full-time matching administrator is not necessarily required. Will the new district nursing officers be trying to create artificially small units to accommodate the wishes of ministers or, more importantly, to provide extra posts for the present area nurses?

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Specific authority is laid down for the directors of nursing. He/she must be given responsibility for managing of the nursing budget and the unit administrator will be responsible for his own services budget and will co-ordinate the others. This is likely to take away any latitude at present to treat the district nursing budget as a total budget. Nearly all the recommendations at unit level are aimed at running each unit as a separate entity. The old rivalries between city hospitals could have been restored by this decision and there does not seem to be any way of running the services at district as a co-ordinated whole. I believe this to be a most retrograde step and politicians will live to regret such a strengthening at unit level at the expense of district organisation. Unit budgets could, even with strict district policy, be used for priorities that would not necessarily be top priorities of the district. What powers district officers will have to redistribute their own professional budgets once they have been given to units is not clear.

Another principle established is that of co-ordination by the administrator at district and unit level. The document stresses that this does not mean that the administrator is given any managerial authority over other chief officers. It remains to be seen if chairmen of the new authorities and administrators themselves interpret paragraph 25 as written. Perhaps five years from now some chief officers may have to write out Chambers Dictionary definition of co-ordination which is 'of the same rank or order, to place or classify in the same order or rank'. If the accepted interpretation is to see that tasks previously agreed to be done meet agreed programme dates, then there should be little conflict. However, people are only human and I can foresee potential conflict in this area both at district and particularly at unit level.

The same proposals as mentioned in 'Patients First' remain for family practitioner committees. The present number remain unchanged and relate to one or more of the new authorities, yet the circular states that planning between FPCs and DHAs is to be strengthened by advice to be given later. It should make fascinating reading!

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There are other matters relating to financial control once area health authority treasurer's departments are disbanded. The role of regions is also mentioned. One matter which has not been decided on which is the most important one of all is the personnel arrangements, particularly for staff at area level below DMT level and the way unit posts are to be filled.

Are we going to have to interview area staff and district staff who did not obtain senior posts for these posts first? Are existing sector administrators and divisional nursing officers having to stand by and see what is essentially their present posts go to other colleagues? Do they now start thinking of calculating early retirement or redundancy monies? The answer is that the General Whitley Council NHS Reorganisation Committee is considering these matters.

Does the DHSS really think that the new officers of DHAs will go ahead and propose radical reorganisation at unit level to their authorities without this matter being settled? Or, even if these arrangements are known, I do just wonder if all authorities will consider making redundant or propose early retirement to those staff who by qualification and experience have dedicated their lives to the Health Service with some expectation that they may continue to do just that until (if they remain healthy) they retire.

Unless this aspect of reorganisation is dealt with with great sensitivity and understanding in each new district, morale, which is the most important ingredient in any organisation, will effectively put back the service to patients by many years.

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