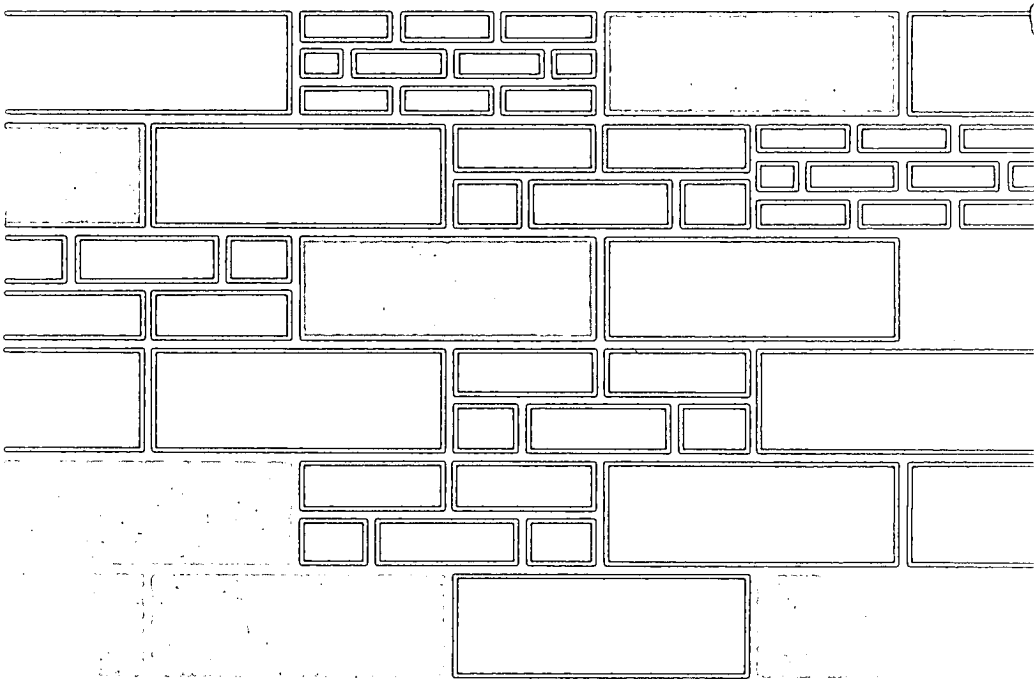
OCCASIONAL HUNDREDS 6

SI VIS PACEM...

PREPARATIONS FOR CHANGE IN THE NATIONAL HEALTH SERVICE

BRIAN EDWARDS · PAUL R. WALKER



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Preparations for change in the National Health Service

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Preparations for change in the National Health Service

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Contents

Background to the study

Serious discussions about the reorganization of the National Health Service have been in progress for the past four years ever since the publication of the first Green Paper in 1968 (1).

During this time the Nuffield Provincial Hospitals Trust and the Nuffield Centre for Health Services Studies at the University of Leeds have both been concerned to stimulate an informed and constructive discussion of the various proposals as they have emerged and to identify the possibilities for innovation that reorganization would present. More recently the attention has shifted to discussions about how the proposed changes might be effected bearing in mind the size and complexity of the NHS.

In recent months the Trust has published *Challenges for Change* (2), a series of essays on the next decade in the NHS and the Centre the Cerberus (3) and Ariadne (4) Senior Management Course Projects.

Following the publication of *Challenges for Change* a meeting was arranged by the Trust, attended by all the contributors, and there emerged at that meeting a concern that whilst national planning for the reorganization appeared to be well under way insufficient work had been done in relating national plans to local situations, and the actual task of reorganization itself was still largely undefined.

At about the same time the Nuffield Centre had become involved, during the course of its management education programme, in an examination of the practical effects of reorganization in west Yorkshire, and it was felt that a short, rapid study of the problem in one area might make a useful contribution to the national preparation for change.

The study is not in any sense of the word definitive, nor is it a piece of academic research. It is a report of conclusions reached following an attempt to relate developing national plans to a real situation.

It was the desire to make a practical contribution that prompted the Trust to prescribe a very tight time-limit for the study which in the event was undertaken during April and May 1972 and updated following the publication in August of the White Paper (5).

A research advisory team was established in the area we were studying and this report draws heavily on their experience.

The members of the group were: Mr D. Cammidge, Deputy Clerk, West Riding Executive Council; Dr R. G. Drummond, Principal Assistant Senior Medical Officer, Leeds Regional Hospital Board; Dr J. F. Fraser, Divisional Medical Officer of Health (Castleford and Pontefract), West Riding County Council; Mr J. Herbert, Clerk, Wakefield Executive Council; Mr F. Mangnall, Group Secretary, Pontefract, Castleford, and Goole Hospital Management Committee; Mr S. W. Smith, Group Secretary, Wakefield Hospital Management Committee.

The opinions expressed are of course our own, and whilst many of them emerged during discussions with the research group they do not necessarily reflect a consensus amongst the members and certainly not the committed view of each member.

In addition discussions were held with people intimately involved in preparing for the change at the Department of Health, Scottish Home and Health Department, regional hospital boards, executive councils, local health authorities, and with one or two university-based research teams working in related fields.

1 Change in the National Health Service

Out of chaos will come a time of crisis. In the ideographs of the Chinese language two characters are used to write the single word crisis—one is the character for danger and the other is the character for opportunity. National Commission on Community Health Services.

There can be no doubt that the reorganization of the National Health Service will produce chaos. Equally certain is that chaos will produce a series of crises. It remains to be seen whether these crises are dangerous or whether they can be used as the opportunity to develop a better health service. Change and crises are not new to the NHS: indeed one might say that change is endemic and that the most common style of management to be seen in the NHS is 'crisis management'. This might seem to be in conflict with the more usual view, certainly of hospitals, that they are institutions hide-bound by tradition and the very epitome of conservatism. This paradox may to some extent be explained by the fact that hospitals are so busy coping with internal change that they have little time or energy to respond to stimuli for change from outside the institution.

Changes in medical practice have been accelerating in recent years as science and technology offer the doctors increasingly sophisticated diagnostic aids and open up new avenues of treatment. Equally significant for the NHS have been changes in social attitudes which have produced, amongst other things, the Abortion Act, and enabled dramatic changes to be made in the treatment and care of the mentally ill and the elderly.

The last decade has also seen an increasing recognition that the NHS needs 'managing' although the decision as to who should manage and how, has been a matter determined largely by personality rather than formal structure. One of the consequences of the medico-scientific revolution has been the growth of a wide range of scientific and para-medical professional groups all of whom are now developing their own

career structures and demanding the right to participate in the over-all management of the NHS. Recent years have also seen an increasing emphasis on productivity and value for money, on positive resource allocation, personnel management, and industrial relations.

Change is essentially a dynamic process; once set into motion a whole range of variables react with each other sometimes with unexpected results. Activities that were thought controllable go awry and external factors frequently intervene. In a fluid organic organization like the NHS change in one sector almost invariably spills over to others until eventually the whole adapts to the new situation.

Perhaps the best illustration of this can be found in the nursing field. Many people reacted with surprise, dismay, and even anger when they discovered that changes in the organization and management of nursing services, as a result of the Salmon (6) and Mayston (7) Reports, was forcing changes in the organization and deployment of other professionals and in established channels of communication and decision-making processes. Another example might be the introduction of incentive payment schemes for ancillary staffs which many observers consider to have created a new relationship between management and staff of all kinds. The old comfortable paternalism that rested on a sense of vocation is, it is asserted, being replaced by abrasive confrontation between trade unions and management.

These and other pressures have had the effect of increasing the tempo of change in the NHS to a very high rate indeed. If the breadth and pace of change is to be accelerated further by reorganization, the changes will have to be controlled and managed with the greatest skill if the NHS is to maintain the present level and quality of care provided to the community and realize the objectives of reorganization.

A moratorium on change

It has been suggested that a moratorium be placed on 'change' during the period of reorganization. This has an immediate attraction, but is it realistic? In recent years the stimuli for change have come primarily from the higher echelons of the

N.H.S. The present areas of greatest pressure are set out below with an assessment of the likely success of a moratorium.

1. The reorganization of professional staffing structures as a result of decisions taken nationally, for example, nursing (Salmon [6] and Mayston [7] Reports), scientific (Zuckermann Report [8]), engineering (Woodbine–Parish Report [9]), pharmaceutical (Noel Hall Report [10]).

It might be possible to arrest the introduction of these changes or at least slow them down, but in each case the changes may be seen as a preparation for 1974. What ought to be said is that any recommended changes that do not fit in very closely with the structure envisaged for 1974 should not be proceeded with for the present. No doubt many of the recommendations of Report of the Committee on Nursing,[1] if accepted, could be incorporated into the new structure. However, the timing of the implementation of accepted recommendations in areas that are not directly related to reorganization ought to be carefully considered and, if possible, held over until the new service has had time to establish itself.

2. The reorganization locally of other professional structures to match changes agreed nationally, for example, the development in hospitals of area administrators to match their nursing counterparts. Development of functional management.

If the changes improve the quality of management in existing organizations and fit broadly into the plans for 1974, it is difficult to justify stopping them.

3. Introduction of 'Cogwheel'.

As this system is almost certain to be adopted as the model for the medical advisory machinery in the new service, its introduction should not be delayed: it is essential preparatory work.

4. Capital development programmes.

Although the capital development programmes ought to be reviewed by the shadow authorities, short-term changes would be almost impossible both from a planning and a financial point of view.

1. Department of Health and Social Security (1972), *Report of the Committee on Nursing* (Briggs Report), Cmnd 5115 (London: HMSO).

5. The 'training' explosion.

The NHS's investment in training will almost certainly increase with reorganization.

6. The implementation of Whitley Council agreements: new grading and pay structures, incentive schemes, etc.

It is unlikely that changes in this field can be arrested: indeed they are likely to increase.

7. The reallocation of resources to the long-stay field and action required following reports and committees of inquiry into alleged malpractice, cruelty, and mismanagement.

Recent years have seen a series of nationally inspired pressures for change in the NHS mainly in the long-stay field. All the recent changes were necessary and long overdue. However, before the long-stay it was the maternity service, and before that something else. The allocation of resources in the NHS is still not in balance, but the Department should think twice about stimulating another 'adjustment' in the next few years.

In any case, a further reallocation would have little chance of success in the turmoil of reorganization.

8. Raising standards of efficiency and developing norms of good practice.

This cannot be stopped, but it could be controlled so that those areas where the greatest improvement can be made receive the attention they deserve.

9. The introduction of new services, for example, Abortion Act, family planning services, etc.

Wherever possible the implementation of these changes ought to be controlled and in no circumstances should existing authorities be expected to contain the resulting increases in work-load within their existing resources, if, in their view, it is impossible to do so.

In addition to the above there is a whole range of stimuli at regional and local levels many of which arise totally unexpectedly and demand immediate responses by local management.

A formal moratorium, no matter how desirable, would appear

to be impracticable. However, an informal moratorium appears to have been operating for some time and many developments are being held back 'until after 1974'. As much of the pressure appears to emanate from the DHSS (although not necessarily at its instigation) it is for it to do all it can to filter and control national demands for change during the period of reorganization.

Objectives of reorganization

The general aim of reorganization is stated in the White Paper to be the provision of 'a better and more sensitive service to the public' and the means by which this is to be achieved is an organizational reconstruction. The existing formal divisions in the service are to be swept away so that one authority has a general responsibility for the health of defined communities.

However a reorganization of the formal structure will not of itself produce 'a better service to the public'. All it will do is remove some of the existing barriers to the provision of a balanced and effective service and create a framework in which people with many different skills will find it easier to collaborate to help others in need.

Operational integration, which will be the real test of whether reorganization has been successful, will only come about as a result of much deeper and profound attitudinal changes which will be much more difficult to effect than the changes in the formal organization. These include persuading doctors, nurses, administrators, and others to extend their horizons beyond their present sectors of the service in order to view a patient's total health care needs and then to consider problems of resource allocation from this new perspective. It will also be necessary to develop further the NHS's commitment to the individual patient in what is becoming an increasingly complex bureaucratic organization. Equally difficult will be the task of harmonizing personal and professional goals with an agreed set of organizational goals; to develop specialist skills without corresponding professional isolation and to develop a philosophy of management and a structure and expertise to go with it that are appropriate to such an important and complex service.

It is vital that the objectives of reorganization are clear from the start for the price of failure is high. Badly handled the

reorganization could destroy existing operational links between the three arms of the NHS, seriously impair the morale of the staff, and as a result reduce the quality of care provided to the community. This in turn will have the effect of destroying public confidence in and support for the NHS.

Priorities for action

The task of reorganization is enormous and must not be underestimated. One of the largest organizations in the country and perhaps the most complex, is to be guided through a period of intense change. A new formal structure has to be created, a new management structure brought into action, new lines of authority and channels of communication established and whilst all this is going on the service provided to the patient must continue undisturbed.

The date 1 April 1974 appears to be a firm one for the creation of new health authorities so that the speed with which much of the preparation must proceed is to some extent predetermined. It would, however, be unrealistic to assume that all the objectives of the change process can be achieved on that date or even that the new structure can be firmly established. The date 1 April 1974 will be remembered, as will 5 July 1948, as a key point in the evolution of the NHS.

It now appears to be generally accepted that the speed with which change is introduced can have a significant influence on its ultimate success. In some cases a careful phasing of change by a coherent series of evolutionary steps will be the only way to reach the objective: in others a rapid transition from one situation to another is necessary. In more complex change processes the 'right' pace will vary and each stage of the process will require careful management.

In an organization as functionally and politically complex as the NHS, which is already in an intense period of change, and under the constraint of having to maintain a full service during the period of change, the careful evolutionary approach seems the most appropriate starting point.

Emphasis on rapid change may hinder or even eliminate the prospect of achieving long-term objectives. Care must be taken to identify matters which will be crucial to these long-term

objectives, at an early stage, in order that their attainment will not be prejudiced by steps taken to resolve short-term difficulties.

The whole change process needs managing so that each stage is carefully prepared and timed.

Those health service staff who have been involved in the amalgamation of hospital management committees in recent years have some appreciation of the problems involved as do officers who were in the NHS in 1948. However, there is a danger that must be avoided of too readily relating the changes in 1948 to the present situation. Whilst one must never ignore the lessons from the past their validity to today must be carefully judged. The NHS is very much larger and more complex than it was in 1948 and the task of reorganization is correspondingly far greater.

Once the preparation for reorganization begins in earnest the problems that demand attention will multiply with almost geometric progression. In solving a problem in one sector two more will be unearthed and two more created. A positive orgy of change will ensue.

In these circumstances it is important to identify some priorities: what must be done, what ought to be done and what can wait until the new service is firmly established?

There are two ways of approaching these questions. The first is to determine sequential priorities by preparing a network and plotting critical paths. This approach is beyond the scope of this short study although we have produced, in a series of appendices, checklists of some of the tasks that will have to be performed.

The second approach is to identify those tasks that are so important that unless they are performed properly the main objectives cannot be achieved at all.

These crucial tasks will include:

a. Creating the right environment for change both within the NHS itself and within the communities it serves. This will entail ensuring that staff understand the reasons for change; feel they can participate in planning and effecting it; and above all, are committed to making it work. It also requires action to maintain public confidence in the NHS.

b. Making arrangements to ensure that the new health authorities can legally and effectively function by 1 April 1974

and that existing operational patterns of activity can if necessary continue undisturbed. To avoid a hiatus between the old and the new it might be necessary to arrange for existing decision-making processes that form part of the day-to-day management of the service to continue until such time as they are replaced.

c. Ensuring that adequate arrangements are made to provide the community services with the support they require. Change may be evolutionary for the hospital and executive council services but is revolutionary for the community services. The organizations, of which they are at present an integral part, will disappear on 31 March 1974.

d. The design of the management structure but in particular, the decisions on the division of areas into districts and the creation of common area and multi-area services. These decisions will, in the short term at least, be irreversible once made.

e. Ensuring that those who are appointed to manage the change are capable of doing the job and at the same time devising selection procedures for posts in the new Service that are seen to be reasonable and above all fair.

2 Preparation for reorganization

Joint liaison committees

The Government announced in the White Paper, their intention to constitute regional and area health authorities in shadow form before 1 April 1974 in order that they might prepare the ground for reorganization. However, as they cannot be appointed until the necessary legislation has been passed, and the 1973 local government elections have taken place, they are unlikely to appear on the scene until the summer of 1973.

Because of the considerable amount of preparatory work that is necessary, existing authorities have been asked to form joint liaison committees to undertake as much of this work as possible short of preempting decisions that can only properly be taken by the new authorities themselves. The JLCs, as they have quickly become known, will have no executive authority at all but will provide a forum for discussing the problems of reorganization and in the light of guidance from the DHSS, of working out, or contributing to their solution. Their constitution and function is set out in HRC(72)3, the third in a new series of national circulars about reorganization. The recommended constitution of two representatives per existing authority, no doubt designed to keep the size of JLCs to workable proportions, appears to have been widely adopted, although the lack of guidance as to who these representatives should be, caused some initial difficulties. Clearly all senior officers cannot be members of JLCs, but on the other hand the JLCs will be unable to discharge their responsibilities unless they have the active and positive participation of all officers. It is vital therefore that JLCs take great care to ensure all senior officers are given the

opportunity to contribute to discussions relating to the future organization of their departments and to involve them in any working parties that may be established.

In preparing preliminary assessments for shadow authorities, it is important that JLCs produce statements of options and not negotiated compromises which, if they are not in the event accepted, could generate considerable friction and confusion. This is particularly important on fundamental issues such as the division of areas into districts.

There is no doubt that JLCs will make very considerable demands on the time and energies of chief officers to existing authorities and it is unreasonable and unrealistic to expect them to take on this increased work without additional administrative and secretarial support. The collection of data, arranging meetings and visits, taking minutes, drawing maps, preparing background papers, etc., will all entail additional work. Each liaison committee could well fully employ a support team comprising perhaps two administrative officers and a secretary. The cost in a full year would amount to no more than £5,000 and the staff concerned could either be recruited from within the service or from outside. No difficulty will be experienced in recruiting good quality staff either to serve the committees or alternatively to replace staff who are appointed from within the service.

JLCs are unlikely to prove effective unless they are given adequate support staff.

Shadow authorities

When the shadow authorities are appointed they will probably function along side rather than replace the JLCs and their principal tasks might provisionally be set out as follows:

1. In conjunction with JLCs and others to create the right environment for change to take place, to ensure staff morale is maintained at as high a level as possible, and that all those responsible for effecting change understand both the reasons for it and the expected rewards.

2. To ensure that all the necessary procedural and legal aspects of the change process are attended to, and that there is a smooth transfer of responsibility from the existing authorities.

3. To relate national plans to local areas and produce plans and policies for their implementation, following consultation with staff and community representatives.

A more detailed checklist of tasks is set out in the appendices and the major tasks are discussed in more detail in subsequent chapters.

The legal status of shadow authorities will no doubt be made clear in the Health Service Bill so resolving questions relating to the employment of staff and the allocation of funds to cover the costs associated with reorganization.

3 The new management structure

In his foreword to the Consultative Document (11) published in 1971, Sir Keith Joseph, Secretary of State for Health and Social Security, made it clear that the essence of his proposals for reorganization, and the basic difference from earlier proposals, was the emphasis on effective management.

This emphasis on improving the management of the NHS is maintained in the White Paper which provides some insight into the principles upon which the new management structure will be designed. The detail will only emerge following the publication of the report of the Management Study Group[1] and after the DHSS have concluded their consultations with all the professional groups concerned.

This will clearly take time but need not preclude a discussion of some of the likely features of the new structure, the design process, or of the extremely difficult task of transforming the new organizational chart into reality.

The broad outlines of the new structure are now clear as are some of the difficulties that can be expected:

1. The new structure will provide for a clear definition and allocation of responsibilities with maximum delegation downwards matched by accountability upwards.

2. The new structure will clearly define the tasks and relationships between senior officers as well as the criteria by which individual performance will be judged.

3. In defining these relationships theoretical concepts such as monitoring and co-ordinating authority, line and staff functions,

1. The Management Study Group was established by the Secretary of State to advise on the detailed management arrangements in the reorganized service.

delegation; supervisory, collateral, and service relationships, attachment, outposting, secondment, and others will be used.

4. The structure will entail a radical change in functions and responsibilities for many senior staff.

5. Formal responsibility will be given to groups of officers working as teams at certain levels.

6. To some extent movement of senior staff will occur as a result of national or regional selection procedures.

7. Areas will in most cases be divided into operational districts which will be managed by a multidisciplinary team.

In the light of the above it is possible to identify immediately certain conditions which must be present if the new structure is to work as intended:

1. The structure should be carefully designed to 'fit' individual areas and regions.

2. The philosophy underlying the structure and the structure itself must be understood.

3. The staff charged with the responsibility of introducing the new structure must feel committed to making it work.

Designing the area and regional management structures

In preparing local 'schemes' for implementing national policy decisions shadow authorities and the DHSS would be well advised to note the advice of D. R. Daniel who in a paper entitled, 'Reorganising for results' (12), examined the reasons why many of the organizational reconstructions carried out by industry in recent years had been unsuccessful.

Perhaps the most conspicuous mistake has been the tendency to rely too heavily or rather, too exclusively—on theory and principle in organisational design. The so-called principles of organisation—those familiar universals dealing with span of control, reporting relationships and so forth—frequently seem to be invested by organisational planners with the authority of moral law. Certain organisational relationships, whatever their apparent practical merits, may be damned because they commit the sin of violating these principles; others seem to be favoured mainly because of their theoretical purity. Actually, of course, most principles should be viewed as no more than

generalisations about what has been observed to work in practice, based upon past organisational experience. Derived from experience they are subject to revision in the light of new experiences and circumstances. Certainly they ought not to be considered sacred; it is as foolish to be bound by past experience as to ignore it.

Another warning sounded by Daniel in the same paper is also highly relevant;

The tendency to reproduce a given organisation pattern simply because it has proved successful for another company has been another common error in organisational planning.

It is hoped the DHSS will resist the temptation to speed up the planning process by laying down a rigid national management structure that has to be applied slavishly to every part of the country. The DHSS should permit, and indeed encourage, shadow authorities to identify their own special management problems and operational patterns and design their structure accordingly. Cynics may argue that 'taking account of local needs' really means establishing enough posts to satisfy existing chief officers. This sort of 'adjustment' is clearly undesirable but it does highlight the dilemma of whether management structures ought to be designed to fit the management talent available or whether the structure comes first, individuals being slotted in later who grow into their new responsibilities.

The risks associated with 'illegitimate adjustments' are far less in the long run than those associated with laying down an inviolate national pattern.

There are quite a few circumstances in which the situation on the ground may demand a modification of national policies. An area previously managed on a highly centralized basis may operate better with one district and a number of sub-districts whilst a neighbouring area of similar size may, because of an existing policy of decentralization be more effectively managed by a number of small or medium-sized district teams. Operational areas of social service departments, which may influence the shape of health service districts, vary in size throughout the country, as do the pattern of local government districts.

The case for some degree of local flexibility assumes that the shadow authorities and their chief officers are capable of recognizing local needs and of designing a complex,

sophisticated management structure that takes account of them. How valid is this assumption? Chief officers will not necessarily have personal knowledge of their new areas and few will have experience of designing anything more than a relatively simple single disciplinary management structure.

Nevertheless all chief officers should be experienced managers capable of meeting the challenge of designing their organization provided they are given the right help and advice when it is required.

The design stage might go as follows:

Stage I. A full-scale briefing on the philosophy and design of the new structure for chairmen and chief officers of the shadow authorities, by the DHSS and their management consultants. These briefing sessions, which could last up to two days, might be organized regionally so as to keep the numbers down to manageable proportions.

They could also usefully include advice on organizational design and the presentation of case-studies drawn from the experience gained in testing the hypotheses in the field. (The Management Study Group reports on the testing exercises they have undertaken would be invaluable to JLCs and ought to be published in any case as soon as possible.)

Stage II. Shadow authorities receive an outline management structure from JLCs which emphasizes any areas where local modification of the national design is felt to be appropriate, and where appropriate, outlines alternative solutions to particular problems.

Stage III. Shadow authorities design a 'scheme' for their area or region. In preparing their 'scheme' the shadow authorities will need to refer constantly to present operational patterns and will require a great deal of local information. They will also, on occasion, require clarification on particular features of the national design and in some circumstances advice about how to resolve a particular problem. They ought to be able to obtain this help quickly and the DHSS might consider establishing a small multidisciplinary central advisory team which could include a representative from their management consultants and professionals from the NHS on temporary attachment.

In addition to helping on request this team might develop a

special series of circulars, in which they could pass on to all authorities, clarifications or advice given to any one. Problems arising in one area will almost certainly arise in others. In addition to assisting shadow authorities the establishment of a team of this kind would help to keep the DHSS in close touch with the direction and speed of progress in the field.

Stage IV. Having prepared a draft 'scheme' shadow authorities should then seek comments from existing authorities through the JLCs and from representatives of local staff interests.

Shadow authorities must be able to assume in seeking these comments that full consultations had taken place with national representatives of staff interests before the Secretary of State announced his policy on the management structure. Discussions at this point should therefore only concern the local interpretation of agreed national policy.

Stage V. Having considered the comments of the various interested groups shadow authorities would then submit a 'scheme' to the DHSS for formal approval. It is essential that the approval stage should not be protracted and if the DHSS do decide to approve each scheme in detail they must have trained staff available for this purpose. The central advisory team suggested above might facilitate this process. One cause of delay may be the extent to which an area includes in the 'scheme' posts that do not exist at all at present and may have to be filled by recruitment of specialists from outside the service. If the posts do not exist at present they will not be funded.

Perhaps the solution would be for the DHSS to approve the proposed 'schemes' as 'being consistent with national policy' but make it clear that the financing of specific posts is a matter of area or regional resource allocation and therefore a decision for authorities themselves.

District organization

One of the most fundamental decisions that the shadow authorities will have to make will be the way an area is divided into districts. This decision will form the basis of the design of the management structure and for all practical purposes once taken will be irreversible, at least in short term.

The White Paper describes districts as 'localities within which it is possible to satisfy the greater part of the public's health care needs'.

As such a district will:

a. Contain a district general hospital or its equivalent.

b. Have a population of between 200,000 and 500,000.

c. Be small enough for professional representative machinery to be effective within it.

The district will probably be managed by a multidisciplinary district management team (DMT) who will be responsible for ensuring that the most effective possible health care is made available to the community they are serving.

The team itself does not necessarily have to meet all needs; some services for example are only viable at area level. It does, however, have to identify the need and arrange for it to be met. For example, in 1974 the community served by the present Goole sub-group of hospitals (at present administered by the Pontefract, Castleford, and Goole HMC) will become the responsibility of a district management team who will be responsible to the Humberside Area Health Authority. The latter may well wish to arrange for Pontefract District General Hospital to continue serving Goole on an agency basis. As a result there will have to be close links between the district management team in Pontefract (providing the service) and the district management team responsible for the Goole area (ultimately responsible for its provision).

In deciding how to divide an area into districts, shadow authorities (and before them JLCs who have to reach some tentative conclusion to enable other work to proceed) will have to produce a compromise from the criteria listed previously.

In addition to this the following may also prove to be of some significance:

a. That the district should usually coincide with the catchment area of existing or planned district general hospitals at least in so far as this catchment area is contained within a single area health authority.

b. That the district is large enough to achieve the benefits of economics of scale and the effective deployment of staff.

c. That the district is small enough to keep health services on a human scale.

d. That the unit is of a size to permit effective management.

There may be problems of achieving balance and it is unlikely that any two situations will be exactly similar.

In order to gain some insight into the practical implications a study was made of West Yorkshire Metropolitan District 6(e) with the research advisory group. A map is included as Appendix C.

Population totals as a criterion

It is possible to identify coherent and viable communities in a wide population range. The 'Celtic Fringe' of the British Isles contains many small communities. In central Wales population is so sparsely distributed that a unit of 300,000 implies a district covering a large area containing several administrative counties.

With the exception of Belfast no urban community in Northern Ireland exceeds 100,000 and outside the city population is sparse by English standards. As a result the report on *Reorganisation of Health and Personal Social Services* (13) recommends health districts all of which have under 200,000 population: all but two have less than 100,000.

England also contains viable coherent communities falling outside the recommended population range. The Isle of Wight contains under 100,000 people who are isolated from the mainland. Barrow in Furness is another relatively small community which is rather isolated from the other areas of economic activity. Indeed in some regions there are potentially contiguous districts falling on both sides of the desired population range. For example the new Humberside Area contains Hull and its environs which may form a district with a population of over 500,000, whilst across the Humber estuary there could well be two districts each of under 200,000 based on Scunthorpe and Grimsby. Densely populated parts of the Midlands may also provide districts with populations over 500,000.

If the problem is related to the West Yorkshire Metropolitan District 6(e) there is a population of some 305,000 distributed almost equally between the areas served by two existing hospital management committees. The Wakefield HMC is responsible for the western part of the new district: the eastern and southern parts are served by the Pontefract, Castleford, and Goole HMC

whose catchment area at present extends much further east than District 6(e) itself. Rigid application of the criterion of population total would probably produce a one-district area health authority since any smaller districts would imply populations of under 200,000. However, the preceding discussion shows that total numbers are of little value without consideration of distribution, density, occurrence of coherent communities, and existing operational patterns. These other features are so much more important that it might be better to disregard population totals altogether.

District general hospitals as a criterion

The location and catchment areas of existing district general hospitals would appear to be a much more useful criterion because it recognizes existing operational patterns which will not be immediately disturbed by the administrative reorganization. Where established district general hospitals have usually developed natural operational health units around them. In District 6(e) there are two district general hospitals each of which is largely independent and forms a focal point of a viable local health service. A short analysis of general practitioner referrals indicated that general practitioners in Pontefract and surrounding localities use the district general hospital in Pontefract almost exclusively. General practitioners in Wakefield appear to have the same relationship with the district general hospital in the town. Local health authority services are organized so that they fit conveniently into these two units. Consultant medical staff work exclusively in one or other of the two groups with the result that each has its own well-established local medical community. All these functional considerations suggest a two-district area health authority within the new local government Metropolitan District 6(e).

Other work has emphasized existing health care patterns. In the Northern Ireland Report the consultants included in their criteria for district identification:

a. That resources should be those of a medium-size hospital group; should include divisional offices of existing health and welfare authorities and a number of health centres.

b. That problems of operation and management associated with travel times and communication should be minimized.

Particular emphasis was placed on maintenance of existing operational units (for example, the proposed Londonderry District). A report prepared by Dr John Powles at the University of Sussex (14), suggests that Area 44 (East Sussex) be divided into three districts and one 'sub-district' on the basis of catchment area information. Brighton (308,000 population), Eastbourne (134,000), and Hastings (141,000) each form coherent, independent health care units. Uckfield (67,000) depends mainly on Tunbridge Wells and mid Sussex both of which will lie outside the proposed Area 44.

Despite the almost identical population size, Brighton and District 6(e) are fundamentally different: the one is of itself an operational health care unit, whilst the other contains two separate units because population is distributed more evenly over a wider area.

Social geography as a criterion

Another important criterion involves the identification of established local communities of common interest which are based on patterns of residence, work (type and place), shopping, and recreation. Most of these activities are undertaken within one functional area where, as a result, there is a definite local identity. Frequently, this functional area will coincide with operational health care units described above and both may cross existing boundaries of local government. Transport links are the arteries of such a functional area and bus services have been used to define urban catchment areas which are naturally similar to communities of interest. Although the boundaries between regions, areas, and districts will not be barriers to the use of health services it would be advantageous wherever possible to recognize the facts of social geography as represented by defined communities of interest and match health services to them.[2]

In District 6(e) there are, broadly speaking, two communities of interest which relate to dominant types of employment. The western part of the area represents the fringe of the west Yorkshire textile industry but to the east and south of Wakefield coal-mining is the main economic activity. In Dewsbury's

2. For a more detailed discussion of communities of interest see references 15 and 21.

Employment Exchange area, which includes Ossett, about one quarter of the insured population is employed in textile industries. In Wakefield the figure is about 10 per cent. The eastern and south-eastern parts of the proposed district contain very little textile employment and relatively little manufacturing. Coal-mining is all-important in Normanton (approximately 41 per cent of insured working population), Castleford (37 per cent), and Hemsworth (40 per cent). It is still the most important occupation in Pontefract and Knottingley though representing a smaller fraction of total numbers.[3]

These two industrial localities have different settlement patterns, identities, and interests. Wakefield forms a more diversified zone between the two extremes.

The original proposals for local government reorganization provided for a 'Mid Yorkshire District' which included Dewsbury, Wakefield, and Pontefract. Mr Senior in his dissent made the following comment on this proposal:

> These form three compact, individually coherent districts . . . the result is a monstrosity of a unit which I defy anybody . . . to describe as coherent or satisfying for planning and development functions, let alone as corresponding to the reality of people's lives. I doubt if it would be possible to create a more organically disharmonious unit of the same size anywhere in England (15).

Revised proposals for local government reforms have amalgamated Dewsbury with Huddersfield. Even so, there is still no great community of interest between Wakefield and Pontefract: the two are in most respects self-contained. A two-district area health authority would recognize 'the reality of people's lives'.

In addition, it is probable that textile and coal-mining communities have different patterns of morbidity which may place differing emphasis on health care services.

A balanced consideration

The general conclusion that may be drawn from the study of District 6(e) and research in other parts of the country is that district organizations should only be established after a

3. The employment information is based upon data supplied by the Yorkshire and Humberside Regional Office of the Department of Employment and relates to 1969. It is unlikely that substantial changes have occurred since that date.

detailed and balanced view of several criteria. These, taking account of local needs and conditions, will probably reflect existing health care operational patterns and the distribution of population to be served rather than mere population totals. What should be avoided at all costs is the arbitrary imposition of inflexible national criteria which may be expected to foster local resentment and resistance to change: the more rigid the standards, the greater the resentment.

Division of District 6(e) into two districts for health care purposes indicates the sort of reasonable compromise that could be made between local conditions and national standards.

Common area services

In a draft report circulated for discussion in February 1972 (16) the Management Study Group proposed that 'certain services which support district services should be provided from a common area base to take advantage of economies of scale or for other medical or technical reasons'.

These common area services may include the following:

Medical supporting services: Area laboratories, area pharmacies.

Supply services: Area supplies, CSSD, laundry, transport.

Technical services: Engineering, building, and vehicle maintenance; project design and management information.

The attraction of economies of scale cannot be denied, but experience to date in the NHS suggests that centralization has the practical effect of reducing the quality of service to the consumer.

It is not always clear what is meant by 'quality' but the main criticism of centralized services appears to be an unresponsiveness to local need upon which a high premium is placed. This suggests either that insufficient regard has been paid to consumer needs during the economic analysis of centralization or that the NHS does not have the management expertise to run services which realize the economic advantages of size, but at the same time provide flexible, responsive services to all their consumers.

A number of potential solutions present themselves. The first is to improve the quality of the management of the individual

services and the creation of an area management tier will help by providing reasonable career structures for the specialist officers concerned. However, this removes decision-making further from the consumer thus creating distance and the illusion, if not the reality, of a remote unresponsive service. This situation might be avoided by devising a very flat management structure which locates decision-making at a point as close to the consumer as possible and by locating the area officers close to their centres of production rather than at area headquarters.

Another option is to leave the management of a particular service at the district level and in the case of a multi-district authority, nominate one of the specialist managers as area advisor.

It would be unwise to lay down a rigid policy as the choice will depend upon the extent to which, in a particular area, the service is already centralized: existing operational links; the geographical size of the area and other factors.

Professional advisory machinery

The White Paper makes it clear that a strong professional advisory machinery will be built into the new service; indeed after reading the White Paper and the proposals for Scotland one is left with the distinct impression that there will be a greater emphasis on professional advice than there is at present.

The shape of the new advisory machinery has not yet emerged and discussions are apparently taking place at the moment with the professions concerned. As the discussions proceed we hope that a distinction can be maintained between the representative and negotiating role of the professions and the participative role of the professional advisory machinery.

It is important that these discussions should not prove too protracted and that agreement can be reached in time for the new machinery to be established in shadow form to work alongside shadow authorities and so contribute to the preparation for 1974.

Organizational chart to reality

How can this new, complex, and undoubtedly sophisticated management structure be successfully introduced? As has

already been noted if it is to have any chance of success at all it is essential that chief officers from all disciplines thoroughly understand the philosophy underlying the structure, the structure itself, and that they feel committed to making it work. The greatest potential difficulties lie with the professional teams that are proposed for the district level. In some cases the members will constitute an enthusiastic, cohesive, effective group utilizing to the full all the talents and experience within the team. In others, after some initial wariness and suspicion amongst the members, non-productive conflict will be the order of the day. The establishment of status and determination of areas of responsibility will occupy the teams' time and energies; petty disputes will assume disproportionate importance and personal dislikes and prejudices will spill over into the day-to-day management of the service. The consequences for the NHS the team is supposed to manage could be disastrous. It should, however, be possible to prevent this sort of situation developing and one method would be to use management consultants to help the teams develop their full potential. A professional from outside the NHS with insight into how individuals behave in groups and experience in helping groups of people mobilize their combined talents to best effect could be of considerable help in converting the new organizational chart for the NHS into reality. Indeed without help of this kind it is difficult to envisage how the new structure can possibly operate effectively.

This is a matter requiring urgent study to establish what could be done and what expertise is available to do it.

The introduction of the new structure will also be easier where account is taken of existing structures during the design stage, thus minimizing the effects of the change, and where the introduction of the new structure is carefully 'phased' in.

It is particularly important that staff, whose role is to change, understand their new responsibilities and how they relate to those of others. They also need to know why their jobs are to change and what is hoped will be achieved by changing them. Staff who feel they are pioneering a new development will be much happier and effective than staff who are forced to change blindly as a result of orders from above. The latter will almost certainly set out to prove that the old way was better; the quickest way to achieve this is to ensure that the new system

collapses and if this fails the new system can be circumvented and the *status quo* retained. D. R. Daniel in advancing a further reason why organizational changes are often unsuccessful states:

> In some companies I have observed top management seems almost to have assumed that switching formal reporting relationships—or adding, deleting or rearranging the boxes on the organisational chart—would automatically change individual behaviour overnight. In reality, established management habits usually tend to persist despite new organisational charts (12).

Integration courses, which are now already well under way, will help to familiarize chief officers with the philosophy, design, and language of the new structure but as these courses can only cater for the most senior officers it is essential that they pass on their understanding, undistorted as far as possible by personal views or fears, to colleagues and subordinate staff. This is a heavy responsibility and its importance should be stressed to those people attending the courses. There are a number of other ways in which staff may be helped to understand the new structure.

National guide to new structure

Once the Secretary of State has reached a decision on the form of the new management structure and the major phases of the reorganization have been timetabled the DHSS should consider preparing or commissioning, a 'Guide to the reorganization'. Its purpose would be to assist existing authorities and shadow authorities and others to explain the reasons for reorganization and the shape of the new service to staff, members of the new authorities, and to interested members of the general public.

Two versions might be necessary: one for general distribution and another (or a supplement) for supervisory and managerial staffs explaining the management structure in more detail.

The DHSS should also consider producing, in conjunction with their management consultants, an information film.

A national broadsheet

A regular progress report on the reorganization produced by the DHSS could prove extremely useful although it would require very judicious editing and a clear appreciation of its intended readership so that the style could be pitched accordingly.

Local seminars

As part of the general effort to keep staff informed about developments JLCs should organize, in conjunction perhaps with local universities or higher education establishments, seminars on the reorganization and encourage staff to attend from all branches of the NHS. Questions will inevitably arise as to whether staff should be released to attend these seminars in working hours; who should meet any fees charged by education authorities; or in the case of meetings organized on NHS premises some recalcitrant member is bound to ask who meets the cost of refreshments.

All supervisory and managerial staff should be released during working hours to attend seminars; fees should be minimal, and should be met by existing authorities. (JLCs being the appropriate forum for agreement.) Existing authorities should be authorized by the DHSS to take whatever reasonable steps they consider appropriate to promote discussion among staff about the reorganization. The only proviso to all this is the usual but important one that staff are released subject to the exigencies of the service.

Members of existing authorities may also wish to attend these seminars.

4 Anxiety and change

Stimulating discussion in order to gain understanding will produce increased anxiety on the part of many staff. Until this point many staff will have dismissed from their minds the prospect of change with its threat of disrupting their lives, and sought comfort from the thought that 1974 was a long way away. Discussions about reorganization seem to have been going on for years and successive plans come to nothing: with luck there will be a general election, or an economic crisis, or something which has the effect of distracting the Government from its intentions or at very least extend the time-scale. These comfortable illusions will be dispelled and anxiety will increase markedly once there is a recognition that change is inevitable.

Few staff will be able to view the changes objectively and the natural reaction will be to ask the question 'where do I fit in?' In some cases personal anxiety will hinder a full understanding of the proposals or even distort the picture completely.

Experience gained in opening new hospitals and closing others shows that whilst anxiety can be eased temporarily by personal reassurance most staff are not really satisfied until they have been offered a firm post in the new organization. Only then can they start to plan their future and that of their families from a firm basis.

The period of uncertainty is illustrated in Fig. 1.

Anxiety will probably be at its highest amongst staff in the community services who fear a hospital take-over and amongst staff whose role may disappear altogether, for example, medical officers of health. Those staff who are currently holding down senior posts which gives them a fair degree of independence and

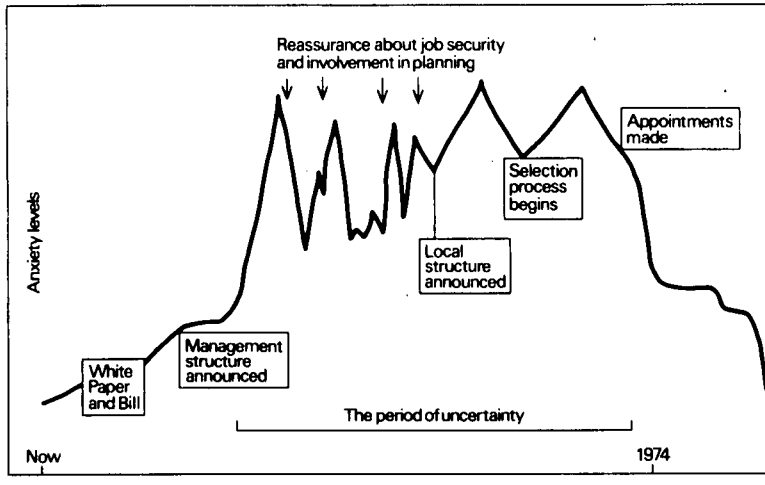

Figure 1

which they are apprehensive about losing, will also be anxious as will staff who are currently fully stretched in holding down their existing posts and therefore concerned about the increased pressures that reorganization will create.

Whilst the impact of reorganization will be at its greatest at the senior levels of the NHS, feelings of anxiety and uncertainty at this level are likely to spread very quickly throughout the organization.

Morale in the period of uncertainty

Anxiety tends to lower morale and if one accepts Revans's proposition (17) that low morale is related to low standards of care then management at all levels has a very clear responsibility to remove the reason for anxiety as quickly as possible. Morale problems will be at their greatest during the period of uncertainty and it is vital therefore that staff should be offered firm appointments in the new structure at the earliest opportunity. Anxiety levels will also be reduced if staff are given the opportunity to contribute to the planning of the new structure and whilst this involvement may complicate the process it is the only real way to obtain commitment and enthusiasm for change.

The other variable which can be controlled is the timing of the final announcement about the management structure. This is

likely to produce an immediate 'peak' in the anxiety level and its timing should be arranged in order that:

a. 'The national guides to reorganization' are ready for immediate distribution.

b. JLCs have set up seminars for staff to explain the new organization: why it is necessary and what it is hoped to achieve by change in the structure of the Service.

c. Chief officers are themselves fully conversant with the plans and can explain them fully and confidently to their staff. Their confidence in the future will be the greatest reassurance they can give to their staff.

The period of uncertainty will see a tendency to stop developments of all kinds at all levels and this must be carefully controlled so as to avoid frustration developing: particularly at middle management levels.

In some cases the period of uncertainty will be spent running down existing organizations and there will be a general upsurge in the workload of all staff who are in any way involved in preparing for change. In many cases new procedures will need to be introduced which may have to run in parallel with the existing systems for a short time. Chief officers will in the main take on the task of preparing for change and deputies and assistants throughout the NHS will as a result shoulder increased responsibilities.

This clearly is the period when the danger of a sudden drop in the quality of service provided to the public is at its greatest, due mainly to overwork and low morale. It is not clear, however, who will monitor this critical time nor who will be responsible for managing it or indeed how they will recognize the point when the problem is getting out of hand and take appropriate action. It may be that at present positive central management of the situation is not really possible and that responsibility will be diffused throughout the NHS. In this case, management at all levels must become acutely sensitive to the morale of staff and pay particular attention to indicators of stress such as sickness and absenteeism.

Reassurance, a display of confidence in the future and a willingness to be open and honest with staff will be the most prominent features of good management during this period.

5 Staffing the new service

Preparing the staff establishment

Once the management structure has been submitted for approval the shadow authorities will move on to preparing a staff establishment. The starting-point for this establishment will be the numbers of staff required to run existing services and the first task, which should be undertaken by JLCs, will be to collate the existing establishments of authorities with responsibilities within a particular area. Adjustments will of course be necessary in the case of those authorities with responsibilities that cover more than one area. An extreme example of this problem is to be found in Yorkshire where the West Riding Local Health Authority and Executive Council presently have responsibilities in fourteen of the new areas.

Agreement will clearly have to be reached about the allocation of the staff of these large authorities. In the case of local health authorities difficulties will arise in the redeployment of specialist officers such as health education officers. Decisions about the deployment of such staff would most appropriately be made by shadow regional authorities as this is consistent with their function of ensuring that resources are properly allocated amongst areas.

There is another, perhaps more serious problem, associated with the integration of community services that does not appear to have been fully appreciated. This is that all the support services that are provided to local health authorities (maintenance of buildings and grounds, legal advice, planning, financial, and statistical services) will not transfer with them and

will therefore have to be provided at what might prove to be some considerable cost.

In the executive council field there are very real problems, both human and logistic, associated with the disbandment of the large and highly centralized county executive councils. The division of the staff and records of the West Riding Executive Council between fourteen area boards is again probably an extreme example. Each of these fourteen areas will need to know in good time how many staff they will be allocated although the problem will not be one so much of numbers as of obtaining the right balance of skills and experience.

Difficulties also arise in preparing the establishment for hospital-based staff. To turn again for an example to District 6(e), the Pontefract Hospital Management Committee employ staff who work in a Goole sub-group that will in 1974 fall into another area board. It is relatively easy to deduct from the total HMC establishment those members of staff who work full time in the Goole sub-group, but what should be done about staff who provide a service to the sub-group from the district general hospital in Pontefract: are they to continue providing the service or not?

This highlights what appears at first sight to be a problem of some importance: the non-coincidence of administrative areas and operational areas. In one part of Yorkshire a district general hospital is situated on the boundary of two areas having a wide catchment extending a considerable way into both. In practice this need not be of such consequence if it is accepted that existing operational patterns will continue at least in the short term and that the new authorities will not be expected to be immediately independent and self-supporting units.

The district general hospital in Pontefract for example could continue to provide support services for the Goole sub-group until such time as they can be provided from a district general hospital in Humberside. Indeed it may be more efficient to continue the operational link with Pontefract well into the future as the district general hospital in Pontefract is both geared up to serve the Goole hospitals and is far nearer than Hull.

This may necessitate some financial adjustments either by recharge or agreed adjustment to the area global allocations but this should not prove too difficult to arrange.

Once the number of staff required to operate the service at its present level has been established it will then be possible to compare the staff complement with the new establishment, although in practice the staff complement will be the basis of the establishment.

The reorganization will be seen by many people as an opportunity to put to rights immediately all the existing faults in the NHS and there will be a temptation at this stage to inflate establishments either to correct existing deficiencies or to match the numbers of staff who appear to be available.

The only way to control this is to give the shadow authorities firm financial allocations for 1974, within which they must frame their establishments.

Appointments and transfer of staff

The new organization will function only when staff are appointed. The quality of the people appointed; the time they have available and the support they are provided with will to a large extent determine the success, or otherwise, of the re-organization.

The timing of the appointment of officers to the new authorities and the selection procedures are already major preoccupations of senior staff in existing authorities. As time passes preoccupation will give way to anxiety. The Act will, presumably, make provision for the transfer of staff from existing authorities to the new ones and, as is the case in Scotland, contain a protection clause that:

as long as an officer continues in the employment of the new body until he is served with a statement in writing referring to the Order and specifying new appointments and conditions of service, he should enjoy terms not less favourable taken as a whole than those which he enjoyed before the date of transfer (18).

If an order is made, so long as the officer is engaged in duties reasonably comparable to those in which he was engaged immediately before the date of transfer, his salary and other terms and conditions of service will be protected.

It is not clear how long protection will last; the Scottish Bill

does not prescribe a time limit, nor is it clear whether protected officers will be given the benefit of future national salary awards which would have applied to their previous grading.

The Act will no doubt provide for an appeal procedure although on some issues individuals may also have access to Industrial Relations Tribunals. In order to avoid unnecessary complications, it might be useful to advise all tribunals of the 'normal appeals procedures'.

No matter how well existing salaries are protected it will not be easy for some well-established senior officers to assume what they might regard as a subordinate role in an area organization. Some officers who are nearing retirement will no doubt wish, if given the opportunity, to opt for early retirement and discussions about the terms under which this might be possible have, we understand, been in progress for some time. It is important that these are concluded at an early date so that the NHS will know the extent of its losses of highly experienced officers at this important time.

The selection procedures for posts with the new authorities have not yet been announced although the Staff Advisory Committee[1] have been examining the problems involved and seeking the views of people who will be affected, ever since their appointment. These efforts to consult staff at an early stage in the proceedings, coupled with the issuing of a number of usefully reassuring circulars, appear to have been well received in the NHS and has established a sound basis for the Staff Commission to develop. However, certain questions need to be resolved quickly. Are appointments above a certain level to be advertised nationally? If so, what is that level?

Are appointments below the national level to be advertised regionally or is a process of assimilation within the new areas to be adopted with existing officers in an area competing for the new posts?

Consider for example a group secretary who might decide to apply for the area administrator post in his locality. If the appointments are handled on a national basis he will clearly face competition. Equally, if the appointment is on a regional basis he

1. National Health Service Staff Advisory Committee for England has been appointed by the Secretary of State to undertake preparatory work pending the appointment of the proposed National Health Service Staff Commission.

will also face competition from fellow group secretaries, clerks to executive councils, and chief administrative officers to local health authorities. In order to safeguard his career prospects he may well decide that he cannot gamble on getting the post in his own area and is, therefore, obliged to apply for many other posts as well, in the hope of eventually landing one. It may turn out that the interviews for the post in his area are later than others for which he has also applied and he finds himself being offered an area post somewhere else. Does he ask the authority offering him the post to wait or does he accept that 'a bird in the hand is worth two in the bush'? Indeed, will the authority offering the post allow him to wait? Clearly, such situations must be avoided if possible and a national timetable arranged for interviews and perhaps a national clearing-house or even screening process instituted for all applications.

Whatever arrangements are finally decided on it is important that they be agreed with representatives of staff interests and announced as soon as possible.

Once the National Management Structure is determined there seems no reason why applications could not be invited at the beginning of 1973 for chief officers to the new authorities either by the Staff Commission or the DHSS itself so that the shadow authorities will be in a position to appoint their chief officers soon after they are established. This would enable shadow authorities to start work at the earliest opportunity and also make it possible for chief officers to be present at the selection of senior officers.

One implication of such a programme is the need to finalize and agree job descriptions and provisional gradings for chief officers before the end of 1972 which may in the event prove to be a considerable stumbling block.

Another issue arising is, whether chief officers to the new authorities will be expected to hold down two posts during 1973 and 1974 or whether they will occupy their new posts on a full-time basis, and be paid accordingly. In view of the size of the task of preparing for change any decision to appoint chief officers on a part-time basis would in our view be extremely short-sighted and mean that the risks associated with reorganization were considerably increased.

If national or even regional selection procedures are adopted

and chief officers appointed from posts outside the area the individuals concerned would find it impossible to hold down two posts anyway. We would also suggest that national agreement be reached limiting the period of notice that existing authorities could expect from officers who were appointed to these posts. This agreement might be effected through the National Associations of Employing Authorities.

The chief officers once they are in post will not be able to function unaided and each will require a small secretarial and administrative support team.

The selection procedures themselves should match the importance of the posts and in order to reduce local bias a professional assessor will no doubt be incorporated.

Once chief officers are appointed a pool of suitable assessors will be available but we wonder who will act as assessors for the chief officers' posts and particularly community physicians. It is important that whoever is chosen possesses not only considerable managerial experience but also an insight into the special problems of management in the NHS.

The basis of the selection process is likely to be the existing grades of officers and it may be that applications for some posts are only invited from officers currently holding posts within certain salary ranges. This is a reasonable means of filling the new posts as long as it is recognized that an officer's present grading may reflect his career peak or, that in some cases, he may already be overgraded. The 'Peter principle' that staff will naturally be promoted to a point immediately above their level of competence applies as much to the NHS as to other organizations (15).

It is, therefore, important that current grade should not in itself entitle an officer to a particular post. The new posts should only be filled by officers capable of fulfilling the responsibilities attached to the post.

This may produce problems if junior officers are appointed over the heads of their current seniors, but these problems shade into insignificance when compared to those that would be created by appointing chief officers who are incapable of handling the delicate and demanding task of reorganizing a very large and complex service.

In any case, with some of the salary protection provisions that

are likely to apply it is almost inevitable that some officers will earn less than their subordinates.

The objective of the selection process should be to find the right men and women for the job balanced by an acceptance that officers from within the NHS should be fully considered and if necessary offered special training before steps are taken to recruit people from outside the service.

Staff whose posts will not materially change will presumably be assimilated into the new authorities but those whose place of work will change must be advised of this fact at the earliest opportunity in order that they may, if they wish to remain in their present area, apply to be considered for posts in other sections of the service where movement is not anticipated.

It must not be assumed that a programme of centralization within areas will be immediately possible and concern for staff interests may dictate a process of gradual centralization over a number of years. It cannot be overemphasized that staff are the NHS's prime resources and the protection of their interests is almost invariably also in the interest of the NHS and the patients it cares for.

Staff who are appointed to completely new posts will require new contracts of employment and other staff will at very least have to be advised who their new employers are. It might save time if specimen contracts of employment and notification to assimilated staff were prepared nationally.

Payment of salaries and wages

One of the first matters JLCs will have to consider is how they and the shadow authorities can ensure that on Thursday, 4 April 1974, weekly paid staff receive their correct pay. Whatever else has to be pushed to one side this question must be resolved and the necessary preparatory work completed before the appointed day. What then are the problems?

On 31 March 1974, local health authorities will disappear and their staff will form part of the reconstituted NHS. From that date the NHS will be totally responsible for those staff and there is little prospect of local government continuing to pay them on an agency basis as was the case in 1948, firstly because of the complete disappearance of existing local health authorities and

secondly because local government will itself be in the midst of its own large-scale reorganization.

Salaries and conditions of service of staff in the community services are presently determined by the National Joint Council for Local Authorities Administration, Professional and Technical and Clerical Services. In the case of medical, nursing, and professional and technical staffs the salary scales are generally identical to those in the hospital service and no particular problems of comparability or assimilation should be experienced. The only possible difficulties with these staff might arise in cases where local authorities, who, because of long-standing recruitment difficulties pay on a scale above the standard and the extent to which this occurs should be established at an early date. Completely new scales will, of course, have to be negotiated for new posts such as the community physician.

The salary scales of other grades of staff, particularly administrative and clerical, are not readily comparable and will either have to be harmonized with the scales agreed by the NHS Whitley Council or protected. A brief comparison of some of the clerical and secretarial scales suggests that local health authority staff would be marginally better off if they were assimilated on to Whitley Council scales, although this would of course add to the 'cost' of reorganization.

Grade	*NHS Whitley Council*	*National Joint Council*
Copy typist	£474–1,197	£477–1,038
Shorthand typist	£549–1,287	£477–1,140
Basic clerical	£474–1,311	£477–1,239

The differences are not great at this level and neither will the job content vary very much. Difficulties will occur at more senior levels and are likely to focus on the 'comparability' of senior posts with their counterparts in the other sectors of the service.

Once the management structure is known there must be early discussions with the trade unions to settle these points. However, in the case of basic clerical and secretarial grades there is no reason for delay and action can be taken immediately. The Whitley Councils could establish a formal working link with the National Joint Council with a view to harmonizing scales at this level. The negotiation of the next pay award would provide

the opportunity. It is fortunate that one trade union, NALGO, is dominant in both sectors and provided the 'harmonization' is upward they are likely to prove co-operative.

The alternative to realigning salary scales is to commence the new NHS with staff earning different rates of pay for undertaking basically the same work; if the balance remains against the community services it will reinforce their feelings of being the poor relations.

Pay is not the complete problem because staff in the community services are employed under differing conditions of service from colleagues in other sectors and these need to be identified as soon as possible, under two headings:

a. Nationally agreed conditions: annual leave entitlement, hours of duty, etc.

b. Locally agreed conditions: regular established customs such as granting staff an additional half-day's leave on the day following a national bank holiday, can in time form part of an employee's conditions of service. Car purchase loans to nurses, etc.

A comparison of nationally agreed conditions should be made immediately and once established Joint Liaison Committees could start identifying 'local customs'.

Again, in the time available before 1974 conditions of service should be harmonized as far as possible.

In the absence of national policies on matters such as loans to staff for car purchase, shadow authorities will have to reach their own decisions so that consistent policies may be applied from the appointed day. It is not clear what the position will be with regard to the repayment of loans made to staff by local authorities that extend beyond 1 April 1974. To whom will the repayment be made?

Once the salary scales and terms and conditions of service of community staff in the new service are clear, the procedures for payment need to be analysed. The first question is whether the staff who currently calculate and pay the salaries and wages of local health authority staff will transfer to the NHS.

If for any reason these staff do not transfer, perhaps because they form part of a centralized local government salaries and wages department, or they do not wish to leave the service of local government, the new health authorities may be in

difficulties. They will have to take over the responsibility for paying staff without expertise or even familiarity with the appropriate salary scales and conditions of service. Particular difficulty might be experienced where payments are based on bonus schemes as may well be the case with ambulance staffs. It might prove necessary to arrange for existing health service staff to be seconded to local authorities for a short period for training. Procedures for notifying absences, sickness, overtime, and all the other variables that affect the make-up of an individuals pay may have to be changed if community staff are to be added to the payroll of an existing HMC (under the new name of the area salaries and wages division). Where changes in payment or notification procedures are adopted the staff concerned will of course need to be informed about them.

Staff employed by HMCs and RHBs do not present anything like the same problems because the existing pay systems may be continued after the appointed day. The only difficulty is the timing of the reallocation of existing HMC payrolls in cases where an HMC is divided between areas. Again the situation that may arise in District 6(e) illustrates this problem.

On 1 April 1974 the major part of the Pontefract HMC will fall within District 6(e) and indeed may form a separate district. However, the Goole sub-group will fall within the Humberside area. At some point in time the personal records of the 200 or more staff working in the Goole sub-group will be transferred to the new area authority who will assume responsibility for paying what will become their staff. When this happens the workload in the salaries and wages department in Pontefract will decrease whilst it will increase in the other area and corresponding staffing adjustments will be necessary. Payment and staff change notification systems may be different and have to be changed and local interpretation of national agreements may also vary.

Clearly the problems of each area need considering in depth once staffing numbers have been established but in the case of District 6(e), the staff in Goole could if necessary continue to be paid after 1 April 1974 from Pontefract and a simple recharge made between areas. This problem could wait if necessary, at least until problems associated with the payment of community staff have been resolved.

No problems of comparability arise as far as the staff of executive councils are concerned as they are paid according to NHS Whitley Council agreements, and arrangements could easily be made for them to continue to be paid on the same basis as at present. It will, however, be necessary to consider the problems of paying staff employed by larger county executive councils like the West Riding of Yorkshire, which will be split up.

Another facet of the problem is the position with regard to computerized payrolls and if re-programming is to be carried out planning will have to commence immediately.

The importance of ensuring that staff are properly paid after 1 April 1974 cannot be over-emphasized.

6 Family practitioner committees

Another early task of the shadow area health authorities will be the appointment of family practitioner committees, who, on the appointed day, will assume responsibility on behalf of the area authorities for the functions at present exercised by executive councils. These include entering into contracts of service with individual practitioners in the general medical, dental, ophthalmic, and pharmaceutical services, administering these services and making appropriate payments according to nationally agreed scales. They will also administer the statutory disciplinary arrangements (which will not change) and deal generally with complaints or disputes that arise out of practitioners' performance of their contracts. The work of the Medical Practices Committee and Dental Estimates board will remain unchanged in the new structure. The Joint Pricing Board will be replaced by a joint health authority exercising the same functions.

The county borough executive councils will normally transfer *en bloc* to the new authority in whose area they fall, but major problems will be experienced in transferring to a number of different area authorities the staff and records of the executive councils that cover large county council areas.

The problem of dividing up the records is serious enough but is overshadowed by problems of redeploying the staff from these large authorities. Many of the staff are married women who are unable to move with their jobs so that the service must be prepared either to offer them posts in other sectors of the service, in the locality of their homes, or to offer generous compensation. It may be possible to recover manpower lost in this way by retaining some of the temporary staff that will have

to be recruited to cope with the actual transfer but this will necessitate a considerable reinvestment in training.

The problems of transferring records is complicated by the absence of standardization in the Executive Council Service and the opportunity should be taken now to design standard records and procedures so that they may be adopted immediately in cases where new systems have to be inaugurated.

To take again the example of the Executive Council for the West Riding of Yorkshire (which may create rather exceptional problems because of its size) 1,800,000 nominal index cards and medical slips will have to be sorted and divided up amongst the various area authorities according to the address of the person concerned. Similarly, prescription charge exemption certificates will have to be sorted and reallocated.

During this sorting and transferring stage records must be continually updated as they form one of the bases of doctors' pay. A list of the major records that will need to be transferred is presented as Appendix B and in Appendix D the scale of the preparation that is required is illustrated by an outline of the task of reallocating the primary registration records.

This work cannot possibly be undertaken without additional staff and the numbers required should be assessed by JLCs as soon as possible, so that a special financial allocation may be sought from the DHSS.

Steps must also be taken to ensure that, if necessary, executive councils such as the West Riding of Yorkshire continue in existence after the appointed day until such time as their staff and records have been fully transferred. Perhaps they could be placed formally under the control of the regional authority for the interregnum.

Preparatory work will also be necessary to ensure each area has adequate accommodation for the staff and records of its family practitioner committees.

The size of the task involved in integrating the Executive Council Service with its other partners must not be underestimated.

7 Training for members

Formal responsibility for the management of the reorganization will rest with the DHSS and the shadow health authorities. It will be the members of the shadow authorities who decide how the NHS evolves locally and how the reorganization itself is conducted. No doubt they will be well advised by their officers but the ultimate responsibility is theirs. If they are to discharge this responsibility they must be familiar with the objectives of the new service, the broad outlines of the new structure, and have an insight into the major problems of reorganization. In addition they will need a clear understanding of their role as a committee and the roles of their chief officers.

Many members will probably have served on existing health authorities and so will bring to the new bodies some understanding of how the NHS functions at present. Other members will be appointed more for their experience in the management field and will know little of the intricacies of the NHS.

Whatever their background all members will need a full 'briefing'.

It would be unrealistic to expect members to give up a great deal of their personal time (or the time of their employers) to attend lengthy induction courses. However, the NHS can and indeed should make it clear to the individuals invited to serve on the new authorities that their acceptance implies a willingness on their part to go to some trouble to familiarize themselves with the NHS they are appointed to manage.

A two-day 'briefing' will probably suffice, possibly over a weekend, coupled with visits to various health care centres for

members who are completely new to the service. The briefing ought to include:

a. The reasons for change.

b. The objectives of reorganization.

c. The philosophy underlying the management structure.

d. An outline of the structure itself with some emphasis on the role of the members.

e. A statement of the primary functions and tasks of the authority of which they are members.

f. The principal tasks and objectives of the shadow authorities.

Wherever possible whole committees ought to go together so that 'they receive the same story'. Such a course might also help members to get to know each other better which usually facilitates the decision-making process.

These 'briefing conferences' should take place soon after the shadow authorities are appointed, ie April or May 1973. They could be organized by the DHSS itself or be undertaken by the centres currently running integration courses for officers.

Visits to health services in the areas or regions could be arranged by JLCs and might very well take place in the period between the appointment of members and the selection of chief officers.

8 Consultations with staff

Management in the NHS is primarily concerned with ensuring that the individual and group skills of people employed in the organization are developed, co-ordinated, and directed to people most in need of these services. In common with every organization that sets out to provide a personal service, the prime resource of the NHS is its staff. Their ability, attitudes, compassion, and morale are the main factors that influence the quality of service provided to the patient.

The majority of health service staffs have a sense, if not of vocation, of performing tasks that are useful to society. Their sense of commitment to the objectives of the organization in which they work (no matter how nebulous these objectives are) is normally high. If this high level of commitment is to be maintained the staff of the service must be involved in preparing the ground for the integrated service which most of them welcome in principle—and in helping to decide how national policies will be applied locally. Participation is a most effective means of building understanding, acceptance, commitment, and enthusiasm, for the new NHS.

Administration reorganization will only produce operational integration as a result of the efforts and initiative of staff working with individual patients. In a recent book on the reorganization of local government, Long and Norton make the important point:

That many staff worry about the more obvious aspects of reorganization—whether they might be redundant, what salary they will receive in the new authority, the kind of work they will be expected to do and, of particular importance, where they will be working. But staff worry equally, if not more, about their role

in the new organization and the sense of personal fulfilment they will obtain from their new job—whether they will be just units in a large organization, what their status will be, what sense of achievement they will gain from their work and so on (19).

Reassurance and advice can be given on all these matters and it is, therefore, vital that effective means of communication and collaboration are established between the authorities managing the change and the staff of the NHS.

Numerous methods are available for establishing communication links, all should be considered. Shadow authorities must keep JLCs fully informed as to progress; the members of JLCs should in turn pass the information down the line to middle management and so on. The national broadsheet will help by providing authoritative statements of policy and progress. Trade unions and professional bodies will also no doubt keep their members informed.

However, something more positive is required if staff are to feel they are participating in the reorganization rather than simply being told what is going to happen.

Joint staffs consultative committees have never really worked successfully in the hospital service primarily because of a lack of enthusiasm on the part of management and also because the sort of issues the committees were permitted to consider were often best resolved on a more informal basis.

However the situation is now quite different, for the issues on which the staff will require information and reassurance are far more important: jobs may be seen to be in jeopardy. Equally staff will want a positive means of influencing the changes and we suggest that each area and region should establish a staff liaison committee with the following objectives in mind:

a. To demonstrate that staff interests are very much in the minds of the shadow authorities who recognize that without staff co-operation the reorganization cannot achieve its objectives.

b. To keep staff informed as to progress in preparing for the unified service.

c. To provide a means by which staff can express their fears and pose their questions to the JLCs and shadow authorities and receive an authoritative response. A means for staff to check

the validity of rumours which, if unchecked, can prove damaging to morale.

d. One of the methods by which JLCs and shadow authorities can seek the views of staff on issues that are of particular concern to them.

Staff liaison committees ought to supplement and not replace discussions between the shadow authorities and trade unions and professional bodies and should as far as possible deal with matters of general concern rather than particular sectional interests. They should certainly not become involved in discussing the problems of individual members of staff.

The constitution and precise function of these bodies could be worked out nationally, but in a typical area the membership might include:

A representative from each HMC in the area for the following groups of staff: medical; nursing; professional, technical, and others; administrative and clerical; ancillary.

A representative from each executive council in the area for the following groups of staff: general medical (local committee nomination), general dental (local committee nomination), ophthalmic (local committee nomination), pharmaceutical (local committee nomination), administrative and clerical.

A representative from each local health authority in the area for the following groups of staff: medical, nursing, professional and technical and others, administration and clerical.

It is appreciated that the general practitioners and other professionals holding contracts of service, rather than contracts of employment may not wish to participate but this is a matter for them to decide themselves. The opportunity ought to be presented to them.

The management side ought to include the chairman, members, and chief officers to the shadow authorities in order to reflect the importance that is attached to the committee.

9 Information for planning the reorganization

Shadow authorities, JLCs, and others are almost certain to generate tremendous demands for information. Amongst other things these bodies will want to know whom they will serve, what resources they will have available, and how they are currently deployed.

Much of the information they require will be readily available but it will need collecting from a number of different sources, and collating. It may also have to be 'vetted' to ensure that information drawn from different sources has been collected on the same basis and is strictly comparable.

Although the task of collation, presentation, and analysis of data may be centralized, the task of actually preparing the data will fall in the main to existing authorities. In order that they are not swamped by the demands that will be made it is important that the planning bodies take care to ask only for data that is really necessary and that they frame their requests in precise terms to avoid the time-consuming task of obtaining supplementary data later on. Wherever possible planning authorities should co-ordinate their demands to avoid the situation where for example a local health authority receives four, five, or more requests from different planning authorities for the same sort of data, at different times. It would be even more frustrating for that local health authority if the planning authorities all asked for the data to be collected and presented in different ways.

Once the major tasks of the shadow authorities have been established it should be possible to predict their information needs quite closely. A standard 'profile' of basic data could be

prepared immediately and made available to shadow authorities on their appointment.

Appendix E lists the likely content of a standard profile which is based upon a *Profile for Change* (20) which was prepared for the 6(e) JLC during the course of this study.

Much of the essential data is already available to regional hospital boards and for this reason we suggest that regional intelligence units be established immediately.

Regional intelligence units

The primary task of these units would be to prepare a standard 'profile' of essential data for each area and act as the information link between the agencies planning the change and existing authorities. These units would very quickly become familiar with the information sources and become experienced enough to 'vet' albeit superficially, the data received from various authorities. They could also establish a close link with the major local government planning departments in their region who have available almost all the geographic, demographic, and socio-economic data likely to be required.

Reference was made earlier to the need for planning authorities to co-ordinate and if possible standardize their information needs and this could be effected by the intelligence unit.

The units might be staffed by an assistant secretary and three or four assistants with a team of specialist advisory staff to call upon as required. One immediate question that arises is where are these staff to come from. They clearly must have experience of the information systems currently operating in the NHS and so must be recruited internally.

They need not all come from regional boards: indeed there would be considerable advantages in seconding officers from executive councils, local health authorities, and hospital management committees to these teams for a period. The staff concerned could be replaced on a temporary basis relatively easily if the necessary funds were made available. The alternative is to leave existing authorities to cope with demands for information as they arise which in the long run will absorb more staffing resources than are necessary to establish the intelligence units.

10 Accommodation for the new authorities

It is assumed that regional health authorities will occupy accommodation currently used by regional hospital boards. Area health authorities and district teams will, however, require accommodation and it will be for JLCs to prepare a statement of the options based upon their preliminary calculations of the number of staff concerned.

In preparing these options two matters of principle arise which are discussed below.

1. It has been suggested that area health authorities ought not to be located in the grounds of hospitals because this would reinforce the view held by many people working in the community services: that reorganization was in effect a 'take-over' by the hospital service. It is also suggested that if area authorities were located in hospital grounds they would be too readily accessible to hospital service professionals who might exert undue influence.

These fears were certainly expressed on a number of occasions during our study and the new authorities should demonstrate at the earliest opportunity their 'health' orientation. However, the decisions on accommodation for the new authorities should be made primarily on two rather different criteria:

a. The best location from a geographical and functional point of view.

b. The availability of suitable accommodation within the NHS. The DHSS is unlikely to approve plans to rent expensive city centre accommodation if suitable accommodation is available in a nearby hospital.

On balance area authorities would be better located away from hospitals but this objective must be tempered by a recognition of the financial realities of the situation. Similar considerations apply to the location of the district management teams, though in their case it is important that they are located reasonably close to the district general hospital that serves its district.

A possibility that might be explored is that of locating district management teams and area boards in the same accommodation as their counterparts in the Social Services. This might facilitate co-operation.

2. The second question of principle is whether to leave executive council staffs in their present accommodation or whether to bring them into the area headquarters. It has been argued that to leave them would perpetuate the separation that reorganization is trying to overcome. This argument does have some force and in the medium term we would hope to see the family practitioner committees integrating fully into the health authority structure.

In the short term, however, it makes little sense to disrupt the work of organizations that are operating perfectly satisfactorily particularly when there are so many other things to be done. In order to encourage the feeling of unity, however, it is hoped that the family practitioner committees themselves and the professional advisory groups will choose to hold their meetings at the area headquarters.

11 Public relations

The public must be kept informed of changes in the organization of their health service and reassured that the administrative changes will not affect to any significant degree the means by which individual patients receive treatment or affect the traditional relationship they have come to expect with their family doctor. With local government reorganization taking place at the same time the possibility of mounting a combined public information campaign ought to be considered. Any national campaign must be supplemented by local initiatives and it is particularly important that each JLC and shadow health authority consider most carefully whether the changes will affect the means by which patients make contact with the services they require. If they do, steps must be taken to ensure that the revised arrangements are well publicized.

Shadow regional health authorities might well find it useful to use the services of regional hospital board public relations officers or press officers on a part-time basis until such time as whole-time public or press relations officers are appointed.

12 The cost of reorganization

How much the reorganization will cost is a question that has not yet been satisfactorily answered. Indeed the question may never be posed for the answer may already have been determined by the amount the Government is prepared to make available. The cost of reorganization in Scotland is officially assessed as £2 million (which may itself be an indication not of cost but of funds available) and whilst the pattern of reorganization is different in England it does suggest that the cost in England could be in excess of £20 million. Direct costs will arise from the following:

The employment of staff by shadow authorities (even if the individuals concerned are not replaced by existing authorities, acting-up allowances will have to be paid).

The payment of chairmen of new authorities and the expenses of members of shadow authorities. (The savings that will accrue from the reduction in the number of members may pay for salaries of chairmen after 1974.)

The redeployment of staff (redundancy or compensation payments, removal expenses, excess travelling allowances, etc.).

The equalization of salary scales within the three sections of the NHS.

The purchases, leasing, or adaptation of buildings for new authorities.

The employment of additional temporary staff to assist in the execution of change and transfer of records.

Employment of management consultants.

Creation of new bodies such as the staff commission and community health councils.

Printing of new stationery.

Training and briefing for the new service.

Public information campaigns.

Provision of support services previously made available by local government to the community services.

Some of these costs will arise only once whilst others will be recurrent and have the effect of increasing the administrative costs of the NHS. There is little doubt that an increase of reasonable proportions can be justified on economic grounds as a sound investment. However the point must be made that the NHS would find it very difficult to absorb these costs within existing financial allocations without seriously affecting the quality of care provided to the community.

The Government must be prepared to make additional funds available as it would be folly to attempt to reorganize without adequate resources.

13 Summary and list of major recommendations

The summary does not include all the tasks identified in the checklists.

1. The NHS is already in a period of rapid change which will be accelerated by reorganization. Management skills of a high order will be required to achieve the objectives of reorganization and at the same time maintain a service to the community.

2. A formal moratorium on change is impracticable. An informal moratorium appears to have been operating for some time and many developments are being held back 'until after 1974'. The DHSS must control national demands for change during the period of reorganization.

3. The objectives of reorganization must be clear. The general aim is to provide a better and more sensitive service to the public and the means by which this is to be achieved is an organizational reconstruction. Profound attitudinal changes are required if the objectives of reorganization are to be realized.

4. The speed with which changes are introduced will have a significant bearing on their success. The whole change process requires careful management.

5. The task of reorganization is enormous but priority should be given to the following tasks:

a. To creating the correct environment for change; ensuring staff understand the reasons for change, feel they can participate in planning and effecting it, and are committed to making it work.

b. To ensuring new authorities can actually function on 1 April 1974 and that existing operational patterns can, if necessary, continue undisturbed.

c. To ensuring adequate arrangements are made to provide the community services with the support they require.

d. To designing local management structures and in particular deciding on district patterns and organization and on creation of common area services.

e. To ensuring that the right staff are appointed to manage the change and to devising selection procedures that are seen to be reasonable and fair.

6. The government intends to constitute regional and area health authorities in shadow form before 1 April 1974 to prepare the ground for change. Because shadow authorities are unlikely to be appointed before early summer in 1973 existing authorities have been asked to form JLCs to do as much preparation as possible without pre-empting decisions that can only be taken by the shadow authorities themselves.

7. JLCs are unlikely to prove effective unless they are provided with a support team.

8. Shadow authorities will function alongside JLCs. Their main tasks will be:

a. Creation of the correct environment for change: morale maintenance and education.

b. To attend to necessary legal and procedural matters and to ensure a smooth transfer of executive power from old to new authorities.

c. To relate national plans to local areas and produce plans and policies for their implementation following consultations with staff and community representatives.

9. The new management structure will only be successful if:

a. The philosophy underlying the structure is understood.

b. Account is taken of local problems and need in designing the structure.

c. Staff are committed to making the new structure work.

10. The design of area and regional management structures could proceed as follows:

a. Briefing for chairman and chief officers of shadow authorities by the DHSS and their management consultants.

b. Draft schemes prepared by JLCs passed to shadow authorities.

c. Local schemes designed and after consultation with exist-

ing authorities and representatives of local staff interests submitted to the DHSS for approval.

11. The DHSS should establish a multidisciplinary advisory team to assist shadow authorities in designing management structures.

12. Departmental approval to shadow authority design should not include reference to the financing of specific posts which is a matter of area or regional resource allocation. The approval stage must not be protracted.

13. The decisions on the pattern of districts are crucial to the achievement of the objectives of reorganization and should only be taken after a detailed and thorough analysis of the community to be served and the existing operational patterns of the health services in the area. Mere population totals are of little value without a consideration of distribution and density. Wherever possible health services should be organized to coincide with local community patterns and 'the realities of people's lives'.

14. In devising the professional advisory machine a distinction should be maintained between the representative role of the professions and the participative role of the advisory machinery. Early agreement on the machinery is desirable in order that it may be established in shadow form to work alongside the shadow authorities.

15. Care should be exercised in creating common area services and their management should be located as close to the consumer as possible.

16. The successful introduction of what will be a complex, sophisticated management structure requires that chief officers fully understand it and are committed to making it work.

17. The greatest potential difficulties in implementing the proposals of the management study group lie in areas where responsibility rests with teams of officers. Management consultants could help teams develop their full potential.

18. Integrated health care courses can only cater for the most senior staff who must themselves pass on their objective understanding of tne new structure to their subordinates and colleagues.

19. To help all staff understand the structure the DHSS should

prepare a 'Guide to the reorganization' with a supplement for supervisory and managerial staffs explaining the management structure in detail.

20. A film illustrating the new structure would also be very useful. A regular progress report on organization, issued by the DHSS, would be welcome.

21. JLCs should organize a programme of seminars on reorganization which should be open to staff in all branches of the NHS and timed to coincide with the national announcements.

22. The impending reorganization will make staff anxious about the future. Anxiety tends to lower morale and in some cases personal anxiety will hinder a full understanding of proposals or even distort the picture completely. Anxiety will probably be at its highest:

a. In the community services who fear a hospital take-over.

b. Amongst staff whose role may disappear.

c. Amongst senior staff likely to lose present independence.

d. Amongst staff already stretched to the limits of their capacity.

23. The period of uncertainty between the announcement of the new management structure and the time when staff are offered firm positions in the new NHS must be kept to a minimum.

24. The final announcement on the management structure should be timed so that:

a. National 'Guides to reorganization' are ready for immediate distribution.

b. JLCs have arranged seminars on reorganization.

c. Chief officers are already fully conversant with the plans and can explain them fully and confidently to their staff.

25. Staff should be given the opportunity to contribute to the planning of the new structure which in turn will lead to a commitment on their part to ensure that the reorganization is successful.

26. During the period of uncertainty management at all levels must become acutely sensitive to staff morale and pay particular attention to indicators of stress such as sickness and absenteeism.

27. The basis of new establishments will be the numbers of staff

required to maintain existing services. Particular problems arise where large local health authorities (such as the West Riding County Council) are to be fragmented among several new health authorities. Decisions about deployment of special staff such as the health education officers should be made by the regional shadow authority. The NHS will have to replace the local government support services that are presently available to community staffs.

28. Shadow authorities should be asked to frame their establishments within a firm financial allocation in order to avoid the inflation of establishments either to correct present deficiencies or match available staff.

29. The problem of non-coincidence of administrative and operational areas need not be of consequence if it is accepted that existing operational patterns will continue at least in the short term. New authorities should not be expected to become independent and self-supporting units at once.

30. The success of reorganization in the short term at least will be determined to a large extent by:

a. The quality of staff appointed to effect the changes.

b. The time they have available.

c. The amount of support they are provided with.

31. The existing preoccupation of senior staff with the number of posts that will be available in 1974, their grading and the timing of the new appointments will soon give way to anxiety. This could be allayed by announcements of:

a. The salary protection arrangements that will operate.

b. The early retirement provisions (if any).

c. The timing of new appointments.

d. The appointment and selection process that will be adopted.

32. Provided the job descriptions and provisional gradings of the new chief officer posts are finalized in time they could be advertised early in 1973 so that shadow authorities could appoint their chief officers soon after they themselves assume office. This would allow the maximum possible time for preparation.

33. As staff may decide to appeal against some aspects of the reorganization to Industrial Relations Tribunals it might be

advisable to advise the Department of Employment of the normal appeals procedure.

34. The appointment procedures should incorporate a national timetable for interviews and perhaps a national clearing house or screening process for applications.

35. Chief officers to the new authorities must be appointed on a full-time basis at the earliest opportunity and given authority to appoint adequate supporting staff.

36. A national agreement should be reached to limit the notice that officers appointed to new authorities need to give to existing employing authorities.

37. New posts should only be filled by those capable of carrying the attached responsibilities. Problems of junior officers appointed over their current seniors' heads would be overshadowed by problems resulting from appointment of chief officers who were incapable of handling the demanding tasks of reorganization.

38. Staff appointed to new posts will require new contracts of employment and it would be useful if specimens could be prepared nationally. All staff must be informed of their new employers.

39. JLCs and shadow authorities must take steps to ensure the correct payment of salaries and wages on 4–5 April 1974 by the new authorities. Particular attention should be given to the procedures for paying staff presently employed by local health authorities.

40. The salary scales and conditions of service of administrative and clerical staff currently employed by local health authorities are not readily comparable with those of other staff in the NHS and will require equating with NHS Whitley Council scales, or protecting. The NHS Whitley Council should establish a link with the National Joint Council for Local Authority Administration, Professional and Technical, and Clerical Services with a view to equating scales in the basic clerical and secretarial grades.

41. Differences in conditions of service between community services and NHS staff should be identified at national and local levels as soon as possible.

42. Hospital staff present fewer problems from a payment point of view because existing pay systems may be continued after the appointed day. The only problem is timing the reallocation of existing payrolls where HMCs are to be divided between new areas.

43. No problems of comparability arise with executive council staff because they are paid according to Whitley Council agreements. It will, however, be necessary to consider the problems of paying staff from the large, county executive councils that are to be divided up amongst a number of area boards.

44. An early task of the shadow area health authority is the appointment of a family practitioner committee which will assume the function previously performed by executive councils.

a. There will be problems in transferring staff and records from large county council areas to several new area authorities.

b. Staff redeployment is perhaps more serious: many staff are married women who are 'immobile'. The new service must either offer them local posts in other sectors or generous compensation.

c. The opportunity should now be taken to standardize executive council records and procedures.

d. The transfer of records cannot be undertaken without the recruitment of additional staff.

45. All members of new authorities will need a full 'briefing' on the aims and methods of reorganization.

A two-day 'briefing conference' supplemented by visits to health care centres for members who are new to the NHS should be sufficient. Where possible complete committees should attend to avoid different interpretations of the briefing and in order that they may get to know each other. Briefings should commence soon after shadow authorities have been appointed.

It should be made clear to individuals invited to serve on new authorities that their acceptance implies a commitment to attend these briefing conferences.

46. Staff must be involved in preparing for the integrated service and deciding upon local application of national policies. Participation is the most effective way of developing understanding, acceptance, commitment, and enthusiasm.

Reassurance and advice must be given on all aspects of the change and an effective two-way communication channel between planning authorities and staffs is, therefore, vital. It is suggested that a staff liaison committee be established within each area and region to:

a. Demonstrate that staff interests are very much in the minds of the bodies responsible for preparing for the new service who recognize that without staff co-operation the reorganization cannot achieve its objectives.

b. Keep staff informed as to progress in preparing for the unified NHS.

c. Provide a means by which staff can express their fears and questions to the JLCs and shadow authorities and receive an authoritative response. A means for staff to check the validity of rumours which, if unchecked, can prove damaging to morale.

d. One of the methods by which JLCs and shadow authorities can seek the views of staff on issues that are of particular concern to them.

Staff liaison committees should concern themselves with general not sectional interests and supplement rather than replace discussions between shadow authorities and trade unions.

47. Shadow authorities, JLCs, and others will generate tremendous demands for information. Where possible these bodies should co-ordinate their information demands. A standard 'profile' of basic data should be prepared immediately and made available to shadow authorities on appointment.

48. Regional intelligence units could usefully be established to prepare profiles and act as the links with major local government planning departments who have available most of the geographic and demographic data likely to be required. These units could also co-ordinate information demands.

49. It is assumed that regional health authorities will occupy accommodation now used by RHBs. Area health authorities and district teams will, however, need new accommodation. JLCs should prepare a statement of the accommodation options based on preliminary calculations of staff numbers.

50. Area health authorities would be better located outside hospitals to alleviate fears of a 'hospital take-over' by staff in the

community services but this objective must be tempered by financial realities and the need to locate area authorities in the best place from a geographical and functional point of view.

51. Similar considerations apply to the location of district management teams except that they must be located reasonably close to the relevant district general hospital.

52. It is arguable that leaving executive council staff in their existing accommodation would reinforce the separation that reorganization is trying to overcome. In the medium term, the family practitioner committee should integrate fully with the health authority structure. In the short term, it would be unwise to disrupt organizations performing satisfactorily especially when there are so many other things to be done.

53. The public must be kept informed of changes in their health service and the possibility of mounting a combined national public information campaign with local government should be considered. Any national campaign must be backed by local initiatives. JLCs and shadow authorities should consider whether the changes will alter channels of public contact. If necessary revised arrangements must be well publicized.

54. The cost of reorganization in England could well be in excess of £20 million.

This expenditure cannot possibly be absorbed by the NHS without materially affecting the quality of care provided to the community and the Government must be prepared to make additional funds available.

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Appendices

A A checklist of some of the major tasks

1. THE DHSS AND OTHER NATIONAL BODIES

Objective: To manage the reorganization

1. Issue circular to existing authorities recommending the establishment of area and regional joint liaison committees: indicate objectives and principal tasks; indicate membership and formal status; indicate procedure for obtaining support staffs and other funds to support them.

2. Principal regional officer to convene first meetings of JLCs.

3. Recommend the creation of regional intelligence units to regional JLCs and fund if necessary. Suggest content of standard area profile.

4. Ensure JLCs and shadow authorities are advised of any formally agreed (or pending) changes in local government boundaries.

5. Initiate discussions about the reconstitution or replacement of Whitley machinery.

6. Establish contact with National Joint Council with a view to identifying differences between salary scales and conditions of service of staff in the community services and staff in the other two sectors. Harmonize the two as far as possible.

7. Announce formally the creation of shadow health authorities and give details of: membership, objectives, major tasks, legal status (particularly whether they will have powers to employ staff), financial arrangements, relationship to existing authorities.

8. Issue guidance on the procedure to be adopted, and by whom, to appoint shadow authorities. Secretary of State to appoint chairman and others.

9. Recommend the establishment of staff liaison committees. Outline their function and constitution.

10. Calculate cost of reorganization and obtain funds by special allocation from Treasury.

11. Make regulations about the payment of chairmen and reimbursement of members' expenses.

12. Prepare programme of 'briefing conferences' for members of new authorities.

13. Announce decision on the form of the management structure. Issue detailed report on:

a. The philosophy underlying the new structure.

b. A detailed description of the structure itself indicating the function of each level, where authority will lie and the role, authority, and accountability of individuals. A glossary of terms is essential.

c. Examples of how the structure might apply to particular situations (drawn from 'testing' experience).

d. The extent to which local decisions are required or permitted.

e. The procedure to be followed by shadow authorities in designing and implementing the new structure locally.

14. Advise existing authorities that they should take whatever reasonable steps are necessary to familiarize staff with the proposed new structure.

15. Prepare, or commission, a guide to the new structure that can be readily understood by members and staff (including if necessary a more detailed supplement for members and middle and first line managers). Produce an information film.

16. PRO to convene first meetings of shadow authorities.

17. Issue JLCs and shadow authorities with a timetable for reorganization. Arrange regular updating.

18. Publish guide, prepared by staff commission, to appointment procedures, timing of appointments, protection arrangements, appeals procedures, early retirement options, etc.

19. Advise Industrial Relations Tribunals of 'normal appeals procedure'.

20. Prepare job description for new posts and negotiate salary scales and conditions of service.

21. Advertise chief officer posts, take up references, etc., in order that shadow authorities may make appointments soon after they themselves are established.

22. Notify existing authorities and JLCs of the procedure for obtaining additional funds to employ temporary staff to assist in the transfer of records.

23. Commission urgent study on the steps that could be taken to help 'teams' function effectively.

24. Issue guidance on the organization of the ambulance service and the consultation procedure that should be adopted before firm proposals are submitted to the DHSS for approval.

25. Issue guidance on the establishment of formal and informal links with local government services pre and post 1974.

26. Consider placing 'freeze' on the filling of senior posts with existing

authorities once the appointment of officers to new authorities has commenced.

27. Establish formal study into the standardization of executive council records and procedures.

28. Issue guidance on the financial procedures that will operate with effect from 1 April 1974 (or an agreed later date) and on the closing of the accounts of existing authorities. Identify in as much detail as possible the preparatory steps that may be necessary.

29. Announce decision on the form of the professional advisory machinery and whether it will operate in shadow form.

30. Discuss co-ordinated national public information campaign with Department of the Environment.

31. Establish multidisciplinary central advisory team to advise shadow authorities on the design of local management structures and to review schemes submitted by shadow authorities prior to their approval. Issue information circulars during the design stage.

32. Arrange briefing sessions for chairman and chief officers of shadow authorities on the philosophy and design of the management structure.

33. Decide if national policy is required on names for new authorities (eg to match local government counterparts).

34. Establish procedure for controlling national pressures for change.

35. Reach agreement with existing authority to reduce to a minimum the 'notice' staff have to give who are appointed to shadow authorities.

36. Consider increasing immediately the graduate intake into management in the NHS by extending national administrative training scheme and opening A-level intake for regional schemes to in-service staff from local health authorities and executive councils.

37. Advise existing authorities and shadow authorities of their relative responsibilities for the submission of estimates during year 1973/4.

38. Notify shadow authorities of their provisional allocation for 1974/5 at the earliest opportunity.

39. Initiate discussion with representatives of staff in local health authorities and executive councils with a view to introducing common staff reporting systems for administrative and nursing staffs.

40. Issue guidance on the transfer of regional staff committee records (including staff reports) to new authorities.

41. Advise shadow authorities of their financial allocation (and the extent to which they may recruit staff) during 1973/4.

42. Instruct existing authorities to supply shadow regional authorities with a statement of endowment fund balances and investments as at 30 September 1973, together with details of:

a. Restrictions and donors' wishes.
b. Approved regular commitments on funds.
c. Programmed expenditure.

43. Announce decision on funding of capital development programme (1974–8) particularly programmes prepared by existing local government authorities.

44. Issue model standing orders for new authorities.

45. Ensure community staff superannuation rights are transferable and consider the staffing implications for the NHS superannuation division of the transfer of staff from local government.

46. Issue a regular progress report on reorganization.

47. Issue advice on the provision of accommodation for new authorities.

48. Recommend model contracts of employment for new staff and model letter to staff who transfer without a change in duties.

49. Issue guidance/regulations on the allocations of endowment funds between area authorities and the allocation of central pool funds.

50. Issue guidance on the objectives, constitution, and appointment procedures for community health councils.

2. AREA JOINT LIAISON COMMITTEES

Objective: To undertake as much of the preparatory work as possible for reorganization short of pre-empting decisions that can only properly be taken by the shadow authorities.

1. Appoint chairman.

2. Appoint convenor/secretary.

3. Agree broad objectives.

4. Identify principal tasks.

5. Consider working arrangements.

6. Decide if support staff required.

7. If support staff required advise the DHSS of numbers and cost.

8. If request approved, nominate appointing officer and nominal employing authority.

9. Arrange accommodation for support staff.

10. Agree arrangements for circulation of minutes.

11. Decide upon means of involving specialist officers.

12. Nominate member(s) to serve on regional JLC and establish contact with liaison committee responsible for preparing for local government reorganization.

13. Arrange on an informal basis for members to visit each others' services so that each may form a view of the total situation.

14. Establish contact with regional intelligence unit and discuss any supplementary data that may be required in addition to basic profile.

15. Make provisional assessment of numbers of staff working from bases within the area by grade and present employer. Determine in general terms the number and grades of staff who will transfer from local government.

16. Establish staff liaison committees and arrange briefing session and regular meetings.

17. Discuss arrangements for ensuring that staff are properly paid after 1 April 1974. Prepare recommendations for shadow authority.

18. Identify local customs that might be considered to form part of staff conditions of service, eg bank holiday arrangements.

19. Consider the personnel policies of the existing authorities in the area and identify variations. Attempt to harmonize any that may prove contentious in a unified area: for example, car loan facilities; grading of ancillary staffs; development and organization of incentive schemes; disciplinary and grievance procedures; reimbursement of removal expenses; granting study leave.

20. Prepare statement on existing utilization of computers.

21. Take whatever steps may be necessary (if any) to seek nominations for membership of area health authorities.

22. Relate national decision on the management structure to the area and prepare 'briefs' for the shadow authority on:

a. The pattern of districts.

b. The need for operational groupings below district level.

c. The potential structure indicating options (with comment).

In particular identify and discuss any special circumstances that would suggest a need to modify national policy.

23. Organize programme of multidisciplinary seminars designed to familiarize staff with the new service and its management structure; use 'guide' and film. Issue news letter at regular intervals indicating progress.

24. Undertake a provisional assessment of the accommodation needs of shadow area authorities and district management teams and prepare statement of options. Discuss with shadow local government authorities with a view to linkage with social service departments.

25. Ensure all staff are advised of the means by which posts in the new authorities are to be filled; timing of new appointments; protection arrangements; appeals procedures; etc.

26. Establish contact with neighbouring liaison committees who will provide services to units within the area and with authorities whose units are presently receiving services to discuss the continuation of these operational links.

27. Take whatever steps may be necessary in conjunction with shadow area and regional authorities to prepare for the introduction of the new financial procedures.

28. Identify all procedures, systems, and records that will need to be changed and records that will need to be transferred.

29. Determine the numbers required and cost of employing temporary staff to assist in the transfer of records. Appoint as soon as financial allocation approved.

30. Review the policies and objectives statements of existing authorities, identify significant variations and harmonize where possible.

31. Arrange a programme of visits for members of shadow authorities to hospitals, health centres, etc., in the area and if required a series of informal discussions with staff about their work.

32. Arrange temporary accommodation and secretarial support for shadow authorities until such time as chief officers take up duties.

33. Identify urgent reprinting needs of shadow authority.

34. Prepare paper on the arrangements that need to be made to ensure the community services have access to all the support services they require: particularly routine supplies; medical and surgical goods, stationery, uniforms and clothing, cleaning materials, etc.

35. Identify all contractual arrangements for supplies or services to community services that will need to be continued or replaced either by the shadow authorities or by (or together with) local government.

36. Prepare list of registered nursing homes with details of last inspection and programme of future inspection dates.

37. Discuss arrangements for the transfer of bank balances, and closure of accounts. Prepare a paper for the shadow authority.

38. Enter into discussions with regional JLC about organization of ambulance services.

39. Arrange temporary accommodation and temporary secretarial support for chief officers of shadow area health authorities.

3. REGIONAL JOINT LIAISON COMMITTEES

Objective: To undertake as much of the preparatory work as possible for reorganization short of pre-empting decisions that can only properly be taken by the shadow authorities.

1. Appoint chairman.
2. Appoint convenor/secretary.
3. Agree broad objectives.
4. Identify principal tasks.
5. Consider working arrangements.
6. Decide if support staff required and advise the DHSS of numbers and cost.

7. If funds provided nominate appointing officer and nominal employing authority.

8. Arrange accommodation for support staff.

9. Agree circulation of minutes.

10. Establish that all major existing authorities are represented: if not consider inviting representatives to attend.

11. Decide upon means of involving specialist officers.

12. Establish regional intelligence units to prepare standard 'profiles' and collect or co-ordinate the collection of information for all JLCs and shadow area authorities.

13. Identify any staff who do not readily assimilate into a particular area (for example, county health education officer) and prepare recommendations for their deployment. Make a provisional assessment of the number of staff likely to be employed by the regional health authority by grade and present employer.

14. Establish staff liaison committees and arrange briefing sessions and regular meetings.

15. Take whatever steps are required in connection with the appointment of shadow authorities.

16. Consider existing utilization of computers in the region by all authorities. Assess possibility of integrating programs. Ensure, where necessary, existing computer arrangements can be continued after 1 April 1974.

17. Relate national decisions on the organization of the ambulance service to the region and prepare report on options for the shadow authority.

18. Monitor and if necessary co-ordinate programmes of seminars and discussions designed to familiarize staff with the new service and its management structure.

19. Relate national decisions on the management structure to the region and prepare a tentative structure identifying and discussing options wherever appropriate. In particular identify and discuss any special circumstances that would suggest a need to modify national policy.

20. Discuss arrangements for ensuring that staff employed by the regional health authority are properly paid on 1 April 1974. Prepare recommendation for shadow authority.

21. Ensure all staff are advised of the means by which posts in the new authorities are to be filled; timing of new appointments; protection arrangements; appeals procedures.

22. Arrange a programme of visits for members and chief officer of shadow authority to major centres in the region and if required a series of informal discussions with staff about their work.

23. Arrange temporary accommodation and secretarial support for chairman of shadow regional health authority.

24. Arrange temporary accommodation and temporary secretarial support for chief officers of shadow regional health authorities.

25. Identify local customs that might be considered to form part of staff conditions of service, for example, holiday arrangements.

26. Review the policies and objectives statements of the regional hospital board, county local health authorities, and executive councils and identify variations. Harmonize wherever possible.

27. Prepare consolidated capital development programme and identify any developments that do not appear to mesh with plans for reorganization (for example, developing area CSSDs that will operate across new area or regional boundaries). If practicable, consult shadow regional authority before proceeding.

28. Take whatever steps may be necessary in conjunction with shadow area and regional authorities to prepare for the introduction of the new financial procedures.

29. Identify all systems and records that need to be changed and records that will need to be transferred.

30. Determine numbers required and cost of employing temporary staff to assist in the transfer of records. Appoint as soon as financial allocation approved.

31. Undertake provisional assessment of accommodation needs of shadow regional authority and prepare paper on the implications. Discuss if necessary with shadow local government authorities.

32. Identify urgent reprinting needs of new authority.

33. Prepare a consolidated regional estimate for 1974/5 based upon existing estimates submitted by the various authorities.

34. Consider the personnel policies of the existing authorities from whom staff will be drawn to form the new regional authority and identify variations. Attempt to harmonize any that may prove contentious.

35. Prepare paper on the arrangements that need to be made to ensure those community services that may be managed after 1 April 1974 at a regional level (for example, ambulance service) have access to all the support services they require, particularly routine supplies.

4. SHADOW AREA HEALTH AUTHORITIES

Objectives:

1. In conjunction with JLCs and others to create the right environment for change to take place; to ensure staff morale is maintained at as high a level as possible and that all those responsible for effecting change understand both the reason for it and the expected rewards.

2. To relate national plans to local areas and produce plans for their implementation in conjunction with staff and community representatives.
3. To ensure that all the necessary procedural and legal aspects of the change process are attended to and that there is a smooth transfer of responsibility and authority from existing authorities.

1. Appoint vice-chairman.
2. Agree provisional objectives.
3. Appoint sub-committee to select chief officers.
4. Agree dates for members to attend DHSS 'briefing conference'.
5. Make arrangements for members to visit major services in the area.
6. Agree circulation of minutes.
7. Appoint chief officers and issue contract of employment.
8. Agree firm objectives and principal tasks.
9. Place tasks in broad priority order and establish target dates for completion of the various stages.
10. Decide upon method of working and frequency and location of full meetings.
11. Authorize chief officers to appoint personal support staff.
12. Arrange meeting with the JLC to hand over finished briefs and establish means of regular contact.
13. Arrange for chairman and chief officers to attend DHSS 'briefing' on the management structure.
14. Consider area statistical profile and establish contact with regional intelligence unit.
15. Make contact with staff liaison committees and arrange for regular meetings.
16. Establish formal links with shadow local government authorities.
17. Design management structure for the area based upon the national guide lines and the 'brief' received from the area JLCs.
18. Seek comment on draft scheme from existing authorities and representatives of local staff interests.
19. Submit scheme to the DHSS for approval.
20. Prepare staff establishment.
21. Cost staff establishment.
22. Determine precisely number of staff available.
23. Identify staff surpluses and deficiencies and advise staff commission.
24. Decide which posts need to be filled prior to 1 April 1974 and seek financial allocation if necessary.

25. Establish selection procedures for senior posts at area level and district management teams in conjunction with staff commission.

26. Commence appointment of senior officers and particularly district management team and issue those appointed with contracts.

27. Ensure that all staff in the area will be properly paid after 1 April 1974. Finalize payroll transfers as appropriate and establishment of notification system of staff hours worked, absence, overtime, etc., where new arrangements are required (for example, local health authority staff).

28. Assimilate staff whose role will not change into the area authority in accordance with the guidance given by the staff commission and advise them all of their new employing authority.

29. Make provisional decision where necessary to ensure a reasonably consistent personnel policy is applied to all the staff employed in the new authority.

30. Establish firmly accommodation needs of new authority and if necessary submit scheme to the DHSS for either purchasing, leasing accommodation or converting accommodation currently owned by the NHS.

31. Review telephone arrangements in chosen accommodation and order any necessary alterations or new equipment at earliest opportunity (note local government reorganization).

32. Establish area professional advisory machinery in shadow form and arrange regular contact.

33. Prepare list of powers that will require formal delegation to officers.

34. Design and order essential stationery (for example, official orders). Order over-printing stamps (remember local government reorganization).

35. Identify any changes in procedure that will affect the operation of the services to the patient or the means by which patients gain access to the service. Include in any public information campaign.

36. Make arrangements either with hospital service or local government to ensure community services have access to all the supplies and support services they require.

37. Finalize the continuation or replacement, of contracts for goods or services particularly those relating to the community services.

38. Take whatever steps may be necessary (advice received from the DHSS and shadow regional health authority) to introduce new financial procedures.

39. Prepare budgets for 1974/5 in as much detail as time will allow.

40. Monitor and if necessary co-ordinate the transfer of records by JLCs.

41. Invite nominations for memberships of community health councils.

42. Appoint community health councils and allocate administrative and secretarial support staff.

43. Announce appointment and function of community health councils

in local press (at a time co-ordinated with national announcements if possible) and include in all public information material (most of which will be issued by local government): telephone directories, patient information leaflets, etc.

44. Establish procedure for community health councils to visit hospitals, health centres, etc.

45. Decide upon committee structure for new authority, when it assumes its full status.

46. Prepare standing orders for adoption at first full meeting.

47. Prepare common seal for adoption.

48. Advise each registered nursing home of new registration authority.

49. Establish procedures for authorization of exchequer and endowment expenditure and approval to the purchase of non-recurrent items.

50. Make arrangements with JLCs for transfer of bank balances.

51. Prepare authorization for officers and members to sign cheques.

52. Establish contact with neighbouring shadow authorities who will provide services to units within the area to finalize arrangements for the continuation of these operational links.

53. Enter into discussions with shadow regional authority about organization of ambulance services.

54. Start to build consolidated policy and objectives statement for the area.

55. Appoint press officer.

5. SHADOW REGIONAL HEALTH AUTHORITIES

Objectives:

1. In conjunction with JLCs and others to create the right environment for change to take place; to ensure staff morale is maintained at as high a level as possible and that all those responsible for effecting change understand both the reason for it and the expected rewards.

2. To relate national plans to local areas and produce plans for their implementation in conjunction with staff and community representatives.

3. To ensure that all the necessary procedural and legal aspects of the change process are attended to and that there is a smooth transfer of responsibility and authority from existing authorities.

1. Appoint vice-chairman.

2. Agree provisional objectives.

3. Appoint sub-committee to select chief officers.

4. Agree date for DHSS 'briefing conference'.

5. Make arrangements for members to visit main centres in region as required.

6. If appropriate set in motion procedure for appointment of shadow area health authorities.

7. Agree circulation of minutes.

8. Appoint chief officers and issue contracts of employment.

9. Agree firm objectives and principal tasks.

10. Place tasks in broad priority order and establish target dates for completion.

11. Decide upon method of working and frequency and location of full meetings.

12. Authorize chief officers to appoint personal support staff.

13. Arrange meeting with regional JLC to hand over finished briefs and establish means of regular contact.

14. Arrange for chairman and chief officer to attend DHSS briefing on reorganization.

15. Consider statistical profile and discuss supplementary information needs with regional intelligence unit.

16. Make contact with staff liaison committees and arrange regular meetings.

17. Design a management structure for the regional health authority based upon national guidelines and the 'brief' received from the regional JLC.

18. Seek comments on draft scheme from existing authorities and representatives of local staff interests.

19. Submit scheme for approval.

20. Prepare staff establishment.

21. Cost staff establishment.

22. Establish precise number of staff available.

23. Decide on the deployment of regional board staff to areas (for example, work study officers) and the deployment of staff from county local health authorities and county executive councils to areas.

24. Decide which posts need to be filled prior to 1 April 1974 and seek financial allocation if necessary.

25. Establish selection procedures for the appointment of senior officers in conjunction with staff commission.

26. Issue staff appointed with contracts of employment.

27. Assimilate staff, whose role will not change, into the regional authority in accordance with guidance given by staff commission and advise them all of their new employing authority.

28. Decide upon extent to which computer programs can be inte-

grated and ensure continuation of present arrangements if necessary after the appointed day (particularly payroll and immunization programs).

29. Ensure that existing operational patterns are not distorted by reorganization without alternative arrangements being made.

30. Ensure arrangements have been made to pay staff properly after 1 April 1974. Finalize payroll transfers and the establishment of notification systems of staff hours, absences, etc., for any staff who may not be absorbed immediately into regional headquarters.

31. Arrange regular regional meetings for chairmen and chief officers of area authorities to discuss progress. In addition disciplinary regional meetings (for example for nursing officers) might be useful for comparing notes and applying, as far as possible, a consistent policy throughout the region.

32. Establish firmly accommodation needs of new authority and submit 'scheme' to the DHSS if significant alterations are required to existing RHB accommodation or new accommodation has to be purchased or leased.

33. Review telephone arrangements in chosen accommodations and order any necessary alterations or new equipment at earliest opportunity (note local government reorganization).

34. Consider consolidated capital development programme prepared by regional JLC and identify any developments that do not appear to mesh with plans for reorganization. Discuss with JLC.

35. Decide on name for new authority.

36. Prepare a scheme for the organization of the ambulance service in accordance with national guidance and taking into account the recommendations of the regional JLCs.

37. Prepare authorization for officers and members to sign cheques.

38. Make arrangements for introducing the new financial procedures and advise shadow area authorities of the preparation steps that may be necessary.

39. Prepare a consolidated regional estimate for 1974/5 if required.

40. Establish formal links with shadow local government authorities.

41. Establish regional professional advisory machinery in shadow form and arrange regular contact.

42. Discuss continuation of supply and maintenance arrangements for ambulance service with shadow local government authorities if appropriate.

43. Design and order essential stationery (for example, official orders). Order overprinting stamps (remember local government reorganization).

44. Consider the personnel policies of the authorities who presently employ staff who will work at regional level in the new service.

Attempt to harmonize any that may prove contentious in a unified authority.

45. Start to build up a consolidated policies and objectives statement for the region.

46. Supervise the allocation of endowment funds between area authorities.

47. Prepare standing orders for adoption at first full meeting.

48. Decide upon committee structure for new authority when it assumes its full status.

49. Prepare list of powers that will require formal delegation to officers.

50. Prepare common seal for adoption.

51. Appoint press officer (RHB officer on part-time basis perhaps).

52. Prepare financial allocation to areas and regional services for 1974/5.

53. Monitor and if necessary co-ordinate the transfer of records from existing authorities.

54. Establish procedures for authorization of exchequer and endowment expenditure and approval to the purchase of non-recurrent items.

55. Make arrangements with regional JLC for transfer of bank balances, etc.

B *Executive council records that will require transfer*

1. Administration

1. General medical services
Transfer of personal folders.
Transfer of records relating to:

a. Postgraduate education.
b. Rent and rates scheme.
c. Trainee assistants and 'trainer' approvals.
d. Group practice.
e. Seniority payments.
f. Assistants employed.
g. Designated areas.
h. Doctors providing restricted service.
i. Improvement grants.
j. Finance corporation loans.
k. Health centres and health centre agreements.

2. Pharmaceutical services
Transfer of personal folders.
Transfer of records relating to:

a. Rota arrangements.
b. Drug testing.
c. Prescription charges from dispensing doctors.

3. Dental service
Transfer of personal folders and records relating to seniority payments.

4. General
Transfer of staff records to new authorities.

2. Finance department

Transfer of the following;

General: Cash books, ledgers, journals, inventories, group practice loans register, etc., bank balances.

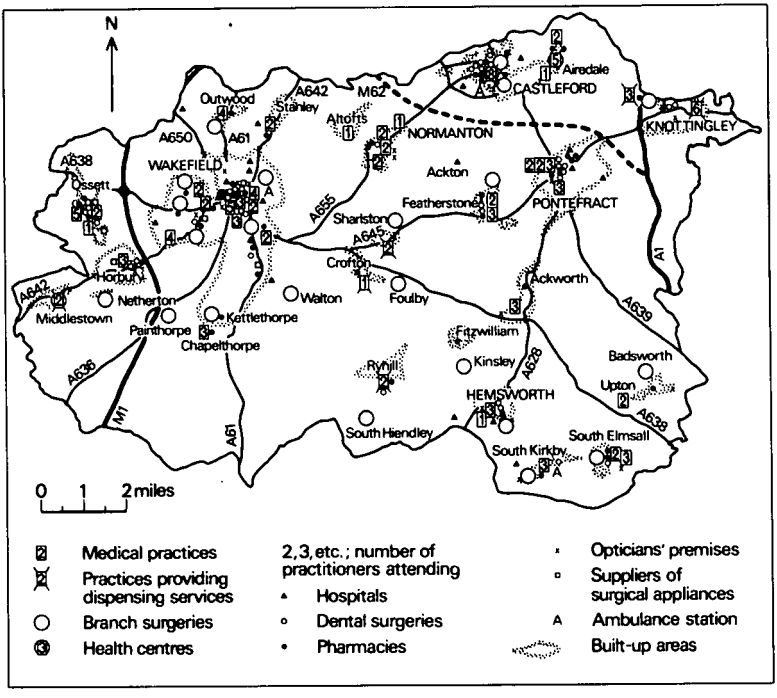
Superannuation: All records for staff, doctors and dentists (SD55 ADP, payment registers, option grant information, personal files, dental seniority records, partnership agreements).

Administration: Salary records (holidays, sickness, tax, National Insurance cards, personal files). Deeds register. Personal files: contractors.

Dental: Personal payment records: dentists, chemists. Pay sheets: dentists, chemists, opticians, and dispensing doctors. Payment authorities, assignment of fees, and special instructions.

Medical: Approved payment applications, and any relevant correspondence, etc. (seniority, assistants, group practice, designated areas, vocational training, initial practice allowance, training grants). Maternity and vaccination and immunization apportionment authorities. Pay sheets. All ancillary staff, rent and rates, and records, etc. Payment authorities and special instructions.

C *Map of the West Yorkshire Metropolitan District 6(e)*



D *Executive council records: the task of reallocation*

Outline of the task of reallocating primary registration records

1. Each doctor's list will have to be analysed, the addresses checked and sorted in accordance with the new boundary changes and allocated to the area health board concerned.

2. A master file will have to be prepared for each doctor for each of the new authorities giving all relevant information relating to the practice, ie designation, seniority payments, mileage, dispensing, bulk prescribing, etc. Where part of the list is to be transferred to a contiguous authority a duplicate file should be prepared.

3. The medical slips relating to lists to be transferred to the same new authority would be extracted for each individual doctor and matched with the corresponding entry cards.

4. These should be checked and counted to ensure the total balances with the doctor's ledger sheet.

5. Where part of the list is to be transferred to neighbouring authorities, ledger sheets should be compiled giving details of the numbers transferred.

6. Depending upon how long it is before the cards are transferred to the new area health board, it may become necessary, in order to carry out the day-to-day work, to re-file all the entry cards for each area back into alphabetical order, thus maintaining a number of separate registers (thirteen in the case of the West Riding of Yorkshire Executive Council). All applications from the Central Register at Southport, additions and deletions from the doctor's list, temporary resident claims, night visit claims, and applications for exemption from prescription charges would then be sorted to the appropriate new authority and dealt with by the section of the present executive council responsible for the records of that new authority.

7. The additions and deletions to the doctor's list should be recorded until the lists are actually transferred.

8. Notification to Central Register of the amended posting would be

made either by the existing council or the receiving new authority by means of the appropriate forms.

9. When all the medical slips and entry cards have been matched there will remain entry cards of patients whose names are no longer included in the list of a doctor but for whom medical records are held. These should be extracted and forwarded to the authorities concerned.

10. Medical records of patients who have died, enlisted, emigrated, or been admitted to a psychiatric hospital, which are retained for a period of three years, should be sorted and forwarded to the authorities concerned.

E *Information for planning the reorganization*

The following data might be included in a standard profile. It has been categorized as essential or illustrative and the latter need not be provided as a routine; only if it appears that it may be particularly significant in the area concerned. Local judgement will be required.

1. A description of the area and its environment

Essential: a map indicating the boundaries of the area, any significant geographical features and transport links.

Illustrative: Physical configurations, weather data, atmospheric pollution, water (supply and composition), density of household occupation, household amenities, statement of housing development policies, architectural features.

2. Demographic data

Essential: Latest population totals broken down by sex and age-group, distribution of population in communities, population projections, migration, birth-rate trends, death-rate trends showing principal causes.

Illustrative: Mortality, morbidity (related to employment data), number of registered handicapped persons.

3. Socio-economic data

Essential: General outline of employment structure, outline of any plans that will materially alter population totals or distribution before 1980.

Illustrative: Indices of status of employed population, car ownership, persons in receipt of supplementary pensions, unemployment rates, kinship patterns, shopping patterns, community units (rivalries and loyalties), income levels, economic development plans for the area, journey to work data.

4. Existing health care services

Building and land

Essential: Function, location, usage, ownership; capital development programmes; vacant or under-utilized accommodation which may be available for office accommodation; a map showing location of all land and buildings.

Illustrative: Potential for development of each building or site, condition of buildings (structure and age).

Major support services

Essential: A general statement of the way in which the major support services are organized and which units they serve: laundry, CSSD and TSSU, supplies, transport, laboratories, pharmacies, plans for development in the next five years.

Illustrative: Details of the range of services provided by each department, current workload, and total capacity.

Staffing

Essential: Detailed breakdown showing the numbers and categories of staff in post and their location; establishments (financed); training schemes; type, length, location, and numbers in training.

Illustrative: Statement of recruitment difficulties, age structures, staff turnover.

General medical, dental, ophthalmic, and pharmaceutical services

Essential: Number and location of practitioners, practice structures, practice premises (location and ownership), designation of areas.

Illustrative: Age structure of practitioners, number of support staff employed by practitioners, workloads, and level of service provided.

Operational patterns

Essential: Catchment areas of district general hospitals, GP referral patterns, hospital sub-groupings, community service operational areas, social service operational areas, ratio of domiciliary and hospital confinements.

Illustrative: Ambulance flowcharts, hospital workload data, waiting-lists.

Costs

Essential: Cost of running existing services at present level.

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