# THE FIRST HUNDRED DAYS

A first impression of the reorganised health service at the end of the first three months studied from the viewpoint of the administrator at hospital level

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NOTE

This document is an abridged version of the report of a project undertaken in connection with a University course of study. Grateful thanks are due to those hospital secretaries who took time from their somewhat troubled circumstances to help by completing questionnaires.

For a number of reasons publication of this report has been delayed, but this may not be a bad thing. It could be a useful, and perhaps enlightening experience to compare the situation and feeling of some administrators in the summer of 1974 with present conditions and opinions.

Much has been said and written about reorganisation in the last two years and it is certain that much more is likely to be said and written in the foreseeable future. Instead of adding more to this verbal deluge one may quote the words of a famous English man of the first Elizabethan age:

> 'There must be a beginning of any good thing but the continuing to the end until be throughly finished, yields true glory.' *

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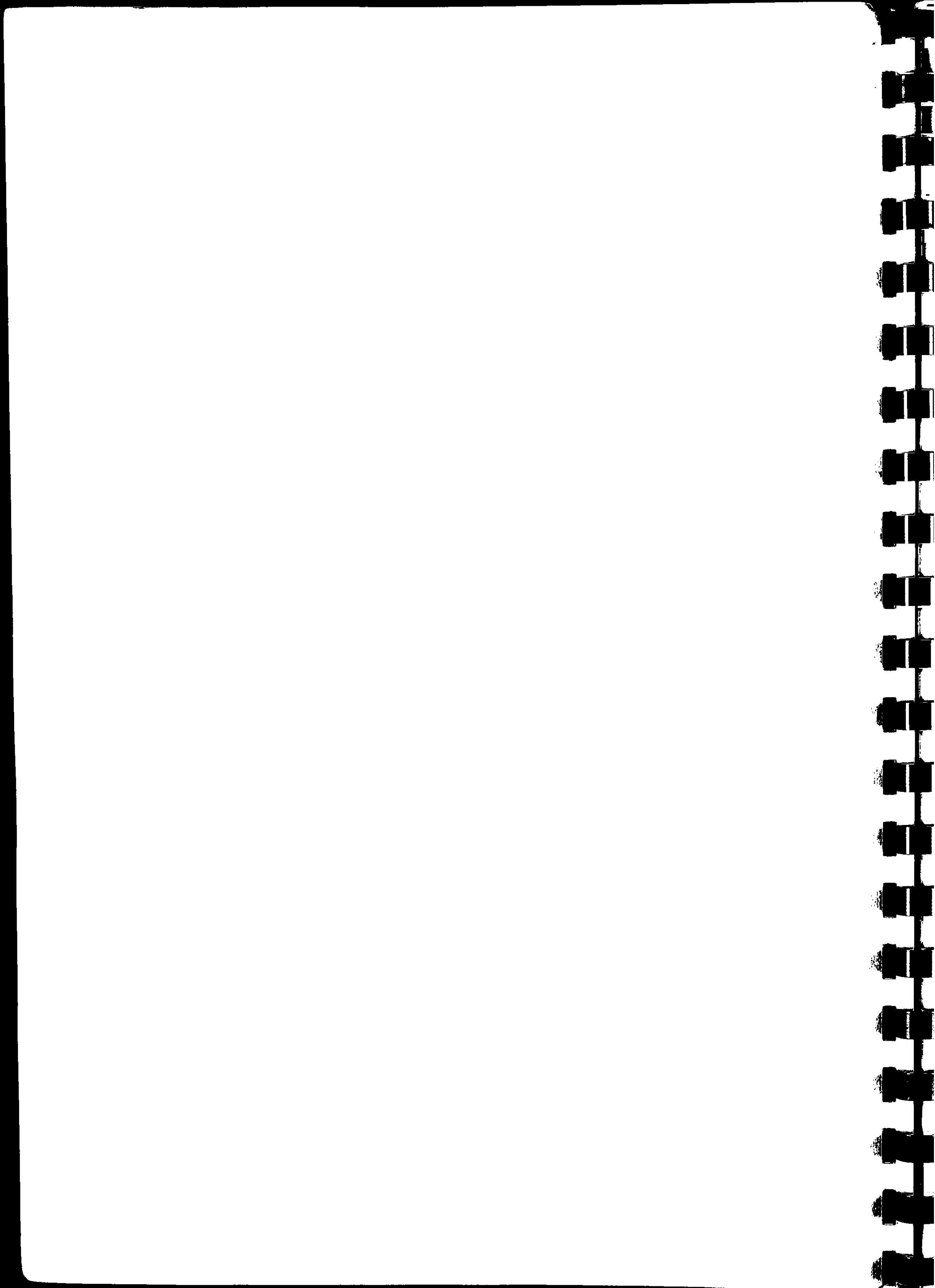
* Sir Francis Drake in a letter to Sir Francis Walsingham, May 1587.



# INTRODUCTION

The purpose of this study was to try and obtain a first impression of the impact of the National Health Service (Reorganisation) Act 1973, which came into force on 1 April 1974 and to ascertain the extent to which the new administrative pattern had been translated into action and to identify any pattern of problems and improvements that might be emerging after the first three months of the new service.

The difficulties and dangers involved in any attempt to make balanced judgements after so short a time were fully appreciated, but it was thought that useful material might nevertheless be collected. As the avowed purpose of reorganisation was 'a better and more sensitive service to the public', [1] it was decided to undertake the survey at the administrative level closest to the patient, that is, at hospital level.

## Method

The survey was carried out by means of a questionnaire prepared and tested with the help of the Council of the Association of Hospital Secretaries who were also responsible for the selection of a representative sample of their membership to cover all areas of England and Wales, and for the necessary publicity and circulation of papers.

A total of 140 copies of the questionnaire was supplied to the Association and 84 were returned completed. Replies were received from hospital secretaries from all but one of the 14 Regional Health authorities in England and from six of the eight Area Health Authorities in Wales. Details of the sources of replies are given in Table 1.

Table 1 Details of replies received

| Region | Total no of Areas | Total no of Districts | No of replies received | |
|---|---|---|---|---|
| 1 Northern | 9 | 16 | 4 | (2) |
| 2 Yorkshire | 7 | 17 | 6 | |
| 3 Trent | 8 | 18 | 8 | |
| 4 East Anglia | 3 | 7 | 5 ** | |
| 5 North-West Thames | 7 | 18 | 4 | (1) |
| 6 North-East Thames | 6 | 17 | 7 * | |
| 7 South-East Thames | 5 | 16 | 10 ** | (1) |
| 8 South-West Thames | 5 | 14 | 6 | (2) |
| 9 Wessex | 4 | 10 | 5 | |
| 10 Oxford | 4 | 7 | 3 * | |
| 11 South Western | 5 | 12 | 9 | (1) |
| 12 West Midlands | 11 | 22 | 9 | (1) |
| 13 Mersey | 5 | 12 | 0 | |
| 14 North-Western | 11 | 18 | 2 | (1) |
| Wales | 8 | 16 | 6 | (3) |
| TOTALS | 98 | 220 | 84 | (12) |

Note:

1 Number in brackets in last column indicates number of single district areas from which replies were received.

2 Asterisk denotes more than one reply received from the same district (total of 6).

# PART ONE: TOWARDS UNIFICATION

## HISTORICAL BACKGROUND

The National Health Service Act of 1946 was intended to promote 'the establishment in England and Wales of a comprehensive health service, designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness'. A similar act passed in 1947 dealt with Scotland and both came into force on 5 July 1948. The act placed on the Minister of Health the responsibility for seeing that health services of every kind and of the highest possible quality were available to everyone who needed them. The health services are the responsibility of the Department of Health and Social Security (DHSS), an amalgamation of the Ministry of Health (first established in 1919) and the Ministry of Social Security, which took place on 1 November 1968.

From 1948 to March 1974 the NHS was administered in three separate parts. Fifteen Regional Hospital Boards were responsible for 332 Hospital Management Committees administering groups varying in size from one large hospital to up to 20 or more hospitals and clinics. Thirty-six Boards of Governors were directly responsible to the DHSS for 150 individual hospitals in teaching groups, each associated with a medical school. Three 'special' hospitals for psychiatric patients requiring special security were responsible direct to the Department. General practitioner, dental, pharmaceutical and supplementary ophthalmic services were organised by 134 Executive Councils. The 174 local authorities throughout the country (the GLC and London boroughs, country councils and county boroughs) were each responsible for a variety of services including health clinics, maternity and child welfare services, ambulance services and preventive medicine.

### Towards reorganisation

In November 1967 the Minister of Health (Mr Kenneth Robinson) announced his intention of making a careful examination of the administrative structure of the medical and related services, which he considered had 'now progressed about as far

as is possible within the present divided administrative structure'. His proposals, published in the rather unusual form of a 'Green Paper', [2] suggested the replacement of the tripatite structure of the service in England and Wales by a system of 40 - 58 comprehensive Area Health Boards. This document 'sparked off a vigorous discussion inside and outside the service' but was rather overtaken by events. A change of Minister and the publication of the report of the Royal Commission on Local Government [3] produced second thoughts eventually published in a second Green Paper in 1970[4]. In the words of the Minister (Mr Richard Crossman) the main aim of the proposals was to 'remove the present administrative barriers between the different parts of the service to enable everyone working at any level in the health service to plan, administer and provide for the comprehensive health needs of every citizen'. The four key phrases of this document were unification, co-ordination, local participation and effective control. Proposals in this paper were restricted to England, and separate Green Papers were later produced for Wales and Scotland [5,6]. The revised proposals for England envisaged 14 or more regional health councils and about 90 area boards.

The next step was a Consultative Document [7] published by the Secretary of State, Sir Keith Joseph, setting out further proposals for public discussion preparatory to the publication of a White Paper. Pointing out that the debate on reorganisation had been going on for a decade, Sir Keith emphasized the need for early decisions to 'revive the creaking structure' of the service 'so that enthusiasm for reform does not wither away'. A similar sentiment had been expressed three years earlier by Mr Robinson: 'The period of uncertainty, anxiety, and in some respects disruption, has been far too long.' * A White Paper was presented to Parliament in August 1972; a Bill was published on 15 November 1972, and the NHS (reorganisation) Act 1973 finally received Royal Assent on 5 July 1973 exactly 25 years after the birth of the National Health Service.

A similar unification of social services had been accomplished two years earlier by the Local Authority Social Services Act 1970 which brought together the work of the children's, welfare and health committees under a single committee.

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* 1st Green Paper 1968.

# PLANNING FOR CHANGE

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'It (the White Paper) is about administration,
not about treatment and care'.

Sir Keith Joseph in foreword to the White Paper (Cmnd. 5055)

The definitive White Paper [1] was published in August 1972, followed by the so-called 'Grey Book' [8] which contained detailed proposals for management arrangements, resulting from a study which collected information from detailed discussions in seven selected representative areas.* It was not until January 1973 that the DHSS announced that, with certain modifications, these recommendations would form the basis for the organisation of the post-1974 NHS. Thus, after over six years of discussion, there was less than 18 months in which to plan and put into action the extensive changes necessary to bring together the three branches of a service employing one of the largest labour forces in the country.

Apart from the DHSS official Working Party, however, a number of experiments were being carried out in various parts of the country. These varied from the appointment of a community liaison officer in a teaching group to full-scale simulated unification plans at area level [9, 10], and an ongoing study of the implementation of change over a period of three years [11, 12, 13]. It should be pointed out, however, that, although statutory unification of the three branches of the service was a new concept, much informal but highly successful co-operation and co-ordination had been developed throughout the country over many years [14]. As the first 'Minister of reorganisation', Kenneth Robinson, commented as far back as 1966 there was 'more and more evidence ....... of intergrated planning of health services as a whole'**.

From June 1972 a series of NHS Reorganisation Circulars (HRCs) gave continuing guidance on the setting up of Joint Liaison Committees, the appointment of new regional and area authorities to exist in 'shadow' form until taking over from previous authorities on 1 April 1974, training schemes for staff and many other administrative matters.

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* Berkshire, Doncaster, Hillingdon, Lambeth/Southwark, Lincolnshire, Nottinghamshire and Oxfordshire.

** The Minister on Administration of the NHS. The Lancet. Vol. II No 7470. 29 October 1966. pp. 951-959.

## PART TWO: SHADOW INTO SUBSTANCE

### SETTING THE SCENE: THE HOSPITAL SECRETARY

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The position of hospital secretary in the NHS has always been somewhat anomalous. The potential importance of such posts and the associated practical problems were clearly delineated by both the Bradbeer [15] and the Guillebaud [16] reports and crystallised in the Noel Hall report [17] which stated that, 'He, (the hospital secretary) must, in his own field, be regarded as the general manager with specific responsibilities and authority'. It has been found that for the majority of staff at hospital level, the unit administrator is the key figure [18] but the powers and responsibilities of the post have tended to become eroded by recent development of functional management. The additional uncertainty resulting from reorganisation has caused acute concern and unrest among the ranks of hospital secretaries.

The first direct reference to this specific post is found in the 'Grey Book' which suggested the possible need for sectorization in some districts with the 'sector administrator analogous to the present hospital secretary'. According to HRC(74)29 and 30, sector administrators 'will normally be accountable to one of the General Administrators'; direct responsibility to the District Administrator is restricted to large sectors only. Thus, for many previous hospital secretaries, accustomed to direct contact with the Group Secretary, another level of authority is imposed.

The personal opinion of some of these officers as shown in this survey can be summed up by one who commented 'Hospital secretaries are cynical about benefits of re-organisation in general and their own future in particular'. However, they can, perhaps, take a little comfort from a recent comment by Dr David Owen, M P to the effect that 'it seems unlikely that there will be any less need for sector and unit administrators in the reorganised service than in the old'.*

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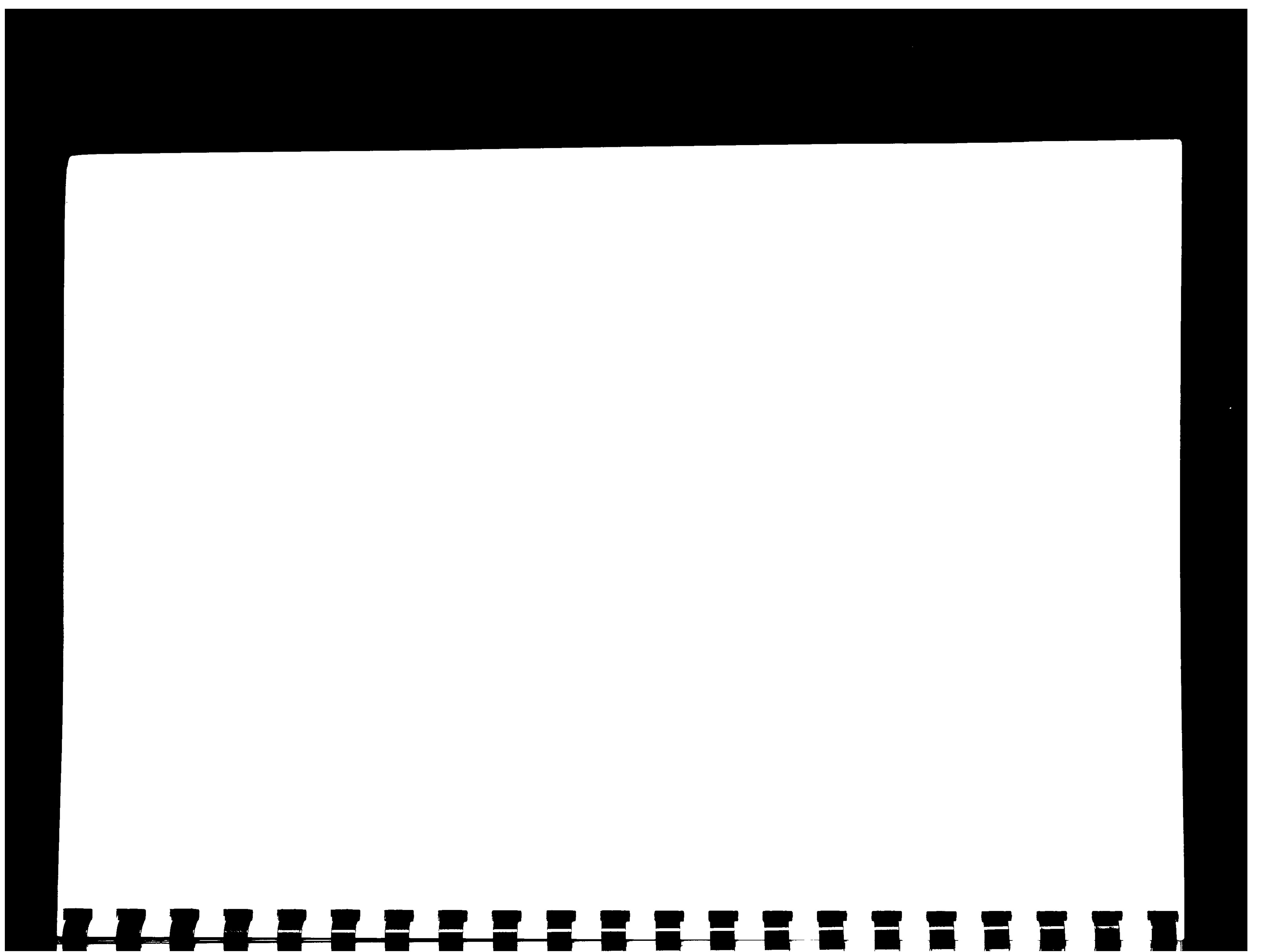
* Dr David Owen M P in a letter to the Association of Hospital Secretaries. 4 September 1974



PREPARATION FOR CHANGE

## Keeping staff in the picture

'Without question, the health service's most important resource is its staff'.*

A recent study has shown that hospital staff are most anxious to know what is happening and what is likely to happen in their hospital situation, and quickly become anxious and insecure if kept in ignorance of events [19]. In the build-up to 1 April 1974, the DHSS attempted to keep staff informed by means of monthly News Sheets (NHS Reorganisation News) and NHS Staff Reorganisation Bulletins in addition to the H R Circulars.

The survey suggest that these efforts were not entirely successful. Tables 2 and 3 suggest that possibly insufficient positive action was taken to ensure that staff were kept informed by official means. Tables 4 and 5 show that these publications were read by only a minority, chiefly senior staff, and understood by even less – 'no more than I could, in some cases', commented one secretary. Among the reasons given for this lack of interest are late arrival of circulars, absence of information of local interest and a feeling that the whole matter did not affect the individual.

Table 2 Were reorganisation circulars passed to all staff?

| | |
|---|---|
| Yes | 53 |
| made available | 15 |
| No | 7 |
| digest only | 5 |
| probably | 2 |
| not received | 1 |
| minimal supply | 1 |
| TOTAL | 84 |

* Barbara Castle in an address at a dinner of the Socialist Medical Association 18 May 1974.

| Table 3 By what means were they made available to staff? | |
|---|---|
| placed on notice boards | 43 |
| given to departmental heads | 33 |
| general distribution | 11 |
| through house journals | 9 |
| with pay packets/on pay parade | 9 |
| placed in staff rooms | 7 |
| through staff organisations | 2 |

(N B: more than one method often used)

| Table 4 Did staff read them? | |
|---|---|
| Yes | 19 |
| doubtful | 17 |
| not many | 11 |
| some | 10 |
| don't know | 5 |
| majority | 5 |
| no answer | 4 |
| senior staff only | 4 |
| generally No | 4 |
| presumably | 2 |
| a minority | 2 |
| No | 1 |
| TOTAL | 84 |

| Table 5 Did the staff understand them? | | |
|---|---|---|
| Yes | 6 | 13 |
| presumably | 5 | |
| most | 2 | |
| some | 7 | 24 |
| only a few | 7 | |
| partially | 6 | |
| often not | 4 | |
| doubtful | 15 | 47 |
| very doubtful | 10 | |
| not known | 11 | |
| no answer | 8 | |
| No | 3 | |
| TOTAL | 84 | |

Some hospitals in the survey planned their own information schemes, running seminars and publishing in their house journals digests of official publications geared to local conditions, and reference was also made to regional publications of a similar nature.

Joint consultation

In the DHSS guidance documents emphasis was placed on the need for adequate consultation. 'Effective communication with staff by existing authorities to obtain the understanding and support to the organisational changes is a vital element in the reorganisation both initially and later when decisions are being reached by health authorities'.*

The survey produced a variety of responses to this statement. (see table 6)

* HRC(73)2 January 1973

| Table 6 Machinery for staff consultation | |
|---|---|
| Type of machinery set up for joint consultation | |
| none | 24 |
| various type of meetings | 21 |
| area and district committees set up | 17 |
| existing JSCCs still functioning | 12 |
| arrangement pending | 5 |
| information unsatisfactory | 5 |
| TOTAL | 84 |

The heading 'various types of meetings' included occasional and 'ad hoc' meetings of different groups, and among this number have been included such vague comments as 'believed to have existed' and 'minimal'.

Informing hospital secretaries

Hospital secretaries were asked what information they were given regarding the various units in the district in preparation for reorganisation. The survey shows that less than half (35) were satisfied on this score, (see Table 7) and that one quarter had received no information.

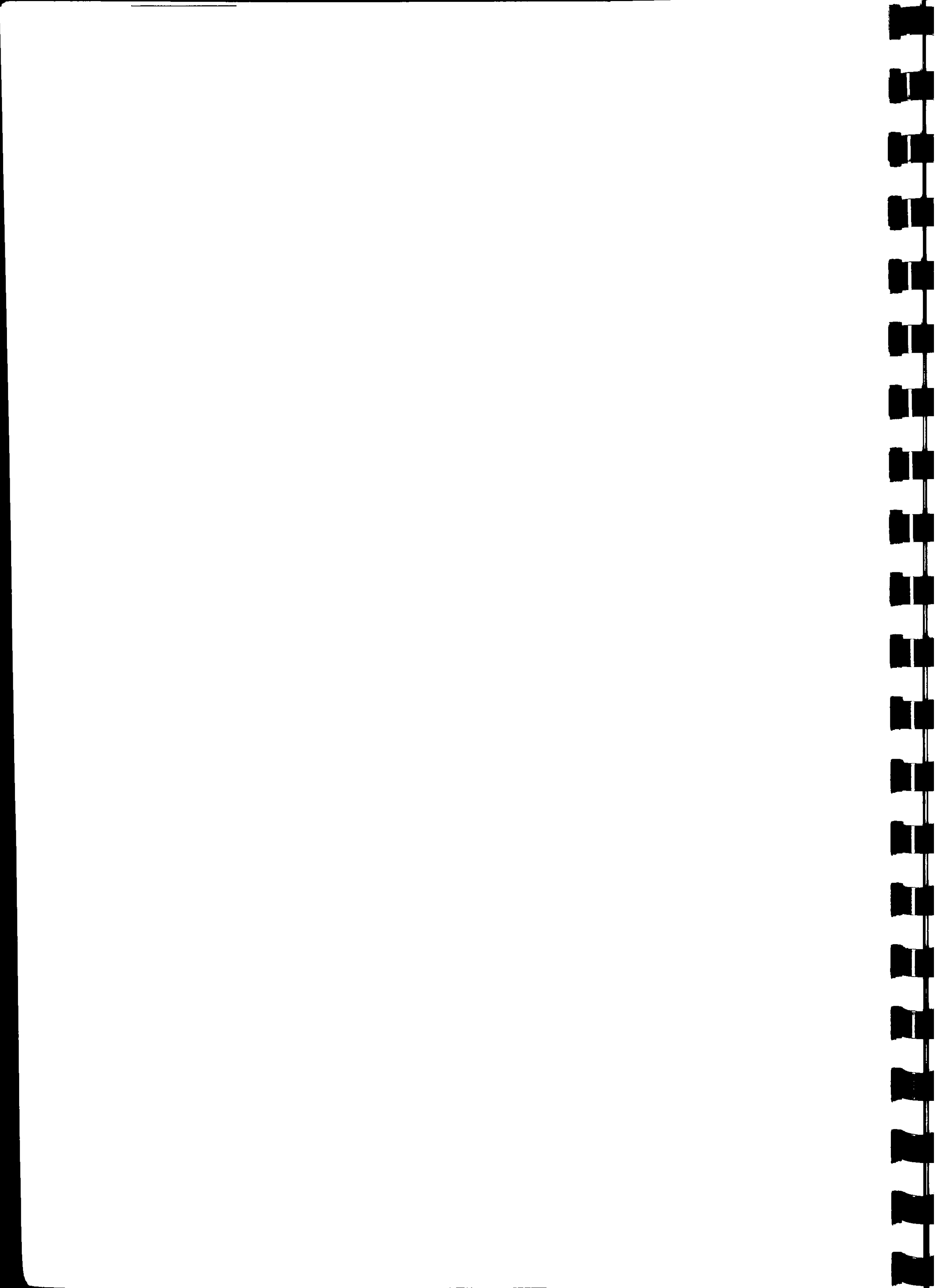
Planning information

Sixty-two (74 per cent) reported that they had been given no information as to how the various units within the district were to be merged into primary health care units. Eighteen did receive such information and a further three had received 'a little'; only one failed to answer this question. Just under one half (38) said that they had an overall picture of how their district would function, but one third (29) gave a negative reply (see table 8).

| Table 7 Satisfaction rate: Information re: units | | |
|---|---|---|
| Information received regarding units in new district organisation | No of respondents | |
| satisfied/fair/adequate | 35 | (41.6%) |
| none | 21 | (25%) |
| very little | 10 | |
| no answer | 9 | |
| very late | 5 | |
| some | 4 | |
| TOTAL | 84 | |

One secretary reported that a consultative document setting out area plans had been received only one week before the last date for comment, and a lecture had been given to staff two days before the deadline 'to justify consultation'. Another complained that the 'the D A was in post for six weeks before I even spoke to him'; a colleague reported that after three months the hospital secretaries in his district had had no meeting with the District Administrator.

| Table 8 Possession of overall picture of the functioning of new district | |
|---|---|
| Yes | 38 |
| No | 29 |
| a little | 14 |
| no answer | 3 |
| TOTAL | 84 |



# DISTRICT ADMINISTRATION

'The district will not in any sense form a separate formal tier of authority below the areas.'

NHS Reorganisation. Cmnd. 5055. para 46.

The purpose behind the district concept is 'to get the most appropriate organisational unit within which to plan for and provide co-ordinated primary and secondary health care'*. It has no statutory committee and control is in the hands of a six-man team - 'a group of equals' acting 'as a consenus-forming group'.

## The District Management Team

In the 78 districts covered by the survey, just over 72 per cent (298) of the DMT posts had been filled by 1 April 1974, and 115 more by 30 June. Eighteen posts were filled on second advertisement and 15 at the third time round; after this stage, 8 still remained unfilled (see tables 9, 10).

Table 9

| District Posts | Filled by 1 April | Filled between 1 April and 30 June | Total filled 30 June |
|---|---|---|---|
| Administrative Officer | 66 | 8 | 74 |
| Finance Officer | 57 | 13 | 70 |
| Nursing Officer | 57 | 14 | 71 |
| Consultant | 39 | 26 | 65 |
| Community Physician | 39 | 26 | 68 |
| General Practitioner | 40 | 28 | 65 |
| TOTALS | 298<br>72.15% | 115<br>27.85% | 413 |

* HRC (73)4 para 3.

| Table 10 | | | |
|---|---|---|---|
| District posts | Filled 2nd time round | Filled 3rd time round | Not filled after 3rd time round |
| Administrative Officer | 4 | 4 | - |
| Finance Officer | 6 | 5 | 2 |
| Nursing Officer | 4 | 3 | 3 |
| Community Physician | 4 | 3 | 3 |
| TOTALS | 18 | 15 | 8 |

Late filling of the DMT posts and the consequent lack of supporting organisation have proved to be problems for some respondents leading to 'a temporary lack of sense of direction - each unit carrying on as best it can'. One secretary referred to a 'no-leadership situation at the time when this was most needed'.

Sixty-four of the DMTs were reported to hold weekly or fortnightly meetings (see table 11). Half of the respondents reported that they received no details of the results of these meetings (table 12). Seven felt that management by consensus of opinion had resulted in quicker action; thirteen thought the opposite. Obviously, much depended upon local circumstances and individual officers. Some respondents regretted the loss of close contact with the Group Secretary; others found the DMT easier of access than the HMC, and commented on the time saved in not having to service HMCs and House Committees. One found matters previously in his own hands now had to be referred to the DMT.

| Table 11 Frequency of DMT Meetings | | |
|---|---|---|
| Frequency | No of DMTs | |
| weekly | 28 | 36% } 64% |
| fortnightly | 22 | 28% } 64% |
| 3 times/week | 1 | |
| monthly | 12 | |
| twice monthly | 4 | |
| 3 times a month | 1 | |
| ? ? ? | 10 | |
| TOTAL | 78 | |

| Table 12 Information regarding DMT Meetings | |
|---|---|
| receive details | 31 |
| receive no information | 39 |
| receive partial information | 6 |
| no answer | 2 |
| TOTAL | 78 |

## Sectorization

A 'sector' is described in HRC(74)29 as a 'substandial sub-division of a district, not a multidisciplinary management tier separate from the district'. 'Most districts', it continues, 'are unlikely to have more than two or three sectors'.

In 42 per cent (34) of the districts covered by this enquiry, respondents had no knowledge of plans for sectorization (table 13). A further 21 per cent (17) reported that proposals had been made and 36 per cent (28) were able to give definite details. (see table 14).

| Table 13 | | |
|---|---|---|
| Sectorization of Districts: (total 79) | | |
| details not known | 34 | (42%) |
| proposed butnot finalised | 17 | (21%) |
| definite | 28 | (36%) |

One secretary reported that his particular hospital had a choice of joining three different districts and that the matter was still unsettled at 30 June. Another wrote 'we only joined our current district on I June 1974. Yet another reported that all sectorization plans in his district had been postponed until 1975 while another colleague complained that he did not have his own sector, 'only a zone'. Thus, just under half of all respondents were still unsure of their future speheres of responsibility after three months.

Table 14

| No of sectors per district | No of districts |
|---|---|
| 1 | 2 |
| 2 | 13 |
| 3 | 14 |
| 4 | 8 |
| 5 | 5 |
| 6 | 1 |
| 12 | 2 |
| TOTAL | 45 |

Financial situation

The general economic crisis has resulted in an overall reduction of 10 per cent in all hospital budgets. Two thirds of the hospital secretaries considered that this would have very serious effects, resulting in an almost complete standstill; no improvements or developments would be possible. 'Before the year is out' warned one, 'there will be a reduction in standards'.

| Table 15 | |
|---|---|
| Results of 10% reduction | No of respondents |
| detrimental | 57 |
| not known | 12 |
| no answer | 10 |
| none | 5 |
| TOTAL | 84 |

In view of this serious situation it was rather distressing to find that 55 (66 per cent) had no knowledge of the allocation for their particular hospital. One had been given a provisional budget by 1 April, and 28 had received theirs by 1 June. Of this total of 29, 11 were reported to be global budgets and 17 broken down into headings. 'Blind control' was the description used by one respondent.

## EFFECT ON HOSPITAL STAFF

> 'I am well aware of the decline in morale in some sections of the service, caused by concern over pay and by NHS reorganisation.' *

The effects of reorganisation upon the morale of hospital staff received greater mention than any other subject in this survey. Respondents were asked to comment on staff morale during the run-up to April 1 and after that date. Only five of all 84 secretaries made no mention of this factor. Table 16 lists the various groups of staff said to be affected.

Table 16: Staff morale adversely affected

| Staff group | Times mentioned |
|---|---|
| Staff generally | 47 |
| Senior officers | 34 |
| Unit administrators | 24 |
| Departmental heads | 17 |
| Works staff | 13 |
| Nurses | 10 |
| Finance staff | 3 |
| Social workers | 1 |

A number of hospital secretaries reported very little interest - even 'complete apathy' - on the part of staff thought to be unaffected by coming changes. Lower grades were much less affected than senior and managerial staff, but in many cases morale was reported to be 'generally low' and the words 'frustration', 'apprehension', 'depression', 'disillusionment' and 'uncertainty' occurred frequently. The following are typical comments:

* Barbara Castle in a speech at a dinner of the Socialist Medical Association, 18 May 1974.

'In the unaffected departments, very little interest was shown, since proper information was not available'.

'General disquiet, apprehension and uncertainty among the middle and upper echelons, disinterest and scepticism in the lower and less involved ranks.'

'The usual feelings of uncertainty about the future; morale was undermined'.

In only two cases was any improvement after 1 April definitely noted. The staff of one hospital were reassured by an early visit from the DMT and in the other, it was reported that 'management has confined its activities to reorganising itself, leaving the hospital in peace and making it a much happier place in which to work.'

Comments on post-reorganisation morale contained a high proportion of references to senior and management staff of several disciplines, generally worried by uncertainty as to their personal future. There were comments on senior officers having to apply for their own posts, and others failing to obtain appointments, to works staff frustrated by delays in advertising their posts and to the chaos caused by industrial action. The comment of the North-East Thames RHA in its memorandum to the DHSS on the recent publication on the 'democratization' of the NHS [20] is apposite:
'We must say that we have serious doubts whether the Secretary of State and the Department really do understand, even after recent events, how fragile is the state of morale in the NHS today.'

## PROBLEMS OF REORGANISATION

> 'There can be no doubt that the reorganisation of the NHS will produce chaos.' *

Sixty-six respondents identified definite problems which they ascribed specifically to reorganisation (see Table 17) but general comments throughout the questionnaires demonstrated that inevitably difficulties arising from reorganisation on such a vast scale had been accelerated by several major circumstances and considerations.

Table 17 Problems arising from reorganisation

| Reply | Number |
|---|---|
| definite problems | 66 |
| none | 10 |
| too early | 3 |
| no answer | 2 |
| no change | 2 |
| TOTAL | 84 |

1 The time schedule: the very short period allowed for the implementation of reorganisation on 1 April, described by one respondent as 'indecent haste', has made it impossible for the necessary advice and guidance to be carefully considered and developed. This is apparently also the view at Ministerial level. Dr David Owen in an address to the Annual Conference of Institute of Health Service Administrators, June 1974, said 'There is no doubt that the reorganisation act became an act much too late to have a smooth and normal transfer on 1 April'. These difficulties have been accelerated by:

2 Financial restrictions: these have prohibited the making of a number of necessary appointments. Consequently, works officers are disgruntled, maintenance work has suffered and in some cases come to a standstill, and administrators at lower grades see little hope of appointments being made at scales equitable with senior posts already filled.

* Edwards B and Walker P. 'Si vis pacem .....' Preparation for change in the NHS. OUP for Nuffield Provincial Hospital Trust 1972.

3 Impact of written communications: 'It was impossible' wrote one secretary 'to assimilate the flood of circulars from the DHSS in their frantic rush to ensure reorganisation started on 1 April'. The fact that so much of this had little relevance for the bulk of staff and was frequently incomprehensible to them led to apathy - 'oh no, not again'. '

4 Staffing changes: the trauma of such a vast change has been increased by the uncertainty at higher and middle levels which has had repercussions on all grades of staff. Gaps were left in the administrative structure in the interim period as newly appointed officers took up their 'shadow' posts, and the additional pressure of work laid on those remaining has taken its toll. The loss of experienced staff who have decided to leave the service has also been pointed out in this survey.

5 Failure of communications: lack of communication, consultation and direction at hospital level comes out very clearly as a major problem. As Dr R Revans points out, communication failures increase the anxiety which is endemic in the hospital world [21]*. This problem has been intensified by the other attendant problems already listed but particularly by:

6 The lengthening of lines of communication: although the DHSS has been at pains to emphasize the official view that management at district (DMT) level and day-to-day administration at sector level do not constitute separate official tiers, (see page 14) respondents in this survey make it clear that, in actual practice, there is now an additional tier of administration which, it is felt, will slow down policy and decision-making, and direct restricted finance away from the main source of need - the patient. There was a hint in the replies that the Area could be superfluous to requirements, one respondent going so far as to describe it as a 'post-box, where work is duplicated and delayed'.

* 'The hospital is an organism characterised by anxiety. Anxiety is enhanced by uncertainty. Uncertainty is magnified by communication failure.'

7 Method of implementation: Finally, and most important, this survey suggests that most problems arise basically from the lack of availability of complete management structures before the event. One respondent expressed his views in these words: 'It is quite ridiculous to finalise an intention (ie the 1973 Act) before the substance (ie the structure) has been worked out in detail'; adding 'this goes to prove a fundamental truism about organisational change - the organisation needs to change itself to survive, not to have reorganisation imposed from without'.

## The heart of the matter

As the whole purpose of this expensive and traumatic exercise is the improvement of services to the patient, the last word in this section should focus on the patient. Every respondent in this survey who mentioned patients (about a quarter of them) considered that under present circumstances, patients would derive no benefit from reorganisation; 'have they,' asked one secretary, 'been forgotten?'

Those who answered the question asking whether patients had benefitted from the fact that social services had been transferred to the local authority were unanimous in the view that there had been no improvement. Some felt unable to give a considered opinion; one at least reported a deterioration in servicesdue to local boundary patterns; another declared that the only difference was the source of the social worker's cheque.

## ON A BRIGHTER NOTE

Twenty-six respondent (32 per cent) listed some specific improvements (see table 18)

| Table 18 | |
|---|---|
| no improvement | 45 |
| some improvement | 27 |
| too early to say | 7 |
| no answer | 5 |
| TOTAL | 84 |

These improvements were chiefly to be found in relationships and understanding at local level between such groups as local authority health and ambulance personnel, and general practitioner and consultants. There were indications of greater understanding of problems by medical colleagues, improvements in multi-disciplinary problem-solving, and an increased appreciation of total health care.

## CONCLUSIONS

> 'Reorganisation did not take place on 1st April. What happened was a legal transfer of responsibility to new authorities, which is not quite the same thing.' *

It is obvious that a period of only three months is far too short for any sort of evaluation, however tentative, of an exercise as extensive and of such a fundamental nature as the reorganisation of the National Health Service involving the unification of three separate branches. The process has been bedevilled by circumstances outside its control and has coincided with similar upheavals in other areas of government and public service.

The service is, however, essentially for the patient, and a glimpse of the situation at the administrative level closest to the patient such as this present survey provides, suggests that the traumatic effects will not quickly disappear and that immediate service to the patient may well suffer in some areas. More appointments in the new service are being made, but the scars of the anxious months that have been endured will remain for a considerable time. It is far easier to demolish staff morale than to build it up, and it is questionable whether, in the emphasis that quite rightly has been placed on the 'administrative' aspects of reorganisation, the human angle has not been overlooked. As one respondent commented, 'the traumatic effect of reorganisation has been grossly under-estimated by its proposers'. It is after all, <u>on</u> people that a service essentially <u>for</u> people is based.

It will take several years for the new service to settle down and there may well be need for considerable re-thinking in some areas. For the moment, the comments of one respondent are apposite - 'any benefits are seen to be long-term and impossible to quantify.' In the meantime, people are born and they die, become ill and recover, and the health and welfare needs of the population increase rather than decrease. Any administrative change on a national level is bound to be a lengthy and possibly a painful process. The real criterion must be 'does it improve the service to the patient?'

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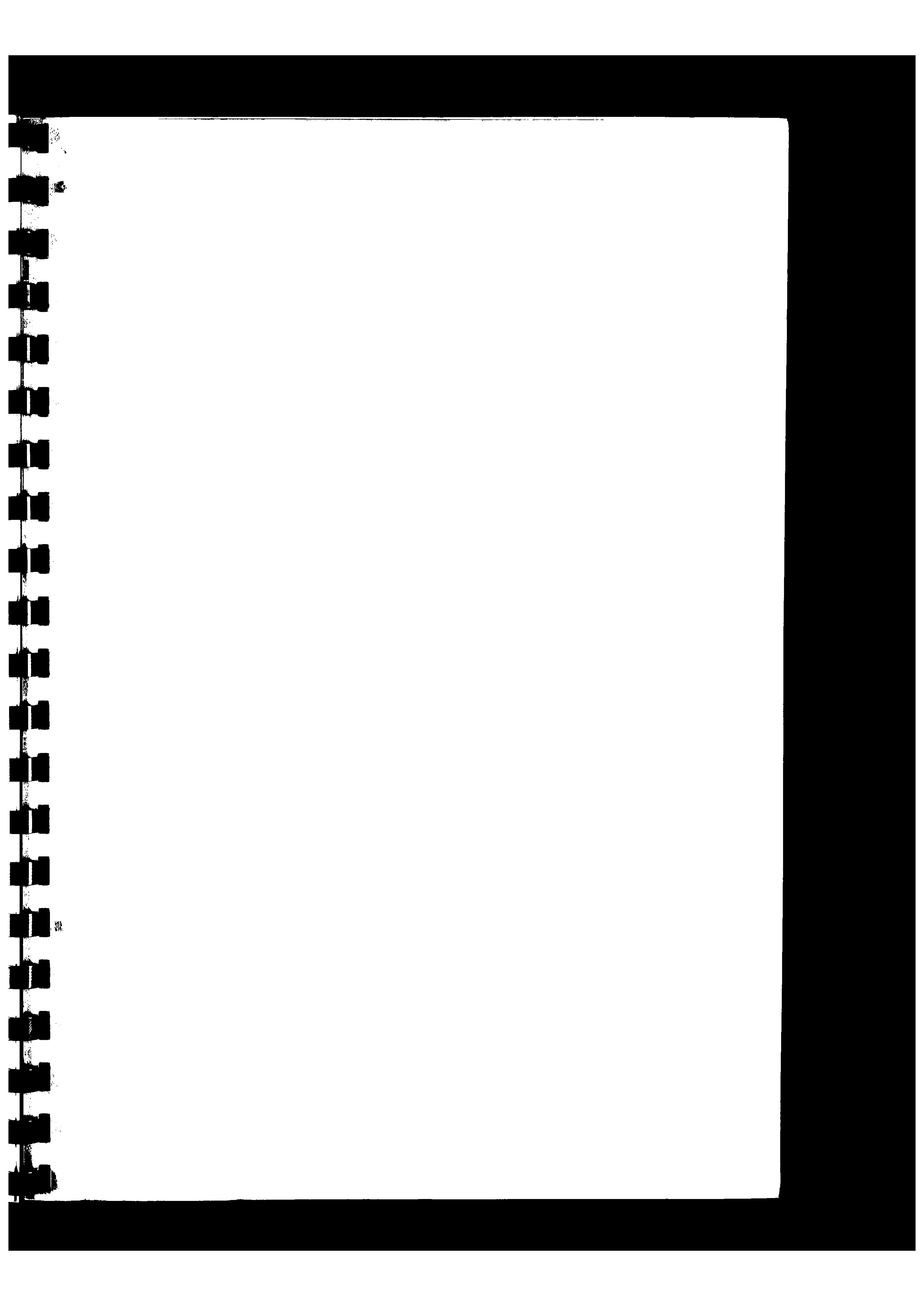

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