Lessons for the Future from the Past

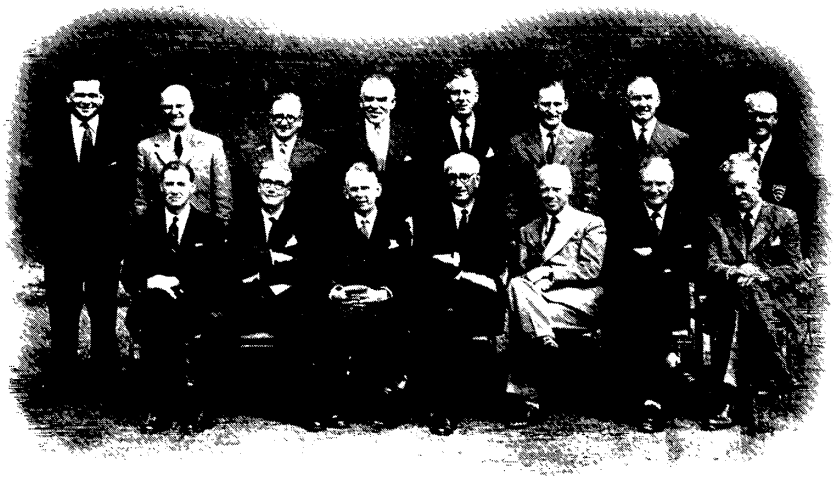
A look at the role of regions in the NHS

REPORT OF THE CONFERENCE
HELD IN LONDON ON MAY 7 1996

Lessons for the Future from the Past

A look at the role of regions in the NHS

Edited by
Dr Alison Walker and Dr Graham Winyard



SAMO Conference – Leeds 1958

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Preface

This report has drawn together contributions made by participants at a conference organised to mark the replacement of regional health authorities by regional offices – and the implications of this for public health.

It was an illustrious gathering – two Chief Medical Officers, Sir Kenneth Calman and his predecessor Sir Donald Acheson, plus over 30 Regional Medical Officers and Regional Directors of Public Health going back to the early 1960s. Collectively they had been through many changes in the health service, and Sir Kenneth Calman regretted that dress for the occasion had not included campaign medals. It was to draw upon this considerable experience that the meeting had been arranged and to provide a chance to discuss the new opportunities for Regional Directors of Public Health.

The report reflects the participants unique knowledge and experience of the health service and captures the spirit of the meeting where people were able to talk openly among a group of colleagues.

We do hope you enjoy reflecting on these personal contributions.

Alison Walker
Graham Winyard
May 1997

1 The Regions in the NHS

Sir George Godber was unable to attend the conference, but submitted the following as what otherwise would have been said then.

The functions of regions were foreshadowed in the Dawson Report of 1920 and the Nuffield Trust produced a plan for Berks, Bucks and Oxon in the mid thirties – following it with some new building. Civil Defence Regions in World War II were slightly different but were used effectively in the Emergency Medical Services. By the time of the ten Hospital Surveys in 1942/44 it was common doctrine that hospital services needed regional coordination and planning and all the surveyors, of whom the writer was one, concurred in that and in functional union and a common medical staff in districts. The NHS Act in 1946 could go farther than that because of the nationalisation of hospitals.

The Regional Boards when appointed were anything but centrally controlled poodles of the Ministry of Health although they were strictly budgeted and required approval for major capital works. Each Board had a Senior Administrative Medical Officer (SAMO) and a Secretary and since the most important immediate regional task was the development of a full specialist professional team in every district the SAMOs had the more prominent role. The deficiencies in staffing at the periphery were large – for example Lincolnshire with two thirds of a million population and five hospital districts had no wholetime specialist pathologist, paediatrician or anaesthetist before World War II and even large centres like Nottingham, Sheffield and Northampton had no specialist paediatrician. The regions carried through a radical reorganisation of specialist staff in the first decade and through their Nursing Officers promoted much improved arrangements for nurse training in the districts.

There were notable figures among the SAMOs such as Patterson in Newcastle and Macaulay in N.W.Met, whose influence went beyond their regions, and later Jof Davies in Oxford and John Revans in Wessex produced ten year regional plans for capital development which were the nucleus from which Enoch Powell's national plan emerged. These two were also prominent in the promotion of Continuing Medical Education and were members of the Nuffield meeting in December 1961 from which came the initiative for postgraduate medical centres in every hospital district.

Whatever happens now in the administration, one feature must continue in the medical field. Professional collaboration in medicine and the other health professions must be preserved and developed without deflection for commercial reasons. Primary care is the basis of the NHS, but it and the specialties can only keep up with the science and humanity if they help each other.

Annual Conference of Senior Administrative Medical Officers
Sheffield – May 1961

Dr H Yellowless NW Met. RHB | Dr E McEwen Birmingham RHB | Dr M Rea N. Ireland Hosp Auth | Dr F Beddard NERHB Aberdeen | Dr T Ramsay NW Met. RHB | Dr D Lowe Leeds RHB | Dr J McMullan SE Met. RHB | Dr G Taylor SW Met. RHB | Dr J Westwater SWRHB

Dr T Lloyd Hughes Liverpool RHB | Dr C Bainbridge Western RHB Glasgow | Dr H A Raeburn South Eastern RHB Edinburgh | Dr W A Ramsay Sheffield RHB | Ald J B Jenkins Chairman Mansfield HMC | Dr F N Marshall Manchester RHB | Dr J Revans Wessex RHB

2 Regional Hospital Boards 1948–1974

This first session was chaired by Sir Donald Acheson. He felt particularly well-placed to do so, commenting that the first day of the NHS in 1948 coincided with his starting on the wards as a clinical medical student.

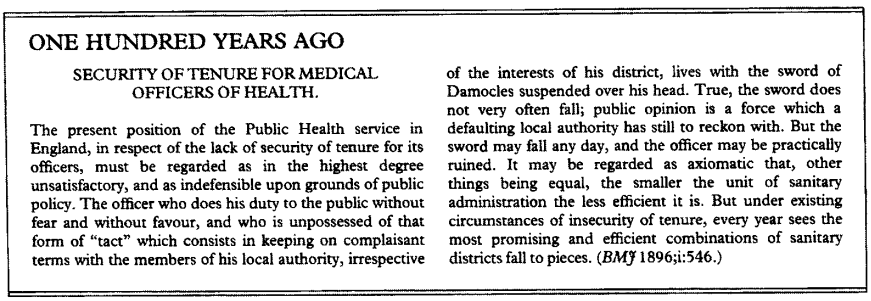
Dame Rosemary Rue

Medicine and science may have dominated, but public health had influence

Dame Rosemary spoke from her own experience as a SAMO in the Oxford Region. The 26 years between 1948 and 1974 had been characterised by three features: medical and scientific dominance; medical developments and increasing expenditure; and the tripartite structure of the NHS (hospital, family practitioner and the local authority health services).

Public health was fragmented during this time. Professional and public interest in Medical Officers of Health (MOH) had been lost. Two of the MOsH biggest realms of influence – infectious diseases and infant welfare – had been dealt with by the arrival of antibiotics and infant welfare clinics. However, the speciality had adapted with these changes, moving into new arenas. By 1974 there was considerable support for the emerging specialty of Community Medicine.

Survival had depended on two important lessons being learnt, both of which still apply. First that the ancient skills of public health (equivalent to the London taxi driver's "knowledge") must not be lost. These include the organisational capability and power to act for public health especially through epidemiological knowledge of infectious diseases and the technique of accessing the population through women and children. Secondly a section



ONE HUNDRED YEARS AGO

SECURITY OF TENURE FOR MEDICAL OFFICERS OF HEALTH.

The present position of the Public Health service in England, in respect of the lack of security of tenure for its officers, must be regarded as in the highest degree unsatisfactory, and as indefensible upon grounds of public policy. The officer who does his duty to the public without fear and without favour, and who is unpossessed of that form of "tact" which consists in keeping on complaisant terms with the members of his local authority, irrespective of the interests of his district, lives with the sword of Damocles suspended over his head. True, the sword does not very often fall; public opinion is a force which a defaulting local authority has still to reckon with. But the sword may fall any day, and the officer may be practically ruined. It may be regarded as axiomatic that, other things being equal, the smaller the unit of sanitary administration the less efficient it is. But under existing circumstances of insecurity of tenure, every year sees the most promising and efficient combinations of sanitary districts fall to pieces. (*BMJ* 1896;i:546.)

BMJ VOLUME 312 20 JANUARY 1996

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Figure 1 MOsH had previously known poor job security

of medical practice must not become isolated. This had already happened to MOsH at the turn of the last century. (Figure 1)

In spite of having to adapt and change, public health did make its mark on health care between 1948 and 1974. SAMOs had been involved in planning medical manpower, and had ensured that standards and facilities had been fairly distributed throughout the country. In particular they had been instrumental in establishing regional and supra-regional specialties and in hospital appointments and disciplinary procedures.

Medical standards soared and the health service developed considerably – although not as rapidly as needed. SAMOs became involved in health service planning, as questions over how to determine need, how to make future projections for services and how to get best value for money began to be asked. Good information became essential, especially as priorities began to emerge. Initial priorities were maternity units, TB, specialist A&E services and mental handicap. Delays in funding and poor recruitment of nurses, however, led to delays in service development.

What can we learn today from the developments in the health service at this time? The NHS still needs to ensure that innovations by doctors are allowed to thrive, that regional and supra-regional specialties continue and that the geographical spread of doctors and high standards of practice are maintained.

Further, setting priorities and attending to waiting lists are not to be recommended. More emphasis is needed in other areas. For example, the nursing profession needs rescuing, and all health service staff need to be planned for and nurtured. Promising (or threatening) change indefinitely to hard-working staff will lower standards. Instead, clear arrangements for agreeing change and for taking action are needed.

Towards the end of the 1960s pressure increased for better integration of health care. Hospitals had lost touch with primary care and public health had become isolated in the local authorities. There were 6 years of consultation before the re-organisation in 1974. Bureaucracy then increased, amidst a loss of skills and confused decision making. Community Medicine made a slow start in 1974, but the value of a more integrated health service, which the reorganisations brought, slowly began to show.

In today's context, changes are similarly happening. Equally true then as now, the detail of the NHS structure and management arrangements are almost irrelevant to the delivery of care. Clinical doctors should be left to manage clinical work – which they do best. Management change seriously wastes the assets of the NHS – the costing and billing system used now are nothing like as sophisticated and efficient as the system the NHS used up to 1974. Between 1948 and 1974 the NHS never overspent. Cost control was never a problem – although value for money certainly was.

Angus McGregor

Formal contact between MOH and SAMO was rare

Angus McGregor led the discussion. As a MOH in Southampton at the time, he observed regions from the "outside". His remit was wide – from port health, schools, mental handicap to social services – working to a variety of statutory committees. The MOH worked as a leader and innovator in local government. His primary duty was to raise the public health, visibly by slum clearance, smoke control, noise abatement and control of infectious diseases, but also via support for health promotion and the provision of community health services.

By contrast there was no planning between region and the local authority, and any work with hospitals and universities was hard. Regional policy and hospital developments happened "out of the blue" with no consultation with the local authority. While informal contact did take place between MOH and SAMO, formal contact was rare and usually limited to complaints against hospital consultants. The lack of contact with region did, however, also work to the local authority's advantage, since it could work unfettered by interference from regional hospital boards.

Despite the lack of planning between region and local authority, things worked at a local level because of personal contact and the dedicated work of individuals. This was as much true then as it will be in the future.

Further discussion revolved around the role of academic departments of social medicine. Not every medical school had one, and those that did, did not communicate well. The real teaching of public health was down to the MOsH.

Finances were also discussed. The problem then was not a shortage of money. Today, the cost of financing, especially pump-priming, new innovations needs to be recognised, if comparisons with existing services are to be made fairly. The high transaction costs of change must also not be forgotten.

Sir Donald Acheson wound up this session by commenting that public health doctors needed to be politicians as much as doctors.

3 Regional Health Authorities 1974–1996

Malcolm Forsythe

Between the awful reorganisations of the NHS between 1974 and 1996 there were some real gems

Malcolm Forsythe spoke from his experience as Regional Medical Officer (RMO) and then Regional Director of Public Health (RDPH) in the old South East Thames Region. There were considerable strengths in the NHS at this time which had been envied on the international stage. The American Senator, Edward Kennedy, had led a Senate Health Sub-Committee to Britain in 1972. Its report had praised the NHS in several areas. First, that the best in modern medicine was free to all, secondly for the role played by the general practitioner (GP), and thirdly for the streamlined specialist services – largely thanks to the gate-keeper function played by the GP and the existence of a regional tier. "For this reason" the report was quoted as saying, "the British manage with fewer neurosurgeons serving its population of 50 million than there are in the city of San Francisco." Other countries also looked to Britain at this time, and saw the benefits of organising health services on a regionalised basis, particularly as a way of optimising specialist services and avoiding wasteful duplication.

Service, Teaching and Research

The vital links between service, teaching and research began to be appreciated during this time. Postgraduate medical centres developed as did courses, many of them multiprofessional, in local institutes of higher education. Academic posts were created, notably when the NHS faced problems with recruitment and service quality. Examples were the creation of a large number of academic posts, with regional service links, in care for the elderly, mentally ill and learning disability, following appalling reports in these areas in the 1970s.

Research did not get off to such a good start. Research Liaison Groups which advised the Department of Health on national research priorities, were criticised for being out of touch with acute services and primary care. Regional research committees were not without blame, being criticised for supporting research of high scientific merit rather than for being useful.

Following the Acheson report in 1988 institutes and schools of public health sprang up. Public health research has now developed around social care and environmental health, as well as acute hospital care. An even closer relationship now exists between service, training and education, and research and development. This must be maintained.

Primary Care and the Community

The reorganisation in 1974 left GPs virtually untouched, creating an even bigger schism between primary and secondary care. A gulf also opened up between the NHS and local government, as public health moved into health authorities. This breach remains today, and public health needs to work hard to keep links going, particularly with social services and environmental health.

Community Health Councils (CHCs) were created in 1974 to represent the consumer's view in health care. Lack of support and under-resourcing left many CHCs marginalised, so many turned more to the role of assisting complainants. Even today public health needs to collaborate more closely with CHCs.

SOME OF THE MINIMUM STANDARDS 1974

	Geriatric	Mentally ill
Chiropodist	*1 attendance/inpatient/6/52*	*1 attendance/inpatient/12/52 or 0.1 attendances per week /100 inpatients > 65 years*
Consultant	*1 per district*	*0.45 cons/100 inpatient beds*
Food	*£2.12 pw + cost of living index*	*£2.06 pw + cost of living index*
Beds	*10/1,000 > 65* *2 day places/1,000 > 65*	*0.5/1,000 population* *0.65 day places/1,000*

Figure 2 Planning 1974 style

Planning

The 1974 reorganisation brought a system of planning "which would have brought smiles to the most planned economies in the world." (Figure 2) Evidence slowly began to accumulate that this degree of provision could not be sustained, especially when it further emerged that resources were not being fairly distributed around the country.

RAWP (Resource Allocation Working Party) was a triumph for this era. The final RAWP report came out in 1976. It was the first time that both demographic and epidemiological data, as well as undergraduate teaching costs, had been used to influence cash allocation. In the same year two further reports came out which influenced health planning, the Consultation Paper on Priorities in the Health Service, and "Prevention and Health Everybody's Business."

Between 1976 and 1982/3, revenue not ear-marked was used for bottom-up planning for local priorities. These halcyon days for regions came to an end as confusion in relation to accountability and responsibility within the NHS was highlighted – particularly in reports of failures in major psychiatric institutions. Performance reviews and action plans were developed in the 1980s and, later, target setting. Today, a better equilibrium is needed between local and national priorities, especially if the NHS is to recruit, and retain, an enthusiastic and innovative workforce, with different models of care to suit different localities.

Management

The development of consensus management in 1974, coupled with the mushrooming of functional managers at all levels can now be seen, with the benefit of hindsight, to have been a "terrible" mistake. Doctors were slow to respond to opportunities to take up managerial posts, and the medical profession seems to have been the long-term loser in this. Today, doctors in chief executive positions are notable by their small numbers, and there are only two medical chairmen in the English NHS health authorities.

This situation needs to be addressed – possibly by developing courses for high-flying doctors with an aptitude for management.

The relationship between Chief Medical Officer (CMO) and the RDsPH has always been important, although the status of these meetings has changed dramatically. Nevertheless these meetings have always been an important source of policy advice.

Malcolm Forsythe concluded with a quote from the Times obituary of Sir William Trethowan, January 1 1996 which, he said, summed up the situation perfectly. "Decisions in the NHS in those days were reached more easily. Trethowan would later fondly recall the weekly meetings between the Dean and the Regional Medical Officer after which 'things just happened'....."

Sheila Adam

"Being Regional Director of Public Health was the best job in the health service."

Sheila Adam, RDPH in North West Thames during this time, led the discussion. Each of the regions was different, and while the quality of public health had improved, this was not universal. Three areas were highlighted where more should have been done. First, public health should have worked more closely with management. Secondly, more public health work was needed in the acute services. Finally, more should have been done to raise the standard of public debate, and listen to views and challenges to the health service put forward by users, carers and communities.

Discussion was wide-ranging, but also critical of the path down which the health service had gone. Concern was raised over the inflexibility of the new health service and the rigid way it is delivered. Services, it was felt, had become too political and all attempts at public accountability had disappeared. There was also real concern that public health was too isolated from the rest of the medical profession. But there was also optimism about the new options presented by working in primary care, which public health needed to seize.

4 Regional Offices – 1996 onwards

Liam Donaldson

Public health "adds value" both centrally and locally

Changes in the health service moved swiftly in the 1990s. Regional health authorities were seen as the embodiment of the old style, and an overhaul was clearly on the cards. They were expensive, and internal problems in two of the old regional health authorities were reported. Plans for the reorganisation were laid out in the Functions and Manpower Review in 1993. The aim was to create a new central management for the NHS with regional offices of the NHS Executive replacing regional health authorities.

In the midst of the reorganisation which followed, the key role played by public health at region, as described in the Acheson report, has remained important. However, there have been additional pressures on public health. These have been around the impact of reorganising staff, becoming civil servants, working with management and the absence of a Statutory Board. Additionally, the volume of public health work has remained undiminished, although the emphasis has changed, even though the size of the public health departments is now smaller. Looking at a typical day in the life of the RDPH in a new regional office, it is easy to see that the quality and character of the job has many similarities with the way it has always been. (Figure 3)

Despite its smaller size, public health clearly "adds value" at regional level. This is both upwards to central management, by improving polices, providing earlier warnings of problems and encouraging more effective interventions, and downwards to local services. At this level it can influence improvements in health by encouraging better quality of care, higher quality of life, greater equity and more efficiency.

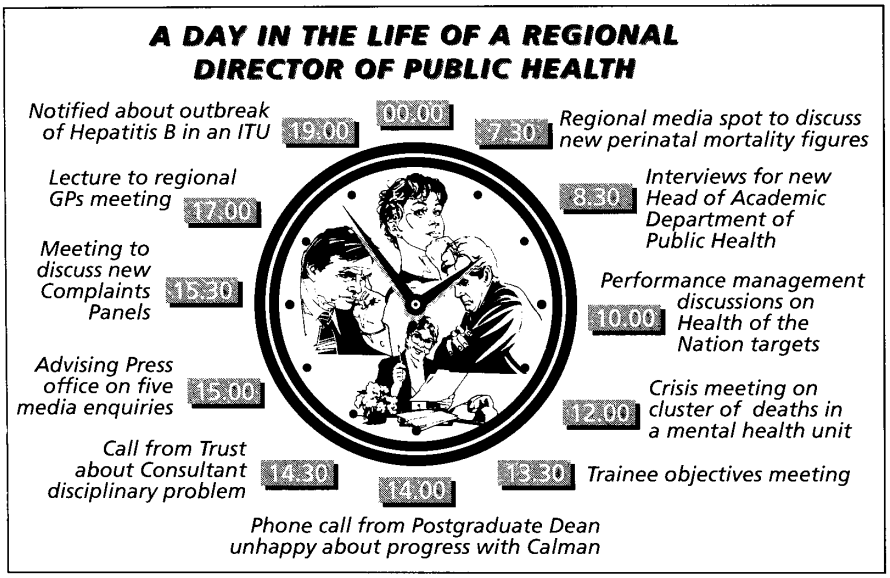

Figure 3 A day in the life of a Regional Director of Public Health

The public health department brings considerable benefit to the regional office and, as such, should become a sought after training post for public health trainees. It enhances corporate management, brings extensive and important networks to the region and has both public and professional credibility. Public health departments work to a high standard of practice, which is evidence-based, making a major contribution to national issues.

SOME IMPORTANT TASKS OF PUBLIC HEALTH PROFESSIONALS IN REGIONAL OFFICE

Day-to-day

- *Performance management of local services*
- *Shaping plans and policies*
- *Handling incidents and crises*
- *Managing outbreaks*
- *Evaluating evidence*
- *Teaching and training*

Long-term

- *Promoting a health culture locally*
- *Developing the public health workforce*
- *Establishing and extending professional and academic networks*
- *Ensuring an emphasis on evidence and outcomes locally*
- *Encouraging an effective medical workforce*
- *Identifying need for public health research*

Figure 4 Future tasks for public health professionals in the regional office

Public health in the new regional office now needs to be prepared for important challenges ahead. (Figure 4) Changes will not happen overnight. In public health terms, it takes at least 5 years to establish effective networks and a further 5 years to achieve change.

John Ashton

Public health must now look forwards

John Ashton, RDPH in North West Region led the discussion. Public health, he said, has moved about like a piece on a chess board. From working in local government it moved into health authorities. Changes at region were nothing new for the specialty. A more striking change, seen by looking back at old photographs, is that now at least 50% of RDsPH are female

The effectiveness of the early SAMO has given legitimacy to current RDsPH. Even before 1948, one of the earliest pioneers of public health in Liverpool, Duncan, had worked with no health committee, no budget and no resources. His job was to liberate resources.

Public health must now look forward. If regions are to survive, they must tackle public health problems as the public sees them, and not just concentrate on the acute clinical sector and primary care. For example, attention needs to be given to developing better services, working in partnerships and looking at the wider public health agenda, including non-communicable and infectious disease. It also needs to look at lay care and self medication, diagnosis and treatment. Attention also needs to be given to health promotion in secondary and tertiary care – it is still possible to be discharged from hospital without a proper rehabilitation programme.

Public health also needs to look outwards. Issues include global concerns such as urbanisation, HIV and AIDS. Public health must not work with fixed frameworks and boundaries. Finally, public

health needs to convince other organisations of its importance. To help achieve this it should not be "owned" by one group.

Comments from participants at the meeting were diverse. Overall there was a mood of optimism. There was a call for more powerful district development, while keeping a broad agenda in the region. It was also recognised that links with academic departments are important (currently three RDsPH are professors). The role of region and the place of public health within it was also touched on. Public health must give region a meaning and encourage dialogue with the civil service. Communication between regions had improved, especially now with E-mail, and there were opportunities now for closer dialogue with CMO. However, the trauma that RDsPH had gone through, especially with cuts in staff numbers, should not be forgotten.

Outside region there was a sense that trusts needed to be re-configured to provide horizontal, not vertical, structures and delivery of care. There are many influences on health which lie outside the NHS, and public health needs to be able to communicate this to those organising the configuration of services.

5 Conclusion

Sir Kenneth Calman

Now is a good time for public health

Concluding remarks came from Sir Kenneth Calman. The health service has been through a number of reorganisations and the profile of public health has changed considerably during these. What is the relevance of past experience today? Are there lessons to be learnt from the past? Changes in health and the health service have been enormous. Throughout all these, maintaining a public view – not just a public health view has been, and will continue to be, important.

Public health has several areas it needs to address. These include supporting initiatives such as Health of the Nation and work on variations in health, not only supporting purchasing in the NHS. Public health also needs to foster its links with its academic departments – otherwise it is at risk of being fragmented due to poor co-ordination. Also a great deal of public health health work is about networking. There are a lot of good stories to tell about this – we should tell them.

Finally, Sir Kenneth Calman finished by considering how public health doctors can influence changes in health, and the way doctors practise, including evidence-based medicine. This will only happen if doctors want it to. Public health needs to encourage this to happen.

People invited and involved in the conference

1. Sir D Acheson
2. Dr S Adam
3. Dr R Alderslade
4. Dr M Ashley Miller
5. Prof J Ashton
6. Dr S Atkinson
7. Dr W Bynum
8. Sir K Calman
9. Dr J Crown
10. Dr D Cunningham
11. Dr M Dalziel
12. Dr B Davies
13. Dr L Davies
14. Prof L Donaldson
15. Dr G Duncan
16. Dr J Egdell
17. Prof M Forsyth
18. Dr M Freeman
19. Sir George Godber
20. Prof M Gray
21. Prof R Griffiths
22. Dr S Griffiths
23. Dr M Harrison
24. Dr S Horsley
25. Dr B Howard
26. Dr A Jones
27. Dr W Kearns
28. Dr A Lane
29. Mr A Langlands
30. Dr A Mason
31. Dr G Matthews
32. Dr R Maxwell
33. Prof A Maynard
34. Dr A McGregor
35. Dr W McKee
36. Dr D Morris
37. Dr F Murphy
38. Dr M O'Brien
39. Dr R Oliver
40. Dr R Pollock
41. Dr J Raison
42. Dr T Ramsay
43. Dr M Reynolds
44. Dr P Roads
45. Dr G Scally
46. Dr A Scotland
47. Dr J Scott
48. Dr F Seymour
49. Dr R Stewart
50. Dr I Sutherland
51. Dr P Troop
52. Dr W Turner
53. Dr D Walford
54. Dr D Wild
55. Sir H Yellowlees

Organisers and steering committee

Dr A Coulter
Ms D Hunter
Dame R Rue
Dr A Walker
Dr G Winyard

RMOs and colleagues at Conference – circa 1980

Bart's College – circa 1984