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District Health Organization

Warren Kinston

Abstract

Government policy in the UK has been to provide comprehensive personalized health care to the whole population free at the point of delivery. However, the first major attempt to unify and regionalize the service in 1974 left a number of problems, and a further restructuring of the NHS was required. This article reports on the results of research into the 1982 restructuring. The main feature of this second reorganization was the formation of territorial entities called "Districts", and their organizational subdivision into "Units". The kind and level of work and authority assigned to Districts and Units is discussed. An important finding, seemingly counter to official policy, is the existence of small Districts which operate at the same level as Units of the larger Districts.

The 1974 reorganization of the British National Health Service (NHS) was an attempt to unify the health and illness services for the entire population within a single managed institution. The 1982 reorganization has been an attempt to improve on the 1974 structure and in this paper some of its intentions are modelled and implications examined. The paper commences by offering principles for determining organizational structure through an analysis of the work to be done, in particular the level of work expected. This level-of-work analysis is then applied to the 1982 reorganization with a focus on the work expected from the basic territory, the new Health District, and its prime internal subdivision, the Unit. Details of research experience in two different Health Districts in the UK will be offered to flesh out the theoretical arguments.

The 1974 Solution

The regionalization pattern implemented in 1974 was complex.[1] The basic territorial unit for service provision was the District (average population: 200,000) and on it was superimposed 3 tiers of progressive super-territorial groupings: Area, Regional and National. The basic territorial unit for political control by a "Health Authority" was, however, the Area with two higher territorial levels superimposed.

Any large scale organizational change produces problems and 1974 was no exception. There were, for example, difficulties produced by lack of understanding of the organization, unprepared personnel, insufficiency of resources, poor or half-hearted implementations and chance events.[2,3] We will not discuss these; nor the important and problematic issue of what the reorganiza-

tion did to and had to say about British society and its values.[4] The concern of this paper is rather with inherent structural difficulties which could not be properly overcome by time, money, education or goodwill, but only by another reorganization.

Political control of the operational units, Area-District relations, immediately proved problematic.[5] The Area Health Authority was responsible for Districts and was assisted in its function by an Area Team of Officers (ATO) consisting of administrator, treasurer, nursing officer and medical officer. Insofar as the Area Officers were the managers of District Officers (as in Scotland), work in the District Management Team (DMT) was weakened because the clinical doctors (on the DMT but not the ATO) saw the seat of power at Area and tended to bypass the DMT. Where Area Officers were placed at the same managerial level as District Officers and given reduced authority (so-called "monitoring and coordination") there was a tendency for the DMT with its clinical representatives to ignore the Area Officers and relate directly to the Authority. The concept of "consensus management" in the management teams had been developed to recognize and reconcile the independence of their members and the complexity of health services which, it was claimed, precluded the use of a chief executive post. As a side effect, this mechanism tended to strengthen District Team functioning and to push them further towards a quasi-autonomous role. The Chairman and members of the Area Health Authority therefore often had a formidable task in dealing with an excessively large number of Area and District Officers and resolving differences between them. Single-District Areas seemed to function more easily and some of these were created between 1974 and 1982 by fusing Districts.

Although most criticism focused on Area-District relations, the Region also seemed problematic, and so did the main subdivisions of the Districts, the Sectors. Administrators, doctors and other staff found the NHS unduly complex and complained of excessive delays, duplication of decisions, proliferation of meetings and committees, and a general blurring of responsibility. Doctors and other NHS staff needing to develop services sometimes could not discover where, how and why decisions on resource allocation and development were being taken.[6–8] At one time or another and in one place or another, every level of management has been regarded as superfluous and it has been argued that the powers assigned should be divided and sent partly upwards and partly downwards.

The NHS seemed top-heavy, and where prompt effective decisions were required — in the wards, theatres, and outpatients — they were often absent. Complaints therefore centred not only on high-level but also low- level decisions involving administrative delays, supply difficulties, failures in works, and nursing and paramedical confusion. In 1976, just nineteen months after the reorganization, the Government set up a Royal Commission to inquire into the NHS.

The Royal Commission reported in 1979 and confirmed the existence of a superfluous territorial tier. The Government then announced its intentions in the Consultative Document *"Patients First"*.[9] The Area tier was to be abolished and substantial decision-making was to be delegated downwards to Districts, and within Districts to new organizational structures called "Units". The

District tier was to become a site of political control through a new District Health Authority (DHA).

However a difficulty in definition rapidly emerged. What was the work of a District to be? And how could Units be determined? Guidance was provided by the DHSS but significant ambiguity remained. The key circular, labelled HC(80)8, stated that Units were to be "one level" below District,[10] but implementing this requires a clear conception of how organizational structure relates to levels of work.

Organizational Structure and Level of Work

The Nature of Organization

An organization such as the NHS is set up to do work on a large scale, and the structure of the organization should facilitate that work. It is easily understood that structure must take into account such matters as techniques, programmes, and the socio-economic environment. It is less often emphasized that work is done by individual people and that structure must be concordant to their abilities and congenial to their personal tendencies. If it is not, the work will get done poorly or inefficiently or may not even be attempted[11,12] and structure will appear to be deficient or mechanistic.

Structure, as referred to above, is revealed and maintained through repetitive and socially enforced patterns of interaction and expectation.[13] Structure may be defined in terms of interlinked positions, and authority relations between positions. I use "position" in the sense of "post" or "office" (e.g. the "Office of the President"); it is the context for activity not the activity itself. By authority relations, I refer to the legitimated exercise of power or influence by one post holder on another.

Posts may need to be described in terms of extent and level, both of which can be contentious. The *extent* of a post refers to the kind(s) of work included within it, e.g. a ward nursing post may need to be distinguished from a ward domestic post. The *level* of work in a post refers to the degree of complexity and the breadth of perspective within which the work should be viewed. For example, standards of nursing care are the responsibility of qualified nurses, but they are also the responsibility of ward sisters, nursing administrators, the Health Authority and the UK General Nursing Council. The problem is the same but the perspective from which it is viewed becomes progressively larger. Correspondingly, the impact of any decision becomes both wider and more far-reaching, and resource implications are greater.

Descriptive terms used in conjunction with work to emphasize its level, like "skilled", "managerial", "professional", "executive", "planning" and "policy-making" are imprecise and may mislead. After all, work of any kind requires skill, and much work has become professionalized; planning is essential prior to all tasks, and all managers must generate policy. Research in organizations suggests that work does become increasingly complex and does undergo marked changes in nature with increase in level, but useful general descriptions have tended to be elusive.

Jaques[14] described comprehensive systems for implementation as

having a maximum of five discrete levels of work permitting four managerial relations. Beer[15,16] similarly argued that viable systems, such as firms, have a five-tier hierarchical structure in which each tier is itself a viable system with the first tier being an autonomous individual. Both refer to higher levels as existing, but outside the system. The important factor in hierarchy as used by these writers is not managerial authority but the different nature of work at each level. Both theorists claim that the five level hierarchical structure is a very general property of systems that are subjectively recognized and that embody human purpose.[16,17] Jaques has described the different mental processes ("levels of abstraction") used by individuals when operating at the various levels of work. By relating level of work in organizations to the maximum time-span within which a person works before his efforts can be subject to realistic review, Jaques provides the link between level and complexity.

Description of Levels in Terms of Work Output

The logic of levels of work in executive hierarchies has been developed by Rowbottom and Billis[18] who offer descriptions of work output at each level. These help to show why the levels are discrete and why they permit managerial authority (but do not imply or necessitate it).

Work at Levels 1 and 2 is not of direct relevance to this paper but deserves mention for completeness. At Level 1, the work output can be completely prescribed beforehand, so far as is relevant. The post-holder (e.g. typist or porter) must assess priorities between tasks, decide among the different ways of doing each and plan their performance, but he is not expected to assess the need for his own work. This contrasts with Level 2 work where each new situation must be assessed and treated as a unique event. The output may be a decision to do nothing. If something must be done and it is easily specified, then it may be delegated to a Level 1 post- holder. This is typical of a health professional or of a first-line manager of (say) laundry staff. At Level 2 there is always further exploration of demands for work to determine the "real needs" or the "underlying problem". Levels of work above 2 concern more general issues of service provision involving populations in the present and in the future. The greater the social impact desired and the more complex the services, the greater the number of levels called for.

At Level 3, the work jumps from dealing with specific cases, one by one, to considering a continuous flow of cases and making due arrangements for their handling. It becomes necessary to predict or determine future patterns and flows of cases and in some posts, to ensure services are provided at Level 2 or 1. This is done by setting up systems, procedures and policies and dealing with their break-down, modification or implementation. Systems maintenance is required and usually daily and detailed involvement with specific instances is called for. The larger decisions, however, may be made six-monthly, annually or less often. This sort of work has a service development or administrative character. The Level 3 post-holder knows all the personnel in his command and is easily available to them. He needs to have the authority and resources to respond rapidly to breakdowns or errors so as to keep the service running.

The maintenance of systems of individuals working to meet current needs is substantially different from the development of new systems to meet completely new needs based on a comprehensive view which is characteristic of Level 4 work. The orientation of the Level 4 manager towards identifying new needs (as distinct from changes in pattern or flow of already identified needs) by definition generates conflict with Level 3 managers providing for current needs. One of the commonest problems in large organizations is failing to distinguish between these two levels. Level 4 management is essentially unconcerned with the particularity of daily activities and Jaques[14] has noted how personnel in these roles move away from the site of activity and out of uniform. If the distinction between Level 3 and Level 4 work is not made and the one individual is expected to carry both roles, the result is unsatisfactory. Needs or gaps which might demand change and so interfere with current systems and activities tend to be ignored and the organization stagnates or becomes out-of-date; and simultaneously, day-to-day management suffers because the manager tends not to be regularly available to his staff and does not know the work in enough detail. As a result, breakdowns slowly accumulate, and morale and efficiency decline.

Level 4 posts often require authority to reallocate resources, to redeploy personnel, and to restructure services. They operate, however, within a specified framework which defines the field of need. The task of defining this field is at Level 5, and this gives the Level 5 institution a maximum capability for self-development. The focus at Level 5 is therefore on policies, and guidelines for their implementation. At this level, there is usually a capital budget. The post-holder interacts with various political and public bodies, and may be frequently away from the zone of operations. Policy formulation at Level 5 should work as a powerful facilitating and coordinating device, and should reflect the articulation of an achievable and coherent vision. This is sometimes called "strategic planning" and it should lead to organizational coherence and maximal responsiveness to and impact upon the environment.

Assignation of Level of Work: The Example of Hospitals

Given the above precise and usable meanings for the loosely used term "level of work", it follows that the levels of work assignable to operational services, are of only three types: 3 (systematic service provision), 4 (comprehensive service provision) or 5 (comprehensive field coverage). We may now consider briefly the issue of assignation of levels to service institutions, before we discuss the level to be assigned to the new Districts and Units in the NHS.

Assignation of level of work depends on two factors. First, the complexity of work naturally thrown up by the work situation; and second, the complexity desired by whomever is responsible. In the simplest situation the desired level is identical to the natural level. If the desired level is greater than the existing level, this is equivalent to a commitment to develop the work substantially through increased resources, specialization, growth or such-like. A current example is community services which probably tick over in many Districts at low Level 3. If they are to become more important in relation to the hospital service then they will require to be moved to Level 4, and key definable posts

such as that of administrator and nurse will need to be allocated responsibilities of a Level 4 type and given the appropriate grading, authority and resources to match. If the desired level is lower than the natural level, this is equivalent to reducing the significance, activity or size of the institution. A current example is the large mental hospital which in terms of staffing and budget could often be run at Level 4. However in view of national policy which is away from such institutions and the development of community care, it would seem more logical to run it at Level 3 within a larger Level 4 structure, such as the "psychiatric service". Substantial expansion or contraction of an institution as implied by change of level of output is a highly emotionally and politically charged event. It involves changes in resource use, in social relations and in pay and grading. For this reason those responsible for organization must be clear about what level of work can be *realistically* expected in the institution.

Hospitals will allow us to demonstrate an application of the notion of "natural" work complexity from the viewpoint of the task of management. A cottage hospital of 20–30 beds without special facilities and mainly used by the local primary care practitioners can run at Level 2. Typically a matron is in charge and she manages the few Level 1 personnel who provide the portering, typing, cleaning, gardening and so on. Such a hospital is often part of a larger Level 3 unit which organizes matters like recruitment but it need not be. As a hospital increases in size to 40–50 beds, its character starts to change. Wards appear, each of which requires a Level 2 nurse in charge, and these require control by a Nurse Manager at Level 3. The number of ancillary staff increases to the point where their Level 2 management cannot be handled by a nurse or, more accurately, the Level 3 nurse comes to feel that nursing should take up most of her time and ancillary services ought to be handled mainly be a specific Level 2 administrator under her control. In this size facility, once again the nurse is the de facto administrator. As medical activity in the hospital increases, so does the number of ancillary staff and the complexity of nursing. Usually an acute 75–100 bed hospital will require so many administrative, catering, domestic, laundry, portering and other support staff that several first line (Level 2) managers are called for and a Level 3 administrator is essential to manage them. He is now seen as the person running the hospital, and handling its day-to-day problems. The Level 3 nurse only runs the nursing, itself now a major responsibility. A hospital of this organizational complexity may grow to a substantial size, possibly to 400 beds or more. The key determinant as to whether Level 4 roles are "naturally" called for comes to depend on the degree of activity in the hospital, and on the sophistication of its medical staff.

To demonstrate this we may consider two actual UK hospitals, X and Y, each with about 400 beds. Hospital X is a low activity hospital mainly caring for non-acute medical, surgical and gynecological patients and with several geriatric wards. Its ancillary staff number about 150 and include approximately 70 domestic, 30 catering, 15 portering, 10 linen and sewing and 15 works staff. It uses many of the services of Hospital Y and could not exist as a hospital without these services. Hospital Y is an active acute hospital with over 700 supporting staff working in clerical, records, portering, linen, transport,

catering, pharmacy, radiography, laboratories, medical electronics, radiotherapy, central sterile department, works and other sections, In addition there are the doctors, nurses and remedial therapists. Hospital Y is continually in the process of pioneering new services, building new wings, redesigning facilities and incorporating services developed in other sites which are then closed down. The sheer variety and number of supporting staff call for Level 4 administration, and the continual major medical developments within the hospital make it even more essential.

The key point to be made here is that a general hospital of any sophistication and size tends to generate Level 4 work; particularly the District General Hospital of 500–800 beds which it is Government policy to build in every District. If the General Hospital is a Teaching Hospital or contains highly specialized Departments, then Level 4 work seems the minimum. It could be argued that some academic medical centres require to run at Level 5 or possibly higher if they are to be protected from inappropriate political intrusions.[19] We have however found Teaching Hospitals with over 2,000 employees and near 1,000 beds being run, ostensibly, by personnel in Level 3 posts. The result is a lack of grip on the institution: constant delays, repeated minor breakdowns, non-functioning arrangements, wasted professional time and accompanying frustration and demoralization.

The Reorganized National Health Service

Level of Work to be Assigned to the New Districts

We may now return to the crucial issue of what level of work is to be expected in the new Districts. Keeping in mind that any system of operational services can be provided at Level 3, 4 or 5, we shall first consider official statements which bear on the issue of desired level, and then examine the level that seems to be thrown up naturally by the size and character of existing institutions. Finally, we will match these two perspectives.

The determination to push significant decisions below District level is a theme of *Patients First* and other recent ministerial statements. This can be interpreted in two ways: either as an insistence on the exercise of Level 3 or of Level 4 authority in hospitals and community close to the clinicians. This immediately indicates a District working at Level 4 or Level 5. Without effective Level 3 authority, there is an absence of the most immediate and basic response to breakdown or changing case flow. However substantial development and resource and personnel control is a Level 4 activity and, clinicians need reasonably easy access to such decisions as well. If clinicians have immediate access only to Level 3 decision-makers, they will attempt direct contact with the DMT and Authority as this is where they will feel and know that "real power" lies. Only Level 5 decisions will feel beyond the daily interests of the average consultant.

DHSS guidelines reinforce the notion that Districts should operate at Level 5. Districts are expected to develop and implement 5–10 year strategic plans, the typical time-scale at Level 5. Furthermore, the services to be provided by a District are not agreed or pre-defined, as would be expected for a Level 4

operation, rather such definition is part of the local task. The District must consider, for example, the mix of services, the balance between hospital and community care, the extent of preventive and educational work, and the boundaries between health, welfare and educational services.

There is a convergence and coherence then in official policy. Specified time-scale of planning, formal work description, and the wish to push major decision-making close to clinicians all suggest that the Government wants Districts to run at Level 5. In other words, the District must *define, develop and maintain a comprehensive range of services for its community in response to the broadest conception of health needs and possible health services.*

Because the Government was creating new Health Districts and not just abolishing the Area tier, it was conceivable that the Districts could be created to ensure a coincidence between natural and desirable levels. However, the dependence of structure on level seems to have been insufficiently appreciated or was outweighed by other issues and the level of work thrown up in the Districts as they now are is markedly varied. This is apparent from a glance at the hospital services which are the most complex existing structures at present.

The UK policy in the 1960's and 1970's for every District to have a large 500–800 bed General Hospital[20,21] resulted in the creation of numerous potential Level 4 institutions. If such a hospital complex is to be but one part of a comprehensive service and not determining the service, a Level 5 District is implied. Such an arrangement is needed to ensure that the Hospital operates within wider policies and does not determine them. In some Teaching Districts there are two or even three such large hospitals and then a Level 5 District seems unavoidable. In many Districts, however, there are only hospitals which can and should function at Level 3, with no resources for more substantial development likely to be forthcoming. In such Districts, a District service could be managed at Level 4.

One way or another, a decision about level of work at Districts has to be made if organizational confusion is to be avoided. Clearly official pronouncements have not taken into account the current variation in work level within NHS Districts. Regions and DHAs will need to balance what is expected with what is feasible. Many Districts will opt for Level 4 functioning as the only realistic possibility. Others may have the choice of Level 4 or Level 5 functioning. Still others need to accept that Level 5 functioning is the only realistic option.

This raises the question of whether such a mix of Districts at different levels should be a transitional phase to be overcome by fusing Districts, or by injecting more resources and upgrading smaller Districts; or whether the mixture is to be accepted as a permanent state of affairs. The existence of Districts doing different levels of work has implications for the functioning of District Health Authorities and for the relationship between Region and the District. A major concern for Region must be neither to expect too much from Level 4 Districts nor to duplicate the strategic work of Level 5 Districts.

It is time to examine the phrase "level of work at District". Does this refer to the work of doctors? Or nurses? Or administrators? Or the DMT as a whole? Or the political body, the DHA? Or is it something else? The DHA carries a general responsibility for the provision of services and for ensuring that the

District does indeed generate long-term plans, carry out national policy, identify unmet needs and so on. The DHA, like the AHA before it, is expected to take or sanction all the major decisions on policy, planning and resource allocation.[22] In order to generate such an output and ensure that it is implemented, the members of the Authority require the advice of the most senior Officers (who will have been appointed by them) together with representatives of the GPs and the consultants: this group exists in the form of the District Management Team (DMT). The DMT may therefore be seen as the body that provides *substance* to the policies, *explanations* for the priorities and *conviction* to the plans and it is therefore the output of this body which requires to be Level 5. If it is not, then it is difficult to imagine that the DHA decisions will reflect an appropriate awareness of the variety of local opportunities, the complexity of problems and the feasibility of options. The output of a group will depend however on the output of its individual members. Given two, or preferably three, individuals including the Administrator working at Level 5, the DMT should be capable of producing a Level 5 output for Authority sanction, and of running the District in accordance with these decisions.

The Subdivision of Districts

Subdivision of the District into Units has provoked tensions between what is desirable and what is feasible, and in particular between "small is beautiful" and "large is viable". DHSS guidance has been minimal and, as given in HC(80)8, calls for both values to be upheld: Districts should be divided into Units to be smaller than the existing Sectors (typically also territorial) *but* with senior managers in control of resources and manpower; these Units should be near to the patient *but* should be only one level down from the District.

The result of the devolution of discretion to DHAs was a torrent of articles in the popular and professional health service press. These articles dealt ostensibly with how HC(80)8 was to be interpreted, typically using the method of Talmudic scrutiny. Commentators seem to have been implicitly aware that a small Level 3 Unit permits a tight effective grip on service provision but that a larger Level 4 Unit provides more resource and developmental flexibility. However, usually the issue of level of work was avoided and the focus was on the kind of work in the Units.

Various solutions to the problem of organizational subdivisions of Districts are possible and are diagrammed in Figure 1. The suitable structure, if District is to be working at Level 5, is for the Unit to be doing Level 4 work (Fig. 1a). The solution that many seem to be calling for, however, would involve a blurring of either or both of the Level 3/4 and 4/5 boundaries (Fig. 1b). As suggested earlier, this avoids organizational reality and tends to produce detrimental effects.

Units could be only one level down from the DMT and close to the front-line service provision if District is placed at Level 4 and Units sited at Level 3 (Fig. 1c) but as indicated earlier this contradicts other DHSS expectations and may not be congruent with natural work levels in certain Units.

Other ways of organizing the District's work have been suggested, for example omitting Level 4 (Fig. 1d), or expecting District Officers to do both

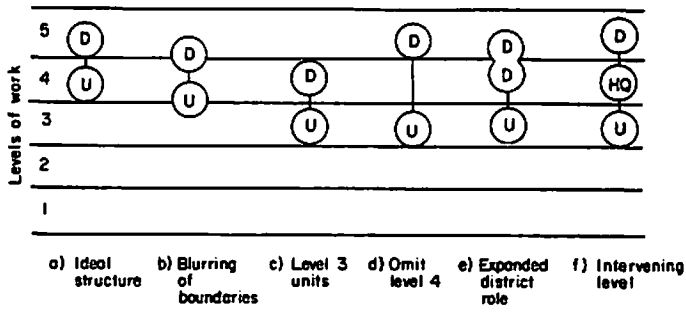

Figure 1: Suggested arrangements of District (D) and Unit (U) in terms of work output. HQ = District Headquarters Roles

Level 4 and Level 5 work (Fig. 1e). Both would be difficult to operate and to sustain. If either of these were put into practice, the Level 5 work would tend to be bypassed leaving District handling Level 4 work and the Units running at Level 3; or staff officers (in operations and planning) would be appointed and a level intervening between District and Unit would be clandestinely created (Fig. 1f) exactly the opposite of what the Government intended.

Omitting the assignation of Level 4 work is unsatisfactory because levels of work below the top level are logically called for and cannot be omitted. A broad strategic policy expressed in Level 5 terms cannot just be passed through to Level 3 managers running a system, but must be translated through analysis of needs, priorities, resources into detailed plans based on the situation in particular facilities. Level 3 managers on site would lack the time, personnel, authority and access to needed information to do this.

A final possibility must be mentioned. Units of different sorts may be assigned work at different levels or the gradings differential may ensure that the personnel recruited to Units such as Community Services or Mental Illness Services are unlikely to operate at Level 4. If the expected or actual level of work in the designated Units varies, the term Unit will be deprived of a clear structural meaning. Its officers will have varying degrees of authority and cross-Unit coordination will be more difficult.

Kinds of Work in Units

The division of functions within a District between various Units may be as difficult as the choice of level. Units might be formed in a variety of ways, in principle: by territory, institutions, type of clientele, or types of service. Organizing Units solely by either of the last two categories has been argued to encourage an "output" orientation and facilitate planning. In our experience suitable arrangements invariably pay heed to institutions as well, as suggested in circular HC(80)8.

As regards division by territory as opposed to institutions, problems exist in principle in Level 5 Districts. Such an arrangement may arise if Units simply replace the Sectors defined after the 1974 reorganization, because Sectors were

often territorial, consisting of one or a few hospitals with their associated community services. If such Sectors were simply relabelled as Units, the District-Unit pattern would then resemble the Area-District arrangement with the potential for the same tendency to strive for autonomy but with less reason. The territorial subdivision is problematic because the basic territory is the District, which is the natural catchment for most specialized services. Hence each Unit should be devised *so as to serve the population of the District.* Another factor to be assessed when combining community services with hospitals to form Level 4 Units on a territorial basis is whether the community services will get the attention called for by national policy or whether they will be seen as an appendage to hospital services. Level 4 Units themselves may, of course, require geographical subdivision into Level 3 structures because the systematic provision of services is often based on a site or locality.

A Unit, whatever its level, is likely to have considerable organizational power within the District because of higher graded staff, line accountability and control over (or access to) information and financial systems. Although the subdivision of a District will be influenced by the pragmatics and politics of the local situation, it must be emphasized that all sites and all services require effective Level 3 and Level 4 management. It will be easier to give substance to the issue of dividing up a District by looking at two different Districts in some detail.

Models and Reality

The Subdivision of Two Districts

District A: Exeter Health Authority

This District, over 50 miles in diameter and situated in rural England, contains one large town with its own University and Post-graduate Medical School. Its population is about 300,000 and its budget £50 million (1980/81). From 1974 to 1981 it was one of four Districts within the Devon Area. There are several acute hospitals in the town, and in recent years they have been organizationally welded into a District General Hospital (DGH) sector, a complex of hospitals on several sites. Hospital X and Y each with about 400 beds (referred to earlier) are the main components, but there is also a 110 bed orthopaedic hospital, a 50 bed ophthalmic hospital, and several smaller hospitals. The staff complement of this complex is 2,500 and the annual budget about £20 million. The rural surround contains general practitioners, domiciliary services, health centres, clinics and small local hospitals. There are 1,500 staff involved and the budget is £10 million. There are three mental hospitals (approximately 100, 300 and 650 beds) which serve both this District and a neighbouring District. They employ 1,650 staff and have a £10 million budget. There are also a variety of mental handicap hospitals: the largest (400 beds) is a special forensic institution and services a number of other Districts; another is also large (350 beds) but is in process of closing down; and the remaining five centres vary from 25 to 100 beds. Staff involved in mental handicap number 1,650 and the budget is £8 million.

The first decision concerned the DGH. This contains one 400 bed hospital (Y) which alone requires Level 4 management. The other hospitals in the

complex could be run at Level 3 and hence can be seen as annexes to Hospital Y. Hospital Y will require internal subdivision in its administration and in nursing. These two disciplines will not however run parallel. The nursing subdivisions will take account of medical practice primarily, whereas administrative subdivisions will deal with the large numbers of ancillary workers, support of medical staff, medical records and the handling of hospital-wide issues such as complaints, negligence, public relations, etc. The Level 4 Unit Administrator and Director of Nursing will site themselves in Hospital Y. Doctors in the various hospitals will approach the appropriate Level 3 administrators to resolve day-to-day problems and will have access to their superior if results are not rapidly forthcoming. The DGH Unit, the doctors and other professionals within it, will be expected to sort out their own priorities and tackle the opportunities and difficulties in developing and implementing plans for the acute service within the policies and guidelines coming from the DHA.

The next institution given Unit status was the Community Service. The District surround can be divided into six urban and rural localities, and several of these contain 50-bedded general hospitals needing to be run at Level 3 by a nurse or an administrator. Because distances between the localities are considerable, it was felt that they should all be run at Level 3 by upgrading if necessary, and this meant that they could be brought together in a Unit operating at Level 4.

The mental illness hospitals posed a different problem. National policy is away from hospital provision and towards community care and in this case the larger hospital served patients living in a different District. This hospital was therefore to be handed over with its associated resources and personnel. The remaining mental illness beds were in two hospitals: one of 300 beds, and the other of 100 on the main DGH site. These were supplemented by some community servies. The long-term policy adopted was to break up mental illness services and integrate the responsibilities into the previous two Units. A similar policy is being adopted for the mental handicap hospitals. The largest is being closed down and the small hospitals will be transferred to neighbouring Districts where applicable. The Special Hospital will however remain as a Sub-regional Centre and will be a Unit (staff 650; budget £3.5 million).

This District will therefore consist of three Level 4 Units, District General Hospital, Community Services, and Special Mental Handicap. Mental illness and mental handicap services will be regarded as Units to facilitate their decommissioning and long-term integration within the DGH and Community Service Units.

District B: Newcastle Health Authority

In contrast to Exeter HA, Newcastle HA is sited within a large city. Its population is also about 300,000 but its budget is £100 million (1980/81). There is a large Medical School associated and the District has many Regional specialities. Prior to reorganization it was a single-District Area. Its most striking feature is three large general hospitals, each with over 650 beds, each with budgets of approximately £20 million, and each employing about 3,000 staff. (Some Districts in the UK will be smaller than just one of these

hospitals!) There is a fourth large hospital (700 beds) solely for mental illness. In addition there are a variety of smaller but active hospitals (another 700 beds in all) concerned with paediatrics, obstetrics and other specialities. Regional Specialty Centres exist in a variety of acute services as well as mental illness. Newcastle is an industry-based city with typical inner-city problems of poor housing, unemployment and social deprivation. Its community services include health centres, clinics, child and school health services and health education facilities.

Prior to reorganization Newcastle presented numerous problems: complaints of over and under-consultation, difficulties in providing necessary information, over-centralization, stifling of initiatives, mis-match in organization of the various functions, excessive competition between hospitals, unnecessary duplication of services and dissatisfaction with the state of medical-administrative relations.

The District was making strenuous efforts to rationalize services available in the three general hospitals as had been successfully achieved in Exeter. However, they were finding it heavy going and discussions had gone on for some time with little result. The problem was that each of the general hospitals is, without a shadow of doubt, at least a Level 4 structure in its own right. The results of failing to provide Level 4 management on each site included duplication of work between the hospitals and the centre, excessive delays in decision-making, and bombardment of the centre by hospital doctors with desperate appeals and furious complaints. It was simply impossible to maintain a low level of work in these large institutions.

Three possible models for Units in relation to these hospitals were examined: 1) Each general hospital as a Unit; 2) each general hospital with its surrounding community as a Unit; 3) Units created by cutting across the three hospitals on a services and care group basis. No. 3 was rejected as unrealistic and impracticable. No. 2 was rejected: first, because it was believed that the community services would receive too little attention; and second, because there was no natural relation between each general hospital and its immediate environs. Choosing the first option set the top level in the District at Level 5 with one of its key responsibilities being the development of policies to coordinate and rationalize the activities of the large Level 4 DGHs. With such Units, the senior Unit personnel would have a particular responsibility to liaise with their counterparts in devising the most efficient provision of acute services. By treating the large general hospitals as Level 4 institutions, it was possible for the various smaller hospitals to be treated as Level 3 sections of one or the other of these.

Other possible Units were less problematic. The DMT were concerned to develop Community Services and therefore assigned it Unit status as the first step in the provision of resources for such development. It was also decided to assign Unit status to a Mental Illness Care Group. This Unit would include the psychiatric hospital, psychiatric departments in two of the general hospitals, and other specialist psychiatric services. The Unit would be responsible for overcoming the long-standing difficulties between the large hospital and the rest of the psychiatric services, and improving the integration of the various professional groups. As with Community Services, becoming a

Unit would be a major step towards improving care, rather than a ratification of what already existed.

A special arrangement for mental handicap in partnership with local government and voluntary agencies had been initiated prior to reorganization. Although it was suggested that mental handicap might be placed with mental illness, and then with Community Services, it was finally left in the partnership but with its major link to Community Services.

A final difficulty arose over the large Dental Hospital associated with a School of Dentistry and administered up to that time within the general hospital in whose environs it was sited. Separate Level 4 planning and budgeting for this hospital was already well-established but the volume of this work could not justify full-time administration or nursing posts at this level. It was finally decided that the Dental Hospital should be a Unit with all that entailed in terms of separate Level 4 identity, but that the posts of Dental Unit Administrator and Dental Director of Nursing should be filled by the same persons as filled the Unit posts in the general hospital.

Management of Units and District-Unit Relations

We may now turn briefly to questions of management structures for the new Units and their relation to District Management. For a start it is essential to distinguish Level 3 and Level 4 Units because, as indicated earlier, Level 3 and Level 4 management are so different. The responsibilities of a Level 4 Unit Officer will have more in common with those of a Level 4 District Officer than with those of Level 3 Unit Officer. Given that official policy opts for Level 5 Districts, then the desirable work level in the Units is Level 4.

The major task of the Level 4 Units will be to develop comprehensive detailed and costed plans to meet the needs of the Unit within the policies and guidelines developed by the DMT and laid down by the District Health Authority. It will be expected that the Units will negotiate objectives with the DMT and then have to sort out their own priorities within a known budget. The District Officers will be aware of what is going on through line accountability and will be checking that policy and guidelines are not being infringed. However, the details of the plans, the resolution of priorities within the Unit, particularly for medical development, the negotiation and consultation to ensure their execution if sanctioned by the DHA, and the examination of options and details of costing will be the responsibility of the Unit. Such work calls inevitably for some team arrangement in the Unit. Membership of the Unit Management Team would naturally include the Unit Administrator, Director of Nursing and a medical representative. Input from the Treasurer's Department would be essential, and there might be a role for a Unit Works Officer. A level 4 Unit Team must function corporately.

The way in which financing and accounts are arranged has a powerful effect, for better or worse, on coordination and cooperation within an organization, and on the stability of the structure itself. Hence the importance of such decisions as who holds the budget, who is delegated a budget and who can exercise virement. In a Level 4 Unit, there will be no grand "Unit budget" as such. It should be noted that the NHS has no agreed mechanisms for

"objectively" determining such a budget. Individual Unit Officers will carry one or more identified budgets for the various services, facilities and departments and virement will be permitted within limits. The Unit Team will be expected to provide a general budgetary oversight to permit the most efficient handling of fortuitous or planned savings or functional overspending.

The budget-holders in this scheme are the Unit Officers, not the District Officers (except for their own Headquarters work), and the budget allocations are authorized by the DHA on the advice of the DMT. The DMT will thus have a collective responsibility for overall resource use (operational services, special programmes, contingency funds) but the District Officers, such as the Administrator and Nurse, will not themselves hold budgets and delegate other, more circumscribed budgets, to their Unit subordinates. Their role will involve developing a budgetary structure, formulating guidelines and appraising their Unit-subordinates' budgetary performance and conformance to policy. Within Units, budgets would be delegated as appropriate to those working within the various functions at Level 3. There may well be other non-Unit based Level 4 budget holders, for example, in Works, Pharmacy and Physiotherapy.

If these administrative arrangements including budgetary systems work, a reorientation in attitudes of medical staff will occur. The medical input to District policy would continue via the DMT and DHA, but for the majority of clinicians, the most immediate centre of substantial power would become the Unit. This is because all incremental changes should be decided at this level, and details of the majority of developments as well.

The Reality of Level 4 Districts

As indicated above, many Districts will run at Level 4. We mean by this that the DMT will be concerned primarily with the detailed development and implementation of medium-term plans. The Chief Officers will be budget-holders, and will develop policy while planning. However, the way plans turn out in practice will often be the de facto policy of the District, and a deep concern with strategic questions by Chief Officers will be lacking. These Districts will need to have their Units working at Level 3. Staff running such Units will be concerned primarily with maintaining the system or implementing District plans, but will not be able to make and cost substantial plans themselves. They will be delegated budgets without power to overspend or vire with other budget-holders, and will not control personnel budgets. Any change from what is defined as the current service will need to be worked out by the District Officers.

The particular structure within such Districts will depend mainly on the institutions already present. For example, some Districts may have a large DGH and little else, while other Districts may be composed solely of a number of natural Level 3 institutions and lack a DGH. If the Government pursues its policies resolutely, then these Districts should be seen as transitional structures necessitated by short-term practical and political expediency.

Conclusion

In this paper we have examined the current structuring of the NHS, aiming to determine the requisite levels of work at District and its prime non-territorial internal subdivision, the Unit. A decision must be made now for each District as to whether its services are to run at Level 4 or Level 5, but the resulting mixture should be seen as a transitional state to one in which all Districts will operate with Chief Officer posts at Level 5.

Organization, at the end of the day, is not words on a piece of paper but patterns of expectation which regularly affect actual behaviour. Changing organization therefore involves changing people's minds, or changing people about. This is not a rapid or easy process, nor is the task ended when implementation has occurred. Organization must also be sustained and this, like implementation, is dependent on the conduct of personnel in the higher levels. If, for example, a District Officer neither endorses valid decisions of a Unit subordinate, nor dismisses him, but instead repeatedly insists on his own decisions in the Unit, then structure is being destroyed. The subordinate and others involved with him will experience a depression in his assigned level of work and feel that authority is being sucked upwards. Few experiences are as demoralizing. The same problem can occur between District and Region or DHSS. It is an assumption of this paper that explicit assignation of authority at the appropriate level, followed by organizational monitoring to prevent drift of level is the key to effective organization within Districts as well as to a successful devolution of power as implied by the restructuring.

There are limits however to an organizational analysis such as this has been. Organization is a framework, and it does not, cannot, determine what decisions are finally made. If well designed it can facilitate constructive efforts. If poorly designed, it can lead to dissatisfaction, dissension and poor output. Results, however, do depend in the end on the people employed. We have spoken of levels on the assumption that level of work in post will be matched by the appropriate pay and grading and that an appropriate person will be appointed. It is important to note therefore that this is currently in doubt.[2,7,23] But personnel calibre is only the start: personality, managerial style, staff development, planning methods, participation, high-trust climates, attitudes of efficiency and equity and an ethos of service to the public will be crucial in the working of a District. Decisions will continue to be subject to political pressures and dominated by values and beliefs, but if a suitable framework exists, those pressures and values will at least be channelled. This is all that is possible in a pluralistic and democratic society.

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Health Services Organization Research Unit
Brunel University
Uxbridge
Middx UB8 3PH

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