NATIONAL HEALTH SERVICE REORGANISATION

Residential Seminar for
General Practitioners and Consultants

25th - 26th January, 1974

Abbot's Barton Hotel
New Dover Road
Canterbury

CONTENTS

INTRODUCTION

This Handbook has been compiled with the object of assembling in one place many of the more important recent official documents about reorganisation which are particularly relevant to consultants and general practitioners wishing to understand the new structure and to contribute to the planning and management of the new services. The Handbook is therefore concerned essentially with supplying information, not with criticism or evaluation. The extracts in the Handbook cover the major areas of concern to the Seminar, starting with an outline of the essential features of the new NHS and passing on to issues of management, community medicine, district organisation, and collaboration with local government. Seminar members are expected to be familiar with the main contents of the Handbook, and it is hoped that the Handbook will continue to be a useful reference for some time to come.

Health Services Research Unit
University of Kent

January 1974

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Miss E. Few	Director of Nursing Services, Buckinghamshire C.C.
Dr. M.S. Harvey	Medical Officer of Health, Canterbury C.B.C.
* Mr. L.E. Forryan	Group Secretary, Isle of Thanet H.M.C.
Mr. J.R. Knighton	Clerk, West Sussex Executive Council
Mr. K.R.D. Porter	Regional Medical Officer, South East Thames Regional Health Authority
Mr. J. Roper	Medical Reporter, The Times
* Professor M.D. Warren	Director, Health Services Research Unit, University of Kent

* Residential

PROGRAMME

Friday 25th January

12 noon to 12.45 p.m.	Assemble at the hotel
12.45 to 2.00 p.m.	Lunch
2.00 to 4.00 p.m.	'The new National Health Service - its promise and potential' Dr. K.R.D. Porter 'The structure of services at district level' Mr. L.E. Forryan A chance to question representatives from the hospital service (Dr. K.R.D. Porter), family practitioner services (Mr. J.R. Knighton), the DHSS (Dr. J. Barnes) and community medicine (Dr.M.S. Harvey) about the future structure of services and present progress
4.00 to 5.00 p.m.	Tea
5.00 to 6.30 p.m.	'Working together: some aspects of collaboration between the district management team and local authorities, community health councils, officer teams and the area health authority' Mr. J.R. Butler
6.30 to 8.00 p.m.	Sherry and dinner
8.30 to 10.00 p.m.	'The work of the specialist in community medicine' Professor M.D. Warren

Saturday 26th January

9.00 to 11.00 a.m.	'Working relationships in the district management team Mr. S. Cang
11.00 to 11.30 a.m.	Coffee
11.30 to 1.00 p.m.	'The task of management in the health services' Mr. M. Brandon
1.00 to 2.15 p.m.	Lunch
2.15 to 3.45 p.m.	The views and expectations of others. A senior nurse (Miss E. Few), a medical journalist (Mr. J. Roper) and a social worker (Mr. A. Ball) will present their viewpoints about NHS reorganisation
3.45 to 4.00 p.m.	Chairman's concluding remarks

Note: Speakers at each session have been asked to talk for no more than 45 minutes in total, so that at least half the time in each session will be available for discussion

GLOSSARY OF ABBREVIATIONS USED IN THE 'GREY BOOK' AND RELATED DOCUMENTS

AA	Area Administrator
ADO	Area Dental Officer
AHA	Area Health Authority
AHA(T)	Area Health Authority (Teaching)
AMO	Area Medical Officer
AMT	Area Management Team
ANO	Area Nursing Officer
APAC	Area Professional Advisory Committee
APO	Area Pharmaceutical Officer
AT	Area Treasurer
ATO	Area Team of Officers
AWO	Area Works Officer
BG	Board of Governors (Teaching Hospital)
CB	County Borough
CC	County Council
CHC	Community Health Council
CNO	Chief Nursing Officer (Hospital)
DA	District Administrator
DBO	District Building Officer
DCP	District Community Physician
DDO	District Dental Officer
DE	District Engineer
DFO	District Finance Officer
DGH	District General Hospital
DHSS	Department of Health and Social Security
DMC	District Medical Committee
DMT	District Management Team
DNO	District Nursing Officer
DNS	Director of Nursing Services (Community)

DPO	District Pharmaceutical Officer
DWO	District Works Officer
EC	Executive Council
FPC	Family Practitioner Committee
HAA	Hospital Activity Analysis
HIPE	Hospital In-Patient Enquiry
HMC	Hospital Management Committee
HRC	Health Reorganisation Circular
JCC	Joint Consultative Committee
JLC	Joint Liaison Committee
LB	London Borough
MAC	Medical Advisory Committee
MEC	Medical Executive Committee
MSO	Management Services Officer
NHS	National Health Service
PAC	Professional Advisory Committee
PNO	Principal Nursing Officer (Hospital)
RA	Regional Administrator
RDO	Regional Dental Officer
RHA	Regional Health Authority
RHB	Regional Hospital Board
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
RPAC	Regional Professional Advisory Committee
RPO	Regional Pharmaceutical Officer
RT	Regional Treasurer
RTO	Regional Team of Officers
RWO	Regional Works Officer
TUC	Trades Union Congress

THE FRAMEWORK OF THE REORGANISED NATIONAL HEALTH SERVICE

in diagrammatic form.

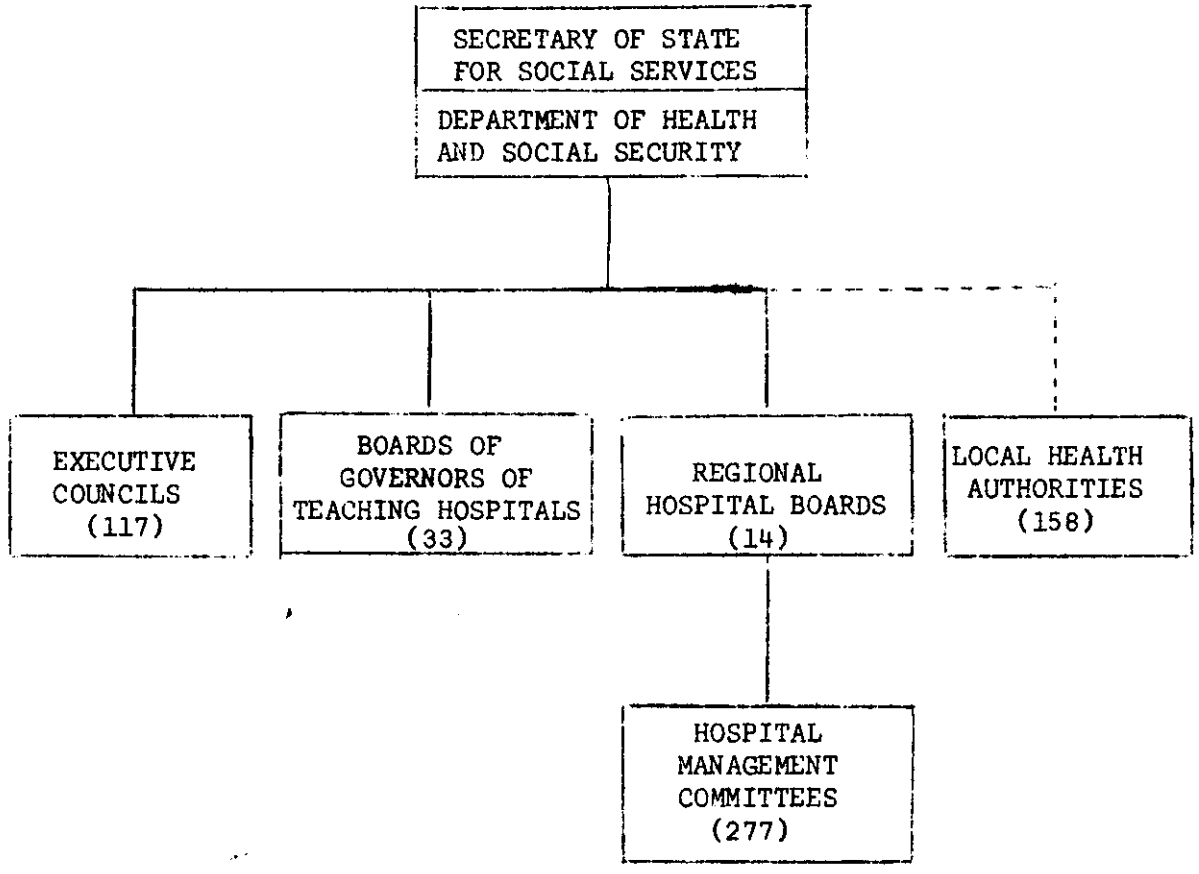
The following six charts display the pre- and post- 1974 structure of the N.H.S. in the form of charts. Chart 1 shows the basic structure prior to reorganisation in April, and Chart 2 gives the framework of the new organisational structure. Chart 3 is designed to illustrate the relationship between officers, members and professional advisory committees in the new structure. The remaining three charts set out the organisation at regional, area and district levels respectively.

It will be helpful to refer to these charts during the course of the Seminar when they will be utilised and clarified by the speakers.

CHART 1

NATIONAL HEALTH SERVICE, ENGLAND

ORGANISATION BEFORE APRIL 1974



General Practitioners
Dentists
Chemists
Opticians

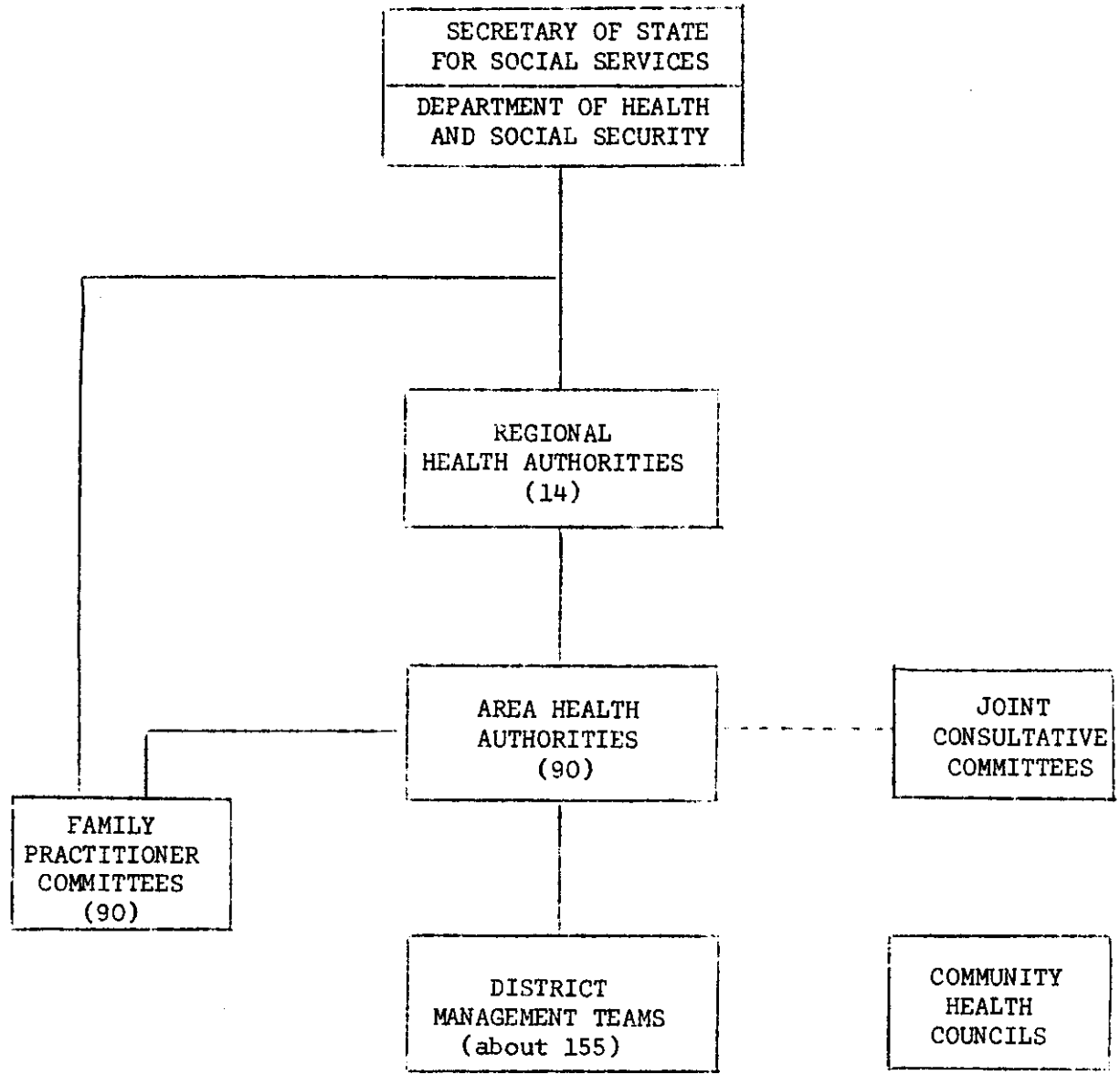
Hospital and Specialist Services

Health Centres
Family Planning
Domiciliary Midwifery
Health Visiting
Home Nursing
Ambulance Services
Chiropody
Vaccination and Immunization
Prevention of Illness, Care and Aftercare.

CHART 2

NATIONAL HEALTH SERVICE, ENGLAND

ORGANISATION AFTER APRIL 1974



General Practitioners
Dentists
Chemists
Opticians

Hospital, Specialist and Community Health Services

CHART 3

N.H.S. COMMITTEES AND OFFICERS

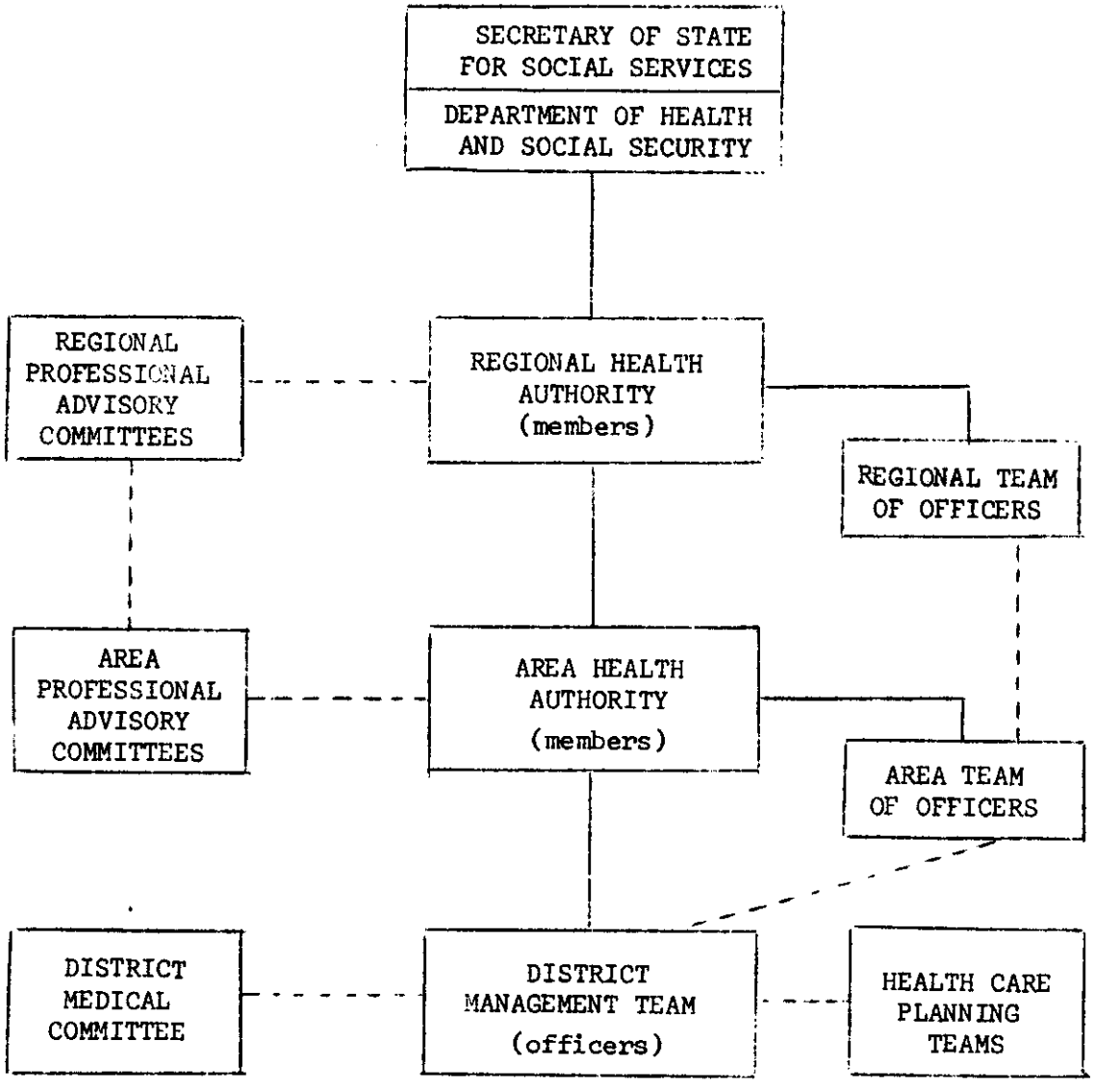
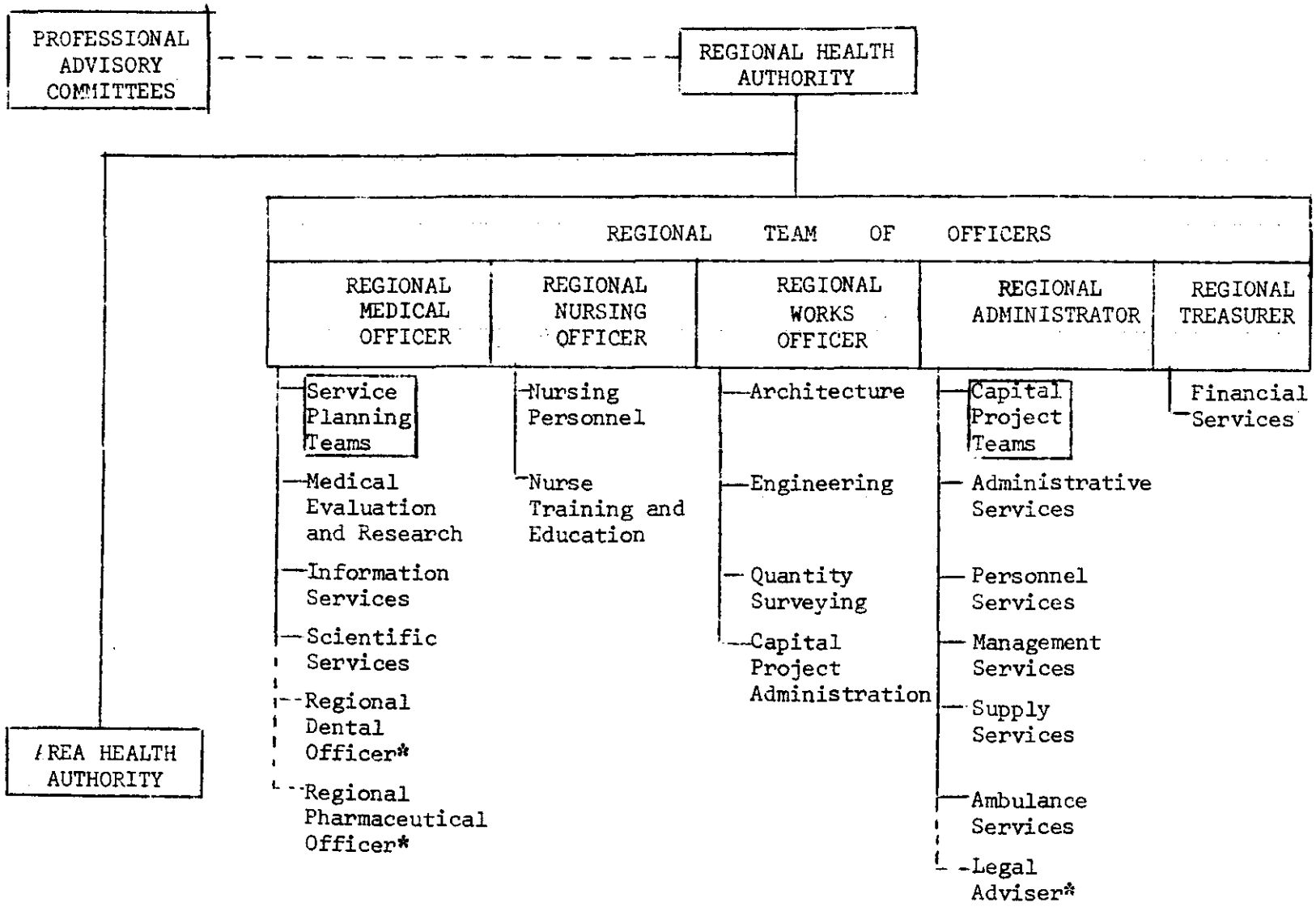


CHART 4

REGIONAL ORGANISATION



*Individually accountable to R.H.A.

CHART 5

AREA ORGANISATION WITH SEPARATE DISTRICTS

(note: in areas with separate districts, the "Area Team of Officers" have the six members corresponding to District Management Teams and are known as Area Management Teams.)

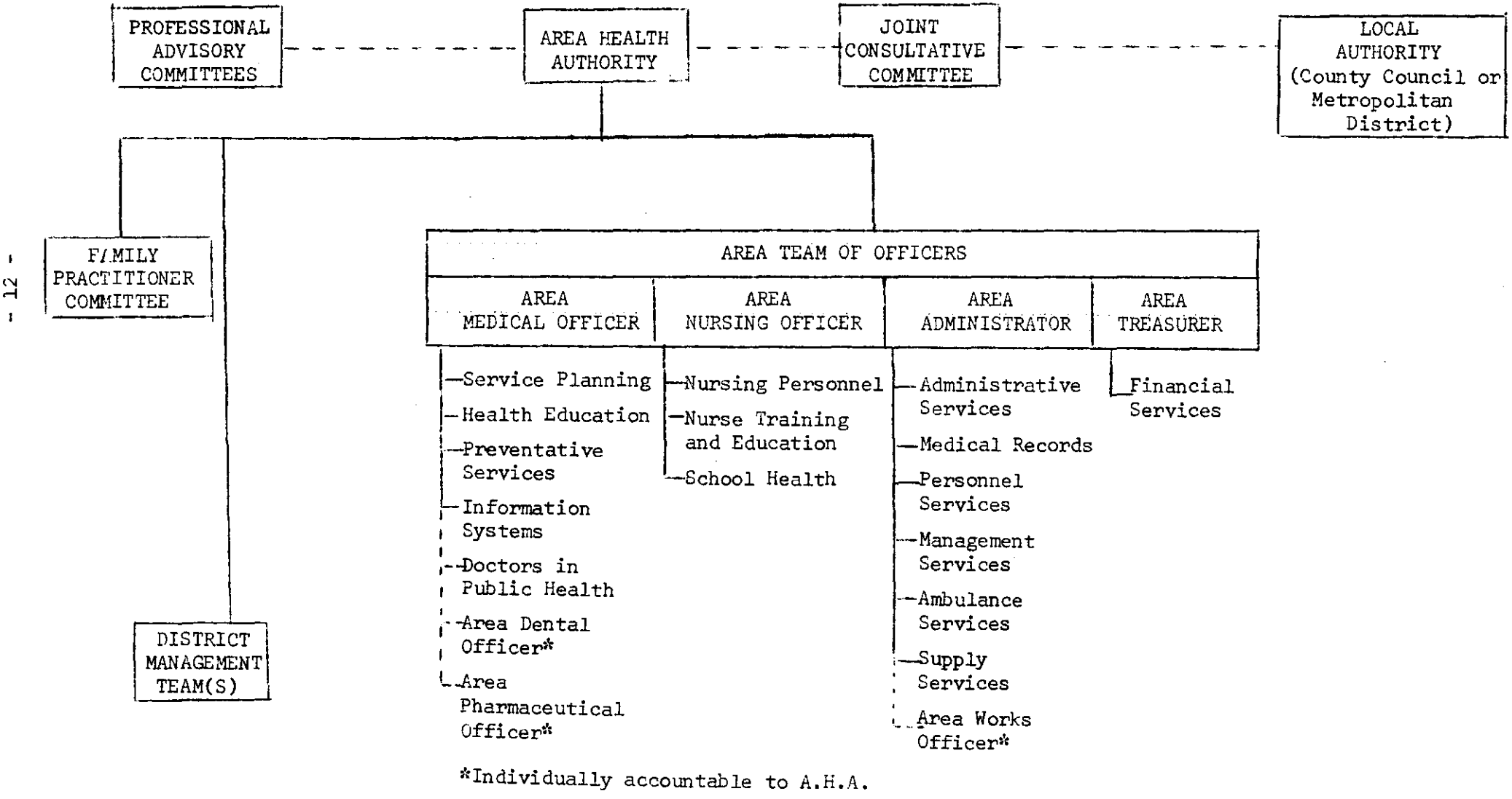
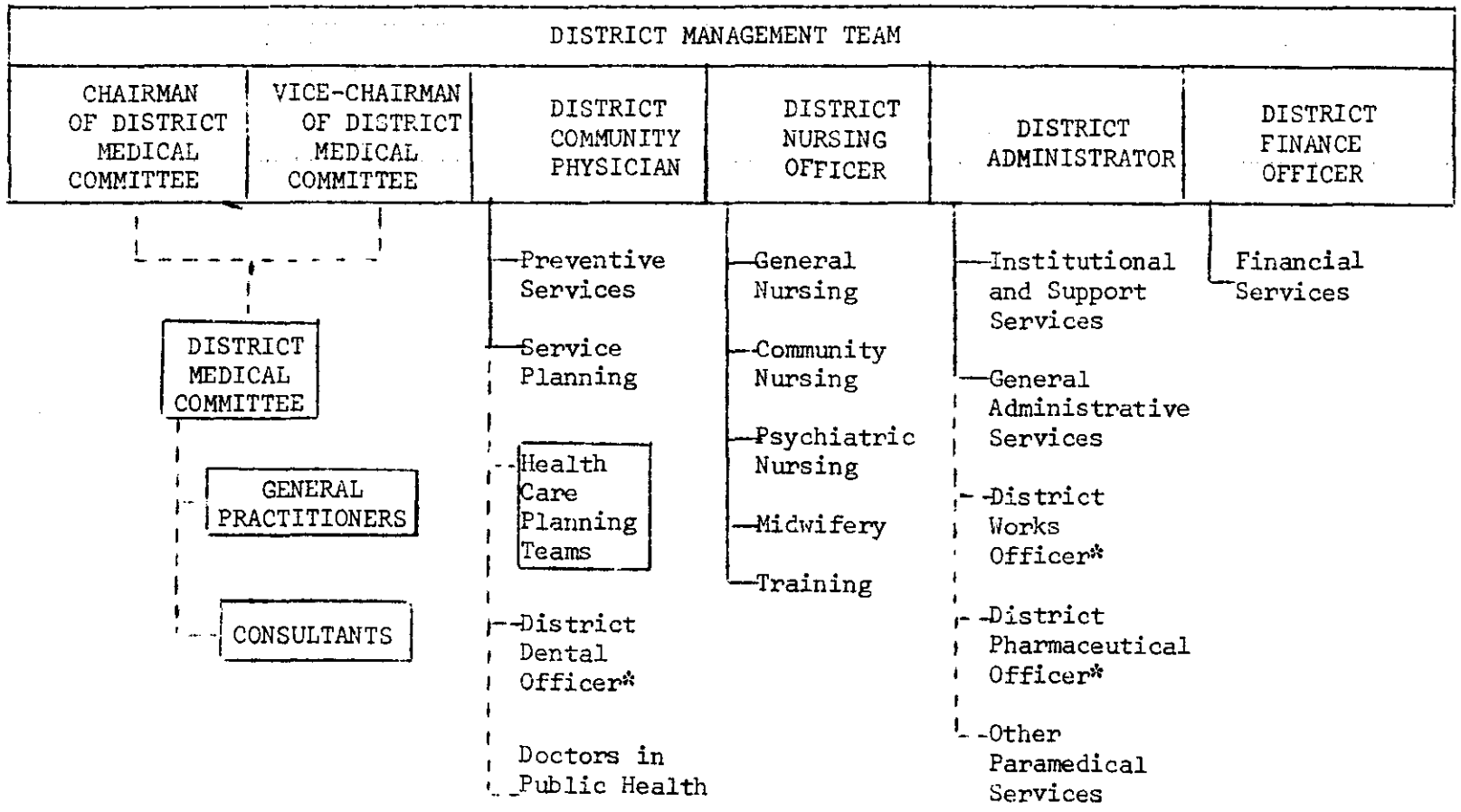


CHART 6

DISTRICT ORGANISATION



*Individually accountable to corresponding Area officers

THE REORGANISED NATIONAL HEALTH SERVICE :

structure, functions and responsibilities

This section of the handbook contains extracts from recent official documents and notes describing the basic structure and dynamics of the new service. The first extract (NHS Note 1A) provides a brief descriptive overview of reorganisation as a whole. The second extract is the Secretary of State's introduction to the White Paper (Cmnd 5055) presented to Parliament in August 1972, which sets out the main purposes of reorganisation. The third extract reproduces certain paragraphs from the White Paper itself and from the Report on Management Arrangements for the Reorganised National Health Service (the 'Grey Book') dealing with the functions and responsibilities of officers and members in the new service. The fourth extract, from the reorganisation circular HRC (73) 26, sets out in tabular form the main functions, methods of appointment and accountability of the new statutory bodies.

NHS Note 1A

NATIONAL HEALTH SERVICE

REORGANISATION (ENGLAND)

Introduction

One of the main defects of the present National Health Service, which started in 1948, has always been that instead of being a unified Service, it has been administered in three parts - the Hospital and Specialist Services, the General Practitioner Services and the Local Health Authority Services. These are now to be unified under the National Health Service Reorganisation Act 1973.

After consultations with the various professions and organisations concerned, a White Paper (Cmnd 5055) was published on 1 August 1972 setting out in detail the plans for the reorganised Service. The new National Health Service will start on 1 April 1974. The personal social services have already been brought together under the Local Authority Social Services Act 1970 (effective from 1 January 1971) and far-reaching changes have been made in local government under the Local Government Act 1972 which will also come into force on 1 April 1974.

Services in the new National Health Service

The services which will be brought together are:

(a) the hospital and specialist services now administered by the Regional Hospital Boards, Hospital Management Committees and Boards of Governors of undergraduate Teaching Hospitals;

(b) the Family Practitioner Services now administered by the Executive Councils;

(c) the personal health services (listed below) now administered by local authorities through their health committees; and

(d) the school health service now administered by the local education authorities.

The personal health services are those which are at present referred to the local authority's health committee under the NHS Acts and the Local Authority Social Services Act 1970. They include ambulance services; epidemiological work; family planning; health centres; health visiting; home nursing and midwifery; maternity and child health care; medical, nursing and supplementary arrangements for the prevention of illness, care and after care and vaccination and immunisation.

The health authorities will have comprehensive health education powers as part of their responsibility for the prevention of illness.

General Organisation

So that the organisation of the National Health Service can be really effective, there will be three levels of planning - regional, area and the central Department. Under these arrangements, there will be central strategic planning and monitoring by the Department of Health and Social Security; regional planning and general supervision of operations by regional authorities; and area planning and operational control by area authorities.

Strong professional advisory machinery will be built into the new structure. It will function at each level of management, and will ensure that the Regional Health Authorities and Area Health Authorities and their staffs make decisions in the full knowledge of expert opinion. It will ensure, too, that at all levels the health professions exercise an effective voice in the planning and operation of the NHS.

Regional Health Authorities

There will be 14 Regional Health Authorities based on the present Hospital Regions but, as each new Region will consist of a number of complete health areas, some adjustments to the present hospital regional boundaries will be necessary. Each RHA will have a University medical school within its boundaries. (For details of the Regions see Appendix I on pages 10-11 .)

The RHA will form part of the chain of responsibility running from the Secretary of State to each AHA. The Chairman and members of the RHA will be appointed by the Secretary of State after consultations with interested organisations, including the Universities, the main local authorities, the main health professions and the TUC. Members will be unpaid (but entitled to travelling and other allowances) but the Chairman will be paid on a part-time basis.

The RHA will develop strategic plans and priorities based on a review of the needs identified by the AHAs and on its judgement of the right balance between individual areas' claims on resources. It will also be responsible for identifying, in consultation with the AHAs, services which need a regional rather than an area approach and arranging for their provision. It will need to develop an overall regional plan for specialist services (paying particular attention to the provision and location of rarer specialties) and it will rely on professional advice in carrying out this task.

The RHA will have a special responsibility for ensuring - with the Universities and AHAs concerned - that satisfactory service facilities are provided to support medical and dental teaching and research.

The RHA will allocate resources between the AHAs, after having agreed area plans with them, and will monitor their performance. The most important of the RHA's executive functions will be the design and construction of new building and works. The RHA will itself undertake the more important projects, subject to any necessary approval by the central Department and to guidance on such matters as design and cost standards and building techniques and methods. All other new building work will be the responsiblity of the AHAs, subject to any necessary approval and guidance by the RHA.

The RHA will employ the architects, engineers and quantity surveyors not only for its own work but also to help AHAs with their building projects. Responsiblity for operation and maintenance of engineering plant and services and for the maintenance of existing premises will be delegated to the AHAs subject to regional supervision.

It will also be one of the tasks of the RHA to see that there is effective co-ordination and collaboration between adjacent AHAs in such matters as emergency cover, the siting and use of ambulance stations, and training.

Area Health Authorities

There will be 90 Area Health Authorities in England whose boundaries will generally match those of the new non-metropolitan counties and metropolitan districts of local government. In London the health authority boundaries will correspond to those of an individual London Borough in four cases, and two, three or, in one case four London Boroughs grouped together in the remaining 12 cases. (For details of the Areas see Appendix I on pages 10-11 and Appendix II on page 12.)

The AHA will be the operational NHS authority, responsible for assessing needs in its area and for planning, organising and administering area health services to meet them. It will also be the employer of the staff who work at area headquarters and in the districts.

For a period, however, medical and dental consultants and senior registrars, except those working in the teaching areas (see page 5) will continue to be appointed at regional level. This arrangement will be reviewed in 1979 when the new Service will have been in operation for 5 years.

The AHA will also be responsible for services such as catering and domestic as well as for other supportive services which back up the health professions and, in so doing, contribute to patient care.

The Chairman of the AHA will be appointed by the Secretary of State after consultation with the Chairman of the Regional Health Authority (see page 2), There will be about 15 members for each AHA, four of whom will be appointed by the corresponding local authority; one by the University concerned (areas with substantial teaching facilities will be administered by Area Health Authorities (Teaching) (see page 5) and the remaining members appointed by the RHA after consultations with the main health professions, the TUC and other organisations. An AHA will always include doctors and at least one nurse or midwife, but otherwise the proportion of professional members will not be prescribed. Members will be unpaid (but entitled to travelling and other allowances) but there will be provision in the legislation for the Chairman to be paid on a part-time basis.

The day-to-day running of the services for which the AHA is responsible will be based on health districts. These will always contain a district general hospital and will usually have a population of between 150,000 and 300,000. The AHAs will decide the number of districts in their areas but it is expected that there will be between one and six districts in each area.

Under the new NHS the status of general and dental practitioners, ophthalmic medical practitioners, opticians and pharmacists as independant contractors will remain unchanged. To administer the contracts the AHA will be required to set up a Family Practitioner Committee which will deal with the central Department on contractual matters. It will have 30 members made up in the same way as Executive Councils at present outside London: half of them will be appointed by the professions; of the other 15, 11 will be appointed by the AHA (at least one being an AHA member) and four by the local authority entitled to appoint members to the AHA. The Chairman will be appointed by the Committee from among its own members.

The staff serving the FPC will be employed by the AHA, but the Committee will be consulted before senior appointments are made.

Central Department

As with the present NHS, the Secretary of State will continue to have responsibility to Parliament for the reorganised Service as a whole and will determine national policy. The Department will assist him in the following ways:

(a) Settling the kind, scale and balance of service to be provided in regions and areas.

(b) Guiding, supporting and (to the extent that this is desirable) controlling RHAs. Here it will be the Department's job to help the authorities to understand the guide-lines and the reasoning behind them. It will also allocate to the RHAs the necessary resources.

(c) Obtaining or developing resources which strongly influence the adequacy, efficiency and economy of the services. This requires specialist work on particular resources - personnel; finance; property and building; supply. The Department will have a special responsibility in relation to staffing - for instance, forecasting staff requirements, planning the number of training places, etc.

(d) Carrying out other functions which are best organised centrally such as some types of research, standardisation and preparation of national statistics. The NHS superannuation scheme will continue to be centrally administered.

(e) Supporting the Secretary of State in his Parliamentary and public duties.

At the national level, the Department must have available to it expert opinion on a wide range of matters, many of which are highly technical, relating to the provision of the NHS. Advisory bodies will continue to be the main source of this advice. The constitutions and terms of reference of the present Central Health Services Council and its Standing Advisory Committees will be adjusted as necessary to meet the needs of the new Service. For instance, it is intended to include on the new Council some people specifically appointed to advise from the patient's viewpoint.

Community Health Councils

These new Councils will represent the views of the consumer. There will be one for each of the area's health districts (see page 3).
Half the members of the Council will be appointed by the local authorities of which the area or part of it is included in the Community Health Council's district, at least one-third by voluntary bodies concerned locally with the NHS, and the remainder by the RHA after consultations with other organisations.

The number of members will vary according to local circumstances, but there will usually be between 20 and 30. Members will be unpaid, but entitled to travelling and other expenses. Councils will appoint their own Chairman from among their members.

The Council's basic job will be to represent to the AHA the interests of the public in the health service in its district. Councils will have powers to secure information, to visit hospitals and other institutions, and will have access to the AHA and in particular to its senior officers administering the district services. Councils may bring to the notice of the AHA potential causes of local complaint, but their function will be distinct from that of the AHA's complaints machinery and of the Health Service Commissioner (see page 7).

The AHA will be required to consult the Community Health Council(s) on its plans for Health Service developments - eg closures of hospitals or departments of hospitals or their change of use. The full AHA will meet representatives of all its Community Health Councils at least once a year; this would be in addition to the less formal meetings which would be held between the Council's representatives and various officers of the AHA. The Council will publish an annual report (and may publish other reports) and the AHA will be required to publish replies recording action taken on the issues raised.

Medical and Dental Teaching

The new NHS will continue to give high priority to providing facilities in support of medical and dental teaching carried out by the Universities and in support of associated research. Areas which will have substantial facilities of this kind will be known as "teaching areas" and the AHAs which administer them will be called AHA(T)s. (For details of AHA(T)s see Appendix I on pages 10-11.) Whereas the AHA without substantial Teaching and research facilities will have one member nominated by the University (see page 3), the AHA(T) will have two. It will also have at least two additional members with teaching hospital experience - more if the area includes more than one teaching hospital (or groups of hospitals of a kind hitherto designated as a single teaching hospital).

Administrative unification is essential if there is to be a properly balanced development of community and hospital facilities to meet the needs of teaching, of research and of services to the public. For this and for other reasons, the teaching areas will be administered as part of the regions in which they are situated. But at the same time the hospitals' individual identity and historic traditions will be preserved. The teaching hospital will have a central role in the health services for the district in which it is situated. There will be close links between the AHA(T) and those responsible for the administration of the teaching hospital. The present close working relationships between the teaching hospitals and their associated medical and dental schools will be maintained. The RHA will receive in its financial allocation from the Department a specific identified allowance for teaching and research. The Department's aim in its review of regional plans and estimates will be to see that a proper balance is kept between teaching and non-teaching areas.

The RHAs will be responsible for seeing that there are satisfactory arrangements for postgraduate medical and dental education and training. To enable them to do this they will be advised by regional postgraduate education committees which will be distinct from the committees advising on undergraduate teaching.

The teaching hospitals' contribution to the new Health Service will be a growing one, but during the early years it is felt that some additional safeguards will be required as reassurance that full weight will indeed be given to the importance of teaching and research functions. For this reason, on the first appointment of the AHA(T)s, the members appointed for their teaching hospital experience will be appointed by the Secretary of State from among the members of the existing Boards of Governors and University Hospital Management Committees. Similarly, on its first appointment, the RHA's teaching and research committee will include members drawn from the present Boards of Governors and University HMCs.

The Staff of the Service

Nearly 70% of the running costs of the NHS are incurred on salaries and wages. Under the newly organised Service, professional and occupational training will be complemented by management training most of which will be multi-professional and will take account of the close relationship between the objectives of the NHS and those of the local authority social services.

There will be a Staff Commission to advise on the arrangements for recruiting and transferring staff to the new authorities and on any problems which may arise, and to consider representations from staff who object to their transfer. The work which the National Staff Committee and the National Nursing Staff Committee have done on behalf of hospital administative and clerical staff on the one hand and of hospital nurses and midwives on the other will be built on in the new Service and developed to meet the needs of an integrated Service. It will also be extended to other groups of staff. In order to do this, the existing Committees have been reconstituted as the National Staff Committee for Administrative and Clerical Staff and as the National Staff Committee for Nurses and Midwives and others will be set up. There will also be a NHS Teaching Council which will work with the staff advisory committees on the training aspects of their work.

Rates of pay and conditions of service will continue to be settled through national machinery. The Review Body will continue to advise the Government on the remuneration of doctors and dentists.

Finance

The cost of the new NHS will continue to be financed mainly from taxation and met from moneys voted by Parliament. The Department will make capital and revenue allocations to the RHAs and from these the RHAs will meet the cost of their own services and will, in turn, allocate money to AHAs to meet the cost of area services including the cost of Community Health Councils. Payments made to general medical and dental practitioners etc. under the terms of their contracts will be separately funded by the Department.

The allocations of available funds to health authorities will be designed progressively to reduce the disparities between the resources available to different regions, and to achieve standards and improvements in services with due regard to national, regional and area priorities.

The transfer of services will relieve local authorities of expenditure and this will be taken into account when assessing the level of grant to be paid by the Central Government to local authorities in April 1974.

Under the present NHS the hospital authorities are trustees of substantial sums given to them by the public. The trusts will be transferred to the new authorities and care will be taken to ensure that both the local administration and the purposes of these gifts are preserved as far as it is possible to do so.

The funds now held by Hospital Management Committees will be transferred to the appropriate AHA. The future administration of the funds held at present by Boards of Governors or by University HMCs will be transferred in most cases to Special Trustees.

The new authorities will have powers to accept fresh gifts to help them in any part of their work. Financial help from voluntary sources has always played an important part in the NHS and this will continue.

Complaints

For the investigation of complaints, each health authority should have arrangements which work well and which command the confidence of the public. Arrangements already exist in most local authorities, and in the present Executive Councils there are long-established statutory procedures for investigating complaints against practitioners. A review of hospital authorities' arrangements for handling complaints has been undertaken by an independant Committee under the Chairmanship of Mr Michael Davies, QC.

Apart from these channels, there will be a Health Service Commissioner who will investigate complaints against NHS authorities. This is an important extension of the ombudsman principle in the public service. The necessary legislation is part of the NHS Reorganisation Act, but the Commissioner will begin work on 1 October 1973 until 1 April 1974 his jurisdiction will not extend to health services at present provided by local authorities, but after that date his jurisdiction will cover the whole of the unified NHS. He will not, however, investigate complaints which, in his opinion, relate to the exercise of clinical judgement by doctors and other staff, nor will he deal with complaints for which statutory procedures already exist (eg those about general medical and dental practitioners, pharmacists and opticians which will continue to be dealt with under the service committee procedure) or which he thinks the complainant could reasonably pursue through the courts.

The complainant will have direct access to the Commissioner who, however will not investigate a complaint until he is satisfied that the health authority concerned has had a reasonable opportunity to investigate it and reply to the complainant who, despite this, is still dissatisfied. Complaints to the Commissioner will not have to be made by the patient himself, although no doubt most of them will be. There will be some cases where the patient is unable to act for himself, and in such cases the complaint may be made on his behalf.

Voluntary Services

Voluntary bodies, which have always played an important part in the development of the health and welfare services, will be encouraged, in close co-operation with the area health and local authorities, to increase and extend their activities. Through their membership of the Community Health Councils (see pages 4-5) they will be able to influence the way in which the health services are developed. The recent growth in the number of organisers co-ordinating voluntary help in hospitals will continue and at present research is being carried out into extending this method of co-ordination to the wider field of voluntary work in the community.

The RHAs and AHAs will be able to make grants in support of voluntary bodies which provide and promote services within the general scope of the authorities' responsibilities. Financial help for national activities will continue to come from the central Department.

Private Sector

In the reorganised Health Service facilities will continue to be provided in NHS hospitals for private patients without prejudice to the needs of those - the vast majority - who wish to be treated as NHS patients and who will continue to be the hospitals' primary concern.

There will be no change in the arrangements which, under the present Health Service, preserved the character of certain hospitals and their association with particular religious denominations when they were transferred to the NHS in 1948

Arrangements for London

There are exceptional features in the health and related services in London. For instance, there are the already established pattern of local government boundaries and services, the way in which hospitals - including the very large number of teaching hospitals, both undergraduate and postgraduate - are distributed, and the fact that Executive Councils administer family practitioner services over much wider areas than those of the individual London boroughs. There are therefore to be certain special arrangements for the London area. These take account of three aspects of the situation in London.

(a) London borough boundaries must be used in forming AHAs so that there can be collaboration between the NHS and borough services;

(b) these boundaries are in the main unrelated to many of the existing health services, and the natural health districts overlap them;

(c) some important health services - eg family practitioner and ambulance services - need units of administration larger than either the borough or the health district.

To meet these aspects, arrangements will be made as follows:

(a) There will be four RHAs with territory outside as well as inside Greater London which will, like such authorities elsewhere (see page 2), include teaching areas.

(b) An advisory co-ordinating working group will be set up to advise on hospital services in London. It will secure co-ordinated planning of facilities for medical and dental teaching and research and the location of regional and sub-regional specialties. (It will be similar to the Joint Working Group under the present NHS.)

(c) AHAs will be formed out of single London borough or groups of boroughs (for details see Appendix II on page 12). The local authority places on the AHA (which, in order to give each grouped boroughs appropropriate representation, will be more than the four mentioned on page 3) will be shared between the boroughs on an equitable basis.

(d) The health districts, each of which will have a Community Health Council (see pages 4-5) will have boundaries which will not always follow the borough boundaries within the health area.

(e) The Greater London Ambulance Service will continue to be administered as a single unit.

(f) In time, each postgraduate teaching hospital will become closely associated with other hospitals and health services in its vicinity, but for a transitional period the Secretary of State will, after consultation with London University, continue each postgraduate teaching hospital's Board of Governors in being for an initial period of five years and the Board will continue to be appointed as at present, except that members now nominated by the RHB will be nominated by the RHA. The Boards of Governors will have a direct relationship with and get their money from the central Department.

The five Executive Councils which at present cover Greater London and parts of the surrounding areas will be replaced by a different number of Family Practitioner Committees (see page 3). This is because in the integrated Service it will be necessary for AHAs and FPCs to correspond on a one-to-one basis in order to get the maximum benefit.

It should be emphasised that none of these special arrangements for London will prevent patients from crossing boundaries to their family doctor or to a hospital outside the health area in which they live. In London, as in the rest of the country, administrative boundaries will not be barriers to the movement of patients.

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APPENDIX I

Regions and Areas with AHA(T)s underlined

Regional Health Authority	Area Health Authorities (Corresponding to the new local government non-metropolitan counties and metropolitan districts, or to one or more London boroughs, including the City of London).	Number of Area Health Authorities
1. Northern	Cumbria; Durham; Northumberland; Cleveland; In Tyne and Wear the districts of Newcastle-upon-Tyne; North Tyneside; Gateshead; South Tyneside; Sunderland.	9
2. Yorkshire	Humberside; North Yorkshire; In West Yorkshire the districts of Bradford; Leeds; Calderdale; Kirklees; Wakefield.	7
3. Trent	Derbyshire; Leicestershire; Lincolnshire; Nottinghamshire; In South Yorkshire the districts of Barnsley; Doncaster; Sheffield; Rotherham.	8
4. East Anglia	Cambridgeshire; Norfolk; Suffolk.	3
5. North-West Thames	Bedfordshire; Hertfordshire; the London Boroughs of Barnet; Brent and Harrow; Ealing, Hammersmith and Hounslow; Hillingdon; Kensington and Chelsea and Westminster.	7
6. North-East Thames	Essex; the London Boroughs of Barking and Havering; Camden and Islington; Enfield and Haringey; Hackney, Newham and Tower Hamlets with the City of London; Redbridge and Waltham Forest.	6
7. South-East Thames	East Sussex; Kent; the London Boroughs of Bexley and Greenwich; Bromley; Lambeth, Lewisham and Southwark.	5
8. South-West Thames	Surrey; West Sussex; the London Boroughs of Croydon; Kingston and Richmond; Merton, Sutton and Wandsworth.	5
9. Wessex	Dorset; Hampshire; Isle of Wight; Wiltshire.	4
10. Oxford	Berkshire; Buckinghamshire; Northamptonshire; Oxfordshire.	4
11. South Western	Avon; Cornwall; Devon; Gloucestershire; Somerset;	5

Regional Health Authority	Area Health Authorities	Number of Area Health Authorities
12. West Midlands	Hereford and Worcester; Salop; Staffordshire; Warwickshire; In West Midlands the districts of Wolverhampton; Walsall; Dudley; Sandwell; Birmingham; Solihull; Coventry.	11
13. Mersey	Cheshire; In Merseyside the districts of Sefton; Liverpool; St Helens and Knowsley; Wirral.	5
14. North Western	Lancashire; In Greater Manchester the districts of Wigan; Bolton; Bury; Rochdale; Salford; Manchester; Oldham; Trafford; Stockport; Tameside.	11

APPENDIX II

AHAs in Greater London

North West Thames RHA

Area : Barnet

Area : Brent
Harrow

Area : Ealing
Hammersmith
Hounslow

Area : Hillingdon

Area : Kensington and Chelsea
Westminster

North East Thames RHA

Area : Barking
Havering

Area : Camden
Islington

Area : City
Hackney
Newham
Tower Hamlets

Area : Enfield
Haringey

Area : Redbridge
Waltham Forest

South East Thames RHA

Area : Bexley
Greenwich

Area : Bromley

Area : Lambeth
Lewisham
Southwark

South West Thames RHA

Area : Croydon

Area : Kingston
Richmond

Area : Merton
Sutton
Wandsworth

APPENDIX A

NATIONAL HEALTH SERVICE REORGANISATION: ENGLAND

FOREWORD TO WHITE PAPER PRESENTED TO PARLIAMENT
AUGUST 1972 (CMND. 5055)

For two years I have been responsible for the National Health Service - and for the personal social services.

Throughout this time my respect for the achievements of the National Health Service has steadily grown. Whatever its defects we would be utterly wrong to take for granted the massive performance of this remarkable network of services and the ease of mind that it has brought to all the people of this country. I am sure that they feel a deep sense of gratitude to all those involved: to the members of the governing authorities; to the men and women who make their careers in the service, whether in direct contact with patients or in supporting services; and to the voluntary workers.

But at the same time I have come to recognise, as many others have, that while this good work will continue, nothing like its full potential can be realised without changes in the administrative organisation of the service.

Hence this White Paper. It is about administration, not about treatment and care. But the purpose behind the changes proposed is a better, more sensitive, service to the public. Administration is not of course an end in itself. But both the patients and those who provide treatment and care will gain if the administration embodies both a clear duty to improve the service and the facilities for doing so.

Let me illustrate this. Everyone is aware of gaps in our health services. Even for acute illness, where we provide at least as good a service for our whole population as any country in the world, there are some respects in which we achieve less than we could. On the non-acute side the services for the elderly, for the disabled, and for the mentally ill and the mentally handicapped have failed to attract the attention and indeed the resources which they need - and all the more credit to the staff who have toiled so tirelessly for their patients despite the difficulties.

It is well understood now, moreover, that the domiciliary and community services are under-developed - that there is a need for far more home helps, home nurses, hostels and day centres and other services that support people outside hospital. Often what there is could achieve more if it were better co-ordinated with other services in and out of hospital. It is well understood too that there must be more emphasis on prevention - or at the least on early detection and treatment.

For the imbalances and the gaps Governments must take their share of the responsibility. Resources were and still are stretched. The acute services had a legitimate priority. But the shortcomings were not rational. They did not result from a calculation as to the best way to deploy scarce resources. They just happened.

Why did they just happen? Because it has never been the responsibility - nor has it been within the power - of any single named authority to provide for the population of a given area of a comprehensible size the best health service that the money and skills available can provide. There has been no identified authority whose task it has been, in co-operation with those responsible for complementary services, to balance needs and priorities rationally and to plan and provide the right combination of services for the benefit of the public.

It is to enable such an authority to operate in each area, with the best professional advice, that the Government proposes to reorganise the administration of the National Health Service as explained in this White Paper.

The National Health Service is one of the largest civilian organisations in the world. Its staff is growing rapidly. It contains an ever-growing multitude of skills that depend on and interact with each other. It serves an ever-growing range of health needs with ever more complex treatments and techniques. And though the Government has made substantial additions to a programme of expenditure which was already planned to grow at an above-average rate, there is never enough money - and never likely to be - for everything that ideally requires to be done. Nor, despite the great increases since 1948, are there ever enough skilled men and women.

Real needs must therefore be identified, and decisions must be taken and periodically reviewed, as to the order of priorities among them. Plans must be worked out to meet these needs and management and drive must be continually applied to put the plans into action, assess their effectiveness and modify them as needs change or as ways are found to make the plans more effective.

Effective for what? - to improve the service for the benefit of all. The plans must therefore be effective in providing what patients need: primarily, treatment and care in hospital; support at home; diagnosis and treatment in surgery, health centre or out-patient clinic; or day care.

Furthermore they must include arrangements whereby the public can express their wishes and preferences, and know that notice will be taken of them. That is why I attach great importance to the establishment of strong community health councils, and to improved methods of enquiring into complaints, including the appointment of a health ombudsman.

The health services depend crucially on the humane planning and provision of the personal social services, and therefore on effective and understanding collaboration with local government. No doubt arguments will continue about the theoretical advantages of making both health and social services the responsibility of a single agency. But the formidable practical difficulties, which have been fully argued elsewhere, rule this out as a realistic solution, and require us to concentrate instead on ensuring that the two parallel authorities - one local, one health - with their separate statutory responsibilities shall work together in partnership for the health and social care of the population. This White Paper demonstrates the Government's concern to see that arrangements are evolved under which a more coherent and smoothly interlocking range of services will develop for all the needs of the population.

The doctor and other professional workers will gain too. The organisational changes will not affect the professional relationship between individual patients and individual professional workers on which the complex of health services is so largely built. The professional workers will retain their clinical freedom - governed as it is by the bounds of professional knowledge and ethics and by the resources that are available - to do as they think best for their patients. This freedom is cherished by the professions and accepted by the Government. It is a safeguard for patients today and an insurance for future improvements.

But the organisational changes will also bring positive gains to the professional worker. He - or she - will have the opportunity of organising his or her own work better and of playing a much greater part than hitherto in the management decisions that are taken in each area. At the same time the more systematic and comprehensive analysis of needs and priorities that will lie behind the planning and operations of each area will help professional workers to ensure that their skills bring the greatest possible benefit to their patients.

We are issuing a White Paper, and promoting legislation about the administration of the National Health Service, solely in order to improve the health care of the public. Administrative reorganisation within a unified health service that is closely linked with parallel local government services will provide a sure foundation for better services for all.

KEITH JOSEPH

Secretary of State for Social Services

1. Some general principles relating to the work of the members of the new health authorities are outlined in the White Paper on National Health Service Reorganisation. (Cmnd 5055).

Relevant passages are:

(a) SCOPE OF THE WORK OF THE NEW HEALTH AUTHORITIES

92. The new authorities will have important work to do. The area authorities for example will employ thousands of staff, professional and others, they will be responsible for the health care of up to a million people or even more, they will administer annual budgets running into millions (in some cases many millions) of pounds and will be responsible for buildings and plant worth many millions.

93. In general terms, members will have two interacting sets of responsibilities: the supervision of the creation and development by their chief officers of policies in response to changing needs; and the overseeing of standards of performance, both in quantity and quality. They will need ability to give guidance and direction on policies to their chief officers charged with the management of the service.

95. An important part of the area health authorities members' work will be to visit the hospitals and other units for the management of which they will be responsible. A planned programme of visiting will be one means by which members will be able to enlarge their understanding of problems requiring their attention and check progress made in dealing with them. But authorities will not need to rely only on their own members for visiting. They will be able to co-opt suitable people to help them.

96. The work to be done by the members calls for general ability and personality. They will need to be interested in the NHS; to have an unbiased, questioning yet constructive approach and good judgment; to set high standards and provide vigorous leadership. A diversity and a proper balance of relevant ability and experience are also called for. These needs can best be met if, in the main, members are chosen for their personal qualities after appropriate consultations, not elected as representatives reflecting the views of particular interests.

(b) THE MEMBER/OFFICER RELATIONSHIP

134. RHA and AHA members are there to see that the right questions are asked and answered in the preparation, operation and review of plans; and to ensure a full awareness of health needs as a basis for the design of policy, the settlement of priorities and the provision of a good standard of service. They are not there to do the work that their officers are trained to do. Not only would this be a waste of time and effort; officers can be expected to give of their best only if they are entrusted with a wide measure of responsibility, and can enjoy a feeling of pride and personal achievement when a good job is done.

2. More detailed application of these general principles were set out in the report on "Management Arrangements for the Reorganised National Health Service".

Particularly relevant passages are:

(a) THE ROLE OF THE AHA

2.8 The AHA is a statutory body corporate and hence the functions described in these paragraphs relate to the Membership as a whole. The Authority has to delegate executive responsibilities to its Area Team of Officers (ATO), to individual officers at Area level, to its DMTs and to individual officers at District level, and focus the limited time of the Authority itself on the critical policy, planning and resource allocation decisions which will shape the services to be provided to the people of the Area. Thus it will review policy recommendations submitted to it by the ATO and by DMTs, and decide on Area policies and priorities within the framework of national and Regional policy. The Authority will decide guidelines on priorities and available resources so that DMTs may make realistic planning proposals. The Authority will subsequently review and challenge objectives, plans and budgets submitted to it by the ATO and the DMTs; resolve competing claims for resources between Districts; and agree a plan and budget for each District against which District performance will be assessed. The Authority will also ensure that the NHS services for which it is responsible, are planned and

co-ordinated with those of the local authority. Some of its Members will therefore have places on the joint consultative committees.

2.9. In addition, the Authority must control the performance of its officers at Area headquarters and in DMTs. To do so, it will receive reports on performance from the ATO and from each DMT, ensure that progress is according to agreed objectives, targets and budgets and that services are being provided with efficiency and economy, challenge DMTs on their performance and ensure that appropriate action is taken to correct unsatisfactory performance. The Authority will also appoint its principal officers, ie the officers of the ATO and DMTs and other officers who are direct appointees of the AHA. Based on its judgement of the capability of officers, the Authority will decide on the extent of delegation to them, and particularly on the extent of delegation to DMTs. To supplement these more formal methods of control, the Authority will also assess the adequacy of the services provided, through visiting by Members (subject to the functions of the FPC in relation to practice premises).

2.10. The Authority will receive advice from its officers, but it will also consult its professional advisory machinery and receive reports from the Community Health Council (CHC). .....

2.11. In addition to the FPC, the AHA will need to establish other committees. These will include appointments committees, and committees (with co-opted members) for visiting and performing duties under the Mental Health Act. Except for these, the AHA should avoid establishing standing committees of Members, with or without delegated powers, to deal with particular functions (such as finance) or professions (such as nursing) or with geographic areas (such as Districts). The AHA will be a small body selected for its capability. Its Chairman will act for the Authority between meetings, consulting with the officers. Certain Members may take an interest in the affairs of particular Districts, but in so doing they will not assume executive responsibilities. The AHA will itself take all the decisions on policy, planning and resource allocation and control the performance of its officers.

(b) THE ROLE OF THE DMT AND ITS OFFICERS

2.13. The members of the DMT will be responsible for managing and co-ordinating most of the operational services of the NHS. An essential part of their management task will be to formulate policies and plans for the services for which they are responsible. Thus the DMT will review the community's needs for health care and the provision of services within the District, in order to be able to assess the gaps in relation to needs. They will identify opportunities for improvements to services or changes in priorities, the aim being to provide the best possible patient care with the resources available, eg by shifting the balance between inpatient and domiciliary or residential care as appropriate. The DMT will discuss proposals for new or modified District policies with the ATO, either in response to new national or Regional policy guidance or in response to local innovation. The DMT will subsequently develop and submit their policy proposals to the AHA.

2.14. One of the ways in which AHAs can delegate major operational responsibilities to their DMTs, while maintaining overall control and holding them accountable, will be through the planning process. DMTs will submit to the AHA, after review and discussion with the ATO and in accordance with previously agreed guidelines, comprehensive annual planning proposals recommending objectives and priorities for the development of services, allocation of resources within the District budget, allocation of additional resources to finance future projects and programmes of action, including performance targets. As part of the subsequent review and approval by AHA members, the DMT will agree targets and budgets against which both the team and individual officers will subsequently be held accountable for their performance. The DMT will then be reasonably free to manage its services within the framework of the agreed plan. Resources may subsequently be re-allocated within limits of discretion prescribed by the AHA. The DMT will report on its performance to the AHA in relation to the agreed plan.

2.15. Members of the DMT will be responsible jointly to the AHA for the functions delegated to them. The team will have right of access to the AHA and to attend any AHA meetings relevant to its own business. It will present its own plans after review and discussion with the ATO and will report on and answer for its own performance. The team will normally be represented on these occasions by a spokesman or spokesmen.

(c) THE ROLE OF THE AREA TEAM OF OFFICERS

2.18. To be able to delegate executive responsibilities to DMTs, while maintaining control of performance and co-ordination between Districts, the AHA will require advice and support from an Area Team of Officers (ATO) at headquarters. The officers of the team will recommend Area-wide policies to the AHA and advise on its review of District policy proposals. The team will advise the AHA on planning guidelines for the DMTs based on a review of the Districts' identified needs for resources and national and Regional guidance. It will support the DMTs in the planning process. It will subsequently review District planning and budget proposals to test their consistency with established AHA policy and planning guidelines and advise the AHA on whether to challenge or approve District plans and on the final allocation of resources to Districts.

2.19. AHAs, will be required to prepare plans jointly with their matching local authorities. ATOs will be responsible for drawing up plans in conjunction with local authority chief officers for presentation to the joint consultative committees. Furthermore AHAs will have to submit their annual plans to RHAs for approval. ATOs will be responsible for preparing overall Area plans and resolving planning issues with the Regional Teams of Officers (RTO).

2.20. In addition the ATO will assist the AHA to control the performance of DMTs. For example, it will review performance information and do special analyses for the AHA, such as comparisons between Districts, to pick out issues on which the AHA should concentrate its attention. To carry out this function effectively the ATO will have monitoring and co-ordinating authority in relation to DMTs. This means that it will review and discuss District plans before their submission by the DMTs to the AHA. It will also measure, assess and report on District performance, and advise the AHA on corrective action.

2.21. The officers of the ATO will not be the managers of their District counterparts, nor will they be accountable for District performance, both sets of officers being directly accountable to the AHA. The status of officers of the ATO will however be higher than that of officers of the DMT, the difference in general increasing with the number of Districts and the size of the Area. An important aspect of the ATO's work will be to see that policies and plans agreed with the matching local authority, through the joint consultative committees, are implemented by DMTs. It will normally do this by using its monitoring and co-ordinating authority. Insofar as Area officers are accountable to the matching local education authority for the school health service, they will be able to direct the work of those officers in the Districts to whom they may assign some of their responsibilities.

2.23. In Areas not divided into Districts the functions described for the DMT and the ATO will be carried out by an Area Management Team (AMT), which, like a DMT, will include representative clinicians. The functions which will be performed by the AMT, in addition to those specified for the DMT, will be developing collaborative plans between the AHA and the local authority for consideration by the joint consultative committees, preparing the AHA's planning submission to the RHA and working on planning issues with the RTO on behalf of the AHA.

(d) THE ROLE OF THE RHA

2.27. The RHA has to delegate major executive responsibilities to its AHAs and to its Regional officers (for Regionally-deployed services), and focus the limited time of its Members on the important issues of policy, planning and resource allocation. The Authority can, therefore, be expected to review proposals on policies and priorities submitted to it by AHAs and by the RTO and decide on Regional policies and priorities within the framework of national policy. The Authority will establish planning guidelines for AHAs on priorities and available resources. Subsequently, it will review objectives, plans and budgets submitted to it annually by AHAs and by the RTO (for Regional services), resolve competing claims for resources between AHAs and agree targets with AHAs against which their performance can be assessed. In making planning decisions the Authority will call upon the advice of the Regional advisory committees.

2.28. In addition the RHA must control the performance of its AHAs and its Regional officers. To do so it will receive reports on AHA performance from each AHA, ensure that progress is according to plan and that services are being provided throughout the Region with efficiency and economy, challenge the performance of AHAs if necessary and ensure that appropriate remedial action is taken. It will also receive performance reports on Regionally-deployed services from its principal Regional officers. RHA Members, and the RHA Chairman in particular, will be expected to meet individual AHA Chairmen regularly to discuss the problems and opportunities of their Areas. The Authority will be responsible for appointing AHA Members, with the exceptions noted in paragraph 2.25,* and for appointing consultants and senior medical staff, with the exception of those employed by AHA(T)s.

2.29. A further important responsibility of the RHA will be to assist the Secretary of State to establish realistic national policies and priorities by providing him with information and advice on developments in the field. Thus RHA Chairmen will be expected to meet regularly with the Secretary of State and with senior officers of the DHSS.

* **The Chairman will be appointed by the Secretary of State. Some members will be appointed by the local authorities. Some appointments by the RHA will be made on the nomination of associated universities. Some first appointments to AHA(T)s will be made by the Secretary of State.**

APPENDIX C

THE NEW STATUTORY BODIES RESPONSIBLE FOR NHS ADMINISTRATION

	Title		Main Functions	Method of Appointment	Accountability
1.	Regional Health Authorities (RHAs)	a.	Regional planning and policies;	Chairman: by Secretary of State	Secretary of State
		b.	Allocation of resources between AHAs;	Members: by Secretary of State after consultation with l.a's, universities, health professions, TUC, voluntary organisations, other interested bodies	
		c.	Monitoring of performance of AHAs;		
		d.	Executive and operational functions which need to be undertaken on a wider basis than area (inc. responsibility for major capital works, metropolitan county ambulance services, computer services);		
		e.	Employment of medical consultants and senior registrars except in "teaching areas" (see 3 below)		
2.	Area Health Authorities (AHAs)	a.	Area planning policies;	Chairman: by Secretary of State	RHA (except for 2e, for which accountability is to the Secretary of State)
		b.	Operation of all services (except for those referred to at 1 d.)	Members (usual pattern): local authority(ies) (statutory minimum)	
		c.	Collaboration with local authorities	1 by RHA on nomination of university	

APPENDIX C

	Title	Main Funtions	Method of Appointment	Accountability
		d. Employment of staff for those purposes (except for those at 1 e.)	9 by RHA after consultation with professions and interested organisations (including federations of workers or organisations)	
		e. Arrangements with family practitioners		
3.	Area Health Authorities (Teaching) (AHA(T)s)	a. As for other AHAs	As for other AHAs but with 1 or 2 additional members appointed on the nomination of universities and with additional appointments of members with teaching hospital experience	As for other AHAs
		b. Provision for university of substantial clinical teaching facilities		
		c. Employment of consultants and senior registrars		
4.	Family Practitioner Committees (FPCs)	Administration of arrangements for family practitioner services	Chairman appointed by and from among members 11 members appointed by AHA (at least 1 to be a member of the AHA) 4 members appointed by matching local authority(ies) 15 members appointed by the professions involved.	Secretary of State AHA

DOCTORS, MANAGEMENT AND THE HEALTH SERVICES

The involvement of doctors in management decisions, whether as active clinicians or as specialists in community medicine, is an essential element in the reorganised health service. The Seminar will explore in depth and in various ways how doctors can be involved in management. This section presents some background material in the form of extracts from two recent documents. First, Chapter 2 of the Hunter Report on Medical Administrators explains why the development of community medicine is related to health service reorganisation, and discusses the issue of management and clinical autonomy. Secondly, Chapter 4 of the Grey Book on Management Arrangements deals in more formal style with the clinician's role in the management process and with the tasks of the specialist in community medicine at district, area and regional levels.

Department of Health and Social Security

Report of the Working Party on
Medical Administrators
(Chairman: Dr. R.B. Hunter)

HMSO 1972

CHAPTER 2

COMMUNITY MEDICINE IN A UNIFIED SERVICE

12. The major objectives in re-organising the administrative structure of the National Health Service might be briefly summarised as follows:-

i To unite the services so that at each level all are administered by a single authority and so that services which have been separated in the past can be integrated.

ii To develop higher standards in the promotion of health and in personal patient care.

iii To define needs locally, regionally and nationally; to set clear objectives and standards for health services and to measure performance aginst them, relating achievement to the use of resources.

iv To provide a framework which makes possible closer working links between the health services and the related services provided by local government.

13. Administrative re-organisation can only facilitate these developments; success or failure will depend on how the new authorities and their staff tackle the task of integration. Whilst unification will solve many existing problems, fresh problems, as well as new opportunities, are bound to arise, particularly in the period when new working relationships are being formed.

14. The National Health Service is unique in its scale and in the wide range of skills that it employs. No single group of staff can have more than a part of the knowledge and expertise required to make integration a success. Whatever responsibilities are formally given to different staff of the new

authorities, the co-operative effort of all will be essential. We believe, however, that community medicine specialists will have a key role to play at every level, because the aims of community medicine are so closely related to the objectives of a unified service.

15. The question of priorities is at the heart of health services administration at every level. The unified health service will make it possible for those running the service to look at deployment of health resources as a whole, and for the first time they will be in a position to try to achieve the best balance of services. The relative strengths of primary and specialist care, choice of priority between new and expensive forms of treatment and less spectacular procedures, the balance which should be struck between preventive medicine and the therapeutic services, between medicine which cures and that which alleviates suffering - these are just some examples of the issues which will concern the new authorities. Within a tripartite service many of these problems are academic as no single authority has the responsibility to decide or the power to act on its decisions. The community medicine specialist is not uniquely endowed to answer such questions, but because of his specialist training and experience he will be qualified to play a major part in the assessment of need, the analysis of existing services and the resolution of problems of choice.

16. Community medicine specialists will also be involved in promoting improvements in health services, particularly through better co-ordination, and in developing new services. At district level they will be actively encouraging co-ordinated working through their contacts with clinicians and other health service staff. At area, regional, and national levels, they will have a continuing concern with the organisation of health care and with promotion and co-ordination of research and development in this field.

17. The concern of community medicine with the general health of the population extends more widely than the direct responsibilities of the new health service authorities. In considering the organisation of health care, community medicine specialists must also have regard to the services provided by central and local government agencies and voluntary organisations, and to the need for full co-operation with these bodies.

20. Some doctors have reservations about the whole idea of "management" of the health services, particularly at a local level; these reservations frequently arise from a concern lest management will interfere with clinical

autonomy, a risk they think will be greater if doctors other than clinicians are engaged in management. We believe these views are mistaken and arise from confusion about the connections and differences between patient care on the one hand and the organisation of services on the other. There are, as we see it, two main aspects to this matter:-

i The doctor-patient relationship, in which the clinician cares personally for an individual to the best of his ability. We accept entirely the duty and right of clinicians to exercise their own clinical diagnostic and therapeutic judgment without individual judgments being subject to assessment by a managerial superior whether or not medically qualified.

ii The doctor's use of the resources of health services. Here the clinician is inevitably faced with constraints of many kinds - changing priorities in public policies (for example, on the care of the mentally ill), public opinion, and the claims of fellow clinicians. At a local level, the decisions of the area authority or district management on such matters as health centre development, the clearing of waiting lists, the redistribution of operating sessions or emergency admissions between hospitals, or the redistribution of consultative out-patient or nursing services between hospitals and general practice, will all act as external constraints on the freedom of action of clinicians, though not their freedom of judgment.

21. Clinicians will wish and need to be involved in these decisions. The specialist in community medicine must also be involved because his concern is essentially with the health of the community generally - the prevalence of ill-health and the need for health services - and with the investigation and evaluation of services provided. Clinicians and community medicine specialists in future are likely to meet more frequently at a local level, for example, in considering the outcome of particular health services in terms of benefits to the local population and in relation to the expenditure of the limited resources of the service. It will be their joint concern to see that the right decisions are reached by the appropriate authorities after an adequate presentation of all relevant available evidence.

22. The type of problem on which a collective approach involving clinicians, community medicine specialists and others will be necessary can be illustrated

by the example of the patient with a heart attack. Opinion on whether he should be kept at home or admitted to hospital has shifted from time to time. This kind of clinical problem is the responsibility of the doctors (the general practitioner and the consultant who may be called in), the patient, and his family. But what hospital facilities the community can provide is a question of priorities and resource allocation - across the whole service - which the appropriate health authority, after full consideration, will have to decide and implement. There is no chance whatever of being able to do everything that everybody would like, such as providing modern "coronary care" at hospitals that are within short and easy access of everyone. The unification of the health services will make possible for the first time the necessary comprehensive community examination of problems which must precede diagnosis and decisions on appropriate action. The knowledge and expertise of the community medicine specialist will be an essential contribution to the processes of examination, diagnosis and decision.

23. Or, again, the local committee of doctors, in the light of the analyses presented to it by the community medicine specialist, may recommend that the identification and control of high blood pressure should be the next step in preventive medicine for the local population. Together with the administrators, they would be concerned with budgeting such a programme, in terms of extra professional time, public education campaigns, possible methods of identifying "silent cases", and so on; it would then be for the area authority to decide how far it could support the proposal in comparison with other desirable advances - including the claims of numerous other people needing help and not receiving it who could be identified by the application of modern epidemiological techniques to clinical practice (for example, drug addicts and alcoholics, or vulnerable young children and old people).

24. In short, we believe that clinicians will have much to gain from a specialist in community medicine, expert on local needs and how far services meet them, assisting those who participate in the service to work more effectively, and advising on the health of the whole of the local population. We believe it would be against the interests of the profession as a whole and of the development of improved management within the health services if this is not generally recognised and accepted by clinicians.

Department of Health and Social Security

"Management Arrangements for the
Reorganised National Health Service"

HMSO 1972

CHAPTER 4

DOCTORS IN MANAGEMENT

4.1. Health services are heavily dependent on the dedication of doctors and the other healing professions. Doctors rely on sound management of the NHS to enable them to serve their patients more effectively and administrators and the management structure are there to support them in their work. So close is this inter-relationship that medical participation is essential in the management of the Service at all levels. This cannot be casual or conflicting but must be woven into the main design. Two kinds of direct medical participation are needed:

a. Doctors giving personal clinical services must bring to management accurate knowledge of current clinical activities, which largely determine the quantity and quality of calls made upon the Service. Resources to meet these calls are limited, and clinicians must therefore help to determine priorities among competing or conflicting claims and recommend and put into practice new ways of making the most of resources available. The first section of this Chapter discusses this issue.

b. The other kind of direct medical contribution will be provided by specialists in community medicine, who will be involved full-time in the planning and organisation of health services and in the provision of general preventive, screening and clinic services. They will be part of the management structure and their particular skills and knowledge have been reviewed in detail in the recent report of the Working Party on Medical Administrators (Chairman, Dr. R.B. Hunter). The second section of this Chapter outlines how their skills will be employed in the reorganised NHS, taking into account also the recommendations of the Working Party on Collaboration. It also refers to the doctors performing clinical work in the public health field and at present accountable to the Medical Officer of Health or Principal School Medical Officer.

4.2. The organisation appropriate for the one does not apply to the other, but the aim of both groups is the same and clinicians and specialists in community medicine have important, complementary and interdependent parts to play.

4.3. In addition to direct participation at the local level in the management process, doctors giving personal clinical service will contribute to management in two other ways. The first is as appointed Members of Health Authorities. The second is through the medical advisory committees which will play an important part in the planning process at these levels. It is still an open question whether doctors appointed as Members of an Authority can also be members of management teams jointly responsible to that Authority.

A. THE CLINICIAN'S ROLE IN THE MANAGEMENT PROCESS

4.4. The first duty of a clinician is to practise clinical medicine. But in doing so, every doctor makes demands upon resources, which have to be reconciled one with another, and his clinical actions interact in complex ways with the work of others, in both the health and personal social services. Clinicians are important innovators and their ideas must be picked up by management, upon which they therefore unavoidably make an impact. The benefits of this impact will be greatest (and the ill-effects least), if the clinicians can:

a. take an active part in the management process;

b. carry out their clinical duties with an understanding of the effects on other parts of the Service;

c. be committed to proposed changes and developments.

4.5. There is need, however, to evolve ways in which clinicians can participate in management effectively, without too great a diversion of their time and energies. This is best done through representative committees. It is therefore, proposed that in each District clinicians should form a District Medical Committee of representatives based on specialty or other groupings.*

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* The experience gained in recent years in hospital management has been useful in proving that suitably motivated representative committees based on functional groupings of doctors ('divisions') can be very successful.

4.6. In an integrated Service the parts played in management by clinicians working in hospitals and in general practice will be equally important, despite the fact that their contracts and organisation will be different. For instance, general practitioners will be under contract for the provision of general medical services with the Family Practitioner Committee, whilst consultants will have contracts of employment with the RHA or AHA(T). Both general practitioners and consultants exercise clinical autonomy* and are consequently their own managers. General practitioners manage their practice affairs and lay staff and this may at times include managing a trainee practitioner or assistant. Consultants will also manage their affairs and their subordinate medical staff, who will mainly be in training grades. Consultants by the nature of their work will have a greater need to co-ordinate their demands on resources than general practitioners, who must, however, also be given an equal opportunity to influence changing policies which can affect their mode of work and potential load.

(1) The District Medical Committee

4.7. The District Medical Committee (DMC), which should represent all general practitioners and hospital doctors and co-ordinate the medical aspects of health care throughout the District, should be fairly small, usually about a dozen. Each member would represent a group of doctors with common interests. The DMC would elect not more than two representatives (who might be chairman and vice-chairman) on to the District Management Team (DMT). Initially one representative should be chosen from general practice and the other from hospital practice, but both would be concerned with the whole range of medical matters. (The District Community Physician, whose role is fully described later, will have much to offer the DMC. He should attend meetings, ex officio, as of right and will be able to provide information and assist in its interpretation. Consideration should also be given to inviting the District Administrator and District Nursing Officer to attend meetings as appropriate.)

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* Clinical autonomy is defined (para 1.18.) as a situation where doctors and dentists work as each others' equals and they are their own managers. In ethics and in law they are accountable to their patients for the care they prescribe, and they cannot be held accountable to the NHS authorities for the quality of their clinical judgements so long as they act within the broad limits of acceptable medical practice and within policy for the use of resources.

4.8. The DMC will have both advisory and executive roles. It will make recommendations to the DMT based on the medical consensus view of priorities and plans. It will use its authority as a self-regulating body to persuade individual clinicians to co-operate in the implementation of plans agreed by the consensus. Its functions will therefore include:

a. Arriving at a consensus view on medical policies and priorities.
b. Considering opportunities to improve or develop medical services, especially involving co-operation among different specialties, and acting as the forum for agreement between consultants and general practitioners.
c. Endorsing the medical view expressed by doctors on health-care planning teams.
d. Ensuring that agreed policies and plans are communicated to individual consultants and general practitioners and persuading them to follow the consensus view.
e. Using persuasion to influence expenditure on certain budget items such as drugs, surgical supplies, etc.

(2) Role of DMC members of DMTs

4.9. The chairman and vice-chairman will lead the proceedings and activities of the DMC, and in so doing will express their personal views as well as those of the specialty grouping to which they belong.

4.10. As full members of the DMT, the DMC representatives will take part in all its discussions and decisions. As team members they are parties to the consensus decisions of the team and share in its collective duties and joint responsibility. But unlike other members of the DMT, they take their places not as heads of hierarchically organised professions but as elected representatives of equals. They must enjoy the confidence of their colleagues, so that they can speak for clinicians not as mere delegates, unable to commit their peers without reference back, but as representatives using the discretion vested in them as a basis for action. Only when clinicians give and accept the confidence of their colleagues in this way can they collectively play their full part in management decisions, many of which concern them vitally.

4.11. These representatives are active clinicians and their continuing credibility as representatives rests on this fact. They will therefore be able to spare only a part of their time for the business of the DMC and the DMT.

Moreover, they should not hold office on the DMC for too long; perhaps five years is as much as most of them will want to serve. Their terms of office should be staggered to ensure continuity of thought, both on the DMC and DMT.

4.12. In these respects the DMC representatives differ from the other medical member of the team, the District Community Physician, who deploys special skills and whose post affords him detailed knowledge of the health circumstances of the District. However, he will not expect to give clinical advice and is not empowered to speak for clinicians (see para 4.24 et seq). The roles of DMC representatives and of District Community Physician are therefore complementary and mutually reinforcing, giving medical advice and commitment across the whole field of District services.

(3) The representative structure

4.13. The DMC has been described as comprising representatives of specialty groupings of doctors in the District. The composition of these groupings will depend on local needs and preferences. But it appears from preliminary discussions that in many Districts the medical staff will wish to be represented in groupings similar to "Cogwheel"* divisions. Each grouping would elect a representative on to the DMC.

4.14. A method is needed to elect general practitioner representatives on to the DMC in equitable numbers. Various ways have been suggested:

a. Groupings of general practitioners might be formed in the District and each might elect its representative to the DMC. Since general practitioners have a common functional interest, these groupings would presumbably be geographically determined.
b. The Local Representative Committee, recognised by the Family Practitioner Committee (FPC) as representing the general medical practitioners of the Area, might nominate members to each DMC from the doctors practising in the District concerned.

4.15. The DMC might also contain representatives of junior doctors, certain specialised groups, such as the clinical doctors who have been working in the local authority services, and of dental practitioners, all of whom will certainly have an interest in the affairs of the functional or specialty groupings from which the DMC derives. Such a committee might be unduly comprehensive for some business and it may be thought necessary to form a sub-committee to co-ordinate the specialist divisions. Here much of the work

*Divisions of diagnostic services, geriatrics, medicine, obstetrics and gynaecology. psychiatry, and surgery (including dental surgery) are those most often seen in current hospital practice though there are many local variations.

currently done in hospital Medical Executive Committees could be carried out but even so some cross-representation from general practice is desirable. A parallel sub-committee for general practice might also be useful. Since an important aim of NHS reorganisation is to integrate and unify the Service, these sub-committees will not be rival factions but complementary offshoots of the united parent DMC in which the different medical disciplines play equal, co-operative parts.

(4) Medical advisory machinery

4.16. Although the structure and functions of medical advisory committees do not directly concern the management study they will be an important means by which the local clinicians can be consulted by the Area and Regional Authorities and their officers on crucial planning issues. The Committees must therefore be not only representative but balanced, so as to provide the best possible advice in the local circumstances.

4.17. In Areas of two or more Districts, these committees will be separate from the District organisation already described although no doubt partly derived from it. In an Area without a District (or a "single-District" Area) one single Area Medical Committee would fulfil the functions of both the DMC and the Area Medical Advisory Committee. For the latter role the membership may have to be augmented to ensure that Regional specialties active in the particular Area are covered.

B. COMMUNITY MEDICINE

4.18. The report of the Hunter Working Party on Medical Administrators has reviewed in detail the work of specialists in community medicine. This section outlines the ways in which their skills will be employed in the reorganised NHS. It is in two parts dealing with:

(1) The role in general of the specialist in community medicine.
(2) The role at different levels.
- The District Community Physician
- The Area Medical Officer
- The Regional Medical Officer

(1) Role of the specialist in community medicine

4.19. The specialist in community medicine must be more than an adviser. As argued in the Hunter Report, he must be a part of the management structure. Hence at all levels he will be an officer of the relevant Authority. He must be a be a member of the multi-disciplinary team at each level - District, Area and Region - since his specialist training is directly related to the work of these teams. Thus the specialist in community medicine will strengthen the team's competence in planning services, establishing health-care priorities and allocating recources, through his knowledge of community needs and the effectiveness of existing services. Like the other officers of the team he will be held accountable for meeting objectives related to the functions delegated to him. He will contribute to consensus decisions and share in the joint responsibility of the team .

4.20. A specialist in community medicine has three main functions; as a specialist, as an accountable manager, and as an adviser to and a manager of services for local government. But it must be made clear that in none of these roles does he have managerial authority over doctors giving personal clinical services.

Role as a specialist

4.21. A specialist in community medicine must stimulate the process of integration. He will provide a service to clinicians, acting as an additional link between them, and also as a link with the local authority services. He will assist clinicians by providing them with information on needs and advice on the effectiveness of alternative approaches to care.

Role in management

4.22. There are four main aspects of his role in management:

a. Planning

In the reorganised Health Service there will be greater emphasis on planning to improve and develop health-care services and to help achieve the best use of resources. The decisions on which plans to adopt and which priorities to recommend will be a team activity, but the planning responsibilities of each team member must be defined clearly. Doctors, both clinicians and specialists in community medicine, must play a fundamental part in the planning of

operational* health services. Clinicians will be engaged in planning through the DMC and its constituent divisions, through the health-care planning teams (see paragraph 2.48) and at Area and Region through the medical advisory machinery. Although the planning task will be different at the different levels, at each the specialist in community medicine will draw together the planning work of clinicians and will also contribute his epidemiological and other knowledge of local health circumstances. He will thus be accountable for the formulation and content of operational health-care plans. He will also be accountable for co-ordinating the activities of the other team members involved in the particular project and for seeing that the related operational and supporting services are complementary to it. He will often do this by co-ordinating the work of multi-disciplinary planning teams.

b. The developments and interpretation of information
Information of many kinds will be required by the team to make effective decisions, and the community medicine specialist will be one source of information. He will also have a role in designing information systems and providing the team and others with medical intelligence, e.g. analysis of needs, performance information and comparative analysis of different approaches to care. He will see that information on health care available to the team and others is of appropriate quality and relevance, and will play an important role in the interpretation of information.

c. The evaluation of service effectiveness
The specialist in community medicine will review relevant information on the provision of health care and assess the adequacy of that care, both in relation to needs and to possible alternative approaches. Such evaluation will often entail monitoring the implementation of plans or improvement projects, but it will not be in any way a clinical audit nor interfere with the clinical autonomy of individual clinicians.

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*"Operational" services have a medical content, as distinct from "support" services, e.g. laundries.

d. Co-ordination of preventive care services, and the deployment of clinical doctors in public health

At Area and District level, the specialist in community medicine will have particular responsibilities for co-ordinating preventive services, including vaccination, immunisation, screening, health education and chiropody. The specialist in community medicine will be responsible for ensuring that preventive services are available for the population as a whole, although some of these services will be increasingly provided by general practitioners with the attached health visitors and nursing staff.

Role in relation to local authorities

4.23. A more detailed working out of the functions of the specialist in community medicine in relation to local government will be found in the Collaboration Working Party reports and in circulars of guidance to be issued subsequently. A summary is included here to indicate the management arrangements to be made by the NHS to ensure that adequate advice and services can be given to matching local authorities in three main areas of work; environmental health, child health including school health, and personal social services.

a. Environmental health

Depending on the characteristics of the Area, either the District Community Physician or the Area Medical Officer (or one of his subordinates) will be appointed by the local authority as proper officer responsible for environmental health.*

b. School health service

The Area Medical Officer, or more usually a specialist in community medicine on his staff with a functional responsibility for child and school health as a whole, will be the adviser to the local education authority. The District Community Physician may carry out functions in relation to the school health service in accordance with policies agreed at AHA level under the direction of the Area Medical Officer and/or his child health specialist subordinate.

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* In AHAs which are coterminous with metropolitan districts, and in AHAs which are coterminous with non-metropolitan counties but which have no health Districts, the Area Medical Officer or a member of his headquarter staff would be the proper officer.

In AHAs coterminous with non-metropolitan counties where there are health Districts, the appropriate District Community Physician would be the proper officer to the local government districts. Finally, in AHAs coterminous with metropolitan districts which have health Districts, e.g. Birmingham, the District Community Physician might have functions within the field of environmental health, but the Area Medical Officer and not he would be

c. Personal social services
The Area Medical Officer, or a specialist in community medicine on his staff, will be responsible for advising the matching local authority.

(2) Role at different levels

4.24 The precise nature of the job to be done by the specialist in community medicine will be different at the different levels and these are considered below.

District Community Physician

4.25 The District Community Physician (DCP) will be a member of the DMT, which differs (except in the "single-District" Area) from teams at other levels by the inclusion of the two elected clinicians. These three doctors will have complementary roles and will work in mutual support. The District is the primary level of integration and District planning will play a major role in its achievement. The DCP will normally have functional co-ordinating responsibilities for health-care service planning (as described in paragraph 4.22a). In particular he will:

a. Identify opportunities to improve the operational health-care services so as to enable the best patient care to be provided with the resources available. He will continuously assess the community's need, maintain a health profile and keep the provision of services under review to identify gaps in relation to need.

b. Co-ordinate the work of the health-care planning teams, including drawing up plans for the DMT and evaluating the effectiveness of changes made.

c. Co-ordinate preventive services in the District, including maintaining operational control of clinical doctors in public health attached by the AMO to him (see paragraph 4.31).

d. Advise his consultant and general practitioner colleagues as a specialist in community medicine, making available his knowledge of the District and his expertise in the organisation of health care, and assist the DMC, particularly in relation to presentation and interpretation of medical intelligence.

4.26. In some Areas he may act as the proper officer to the local authority on matters relating to environmental health and may also perform functions in relation to the school health service.

4.27. There will only be one DCP but he will receive support from specialists in community medicine on the AMO's staff who have specialised fields of interest. In certain circumstances he may need to be assisted by an additional specialist or specialists in community medicine at District level, in which case special local arrangements will be made. He will also be assisted by an administrator, attached to him by the District Administrator, whose primary role will be to give him support and also to support the health-care planning teams in the District.

4.28. The DCP, as a member of the DMT, will be directly accountable to the AHA. In this capacity he will be subject to the monitoring and co-ordinating authority of the Area Team of Officers. Thus the Area Team of Officers, and the AMO in particular, will review District health-care plans, ensuring that they conform to established Area policies and priorities, and will monitor District performance. The DCP may also have functions, in relation to those aspects of the school health service for which the local authority remains responsible, assigned to him by the AMO as the medical adviser of the local authority. For these specific local authority functions (and for these purposes only) the DCP will be responsible, not to the AHA, but directly to the AMO. Finally, when the DCP acts as proper officer to a local authority district on environmental health, he will be directly accountable to that district authority.

Area Medical Officer

4.29. The Area Medical Officer (AMO) will be a member of the Area Team of Officers. As a member of the team he will share responsibility for advising the AHA, establishing guidelines for district planning, reviewing District plans, and monitoring and co-ordinating DMT's performance. His particular responsibilities regarding these team functions will be to:

a. Advise the team on health-care policies after review of national and Regional policy initiatives, policy proposals submitted by District management and the matching local authorities.

b. **Recommend to the team District planning guidelines on health-care policies, priorities and allocation of resources. He will later review the operational health-care aspects of the District planning proposals against these guidelines.**

c. **Assist the team to monitor and co-ordinate the performance of District management, particularly in relation to the functions of the DCP.**

4.30. **In addition, the AMO will co-ordinate the planning of operational health-care services with the matching local authority,** both **through** the joint consultative committees and by other less formal means.

4.31. In addition to these team responsibilities, the AMO will also have duties as an individual, such as to:

a. Advise the AHA on how to use their medical advisory machinery effectively, convening specialist advisory groups, if necessary, in consultation with the Medical Advisory Committee.

b. Promote research and studies related to the delivery and organisation of health care and the development of information systems.

c. Co-ordinate child health services, including the school health services, throughout the Area and provide advice to the education authority, or, with the agreement of the education authority, appoint a senior member of his staff for the purpose.

d. Advise the local authority social services department.

e. Organise the development of clinical doctors in public health. These clinical doctors are at present employed by local authorities to do clinical work for infants, pre-school children and in the school health service, but they are also concerned with family planning and screening. They are hierarchically organised, exercising professional discretion. In the reorganised NHS, they will be on the staff of the AMO and deployed by him to continue their present work. They may work at District level under the operational control of the DCP.

4.32. In an AHA(T) the AMO will provide certain personnel services for consultants and senior registrars in relation to their contracts. In all AHAs however, he will have personnel duties for medical staff below senior registrar.

4.33. The AMO will have a number of specialists in community medicine on his headquarters staff, who will be accountable to him. The number will vary according to the population served and its health and social characteristics. The specialists will have functional responsibilities as follows:

a. A specialist responsible for service planning, information and analytical studies, including epidemiology and statistical analysis.*

b. A specialist responsible for the planning and co-ordination of child health and liaison with the local education authority.

c. A small number of specialists responsible for (i) psychiatric services and liaison with the personal social services department on mental health problems; (ii) geriatric services and services to the chronic sick and disabled, and liaison with the local authority in relation to these services and (iii) co-ordination of the development of health centres.

4.34. He will also usually have on his staff a health education officer, a chief chiropodist and a chief speech therapist, all of whom will be accountable to him for deployment and performance within their own fields.

4.35. The AMO will be accountable to the AHA for functions delegated to him. He will not be accountable for District performance but will share monitoring and co-ordinating authority in relation to the DMTs and co-ordinating authority in relation to the Area Dental Officer and Area Pharmaceutical Officer, both of whom will, as heads of their professions, be directly appointed by the AHA. He may also co-ordinate some paramedical services. In addition he will be accountable directly to the local authority for those functions which he exercises on its behalf, e.g. to the education authority for its part of the school health service. Should he assign any of these functions to the DCP, he will remain responsible for the latter's performance in this limited sphere. Finally, the AMO will be regarded as the professional head in the Area of the specialty community medicine and will co-ordinate the community medicine team throughout the Area. In an AHA(T) he will have the benefit of working closely with the professional staff of the department of social or community medicine of the medical school.

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* This officer may also have responsibilities in relation to environmental health.

Regional Medical Officer

4.36. The Regional Medical Officer (RMO) will be a member of the Regional Team of Officers. In this capacity, he shares responsibility for advising the RHA, establishing guidelines for AHA planning, reviewing and challenging Area plans and monitoring the performance of Area Teams of Officers. He will have particular responsibilities for the Regional planning of operational health-care services. Specifically he will:

a. Co-ordinate the development of planning guidelines for AHAs on Regional policies and priorities for the operational health-care services. The guidelines will often be developed by multi-disciplinary service-planning teams, specialising in particular health-care groups.

b. Develop priorities for the distribution of medical specialties, the deployment of medical manpower and the scheduling of capital project starts.

c. Review AHA planning proposals for operational health-care services, particularly in relation to the agreed guidelines.

d. Co-ordinate the briefing stage of capital building projects with a significant medical content.

4.37. He will also have a number of individual responsibilities. He will, for example:

a. Ensure that the Regional medical advisory machinery can work effectively.

b. Provide the necessary personnel services for Regionally-employed medical staff.

c. Co-ordinate the development of postgraduate medical education and training throughout the Region, in liaison with the postgraduate dean.

d. Recommend priorities for the use of RHA funds available for health-care research, and co-ordinate community medicine research in liaison with the departments of social medicine and of general practice of the associated medical school and other universities.

e. Develop in conjunction with other disciplines adequate and effective health-care information systems throughout the Region.

4.38. The RMO will also monitor the extent and effectiveness of collaboration between the AHAs and the local authorities in relation to health-care planning.

4.39. The RMO will manage the Regional Pharmaceutical Officer and the Regional Scientific Officer and co-ordinate the work of the Director of the Regional Blood Transfusion Service. He will also have a number of specialists in community medicine accountable to him. The number will vary according to the size of population and other characteristics of the Region. These specialists will have functional responsibilities as follows:

a. Health-care service planning and monitoring. These medical officers will assist the RMO to co-ordinate the planning and monitoring activity, often supported by multi-disciplinary service-planning teams.

b. Capital building projects. This medical officer will co-ordinate the briefing stage of major capital building projects and give specialist medical advice to multidisplinary project teams.

c. Information services and research. This medical officer will be responsible for developing, introducing and maintaining effective health-care information systems throughout the Region.

d. Personnel and postgraduate medical education. This medical officer will be responsible for the administration* of contracts of Regionally-employed consultants and senior registrars and for liaison with the postgraduate dean and the postgraduate education committee. He will also be responsible for the general deployment of medical staff.

4.40. In addition to these functional responsibilities, each specialist in community medicine will also have expertise in subject areas, e.g. psychiatric services, and will advise the service-planning teams in their particular spheres of interest.

4.41. The RMO will be accountable to the RHA for those functions delegated to him. AMOs will not be his subordinates and he will not be accountable for their performance, but, as a member of the Regional Team of Officers, he will share monitoring, and co-ordinating authority over Area Teams of Officers.

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* He will work closely with the AMO of any AHA(T)

COLLABORATION BETWEEN THE NHS AND LOCAL GOVERNMENT

The lack of administrative unification between the National Health Service and certain services provided by local government (most notably the social services) means that special arrangements must be made to ensure that the appropriate degree of collaboration between the NHS and local government can be achieved. In this section we reproduce a summary of the main proposals of the Working Party on Collaboration, published in 1973; and we give a chart to show how health service and local government areas inter-relate. The extract from the Working Party's report was published before the NHS Reorganisation Act 1973 was passed, and readers should note that the statutory provisions outlined in the concluding section of the extract have now been incorporated in the Act.

Department of Health and Social Security

Welsh Office

A report from the Working Party on
Collaboration between the NHS and Local
Government on its activities to the end
of 1972

HMSO 1972

CHAPTER 2

SUMMARY OF MAIN PROPOSALS

2.1. As explained in chapter 1, the Working Party initially set up three sub-committees to consider the problems of collaboration in the fields of environmental health, personal social services and the school health services. These three sub-committees worked in parallel on the same problems, although different aspects acquired particular significance and were dealt with more or less fully according to the functions under consideration. For instance although all sub-committees considered joint consultative machinery and sharing of staff, the personal social services sub-committee paid particular attention to joint consultative committees, while the sub-committees on environmental health and the school health services concentrated more on the detailed arrangements for sharing professional staff. On several points, however, the proposals of a sub-committee are applicable only to that service. The Working Party, while broadly adopting the sub-committees' reports, rejected one or two of their conclusions. (These points of disagreement are noted at appropriate points in later chapters.)

2.2. The three sub-committees came to the same conclusions on the need for collaborative machinery between the two sets of authorities in the form of joint consultative committees and on the principles underlying the sharing of professional staff. This chapter draws together the proposals from these sub-committees and sets out the conclusions reached by the Working Party on them and on how the new health and local authorities could best collaborate.

2.3. Aspects of the collaborative machinery still being considered by the Working Party are indicated in footnotes. In addition the London sub-committee is considering how the general principles enunciated here by the Working Party can be applied to the special circumstances of local government and the National

Health Service in Greater London; the conclusions will be the subject of a later report.

2.4. The proposals of the Working Party in this report have, after consultation with outside interests, been approved by the Government and are embodied in legislation or will be embodied in guidance as appropriate. The closing sections of this chapter indicate the clauses in the NHS Reorganisation Bill which are based on the Working Party proposals. Briefly, however, the Bill lays down the general requirement to collaborate, the requirement to set up joint consultative committees and the statutory basis for the provision of goods and services and for the sharing of certain professional staff.

2.5. The Working Party's conclusions on the reports from the three sub-committees are arranged under the subheads below. On many points the conclusions merely endorse the proposals in summary of the sub-committees, and accordingly the subheads show references to the chapters where there are fuller discussions of the points at issue. There are references in this and subsequent chapters to documents, studies or legislative proposals which have since been superseded, changed or become law. Where appropriate, therefore, footnotes have been added to explain the latest developments.

Duty to collaborate

2.6. There should be a statutory obligation on the health authority and the corresponding local authority(ies) to collaborate so as to secure the health and welfare of the people of their areas. This proposal has been adopted, and is at present in Clause 10 of the Bill.

Joint consultative committees

2.7. A statutory requirement should be placed on the area health authority and the corresponding local authority(ies) to set up joint consultative committees. While flexibility to suit local circumstances would be necessary and desirable, the general pattern should be as follows:

a. In each metropolitan district a single committee covering environmental health, personal social services, education and other functions in respect of which health and local authorities collaborate. It would represent, on the local authority side, the metropolitan district council.

b. In each non-metropolitan county, one committee for education and personal social services representing, on the local authority side, the county council; and another, linked by common membership and collaboration between officers, for environmental health, which would include representives of all the local authority district councils and of the county council. Other arrangements for collaboration between the area health authorities and the local authorities could be brought under whichever level of consultative committee was appropriate.

2.8. This proposal has also been adopted and Clause 10 of the Bill requires the setting up of joint consultative committees.

2.9. Arrangements for joint consultative committees in non-metropolitan counties in relation to local authority housing functions were under review early in 1973. The Working Party reached the conclusion (which is under consultation) that housing matters should generally be considered on the committee for environmental health, on which there should be representation from the county council's personal social services committee; when however housing was considered in relation to social services, it should be considered on the committee for education and personal social services, with representatives from the district councils at that meeting.

2.10. Arrangements for joint consultative committees in health districts overlapping two area health authorities are still under consideration.

2.11. The joint consultative committees should be composed of members from the two sets of authorities; but a group of senior officers from the authorities would work in parallel with and support the committees. The Working Party did not think it desirable to specify the membership of the committees but thought the working groups of officers should include chief officers.

2.12. In England the regional health authority's concern with collaborative arrangements would be reflected by its representation on the joint consultative committees at area level.

2.13. The function of these committees would be to examine jointly the needs of each area, the plans of the two sets of authorities for meeting those needs and the progress made towards meeting them; and to advise on both the planning and the operation of the services in matters of common concern.

The objective would be to secure genuinely collaborative methods in working throughout the process of planning, and close and continuing co-operation between the officers of the two sides.

2.14. It would be unnecessary to provide formal machinery for resolving disputes which might arise on the joint consultative committees or between the authorities: each authority would, as now, be able to make its views known to the responsible central government department and to seek its good offices in finding a solution. The Secretaries of State for Social Services and for Wales will have powers to issue directions to the new health authorities. The Working Party, after full discussion, concluded, however, that there were strong arguments against seeking a similar specific power for Ministerial direction of local authorities in respect of collaborative arrangements in the personal social and environmental health services.

Publicity for the consultative committees

2.15. The recommendations of the joint consultative committees to their parent authorities should be made known to the public and the press in some suitable manner. The parent authorities should also report periodically to the Secretary of State on how each joint consultative committee was working.

2.16. The Working Party is considering further the arrangements for publicising the work of the committees and its conclusions will be the subject of a later report.

Collaboration at local government and health district level

2.17. The discussion here centred on environmental health and personal social service functions. For environmental health functions, proposals have been made for joint consultative committees and sharing staff. It was noted that administrative difficulties would be caused by the fact that health districts and local government non-metropolitan districts would not necessarily be coterminous.

2.18. On the social services side it was thought that operational boundaries of the two services should be brought into correspondence with one another to the greatest possible extent. Joint consultative committees should pay particular attention to problems of collaboration at district level to ensure that good working relationships were not impaired by organisational divergencies that were bound to exist.

2.19. In planning affecting the personal social services the health authority's district management team should communicate and consult with senior officers of the social services department in the local authority. While it would not be appropriate for such officers to act as members of the district management team, they should be drawn into consultation whenever issues of joint concern are under consideration.

2.20. Social service staff of local authority departments working at field level in the health districts should where appropriate be included in the health care planning teams which the AHA's district management teams are to set up to plan services to meet particular groups of needs, e.g. services for the elderly, children, and the mentally ill and mentally handicapped.

2.21. There would also be a need for close working between individual schools and the health staff at district level, as well as at other levels. One of the most important and continuing tasks of the joint consultative committees would be to ensure that such close working links were forged and maintained.

Co-option to local authority committees

2.22. Under the proposals in the Bill each area authority will include members appointed by the corresponding local authority, thus helping both the health authority and the local authority to understand each other's needs and policies. This would be reinforced if, in addition, other representatives of the area health authority participated in the local authority's consideration of matters of common concern. Local authorities should be strongly urged to co-opt to the committees concerned members or officers of the area health authority nominated by that authority. (Some Working Party members would have preferred to make this a statutory requirement.)

Power to provide goods and services

2.23. The health and local authorities should have full powers to provide goods and services to each other, including the services of staff and the use of premises and other facilities. The necessary provision has been included in Clauses 11 and 12 of the Bill, and the Working Party is looking in detail at the way in which such powers should be used. This will be the subject of a further report.

Sharing of professional skills

2.24. Staff with similar professional skills should be based in the same employing authority in the interests of the professions themselves and of the their patients and clients. This should promote professional cohesion, facilitate career development and training, secure the most effective deployment of scarce manpower resources, and encourage collaboration through interdependence in staffing. Medical, dental and nursing staff should therefore be based in NHS employment, including those needed for local authority functions. Social work staff including those needed by the NHS should be based in local authority employment. The area health authorities should make available to local authorities the advice and support of medical, dental, nursing and other health services staff. In particular they should be required by statute to make such staff available to enable local authorities to carry out their responsibilities in the field of personal social services, education and environmental health. Similarly the local authorities should be required by statute to make social work skills available to health authorities to enable them to carry out their health care functions. And each authority should be encouraged to look to the other for these skills. The Government has adopted these recommendations and included the necessary provision in clauses 11 and 12 of the Bill. The Working Party further recommended that the arrangements for each main service should be as follows:

(i) Staffing in relation to environmental health

2.24.1. The area health authority when invited by a local government district council to do so should arrange to second a doctor to each council as their adviser and "proper officer" on environmental health functions. Generally such a doctor would be working part-time for the district council and part-time for the area health authority. He would be appointed with the agreement of the district council who would give him a letter of appointment, as their "proper officer", under the provisions of the Local Government Bill (now Local Government Act 1972), thus making him accountable to the district council for the medical aspects of their functions. This doctor would in non-metropolitan districts usually be the appropriate health district community physician; in metropolitan districts and in some non-metropolitan districts he might well be the area medical officer or one of his staff.

(ii) Staffing in relation to personal social services

2.24.2. A statutory duty should be placed on local authorities to provide social work support for the health services and on area health authorities to provide medical and nursing support for the local authority social services. (Such duties are imposed by clause 11(3) of the Bill as regards the NHS and by clause 12(2) as regards local authorities.)

2.24.3. Local authorities should assume responsibility for social work in hospitals, but with a series of safeguards, both for the hospital service and for the hospital social workers affected. The management structure of both authorities should provide at senior level for an officer to have special responsibility for the professional support which his service is to provide for the other. Thus, in the area health authority a senior medical and a senior nursing officer should carry responsibility for ensuring the provision of, respectively, medical and nursing support to the local authority; and in the local authority a senior officer in the social services department should be responsible to the Director of Social Services for ensuring the provision of social work support for the health authority.

2.24.4. Joint consultative committees should pay particular regard to arrangements for sharing of skills; in particular, they should set up standing sub-committees to supervise arrangements for social work provision to the health services.

2.24.5. Two members of the health and social service sub-committee dissented from the conclusions on hospital social workers. Some Working Party members also thought that area health authorities should be allowed to appoint their own hospital social workers, without needing to secure the approval of the Central Department, in the same way that local authorities would be free to recruit their own medical and nursing staff. The necessity for doing so might arise where, exceptionally, an authority judged that the measure of support which it was offered was inadequate to enable it to discharge its statutory duties effectively. The Secretaries of State take the view that this is a matter for management within the NHS.

(iii) Staffing in school health services

2.24.6 There should be statutory obligations on the National Health Service: first to provide medical and dental inspection and treatment to school children,

on the lines of Section 48 of the Education Act, 1944; and, second, to provide the necessary services to assist local education authorities to carry out their health related functions.

2.24.7. A senior doctor responsible for child/school health should be appointed by the area health authority in agreement with the matching local education authority, whose responsibility it would be to give advice independently to each authority. A senior dental officer and a senior nurse in the area health authority should carry similar responsibilities for dental and nursing services.

2.24.8. It would be for such senior officers to ensure that the staff working in the school environment understood their responsibility to the school and to the child. Moreover the close integration of all those working together for the furtherance of the health of children in an educational context would be a prime responsibility of the joint consultative committees.

Collaboration and voluntary bodies

2.25. Joint consultative committees should review arrangements with the voluntary sector in their area and develop them to ensure that:

- overlapping demands on existing organisations are co-ordinated so that the organisations are used to the best advantage of the community;
- community resources of voluntary service are mobilised by joint efforts to provide the maximum contribution to services;
- the contribution which voluntary organisations can make in joint planning of services is fully taken into account.

Child health services

2.26. There should be an early review of future child/school health needs. (The Government adopted the proposal and has announced the setting up of such a review.)

Ambulance services

2.27. Local authorities should examine the economics of different systems of transport and decide the extent to which it would be convenient to make use of the ambulance services. Local authorities and the health authorities

should co-ordinate their services to ensure a comprehensive transport service and joint consultative committees should consider the development of the hospital car service to provide transport for social services as well as hospital patients.

Collection of information

2.28. The Working Party wished to draw the attention of the new local and health authorities to the importance of collecting and publishing information about comparative performance in collaborative working. It was accepted however that statistical information could not of itself give a complete picture of the extent or effectiveness of collaboration.

Statutory provisions

2.29. Clauses 10-12 of the NHS Reorganisation Bill (as introduced into the House of Commons) cover aspects of collaboration and assistance considered by the Working Party, and make the necessary statutory provision required by its recommendations. The effect of these clauses may be summarised as follows:

2.29.1. Clause 10 lays a general duty on health and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

2.29.2. Clause 10 also requires the setting up of joint consultative committees between local authorities and health authorities, and gives the Secretary of State powers to make Orders relating in particular to the structure of the committees, the appointment of sub-committees, the co-option of outside members, financial arrangements and the making of reports by the parent authorities.

2.29.3. Clause 11 gives the Secretary of State power (which he can delegate to health authorities) to supply goods, materials, facilities and services to local authorities. It also lays a duty on the Secretary of State to make available NHS goods, services and facilities, and in particular the services of medical, dental and nursing staff, so far as is reasonably necessary and practicable, to enable local authorities to carry out their functions relating to social services, education and public health.

2.29.4. Clause 12 enables local authorities to supply goods, services and facilities to the NHS, and in particular lays on local authorities the duty to make available to the health authority staff employed under the Local Authority Social Services Act 1970, so far as is reasonably necessary and practicable, to enable health authorities to carry out their health functions.

CHART 7

HEALTH SERVICE AND LOCAL GOVERNMENT TERRITORIES

HEALTH SERVICE	Comment	LOCAL GOVERNMENT
REGIONAL HEALTH AUTHORITY		No equivalent
No equivalent		METROPOLITAN COUNTY COUNCIL
AREA HEALTH AUTHORITY FAMILY PRACTITIONER COMMITTEE (corresponds exactly with AHA)	AHA boundaries coincide exactly with those of Metropolitan Districts and Non-Metropolitan Counties Joint Consultative Committees, composed of members of AHA and matching local authority, will operate at this level	METROPOLITAN DISTRICT COUNCIL (Socal services, housing, education, environmental health) NON-METROPOLITAN COUNTY COUNCIL (Social services, education)
DISTRICT MANAGEMENT TEAM HEALTH CARE PLANNING TEAMS COMMUNITY HEALTH COUNCIL	Where possible health district boundaries will match those of non-metropolitan districts, but will not always be the case	NON-METROPOLITAN DISTRICT COUNCIL (Housing, environmental health)
No equivalent		SOCIAL SERVICE AREAS (Non-statutory operational areas for social services)
SECTOR (Management co-ordination below district level)		No equivalent

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