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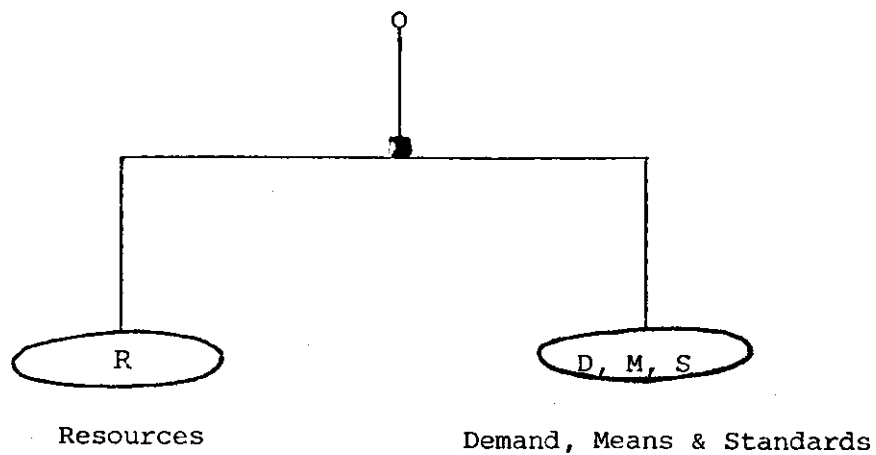
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# MANAGEMENT FOR CLINICIANS

## A HANDBOOK

Compiled by Professor Michael Warren  
Honorary Director, Health Services Research Unit,  
University of Kent at Canterbury.



## PREFACE

This Handbook has been compiled with the object of assembling together many of the more important recent official documents and informed statements about the organisation, planning and management of the National Health Service. The contents of the Handbook are therefore concerned essentially with supplying information, not with criticism or evaluation. The sections in Part 1 of the Handbook cover the major areas to be discussed at the Seminar. The first section discusses the involvement of clinicians in management, and the next section examines the demands and constraints facing providers of health care. This is followed by a section setting out the revised structure of the NHS. The final four sections are concerned with planning, the medical advisory machinery, industrial relations, and allocating money in the NHS. Part 2 of the Handbook presents some facts about the Region and Part 3 reproduces, FOR REFERENCE ONLY, some of the key circulars about the structure and management of the NHS.

There are a number of publications about the organisation and management of health services. The National Association of Health Authorities produces a useful handbook<sup>1</sup>, a section of which is quoted in its entirety in this Handbook. The Institute of Health Service Administrators have produced a small booklet entitled 'Getting It Right'<sup>2</sup> which describes and discusses many aspects of the current re-structuring.

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<sup>1</sup>National Association of Health Authorities, 1980, NHS Handbook, The National Association of Health Authorities (with the help of the King Edward's Hospital Fund for London). Available from The National Association of Health Authorities in England and Wales, Park House, 40 Edgbaston Park Road, Edgbaston, Birmingham, B15 2RT, price £6.00.

<sup>2</sup>N. Chaplin, 1981, Getting It Right? The 1982 Reorganisation of the National Health Service. The Institute of Health Service Administrators. Available from The Institute of Health Service Administrators, 75 Portland Place, London, W1N 4AN, price £2.75.

#### ACKNOWLEDGEMENTS

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- HC(82)1 Health Service Development. Professional Advisory Machinery

## GLOSSARY OF ABBREVIATIONS

AHA	Area Health Authority
AHA(T)	Area Health Authority (Teaching)
CHC	Community Health Council
CMO	Chief Medical Officer (DHSS)
CNO	Chief Nursing Officer
COHSE	Confederation of Health Service Employees
DA	District Administrator
DCMO	Deputy Chief Medical Officer (DHSS)
DCP	District Community Physician
DE	District Engineer
DFO	District Finance Officer
DGH	District General Hospital
DHMC	District Hospital Medical Committee
DHSS	Department of Health and Social Security
DHA	District Health Authority
DMC	District Medical Committee
DMO	District Medical Officer
DMT	District Management Team
DNO	District Nursing Officer
DNS	Director of Nursing Services (Community)
DPO	District Pharmaceutical Officer
DWO	District Works Officer
FPC	Family Practitioner Committee
HAA	Hospital Activity Analysis
HC	Health Circular
HD	Health District
HMSO	Her Majesty's Stationery Office
HIPE	Hospital In-patient Enquiry
HN	Health Notice
IHSA	Institute of Health Service Administrators
JCC	Joint Consultative Committee
JLC	Joint Liaison Committee
LMC	Local Medical Committee
MAC	Medical Advisory Committee
MEC	Medical Executive Committee

GLOSSARY OF ABBREVIATIONS (continued)

NAHA	National Association of Health Authorities
NALGO	National Association of Local Government Officers
NHS	National Health Service
NUPE	National Union of Public Employees
OPCS	Office Population Censuses and Surveys
PAC	Professional Advisory Committee
PNO	Principal Nursing Officer (Hospital)
RA	Regional Administrator
RAWP	Resource Allocation Working Party
RCCM	Regional Committee for Community Medicine
RCHMS	Regional Committee for Hospital Medical Services
RCN	Royal College of Nursing
RDO	Regional Dental Officer
RFO	Regional Finance Officer
RHA	Regional Health Authority
RHJSC	Regional Hospital Junior Staff Committee
RMAC	Regional Medical Advisory Committee
RMC	Regional Manpower Committee
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
RPAC	Regional Professional Advisory Committee
RPC	Regional Planning Committee
RPGMEC	Regional Postgraduate Medical Education Committee
RPO	Regional Pharmaceutical Officer
RSG	Regional Strategies Group
RT	Regional Treasurer
RTO	Regional Team of Officers
RWO	Regional Works Officer
SMR	Standardised Mortality Ratio
TUC	Trades Union Congress

SECTION 1

CLINICIANS AND MANAGEMENT

For many years there has been concern about the organisation of medical work in hospitals and, more widely, about the means to involve hospital medical staff and general practitioners in the management of the NHS. The need for such involvement was set out in the paragraphs quoted below taken from "Management Arrangements for the Reorganised National Health Service", HMSO, 1972, (known by its friends and enemies as 'The Grey Book').

"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.
- (b) The other kind of direct medical contribution is provided by specialists in community medicine<sup>1</sup>, 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. ....

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<sup>1</sup>Community medicine is defined by the Faculty of Community Medicine as being concerned with the promotion of health and the prevention of disease, with the assessment of a community's health needs and with the provision of services to communities in general and the special groups within them. It complements the concerns of clinical medicine with the health of individual patients. Epidemiology is the science fundamental to the study and practice of community medicine.



There is need to evolve ways in which clinicians can participate in management effectively, without too great a diversion of their time and energies.

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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) [to be the teaching districts]. 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.

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The management arrangements required for the NHS are different from those commonly used in other large organisations because the work is different. The distinguishing characteristic of the NHS is that to do their work properly, consultants and general practitioners must have clinical autonomy, so that they can be fully responsible for the treatment they prescribe for their patients. It follows that these doctors and dentists work as each others' equals and that 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.

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The essential task of management in the Health Service is to organise limited resources - human, financial and physical - so as to enable the community to be provided with the best possible standard and balance of care. This entails establishing priorities between conflicting claims. The demands which are made on resources by clinicians in providing care have to be reconciled one with another. The actions of clinicians also interact in complex ways with the work of other people in the Health Service and personal social services. Also, clinicians are an important source of innovation, in both medical practice and general approaches to care, and their ideas must be evaluated - and, where appropriate, translated into action by management."

(From paragraphs 4.1, 4.5, 4.6, 1.18 and 1.19 of  
"Management Arrangements for the Reorganised NHS,  
HMSO, 1972.)

SECTION 2SETTING THE SCENE

In February 1981 the Secretary of State for Social Services set out the main policies and priorities for the re-structured NHS in a handbook entitled "Care in Action" (HMSO). The opening chapter (most of which is reproduced below) set the scene; subsequent chapters discussed prevention, the voluntary sector, the statutory services, priority groups and services (elderly people, services for the mentally ill, services for the mentally handicapped, services for disabled people, services for children and the maternity services) and partnership with the private sector.

DHSS "CARE IN ACTION" HMSO 1981

## 1.

SETTING THE SCENE

1.1 New health authorities and their partners in local government will face a common challenge in providing the best possible services within the limits of available resources. Local circumstances will vary but certain national trends and constraints will affect all to some degree. This chapter outlines the more important of these factors, and is intended to help chairmen and members see the national context in which they will have to establish local priorities within the guidance set out in later chapters.

POPULATION

1.2 In mid-1980 the population of England was nearly 46.5 million, and it is expected to grow by almost one million over the next ten years. Figure 1 shows the latest available breakdown by age groups, and figure 2 the changes over the last decade and those projected in the next for each group. The changes which will have most effect upon the health and personal social services are:

- (a) Increase in the numbers of very elderly people. The numbers of people aged 65 and over will continue to increase but at a much slower rate than in the past. There will be about 7.2 million at the end of the decade compared with 7.0 million now. However, within this group the numbers aged 75-84 are projected to increase by nearly 300,000 to 2.4 million and very elderly people aged over 85 by 150,000 to 625,000. People in these age groups make significantly greater use of both health and social services than younger people.

Figure 1: The percentage of the population in the key age groups: England 1979

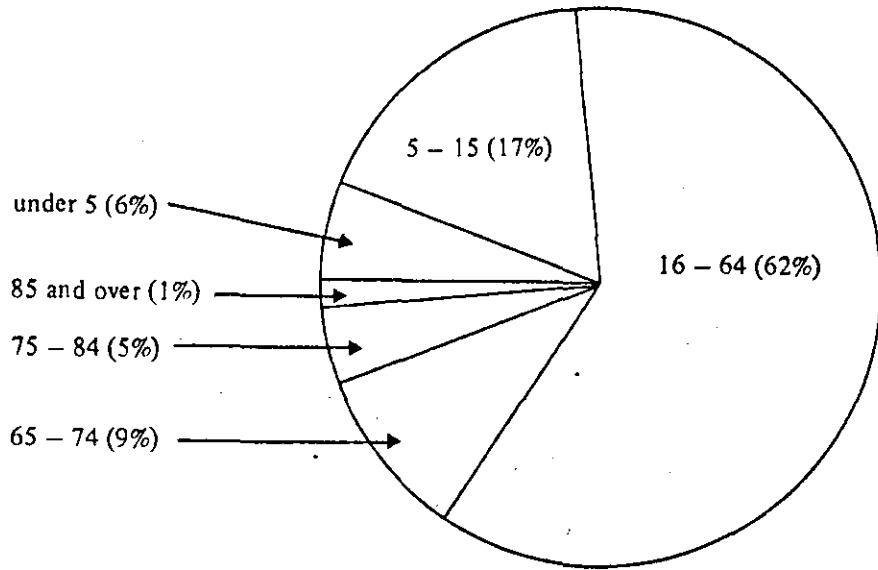
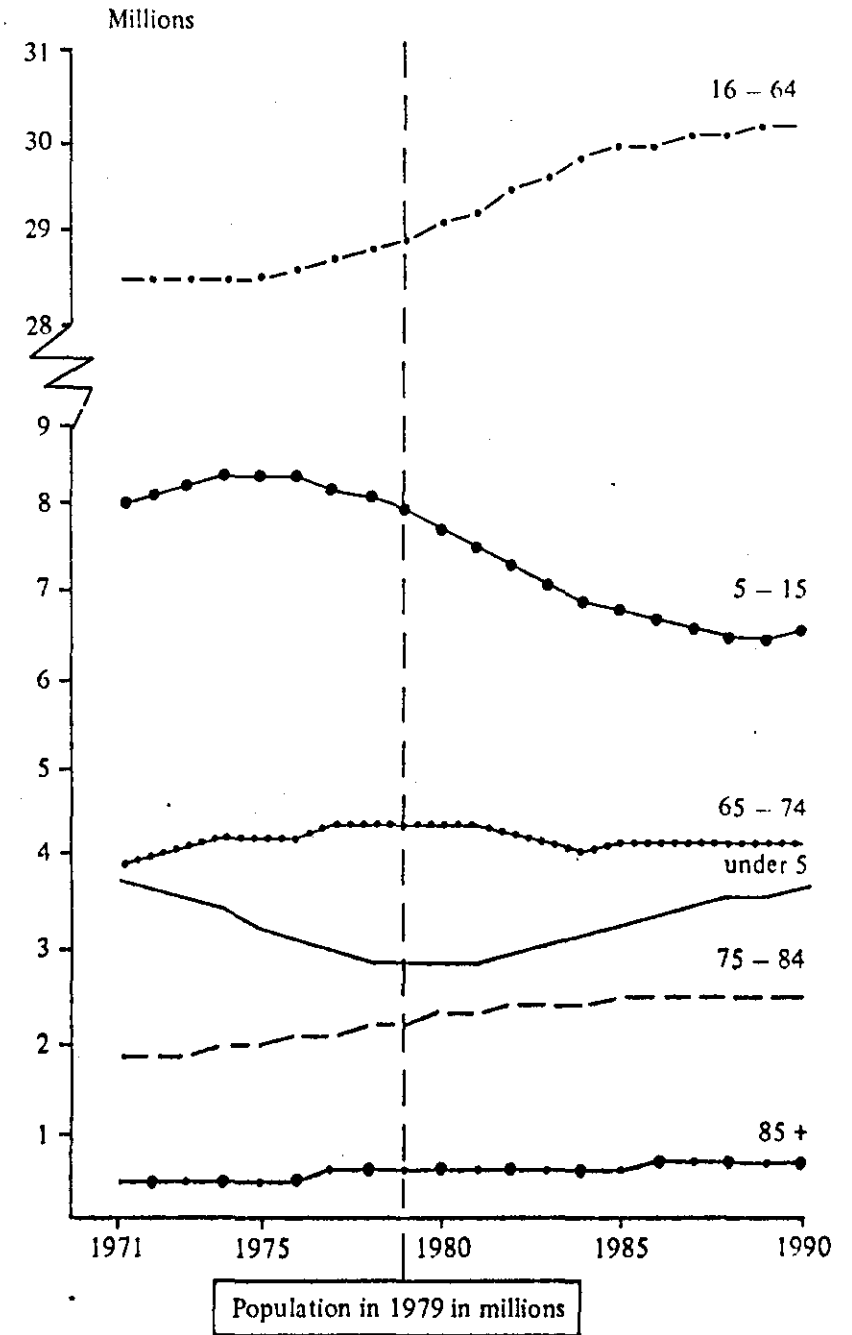


Figure 2: Population estimates 1971 - 1979; 1979 based projections to 1990



- (b) Increase in the numbers of young children. In 1978 the birth rate began to rise again after falling for 13 years and the latest figures show that this trend is continuing. By 1990 the number of children under five is projected to be 800,000 higher at 3.6 million and the annual number of births may rise by 130,000 to 750,000.

Over one million people with physical or sensory handicaps are registered with local authorities - a number which certainly understates the total who have a significant disability. Physical, sensory and mental impairments increase with age and there are therefore important consequences for the health and personal social services from this increase in the numbers of very elderly people.

#### FINANCE

1.3 Planned health spending has in total been largely protected from recent public expenditure economies. But constraints will be tight for the foreseeable future; decisions have yet to be taken as to the amount that can be devoted to health beyond 1982/83. Against this background the document emphasises the need to obtain the best value for money in terms of health care for the public, and the need for a proper ordering of priorities. This is fundamental; when resources are constrained, this need becomes more important than ever. Recent and present expenditure on health and personal social services is summarised in table 1. The Government's expenditure plans for the period up to 1983/84 will be published in March. Currently the position is as follows:

- (a) NHS spending. Net spending on the NHS in 1980/81 accounts for about 11 per cent of all public expenditure. Over two-thirds of this goes on current expenditure in the hospital and community health services and most of the remainder on the family practitioner services. Although the Government's aim is to reduce public spending overall, the expenditure plans published in the last Public Expenditure White Paper<sup>1</sup> allowed for a growth in gross NHS spending in England from £7,820m in 1978/79 to £8,390m in 1982/83 (November 1979 prices), an increase in real terms of some 7 per cent. In November 1980 the Chancellor of the Exchequer announced that £25m of the planned growth for 1981/82 should be found through efficiency savings. Decisions for further years have not yet been announced.

- (b) Local authority personal social services: current spending. Local authorities are expected to contribute to the planned reduction in public expenditure and to conform to the Government's target for spending overall. No service can be exempt from the search for economies, although it is for authorities to determine the distribution of their spending between services. Net current expenditure on the personal social services rose by more than 4 per cent in real terms in 1979/80 to £1,310m (provisional) and the revised budgets for 1980/81 submitted in August 1980 suggest that the level may have been maintained this year, when local authorities were asked to reduce their overall net spending to about 2 per cent below that for 1978/79. It remains to be seen what decisions authorities will make on priorities in subsequent years, in which they have been asked to reduce their total net expenditure further (in 1981/82, to 5.6 per cent below the 1978/79 level).
- (c) Local authority personal social services: capital spending. Net capital spending in 1979/80 rose by some 3½ per cent in real terms to £59m. A somewhat similar out-turn is expected in 1980/81. In 1981/82 a new system of capital expenditure controls comes into operation under which allocations have been made in five major service blocks of which the personal social services is one. Bids for personal social services capital spending exceeded the planned total by about 13 per cent and allocations to some authorities have had to be restricted, but as individual authorities will have freedom to transfer capital resources between service blocks the final outcome is uncertain.
- (d) Joint Finance. To assist collaboration between health and local authorities a portion of health expenditure is set aside nationally each year for projects in the personal social services which are also of benefit to the health services. In 1980/81 this sum is £54m; increasing to £56m in 1981/82 and £58m in 1982/83.

TABLE I  
HEALTH AND PERSONAL SOCIAL SERVICES  
GROSS EXPENDITURE

<i>England £m at 1980 survey prices</i>				
	1978/79	1979/80	Provisional Outturn 1980/81	Planned 1981/82
<i>Health</i>				
Hospital and community health services				
-current	5,405	5,407	5,510	5,635
-capital	434	395	418	454
Family practitioner services	1,698	1,704	1,744	1,789
Central health services	287	304	339	341
<b>Total health</b>	<b>7,824</b>	<b>7,810</b>	<b>8,011</b>	<b>8,219</b>
<i>Personal Social Services<sup>1</sup></i>				
Local authority				
-current	1,438	1,486	1,370	1,364 <sup>2</sup>
-capital	57	59	70	69
Central government	7	8	9	8
<b>Total PSS</b>	<b>1,502</b>	<b>1,553</b>	<b>1,450</b>	<b>1,442</b>
<b>Total HPSS</b>	<b>9,326</b>	<b>9,364</b>	<b>9,460</b>	<b>9,662</b>

<sup>1</sup>Figures for 1980/81 and 1981/82 are tentative as distribution of total local authority expenditure is for individual local authorities to determine.

<sup>2</sup>Expected to be increased above 1980/81 by a transfer in respect of the Urban Programme. Discrepancies in totals are due to rounding.

#### HEALTH SERVICE BUILDINGS

1.4 In the last twenty years major new construction work has been carried out on about 300 hospital sites, but a significant proportion of hospital care is still provided in old and outmoded buildings. However, health authorities are currently planning to carry out by 1990 work on 350 hospital sites with a contract value in each instance of over £1m. The policy of previous governments has been to concentrate most of the general acute services, together with some geriatric and mental illness services, in district general hospitals. In recent years some of these district general hospitals have been planned to reach well over 1,000 beds. The Government favours a return to smaller district general hospitals, supported by local hospitals which will include both acute and longstay services. A consultative document, "The Future Pattern of Hospital Provision in England"<sup>2</sup>, was published in May 1980. Comments are being considered.

#### MANPOWER

1.5 Nearly one million people work in the NHS and 200,000 in social services departments of local authorities. The main staff groups employed in the NHS and the change from 1976 to 1979 are shown in table 2. Some two-thirds of administration and clerical staff are engaged in operational activities mostly in support of clinical activity. The remaining one-third, together with small

proportions in other disciplines are engaged in management. The numbers so engaged have been reduced, and it is the intention to reduce still further the proportion of NHS expenditure devoted to management. Table 3 shows the change in the numbers of social workers and other staff employed in local authority social service departments.

TABLE 2  
NHS DIRECTLY EMPLOYED STAFF  
ENGLAND

Category of Staff	'000 whole-time equivalent		Average annual % change
	1976	1979	1976/79
Medical and dental staff <sup>1</sup> : hospital, community and school health medical and dental staff and locums	34.0	37.1	2.9
Nursing and midwifery staff: hospital, community, school health, blood transfusion and agency staff	341.7	358.5	1.6
Professional and technical staff: hospital pharmacists and opticians, scientific, technical, dental ancillary and remedial staff	52.5	60.1	4.6
Works professional staff	5.3	5.6	1.5
Maintenance staff	19.7	20.1	0.7
Administrative and clerical staff: administrators; clerical and secretarial staff in management or operational services; support service managers; etc	98.5	103.0	1.5
Ambulance staff: ambulance officers, control assistants and ambulancemen/women	17.2	17.1	-0.2
Ancillary staff and others: catering, laundry, domestic, portering etc staff	173.6	171.9	-0.3
<b>Total Employed Staff</b>	<b>742.5</b>	<b>773.4</b>	<b>1.4</b>

<sup>1</sup>Excludes hospital practitioners, part-time medical officers (clinical assistants), general medical practitioners participating in hospital staff funds and occasional sessional staff in the community health services.

TABLE 3  
STAFF EMPLOYED IN LOCAL AUTHORITY SOCIAL SERVICES  
DEPARTMENTS  
ENGLAND

	'000 whole-time equivalent		Average annual % change
	1976	1979 (Provisional)	1976/79
Social workers <sup>1</sup>	21.2	22.8	2.44
Other local authority social services staff <sup>2</sup>	162.7	171.8	1.83
<b>Total</b>	<b>183.9</b>	<b>194.6</b>	<b>1.90</b>

<sup>1</sup>"Social workers" includes senior social workers, other social workers, community workers, trainee social workers and social work (welfare) assistants.

<sup>2</sup>Directing, management, administrative, clerical and support, residential day care and other staff.



VOLUNTARY SERVICES

1.6 Most people who need help or care look first to family and friends. Nine out of ten elderly people live in the community, supported in this way where necessary. Voluntary resources too are large. The Wolfenden Committee<sup>3</sup> estimated that in 1976 the size of the volunteer force in personal social services in Great Britain was roughly equivalent to 250,000 full-time staff - more than the total employed in all social services departments. There are, in addition, some tens of thousands of paid staff in voluntary organisations. The Committee put the total income of voluntary organisations in the fields of social and environmental services at about £1,000m mostly from private sources. In the health field volunteers, co-ordinated by about 300 organisers of voluntary services, make a valuable contribution in hospitals, in care of the sick and handicapped in the community, in first aid and in fund-raising.

PRIVATE HEALTH CARE

1.7 Private health care includes private treatment for acute medical or surgical conditions, long-term nursing home care, general practitioner services and private prescriptions for drugs and dressings. It amounts to about 3 per cent of total spending on health care.

1.8 About 31,500 beds in England are provided in private hospitals and nursing homes which may be profit-making or charitable organisations. They include about (a) 5,500 acute beds in hospitals;

(b) 3,500 beds in hospitals or nursing homes for those suffering from mental illness or disability; and

(c) 22,500 long-stay beds in hospitals and nursing homes, primarily used by elderly people.

In addition, about 2,400 beds in NHS hospitals are designated as "pay beds", and private out-patient facilities are available in many NHS hospitals. In 1979 over 90,000 people were treated in pay beds and there were over 160,000 private out-patients or day care attendances. To put these figures in perspective, about 130,000 acute beds are provided in NHS hospitals, treating annually about 4 million patients.

1.9 About half of those who seek private acute hospital medical or surgical treatment are covered by medical insurance. At the end of December 1980 3.6 million people were covered by private medical insurance, often through group schemes.

Textual References

- <sup>1</sup>The Government's Expenditure Plans 1980/81 to 1983/84. Cmd 7841. HMSO, 1980.
- <sup>2</sup>DHSS. The Future Pattern of Hospital Provision in England - A Consultation Paper. DHSS, 1980.
- <sup>3</sup>Committee on Voluntary Organisations. The Future of Voluntary Organisations. Croom Helm, 1977.

Other References

DHSS. Health and Personal Social Services Statistics for England, 1978. HMSO, 1980.

Copies of publications referred to above and elsewhere in this document may be obtained from NHS or other libraries. The Department publishes "Current Literature on Health Services", a monthly listing of new official, commercial and NHS monographs, periodical articles and research reports; and "Health Trends", a quarterly periodical on subjects relevant to the management of medical work and administrative planning in the NHS.

SECTION 3THE STRUCTURE OF THE NATIONAL HEALTH SERVICE

In December 1979 the Department of Health and Social Security and the Welsh Office published a 'consultative paper' on the structure and management of the National Health Service in England and Wales, entitled "Patients First" (HMSO). The consultative paper sets out the objectives and shape of the re-structured NHS. The following extracts are taken from the paper.

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"1. The report of the Royal Commission on the National Health Service, published on the 18th of July this year as Cmnd.7615, provided the first comprehensive review of the NHS since the Guillebaud Committee reported in 1956. The Commissioners received much evidence critical of the NHS, but concluded - 'we need not feel ashamed of our health service and there are many aspects of it of which we can be justly proud'. The Government, while accepting this assessment, believes that the Service can be improved by changes which will make it more responsive to patient needs and a better service to work for. This consultative paper points the way.

2. The Royal Commission made over a hundred recommendations, covering a wide range of issues. As Parliament was told when the report was published, the Commission's recommendations on many matters are being studied by the Health Departments through the ordinary machinery. This paper deals only with the structure and management of the Service in England and Wales. If these are not right, then nothing else will work properly.

THE GOVERNMENT'S APPROACH

3. The first objective of the 1974 reorganisation, the integration of services for patients in the hospital and in the community, has been substantially achieved. But there has been widespread criticism of the 1974 changes which the Royal Commission summed up as:

- too many tiers;
- too many administrators, in all disciplines;
- failure to take quick decisions;
- money wasted.

4. The Government is in no doubt that these criticisms are well-founded and that morale in the Service has suffered as a result...

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5. The NHS exists to serve patients. The Government's main objective is therefore to establish a structure for the Service which will enable health services to be planned and managed most efficiently, and within which decisions can be taken quickly by those who are close to and responsive to the needs of patients. Changes in the structure alone will not be sufficient; the Service must be managed in a way that enables those with prime responsibility for providing the services to patients to get on with the job.

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7. ... the Government's approach is to propose only those adjustments to the present structure which experience suggests are needed to achieve better services to patients. Its proposals have four main elements:

- (a) the strengthening of management arrangements at the local level with greater delegation of responsibility to those in the hospital and in the community services (paragraphs 10-13); \*
- (b) simplification of the structure of the Service in England, by the removal of the area tier in most of the country and the establishment of district health authorities (paragraphs 14-24); \*
- (c) simplification of the professional advisory machinery so that the views of clinical doctors, nurses and of the other professionals will be better heard by the health authorities (paragraphs 34-35); \*
- (d) simplification of the planning system in a way which will ensure that regional plans are fully sensitive to district needs (paragraph 36). \*

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#### MANAGEMENT IN THE HOSPITAL AND IN THE COMMUNITY SERVICES

10. The main structural change proposed is the establishment in England of district health authorities. But the Government's aims will not be achieved unless structural changes are complemented by changes in manage-

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\* Not reproduced here.

ment arrangements. It shares the view of the Royal Commission that there has been a decline in the quality of hospital administration and that there is a clear need to simplify and improve the management of the hospital and the community services.

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12. The Government believes that the maximum delegation of responsibility to those in the hospital and community services, within policies determined by the district health authority, matched where necessary by a strengthening of management at hospital level, is the most important single change necessary. The Government proposes to issue advice to authorities on these matters; its present view is that authorities should develop their management structures on the following general principles, which it believes to be likely to lead to quicker and more effective decisions:

- (a) There should be maximum delegation of responsibility to hospital and community services level. For each major hospital, or group of hospitals, and associated community services, there should be an administrator and nurse of appropriate seniority to discharge an individual responsibility in conjunction with the medical staff.\*
- (b) There should not be a managerial tier between hospital and community services level and district headquarters; the senior administrator and nurse in the hospital and the community services should wherever possible be directly responsible to the district administrator and nursing officer respectively. This implies that, provided individuals of required quality are available, officers at hospital and community services level will often be of more senior grading than is usual now, and there will be no sector tier.

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\* In respect of management arrangements for psychiatric services, account should be taken of the recommendations of the Working Group on Organisational and Management Problems of Mental Illness Hospitals. This Group's report is being circulated to authorities and other interested bodies. (The Nodder Report).

- (c) Wherever possible staff working within hospitals in non-clinical support functions should be accountable to the hospital administrator rather than to district level managers. In general there should be no line management hierarchy above hospital level; there may need to be a few exceptions, and there will be discussions with the NHS to identify which these should be.

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#### FAMILY PRACTITIONER COMMITTEES

25. The Royal Commission recommended that family practitioner committees should be abolished and their functions assumed by health authorities. The Government does not believe that there is any major advantage that would justify upsetting the present system, and has decided that the present arrangements for the administration of family practitioner services should be retained. The Government has therefore introduced legislation to amend the National Health Service Act 1977 to make it possible for one family practitioner committee, where appropriate, to cover more than one district health authority. Separate consultations will be held later about the membership, funding and staffing of those family practitioner committees which relate to two or more district health authorities.

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#### PROFESSIONAL ADVISORY MACHINERY

34. The Royal Commission recommended that the health departments should consider with the professions concerned the best way of simplifying the present professional advisory committee structure. The Government agrees that this is necessary in respect of the medical advisory machinery, especially to ensure that the doctor's voice is fully heard by the health authority, and it has established a working party under the chairmanship of the Chief Medical Officer, with the following terms of reference:

'In the light of possible changes in NHS structure, to consider the current arrangements for the involvement of the medical profession in the strategic planning and operational management of the NHS with particular reference to the role of medical advisory and representative committees, and to make recommendations.'

Similarly the Chief Dental Officer will discuss with representatives of the dental profession what arrangements would be appropriate for dentistry.

35. The same need exists for nurses and midwives. Professional advisory machinery for nurses and midwives is set up under a model constitution agreed by the established Steering Committee representative of nurses and midwives professional organisations. The Chief Nursing Officer will remain in close contact with this Steering Committee in their consideration of changes to improve the existing machinery, and to make the necessary adjustments to the constitution in the light of proposed changes in NHS management arrangements.

#### PLANNING

36. The discipline of planning in both the Department and the NHS has demonstrated its value and is to be retained. It provides the opportunity for the Government's policies and priorities to be reconciled with available resources. It also enables health authorities to appraise systematically their own services and to influence the Government. But existing planning arrangements are over-complicated and bureaucratic. A simpler planning system is being worked out and will be discussed with the Service.

(See Section 4 of this Handbook).

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Since the publication of "Patients First", DHSS have issued a number of Health Circulars and Health Notices setting out the final decisions about the structure and management of the NHS. The more important of these circulars and notices (which are reproduced in Part 3 of this Handbook) are:

- HC(80)8. Health Service Development - Structure and Management.
- HC(81)6. Health Services Management - The Membership of District Health Authorities.  
(This includes an appendix on the role of the DHA and its members.)
- HN(81)34. Health Service Development - Management Arrangements Within Districts: RHA's Role.
- HN(81)10. Health Service Development - Arrangements for the Administration of Family Practitioner Services: A Consultative Paper.
- HC(81)15. Health Service Development - Community Health Councils.

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#### Department of Health and Social Security

At the top of the structure is the Secretary of State for Social Services in the Department of Health and Social Security (diagram 1). The DHSS is responsible for three major services - the NHS, personal social services (part of local government) and social security. The two main functions of DHSS in relation to the NHS are:-

- Allocating resources to regions
- Deciding policy and priorities

#### Regional Health Authorities

There are fourteen regional health authorities in England. Each authority consists of about twenty members appointed by the Secretary of State after consultation with interested organisations including professional groups, trade unions, local authorities, and voluntary bodies. All members are unpaid apart from the chairman who receives a part-time salary. RHAs normally meet monthly. Each authority is served by paid officials headed by the Regional Team of Officers (RTO), made up of the regional administrator, regional medical officer, regional nursing officer, regional treasurer, and regional works officer (diagram 2). The RHAs provide a few services themselves, but their main task is to plan and review the development of health



services and allocate resources to the district health authorities. The RHAs are concerned with the appointments of consultants and senior registrars in non-teaching hospitals, postgraduate medical education (through the postgraduate dean) and indirectly the development of general practice (through regional advisers). The RHAs are responsible for major capital projects. The RHAs appoint some of the members of each DHA and the members of each CHC.

#### District Health Authorities

Each DHA is comprised of about 16-19 members, some appointed by the RHA after consultation with interested organisations, and some nominated by local government authorities. The DHA chairman is nominated by the Secretary of State and receives a part-time salary. Members are unpaid and should include a hospital consultant, a general practitioner, a nurse, midwife or health visitor, a nominee of the appropriate university with a medical school in the region, a trade unionist and 4-6 members appointed by the local government authorities. A DHA containing a university medical school and teaching hospital facilities includes additional members with medical school or teaching hospital experience. DHAs usually meet monthly in public. The related CHC can send observers to each meeting of the DHA with the right to speak but not to vote. Each DHA is served by a district management team (DMT) made up of four appointed officers (district administrator, district finance officer, district medical officer, and district nursing officer) and two elected medical representatives - a consultant and a general practitioner (see diagram 3). The DHAs are responsible for the planning and provision of health services and through a structure of unit management their day-to-day management. An important function is to work with other local services - both statutory and voluntary. To assist collaboration, DHAs and local government authorities are required to set up Joint Consultative Committees (JCCs) to co-ordinate plans and decide on the use of 'joint funding' money.

#### Family Practitioner Committees

The contracts of general practitioners, dentists, pharmacists and opticians are administered by family practitioner committees (FPCs). There are thirty members of each FPC, appointed by DHAs, local authorities and local professional groups. The FPC has no managerial authority over practitioners, as each family practitioner is an independent contractor who has

contracted with the FPC to provide a service to those members of the local population who have registered with him or her. The future organisation of FPCs is still under discussion - (HN(81)10 is a consultative paper - see Part 3).

#### Community Health Councils

The community health councils are statutory bodies, set up by the RHAs. They have between 18-24 members nominated by local authorities, voluntary organisations and RHAs. The secretary is chosen by and accountable directly to the CHC, although technically employed by the RHA. Each CHC has a right to send an observer to DHA meetings who has a right to speak but cannot vote, and DHSS has recommended that FPCs should accept CHC observers at their meetings. Each CHC has a right to obtain information from the DHA and the DHA is obliged to consult the CHC about proposed hospital closures. The CHCs help individuals who want to find out how to obtain a service or who want to make a complaint; they review the range, quality and achievement of the local health services; and they study and comment on health authorities plans and participate in planning team discussions.

#### COMPLAINTS

The procedure for handling complaints other than those relating to family practitioner services is set out in detail in Health Circular HC(81)5, a copy of which is reproduced in Part 3. Complaints against family practitioners are heard by sub-committees of FPCs, made up of professional and lay members. The Health Service Commissioner (or Ombudsman) is another channel for complaints, though services covered by FPCs and grievances involving clinical judgement are outside his jurisdiction. He investigates complaints after the health authority has had an opportunity to reply to the complainant.

DIAGRAMS

Diagram 1

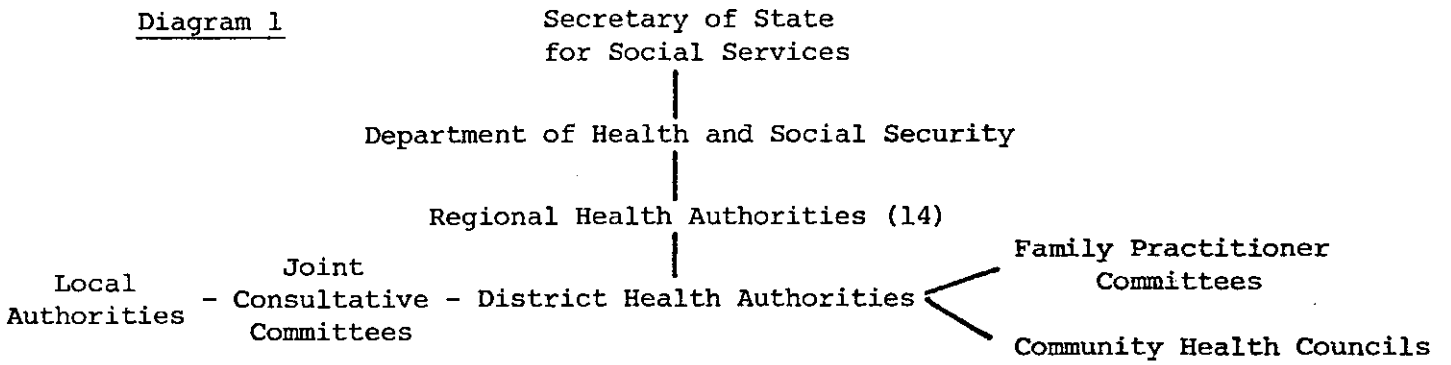


Diagram 2

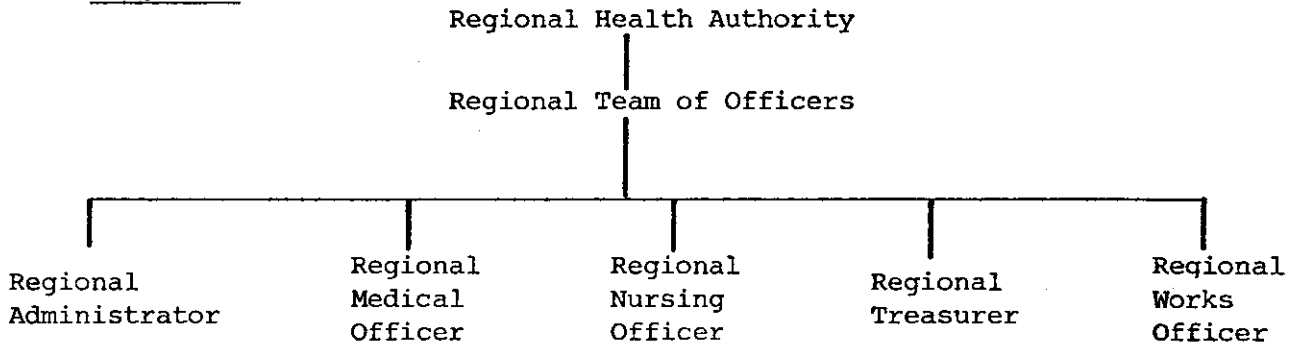
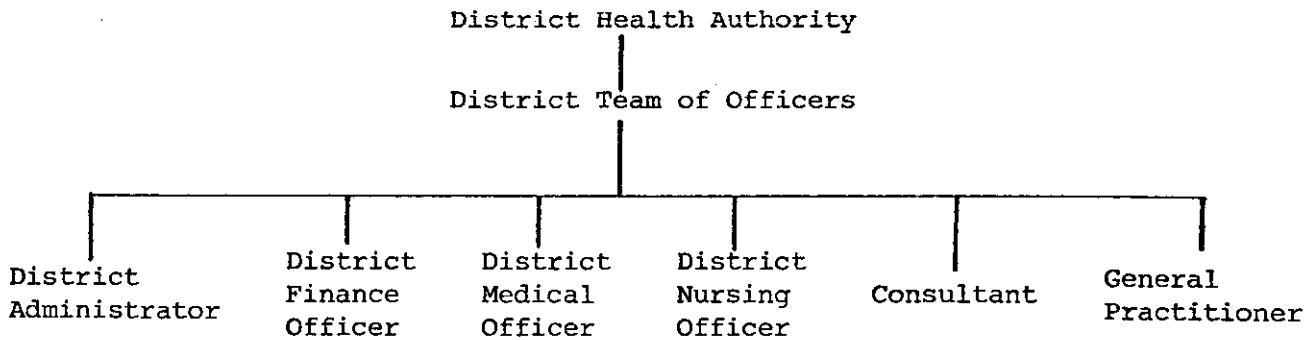


Diagram 3



SECTION 4PLANNING

A planning system was first introduced in 1976, and this is described in broad terms in this section. The material is reproduced, with the kind permission of the National Association of Health Authorities, from their manual "NHS Handbook". The omissions from the original text refer to the area authorities which have now been removed from the structure. Since the publication of the NAHA Handbook, DHSS have issued a consultative document (HN(81)4) reviewing the NHS planning system (reproduced in Part 3). The document repeats the basic principles of the previous planning system, particularly in regard to the preparation and review of regional and district strategic plans and the need for wide consultation. The document sets out suggested time-tables for planning activities.

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PLANNING IN THE NHS

## EVOLVING A SYSTEM

1. The most remarkable thing about the NHS planning system is that it was so long in coming. After pilot studies in selected locations in the previous two years, the planning system was described in a manual issued by the DHSS in June 1976, 28 years after the establishment of the NHS. During that time, planning had of course been undertaken, but it was capital-led, and hospital-oriented, largely under the impetus of the 1962 Hospital Plan for England and Wales (Cmnd.1604). The 1962 Hospital Plan was matched by a set of community health plans, also published by the DHSS, which were concerned with staff as well as buildings.
2. The Hospital Plan formalised the concept of the district general hospital and by suggesting population-related bed norms, was the first positive step in the direction of equitable distribution of the physical stock of the NHS. But some localities continued to receive more than their fair share of resources and some got new hospitals but found themselves without enough money to run them, sometimes because of the inequitable method of distributing NHS revenue. The RAWP report of 1976 pointed the way to redistribution of revenue so that more

could go to needy localities or parts of the service, and, with the planning system manual, made the NHS plan within its resources of money and of relevant skills. A formula for the distribution of capital is still awaited although RAWP has influenced the distribution of capital.

3. By requiring the proper measurement of present resources against need and of performance obtained from them, the definition of objectives to be reached, the charting of the route to their achievement, the declaration of expected results, and the monitoring of the whole process, the planning system is intended to provide an ordered process whereby the NHS knows where it is going, how long (and what it will cost) to get there, and what needs to be done to get there on time and with a well functioning service. The system removes past secrecy, or diffidence, about plans, since they are public documents to which all have access and to which all can contribute through community health councils, local authorities, advisory bodies, trade unions, professional associations and so on, by a process of consultation. One of the objectives of the consultation process is to see not only that reasonable public aspirations are met, but also that what is proposed for the NHS fits into the overall pattern of services for each particular locality which other Government agencies, such as the local authorities, are planning to provide and which society will require. Properly drawn, measured and costed plans from the NHS will be an effective tool for use by successive Secretaries of State in seeking resources for the NHS from Parliament.

#### THE SYSTEM IN OPERATION

4. The actual working of the planning system is designed to ensure that national policies for the development of the NHS are systematically stated in realistic, resource-related terms, and that such policies will themselves reflect the knowledge and experience of those responsible for the other extremity of the spectrum - i.e. those who actually deliver health care to the population. Thus the system, being cyclic, should provide constant and positive interaction between the local and national elements.

5. For this reason a starting point for describing the system must be an arbitrary choice. At the national level, the starting point is the provision by the DHSS of national guidelines which should set out resource availability

in financial and staffing terms. Within these guidelines the service should develop long-term (strategic) plans, with at least a ten-year span. These guidelines are translated by RHAs into regional guidelines. The development of strategic plans within the guidelines then begins. District proposals for longer term development of services are submitted to regions and regional strategies to the DHSS, subject to a consultation process all along the line. Strategic planning is defined in the planning manual as "the means by which NHS authorities determine their long range objectives and priorities for the development of the full range of health services, and plot the course towards the achievement of those objectives". A strategic plan should, therefore, indicate not only the level and pattern of services to be provided over the strategy period, but also what the effect of the proposed developments will be in terms of more staff of the various categories where there are shortages. It should also indicate the impact upon training programmes; what new facilities are needed (and how they will be provided) to enable staff to deploy their skills; what the distribution of hospital beds is likely to be; how the beds will be used; which hospitals currently in use will be closed or find their use changed; what new health centre provision will be made and where; how primary care and community services will be developed and how they will relate to secondary care services; how the ambulance service will be affected and so on.

#### LEVELS OF PLANNING

6. The regional strategic plan ... will try to give the whole regional picture, identify the key issues facing the service, and will determine priorities for development. It will be a picture of the region's need and the steps being taken towards meeting it and also an input to the DHSS for the next re-statement of national guidelines, since it will indicate the current problems of the NHS. At each stage the authority considering plans from the lower tier generally approves them, unless they positively go against guidelines. Thus while the higher tier requires broad adherence to the guidelines, local initiative and flexibility are at least in theory intended to be preserved.

7. The strategic plans are expected to be revised every four years, though parts of them will require continuous review during that period and provision is made for annual updating. Once strategic plans exist there is a proper

framework for the monitoring of the progress by regions and districts towards their achievement. They also provide a base for short-term operational planning.

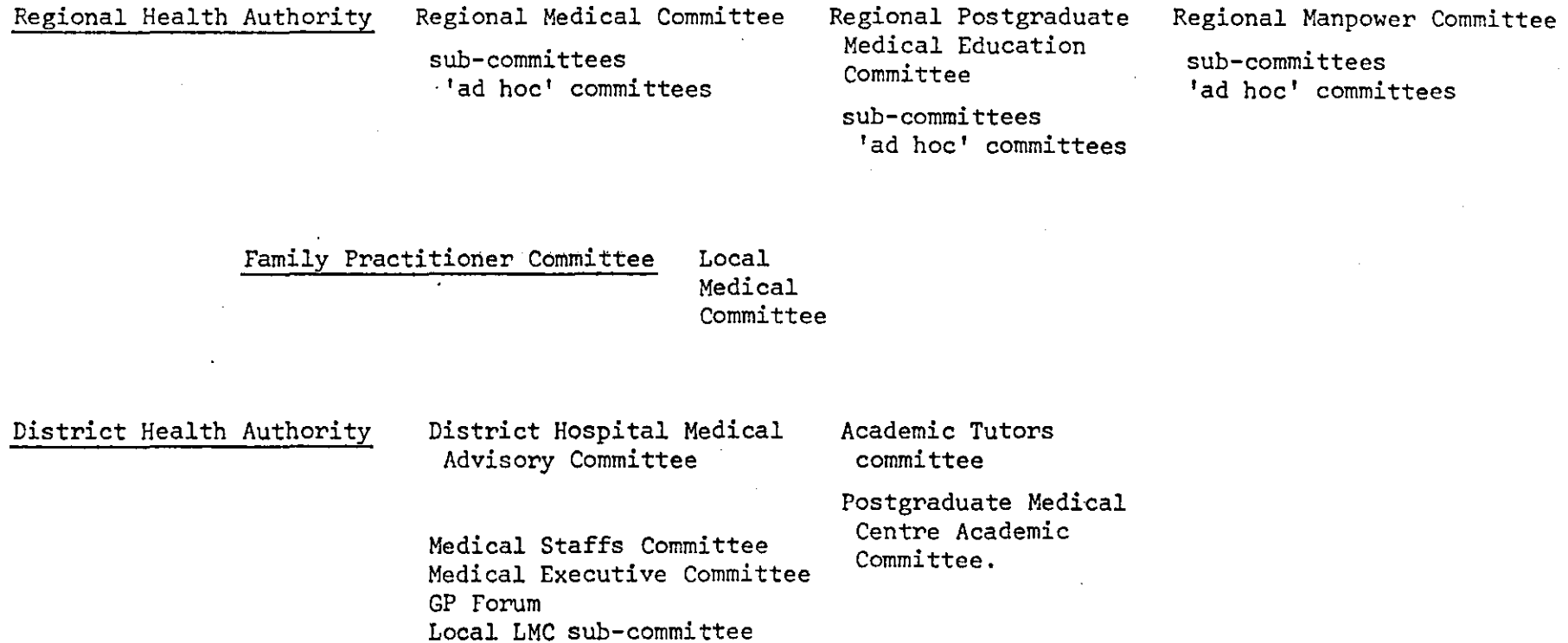
8. This is defined in the planning manual as "the process by which decisions are reached on actual changes in the patterns of service provision". Annual operational guidelines are issued by the Department to the regions, by regions to their districts. Three-year operational plans are required to be produced each year on a rolling basis. This means that they will contain firm proposals for the first of the three years, provisional proposals for the second and outline proposals for the third. The operational planning base is, of course, the district, except for those few services for which the region is operationally responsible. The operational plans have to be all-embracing in that all changes and developments in the NHS over the immediately ensuing three year period are charted and their implications in cost, staffing and so on worked out, whatever the source of these changes and developments.

9. A key element in central monitoring of planning and the implementation of plans is the annual planning report which each region submits to the DHSS. This reports progress on the implementation of agreed strategy through operational plans and gives detailed consideration to a small number of specific topics of current national interest. RHAs are invited to use the planning reports as a formal vehicle for comments on the feasibility of national policies and priorities within their own regions in years when a full strategic plan is not being prepared.

10. Though the aims of the NHS planning system are basically simple and sound, its critics say that the system is too complex and its timescales too short for the procedures (especially consultation) to be undertaken properly. They also complain that some key aspects of NHS policy which are nationally determined, such as medical manpower planning, are not yet fully geared into the planning system. However, the DHSS is working continually with the NHS to improve the system. No real challenge can be offered to the basic premises and no realistic alternative seems to have emerged.

(NAHA, 1980)

The Structure of the Main Medical Advisory Committees after Reorganisation April 1982





SECTION 5MEDICAL ADVISORY MACHINERY

The Royal Commission on the National Health Service was critical of the working of the professional advisory machinery. The Report stated "... the process of consultation has proliferated unduly, particularly in the medical profession. Medical committees of one kind and another are particularly numerous .... Furthermore some of the committees may not be particularly good at their jobs" (from paras. 20.18 and 20.19). The Commissioners recommended discussions between the health departments and the professions to simplify the structure. In June 1980, the Chief Medical Officer, Sir Henry Yellowlees, convened a small Working Group to consider the future of the medical advisory machinery. The Working Group have issued two reports, one concerned with arrangements at district (which also considers the role of the medical members of the DMT and of the DHA) and the other with arrangements at region. Both of these reports (but without their annexes) are reproduced in this section. A general statement about the establishment of professional advisory machinery in the re-structured service is contained in a health circular (HC(82)1), which is reproduced in Part III. It should be noted that "professional" advisory machinery includes advice from dentists, nurses, midwives, pharmacists, opticians and other professions in addition to that from doctors.

JOINT WORKING GROUP  
ON  
MEDICAL ADVISORY AND REPRESENTATIVE MACHINERY  
REPORT  
ON  
DISTRICT MANAGEMENT ARRANGEMENTS

DECEMBER 1980

## INTRODUCTION

1. The current guidance on the framework and structure of medical committees at district and hospital level was prepared before the re-organisation of 1974 and is included in the 3 reports of the Joint Working Party on the Organisation of Medical Work in Hospitals (HMSO 1967, 1972, 1974), the grey book "Management Arrangements for the Re-organised Health Service" (HMSO 1972) and in the HRC series of circulars, principally in HRC(74)9 issued in 1974.
2. Experience of the working of the committees and of the use made of them has varied widely over the country. Some health districts have never set up some of the recommended structures (eg a 2 tier cogwheel system); others have abandoned certain committees because they found no purpose for them (eg the district medical committee). Although the recommended arrangements have worked satisfactorily in many districts there has been widespread criticism of the multiplicity, complexity and time-consuming nature of the various bodies and of the system as a whole.
3. Evidence given to the Royal Commission on the National Health Service (HMSO 1979) by medical bodies emphasised repeatedly that it was essential that doctors should play their full part in the running and planning of the NHS but commented that the current arrangements often led to an intolerable drain on the time and energy of doctors and removed them from their clinical duties. The Royal Commission recommended that the health departments should consider urgently with the professions concerned the best ways of simplifying the present professional advisory machinery.
4. The Joint Working Group was set up in June 1980 with the following terms of reference:  

"In the light of possible changes in the NHS structure, to consider the current arrangements for the involvement of the medical profession in the strategic planning and operational management of the NHS with particular reference to the rôle of medical advisory and representative committees and to make recommendations".

A list of the members who served on the group is at appendix A.\*
5. New structural arrangements for the NHS were announced in July 1980 in circular HC(80)8 and include the removal of the area tier of management, the establishment of more accessible district health authorities, and the strengthening of unit management. Among other objectives, these changes are intended to ensure that decisions are taken quickly; and predominately at local level. They should make it possible to improve ways in which doctors are involved in the planning and running of the NHS. The Working Group

\* Not included in this handbook.

has attempted to identify how this can best be achieved and has given special attention to management arrangements in the new districts.

6. In making their recommendations the Working Group has borne 3 basic principles in mind:

a. Guidance should be concentrated on the tasks that committees have to perform; the detailed composition of committees should be left for local decision.

b. Guidance should be flexible and should allow for the marked variability between health districts.

c. Guidance should ensure that there are as few committees as is consistent with the work to be done.

## CHAPTER 1

## THE DISTRICT HEALTH AUTHORITY AND ITS RELATIONSHIP TO CLINICAL DOCTORS

## THE DISTRICT HEALTH AUTHORITY (DHA)

1.1 The Government announced in health circular HC(30)8 that throughout the NHS in England there should be a pattern of operational authorities similar in the main to existing single district areas. DHAs will generally consist of 16 members, plus a chairman. Membership will include a consultant, a GP, a nurse, a university nominee, a member drawn from the trade union movement, 4 members appointed by local government and 7 generalist members appointed by RHAs

1.2 Members of the new DHAs will have the same role as current members of AHAs: that is, they will be expected to decide on district policies and priorities within the context of national and regional policy; to review and challenge objectives, plans and priorities submitted by the DMT; to appoint and monitor the performance of chief officers; and to assess the adequacy of services provided.

1.3 Each district health authority will have at least 2 medical members, a consultant and a general practitioner. Their contribution to the authority's work will be to bring their understanding of health and disease, and of health services, to bear on the authority's deliberations. They will be chosen for their individual qualities.

1.4 Doctors appointed to district health authorities could be drawn either from inside or from outside the district. The appointing authority should seek advice on this matter from the profession locally. Regardless of where they work, medical members of an authority do not represent doctors working in the district. Nor will they be the source of formal medical advice to the authority. However they will be concerned to ensure that professional views have been properly taken into account when decisions are taken. For example they will wish to assure themselves that the authority has sought advice from the medical members of the district management team. (See paras 1.20 and 1.21.)

1.5 It is anticipated that the current procedure will continue by which nominations from medical organisations are forwarded to the regional health authority, which then appoints doctors to the district authority from among the nominations which it has received. Organisations which currently put forward nominations include the British Medical Association, Royal Colleges and Faculties, and the Overseas Doctors Association.

1.6 The medical members, like other members of authorities, are corporately accountable through the RHA to the Secretary of State and these latter bodies have the power of dismissal "in the interests of the NHS", and of non-reappointment.

1.7 Some districts contain hospitals with a significant undergraduate teaching role. To enable the authority to make decisions taking due account of the needs of medical education and service to patients, the medical and dental faculties of the relevant university should be appropriately represented.

#### DISTRICT MANAGEMENT TEAMS

1.8 The Government has proposed that throughout the NHS in England there should be a pattern of operational authorities similar in the main to existing single district areas. Each authority will have a management team with the same composition as existing area management teams, which consist of 4 officers of the health authority and 2 clinical representatives, one being a hospital consultant and the other a general practitioner. Team decisions can only be reached when all members are agreed, at least in the sense that none is opposed to a proposal, although not all may be equally in favour.

1.9 In a few districts, the consultant and general practitioner membership of management teams has been doubled in order to take account of special local factors. The introduction of the new district health authorities may reduce the number of districts in which it is felt that this is necessary.

1.10 In districts with one or more major teaching or research institutions, representatives of the academic institutions have regularly attended meetings of the management team. This practice has been found to be mutually acceptable and should be continued or introduced if this has not already been done.

1.11 In many management teams there has been strong pressure for the team to reach consensus and thus have an agreed view to take to the authority. It is obviously desirable that, whenever possible, management teams should act unitedly on the basis of consensus freely reached. However, in some parts of the country, principally in multi-district areas, the remoteness of the authority, the presence of an area team of officers, and the existence of competing district management teams have all tended to lead to a less desirable philosophy of "agree at all costs". The restructuring exercise heralded by HC(80)8 should remove many of these pressures and in future when acceptable consensus is not readily obtained, teams should then be able to take unresolved business to the authority without a feeling that in doing so the team has failed. In doing this it will be possible to demonstrate the extent to which agreement has been reached and where residual difficulties remain, thus giving the authority a clearer sense of the nature of the underlying issues.

#### CLINICAL REPRESENTATIVES ON MANAGEMENT TEAMS

1.12 Clinical representatives are accountable as individuals to the group which elected them but this does not prejudice the collective accountability of the management team to the authority.

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1. The arrangements for the governance of special postgraduate hospitals are under review: any changes may have further implications

At meetings of the health authority clinical representatives would support recommendations on which they have reached agreement with colleagues on the management team but they will also have a responsibility both to the authority and to their electorate to ensure that the views of medical colleagues are known and understood.

1.13 It is the right and responsibility of each team member to attend meetings of the authority and to tender advice. An exception to this general rule would be the rare occasion when the authority is discussing the competence or performance of officers of the authority who are members of the management team; there may be other exceptions.

1.14 Both clinical representatives will comment on all the business of the team, not confining themselves to sectional interests, and it is hoped that on most issues there will be agreement between hospital consultants and GPs. Nevertheless the Working Group considers that the team consultant and the team GP should represent hospital and general practice interests respectively. The consultant representative should therefore be elected by a body including all the senior hospital medical staff in the district (district hospital medical staff committee), or, if that body so wishes, by a representative group (eg medical executive committee). The committee responsible for electing the consultant representative must contain representatives of hospital doctors in training. Similarly the general practitioner representative should be appointed by the Local Medical Committee for the Family Practitioner Committee serving the district, or by a committee of general practitioners authorised by the LMC.

1.15 It is an essential part of the role of a clinical representative to report back to the electorate about actions taken and thus to ensure that there is support for what has been done and what will be done. The clinical representatives should report regularly to the body which elected them. If this body does not consist of all doctors belonging to the group which they represent, consideration should be given to ways in which the whole group of all hospital doctors or all general practitioners in a district can be kept informed.

1.16 The length of the term of office of clinical representatives should be a matter for local decision. However, it is important that the tenure should be long enough to ensure continuity and to enable good experience of management team problems to be accumulated. The Working Group recommends that these criteria may best be met by appointment for a term of 3 years after which the incumbent would be eligible for re-election for one more term.

1.17 As clinical duties will sometimes necessitate the absence of representatives from management team meetings, each should have a designated deputy, who can attend in his place when necessary. The opportunity to act as a deputy enables a potential team representative to gain useful experience and to acquaint himself with the problems of serving on a management team. Many districts now elect their

representatives a year or more before they take office and this makes it possible for the selected doctor to act as a deputy and attend relevant training courses before taking up an appointment. Newly appointed DMT clinical representatives may require help in understanding the management structure of the NHS, its resource allocation and planning systems, and the key management issues and problems which arise.

1.18 The effective involvement of clinicians in management teams necessitates the provision of appropriate administrative and secretarial support and relevant, accurate, and timely statistical information on which decisions can be based.

#### MEDICAL ADVICE TO DISTRICT HEALTH AUTHORITIES

1.19 Authorities require medical advice of 2 main types:

- a. Specialised advice on the current and future needs of patients and on methods available for treating them from the various individual specialties.
- b. General advice based on the broad medical view of priorities and the way in which resources should be allocated.

1.20 When an authority requires specialist advice it should seek the advice of the medical members of the DMT as to the most appropriate sources. For example, it may be appropriate to seek the view of the relevant regional committee; to approach a local committee; or to seek advice from individual doctors. Whatever the source, the specialist advice should reach the health authority in the context of the comments of the medical members of the DMT.

1.21 When a broad medical view is required an expression of the general view of doctors in the district should be channelled to the authority through the 3 medical members of the management team. The way in which the District Medical Officer obtains the views of doctors working in community medicine and the community services is for local decision, but he must be able to satisfy the authority that he has sought and considered such views. The responsibilities of the consultant and GP members of the team have already been discussed above. (See also para 1.23 below.)

1.22 The Working Group sees no need for a specific committee to be set up to integrate or co-ordinate a medical view for the district health authority. Integration can occur by cross representation between single discipline committees and by discussion between the 3 medical members of the management team. Thus representatives from the Local Medical Committee (including the general practitioner member of the management team or his deputy) and the District Medical Officer must attend the appropriate hospital medical committee. Consultant representatives (including the consultant member of the management team or his deputy) and the District Medical Officer must



attend the Local Medical Committee.

1.23 In some districts in which there are many doctors and where problems are particularly complex the clinical representatives on the management team may feel the need for more detailed briefing so that intra-professional difficulties can be sorted out before management team meetings. This could be obtained by holding regular or ad hoc briefing meetings at which attendance varied according to the items to be discussed at the management team meeting.

1.24 In a single district area (the future structural norm) there is a statutory area medical committee which gives medical advice to the authority, elects clinical representatives to the management team, and helps develop an integrated medical view for presentation to the management team and the health authority. All these functions can be carried out in alternative ways (See paragraphs 1.14, 1.20, 1.21 and 1.22.) The Working Group therefore takes the view that there is no need for the new district health authorities and the profession to set up district medical committees and recommends accordingly.

## CHAPTER 2

## MEDICAL COMMITTEES IN HOSPITALS AND MEDICAL COLLABORATION AT UNIT LEVEL

## MEDICAL COMMITTEES

2.1 The new district health authorities will vary considerably in size both in terms of population and geographical area, and in the provision of hospital facilities. The number of hospitals, the type of hospitals, the absence or presence of a teaching function and the way in which hospitals are grouped to form administrative units will differ and all will be important factors to be considered in setting up medical committees in a district. The committee structure will also have to take into account the number of hospital doctors working in the district. It is likely that a simpler structure will suffice for a rural district with, say, 50 consultants than one which will be required for an inner city district with major undergraduate teaching commitments in which 200 consultants may be working.

2.2 The Working Group has noted that many different patterns of hospital medical committee structure currently exist and has come to the conclusion that no set pattern can be laid down centrally for the new districts. Each district must tailor a system to meet its specific needs. However there are certain functions which need to be covered in all districts and some broad principles which are generally applicable.

2.3 In each district a committee of senior hospital medical staff is required to form a hospital medical view on priorities and resource allocation, to elect and brief representatives to the district management team and other groups, and to receive reports from representatives. The membership of a district hospital medical committee (DHMC) would include as full members hospital consultants, medical assistants, scientists of consultant status and representatives of doctors in training. Representatives of the local general practitioners and of community medicine should normally be present. Administrative and nursing interests should be represented. To fulfil its function, the committee should meet regularly and be properly serviced by administrative staff.

2.4 In a large district with a considerable number of consultants, the district hospital medical committee may become too large for the effective resolution of inter-specialty differences and the development of an agreed hospital view. In this situation the DHMC may decide to set up a medical executive committee (MEC) which includes as full members representatives of hospital consultant staff and of other groups of doctors working predominantly in hospital - particularly representatives of doctors in training. A general practitioner, the District Medical Officer, and representatives of nursing and administrative interests would also be in attendance

at meetings. The chairman of a medical executive committee might also serve as the consultant member of the district management team. Whether the consultant member on the team is elected by and thus reports to the medical executive committee or is elected by the district hospital medical committee is a matter for local decision by the DHMC.

2.5 A medical executive committee set up by a district hospital medical committee could be composed of chairmen or representatives of specialty divisions (see paragraph 2.12) or it might be a committee entirely elected by the DHMC. A third alternative would be a combination of the 2. It is up to the district hospital medical committee itself to decide which pattern they think is preferable.

#### THE UNIT

2.6 In the guidance issued to authorities in Circular HC(80)8 about management arrangements it was recommended that the only level of management below the district health authority should be the administrative unit.

2.7 Authorities are free to establish as many units of management as they think appropriate. Examples of such units might include:-

- a. a major hospital or a group of hospitals with complementary functions (eg a district general hospital);
- b. the community services of a district; or
- c. services for a particular client group (eg a psychiatric unit covering both hospital and community services).

2.8 Each unit will have an identifiable administrator and a nurse, accountable to the district administrator and nursing officer respectively. Associated with these officers will be a representative or representatives of medical staff working in the appropriate unit.

2.9 Units will differ greatly in size and in the type of work performed. The groups of staff responsible for running the units will therefore work in different ways but no group will operate on a formal basis of consensus as does the district management team. Close collaboration and co-operation will obviously be necessary but disagreement over important matters of mutual concern, if not capable of resolution at unit level, will be referred to the district management team.

2.10 The medical representative(s) on a unit group should be elected by all the medical staff working in the unit or by an appropriate subset. Thus in a district with one district general hospital unit, the medical representative on the unit group would be a consultant elected either by the district hospital medical committee or by the medical executive committee.

2.11 In a mental illness or mental handicap unit the medical representative would be elected by colleagues in these specialties.

In a unit responsible for community services, general practitioners, clinical medical officers, and hospital consultants may all be involved in providing services and local arrangements should be made to elect one or more doctors to the unit group. In those units involved with both hospital and community work special consideration must be given to the involvement of a general practitioner.

#### SPECIALTY DIVISIONS AND MULTI-DISCIPLINARY GROUPS

2.12 In many hospitals it has been useful for doctors to establish specialty (Cogwheel) divisions which provide a forum in which doctors working in hospitals are able to co-ordinate their work, to review the service they are providing, and to choose colleagues to represent them on other bodies. Although specialty divisions or committees are primarily of and for doctors, other disciplines may attend meetings as appropriate. Specialty divisions may report either to a district hospital medical committee or to a medical executive committee. If specialty divisions have been found to serve a useful purpose in any particular district they should be continued.

2.13 Where a district management team believes that patient care in the district will be improved by setting up a multi-disciplinary group to deal with a particular aspect of patient care, this should be done after discussion with the various interests involved. However it should be realised that these groups take up a lot of time and care should be taken to avoid overlap of functions with those of other bodies. It should be made clear to whom the new group should report and exactly what its function is to be. In particular it is necessary to avoid any overlap of functions between specialty (Cogwheel) divisions and multi-disciplinary groups.

#### OTHER DISCIPLINES

2.14 In accordance with its terms of reference the Working Group has reported on the involvement of doctors in the strategic planning and operational management of the NHS. However, throughout its discussions it has been conscious that other professions must play their part in providing Health authorities with the balanced advice which is needed and that close co-operation between the health professions is essential to the proper running of the Service. The Working Group has therefore specifically recommended that Administrative and Nursing interests should be represented at meetings of hospital medical committees (para 2.3) and at meetings of any medical executive committee that may be formed (para 2.4). The Working Group believe that the informal contact between the 3 medical members of the management team envisaged in paragraph 1.22 above should not always be exclusively medical and that it should include other disciplines when appropriate.

References

1. Circular HRC(74)9, "Local advisory committees", published in February 1974.
2. Circular HC(80)8, "Structure and management", published in July 1980.
3. Joint working party on organisation of medical work in hospitals, reports published by HMSO 1967, 1972, 1974.
4. "Management arrangements for re-organised health service", published by HMSO 1972.
5. Royal Commission on the National Health Service, report, published by HMSO 1979.

JOINT WORKING GROUP  
ON  
MEDICAL ADVISORY AND REPRESENTATIVE MACHINERY

REPORT

ON  
REGIONAL MANAGEMENT ARRANGEMENTS

December, 1981.

## JOINT WORKING GROUP ON MEDICAL ADVISORY AND REPRESENTATIVE MACHINERY

## REPORT ON REGIONAL ARRANGEMENTS

## INTRODUCTION

1. The current guidance on Regional Medical Advisory Committees (RMACs) is contained in circular HRC(74)9, which sets out the statutory framework governing advisory committees and gives advice on model constitutions. The basic purpose of these committees, set out in HRC(74)9, is to help authorities and their officers to reach decisions on the provision of health services in the full knowledge of expert medical opinion and advice.
2. Regional Manpower Committees (RMCs) originated from the Second Progress Report on Hospital Medical and Dental Staffing Structure agreed between the DHSS and the Joint Consultants Committee, and published in 1971. It was suggested that regional committees would enable the profession to express informed and considered views on the development of medical staffing to employing authorities without encroaching on the latter's responsibility for decisions. No formal Departmental guidance has been issued concerning these committees.
3. Advice on Regional Postgraduate Medical Education Committees (RPCMECs) was contained in circular HM(64)69. Usually established jointly by universities and Regional Health Authorities (RHAs), their broad purpose now is to promote and advise on the development of professional postgraduate education and training.
4. The Royal Commission on the National Health Service drew attention to the complexity of advisory machinery and recommended that the health departments should consider with the professions concerned the scope for simplifying the present professional advisory machinery.
5. The Joint Working Group was set up in June 1980 with the following terms of reference:

"In the light of possible changes in NHS structure, to consider the current arrangements for the involvement of the medical profession in the strategic

planning and operational management of the NHS with particular reference to the role of medical advisory and representative committees and to make recommendations."

A list of the members who served on the Group is included in Annex A.

6. The Working Group were aware that a separate working party chaired by the Chief Dental Officer was set up to consider arrangements for the involvement of the dental profession in similar matters. The Working Group noted the Dental Working Party's report (issued under cover of circular DA(80)20, in December 1980); in particular the recommendation that regional dental advisory committees should be retained. Nevertheless it has also considered the need to involve hospital dentists in the arrangements which are recommended in the following chapters.

7. This is the second part of the Working Group's Report; the first, on arrangements at district level, was issued in January 1981. Although the district report was issued separately because of the need to prepare advice in advance of the creation of the new district health authorities, the Working Group has sought to ensure that its proposals for arrangements at district and regional levels are compatible.



## THE REGIONAL HEALTH AUTHORITY AND ITS MEDICAL COMMITTEES

1.1 The Government announced in circular HC(80)8 that in due course it would review the relationship between RHAs and District Health Authorities (DHAs), the composition and functions of RHAs, and the role of the Department in relation to them with a view to enhancing local autonomy. The Working Group has taken note of the proposed review but has felt it right to make its proposals against the background of the existing role of region. Some modification to the Working Group's proposals may be necessary in the light of the review.

1.2 In the present circumstances the Working Group recognise ~~that~~ RHAs need medical advice on a number of matters concerning the strategic planning and operation of clinical services, as well as medical and dental manpower and education. Aspects of an RHA's work that particularly require medical advice are:

- a. long term planning of health care services, including the preparation of planning guidelines with particular concern for the ways in which changes in clinical practice affect the distribution of resources;
- b. the arrangements for supra-regional clinical services;
- c. the need and arrangements for regional and sub-regional services;
- d. the allocation of revenue and capital monies between health authorities;
- e. setting of priorities for major capital investment in buildings and equipment;
- f. the deployment of hospital medical and dental manpower. Factors to be taken into consideration include changes in clinical practice, the development of clinical services, the provision of training and the maintenance of a career structure;
- g. the provision of appropriate resources for undergraduate teaching and for research;
- h. the encouragement of clinical and health services research;

i. the development of policy for the provision of postgraduate medical and dental education;

j. the provision of a careers advisory service for doctors throughout the service.

1.3 To meet the need for this advice, different patterns have evolved in different regions. These patterns have varied in effectiveness but the main medical advisory committees in each region are the Regional Medical Advisory Committee (RMAC), the Regional Manpower Committee (RMC) and the Regional Post-graduate Medical Education Committee (RPGMEC).

1.4 The Working Group has not considered the role and composition of the University Liaison Committee and the Regional Scientific Committee because they are both multidisciplinary committees, and thus outside the Working Group's remit. RHAs have a major role in ensuring the provision of facilities for the training of medical and dental students. The main formal channel of communication between an RHA and a university is through the multidisciplinary University Liaison Committee. The Department has recently issued Circular HN(80)40 seeking views about a number of aspects of policy concerning undergraduate medical education. With regard to the Regional Scientific Committee, it has been assumed that for the present its function and composition will remain unchanged.

1.5 Two other committees have not been considered in detail:

a. the Regional Study Leave Committee. The function and composition of this committee have only recently been negotiated between the Department and the BMA; and promulgated in Circular HN(79)10. Although this committee does come within its terms of reference, the Working Group considered that as the introduction of this committee was so recent, no further recommendations should be made;

b. the Regional Committee for Locally Organised Research.

1.6 The Working Group conducted a survey of the different ways in which advisory committees operated and in this connection would like to thank the Regional Medical Officers for their ready co-operation. The survey revealed a number of different practices. For example, the numbers serving on RMACs varied from

25 to 50. The number of specialty sub-committees of the EMACs varied from 9 to 25 and the number of working groups from none to 15. Comparable variations were noted in respect of the RMC and RPGMEC. A summary of the survey is at Annex B.

1.7 There have been criticisms of the complex nature of some advisory machinery and of its costs. As previously noted by the Working Group in its report on District Management Arrangements (January 1981: Introduction, paragraph 3), the Royal Commission on the National Health Service (HMSO 1979) had received evidence to suggest that the present professional advisory machinery required simplification. However, there has been little complaint about the quality of advice provided to regional health authorities and the Working Group wish to see effective features of the current machinery preserved and strengthened.

1.8 Nevertheless the Group did consider whether it would be possible to amalgamate the three main advisory committees. It noted that there were three distinct types of subject on which RHAs required medical advice. A committee whose composition enabled it to give general, manpower and postgraduate education advice would be very large and unwieldy. An omnibus committee of this kind would also place a very heavy burden on its members; especially its Chairman and members of any executive committee. The Group therefore concluded that it could not recommend the amalgamation of the three main advisory committees for general adoption.

1.9 Against the background that in some regions the existing arrangements are simpler and more economical than in others the Working Group recommends that each Region should examine its own machinery in order to establish the simplest system which can provide advice on the matters listed in paragraph 1.2 above. It is possible that the existing main committees, in reviewing the items on which they have to give advice, may decide that their work could be done still more economically in terms of time and money. If the professional committees think it appropriate, they should recommend to the RHA a reduction in the number or size of main committees. Where this is contemplated, the views of the Regional Committee for Hospital Medical Services (RCHMS), the Regional Hospital Junior Staff Committee (RHJSC), the Regional Committee for Community Medicine (RCCM) and the relevant Local Medical Committees (LMCs) should be sought on the proposal.

1.10 The Working Group suggests that one way in which administrative economy could be achieved is through the creation of common specialty committees advising all the three main committees. It is recognised that this proposal could create difficulties in that the nature of the specialty advice which is required varies according to which main committee is concerned. However, with careful attention paid to the composition of membership, the Working Group considers that a single series of specialty committees is a practicable proposition.

1.11 Moreover, the NHS should not be expected to give open-ended support to every specialty committee which might be set up, particularly at a time of reductions in the proportion of resources devoted to management costs. The Working Group considers, therefore, that the number of specialty and other committees attracting financial support should be limited. Chapter 3 deals with the question of specialty committees in greater detail..

## CHAPTER 2

## THE MAIN COMMITTEES - TERMS OF REFERENCE AND COMPOSITION

2.1 In the light of its general conclusions on medical committees of the RHA, the Working Group has considered terms of reference and composition in some detail. Where it is decided that there should be three main committees, the Working Group commends the following models. Where it is decided to amalgamate the committees, the Working Group recommends that the same principles of representation should be adopted, bearing in mind the functions which are to be amalgamated. In all cases it is important that the size of the committee is as small as possible.

Regional Medical Advisory Committee

2.2 The RMAC advises the RHA and its officers on the provision of medical services and it is the main channel through which clinical doctors relay their advice on all aspects of the authority's business which have implications for medical services. Advice should relate primarily to items a. to h. in paragraph 1.2.

2.3 The Working Group recommends that the composition of the RMAC should be as follows:

- a. one senior hospital doctor from each district, unless the district is already represented under b, c, d or e below. The senior hospital doctor should be elected by his colleagues in the district, eg by the district hospital medical committee;
- b. one member from each of the eight hospital based specialty committees (see chapter 3);
- c. the chairman or secretary of the Regional Committee for Hospital Medical Services;
- d. the chairman of the Regional Postgraduate Medical Education Committee, or his deputy;
- e. the chairman of the Regional Manpower Committee, or his deputy;

- f. two hospital doctors in training elected by the Regional Hospital Junior Staff Committee;
- g. one general practitioner for each Family Practitioner Committee area, elected by the appropriate Local Medical Committee;
- h. two representatives of community medicine elected by the Regional Committee for Community Medicine;
- i. one representative of the Regional Dental Advisory Committee;
- j. the Dean, or his representative, from each undergraduate medical and dental school in the region;
- k. the Regional Postgraduate Dean;
- l. in the Thames regions, one representative of the hospitals administered by preserved Boards of Governors.

2.4 The Regional Medical Officer should attend meetings of the RMAC and contribute to its discussions. The RMAC might consider inviting the medical members of the RHA to attend meetings as observers.

2.5 The RMAC advises the RHA and, although it is for the authority to decide, the Working Group recommends that the chairman of the RMAC should attend RHA meetings as an observer with the right to present the minutes of the RMAC and to take part in discussion on them. The RHA chairman may wish to ask the views of the chairman of the RMAC during the discussion of other agenda items.

#### The Regional Manpower Committee

2.6 Although general policy in the field of hospital medical and dental manpower is a matter for the RMAC, which is concerned with changes in practice and developments in clinical services, detailed advice about the deployment of hospital medical and dental manpower is the responsibility of the Regional Manpower Committee. Such advice must be within national policies concerning medical and dental education and training and will be in accord with national agreements

concerning the maintenance of a career structure for hospital doctors and dentists. The detailed matters upon which the RMC will advise the regional authority and its officers are:

- a. the number and distribution of consultant posts;
- b. the number and distribution of senior registrar, registrar, and senior house officer posts, subject to advice from the relevant bodies with responsibility for the education content of training posts, and in accordance with national agreements about manpower targets;
- c. the establishment of posts for associate specialists (medical assistants) and hospital practitioners.

In giving its advice to the RHA, the RMC will have to consider not only the staffing requirements in relation to career structuring, but also staffing priorities taking into account regional strategic planning guidelines, and the available resources.

2.7 The Working Group recommends that the composition of the RMC should be as follows:

- a. one consultant from each district, unless the district is already represented under b, c, d or e below. Each district would select two or three nominations to be forwarded to the Regional Committee for Hospital Medical Services, who should select the district representatives so as to ensure an equitable balance of consultants from different specialties;
- b. one member from each of the eight hospital-based specialty committees (see chapter 3);
- c. the chairman of the Regional Medical Advisory Committee, or his deputy;
- d. the chairman of the Regional Postgraduate Medical Education Committee, or his deputy;
- e. the regional representative on the Central Manpower Committee;

- f. two hospital doctors in training elected by the Regional Hospital Junior Staff Committee;
- g. two general practitioners, one of whom should be drawn from the hospital practitioner grade, elected by the general practice specialty committee (see chapter 3);
- h. two representatives of community medicine elected by the community medicine specialty committee (see chapter 3);
- i. one associate specialist (method of selection to be determined locally);
- j. the chairman of the Regional Dental Advisory Committee, or his representative;
- k. one clinical academic representative from each undergraduate medical school in the region. If there is only one school in the region, there could be two representatives from it;
- l. the Regional Postgraduate Dean;
- m. in the Thames regions, one representative of the hospitals administered by preserved Boards of Governors.

2.8 The Regional Medical Officer, or his deputy, should attend meetings of the RMC and contribute to its discussion. The Regional Dental Officer (where one has been appointed) should also attend when dental matters are discussed.

#### The Regional Postgraduate Medical Education Committee

2.9 The terms of reference of the RPGMEC should be to advise the relevant university and the RHA on:

- a. broad policy concerning the promotion of postgraduate medical and dental education;
- b. the maintenance of an adequate educational content in all training posts in the light of advice given by the Higher Training Committee (senior registrar posts) and the Royal Colleges and Faculties (registrar and SHO posts);



- c. the selection of hospital and community medicine posts suitable for general practice vocational training;
- d. the provision of posts suitable for training pre-registration house officers;
- e. the approval of GP trainers and practices;
- f. the availability and suitability of postgraduate education courses;
- g. the provision and working of Postgraduate centres - responsibility for individual centres rests with district authorities;
- h. provision of a careers advisory service in collaboration with the regional specialty committees (see chapter 3).

2.10 The Working Group recommends that the composition of the RPGMEC should be as follows:

- a. one senior hospital doctor from each district (who might well be a clinical tutor) unless the district is already represented under b, c or d below;
- b. one member from each of the eight hospital based specialty committees (see chapter 3);
- c. the chairman of the Regional Medical Advisory Committee, or his deputy;
- d. the chairman of the Regional Manpower Committee, or his deputy;
- e. two hospital doctors in training, elected by the Regional Hospital Junior Staff Committee;
- f. one general practitioner from each Family Practitioner Committee area, elected by the appropriate Local Medical Committee (unless represented under g below);
- g. one member from the general practitioner specialty committee (see chapter 3);

- h. one trainee in general practice, elected by the Regional General Practice Trainees Committee;
- i. one member from the community medicine specialty committee (see chapter 3);
- j. one trainee in community medicine (method of selection to be determined locally);
- k. the Dean, or his representative, from each undergraduate medical and dental school in the region;
- l. the regional Postgraduate medical and dental Deans;
- m. the Postgraduate Dean, or his representative, from each medical school in the region;
- n. in the Thames regions, one representative of the hospitals administered by preserved Boards of Governors.

2.11 The Regional Medical Officer, or his deputy, should attend meetings of the RPGMEC and contribute to its discussions. The Regional Dental Officer (where one has been appointed) should also attend when dental matters are discussed.

2.12 The Working Group has noted that the RPGMEC advises both the REA and the relevant university. In some instances the RPGMEC is established jointly with the university and is serviced by the latter or, in the case of the Thames regions, the British Postgraduate Medical Federation. The Working Group's re-commendations are not intended to disrupt current arrangements if these are working well: the proposals should be the subject of local discussion with university interests.

2.13 It is the responsibility of the medical advisory machinery at regional level to monitor the progress of doctors in training in the hospital specialties. At senior registrar level this is done by a review after one year in post and advice is also given to the relevant health authority when a doctor has completed training but failed to obtain a consultant post. The Working Group

suggests that this might be done by a small review panel set up by the specialty committee (see chapter 3) in conjunction with the RPGMEC. The detailed composition of the panel would be for local decision but should include the College or Faculty Regional Adviser and the head of the relevant clinical academic department from a medical school in the region.

2.14 If it is agreed between the Department of Health and Social Security and the profession that career guidance should be given to doctors in training in one of the popular specialties at an early stage of training, this review panel might be a suitable body to give such guidance.

2.15 Some regions have clinical tutors sub-committees of the RPGMEC. There seems to the Working Group to be no reason why regular meetings of clinical tutors within a region should not continue to take place, if this is found useful, without their being elevated to the status of a formal committee.

#### General Considerations

2.16 The Working Group recognises that the recommendations it has made for the composition of the RMAC, the RMC and the RPGMEC could lead to the establishment of very large committees in those regions with a large number of Districts. In such circumstances it may be possible - by local agreement as indicated in paragraph 1.9 above - to modify the composition in order to reduce the size.

2.17 The Working Group recommends that as an aid to the efficient working of the main committees there may be merit in establishing small executives.

2.18 None of the committees described above should be concerned with the representation of the interests of groups of staff. Nor are they substitutes or alternatives to general staff/management consultation arrangements. General personnel matters and questions relating to pay or conditions affecting the profession are dealt with in other committees.

## CHAPTER 3

## SPECIALTY COMMITTEES

3.1 The Working Group believes that there would be great advantage in establishing a limited number of specialty committees to advise all the three main committees. It is recognised, however, that in practice it may be difficult to ensure that the specialty advice required by a main committee comes from an informed and appropriate source. Nevertheless, with careful attention paid to composition, the Working Group considers that the establishment of specialty committees to advise all the main committees is a viable proposition.

3.2 The NHS should not be expected to give open-ended administrative support to every group who consider that their interests merit a separate specialty committee. The Working Group recommends that the committees set up to advise the three main committees should be limited to the following ten specialties, or specialty groupings, eight of which are hospital based.

- a. Anaesthetics
- b. Medical specialties
- c. Obstetrics and gynaecology
- d. Paediatrics
- e. Pathology
- f. Psychiatry
- g. Radiology and Radiotherapy
- h. Surgical specialties (including hospital dental specialties - see paragraph 3.3 below)
- i. Community medicine
- j. General Practice

3.3 As previously stated in this report (see paragraph 6 of the Introduction) the Working Group has noted the report about dental advisory machinery. Although that report recommended the retention of the Hospital Dental Surgery Sub-Committee of the Regional Medical Advisory Committee, this Working Group believes that the number of specialty committees should be limited and thus recommends that the hospital dental specialties be included in the wider grouping of surgical specialties. This specialty committee, like all the others, will advise the three main committees, not just the RMAC.

3.4 Although the need for advice from the smaller specialties is recognised and discussed further in paragraph 3.6, the Working Group recommends that the NHS should be required to give financial support only to the specialty committees listed in paragraph 3.2.

3.5 The Working Group recommends that the composition of the specialty committees advising the three main committees should be as follows:

- a. one doctor from each district (or, in the case of general practitioners, one from each Family Practitioner Committee area). For those committees representing a group of specialties each district would select two or three nominations to be forwarded to the RMAC, who should select the district members so as to ensure representation of the various specialties. In the case of general practice and community medicine at least one member should also be a member of the RMAC as a general practitioner or a community physician respectively;
- b. the College or Faculty Regional Advisers;
- c. two doctors in training;
- d. one representative from each undergraduate medical school;
- e. in the Thames regions, a representative of each of the appropriate hospitals administered by preserved Boards of Governors.

3.6 The Working Group is concerned that by limiting the number of specialty committees to ten, advice about smaller specialties should not be overlooked. Nevertheless it feels that additional formal machinery to cover smaller specialties should not be necessary. The Working Group recommends regions to consider their needs locally and establish informal arrangements as appropriate.

SECTION 6

INDUSTRIAL RELATIONS IN THE NHS

Derek Warlow, Regional Personnel Officer, has very kindly contributed this section on the important and complex subject of industrial relations. As he says, the NHS is one of the largest employers in the country and embraces a very wide diversity of occupations and thereby of professional associations and trade unions.

INDUSTRIAL RELATIONS IN THE N.H.S.I N T R O D U C T I O N :HEALTH SERVICE EMPLOYMENT.

The Health Authorities within the S.E. Thames Region employ approx 80,000 people including part-timers. This makes them among the largest employers in the country and demonstrates the labour intensive nature of the service provided. The range of employment provided by the NHS is most diverse, ranging from low-skill occupations traditionally characterised by low pay and status (such as cleaners and porters who are employed in large numbers) through a range of skilled, technical craft, clerical, administrative, scientific, therapeutic and semi-commercial occupations to consultants with substantial private practices and highly paid research orientated professionals working in close conjunction with universities and independent foundations.

The NHS is also one of the largest employers of female workers in the United Kingdom. Within this region some 75% of employees are women. In some areas (such as nursing) women comprise 90% of the workforce. In times of staff shortage the NHS is often obliged to hire temporary or contract staff from private employment agencies, particularly in the nursing and secretarial areas. In recent years arrangements have increasingly been made to contract out some domestic and catering services to commercial operators on a medium term basis in spite of trade union opposition.

The wide diversity of occupations that exists within the NHS adds to the problems of definition, analysis and management of the system. Traditionally, different occupations adjust to each other through a complex mechanism of prestige, knowledge, influence and power.

Geographical span is another significant factor. Several hundred locations are enclosed in the system, ranging from individual practitioners to large sites, such as district general hospitals employing many thousands of staff.

TRADE UNIONS IN THE NHSGrowth:

There has been a rapid growth in trade union membership by NHS staff, particularly over the last 10 years and this has meant that Industrial Relations has increasingly become a fact of everyday life throughout the service. NHS Trade Unionism developed initially in the mental hospitals and institutions with the formation of the National Association of Asylum Workers (later through amalgamation, to become the Confederation of Health Service Employees (COHSE) in

the first real expansion in membership took place in the then Local Authority hospitals and this consisted mainly of Ancillary staff. Attempts by the unions to recruit nurses (by far the largest staff group in the service), achieved little success in this period.

It was not until the 1970's that the second main membership expansion took place as the following figures show:-

	<u>1974</u>	<u>1981</u>
National Union of Public Employees (NUPE)	165,000	292,000
Confederation of Health Service Employees (COHSE)	143,479	216,487
R.C.N.	90,616	134,387
National & Local Government Officers Asscn. (Nalگو)	64,487	89,900

It is probable that this expansion was due primarily to the unionisation of the nursing profession during and following the dispute in 1974 which resulted in the Halisbury Pay awards.

There are basically two types of staff organisations in the NHS:-

### 1. PROFESSIONAL ASSOCIATIONS

These generally set out to recruit one identifiable professional group which is usually largely confined to the N.H.S. Although they may participate in collective bargaining through representation on Whitley Councils this is seen as only one of a range of responsibilities which also includes the protection of professional standards, qualifications, examinations, training etc.

Since they represent one group of staff they tend to be small, except the Royal College of Nursing, and membership between them does not often overlap.

Most professional associations have become certified as independent trade unions to gain the advantages from recent employment legislation, i.e. the right to request certain information, to be notified or consulted over redundancy issues; their members and official obtain greater job security and have a statutory entitlement to time off in certain circumstances, and they are able to appoint safety representatives with statutory protection and rights. Only the Association of Health Visitors is a professional association an independent trade union and affiliated to the Trades Union Congress.

### 2. TRADE UNIONS

A trade union is defined in the Trade Union and Labour Relations Act 1974 and 1976 (TULRA) as an organisation consisting wholly or mainly of workers whose principal purposes include the regulation of relations between those workers and employers. To benefit from the provisions of employment legislation a trade union must be 'independent' i.e. not under the domination or control of an employer. Independent status is decided by the Certification Officer for Trade Unions.

Trade unions tend to be much larger organisations who recruit



Most of them have substantial membership outside the N.H.S. e.g. National Union of Public Employees, Transport & General Workers Union, etc., etc.

The Confederation of Health Service Employees, The British Hospital Doctors Federation and some others, on the other hand, have their membership almost exclusively within the N.H. S.

Trade Unions regard collective bargaining as their main activity to secure protection of their members' interests, whereas professional associations are primarily concerned with training and qualifications. There is considerable overlap in their recruitment areas and often some of their members will also be members of a professional association which could also be a certified independent trade union.

Among Trade Unions there is a distinction between:

- (a) T.U.C. Affiliated -  
That is to say the Union is part of the Trades Union Congress (T.U.C).  
Of 463 certified independent trade unions in the country 113 are affiliated to the T.U.C. but they represent 90% of the 11,000,000 trade unionists in the country. The country has a working population of 25,000,000. Generally speaking the long established union in the N.H.S. are affiliated.
- (b) Non T.U.C. Affiliated -  
Unions which are not affiliated to the T.U.C. Examples of which would be the British Medical Association (B.M.A.) the Chartered Society of Physiotherapy, the Royal College of Nursing (R.C.N) and the Royal College of Midwives (R.C.M).
- (c) Recognised -  
A recognised staff organisation means, in the N.H.S, one recognised by the D.H.S.S. to negotiate on behalf of its members with the employing authorities, i.e. generally those staff associations and trade unions which have seats on the Whitley Councils.

### ORGANISATION

The differences in organisation depend on:

- the size
- the primary aim
- the particular political philosophy.

#### (a) Professional Associations

As these recruit from one clearly identifiable group of staff they tend to be small. Their major interest lies in maintaining professional standards by education and examination. Individual associations may differ in their organisations but generally they follow the pattern as identified below:-

	Annual Conference	
National	National Committee	Elected, unpaid, part-time.
	Secretary	Selected, paid, full-time
	H.Q. Staff	Selected, paid, full-time
Region	Regional Committee	Elected, unpaid, part-time
Hospital, District, Area	Local Committee	Elected, unpaid, part-time
Individual Staff	Members	

At the various levels activities of a largely educational and social nature take place and to a limited extent collective bargaining.

A journal of the profession is generally produced at a national level and is often the extent of many members involvement as they join to gain the professional qualification.

The Annual Conference is likely to have a strong educational bias but usually contains an Annual General Meeting which decides the policy of the Association.

(b) Trade Unions

As they recruit over a wide field they tend to be larger and their primary interest tends to be collective bargaining.

In bare outline the organisation of trade unions is straightforward. Trade Unions' policies are generally formulated at their annual conference. The interpretation of such policies and the organisation of their implementation are responsibilities of the Unions' executives and general secretaries; the policies are carried out by the Unions' full-time staff at the centre and in the districts. Matters of concern to the members are passed up the hierarchy via the branch organisation and shop stewards to district and regional bodies and then to head office or, alternatively, passed in the form of resolutions from branches to annual conference.

British trade unions are democratic organisations; their members can, and do, influence union policy and organisation. Again the organisation of individual unions will differ but generally they follow the pattern

	Annual Conference	
National	National Executive General Secretary H.Q. Staff	Elected, full-time/ part-time. Elected/appointed, paid, full-time Elected/appointed, paid, full-time
Union Region or N.H.S. Group	Regional/N.H.S. Officer	Elected/appointed, paid, full-time.
Union District	District Officer	Elected/appointed paid, full-time
Union Branches	Branch Officers	Elected, unpaid, part-time (but see i below)
	Staff Represent- atives, Shop Stewards	Elected, unpaid, part-time.
Work groups of individual staff	Union Members	

#### THE NATURE OF N.H.S. TRADE UNIONISM

There are some important factors which, when combined, have resulted in Health Service Trade Unionism developing a series of constraints which set them apart from similar organisations in the remainder of the Public or Private sectors. It could be argued that these constraints have limited the ability of the Unions to actively influence, for example, substantive improvements in the pay of their members relative to the rate of increase made by groups outside the service.

A brief consideration of three areas will help to illustrate this.

(i) Health Care Environment

The N.H.S. Unions exist in the Health Care Environment which, although attitudes are gradually changing, is still extremely influential on them. As a result the wider Trade Union objectives become more difficult to achieve.

A glance at the historical development of the N.H.S.. highlights the development of a complex and fragmented diversion of labour with the evolution of independent professionalism as a very prominent feature. As a result the development of Trade Unions has mirrored this parallel professional development and occupational diversity is found in

- (a) Wages levels
- (b) Collective bargaining
- (c) Sectionalism
- (d) Internal hierarchy
- (e) Development of sectional interests
- (f) Representation.

More fundamentally this has resulted in the existence of 43 recognised staff organisations. Inevitably, there is great competition for membership particularly in nursing and the ancillary fields with inter-Union rivalry and hostility not uncommon. This situation inevitably makes the management of local Industrial Relations complex and places pressure on the Unions to maintain and expand their membership - often at the expense of other organisations.

(ii) Industrial Action

A further manifestation of the influence of the Health Care Environment is the limited extent (in comparison with the Private sector) to which the Unions are able to influence circumstances through the withdrawal of labour. Union members and officials alike are bound by the moral constraints imposed by the nature of the enterprise and by the fact that many Union members in the NHS are not 'typical' Union members and many are still proud of their 'vocation'. The Unions awareness of this moral dilemma is not only illustrated by the fragmented form which industrial action takes in the service, but more recently by the T.U.C. Health Services Commission report on "Improving Industrial Relations in the N.H.S." which recommends the acceptance of a code of practice for conduct by Unions during an industrial dispute aimed at the protection of patients. It is also noteworthy that the incidence of strike action in the N.H.S. is very small in relation to the size of the organisation, although this is often exaggerated by the media.

(iii) Role of Government

The Unions' ability to influence the levels of Health Service pay settlement has always been limited and although both pay and the conditions of service of N. H.S. staff have improved substantially they have, generally speaking, failed to keep pace with the levels of improvement experienced outside the service.

Inevitably, the attitudes of successive governments to public sector pay, the inability of the N.H.S. to either measure productivity effectively or to generate wealth, the large number of disparate staff organisations and the influence of the health care environment have defined the nature of trade unionism in the service and have reduced the ability of the Unions to overcome their problems. It is these and other associated factors, which contribute towards the nature of Industrial Relations that exist in the NHS and which have created a type of Trade Unionism that is substantially different to its counterparts in other parts of the Public and Private sectors.

POLICES & PROCEDURES:

Clear and comprehensive policies and procedures are an aid to good relations between management and employees. They can ensure a common approach to situations, ensure equality and fairness of treatment of employees in different working situations. Furthermore, there are legal requirements, and in some cases, for written policies and procedures.

A Policy expresses broad intentions and attitudes and sets out philosophies, principles and objectives which guide decision making on particular matters. These may or may not be jointly agreed. Policies should be -

- (1) a declaration of intent
- (2) a definition of the means by which that intent is to be achieved.
- (3) a statement of the guidelines and constraints that enable managers to understand the limits of their authority.

A Procedure sets out the course of action to be followed in specified circumstances by members of the organisation and turns policy into practice.

The appropriateness and effectiveness of policies and procedures is judged by monitoring performance so that amendments may be made from time to time to ensure that the action resulting from them are those which they were designed to achieve.

Policies and procedures which affect industrial relations can be divided into two categories - those that are peripheral to Industrial Relations and those which are directly concerned with it.

Peripheral Industrial Relations policies and procedures:

- (a) Recruitment and Selection
- (b) Induction
- (c) Training and Development.
- (d) Performance and Appraisal Review.
- (e) Manpower Planning, i.e. taking stock of existing staff resources, working out future manpower needs, and identifying what should be done to ensure that future manpower match those needs. The relevant issues include avoiding unnecessary fluctuations in staffing levels, where changes are necessary they should be made with as little disruption as possible to the staff concerned; arrangements for transferring staff to other work: etc., etc.

- (f) Status and Security, i.e. providing stability of employment including job security for staff absent through sickness or other causes beyond their control. In this case relevant issues include the N.H.S. super-annuation scheme, redundancy matters, sick and maternity leave, etc., etc.
- (g) Working Conditions, i.e. the authority's policy and arrangements to maintain safe and healthy working conditions.
- (h) Communications, i.e. what information should be given to staff, in what manner, by whom, how frequently. The role and status of department/unit and DMT meetings.

Direct Industrial Relations policies and procedures:

- (i) Consultation, i.e. the principles and arrangements for seeking mutually acceptable solutions to problems of joint concern to management and staff through a genuine exchange of views and information.
- (j) Collective Bargaining, i.e. the negotiations that take place between management and employees, and which includes Procedural and Substantive agreements.  
Procedural agreements (usually made at local level). These lay down the constitution of any joint negotiating body or specify the parties to the procedure.  
They cover:-

- matters to be bargained about:
- level at which bargaining should take place:
- arrangements for negotiating terms and conditions of employment:
- facilities for trade union activities:
- procedures for settling disputes, grievances and disciplinary matters:
- constitution and scope of any consultative committees.

Substantive agreements (mainly made at National Whitley Council level) These settle terms and conditions of employment:-

- wages and salaries, overtime rates, bonuses etc.,
- total hours of work:
- techniques for determining levels of performance and job grading:
- redundancy procedures:
- guaranteed pay, sick pay, superannuation scheme:
- deductions of trade union contribution at source (DOCAS):
- holiday entitlement and pay (but consider extra-statutory holidays which were agreed in principle at National level but the actual day of the holiday has been negotiated locally)

- (k) Disclosure of Information, i.e. the requirement, under Code of Practice No: 2 published by the Advisory, Conciliation and Arbitration Service (ACAS) that management meets all reasonable demands from trade unions for information which is relevant to the negotiations in hand.
- (l) Attitude to Staff Organisations, i.e. that staff are encouraged to join a staff organisation that is recognised as representing staff in his/her particular job. (Message from Joint Secretaries of General Whitley Council HM.(69)63)
- (m) Facilities for Shop Stewards, i.e. the nature and extent of those facilities which would be made available to shop stewards by local management. They will probably include:
  - list of new employees:
  - accommodation for meetings:
  - access to telephone
  - provision of notice boards:
  - use of office facilities (where volume of steward's work justifies it):
  - time off with pay to carry out their Industrial Relations function including training (ACAS Code of Practice No: 3)
  - time off with pay to attend other trade union activities (also ACAS Code of Practice No: 3):
  - disclosure of information (see (K) above).
- (n) Grievance and Disputes Procedures.
- (o) Disciplinary Procedure (ACAS Code of Practice No. 1)
- (p) Industrial Relations - few authorities have a written policy on Industrial Relations itself.

The existence of policies and procedures, especially if they involve the full participation of all levels of management, unions and staff, aid the effective management of industrial relations. They also ensure that the responsibilities for industrial relations are clearly defined for all concerned from senior management to basic grades - and that proper arrangements are made to establish the continuing accountability for managers to achieve good industrial relations. Making managers accountable for industrial relations in the same way as they are accountable for patient care, services, budgets, and standards is probably the best way to establish good industrial relations. But managers can only be held accountable for what they know they have to do. This is the function of policies and procedures, and for this reason they must be effectively communicated to staff and managers throughout the organisation.



(i) COLLECTIVE BARGAININGIntroduction

Two systems of Industrial Relations have developed within the National Health Service and may at times appear to be in conflict with each other. The formal system operates through the Whitley Councils which have the capability to impose decisions on Authorities and Unions alike; collective bargaining at this level is restricted to a narrow range of issues; pay, annual leave entitlement and similar conditions of service.

There is also an informal system which rests on the wide autonomy of officers in individual Authorities and the power of industrial work groups; with bargaining at local level of equal importance to that at the national level and covering a wider range of issues including discipline, grievance, redundancy and work practices, and with the distinction between collective bargaining and joint consultation blurred. This system consists largely of tacit agreements, understandings and custom and practice.

Conflict between these two systems may occur where bargaining at national level encroaches on local interests in the interpretation of national agreements.

Whitley Councils

1. The constitution of the Whitley Councils for the Health Services provides at present for eleven different Whitley Councils, a General Council and ten Functional Councils:
  - Administrative and Clerical Staffs
  - Ambulancemen
  - Ancillary Staffs
  - Dental (Local Authority)
  - Medical and (Hospital) Dental
  - Nurses and Midwives
  - Optical
  - Pharmaceutical
  - Professional and Technical 'A'
  - Professional and Technical 'B'
2. In practice the Dental and Medical Councils never meet. The pay of Doctors and Hospital Dentists is based on recommendations of the Doctors' and Dentists' Review Board and agreed Negotiating Committees which also negotiate certain conditions of service and are outside the formal Whitley system.
3. Community Dentists have a similar negotiating committee as do certain groups of Maintenance Craftsmen. In all these cases the Management Side consists entirely of representatives of the Health Departments.

4. The constitution of most Whitley Councils provides for a certain number of Management Side Members to come from the English, Scottish and Welsh Health Authorities and from the three Health Departments. As far as Authority Members are concerned, the aim is to achieve a good geographical representation on each Council.
5. Management Sides consist of Departmental Representatives and Employing Authority Representatives who are nominated by Regional Selection Committees which comprise the Chairman of Regional and District Health Authorities within a Region. These members may be either Members or Officers of Health Authorities. Secretarial services to each Management Side are provided by officers of the DHSS.
6. The DHSS employs professional advisers and also has a statistics and research division and the services of both are available to the Management Sides.
7. The constitution of the General Whitley Council is rather different in that its membership is derived mainly from representatives (usually the Chairmen), of the Management Sides of the Functional Councils, but some of its members are appointed directly.
8. The Council has no power to direct or oversee the negotiations undertaken in the Functional Councils. It negotiates some conditions of service which are applicable to all or most groups of staff and also has certain general responsibilities such as the admission of new groups of staff to the purview of the Whitley Councils, and the allocation of newly defined groups to an appropriate Council.

The individual Councils are entirely separately constituted and autonomous, though the Secretaries and the Departmental Representatives of Management Sides regard it as their responsibility to consider possible repercussions of an agreement for other Councils.

(ii) BRIEFING GROUPS

In 1977, the Regional Selection Committee within this Region endorsed the establishment of a system whereby each Whitley Council Representative was provided with expert advice from within the Region, an opportunity to discuss the limits of negotiation on specific topics and access to relevant background information. Considerable progress has been made towards the achievement of these objectives by the establishment of a Whitley Council Briefing Group for each functional Whitley Council and the General Council which comprise a number of senior officers of relevant professions from Authorities within the Region.

The functions and constitution of the Briefing Groups are currently under review and it is suggested that membership be extended to include representation of health authorities.

(iii) REORGANISATION

It is expected that the current reorganisation of the NHS will lead to a shift towards the localisation of industrial relations. An inevitable consequence of this will be the need for senior managers to give consideration to the current industrial relations situation with a view to establishing a stable and effective environment for the future.

Derek Warlow

ALLOCATING THE MONEY

(Contributed by J.C. Minty, Area Treasurer, Kent AHA.)

TREASURY - DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Basis of allocation to Health is POLITICAL

MARCH 1981 GOVERNMENT EXPENDITURE PLANS

All Public Health services are to receive 4.4% in the three-year period 1980/81 to 1982/83. Within this total, Health and Community Service to receive 1 $\frac{1}{2}$ % and 1 $\frac{3}{8}$ % in 1981/82 and 1982/83.

Current expenditure in 1983/84 is shown at the 1982/83 level. Spending in 1983/84 will be decided in the light of the availability of resources and the scope for improved efficiency, taking into account demographic trends, the Department's priorities, health care needs, and an assessment of the effect of medical advances. Meanwhile, health authorities' strategic plans are based on the assumption that over the longer term growth in health care provision will average between 1 per cent and 2 per cent a year, while recognising that plans for developments may need to be revised.

Some of the growth from 1980/81 to 1982/83 has been raised from increased charges and increased efficiency.

Recommended Reading: Government Expenditure Plans 1981/82 to 1983/84  
Cmd 8175

DEPARTMENT OF HEALTH AND SOCIAL SECURITY - REGION

The basis of allocation to Regions is R.A.W.P. (Resource Allocation Working Party). The progress to R.A.W.P. targets has been by giving differential growth to each Region based on their R.A.W.P. position. The allocations have been on the basis of no Region receiving a reduction in resources even if they receive an allocation of more than 100% of their R.A.W.P. target.

There is very little central funding by the Department of Health and Social Security but decisions taken at the Department of Health and Social Security tend to affect the National Health Service budgets, e.g. medical manpower, pay settlements.

The Department of Health and Social Security also issue guidance on central priorities, e.g. The Way Forward.

Progress on R.A.W.P.

	<u>Growth in 1982/83</u>		<u>Progress on Moving To R.A.W.P. Targets</u>	
	%	Amount £000	1978/79	1982/83
East Anglia	3.25	8,549	92.17	94.35
North Western	2.79	18,059	87.65	94.60
Northern	2.45	11,525	88.42	95.03
Wessex	2.79	10,478	94.12	94.63*
South Western	2.36	10,868	94.52	95.73*
Trent	3.00	18,503	88.30	94.50
West Midlands	2.20	16,205	92.32	96.17
Yorkshire	1.95	10,328	94.80	96.43
Oxford	2.20	6,649	101.02	98.40
Mersey	1.13	4,427	96.22	99.38
South West Thames	0.46	2,316	105.67	105.65
South East Thames	0.34	2,124	110.81	107.89
North East Thames	0.33	2,171	112.70	108.23
North West Thames	0.30	1,798	113.49	112.32
	<u>1.73</u>	<u>124,000</u>	Range: 87 - 113	94 - 112

Recommended Reading: Sharing Resources for Health in England

REGION - AREAS

The basis on which Region decides allocations to Areas is R.A.W.P. refined for special factors within the Region, e.g. costing of Regional specialties.

The growth rates for recent years are:-

	<u>Teaching Area</u>		<u>Kent</u>	
	£000	%	£000	%
1980/81	480*	0.3	1,020	0.5
1981/82	-	-	1,495	0.8

\* Grove Park Development

The very limited amount of growth available to the Regional Health Authority means either very slow progress up to R.A.W.P. targets in Kent and East Sussex or re-distribution away from over-provided Areas, e.g. Teaching Areas, Greenwich and Bexley.

The net effect of either of the policies is certain to be that the differences in the R.A.W.P. position of Areas/Districts within the London Regions are likely to widen rather than reduce. This is at a time when the R.A.W.P. positions within the non-London Regions are narrowing significantly.

The movement of resources away from London can be made by reducing non-direct patient care expenditure in the London Areas for some time to come. However, the relentless application of this policy over a long period is bound to result in a reduced quantity of patient care in these R.A.W.P. over-provided Areas.

The Region should be able to convince the Department of Health and Social Security that R.A.W.P. equalisation in the London Regions will only be possible by levelling up and this will require an increased share of the growth available to the National Health Service.

Very recently, the Regional Health Authority has adopted a funding policy aimed at achieving the closure of Darent. The Regional Health Authority has also commenced a policy of special funding of developments, e.g. Chair in Geriatric Medicine. Whilst these may well be key strategic Regional objectives, it leaves little available for R.A.W.P. distribution. The Regional Health Authority should confine its role in direct planning to the minimum consistent with achieving its key objectives and, where this is necessary, it must ensure that the "data" base on which it makes its key decisions is adequate (it was clear that this was not so as far as the first Mental Handicap policy was concerned).

Recommended Reading: Regional explanation of R.A.W.P. methodology based on Camberwell Health District

Annual Resources Paper (Due soon!!)

KENT AREA POLICY TO DISTRICTS

Basis of the allocation of growth moneys is R.A.W.P. as amended for special factors within Kent.

Within the strategic plan, each District was given a ten-year resource assumption within which they must manage all Revenue requirements, including the Revenue implications of Capital Schemes. Districts then were asked to choose the pattern of their take-up each year.

The actual resources given to each District was then judged in the light of the overall Area position from year to year.

From 1979/80 Medway was given 3% Revenue growth. This was judged to be the maximum which could be utilised sensibly from year to year without Capital developments.

Dartford's Revenue allocation in 1981/82 was reduced by 0.7% but this money was made available to the District to promote Capital rationalisation. It will be returned to the District in 1984/85 to be used for the Revenue required to run Archery House.

KENT ADJUSTMENTS TO R.A.W.P.

1. Recognises that within ten-year strategic period the large psychiatric hospitals will run down numbers of in-patients but does not assume self-sufficiency of Districts who presently rely on the institutions. Adjustment recognises "new long stay" patients. This avoids the position where under National R.A.W.P., Medway is given a target credit of £7m. for psychiatric services provided by Maidstone, Canterbury and Thanet and Tunbridge Wells.
2. Based on 1991 populations rather than data which is two years old.
3. Builds in charges to cross boundary flows which will arise from Capital developments to be completed within the strategic planning period.
4. Out-patients costs protected due to lack of information on cross boundary flows.
5. Supra District specialty costs protected.

COMMENTS ON R.A.W.P.

1. Morbidity is reflected in the formulae by the use of Standardised Mortality Ratios as a proxy.
2. Deliberate exclusion from the formulae of the resources invested by either Local Government or F.P.C. Black and Acheson reports both highlighted the demand on Health services of inner city deprivation.
3. The adequacy of the allowance within the formulae for Teaching costs is often criticised.
4. Data used is historical (two years out of date).
5. R.A.W.P. created expectations of self-sufficiency for every District.
6. No distinction between patient flows across District boundaries arising from natural flows, flows which occur for medical reasons and flows which only occur because of a shortage of facilities in local population.
7. The relative effectiveness in the uses of resources in different Districts is not recognised..
8. Gaining Regions appear to be experiencing difficulty in spending additional resources sensibly whilst losing Regions will eventually need to consider reducing services.

Recommended Reading:

1. R.A.W.P. Report
2. Buxton & Klein Commentary on R.A.W.P.  
(Research Paper No. 3 for Royal Commission)

CAPITAL ALLOCATIONS

The Regional Health Authority do not give Capital planning resource guidelines - they rely on bids. The total Regional Health Authority allocation is divided into a number of separate "boxes". There is a direct incentive to Areas and, in future, Districts to indulge in opportunity bidding.

The Regional Health Authority decision making criteria is not known and probably does not exist. Yet the Regional Health Authority makes over 90% of all Capital decisions.



## CONTROL OF PUBLIC EXPENDITURE

### INTRODUCTION

Health Authorities rely almost entirely (over 98%) on Central Government for funds and it is, therefore, important that Members and Officers understand the way in which Central Government controls Public Expenditure and the implications for Health of these control mechanisms.

### PUBLIC EXPENDITURE SURVEY (PESC)

Each year the Government produce expenditure figures for each programme including Health. The programmes are at the preceding November price base and are shown at the constant November price base for the following three years. Thus the 1981 survey would show expenditure details for the Financial Years 1982/83 to 1984/85 - although 1984/85 was omitted from that survey. The programmes shown are at the November 1980 price base - thus being almost seventeen months out of date.

### CASH LIMITS

The introduction of annual Public Expenditure plans in the early 1960's gave significant control over the "volume" of public expenditure levels. However, rapid inflation in the early 1970's meant that the actual cash required by the Government was far in excess of the amount planned in volume terms and often meant that the Government could not match this with finance available from taxes and charges. This led to the need to borrow more than planned to balance the National budget. This, in turn, led to further inflation.

Cash limits were introduced in 1976 to try to control the effect of inflation on public expenditure programmes. Under this system, the Government provides a fixed amount of cash to cover inflation in the Financial Year ahead. The "contingency" amount is determined by the Government expectations of the level of pay and price rises in the year ahead - separate assumptions were made for pay and price components. For example, in 1981/82 6% was provided for pay rises. Actual pay and price rises in the current year were not funded under the system and, if they exceeded the sum provided, then this had to be absorbed. In the years from 1976, the Central Government nearly always under-estimated the annual level of inflation.

The revaluation to a November price basis of the amount needed to provide the agreed volume of services continued under the cash limits system. Thus any under-funding was for the first year only and the actual level of pay and price rises experienced in Year 1 was made good the following November when Year 2 became Year 1. As far as Kent is concerned, the A.H.A. received £2.84m. for expected inflation on non-Pay items for the Financial Year 1979/80. Actual price rises cost the Authority £5.88m. The difference had to be absorbed by the Authority in 1979/80 but was built into the November 1979 base for the allocations from 1981/82 onwards.

The Regional Health Authority has a poor record in public decision taking, cost escalation and cost control. The review recently undertaken by the Regional Health Authority was done on entirely pragmatic decisions aimed at bringing a £70m. over-commitment into balance. The relative priorities were not an issue and the present programme excludes very high priority schemes, e.g. Thanet rationalisation, Darenth Park.

Although much of this past performance has been acknowledged by the Regional Health Authority its proposed solutions are disappointing since they amount to increased rather than decreased Regional Health Authority control.

They invite Districts to put forward schemes within resource guidelines for inclusion in a Regional building programme. The final decisions will still rest with the Regional Health Authority and control of the Capital resources will remain with the Regional Team of Officers, despite past performance.

Surely the Regional Health Authority involvement is to confirm that the Capital spending proposals by Districts reflect the right priorities and, having confirmed this, the Districts should exercise all control from that point on - albeit under monitoring by Region.

The Regional Health Authority should operate the cost of professional works staff as a trading account by charging scale fees to client Districts. In this way the Regional Health Authority would introduce more accountability into its procedures.

J C MINTY  
AREA TREASURER  
KENT AREA HEALTH AUTHORITY

JCM/EAG  
25.2.82



Table 2Cash Planning

	<u>Basic</u> <u>Allocation</u>	<u>Inflation</u> <u>Prov.</u>	<u>Total</u>	<u>Act.</u> <u>Inf.</u>	<u>T</u> <u>Required</u>	<u>Under</u>
1982/83	37.0	3.7	40.7	4.1	41.1	0.4
1983/84	40.7	4.1	44.8	4.5	45.6	0.8
1984/85	44.8	4.6	49.4	5.1	50.7	1.3
						<u>2.5</u>

6. In the past few years, under-funding on the old cash limits system has meant that short term measures have needed to be taken to reduce budgets in order to live within the allocation. Inevitably, these reductions have impacted on the budgets which are capable of being reduced quickly, e.g. maintenance. This cannot continue indefinitely without causing infrastructure problems.
7. Health Authorities will need to concentrate on the best way of utilising resources and this will undoubtedly mean careful evaluation of all the options.
8. Health Authorities must identify "creeping" growth and decide the relative priority of the proposals.
  - a. Capital Developments - even minor schemes often have Revenue consequences which are not foreseen. A more rigorous evaluation of these ongoing costs must be made before agreement to the Capital expenditure.
  - b. Voluntary Sector - some authorities have, in the past, been unable to fund the Revenue implications of Capital moneys raised by the Voluntary Sector. Closer co-operation may avoid this problem.
  - c. Medical and Scientific Equipment - new technology often causes increased Revenue requirements. The Regional Scientific Officer will need to identify this before the Districts are asked to commit themselves to the purchase.
  - d. Drugs - money can be saved without affecting clinical freedom. This is by better stock control, reduced wastage and better cost information to groups of clinicians.

PART 2

This part contains some facts relating to the South East Thames Region. Many more details are contained in the following regional publications:-

1. SETRHA. Planning Guidelines and Policies. 1981
2. SETRHA. Strategic Plan 1979 - 1988. 1979
3. SETRHA. Health Care in the South East Thames Region. 1979

I am grateful to Mr. C.W. Lowe, Regional Statistician, for providing the tables.

The South East Thames Regional Health Authority

Chairman - Sir John Donne

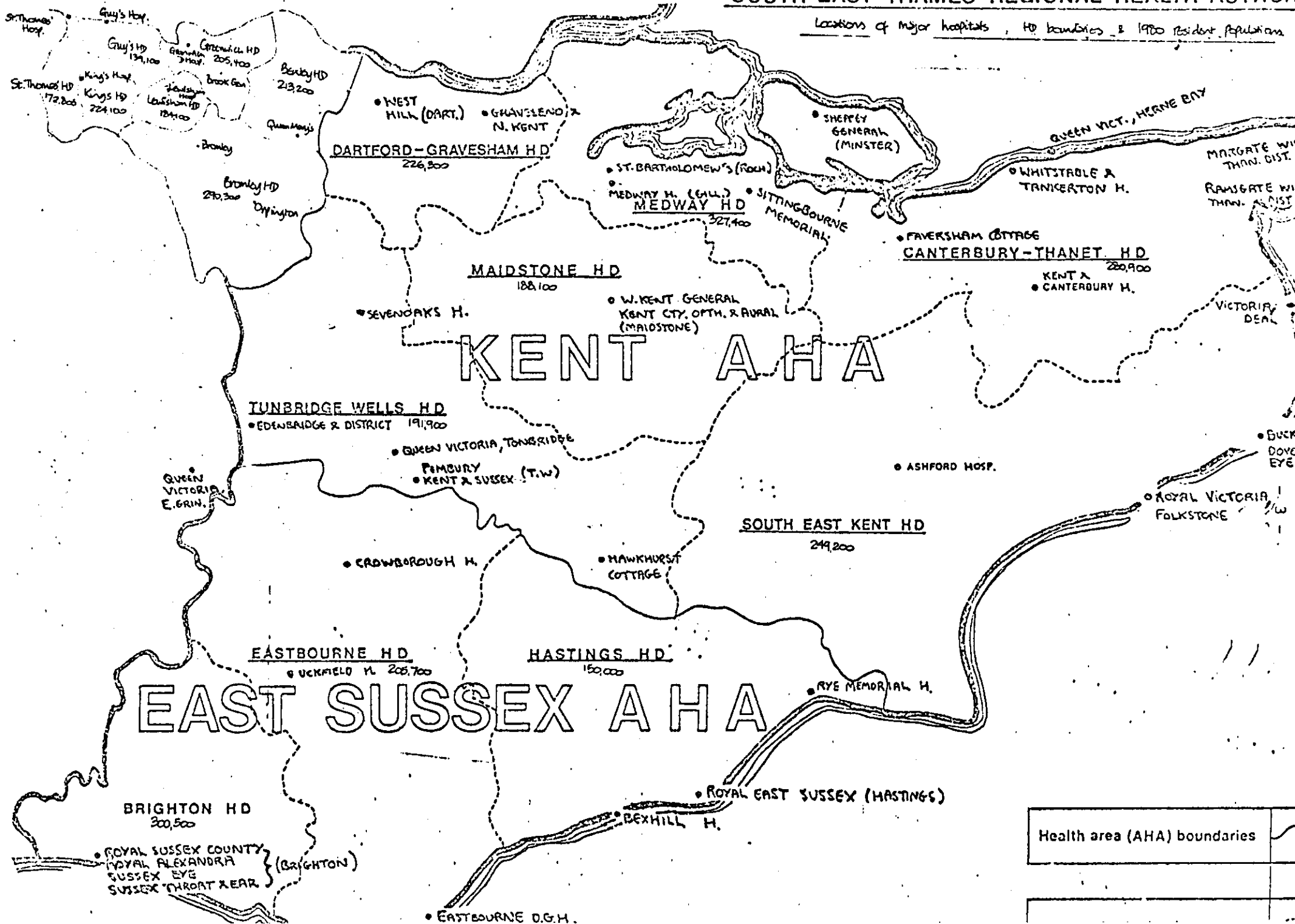
Members - R.A. Balfe  
Miss K. Ruth Bryant  
L.T. Cotton  
D.L. Crouch  
B.M. Gnanapragasam  
R.F. Hayliar  
Professor P.M. Higgins  
R.F. Holland  
G.W. Humphrey  
Dr. R.C. King  
Mrs. A. Ledward  
J. Lynch  
Mrs. M.A. Roe  
Professor N.J.D. Smith  
Mrs. J. Stearne  
G. Templeman  
Mr. J. Waite  
Mrs. J.N. Waters  
Lady Willis

Regional Team of Officers -

Regional administrator - P.H.J. Le Fleming  
Regional medical officer - Dr. J.M. Forsythe  
Regional nursing officer - Miss A.C. Emerton  
Regional treasurer - K. Sutton  
Regional works officer - M.L.F. Franck

# SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY

Locations of major hospitals, HD boundaries & 1980 Resident Populations



Health area (AHA) boundaries	<input checked="" type="checkbox"/>

Table 4.1

## Population Statistics 1974-

## Resident Population

## District Acute Catchment Population

District / AREA	1974	1975	1976	1977	1978	1979	1980	1974	1975	1976	1977	1978	1979	1980
BROMLEY RHA	301.5	294.9	299.1	293.1	292.2	290.7	290.3	286.8	269.4	267.0	266.6	264.7	256.4	244.5
Brighton	305.5	306.0	302.2	301.6	301.1	300.1	300.5	303.1	293.3	303.6	311.0	301.7	301.6	303.4
Eastbourne	202.7	201.5	203.0	201.6	202.4	205.3	205.7	138.2	129.3	141.6	146.3	150.7	153.1	154.8
Hastings	150.7	149.8	150.4	149.7	149.0	149.2	150.0	150.8	145.3	145.2	149.2	146.9	145.7	145.7
EAST SUSSEX RHA	658.9	657.3	655.6	652.9	652.5	654.6	656.2	592.1	567.9	593.4	606.5	599.3	600.5	606.9
Bexley	216.9	216.9	213.5	214.7	213.8	213.0	213.2	214.3	195.7	195.1	113.2	123.8	124.8	131.6
Greenwich	212.8	209.8	207.2	206.2	204.5	204.6	205.4	351.4	309.0	309.6	316.0	304.2	293.6	287.7
GREENWICH-BEXLEY RHA	429.7	426.7	420.7	420.9	418.3	417.6	418.6	435.7	407.7	417.7	429.2	428.0	427.3	417.4
Canterbury-Thames	275.1	275.7	276.4	277.6	279.0	278.8	280.9	336.4	310.2	313.7	316.6	311.7	310.2	299.4
Dartford-Grovesham	214.2	219.1	218.5	222.2	223.4	225.3	226.3	243.6	230.1	217.3	229.5	218.8	216.6	221.3
Maidstone	170.0	180.5	181.8	183.9	185.3	186.8	188.1	136.8	132.7	132.7	132.3	129.8	131.5	131.3
Medway	319.4	322.1	321.9	318.1	321.0	325.0	327.4	297.9	291.2	292.1	291.9	290.5	295.0	295.6
South East Kent	249.8	249.9	250.8	248.3	247.9	248.0	249.2	213.9	201.0	198.8	202.4	201.6	209.2	225.7
Tunbridge Wells	147.3	148.1	149.0	149.0	148.4	148.2	149.9	259.4	241.0	230.5	229.5	214.7	212.6	242.7
KENT RHA	1440.8	1445.4	1445.1	1445.1	1449.0	1456.1	1463.8	1488.0	1406.2	1385.1	1452.2	1397.1	1405.0	1415.9
Guy's	150.0	146.0	140.3	141.1	138.9	139.3	139.1	251.9	240.5	227.4	219.6	230.8	240.0	242.9
King's	248.8	245.6	236.7	233.9	228.0	225.2	224.1	300.8	277.6	269.6	262.0	242.2	237.5	234.0
Lewisham	196.7	191.7	184.6	189.4	186.6	183.5	184.1	209.3	189.4	182.9	190.1	186.2	187.6	179.8
St Thomas'	194.6	195.6	191.2	186.4	179.4	175.6	172.8	237.9	203.7	211.8	224.2	228.5	212.3	217.5
L-S-L RHA(T)	190.1	178.9	173.8	170.8	172.9	173.6	170.1	999.9	911.2	891.7	896.1	887.7	877.4	845.0
SE THAMES RHA	3621.0	3603.2	3576.0	3562.8	3544.9	3542.4	3549.0	3802.5	3562.4	3555.1	3630.5	3576.8	3567.7	3577.7

Source: OPCS.

Figures in thousands.



1930 RESIDENT POPULATION - MID-YEAR ESTIMATE

		0 - 4	5 - 14	15 - 44	45 - 64	65 - 74	75 +	TOTAL
BRIGHTON H.D.	M	7.0	19.6	57.3	31.3	14.1	8.3	137.6
	F	6.8	19.4	58.5	37.3	21.9	19.0	162.9
	T	13.8	39.0	115.8	68.6	36.0	27.3	300.5
EASTBOURNE H.D.	M	4.9	13.1	35.2	21.3	11.8	6.6	92.9
	F	4.6	12.0	37.1	26.2	17.7	15.2	112.8
	T	9.5	25.1	72.3	47.5	29.5	21.8	205.7
HASTINGS H.D.	M	3.7	9.5	25.5	15.2	8.8	5.5	68.2
	F	3.1	8.2	25.9	19.6	13.5	11.5	81.8
	T	6.8	17.7	51.4	34.8	22.3	17.0	150.0
EAST SUSSEX A.H.A.	M	15.6	42.2	118.0	67.8	34.7	20.4	298.7
	F	14.5	39.6	121.5	83.1	53.1	45.7	357.5
	T	30.1	81.8	239.5	150.9	87.8	66.1	656.2
S.E. KENT H.D.	M	7.0	18.1	52.0	26.4	11.4	5.8	120.7
	F	6.6	17.4	46.8	29.3	15.5	12.9	128.5
	T	13.6	35.5	98.8	55.7	26.9	18.7	249.2
CANTERBURY / THANET H.D.	M	7.6	19.7	54.1	28.4	14.7	7.2	131.7
	F	7.3	17.5	53.0	33.3	20.8	17.3	149.2
	T	14.9	37.2	107.1	61.7	35.5	24.5	280.9
DARTFORD / GRAVESHAM H.D.	M	8.0	19.5	47.3	25.5	8.2	3.6	112.1
	F	7.3	17.9	46.8	25.0	10.1	7.1	114.2
	T	15.3	37.4	94.1	50.5	18.3	10.7	226.3
MAIDSTONE H.D.	M	6.2	14.4	40.2	20.9	7.0	3.1	91.8
	F	5.9	14.6	40.9	20.6	8.6	5.7	96.3
	T	12.1	29.0	81.1	41.5	15.6	8.8	188.1
MEDWAY H.D.	M	12.5	27.7	74.5	32.8	11.6	4.7	163.8
	F	11.1	25.7	68.8	32.9	14.2	10.9	163.6
	T	23.6	53.4	143.3	65.7	25.8	15.6	327.4
TUNBRIDGE WELLS H.D.	M	5.3	14.9	39.0	20.7	8.2	3.5	91.6
	F	5.5	13.9	39.7	23.1	10.5	7.6	100.3
	T	10.8	28.8	78.7	43.8	18.7	11.1	191.9
KENT A.H.A.	M	46.6	114.3	307.1	154.7	61.1	27.9	711.7
	F	43.7	107.0	296.0	164.2	79.7	61.5	752.1
	T	90.3	221.3	603.1	318.9	140.8	89.4	1463.8

1980 RESIDENT POPULATION - MID-YEAR ESTIMATE

		0 - 4	5 - 14	15 - 44	45 - 64	65 - 74	75 +	TOTAL
BEXLEY H.D.	M	6.5	16.6	43.7	23.9	8.3	3.7	102.9
	F	5.4	15.7	45.9	24.9	10.3	8.1	110.3
	T	11.9	32.3	89.8	48.8	18.6	11.8	213.2
GREENWICH H.D.	M	6.4	14.8	42.5	22.3	8.4	3.6	98.0
	F	7.5	15.0	41.5	24.0	10.7	8.7	107.4
	T	13.9	29.8	84.0	46.3	19.1	12.3	205.4
GREENWICH & BEXLEY A.H.A.	M	12.9	31.4	86.4	46.2	16.7	7.3	200.9
	F	12.9	30.7	87.4	48.9	21.0	16.8	217.7
	T	25.8	62.1	173.8	95.1	37.7	24.1	418.6
BROMLEY A.H.A.	M	8.4	20.8	59.9	34.5	12.2	5.7	141.5
	F	7.4	19.3	57.3	36.6	16.7	11.5	148.8
	T	15.8	40.1	117.2	71.1	28.9	17.2	290.3
ST. THOMAS' H.D.	M	4.7	12.9	34.6	19.2	7.4	3.3	82.0
	F	4.9	11.8	37.4	19.7	9.2	7.8	90.7
	T	9.6	24.6	72.0	38.9	16.6	11.1	172.8
KING'S H.D.	M	6.4	16.0	44.3	26.6	10.2	4.4	107.9
	F	6.0	13.9	45.6	27.3	13.0	10.4	116.2
	T	12.4	29.9	89.9	53.9	23.2	14.8	224.1
GUY'S H.D.	M	4.4	10.5	27.0	16.1	6.3	2.8	67.1
	F	4.0	9.7	27.7	16.5	7.9	6.2	72.0
	T	8.4	20.2	54.6	32.6	14.2	9.0	139.1
LEWISHAM H.D.	M	5.0	12.8	35.1	21.1	8.6	4.1	86.7
	F	4.5	13.1	36.5	23.1	11.4	8.8	97.4
	T	9.5	25.9	71.6	44.2	20.0	12.9	184.1
A.H.A. (T)	M	20.5	52.1	141.0	83.0	32.5	14.6	343.7
	F	19.4	48.5	147.2	86.6	41.5	33.2	376.4
	T	39.9	100.6	288.2	169.6	74.0	47.8	720.1
S.E.T.R.H.A.	M	104.0	260.8	712.4	386.2	157.2	75.9	1696.5
	F	97.9	245.1	709.4	419.4	212.0	168.7	1852.5
	T	201.9	505.9	1421.8	805.6	369.2	244.6	3549.0
ENGLAND & WALES	M	1523.5	3762.1	10437.8	5398.7	2007.7	905.8	24035.6
	F	1462.2	3562.8	10096.6	5647.6	2603.6	1909.4	25262.2
	T	2985.7	7324.9	20534.4	11046.3	4611.3	2815.2	49397.8

SOURCE: OPCS MID-1980 ESTIMATES

SCAN 100/11

H.D. A.H.A. (T) REMARKED TO SELECT UNITS

STATISTICS & D.R. DEPARTMENT

ALL TOTALS SUBJECT TO ROUNDING

1971 RESIDENT POPULATION PROJECTIONS

		0 - 4	5 - 14	15 - 44	45 - 64	65 - 74	75 +	TOTAL
BRIGHTON H.D.	M	9.4	15.3	65.3	29.6	11.1	7.9	138.6
	F	8.9	14.5	62.5	31.4	16.4	19.2	152.9
	T	18.4	29.8	127.8	61.0	27.5	27.1	291.5
EASTBOURNE H.D.	M	6.6	11.2	41.1	20.3	10.5	7.1	96.9
	F	6.3	10.1	41.8	22.4	14.1	14.8	109.5
	T	12.9	21.3	82.9	42.8	24.6	22.0	206.5
HASTINGS H.D.	M	4.7	7.9	28.1	14.4	7.7	5.9	68.7
	F	4.4	7.5	28.4	17.1	11.0	13.4	81.8
	T	9.1	15.4	56.5	31.4	18.7	19.3	150.4
EAST SUSSEX A.H.A.	M	20.8	34.4	134.5	64.4	29.3	21.0	304.2
	F	19.6	32.0	132.7	70.9	41.6	47.4	344.2
	T	40.4	66.5	267.2	135.2	70.8	68.4	648.4
S.E. KENT H.D.	M	9.7	16.2	53.0	26.7	11.4	7.3	124.2
	F	9.1	15.5	50.7	29.2	14.8	14.3	133.5
	T	18.8	31.7	103.7	55.9	26.2	21.6	257.8
CANTERBURY / THANET H.D.	M	9.1	16.8	54.5	29.7	15.0	9.9	135.1
	F	8.6	15.6	53.7	34.4	20.3	19.4	152.0
	T	17.7	32.4	108.2	64.1	35.3	29.3	287.1
DARTFORD / GRAVESHAM H.D.	M	9.6	15.5	54.0	23.3	6.6	3.6	112.5
	F	9.1	14.7	50.6	22.1	7.8	7.3	111.6
	T	18.7	30.2	104.6	45.3	14.4	10.9	224.1
MAIDSTONE H.D.	M	8.6	13.0	46.7	19.7	6.0	3.4	97.5
	F	8.2	12.3	43.5	19.6	7.3	6.5	97.5
	T	16.9	25.3	90.2	39.3	13.3	10.0	195.0
MEDWAY H.D.	M	15.6	22.4	81.7	32.0	10.2	5.9	167.8
	F	14.6	21.5	74.7	31.7	12.3	10.8	165.7
	T	30.2	44.0	156.4	63.7	22.6	16.7	333.5
TUNBRIDGE WELLS H.D.	M	7.4	13.2	42.3	20.4	6.8	4.2	94.3
	F	7.1	12.2	41.5	21.7	9.4	9.8	101.9
	T	14.5	25.4	83.8	42.2	16.2	14.0	196.2
KENT A.H.A.	M	60.0	97.3	332.2	151.8	56.0	34.2	731.6
	F	56.8	91.2	314.7	153.7	72.0	68.1	762.1
	T	116.8	189.0	646.9	310.5	128.0	102.4	1493.7

1991 RESIDENT POPULATION PROJECTIONS

		0 - 4	5 - 14	15 - 44	45 - 64	65 - 74	75 +	TOTAL
BEXLEY H.D.	M	8.6	13.6	44.9	21.9	6.8	4.3	100.0
	F	8.2	12.1	45.2	22.9	9.4	9.1	107.9
	T	16.8	25.7	90.1	44.8	16.1	13.4	207.9
GREENWICH H.D.	M	9.1	13.6	42.8	18.5	6.8	4.0	94.7
	F	8.6	12.9	42.5	19.9	8.6	9.2	101.7
	T	17.6	26.4	85.4	38.5	15.4	13.2	196.5
GREENWICH & BEXLEY A.H.A.	M	17.7	27.1	87.7	40.4	13.6	8.2	194.8
	F	16.8	25.0	87.8	42.8	17.9	18.3	208.6
	T	34.4	52.2	175.5	83.2	31.5	26.5	403.4
BROMLEY A.H.A.	M	9.7	14.7	57.0	28.4	9.6	6.1	125.5
	F	9.2	14.4	55.0	31.4	13.7	13.0	136.8
	T	18.9	29.1	112.1	59.9	23.3	19.0	262.3
ST. THOMAS' H.D.	M	6.3	8.9	34.2	16.2	5.3	3.5	74.3
	F	6.0	8.9	35.5	18.5	7.7	7.3	83.8
	T	12.3	17.8	69.6	34.7	13.0	10.7	158.1
KING'S H.D.	M	7.8	11.0	41.1	20.2	6.9	3.8	90.9
	F	7.4	10.6	40.6	21.9	10.1	9.0	99.7
	T	15.2	21.7	81.8	42.1	17.0	12.8	190.6
GUY'S H.D.	M	5.0	7.0	24.6	12.2	4.4	2.5	55.6
	F	4.7	6.6	24.3	13.0	6.3	5.7	60.7
	T	9.7	13.6	48.9	25.2	10.7	8.2	116.3
LEWISHAM H.D.	M	7.2	10.2	34.0	16.6	6.1	4.1	78.3
	F	6.9	9.9	35.7	18.3	8.6	8.3	87.6
	T	14.2	20.1	69.7	34.9	14.7	12.4	165.9
A.H.A. (T)	M	26.2	37.1	133.9	65.2	22.8	13.9	299.0
	F	25.1	36.0	136.1	71.7	32.7	30.3	331.8
	T	51.3	73.1	270.0	136.8	55.5	44.1	630.8
S.E.T.P.H.A.	M	134.4	210.6	745.3	350.2	131.2	83.4	1655.1
	F	127.5	199.3	726.3	375.5	177.9	177.1	1783.6
	T	261.9	409.9	1471.7	725.7	309.1	260.5	3438.7
ENGLAND & WALES	M	1987.0	3309.0	11056.0	5291.0	1929.0	1084.0	24656.0
	F	1879.0	3134.0	10718.0	5435.0	2438.0	2160.0	25764.0
	T	3866.0	6443.0	21774.0	10726.0	4367.0	3244.0	50420.0

N.B. All figures in Thousands

1975-80 OVERALL SMR'S BY HEALTH DISTRICT

Brighton	98.87
Eastbourne	87.82
Hastings	94.43
S.E. Kent	95.01
Canterbury/Thanet	98.96
Dartford/Gravesham	98.84
Maidstone	99.06
Medway	97.77
Tunbridge Wells	101.17
Bexley	90.73
Greenwich	100.41
Bromley	90.80
West Lambeth	94.47
Camberwell	96.06
Lewisham & N. Southwark	94.66
S.E. THAMES RHA	95.77

1975-80 CONDITION-SPECIFIC SMR'S FOR S.E. THAMES RHA

<u>I.C.D. Chapter</u>	SMR
I. Infectious and Parasitic Diseases	96.35
II. Neoplasms	100.43
III. Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders	91.79
IV. Diseases of the Blood and Blood-forming Organs	87.70
V. Mental Disorders	98.59
VI. Diseases of the Nervous System and Sense Organs	95.14
VII. Diseases of the Circulatory System	93.06
VIII. Diseases of the Respiratory System	99.20
IX. Diseases of the Digestive System	97.09
X. Diseases of the Genitourinary System	101.45
XI. Complications of Pregnancy, Childbirth, and the Puerperium	80.79
XII. Diseases of the Skin and Subcutaneous Tissue	86.27
XIII. Diseases of the Musculoskeletal System and Connective Tissue	97.87
XIV. Congenital Anomalies	98.55
XV. Certain Conditions originating in the Perinatal Period	99.45
XVI. Symptoms, Signs and Ill-defined Conditions	79.15
XVII. Injury and Poisoning	91.82
ALL CAUSES	95.77

Allocated Beds 1974 -

District / Area	1974	1975	1976	1977	1978	1979	1980											
BROMLEY AHA	3038	3020	2856	2830	2686	2501	2511											
Brighton	1987	1982	1906	1906	1907	1891	1791											
Eastbourne	1635	1639	1683	1712	1728	1700	1698											
Hastings	1138	1145	1160	1102	1055	1070	978											
EAST SUSSEX AHA	4780	4766	4749	4720	4690	4661	4467											
Bexley	1900	1866	1835	1841	1651	1667	1666											
Greenwich	1613	1623	2013	1971	1816	1753	1630											
GREENWICH-BEXLEY AHA	3813	3791	3848	3812	3467	3420	3296											
Canterbury-Thames	3279	3351	3209	3037	2939	2900	2748											
Dartford-Gravesend	3214	3132	2909	2813	2747	2613	2510											
Maidstone	2115	1974	1983	1897	1822	1709	1704											
Medway	1041	1030	996	1008	1021	986	995											
South East Kent	1022	1031	1024	1053	999	1032	1064											
Tunbridge Wells	2596	2576	2586	2338	2456	2423	2380											
KENT AHA	13267	13094	12707	12346	11984	11663	11298											
Guy's	1492	1452	1453	1427	1409	1264	1297											
Kings	1623	1606	1561	1540	1457	1390	1377											
Lewisham	1276	1247	1187	1040	1015	1005	971											
Sr. Thomas	2674	2596	2458	2362	2312	2242	2238											
L.S.E. AHA(T)	7065	6901	6579	6369	6193	5901	5883											
SE THAMES AHA	31963	31572	30739	30077	29020	28146	27555											
ENGLAND	401563	394778	388022	379620	372292	363193	359900											
Source SH3																		

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Table 5.9.2 Inpatient Statistics 1974 - 1980

Number of Discharges and Deaths

District / AREA	1974	1975	1976	1977	1978	1979	1980
BROMLEY AHA	31 357	28 884	29 492	30 702	30 632	29 715	29 115
Brighton	31 472	28 927	30 103	31 532	31 298	31 671	33 040
Earlstone	14 596	14 151	15 971	17 505	17 613	15 059	19 714
Hastings	16 437	16 107	17 608	18 623	18 622	19 039	18 758
EPST SUSSEX AHA	62 505	59 185	63 682	67 660	68 133	68 769	71 512
Bexley	11 209	12 920	14 288	15 589	16 316	16 601	17 496
Greenwich	37 527	35 772	40 115	42 017	41 057	39 803	39 990
GREENWICH-BEXLEY AHA	48 736	48 692	54 403	57 606	57 353	56 404	57 486
Canterbury-Thanel	38 149	36 147	38 472	39 696	38 567	38 849	39 194
Dartford-Gravesham	24 037	23 699	24 574	26 646	24 705	25 023	26 106
Maidstone	16 455	16 569	17 027	17 259	16 626	16 692	17 769
Medway	26 910	26 551	26 910	28 028	27 511	28 759	30 394
South East Kent	19 197	17 232	18 683	19 869	19 931	21 560	24 681
Tunbridge Wells	28 366	27 391	29 939	31 026	29 281	29 313	31 040
KENT AHA	153 164	147 589	155 605	162 524	156 621	160 196	169 174
Guy's	29 830	30 806	33 207	32 518	32 347	31 915	32 551
Kings	36 647	35 128	37 168	36 989	35 538	35 266	36 261
Lewisham	23 858	22 284	23 268	22 500	21 882	22 552	22 468
St Thomas	33 472	31 934	31 730	32 607	33 934	33 680	34 630
L-S-L AHA (T)	123 857	120 152	125 373	124 614	123 701	123 413	125 910
SE THAMES RHA	419 649	404 502	428 555	443 106	436 440	435 500	453 197

Source: S11.3

Table S.9.1:

## Inpatient Statistics 1974-1981

Mean Duration of Stay, days

Average Turnover Interval, days

District / AREA	Mean Duration of Stay, days							Average Turnover Interval, days						
	1974	1975	1976	1977	1978	1979	1980	1974	1975	1976	1977	1978	1979	1980
BROMLEY AHA	29.4	30.2	29.6	26.3	26.0	25.9	25.5	7.1	8.1	7.5	6.6	6.4	5.9	5.5
Brighton	19.0	20.3	19.3	18.0	17.5	17.6	16.5	4.7	4.7	4.8	4.1	4.2	4.3	4.0
Fulbourn	35.3	34.6	30.7	28.4	27.7	27.3	24.6	7.4	7.4	7.7	6.9	7.5	7.3	7.2
Hastings	20.8	20.7	18.9	17.7	17.2	16.4	15.7	4.5	5.3	5.1	4.5	4.2	4.0	4.2
EAST SUSSEX AHA	23.3	23.8	22.0	20.6	20.0	19.8	18.5	5.3	5.5	5.6	4.9	5.1	5.0	4.9
Borley	50.0	43.0	39.4	34.8	34.4	30.8	29.8	13.2	9.7	7.8	8.5	5.9	5.5	5.1
Greenwich	14.7	14.6	13.7	13.4	13.3	12.9	12.1	4.0	4.4	3.9	3.5	3.6	3.4	3.1
GREENWICH-BEXLEY AHA	22.5	22.2	20.8	19.1	18.7	18.2	17.5	6.1	5.5	4.9	4.9	4.3	4.0	3.7
Canterbury-Thornt	26.8	27.2	24.9	23.3	22.7	21.8	21.3	5.2	6.2	6.2	5.3	5.5	5.6	5.2
Dartford-Gravesham	40.8	38.5	35.7	32.0	32.2	31.6	29.6	10.8	11.4	9.7	7.5	7.1	7.0	6.2
Maidstone	40.0	37.6	35.7	34.2	33.5	31.8	29.8	7.1	5.9	6.3	6.8	7.3	6.3	5.4
Medway	10.6	10.7	10.2	9.4	9.7	9.6	9.1	3.4	3.3	3.3	3.4	3.7	3.0	2.7
South East Kent	15.4	16.3	15.6	14.6	14.3	12.8	11.9	4.4	4.8	4.1	4.2	4.2	4.2	3.8
Tunbridge Wells	28.0	23.3	26.1	25.2	25.4	25.0	23.6	5.3	6.2	5.3	5.1	5.2	5.1	4.7
KENT AHA	26.4	26.1	24.3	22.8	22.7	21.6	20.3	5.9	6.3	5.8	5.3	5.4	5.2	4.6
Guy's	16.0	13.9	13.2	13.4	16.7	12.8	11.8	3.0	2.8	2.1	2.3	2.6	2.6	2.2
Kings	13.4	13.5	12.7	12.8	12.5	12.2	11.7	2.6	3.2	2.8	2.3	2.7	2.6	2.1
Lewisham	13.5	14.1	13.4	12.9	12.9	12.4	12.4	5.9	5.9	5.1	4.2	3.6	3.4	3.8
St Thomas	25.7	25.0	24.3	23.4	22.5	21.7	20.7	4.3	3.9	3.9	2.7	2.3	2.4	2.4
L-S-L AHA (T)	17.1	16.8	15.9	15.7	15.3	15.0	14.3	3.8	3.7	3.3	2.8	2.7	2.7	2.5
SE THAMES AHA	23.1	22.8	21.2	20.2	19.9	19.3	18.4	5.3	5.5	5.0	4.6	4.5	4.4	4.0

Source: calculated from Tables



Table 7.2.1

Outpatient Statistics 1974-1981

Number of Clinic Sessions

Number of New Outpatients

District / AREA	Number of Clinic Sessions							Number of New Outpatients						
	1974	1975	1976	1977	1978	1979	1980	1974	1975	1976	1977	1978	1979	1980
BROMLEY AHA	5 487	5 354	5 456	5 565	5 525	5 165	5 168	46 485	38 668	40 745	41 673	41 229	41 066	41 618
Brighton	11 150	11 014	11 403	12 661	12 988	13 158	13 987	64 588	51 839	53 896	59 825	59 378	59 128	61 006
Eastbourne	3 451	3 454	3 908	4 398	4 720	4 633	4 592	18 591	16 695	19 975	22 200	22 532	22 727	23 703
Hastings	5 398	5 083	5 487	5 655	5 701	6 095	6 271	26 504	21 975	24 287	26 195	26 434	26 833	27 572
EAST SUSSEX AHA	20 059	19 551	20 795	22 714	23 409	23 866	24 850	109 683	90 509	98 158	108 210	108 344	108 668	112 391
Hove	3 546	4 097	3 712	3 766	3 972	4 072	4 165	16 654	16 088	18 448	20 163	22 184	22 281	22 370
Greenwich	12 429	12 360	12 624	12 418	12 492	11 943	11 527	65 793	52 215	62 670	64 978	64 386	59 787	58 430
GREENWICH-BEXLEY AHA	16 273	16 457	16 336	16 184	16 464	16 015	15 692	82 447	72 303	81 118	85 041	86 170	82 068	80 800
Canterbury-Thames	11 214	11 124	11 597	11 719	11 576	11 372	11 703	49 204	38 668	42 331	44 160	44 304	43 950	44 500
Dartford-Grazeham	8 028	7 913	8 235	8 715	8 787	9 590	9 019	36 057	31 282	33 963	33 334	35 854	37 767	35 423
Maidstone	3 881	3 884	4 252	4 449	4 450	4 624	4 952	22 568	20 548	21 178	20 903	19 976	21 601	21 446
Medway	7 500	7 593	8 347	7 853	8 187	8 061	8 381	43 138	38 753	40 815	41 683	43 314	43 057	42 063
South East Kent	5 740	5 731	6 148	6 245	6 398	6 523	7 088	31 019	25 636	28 829	29 547	29 993	31 506	32 182
Tunbridge Wells	8 974	8 691	8 833	9 037	9 023	9 577	9 602	45 312	40 034	42 516	44 015	43 722	44 177	47 198
KENT AHA	45 641	46 971	47 412	48 018	48 421	49 737	50 745	227 298	194 921	209 552	213 692	217 165	222 058	222 512
Guy's	16 597	16 345	16 790	18 907	18 801	16 220	17 452	57 174	54 610	61 520	60 104	59 898	61 225	57 416
King's	18 268	20 479	19 752	17 228	17 289	17 924	17 397	73 368	64 411	68 884	70 373	68 554	66 542	72 536
Lewisham	8 586	8 737	8 797	8 420	8 127	7 930	7 794	40 658	31 734	35 010	35 918	33 134	32 427	31 726
St Thomas'	13 358	13 905	12 272	13 213	12 676	12 869	14 726	61 138	56 006	58 665	64 963	63 446	63 732	65 700
L-S-L AHA (T)	57 109	59 466	57 611	54 768	53 893	54 763	57 369	237 338	206 761	224 079	231 358	225 032	223 926	227 448
SETHAMES AHA	147 589	148 829	150 610	150 527	151 015	153 566	157 801	698 251	603 152	653 682	679 774	678 240	678 086	685 069

+ 13 -

Source: SH 3

Table 7.8.2.

## Outpatient Statistics 1974-1981

## Total Outpatient Attendances

## Average Attendances per New Outpatient

District (AREA)	1974	1975	1976	1977	1978	1979	1980										1974	1975	1976	1977	1978	1979	1980
BROMLEY RHA	263,548	183,502	183,167	188,398	191,031	193,237	187,991										4.38	4.73	4.50	4.54	4.63	4.67	4.52
Brighton	241,181	214,796	219,046	240,223	243,707	239,822	244,870										3.73	4.14	4.06	4.01	4.10	4.06	4.01
Eastbourne	72,513	67,339	60,930	97,577	104,831	106,917	116,343										3.90	4.03	4.05	4.40	4.65	4.70	4.89
Hastings	107,381	97,562	99,689	101,712	101,152	103,839	104,527										4.05	4.44	4.10	3.88	3.83	3.87	3.79
HEANT SUSSEX RHA	671,105	374,677	399,665	439,512	449,692	450,516	445,710										3.84	4.20	4.07	4.06	4.15	4.15	4.14
Bexley	75,551	78,656	83,327	92,471	101,932	103,755	108,448										4.54	4.89	4.52	4.59	4.60	4.66	4.85
Greenwich	287,880	263,068	275,788	289,224	299,890	271,612	267,523										4.41	4.68	4.40	4.46	4.51	4.54	4.55
GRIFENWICH-DEXLEY RHA	365,431	341,704	359,115	381,695	391,842	375,397	376,031										4.43	4.78	4.43	4.49	4.53	4.57	4.65
Canterbury - Thanet	207,243	174,859	182,010	194,649	197,551	200,502	206,557										4.21	4.52	4.30	4.41	4.46	4.56	4.64
Dartford - Gravesham	166,375	151,228	147,404	152,715	161,093	164,089	160,895										4.62	4.83	4.40	4.58	4.49	4.34	4.54
Maidstone	93,469	87,374	91,397	95,000	93,869	92,650	97,641										4.14	4.26	4.33	4.54	4.70	4.34	4.55
Medway	148,679	140,954	144,258	144,613	152,473	154,600	161,178										3.45	3.64	3.53	2.82	3.52	3.64	3.83
South East Kent	117,388	101,207	107,160	133,360	118,468	125,561	130,983										3.78	3.95	3.72	3.83	3.95	3.99	4.07
Tunbridge Wells	180,522	160,287	173,074	171,533	179,554	178,822	189,614										3.98	4.00	4.07	3.90	3.92	4.05	4.02
KENT RHA	913,674	816,111	849,293	873,868	892,008	919,144	946,790										4.02	4.19	4.04	4.07	4.11	4.14	4.25
Guy's	287,856	272,881	300,407	322,986	324,275	341,301	340,067										5.03	4.98	4.88	5.07	5.50	5.57	5.92
King's	376,840	263,195	337,747	409,650	403,434	380,348	391,093										5.41	5.64	5.63	5.82	5.88	5.72	5.39
Lewisham	198,983	176,875	180,046	180,591	176,416	168,222	167,672										4.92	5.57	5.14	5.03	5.32	5.19	5.29
St Thomas'	304,454	230,851	294,012	313,912	328,329	318,931	315,727										4.92	5.19	5.01	4.83	5.18	5.00	4.80
L-S-L RHA (T)	1,189,135	1,103,220	1,162,212	1,227,039	1,237,534	1,209,662	1,214,559										5.12	5.34	5.19	5.30	5.50	5.40	5.34
SF TRAMES RHA	3,042,909	2,823,554	2,951,452	2,110,512	2,162,113	3,147,268	3,191,111										4.43	4.68	4.82	4.58	4.66	4.64	4.66

Source: SH3



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities - for action

Area Health Authorities	)	
Boards of Governors	)	
Family Practitioner Committees	)	
Community Health Councils	)	
Metropolitan and Non-Metropolitan County Councils	)	for information
Metropolitan and Non-Metropolitan District Councils	)	
London Borough Councils	)	
Greater London Council	)	
Common Council of the City of London	)	

July 1980

HEALTH SERVICE DEVELOPMENT  
STRUCTURE AND MANAGEMENT

SUMMARY

The Department has received over 3,500 comments from organisations and individuals on the consultative document "Patients First". Ministers are gratified at the concern and interest which have been shown. A summary of comments is being published separately. Their broad thrust supports the aims set out in "Patients First". This Circular provides the necessary guidance to RHAs and to the new district authorities to implement the changes in structure and management organisation which are needed to fulfil these aims.

THE DISTRICT

*Changes in existing arrangements*

1. The Government has decided that all area health authorities and health districts in England will, subject to the enactment of the Health Services Bill, be replaced by one or more district health authorities, each served by one team of officers. While these authorities will be referred to generically as district health authorities (DHAs), they will be individually known as, for example, the Bradcaster Health Authority. After consultation with AHAs and other local interests, regional health authorities will be responsible for making recommendations to the Secretary of State about the future pattern of DHAs.

*Functions of district health authorities*

2. Each DHA will be responsible for the planning, development and management of health services in its district within national and regional strategic guidelines.

*Criteria for reviews*

3. DHAs should be established for the smallest geographical areas within which it is possible to carry out the integrated planning, provision and development of primary care and other community health services, together with those services normally associated with a district general hospital, including those for the elderly, mentally ill and mentally handicapped. The new authorities should not necessarily be self-sufficient in all these services. They should as far as possible comprise natural communities, and the boundaries of one or more DHAs should normally be coterminous with the boundary of a social services or education authority.

4. With these criteria in mind, but also to minimise the disruption to health services involved in changing boundaries, Ministers expect that, unless there are powerful reasons to the contrary, new DHAs should follow the boundaries of existing districts or single district areas. Examples of reasons to the contrary are:

- a. where a DHA formed in this way would be too small to be viable in the terms of paragraph 3;
- b. where the existing district or single district area is so large and contains so many hospitals or other health service facilities that members and chief officers would find it difficult to gain a full appreciation of the needs of the local population and would be remote from their staff and the services they provide - only in the most exceptional case would the Secretary of State be prepared to agree to the establishment of DHAs serving populations of over 500,000;
- c. where the scope of the management task of the DHA would be excessively heavy (because of the inclusion of several major hospitals within its responsibilities);
- d. where the improvements in organisation that would flow from a change of district boundaries within an existing area would be such as to justify the disruption that would be caused;
- e. where the pattern of health services was such that there was a substantial case for establishing a DHA which crossed the boundary of a social services authority (even if that implies a change in the RHA boundary).

5. The advice of the London Advisory Group is attached at Appendix 1; Ministers commend it to the four Thames RHAs to be taken into account in proposing DHAs in inner London.

*Arrangements for regional reviews*

6. RHAs should issue their provisional proposals for DHAs to the following bodies in their regions:

AHAs and their area and district teams, and Boards of Governors

Regional and area professional advisory committees

Local medical, dental, pharmaceutical and optical committees

Recognised staff organisations including joint staff consultative committees

Community health councils

Family practitioner committees

County and district councils and London authorities

Universities

Members of Parliament

Any other body or person not covered by the above which the RHA consider should be consulted

Similar bodies outside the region where there are significant patient flows across regional boundaries, or where proposals affect the boundaries themselves.

A copy should also be sent to the Department (the appropriate Regional Principal) for information. A press statement should be issued and copies of the provisional proposals made available on request to any other body or individual.

7. Three months should be allowed for consultation, at the end of which RHAs should review their provisional proposals in the light of all the comments they have received. Recommendations should be made to the Secretary of State by the end of February 1981. Where appropriate an RHA may submit proposals for part of its region in advance of the rest.

*Form of submission to the Secretary of State*

8. As well as setting out the RHA's recommendations to the Secretary of State, the submission should include a summary of all the comments received on the provisional proposals, with copies of any comments dissenting from the recommendations. A list of the matters to be covered is set out in Appendix 2. Copies of the recommendations made to the Secretary of State should be sent to the bodies who were consulted on the provisional proposals.

### *Timetable for implementation of structural changes*

9. The Secretary of State hopes to reach decisions on most recommendations within three months of receiving them. He judges that it will be in the best interests of the Service and staff if decisions are implemented as soon as possible, and he hopes that, subject to Parliamentary approval of the necessary orders, most DHAs can be brought into formal existence on or before 1 April 1982. The process of structural change should in any case be completed by 1 April 1983, though it is recognised that there might be unavoidable exceptions. It will be for RHAs to propose when decisions should be implemented having regard to: the time needed for the appointment of chairmen and members; the time needed by authorities in shadow form to appoint officers and carry out other tasks; and the practicability of making changes other than at the beginning of a financial year.

### SIZE AND COMPOSITION OF DISTRICT HEALTH AUTHORITIES

10. Further guidance on membership and on consultations on membership will follow in the Autumn when new membership regulations are laid, but the general principles are that each DHA will comprise:

- a. a chairman appointed by the Secretary of State
- b. members appointed by the RHA after appropriate consultation, as follows:
  - i. one hospital consultant
  - ii. one general medical practitioner
  - iii. one nurse, midwife or health visitor
  - iv. a nominee of the appropriate university with a medical school in the region
  - v. a member from among those recommended by the trade union movement
  - vi. generalist members in such numbers as normally to bring the total membership to 16 including the members referred to at c below
- c. four members appointed by local authorities.

Paragraph 35 below refers to the designation of teaching districts.

11. In metropolitan areas the local authority representatives will be appointed by the district councils or London boroughs. In non-metropolitan areas four members will be appointed by the county council, although it should be open to a county council to agree to reduce its membership on a DHA in favour of non-metropolitan district council members where the number of DHAs in the county makes it difficult for it to provide sufficient members. It is the Secretary of State's intention to introduce legislation that would enable two of the four local government members of a non-metropolitan DHA to be appointed by district councils.

12. It is also open to RHAs to propose a slightly larger membership if in their view local circumstances justify this.

### ARRANGEMENTS FOR SERVICES AND FUNCTIONS COVERING MORE THAN ONE DISTRICT

13. For a short transitional period services and functions covering more than one district should be left unchanged (unless there are already plans for reorganising them which could not sensibly be abandoned); it will be for the new DHAs to take early decisions about the future of these services. While in shadow form the new DHAs should, in consultation with each other and the RHA, agree which district should manage such services, and become the employing authority of the staff concerned, until permanent arrangements have been settled.

14. In deciding the future of these services, DHAs should be guided by a presumption in favour of dividing them into district components unless there are strong arguments, for example of effectiveness and economy (particularly perhaps where there has been a measure of rationalisation), against doing so. This may particularly apply to some clinical services. Authorities should take full account of the experience during recent years of the many ways in which the quality of services has been improved (for example, the follow-up to the Noel-Hall recommendations in relation to pharmaceutical services). Local authorities should be consulted about arrangements for services and functions provided to them, or carried out on their behalf. The Supply Council will be giving guidance on the organisation of supplies. The Department will be giving guidance on ambulance services following consideration of the recommendations to be made by the Working Party on Patient Transport Services.

15. In the case of services that are not divided, arrangements should be agreed among the DHAs concerned for the way the services should be run on their behalf. In the absence of agreement, the RHA will decide.

16. For a few highly specialised services where remoteness from the unit is less important (for example some of the capital works currently undertaken from area level) it may be desirable for the function to be transferred to the regional level. There should be arrangements, both for those services as well as for the support services already provided by RHAs, that ensure that the extent of services and the programmes of work are agreed by the DHAs.

17. Following the implementation of the Nurses, Midwives and Health Visitors Act, there may be a need for some alteration in the arrangements for nurse education and training. Meanwhile authorities are asked to ensure that existing arrangements continue undisturbed as far as possible. Where a school of nursing serves more than one district, the DHAs in shadow form should agree with the RHA which authority should manage the school and become the employing authority of the staff concerned. In any proposed changes for education and training, the General Nursing Council or the appropriate national body should first be consulted.

#### ARRANGEMENTS FOR FAMILY PRACTITIONER COMMITTEES

18. The present arrangements for the administration of family practitioner services will be retained, subject to the enactment of the provision in the Health Services Bill enabling an FPC to relate to more than one DHA. A further circular will be issued later about the funding and membership of FPCs with a view to strengthening the relationship between them and the DHAs in the planning of services.

#### ARRANGEMENTS FOR LINKS WITH THE LOCAL AUTHORITIES

19. The present statutory requirement for the establishment of joint consultative committees is flexible and remains in force, and this permits the establishment of one JCC covering two or more DHAs within the area of a local authority. The exact arrangements for formal and informal links should be determined by the DHAs and the local authorities concerned. RHAs will be required in their submissions to draw attention to any particular difficulties which are envisaged by local authorities.

20. DHAs in shadow form should discuss with local authorities arrangements for those statutory services which AHAs have hitherto provided for them and, more generally, how adequate advice on health matters can be made available. Where two or more DHAs match one local authority, it may be appropriate for one of the health authorities to act on behalf of the others in the provision of advice and liaison. In relation to child health services there should continue to be named and appropriately qualified individuals who would have, among their responsibilities, the tasks described in HRC(74)5 on behalf of one or more DHAs, and in relation to the control of communicable diseases and food poisoning appropriate arrangements will be necessary to ensure that local authorities have available to them community physicians able to act as proper officers.

#### COMMUNITY HEALTH COUNCILS

21. CHCs will be retained. There should be one council for each DHA. The Government will issue a consultative paper in the Autumn seeking views, for example, on the membership and role of CHCs. Later on, when it is possible to form a considered judgement of the need for separate consumer-representative bodies to exist alongside the new, more locally-based health authorities, the position will be looked at again.

#### MANAGEMENT ARRANGEMENTS WITHIN DISTRICTS

##### *The Government's approach*

22. Each DHA should have wide discretion in determining its management arrangements. Accordingly, the prescription of particular posts contained in previous circulars is now withdrawn and replaced by the requirements to appoint a district management team and unit posts (see paragraphs 23 and 27 below). Within these limits, and subject to management costs limits, each authority will be free to establish only those posts which will provide the most effective and economical delivery of services in its own circumstances. Once a pattern of posts has been established existing guidance on the relationships between officers of different disciplines will continue to apply, except where inconsistent with what is said in paragraph 31 about functional management.

##### *District management team*

23. Each authority will appoint a district management team, with the same composition and functions as existing area management teams. In its joint responsibilities - the formulation of advice to the authority on district-wide policies, priorities and programmes and determining how decisions of the authority should be implemented - the team will operate by consensus. This does not mean seeking unanimity at all costs; significant differences of view should be reported to the authority.

24. Officers will be accountable individually for the performance of their own functions as well as being responsible jointly as members of the management team. The Royal Commission on the NHS pointed to the risk that "consensus management may sap individual responsibility by allowing it to be shared". Both authorities and team members must ensure that the personal responsibilities of individual managers are not blurred or qualified by their responsibilities as members of the management team.

### *Co-ordination*

25. In a service as complex as the NHS and comprising so many different independent disciplines and functions there must be clear arrangements for administrative co-ordination, which are understood and accepted by all. This will be a responsibility of the district administrator. This does not give him any managerial authority over other chief officers, but it does impose on him a responsibility to see that an account is provided to the authority on how its policies and priorities are being implemented. He will also be responsible for ensuring that individual responsibility is identified for each piece of action which the authority requires to be carried out. He will be the secretary of the authority and thus will be required to act as the official channel of communication on behalf of the authority with public authorities, the press and the public, obtaining reports from other officers as necessary for circulation to the authority.

### *Other posts at district level and below*

26. Apart from the team posts and the unit posts referred to in paragraph 27 below it will be for DHAs, in shadow or substantive form, to decide what appointments to make and determine arrangements for accountability. Authorities will thus have to consider management arrangements in respect of all disciplines, including community medicine, dentistry, nursing,\* health education, pharmacy, psychology, scientific, technical, radiography, chiropody, dietetics, the remedial professions, speech therapy, works, finance and administration. In deciding these matters authorities will wish to bear in mind two principles:

- i. In considering whether to establish a particular post the first consideration should be the work to be done. Authorities should, for example, avoid full-time posts at district level or below in any discipline or function unless they are sure that there is the work to warrant them. This should be the sole criterion for establishing posts. Alternatives are part-time appointments, or the appointment of individuals who could serve two or more authorities or who could combine a district role with a post at unit level.
- ii. When considering management accountability of officers, authorities should assure themselves that a manager can appropriately be held accountable for the work of a particular individual. This is especially relevant when considering whether a member of the administrative discipline can be made managerially accountable for non-administrative staff.

### *Organisation below district level*

27. Authorities should arrange their services into units of management, each with an administrator and a director of nursing services, directly accountable to the district administrator and district nursing officer respectively, of appropriate seniority to discharge an individual responsibility in conjunction with a senior member of the medical staff.\*\* The unit administrator will carry responsibility for administrative co-ordination at that level on the same principle as the district administrator in paragraph 25.

28. In the main authorities should establish units that are smaller than existing sectors and nursing divisions, although there may be a limited number of exceptions where the sector or division is small enough already. Examples of the types of units that may be established are:

- a. A large single hospital.
- b. The community services of the district.
- c. Client care services, for example a mental illness hospital with psychiatric community services and possibly the psychiatric unit of a district general hospital on the lines described in the report of the Working Group on Organisational and Management Problems of Mental Illness Hospitals. However, larger client care groups may need to be divided into two or more units, provided that there is adequate co-ordination between units.
- d. The maternity services of the district (in this case, however, it may in some circumstances not be necessary to appoint a unit administrator as required by paragraph 27, though there should nevertheless be an administrative point of reference).
- e. An individual hospital, or group of hospitals, with the community services that is a 'geographical' unit.
- f. A group of smaller hospitals.

\* Whenever the term nursing is used in this circular, it should be construed as applying to midwifery or health visiting where appropriate.

\*\* Further advice will be given in the light of the recommendations of the working party on medical advisory and representative machinery chaired by the Chief Medical Officer.

### *Delegation to units*

29. To achieve maximum delegation to units of management there is a need for authorities to determine:
- a. which decisions currently taken at area or district level could be delegated to units,
- and
- b. which decisions originating within units but currently drawn up to district headquarters level as a result of the existence of functional management hierarchies, should in future be contained at unit level by limiting the functional chain.
30. The early establishment of unit budgets is an essential element in increasing local responsibility and accountability. The unit nurse should be given responsibility for the control of the nursing budget (allocated as part of the district nursing budget) and the unit administrator should control the budgets for departments for which he is managerially responsible and should also be responsible for the co-ordination of other unit budgets. They should operate within financial allocations and policies for virement between and within units set by the DHA. They should exercise this responsibility in consultation with the senior member of the medical staff referred to in paragraph 27.

### *Functional management at unit level*

31. Wherever possible staff working within units in non-clinical support functions (works, catering, domestic services, medical records and personnel) should be accountable to the unit administrator rather than to district level managers. It is, however, open to authorities to arrange for professional advice and guidance across the district, either by appointing one of the specialist managers in a unit to give that advice or where there is a clear justification in terms of cost effectiveness, by appointing a specialist adviser, perhaps shared with a neighbouring authority or authorities. This adviser might also undertake specialist functions such as training.

### *Timing of changes in management arrangements*

32. Once the DHA is established and has appointed the officer members of the district management team, it should consider, either in shadow or substantive form, how best to institute management arrangements (including those for area based services) which meet the requirements of this circular. Authorities should aim to have instituted arrangements meeting the Government's requirements no later than twelve months after being established.

## FINANCIAL CONTROL AND MANAGEMENT COSTS

33. The disappearance of AHAs, whose treasurers' departments provide various centralised financial services, will impose special strains which could lead to a serious breakdown in financial control in the transitional phase. This must not be allowed to happen. RHAs will be responsible for ensuring that it does not. They will assist DHAs in developing adequate financial systems and budgetary control procedures at and within districts. Subject to that, DHAs will be free to exercise their financial responsibilities, and budget control and cash limit arrangements should provide for the maximum local delegation consistent with overall control of the DHA cash limit. District treasurers should also provide financial advice as necessary to the budget holder at unit level through improved financial information systems.

34. The central control of management costs will continue, and a new target will be set. The same management costs proportion will be fixed for all regions and therefore some regions will have to make greater reductions than others. It will be for each RHA with its districts to agree how the new objective should be achieved. The new common target will be 10% lower than the national managerial proportion at 31 March 1980, and will be announced as soon as the March 1980 figure is available. The Department will monitor progress towards the target through annual returns, and will require the target to be achieved (discounting transitional costs, such as compensation and protection) by the end of the financial year 1984/5.

## LINKS WITH UNIVERSITIES

35. The Secretary of State attaches importance to close working between the NHS and universities with medical schools and will look to the new authorities and the RHAs to maintain this. He proposes to review the present arrangements for designating some authorities as teaching authorities, taking account of the original reasons for designation, the extent to which medical students are now taught in hospitals in non-designated AHAs and districts, and the implications of the structural changes announced in this circular. This review will also consider the question of the representation of teaching interests on DHAs.



## PROFESSIONAL ADVISORY MACHINERY

36. Guidance will be issued in due course, following completion of the discussions referred to in paragraphs 34 and 35 of "Patients First".

## PLANNING

37. A consultation paper on a simplified planning system will be issued shortly.

## THE ROLE OF REGIONS

38. RHAs will be responsible for initiating and overseeing changes in structure at area/district level, and for ensuring that authorities maintain effective financial control during the period of change. They should satisfy themselves that the management arrangements proposed by each DHA meet the broad requirements of this circular. In particular, they should examine the proposed unit structure, compare it with the existing arrangements and ensure that it complies with the objective in paragraph 28 about the size of units.

39. As to the longer term, the Government is clear that there will remain an important regional role, including the co-ordination of strategic plans; resource allocation; ensuring that expenditure is kept within cash limits; determining the extent and distribution of certain specialised hospital facilities, including the provision of facilities for undergraduate medical education; co-ordinating specialised services, for example in connection with major capital building projects; medical manpower planning, including post-graduate medical education and liaison with universities; and generally promoting the implementation of national policies. The Government intends in due course to review the relationship between RHAs and DHAs (under which DHAs exercise their functions by delegation and are accountable to RHAs) and the composition and functions of RHAs and the role of the Department in relation to them and with a view to enhancing local autonomy.

## MANAGEMENT ADVISORY GROUP

40. In paragraph 38 of "Patients First" reference was made to the possible establishment of an advisory group for monitoring the quality and efficiency of the way in which health services are managed. The Secretary of State will welcome experiments on these lines. These will be evaluated before consideration is given to establishing such arrangements on a wider basis.

## PERSONNEL ASPECTS

41. The changes described in this circular will affect many NHS staff. The Government has undertaken that staff interests will be fully consulted, and staff kept informed, about what changes should be made and how they should be carried out. RHAs will be responsible for ensuring that there is effective regional staff consultative machinery to handle whatever consultations are necessary on regionwide issues, and for advising health authorities in their regions on ways in which local staff consultative machinery can be maintained for use throughout the period of transition, and staff kept informed about matters which may affect them.

42. The General Whitley Council NHS Reorganisation Committee is negotiating agreements on protection terms for any downgraded staff, the terms of a premature retirement scheme and compensation arrangements for any staff who may become redundant, and arrangements for the filling of posts in the new DHAs. Information about the Management Side's initial offers has already been widely distributed (DA(80)12) and it is the intention of Management and Staff Side to issue regular bulletins on the progress of the negotiations.

From:

Regional Liaison Division 5A  
Room 1414 Euston Tower  
286 Euston Road  
London NW1 3DN

Tel. 01-388-1188 Ext 308 or 486

Further copies of this circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

## LONDON ADVISORY GROUP

### RESTRUCTURING IN LONDON

#### INTRODUCTION

1. The London Advisory Group was asked by the Secretary of State to consider whether any specific guidance on restructuring in London was required, in addition to what he was proposing to issue for the country as a whole, and if so what form this should take. The Advisory Group was informed of the guidance which the Secretary of State was considering. It accepts that this guidance should also apply to London. But it believes that for inner London a more extensive review of districts than envisaged in the national guidance should be considered. The Group also considers that an early statement is needed on the future of the postgraduate hospitals.

2. The Group is conscious of the fact that it has not yet been able to study strategies for major changes in hospital and health service provision in London and that these may have implications for restructuring.

#### WHY IS LONDON DIFFERENT?

3. London's characteristics are different, in a number of ways:

First, the present boroughs do not reflect "natural communities" and the major hospitals do not provide services exclusively to one borough or to a defined community. The district boundaries drawn up in 1974 related largely to hospital catchments but as a result they produced overlap and agency arrangements which increased the difficulty of liaison with local authorities. These inadequacies will be exposed by the removal of the area boundaries.

Second, inner London is served by a large number of major hospitals - most of London's undergraduate and postgraduate teaching hospitals are situated there. They are close to each other and some are found in the same borough or straddle borough boundaries.

Third, inner London is deficient in non-acute hospital facilities, in community and primary care and as a result a greater burden falls on acute hospital services and the local authorities.

Fourth, plans are being made to change the balance of services in London: to rationalise specialist services, to reduce acute services and to develop locally non-acute facilities. In many instances these changes will entail associations amongst hospitals which are different from those which exist today. These new associations will need to be reflected in the new boundaries.

Fifth, the medical schools and institutes are the subject of a major organisational review and undoubtedly this is a factor to be taken into account.

#### IS THE NATIONAL GUIDANCE SUFFICIENT FOR LONDON?

4. The Advisory Group examined the national guidance being considered by the Secretary of State. It believes that this guidance would be appropriate for London. A good many districts, especially in the outer circle, could straightforwardly convert into new DHAs and could remain co-terminous with the boroughs. Others might benefit from minor adjustment to remedy overlap problems or to align their boundaries with those of the boroughs. The Advisory Group believes that, for this group of districts, the review can begin with the assumption that existing districts will be retained and that any desired changes should be tested against the specific reasons for change listed in the guidance.

5. But some districts in inner London are regarded as unsatisfactory and they will need special consideration (such consideration might prove to have implications for the boundaries of a few districts on the periphery). The Advisory Group believes that the opportunity should be taken to remedy the undesirable features of the present boundary arrangements in these cases. Applying the exceptions specified in the national guidance would not be sufficient and some further elaboration is considered necessary.

#### THE APPROACH FOR LONDON

6. The Advisory Group examined a study by the four Thames RHAs on the determination of health authority boundaries. The study had tested, on four sample AHA(T)s, the criteria proposed in Patients First, in order to identify problems posed in inner London. Although the Advisory Group did not accept the analysis in full, it did accept the conclusion that no one criterion, taken by itself, could produce satisfactory results; whatever solution emerges will represent a balance between several criteria. And as the problems will vary from place to place, the emphasis on the different criteria will also vary. In the light of this, the Advisory Group agrees that what is needed is a sensible application of the criteria suggested in the national guidance. But for inner London the national guidance should be supplemented by an emphasis on two aspects: links with the local authorities and support for clinical teaching.

7. *Links with local authorities:* The national guidance suggests that the boundaries of one or more DHAs should be coterminous with a single social service authority, in order to facilitate collaboration between them. Such collaboration is particularly important in London, as the nature of the facilities available there produces problems, which can be dealt with only by a determined joint effort between health and local authorities. Where a one-to-one match is possible, it should be encouraged.

8. However, the scope for this is limited in the difficult part of London in question. There are a number of hospitals which straddle borough boundaries and are the major provider of services to communities in more than one borough. In these instances, it will prove difficult to identify a community which is clearly common to one health district and one borough. In the circumstances, an alternative basis for collaboration will need to be found either by matching two boroughs to one DHA or by including part of one borough and part (or the whole) of a neighbouring borough into one health district.

9. As a starting point for the review, therefore, districts which are regarded as unsatisfactory should be considered initially, either singly or in groups, in relation to links with social services. Where a match with whole boroughs proves impracticable, efforts should be made to establish new DHA boundaries, from a combination of whole social services divisions of adjacent boroughs. In some cases a solution may be found only after negotiating an adjustment to the boundaries of social services divisions. The other criteria should then be applied and variations introduced as seem desirable. The result should provide a good base for the health and local authorities themselves to collaborate on the planning and provision of services, and for their respective staffs to liaise effectively on day-to-day patient care.

10. *Clinical Teaching:* The Secretary of State has a duty to make available such facilities as he considers are reasonably required for clinical teaching. Students at a London medical school usually receive clinical teaching at a principal teaching hospital with its supporting units and one (occasionally more than one) other major hospital with which it has historical, administrative or staffing links. From the University's point of view, it would be preferable for all the main hospitals associated with a particular medical school to be managed by one DHA. The Advisory Group accepts that this is a desirable objective, provided it can be achieved without producing districts of a size where the management task would be excessively heavy. The Group recognises that some medical schools will have to be associated with more than one DHA, that in such instances these DHAs should be in the same region and that effective working machinery will be needed between the relevant DHAs and the medical school.

11. The above paragraph relates to London medical schools as they are at present. If in future they are grouped into larger schools clearly the scope for including all hospitals associated with the combined schools in a single DHA would be very limited.

12. The Advisory Group understands that the University of London will not reach any decisions on the recommendations of the Flowers Report until early November. The Group believes that the time-table for restructuring, outlined in the national guidance, should also apply to London. The Thames RHAs may however need to go out to consultation on the basis of alternative sets of proposals.

**FORM OF RHA SUBMISSIONS TO THE SECRETARY OF STATE**

The submission should include:-

1. The recommended future pattern of DHAs, including the proposed names.
2. A particular justification for proposing, exceptionally, the establishment of a DHA with a population of over 500,000, including an assessment of the effects on span of control.
3. For a proposed DHA with a population of below 150,000 an assessment of the extent to which it would be viable in the terms of paragraph 3.
4. An outline of the implication for collaboration between DHAs and universities, particularly in respect of provision of clinical facilities for use in the education of medical students.
5. The timetable proposed for changes in structure and management arrangements in the region, indicating the date for the formal establishment of each DHA and whether it is proposed that the new authorities should determine their management arrangements while in shadow form or after they have been brought into formal existence.
6. Whether any DHA should, exceptionally, have more than 16 members.
7. An indication of the implications of the proposals for the reduction in the region's management costs.
8. Whether any adjustments to existing regional boundaries are envisaged, and whether these have been agreed between the RHAs concerned.
9. Whether any changes in existing schools of nursing or in other arrangements for nurse, health visitor or midwifery training are envisaged, and whether these changes have been agreed by the RHA, GNC and any other national body concerned.
10. Any particular difficulties which local authorities have identified in respect of arrangements for collaboration.
11. A summary of all comments received, with copies of any comments dissenting from the recommendations which the RHA is making to the Secretary of State for the pattern of districts, timing of changes etc.



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: **Regional Health Authorities** )  
**Non-Metropolitan County Councils** )  
**Metropolitan and Non-Metropolitan** ) **for action**  
**District Councils** )  
**London Boroughs and ILEA** )  
**The Common Council of the City of London** )

**Area Health Authorities** )  
**Boards of Governors** )  
**Family Practitioner Committees** ) **for information**  
**Community Health Councils** )  
**Greater London Council** )

May 1981

HEALTH SERVICES MANAGEMENT

THE MEMBERSHIP OF DISTRICT HEALTH AUTHORITIES

SUMMARY

This Circular gives guidance on arrangements for the appointments to be made to District Health Authorities once the future pattern of DHAs has been established. It announces the intention to seek Parliamentary approval for new provisions governing the terms of office of and eligibility for membership of these Health Authorities. Guidance is also given on the role of members of DHAs, on the making of Standing Orders for the regulation of each Authority's proceedings and business and on the position of certain DHAs with teaching responsibilities.

PART I

BACKGROUND

1. Members of DHAs will be appointed mainly by RHAs and in part by specified local authorities (non-metropolitan counties, metropolitan and non-metropolitan districts, London boroughs, the City of London, Inner London Education Authority and the Council of the Isles of Scilly).

CONSTITUTION AND MEMBERSHIP OF DHAs

2. The constitution and membership of DHAs will be governed by the following legislation:
- a. The National Health Service Act 1977, as amended by the Health Services Act 1980. Schedule 5 to the 1977 Act (as amended) lays down the broad composition of DHAs and the authorities empowered to appoint members to them. It also establishes certain requirements for the consultations which RHAs should undertake before making appointments to DHAs.
  - b. The National Health Service (Constitution of District Health Authorities) Order(s). Parliament will be asked to approve new orders which will be made after the Secretary of State has announced his decisions on the future pattern of DHAs in each region in England. It is intended that the constitution order(s) will specify the size of membership of each DHA and the numbers of members to be appointed by RHAs and named local authorities.
  - c. New National Health Service (Authorities: Membership) Regulations will also be laid for Parliamentary approval. These will augment Part III of the National Health Service (Regional and Area Health Authorities: Membership and Procedure) Regulations 1973 (SI 1973 No 1286)\* and provide for the terms of office of DHA members.

\*which will also be amended, as respects District Health Authorities.

## TENURE OF OFFICE

3. Subject to paragraph 2(c) above, the tenure of office of members of DHAs appointed by RHAs will be for a period not exceeding four years. RHAs will be free to time all their appointments to expire on the same date, or at intervals. The regulations will also extend or curtail the term of office of existing AHA members until the AHAs are succeeded by DHAs.

4. It is intended that the local authorities (specified in the DHA constitution order(s)) will continue to determine the tenure of office of their appointees when the appointments are made, as currently prescribed by Regulation 3(e) of SI 1979 No 738.

5. Two substantive changes relating to tenure of, and disqualification for, office are intended to be made in the new membership regulations. First, while a person shall continue to be disqualified for appointment as a chairman or member if he has been dismissed, otherwise than by reason of redundancy, from any paid employment with a Health Authority, there will be scope for the Secretary of State to waive disqualification at any time after two years have elapsed from the date of termination of membership. Second, where an appointing authority terminates a member's appointment, that authority will be required to specify a period of disqualification of at least two years. Previously there was no requirement to specify a period of disqualification, which could result in indefinite disqualification where no period was specified.

## COMPOSITION OF DHAs

6. In addition to a Chairman (appointed by the Secretary of State), each DHA shall include:

- a. members appointed by the RHA (after appropriate consultation):
  - i. one hospital consultant
  - ii. one general medical practitioner
  - iii. one nurse, midwife or health visitor
  - iv. a nominee of the appropriate university with a medical school in the region
  - v. other members (known as 'generalists') in such numbers as to bring the total membership (excluding the chairman), including the members referred to at b. below, to the numbers specified in the constitution order(s) (normally 16).
- b. four members appointed by local authorities, except where a higher number is specified by the constitution order(s).

The Secretary of State's decisions on the matters dealt with in the discussion paper "Medical Teaching in the NHS" (HN(80)40) are contained in Appendix 5. In the context of appointments to DHAs:

- c. Health Authorities with substantial medical teaching responsibilities should have two university representatives (including the nominee referred to at a.iv. above) plus a "dental" representative where there is a dental school. (Under paragraph 4(a) of Schedule 5 to the NHS Act 1977, as amended, extra members with knowledge of and experience in the administration of a hospital providing substantial facilities for undergraduate or post-graduate clinical teaching should be appointed to AHA(T)s and DHA(T)s. RHAs are asked to note that the Secretary of State intends to seek legislative approval to repeal this statutory provision).

## PART II

### CONSULTATIONS ON, AND QUALIFICATIONS FOR, MEMBERSHIP

7. Before making appointments to DHAs, RHAs are required to consult appropriate bodies in accordance with paragraph 2 of Schedule 5 to the National Health Service Act 1977. In addition, Community Health Councils and such other bodies as RHAs consider appropriate should be invited to submit recommendations for membership. In general, bodies thus consulted should be asked to submit a choice of names.

8. There may be advantage in appointing as DHA members those with previous CHC experience. Statutorily, it is not possible to serve on a CHC and DHA concurrently. People appointed to DHA membership are required, therefore, to resign from membership of a CHC. Although the statutory restriction applies only from the date a DHA formally comes into existence, conflict of interest could arise during the 'shadow' phase of a DHA's life and concurrent membership would be equally inappropriate in those circumstances. Concurrent appointments to membership of a DHA and a RHA should not be made.

9. As a result of discussions in Parliament during the passage of the Health Services Act 1980, RHAs are asked to consider appointing members with a particular interest in homoeopathy to those DHAs with responsibility for homoeopathic in-patient and out-patient treatment facilities. Such appointments would be expected to fall within the generality of seats on the DHA and would not become extra or reserved seats.

## CRITERIA FOR APPOINTMENT

10. Ordinarily, members (other than NHS employees - see paragraph 17) should reside or work in the district of their Authority but those with an interest in the health services of or who have other associations with the district are not precluded. Appointing authorities should ensure that members will be able to devote sufficient time to the DHA's business - participating in regular meetings, committee work and the other duties which are involved. As a general guide, members should be able and prepared to devote some 2-4 days a month, during and outside normal working hours, to the work of the Authority.

11. There is a special need for younger men and women to serve on Authorities, to provide for continuity of experience for the future. It is important also to make appointments only where it is likely that prospective members will have the health and vigour to make an effective contribution throughout their term of office. Appointment or re-appointment over the age of 65 should be regarded as exceptional and should only be offered if equally suitable younger candidates are not available.

12. As well as providing for a suitable geographical balance among the membership, RHAs should bear in mind a reasonable balance of age and sex, together with such factors as experience of management and administration in business or the public service, experience in the mental health and handicap fields, and in appropriate cases, suitable representation of ethnic minorities.

## TRADE UNION MEMBERSHIP

13. The National Health Service Act 1977, as amended, requires that in appointing DHA members RHAs should consult "such . . . . bodies (including any federation of workers' organisations) as appear to the relevant Regional Health Authority to be concerned". One member of each DHA should be appointed from among those recommended by the trade union movement. Past Departmental circulars have asked RHAs to obtain nominees from the Regional Councils of the Trade Union Congress. Some trade unions, however, are not affiliated to the TUC, and a number of these are members of the Managerial, Professional and Staff Liaison Group (MPSLG).

14. RHAs should in future seek nominations from the MPSLG as well as from the Regional Councils of the TUC. Both bodies should be asked to supply at least two names for each District for which they wish to nominate a member. In deciding who to appoint RHAs should have regard to the personal qualifications of the nominees and their experience in the trade union movement. They should also bear in mind that the great majority of trade unionists belong to TUC-affiliated bodies. Because of the present relative strengths of the two organisations Ministers would not expect any RHA to appoint a MPSLG nominee to more than one DHA in the Region (unless, perhaps, the TUC do not supply two names for each District and confirm that they will be unable to do so). In deciding to which DHA they might appoint a MPSLG nominee the RHA should have regard to the nature of the Districts in the Region, and in deciding who to appoint from the nominations they receive RHAs should give careful consideration to any preferences expressed by the nominating bodies.

15. The trade union place on a DHA is for a representative of the wider trade union movement, not for a member of a NHS staff organisation. (Ministers believe that the views of NHS employees should be obtained through consultative machinery). The trade union member of a DHA should therefore not be a NHS employee or a NHS trade union officer (except where the RHA receive a nomination for an existing member of an AHA in that category who would be badly missed or where a nomination is received for an officer of a union with a substantial membership outside the NHS and the officer's work does not involve him in NHS affairs).

## PROFESSIONAL MEMBERS

16. Subject to paragraph 17 below, each DHA should contain two doctors (one hospital consultant and one general medical practitioner) and a nurse, midwife or health visitor who either work in the NHS or have knowledge of the health needs of the District to which they are appointed. RHAs are asked to apply the other general guidance in paragraphs 10-12 to these appointments also. The underlying principle of medical and nursing representation is that such members should bring to bear their wide professional knowledge and experience of health services, rather than act as spokesmen of professional interests or as staff representatives.

## EMPLOYEES OF HEALTH AUTHORITIES

17. The Secretary of State believes that NHS employees, other than doctors, should not normally serve as members of the DHA which employs them. He does not consider it appropriate that staff representatives should serve on Authorities because the staff of disciplines other than medical ones work in recognised hierarchies which report ultimately to a chief officer, who should not be placed in the position of advising an Authority which contains his or her own subordinate. However, for some Authorities (eg the geographically larger ones) it may be difficult to appoint a nurse member from outside the District. In these circumstances RHAs may exceptionally appoint a nurse employed within the District. Within the medical field it would be inappropriate for the consultant or GP members of DMTs to sit on the Authority they serve, or for community physicians to serve on their employing Authority.

## LOCAL AUTHORITY MEMBERS

18. Local authorities are asked to conform to the guidance in the preceding paragraphs in the appointments they make. They should supply the Regional Administrator, and the District Administrators concerned, with curricula vitae, giving the names, addresses, dates of birth and other background information of members appointed by local authorities. RHAs are asked to provide a standard proforma for such details. The purpose of this request is to aid RHAs in their tasks of ensuring an appropriate balance of age, sex and geography among the remainder of the membership. The appointment of non-metropolitan district council members will be made jointly by the district councils concerned in districts where there are more such councils than places for them. RHAs should report any cases of difficulty encountered in these arrangements to the Regional Principal at DHSS, Euston Tower, 286 Euston Road, London NW1 3DN.

19. Appointing local authorities are asked to bear in mind the advantages of appointing representatives who are members of committees which have links with the NHS (particularly social services, but also policy and resources, housing, education or environmental health) in order to encourage closer collaboration between the NHS and Local Government in the provision of local services.

## THE ROLE OF THE DHA AND ITS MEMBERS

20. Guidance on the role of DHA members is contained in Appendix 1.

## TRAINING OF DHA MEMBERS

21. No centrally organised training course(s) could encompass the variety of training needs of DHA members. The Secretary of State considers that training is vital but will be more effective if organised locally - either by each RHA or perhaps by DHAs severally or jointly. Nor should training be confined to induction training for new members, important though this is. Experience has shown that great advantage can be gained from specialised training in particular aspects of an authority member's work and from residential seminars designed to improve the ways members work together and with their officers. It is expected that a training pack to aid the induction of new members will be available later in the year from a consortium consisting of the School for Advanced Urban Studies, Bristol, the Health Services Management Centre at Birmingham University, and the King's Fund College. The pack will be available to authorities who wish to undertake their own induction training but the consortium will also be offering its own seminars for authorities who wish to use them.

## COMMITTEES

22. Circular HRC(73)22 is cancelled and with it the restriction on the formation of committees and sub-committees. It will be open to DHAs to establish committees as they see fit, although it is important to guard against:

- i. any disproportionate increase in administrative workload and expenditure;
- ii. any erosion in the concept of members' collective responsibility for all major decisions taken by the DHA (ie issues of major significance or of substantial public interest should not be remitted to committees for executive decision); or
- iii. any diminution of the public's knowledge of the Authority's affairs, eg through their access to DHA meetings under the Public Bodies (Admission to Meetings) Act 1960. See also Appendix 4.

## PART III

### SPECIAL TRUSTEES

23. The role and constitution of Special Trustees will not be affected by restructuring and the current cross-representation between AHA(T)s and Special Trustees will be replaced by a similar arrangement with appropriate DHAs.

## PART IV

### CANCELLATION OF EARLIER GUIDANCE

24. The following circulars, relating mainly to Area Health Authorities, should be cancelled upon the establishment of successor DHAs:

HRC(73)22  
HSC(IS)194  
HC(76)55  
HC(77)12  
HC(79)1  
HC(79)13



## **PART V**

### **APPOINTMENTS AND OTHER ACTION**

25. Subject to Parliamentary approval, described in paragraphs 2-4 above, RHAs should:
- i. notify members of Area Health Authorities of the extension or restriction of their existing tenure of office until such time as those Authorities are succeeded by DHAs; and
  - ii. together with the appropriate local authorities, set in hand the necessary arrangements for the appointment of DHA members.
26. On appointment, now and in future, DHA members should be provided with copies of:
- i. the DHA's standing orders (when adopted in accordance with Appendices 2 and 3 of this Circular);
  - ii. the relevant Membership and Procedure Regulations\*;
  - iii. this Circular; and
  - iv. "Care in Action"

and each member's attention should be drawn to the statutory provisions governing attendance at Authority meetings and the declaration of pecuniary and other interests. Members should be advised that, although unpaid, they may be entitled to claim travelling and subsistence allowances and, in appropriate circumstances, some compensation for additional expenses or for loss of earnings.\*\*

**From:**

**Regional Liaison Division (RL1D)  
Euston Tower  
286 Euston Road  
London NW1 3DN**

**Telephone: 01-388 1188 Ext 987**

**RLA26  
(G3/H223/65)**

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\* To be made available to appointing authorities when these have received Parliamentary approval.

\*\* The allowances approved for members of National Health Service authorities apply also to local authority members when they are engaged on Health Authority business.

## THE ROLE OF THE DHA AND ITS MEMBERS

1. DHAs are responsible, within the resources available, for administering health services in their districts, including the integrated planning, provision and development of primary care and other community health services, general hospital services, maternity and child care services and those for the elderly, the mentally ill and the mentally handicapped. In order to carry out this general role, certain tasks fall to Authority members.

### DISTRICT POLICIES AND PRIORITIES

2. It is a function of members to determine policies and priorities for their District. National and Regional guidelines and priorities form the framework within which district policies and priorities are to be established, but it is the members' task, on the advice of their officers, to devise a sensible formulation and application of policy to local conditions. They will need to take into account the views of the public in their District, as expressed formally by CHCs, local authority or other interests and through members' own knowledge and judgement of local aspirations and needs.

3. The Secretary of State must look to District (and Regional) Authorities to enable him to fulfil his commitments under section 51 of the NHS Act 1977 to "make available such facilities as he considers are reasonably required by any University which has a medical or dental school in connection with clinical teaching and with research connected with clinical medicine or, as the case may be, clinical dentistry". Whilst the majority of Districts will be called upon to provide such clinical facilities in some measure, the presence within some districts of universities with schools deeply engaged in teaching and research imposes particular obligations upon all members of those Authorities.

4. Members are also responsible for ensuring that there is satisfactory collaboration and joint planning with local authority services, through joint consultative machinery agreed locally. They will also need to take account of the views of NHS staff which may be channelled through the district management team, the professional advisory machinery or whatever consultative machinery exists with the staff side.

### REVIEW, CHALLENGE AND IMPLEMENTATION OF DMT PROPOSALS

5. It is the responsibility of members to review, and where necessary, challenge proposals put forward by its DMT; and to make effective arrangements for the implementation of proposals approved by the Authority. Members should, therefore, satisfy themselves that sufficient background information about all the options available accompanies proposals to enable them to make informed judgements. The DMT will normally advise the Authority on the course of action which it recommends but there will be occasions when the DMT feel that the arguments are balanced in favour of a number of possible options and seek the Authority's guidance on which it prefers. Equally, the officers of the DMT may not be agreed among themselves on a preferred course of action, in which case it will be for members to consider the case on its merits and form their own conclusion.

### APPOINTMENT AND MONITORING PERFORMANCE OF STAFF

6. The Authority appoints and monitors the performance of its chief officers. It should, also, as the direct employer of a large number of staff, concern itself with their working conditions, general interests and welfare. These responsibilities will involve some members in serving on a range of committees, such as joint consultative committees with the staff side, appointments or disciplinary committees.

### ASSESSMENT OF SERVICES AND MANAGEMENT ARRANGEMENTS

7. It is not the members' role to intervene in day-to-day operational management but rather to stand back in order to take policy and strategic decisions. Nevertheless, they need enough information to make informed decisions and to assess the quality of services provided. This knowledge of operational services may be acquired in a number of ways. Visiting by members has a crucial role. How visiting is arranged will vary in accordance with local circumstances and no central blueprint can be laid down. But members should avoid the twin extremes of constant unannounced inquisitorial visits on the one hand and a routine pattern of visiting which concentrates on trivia on the other. The Secretary of State commends to members' attention the passages on visiting in the National Association of Health Authorities' discussion paper 'The Authority Member'. The use of outside agencies such as the Health Advisory Service or the Development Team for the Mentally Handicapped is also important. The establishment of committees or of working parties of officers and members may give members more detailed knowledge of services. Finally, members should assess not only services to patients but should also keep the efficiency and effectiveness of their Authority's own management arrangements under review to take into account changes in the pattern of services and changes in personnel.

## CONDUCT OF MEMBERS AND OF AUTHORITY BUSINESS

8. The conduct of members and their Authority's business is dealt with in part in the model standing orders attached to this circular. The Secretary of State, while recognising the right of Authorities to exclude the press and the public from their meetings when confidential matters are to be discussed, hopes nonetheless that Authorities will use this power sparingly. It is important that Authorities, both through their meetings and in other ways, should be as open as possible to the populations they serve; to this end Authorities are asked to consider ways, such as the publication of addresses or other points of contact for individual members, in which public access to Authority members can be facilitated.

9. No member is appointed to represent a sectional or personal interest. It is important that members contribute in a constructive as well as questioning way to the whole work of an Authority, avoiding the temptation to concentrate on matters of particular personal interest. The views of individual members with specialised knowledge and experience will, of course, be particularly valued on relevant issues; the decisions of the Authority are, however, at all times corporate and collective. Members must, therefore, be prepared to recognise not only the duty of the Authority to reach decisions but also the corporate responsibility of the members for those decisions once taken.

## MEDICAL TEACHING IN THE NHS

1. HN(80)40 invited views on ways in which health authorities can most effectively promote and safeguard medical education within the NHS without prejudice to their continuing responsibilities for the provision of a full range of services to the populations they serve. The Secretary of State has completed his review of the question, taking account of the views received, and his conclusions are set out below.

### Recognition of health authorities with significant medical teaching responsibilities

2. Since 1974 certain Area Health Authorities have been designated as "teaching" in recognition of their substantial teaching responsibilities. The Secretary of State has accepted the majority view of those commenting on HN(80)40 that recognition of authorities in such circumstances should continue, and he has asked RHAs, in consultation with the appropriate Universities, to put forward proposals for the designation of all DHAs responsible for the main university hospital closely associated with a medical or dental school. In cases where a school makes broadly equal use of more than one major hospital in different DHAs, each DHA may be proposed for designation.

3. Existing designated AHAs have additional University representation among the authority membership and have the suffix "Teaching" in the title. As indicated in paragraph 6(c) of the main circular, designated DHAs will contain additional university members. This additional membership will be specified in the Constitution Order establishing the new DHAs. The Secretary of State has, however, decided that the suffix "Teaching" is unnecessary and he intends to seek Parliamentary approval for the repeal of the statutory provisions with regard to its use.

### University Liaison Committees

4. There was general support among those commenting on HN(80)40 for the view that there should be one University Liaison Committee (ULC) to link each medical and dental school with the authorities (RHA and DHA(s)) which provide facilities for them. RHAs are accordingly invited to set up in consultation with the relevant university and DHA(s), a ULC for each medical/dental school. In regions containing more than one school there should be consultation with the relevant universities and DHAs whether a single ULC should be established covering the whole Region. In all cases the RHA will need to agree with the appropriate DHAs (not necessarily all designated) how they should be represented on the ULC. In the case of DHAs not directly represented on the ULC, there should be a mechanism to involve them when teaching matters affecting them are discussed.

### DHA Representation on School or University Councils

5. At present members or staff of AHA(T)s are frequently members of major university bodies (such as Faculty Boards and the Councils of the relevant London medical and dental schools). In the light of comments received, the Secretary of State commends to university authorities the continuance of this practice with regard to appropriate DHAs.

### Attendance of Medical or Dental Dean at DMT Meetings

6. HN(80)40 invited views on whether existing guidance, whereby Deans may attend DMTs as observers, should be replaced by a formal requirement that they be allowed to do so. While there was some support for a statutory right of attendance, the general view was that the existing arrangements worked well. The Secretary of State accordingly commends to DHAs the existing practice with regard to attendance of Deans at DMT meetings - including appropriate team meetings in DHAs where matters affecting teaching are discussed even though that authority is not designated.

### Pay

7. It is intended that certain staff of designated authorities shall continue to receive additional pay in recognition of their extra responsibilities.



## DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities - for action  
 Area Health Authorities )  
 Boards of Governors ) for information  
 Community Health Councils)

## HEALTH SERVICE DEVELOPMENT

## MANAGEMENT ARRANGEMENTS WITHIN DISTRICTS: RHAS' ROLE

## SUMMARY

1. HC(80)8 (paragraph 38) required regional health authorities to satisfy themselves that the management arrangements proposed by each district health authority meet the broad requirements of the Government's policy. This note sets out the issues that Ministers wish RHAs to examine in discharging that responsibility, and the points to be covered in reports which RHAs are asked to submit recording progress to 30 June 1982 and 31 March 1983.

## DISTRICT MANAGEMENT: THE GOVERNMENT'S POLICY

2. As Ministers have made clear, their overall policy is to decentralise responsibility within the Service. Major elements of this policy are that DHAs should be as autonomous as practicable, and that within districts there should be maximum delegation to unit level.

3. Ministers believe that, in general, DHAs themselves will be best placed to develop policies of delegation, and management arrangements consistent with them. Accordingly, DHAs will have wide discretion in determining their arrangements, subject only to containing them within management costs limits agreed with RHAs, and to meeting the following requirements:

(i) Each DHA will appoint a district management team, with the same composition and functions as existing area management teams. The district administrator will have a specific responsibility for administrative co-ordination (paragraphs 23 and 25 of HC(80)8).

(ii) Services should be divided into *units* of management, in the main smaller than existing sectors and nursing divisions. Each unit should have an administrator, or administrative point of reference, and director of nursing services directly accountable to the district administrator and district nursing officer respectively (paragraphs 27 and 28 of HC(80)8).

(iii) For each unit there should be a senior member/members of the medical staff to whom the administrator and director of nursing services can relate (paragraph 27 of HC(80)8. Further advice will be issued in the light of the report of the CMO's working party.)

(iv) Wherever possible staff working within units in non-clinical support functions (works, catering, domestic services, medical records and personnel) should be managerially accountable to the unit administrator. (Paragraph 31 of HC(80)8, to be read in conjunction with paragraph 26(ii).)

(v) Arrangements for supply services should be agreed between DHAs and the RHA in the light of advice from the Health Service Supply Council (SCC(81)2).

(vi) Statutory responsibilities to local authorities, for example in respect of environmental and child health.

(vii) (Where appropriate) Enabling the family practitioner committee to meet its statutory and other responsibilities by provision of adequate staff, resources and supporting services.

## RESPONSIBILITY OF REGIONAL HEALTH AUTHORITIES

4. When RHAs and their DHAs have agreed management cost targets for each authority, it will be for DHAs to draw up management arrangements consistent with the broad policy of delegation of responsibility to the most local level practicable and meeting the requirements listed in paragraph 3 above. In drawing up their proposals DHAs must consult staff interests fully. Once a DHA has prepared its proposed structure it must be submitted to the RHA for approval.

5. The RHA should satisfy itself that:

- (a) the proposed structure is consistent with the DHA's agreed management costs limit;
- (b) the gradings proposed are appropriate to the duties and responsibilities and not out of line with existing grading standards; the way the Secretary of State wishes RHAs to discharge this responsibility is described more fully in Annex A;
- (c) the proposed structure meets the requirements listed in paragraphs 3(i)-(vii) above.

The RHA should not, however, seek to substitute its own judgement of what might be a better structure.

6. The aim should be to implement arrangements by no later than 31 March 1983.

## REPORTS TO THE DEPARTMENT

7. In "Patients First" Ministers said that "the maximum delegation of responsibility to those in the hospital and community services, within policies determined by the district health authority, matched where necessary by a strengthening of management at hospital level, is the most important single change necessary". Accordingly, great importance is attached to the establishment of district management arrangements in conformity with HC(80)8. RHAs are therefore asked to send reports to Regional Principals on progress by 30 June 1982 and 31 March 1983 respectively. The reports, which should be submitted by 31 July 1982 and 30 April 1983 respectively, should cover the matters in Annex B.

## ENQUIRIES

8. Enquiries about reports for individual regions should be addressed to the appropriate Regional Principal. Enquiries on more general aspects should be sent to RL1A, Room 1414, Euston Tower, London NW1 3DN.

## ACTION

9. RHAs should satisfy themselves that the management arrangements proposed by each DHA are in line with the broad requirements of Government policy and aim to implement arrangements by no later than 31 March 1983. RHAs are asked to send reports to Regional Principals on progress up to 30 June 1982 and 31 March 1983 respectively, which should be submitted by 31 July 1982 and 30 April 1983 respectively, and should cover the matters in Annex B to this Notice. RHAs are also asked to ensure that five copies of this Notice go to "shadow" District Health Authorities when established.

From:

Regional Liaison Division 1A  
Euston Tower  
286 Euston Road  
London NW1 3DN

Tel. 01-388 1188 Ext. 308

ORF1/15

Further copies of this Notice may be obtained from DHSS Store, Health Publications Unit, No. 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting the code and serial number appearing at the top right hand corner.

## REGIONAL ROLE IN THE GRADING OF POSTS IN DHA MANAGEMENT STRUCTURES

### WHITLEY NEGOTIATIONS: MANAGEMENT SIDE PROPOSALS

1. The Management Sides of the appropriate Whitley Councils are seeking to negotiate flexible arrangements for grading the posts in paragraph 2 below that would replace prescriptive grading based on population or other quantitative measures. Some illustrative yardsticks may, however, be suggested by the Councils which authorities could use to assess the scope of management responsibilities.

### THE RANGE OF POSTS OVER WHICH RHAs WILL OPERATE GRADING SURVEILLANCE

2. Subject to the outcome of current Whitley negotiations these will include:

2.1 Administrative and finance posts graded on PAA (Scale 9) and above other than posts whose grades are designated by the Whitley Council.

2.2. The following nursing posts:

Any chief officer posts for whose grading a Whitley agreement provides flexibility.

Nursing staff support posts at District level.

Directors of Nursing Services (DNS).

Such intermediate-level nurse management posts as are established between the DNS and the Ward or Department.

2.3 First and second-level works posts (for the time being).

2.4 Senior posts in professions supplementary to medicine (grades to be advised later).

### THE OPERATION OF THE REGIONAL ROLE

3. The new DHAs, in either shadow or substantive form, will be required to submit to the RHA proposed management arrangements, including unit management and other second-level posts. RHAs are asked to consider whether the grading levels proposed are appropriate to the duties and responsibilities, and not out of line with existing grading standards. For unit management posts particular attention should be given to the overall level of duties and responsibilities and, where appropriate, the use made of the higher grades expected to be made available for the first time by Whitley agreements. Where an RHA questions the grading proposed for a post the DHA will be expected either to provide further information to justify the grading to the RHA's satisfaction or, failing that, to adjust it in accordance with the RHA's judgement of the grading appropriate to the defined responsibilities.

4. RHAs should agree as early as possible with DHAs (in shadow or substantive form) the form in which staffing structures should be submitted, a timetable for submissions, the supporting information required and the arrangements to be made for the examination and approval of gradings and the provision of advice. They should also consider whether prior training of extra staff of any discipline in grading standards and skills is needed and arrange accordingly.

**FORM OF RHA SUBMISSIONS TO THE SECRETARY OF STATE**

The submission should include, for each DHA within the region:

1. Whether a DMT has been appointed with the same composition as existing AMTs. If not, which posts remain unfilled.
2. The number and type of units - as set out in paragraph 28 of HC(80)8 - established and, where the DHA has substantially the same boundary as an AHA or health district, how this compares with the number of sectors/nursing divisions existing before April 1982.
3. Whether the job descriptions of unit administrators and directors of nursing services show that they are directly accountable to the district administrator and district nursing officer respectively.
4. Whether for each unit there is a senior member(s) of the medical staff to whom the administrator and director of nursing services can relate.
5. Whether staff working within units in non-clinical support functions (works, catering, domestic services, medical records and personnel) are all managerially accountable to the unit administrator. Where such posts are managerially accountable to the unit administrator, whether the DHA has confirmed that the administrator can carry out the responsibilities in accordance with paragraph 26(ii) of HC(80)8. Staff not so accountable should be identified by grade and discipline and arrangements for their accountability and the reasons for departure from that proposed in paragraph 31 of HC(80)8 given.
6. Whether the RHA has received a fully costed structure and has satisfied itself that the structure can be contained within the DHA's management cost limit.
7. Whether the RHA has satisfied itself that the structure provides for effective financial control.
8. Whether the RHA has satisfied itself that the structure provides for the DHA to meet its statutory responsibilities to local government.
9. (Where appropriate) Where the RHA has satisfied itself that the structure provides adequate staffing, resources and supporting services for the family practitioner committee to meet its statutory and other responsibilities.
10. Whether the RHA has authorised the DHA to implement the structure, and the date by which the structure is expected to be implemented.





DEPARTMENT OF HEALTH AND SOCIAL SECURITY

- To: Regional Health Authorities )  
 Area Health Authorities )  
 Boards of Governors ) for action  
 Family Practitioner Committees )  
 Community Health Councils )
- County Councils )  
 Metropolitan District Councils )  
 London Borough Councils ) for information  
 City of London )  
 Council of the Isles of Scilly )

March 1981

HEALTH SERVICE DEVELOPMENT

ARRANGEMENTS FOR THE ADMINISTRATION OF FAMILY PRACTITIONER SERVICES:

A CONSULTATIVE PAPER

SUMMARY

A consultative paper on arrangements for the administration of family practitioner services is enclosed with this notice; the Department invites comments from health authorities, family practitioner committees, community health councils and those bodies listed in the Annex. Comments from any other interested body or individual will also be welcomed.

BACKGROUND

- Paragraph 18 of HC(80)8 Structure and Management of July 1980 said  
 " The present arrangements for the administration of family practitioner services will be retained . . . . .  
 A further circular will be issued later about the funding and membership of FPCs with a view to strengthening the relationship between them and the DHAs in the planning of services".
- The attached consultative paper seeks comments on possible future arrangements.

ACTION

- Authorities, family practitioner committees (for whom copies are enclosed for local medical, dental, pharmaceutical and optical committees), community health councils and bodies listed in the annex are asked to send comments to Regional Liaison Division 1A, at the address below, by the end of May 1981.

From:

Regional Liaison Division 1A  
1406  
Euston Tower  
286 Euston Road  
London NW1 3DN

Tel. 01-388 1188 Ext 980

G3/M303/156

Further copies of this Notice and the consultative paper may be obtained, by written request only, from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs, OL10 2PZ, quoting the code and serial number appearing at top right-hand corner.

**Association of Chief Administrators of Health Authorities  
Association of Community Health Councils  
Association of County Councils  
Association of District Councils  
Association of Health Service Treasurers  
Association of Metropolitan Authorities  
Association of Nurse Administrators  
British Medical Association  
British Dental Association  
British Optical Association  
Community Medicine Consultative Committee  
Central Midwives Board  
Council for Education and Training of Health Visitors  
County Councils Association  
Dental Estimates Board  
General Dental Council  
General Medical Council  
General Medical Services Committee  
General Nursing Council  
Health Visitors Association  
Institute of Health Education  
Institute of Health Service Administrators  
London Boroughs Association  
Medical Practices Committee  
National Association of Health Authorities  
Pharmaceutical Society of Great Britain  
Pharmaceutical Services Negotiating Committee  
Prescription Pricing Authority  
Royal College of Nursing of UK  
Royal College of Midwives  
Royal College of General Practitioners  
Society of Apothecaries of London  
Society of Family Practitioner Committees  
Society of Administrators, Family Practitioner Services  
TUC - Health Services Committee**

9. The FPC deals directly with the Department on matters concerning the administration of the independent contractor services. The Administrator (Family Practitioner Services), although an employee of the AHA, is seconded to the FPC and accountable to it for work done on its behalf. He is not a subordinate of the area administrator (although there is provision (in circular HRC(73)3) for agreement to be reached under which for part of his time the administrator (FPS) works for the AHA in contributing to the planning of primary health care services, and in this role he is accountable to the area administrator). The FPC itself is responsible for the general efficiency and management of its business, but through its responsibility to provide the FPC with staff the AHA has the right to satisfy itself that its staff are being used effectively.

10. FPCs' *administrative* costs are met by AHAs. In respect of *payments to practitioners* for the provision of Part II services FPCs are funded by the Department. The AHA is not accountable for the use of these funds by the FPC; accountability is direct to the Secretary of State.

#### THE FUTURE ORGANISATION OF FPCs

11. While the Government's decision that present arrangements for the administration of family practitioner services should be retained was welcomed by the contractor professions and FPCs, it was criticised by health authority and other professional interests as missing the opportunity to strengthen the development of good primary health care and better relationships between primary and secondary care services. To establish one FPC for each DHA would be the arrangement most conducive to effective collaboration, but would be administratively expensive and add to the disturbance caused by NHS Reorganisation. Ministers have therefore ruled out such a change. The Government would welcome views as to which of the following options for the future organisation of FPCs is most likely to promote effective collaboration.

- (i) where the boundaries of an existing FPC and a new DHA are coterminous, to retain the present arrangements; in other cases, to relate existing FPCs to two or more new DHAs, in both cases retaining the same statutory relationship as exists now between AHAs and FPCs;
- (ii) to retain existing FPCs, granting them full employing authority status, each relating to those DHAs serving the same population on the basis of one statutory authority relating freely to others;
- (iii) to retain existing FPCs, relating them to regional health authorities on the same statutory relationship as exists now between AHAs and FPCs.

The arguments for and against each of these options are considered in the following paragraphs.

12. **Retaining present arrangements wherever possible, and relating one FPC to two or more DHAs where necessary.** Present indications are that between 30 and 40 FPCs would each relate to one DHA, while the remainder would each relate to between two and six DHAs. This option requires least change and creates minimum disturbance, is consistent with existing legislation, and facilitates the movement of senior administrative staff between FPCs and other parts of the Service, with the advantage this wider experience can bring to both.

13. This option does, however, involve the disadvantage that it would be administratively cumbersome in a significant proportion of cases where up to six DHAs would need to agree to agency or consortium arrangements for providing FPCs with accommodation and staff.

14. **Retaining existing FPCs, granting them full authority status.** From comments received on "Patients First" it is clear that this is the preferred option of the contractor professions and FPCs, who believe it would make FPCs more effective, and that discussions with health authorities on a basis of equality would lead to improved relationships. This option would avoid the administrative complexities indicated in paragraph 13 above, and would enable FPCs to take immediate decisions on accommodation and staff, something to which they attach importance.

15. This option carries some disadvantages. First, such a change could require a minor amendment to existing legislation. Second, it would also be necessary to establish new arrangements for funding FPCs for, and controlling the level of expenditure on, accommodation and staff. This would require either greater involvement in FPC activities by the Department or bringing FPCs in their own right into regional arrangements for determining how the total permitted level of expenditure on management should be apportioned. There is no question of the total management costs of the NHS being allowed to increase if FPCs become employing authorities - any extra costs would have to be contained within the level of management costs envisaged in Circulars HC(80)8 and HC(81)2.

16. **Relating FPCs to RHAs.** This has been suggested as a way of avoiding the administrative complexity of having up to six DHAs collectively responsible for providing one FPC with accommodation and staff. A possible advantage is that one body - the RHA - would have the incentive to seek agreement to the use of resources available within the region as a whole, for example management services and computers.

# ARRANGEMENTS FOR THE ADMINISTRATION OF FAMILY PRACTITIONER SERVICES

## A CONSULTATIVE PAPER

### INTRODUCTION

1. In Circular HC(80)8 Ministers confirmed that the present arrangements for the administration of the family practitioner services would be retained. This consultative paper outlines the responsibilities of the new district health authorities and family practitioner committees, and invites comments on options for the future relationship between them and ways in which effective collaboration can be secured.
2. As the Government made clear in "Care in Action", it attaches priority to the further development of primary care services in all districts, as part of an integrated and efficient health service. The benefits of a strong primary health care service include early detection of illness, swift treatment to prevent deterioration, the care of people in the community rather than in hospital, and drawing on the resources of the family, neighbours and voluntary groups rather than relying on the expensive services of full time professionals in hospitals. It is in the context of securing these benefits that the future key relationships and options in the paper fall to be considered. Which will help best to ensure that they are achieved?

### RESPONSIBILITIES OF DHAs AND FPCs

3. DHAs will have the same role as existing area health authorities, outlined in Circular HC(80)8 as responsibility "for the planning, development and management of health services . . . . . within national and regional strategic guidelines". This includes primary health care services, except to the extent - and it is a vital qualification - that parts of those services are provided by doctors, dentists, opticians and pharmacists working as independent contractors, whose contracts with the NHS are administered by family practitioner committees (FPCs).
4. The range of services DHAs will provide, and their plans for the future, can have a marked effect on the provision of services by independent contractors, particularly general medical practitioners. For as members of the contractor professions plan to develop and maintain viable practices, the services they can offer will be influenced by DHAs' policies, particularly on the nature and extent of community services (where close working relationships between general medical practitioners and community nursing staff are of high importance), diagnostic and pathology laboratory facilities available, and the effectiveness of communications on such matters as discharge arrangements and waiting list information.
5. In turn, FPCs can provide a valuable input to DHAs' planning. For example, general medical practitioners deal with most references for health care and their knowledge of their practice populations and the incidence of disease, and its prevention, will be of great importance to DHAs. And the extent and nature of services provided by general medical practitioners will influence DHAs when determining the services they should provide.
6. All this provides sound reasons for ensuring that there will be effective collaboration in the development and operation of DHA services in relation to those provided by contractors. Collaboration has indeed developed since 1974, but the aim for the future is to sustain existing links and to forge others.
7. The role of the FPC is to administer, in accordance with regulations, the arrangements for the provision of general medical, dental, ophthalmic and pharmaceutical services. The range of FPCs' tasks is indicated in the Annex. Of particular importance is the advice that FPCs can offer to their contractors and also to members of the public in matters concerning the independent contractor services. The planning role already undertaken by FPCs is probably under-estimated; much of the planning they do for general medical services and medical manpower is to some extent masked because it is provided to, and acted upon by, the Medical Practices Committee, which is responsible for ensuring that there is an adequate distribution of general medical practitioners throughout England and Wales. (The Committee, in consultation with FPCs, delineates and classifies localities; it is empowered to refuse an application to provide general medical services if, in its view, the number of general medical practitioners undertaking to provide such services in the locality is already adequate. The assessment of adequacy is dependent upon the reports of FPCs concerning local medical manpower and the special needs of a particular locality).
8. Although at present each area health authority establishes an FPC, the FPC is not a sub-committee of the authority. Once the FPC has been established, the AHA's formal relationship is limited to:
  - (i) nominating eleven out of the FPC's thirty members;
  - (ii) providing the FPC with accommodation, staff and certain services - for example advice on financial systems (FPCs are statutorily barred from employing their own staff).

## THE FUNCTIONS OF FAMILY PRACTITIONER COMMITTEES

Family Practitioner Committees are responsible for administering the arrangements for the provision of general medical, dental, ophthalmic and pharmaceutical services. The specific tasks which they carry out in undertaking that function includes:-

- (a) Arranging with general medical and dental practitioners, pharmacists, appliance contractors, ophthalmic medical practitioners and opticians (hereinafter referred to as "contractors") for the provision, within the FPC's area, of the services which patients who wish to take advantage of those arrangements are entitled to receive. Ensuring, through the application of the appropriate Regulations, that such persons receive adequate personal care and attendance. On request, assigning a person to a general medical practitioner in those cases where the person has previously been refused acceptance.
- (b) Maintaining lists of contractors who have undertaken to provide family practitioner services in the area.
- (c) Dealing with applications for inclusion in those lists and the implications arising therefrom. Those from medical practitioners may only be granted by the Medical Practices Committee who also deal with medical practice vacancies. In the matter of applications to succeed to a practice vacancy, the FPC will advertise the vacancy and then consider all applications, draw up and interview a short list of candidates, and obtain references before sending all applications to the MPC with the FPC's recommendation as to the doctor or doctors to be appointed.
- (d) Administering the terms of service under which independent contractors provide services. FPCs are responsible for ensuring that obligations under those terms of service are met.
- (e) Providing advice and guidance to both contractors and patients. FPCs are responsible for establishing service committees under relevant regulations to investigate any complaints which allege that a contractor might be in breach of his terms of service. Service Committees also investigate complaints and references from the Dental Estimates Board which involve allegations of breaches of the terms of service for dentists, and references about alleged irregular certification from local Social Security offices, and other matters, relating to the administration of the Family Practitioner Services. They also establish dental conciliation committees.
- (f) Calculating the fees, allowances and reimbursements to which contractors are entitled and ensuring their prompt payment; dealing with claims for travelling and subsistence allowances by doctors who attend approved educational activities. Monitoring claims to detect irregularities; operating checks on remission of charges and refunding charges to patients in certain circumstances.
- (g) Approving where so required under the terms of service specific arrangements concerning the provision of services. For example, in the case of general medical practitioners, consent to the use of deputising services; approval of surgery premises and the time at which the doctor is available for consultation: consent to the employment of an assistant for more than 3 months in any twelve, etc. Inspecting medical practice premises and assisting doctors to improve such premises by telling them of, and guiding them through, the improvement grant and cost rent schemes.
- (h) Maintaining lists of patients registered with general medical practitioners in the form of a nominal index, doctors register of patients by doctor, and doctors ledger showing numbers at the beginning of a quarter, additions, cancellations and number at the end. Notifying movements of patients from other areas to the FPCs concerned and the NHS Central Register: issuing medical cards to patients; checking doctors' lists to eliminate duplicate registrations ("inflation").
- (i) Arranging for the transfer of medical records between doctors and FPCs when a patient changes his doctor.
- (j) Ordering, storing and supplying to general medical practitioners sterile single-use syringes and needles and the various items of stationery and forms required for use by contractors. Issuing to doctors the Statement of Fees and Allowances and amendments, National Insurance Medical Certificate (doctor's statement) forms and prescription forms.
- (k) Administering the arrangements made for (i) general practitioner maternity medical services and contraceptive services and (ii) the supply of drugs and appliances by doctors.
- (l) Provision to health authorities of data on immunisation.
- (m) Assisting in the local operation of the cervical cytology recall system.

17. The option (which would require legislation) would have the disadvantage of requiring RHAs to concern themselves with essentially local matters - the staffing and accommodation needs of FPCs - in which at present they have no role, and which is not consistent with the primarily strategic role Ministers wish RHAs to play. Second, the option would not meet FPC arguments against being dependent on health authorities. Third, this option would break the statutory relationship between FPCs and area (district) health authorities, and as such it could be argued that FPCs might be less inclined to collaborate effectively with DHAs.

18. Views on the options described above and any alternative approaches are invited.

#### STRENGTHENING LINKS BETWEEN FPCs AND DHAs

19. In principle the move away from a one-to-one relationship is likely to make effective collaboration between DHAs and FPCs more difficult. There are, however, a series of measures, applicable whichever option is chosen, which could encourage collaboration.

20. **Membership.** At present FPCs have thirty members, half drawn from the four independent contractor professions, and half lay members. Ministers have no plans to vary this balance. Eleven of the fifteen lay members are appointed by the matching AHA (in future one or more DHAs) and four by the matching local authority.

21. In principle, cross-membership should promote a greater understanding of the work of both bodies and effective collaboration. The demands on members, either of health authorities or FPCs, are, however, considerable, and it would be unrealistic to expect many people to be able to devote sufficient time to the health service to be effective members of both. With this in mind the scope for *increasing* cross-membership is fairly limited, but Ministers would welcome comments on the following proposals:

- (i) in cases where one FPC matches one DHA, that the requirement that *at least one* of the eleven members of the FPC appointed by the DHA must be a member of the DHA should be increased to *at least two*. (In cases where one FPC matches two or more DHAs, the 1980 Health Service Act already provides that the DHAs collectively should agree how the eleven health authority places should be filled, but that at least one member of *each* DHA should be appointed to the FPC.);
- (ii) that there should be provision to reduce the number of members appointed by local authorities, and correspondingly increase the number appointed by DHAs, where one FPC matches four or more DHAs, and where without such flexibility individual DHAs could be limited to appointing only one or two FPC members. (This proposal would require legislation.);
- (iii) bearing in mind the importance of primary health care nursing services, each DHA (or two or more DHAs where they jointly relate to one FPC) should ensure that one of the DHA-appointed members of each FPC is a nurse, midwife or health visitor with community experience;
- (iv) RHAs should appoint at least one member of each FPC (but not a member appointed by a DHA) to each DHA to which the FPC relates.

#### 22. Establishing a statutory duty for FPCs and DHAs to collaborate

Two possibilities are:

- (i) to require DHAs and the "matching" FPC to set up joint liaison committees, analogous to health authority/local authority JCCs - this would provide a formal setting for members of DHAs and FPCs to meet to discuss issues of mutual interest; and/or
- (ii) to place a statutory duty on FPCs to provide DHAs with all reasonable information (paying due regard to the confidentiality of personal records) relevant to the general aims for the organisation and development of services.

23. Comments on these proposals, and any other suggestions for promoting collaboration, will be welcomed.

#### CONCLUSION

24. Comments should be sent to the Department, Section RL1A, room 1406, Euston Tower, 286 Euston Road, London NW1 3DN by the end of May 1981.

- (n) The receipt and monitoring of prescription charges from dispensing doctors and the checking arrangements concerning claims for exemption from prescription charges. Returns to the Secretary of State on these matters. Maintaining, for renewal purposes, records of holders of prepayment certificates for prescriptions.
- (o) The Drug Testing Scheme - preparing and administering scheme for testing the quality and checking the amounts of drugs and appliances supplied by pharmacists.
- (p) Administering the domiciliary oxygen therapy scheme, maintaining lists of voluntary contractors (pharmacists, general medical practitioners and appliance contractors) and controlling holdings of approved equipment.
- (q) Organising rotas of duty pharmacists. Preparing and maintaining lists of pharmacists available to dispense urgent prescriptions outside normal and rota hours.
- (r) Consulting funding and involving as required the local professional committees representing contractors.
- (s) Providing as necessary secretariat services to serve the lay and professional members of FPCs and enable it and its associated sub-committees to function efficiently.
- (t) General planning of services including planning of family practitioner services in e.g. new town developments: liaison with health authorities and, where necessary, any other relevant bodies on service planning including e.g. the planning of health centres.
- (u) Keeping accounts of receipts and expenditure and forwarding these to the Secretary of State.
- (v) Channel of communications for conveying the Secretary of State's policy guidance and advice to the contractor professions.
- (w) Liaison with DHSS as appropriate on matters relating to practitioner services; the provision of statistics and returns to DHSS.



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities - for action

Area Health Authorities	)
Boards of Governors	)
Family Practitioner Committees	)
Community Health Councils	)
Metropolitan and Non-Metropolitan County Councils	) for information
Metropolitan and Non-Metropolitan District Councils	)
London Boroughs	)
Common Council of the City of London	)
ILEA	)
Greater London Council	)

December 1981

HEALTH SERVICE DEVELOPMENT  
COMMUNITY HEALTH COUNCILS

SUMMARY

This circular clarifies certain aspects of the role of community health councils (CHCs) and gives details of the changes in membership and appointments procedures which the Secretary of State has decided to implement in the light of the proposals put forward in the consultative document, "Community Health Councils in England", and the reactions to them. Guidance is also given on the special arrangements for appointments to CHCs in 1982 to take account of the constitution of district health authorities (DHAs).

PART 1 - BACKGROUND

1. Regulations are being laid to provide for community health councils in the restructured NHS. Copies will be issued under separate cover. Other detailed guidance is contained in this circular, with guidance on the role of CHCs in Appendix 1.
2. It was announced in HC(80)8, that CHCs would be retained alongside DHAs for a period and that the longer term case for retention would be reconsidered in the light of the experience of the operation of the more locally based DHAs. It is still the intention to undertake that reconsideration, although some provisions of the Regulations relating to period of office have, for convenience, been drawn up in a form which would cover a longer period of retention, should that be decided upon as a result of the review.

PART 2 - MEMBERSHIP

Size

3. CHCs should normally have 18-24 members. The Secretary of State expects most CHCs to be at or near the lower end of this range.

Composition

4. CHC members will continue to be appointed by local authorities, voluntary organisations and regional health authorities. For the time being, the proportions of the membership of CHCs appointed by local authorities and voluntary organisations as laid down in the NHS Act 1977 will remain at one-half and one-third respectively.



## Term of Office

5. The normal term of office for CHC members will continue to be four years expiring on 31 August, but this will be varied in relation to some appointments in 1982 - see Paragraph 17 below. The rule whereby members who have served two consecutive terms of office are ineligible for re-appointment until a further four years have elapsed will be replaced by one designed to ensure that members serving short terms of office by filling casual vacancies are not penalised. The new rule will be that where a member has completed consecutive terms of office amounting in total to eight years or more, he will be ineligible for re-appointment until a further four years have elapsed. This rule will not operate retrospectively, so existing CHC members whose terms of office expire on 31 August 1982, or whose appointments are terminated in accordance with the arrangements in Paragraph 15 below will, unless ineligible on other grounds, be eligible for re-appointment.

## Eligibility and Criteria for Appointment

6. Members of RHAs, DHAs and family practitioner committees will be ineligible under the regulations to be CHC members. If a CHC member accepts appointment to any such authority, his membership of the CHC will automatically lapse. The regulations will also provide for former NHS employees dismissed from NHS employment for reasons other than redundancy to be disqualified, subject to appeal to the Secretary of State after two years, for appointment as CHC members. The Secretary of State does not consider it appropriate for NHS employees or family practitioners to be members of CHCs matching their employing or contractual authority. No one should be a member of more than one CHC.

7. Appointing bodies should not appoint people over the age of 70 unless there is a special reason: for example, an appointment by an organisation concerned mainly with elderly people.

8. CHC members should normally live in the district covered by their CHC, but it is open to appointing authorities to appoint people who work in the district (other than NHS employees and family practitioners - see Paragraph 6 above), and who have a real knowledge of and commitment to the community and its needs.

9. In order to carry out their role effectively, CHC members should be prepared to devote a sufficient amount of time and energy to their council's work. It is important that appointing bodies take account of this, and confirm with prospective members that they can undertake the duties, before proceeding with appointments.

10. The rule whereby local authority members appointed to CHCs automatically and immediately lose their CHC places if defeated is to be modified, to ensure greater continuity of CHC membership after local government elections and to give local authorities discretion to retain defeated councillors on CHCs if they wish. Defeated councillors will continue as CHC members for one month unless replaced within that time (or unless they cease to be members for some other reason, eg resignation or appointment to a health authority). After one month CHC membership will lapse unless the appointing local authority has within that time given written notice that it is to continue. Members retained in this way will serve out their normal term of office unless they cease to be members for some other reason.

11. The rule enabling the place of a member who fails to attend a meeting for six months to be declared vacant at the discretion of the appointing authority is also to be modified. In such cases the establishing RHA will, after consultation with the appointing body concerned where that body is a local authority or voluntary organisation, declare the place vacant unless satisfied that absence was due to a reasonable cause.

## PART 3 - ESTABLISHMENT, RESOURCES AND STAFFING

12. RHAs will remain responsible for establishing CHCs, determining their allocations, and employing their staff. It will be open to them to use the services of DHAs for certain of the more routine establishment functions, for example, payroll services, provision of office premises, and payment of approved expenses.

13. The Secretary of State expects there to be no general increase in the level of resources allocated to CHCs. Moreover, where the total number of CHCs within a region is to be reduced as a result of Re-organisation he expects some savings to be made as a result.

14. The Secretary of State intends to impose in regulations a duty on CHCs not to spend sums in excess of the expenses approved by the establishing RHA.

## PART 4 - TRANSITIONAL ARRANGEMENTS.

15. RHAs should ensure that CHCs of an appropriate size in accordance with Paragraph 3 of this Circular are brought into operation alongside DHAs. There should be one CHC relating to and established for the same district as each DHA.\* It will be open to RHAs to establish a new CHC for each DHA or, if they prefer, to

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\* The Secretary of State has decided that there should be separate CHCs for the Isles of Scilly and for Weston, and also for each of the two sectors of the Liverpool DHA, but that no further exceptions will be considered until the new structure of the NHS has had time to settle down, and then only where exceptionally strong arguments are advanced by the local communities concerned.

leave existing CHCs in being where they are already established for districts which will, subject to any minor boundary changes, match those of the DHAs to which they will relate. Where existing CHCs are to be retained RHAs should where necessary use the powers in Regulations 4 and 11 of SI 1973 No. 2217 to reduce the membership to an appropriate size. RHAs will no longer be required to consult local authorities before making changes in the number of CHCs established by them, the districts to which they relate and the size of their membership. RHAs may find it convenient to bring the new arrangements into effect from a single date on or after 1 April 1982, or to bring them in in stages. In any event all the new arrangements should be brought into effect from no later than 1 September 1982.

16. Where new CHCs are to be established after 1 April 1982 RHAs should make temporary arrangements for those existing CHCs which prior to that date were established for the areas for which new CHCs are to be established to represent the interests of those areas to the relevant DHA or DHAs. To do this RHAs will need formally to establish the existing CHCs concerned, with effect from 1 April 1982, for the corresponding areas of the relevant DHA or DHAs. Pending the establishment of the new CHCs, the existing CHCs should be given the opportunity to send observers to the non-confidential parts of DHA meetings. The Secretary of State also expects that DHAs while still in "shadow" form will admit CHC observers on the same basis.

17. Where new CHCs are established, one half (as near as may be) of the original members should be appointed, in accordance with Part 5 of this Circular, for a term of office expiring on 31 August 1984, the remainder for a term of office expiring on 31 August 1986. Each category should comprise one-half (as near as may be) of the members appointed by local authorities, one half of those appointed by voluntary organisations, and one half of those appointed by RHAs. It will be for the appointing bodies to agree, or in the absence of agreement for the establishing authority to determine, which of the members they appoint fall into which category. RHAs should convene the first formal meetings of the new CHCs as soon as possible. Where existing CHCs are to continue appointments to replace or reappoint those members whose terms of office expire on 31 August 1982 should proceed in accordance with Part 5 of this Circular, subject to any action necessary in accordance with Paragraph 15 to reduce CHCs to an appropriate size.

#### **Staff, Premises and Expenses**

18. RHAs will continue to be responsible for controlling the staff establishment of CHCs and formally appointing their secretaries. The level of establishment must take account of what is said in Paragraph 13 above about resources for CHCs. The secretary and any other staff should be employed by the RHA on the appropriate NHS terms and conditions of service, including superannuation.

19. Existing CHC staff are covered by the Whitley agreement on staffing arrangements for NHS Reorganisation, and will thus be eligible to compete or be "slotted in" to posts in the reorganised service on the same basis as other NHS staff employed in the same area. In accordance with the agreement, it will be for Regional and Local Management and Staff Sides to agree within the national guidelines whether posts serving new CHCs should be filled by competition or by "slotting in". Where posts are to be filled by competition, the selection should be made by a committee established by the CHC. Appointments to new CHCs should not in any event be finalised until it is confirmed that they are acceptable to the CHC concerned. Until permanent staffing arrangements are agreed with the CHC, the RHA should make temporary arrangements for such assistance as the CHC may require, for example, by retaining the staff of a wound-up CHC to serve a successor.

20. The RHA will be responsible for providing each new CHC with accommodation and supporting facilities. In practice it should usually be sufficient for existing CHC accommodation to be made available.

21. The RHA will continue to be responsible for approving the budget of each CHC and for providing the funds from the regional allocation. It may be convenient and economic for the DHA to administer arrangements for accommodation, and to pay staff salaries and approved expenses. New CHCs should be advised to submit estimates as soon as possible looking to the District Treasurer for assistance or advice on their formulation. The RHA should inform the DHA and the CHC of the approved estimates and allocate the requisite funds to the DHA. The payment and accounting facilities of the relevant DHA will be used, and thus a separate bank account will not be necessary.

#### **PART 5 - APPOINTMENTS PROCEDURE**

##### **Appointment of Members (At Least One-half) by Relevant Local Authorities**

22. Each relevant local authority (that is, London Borough, metropolitan or non-metropolitan county or district, or Common Council of the City of London), with territory in a CHC's district is entitled to appoint at least one member to that CHC and it is for the local authorities to agree among themselves on the allocation of the remaining seats (in the absence of agreement, it would be for the establishing authority to determine this allocation). At the appropriate time RHAs should invite the relevant local authorities to proceed with their appointments. Local authorities may appoint councillors or non-councillors as they wish, and are asked to bear in mind the value of appointing a representative of parish, community or town councils, particularly in rural areas. What is said in Paragraph 9 about the demanding nature of CHC work may be of particular relevance when councillors are being considered for appointment to CHCs, as their local authority duties may absorb a great deal of their time. However, the value to a CHC of having local authority members with relevant experience, particularly current membership of social services or housing committees, should also be borne in mind. The local authorities should notify the RHA of the names of their appointees as soon as possible.

## Appointment of Members (At Least One-third) by Voluntary Organisations With an Interest in the NHS

23. Any voluntary organisation interested in health matters and active in a CHC's district, or with a particular interest in a health service institution within that district, can apply to take part in appointing members to the CHC. The final decision on the organisations to be invited to take part in making the appointments is for the RHA. For this purpose, RHAs should maintain for each CHC a register of suitable organisations, and take steps to bring it up to date before each round of appointments. Existing lists of voluntary organisations who have been invited to take part in previous rounds should be used as the basis for compiling the registers. Care should be taken to take account of boundary changes in compiling registers for new CHCs. RHAs will no longer be required to consult local authorities before deciding which organisations are to be invited to take part, but may find it useful to contact them (and other organisations such as local co-ordinating bodies and CHCs themselves) when bringing their registers up to date. It will be for RHAs to decide whether to advertise, and if so, where and by what means.

24. The procedure for arranging the selection of voluntary organisations is to be modified as follows:

- a. Political parties should not be included in the register of voluntary organisations.
- b. A place for trades councils will no longer be reserved within the RHA share of appointments, but the Secretary of State considers it essential that trades councils have a full opportunity to participate as voluntary organisations in the selection procedure. The appropriate trades council must therefore always be included in the register of voluntary organisations.
- c. RHAs will no longer be required to give each CHC an opportunity to comment on the procedure for making appointments to that CHC.
- d. The Secretary of State does not think it right for any one voluntary organisation to have more than one seat on any one CHC. Organisations should not be invited to take part in a round of appointments if their appointees' term of office does not expire until the subsequent round.

25. A summary of the procedure for arranging these appointments is in Appendix 2.

### Appointment of Remaining Members

26. The proportion of these members should amount as near as is practicable to one-sixth of the total membership of the CHC. The RHA will appoint these members after giving the matching DHA an opportunity to submit names for consideration. DHAs should be invited to give reasons for their suggestions. RHAs should also undertake whatever other consultations they see fit; they will no longer be required to consult local authorities, but may find it helpful to do so.

27. In making their appointments RHAs should consider organisations with a particular interest in local health services who would not otherwise be represented, and individuals likely to have a valuable contribution to make (eg because of previous health service experience). The Secretary of State considers trades councils to be a valuable source of CHC membership, and RHAs should give particular consideration to appointing a nominee of the appropriate trades council where there would otherwise be no trades council representation. Where appropriate RHAs should also bear in mind organisations with a particular interest in a health service institution (eg a miners' rehabilitation centre) and organisations representing ethnic minorities. RHAs may also wish to consider religious organisations, employers' organisations, women's organisations, youth bodies, and tenants' and residents' associations. RHAs may find it helpful to ask organisations to submit a choice of names.

## PART 6 - MISCELLANEOUS

### Information About the NHS for CHC Members

28. While some CHC members will have considerable previous knowledge and experience of the health services, a number may not, and RHAs should consider in consultation with CHCs and their matching DHAs the need to arrange seminars or make other arrangements by which new members can be informed about the NHS and how it works. A training pack for new CHC members has been produced by the School for Advanced Urban Studies, Bristol, and is currently being brought up to date. The revised version will be available shortly from

School for Advanced Urban Studies  
University of Bristol  
Rodney Lodge  
Grange Road  
Bristol BS8 4EA

## Meetings of CHCs

29. Regulation 14 of SI 1973 No. 2217 governs the arrangements for setting up and conducting CHC meetings, and these provisions will be retained.

30. The provisions of the Public Bodies (Admission to Meetings) Act 1960 apply to CHCs. The public, including the press, will therefore normally be admitted to meetings of CHCs. The public may be excluded if a CHC resolves in respect of particular business that publicity would be prejudicial to the public interest by reason of the confidential nature of the business, or for other special reasons which must be stated in the resolution. Where meetings are open to the public, the CHC has a duty to give public notice of the time and place of the meeting normally three clear days at least before the meeting; to furnish for the benefit of any newspaper a copy of the agenda for the meeting; and to provide accredited representatives of the press, so far as practicable, with reasonable facilities for taking a report of the meeting.

## Association of CHCs for England and Wales

31. Subject to continuing support from CHCs, the Association of CHCs will continue in being, financed by subscriptions from member CHCs.

## PART 7 - CANCELLATION OF EARLIER GUIDANCE

32. The following circulars are cancelled:

HRC(74)4;  
HSC(IS)49;  
HC(76)25;  
HC(FP)(77)2.

## PART 8 - ACTION

33. RHAs should -

- i. determine arrangements for CHCs within their Regions in accordance with Paragraphs 15 and 16 and set in hand as necessary the establishment of, and appointment of members to, new CHCs;
- ii. arrange in respect of each new CHC for the provision of office accommodation as necessary;
- iii. make temporary staffing arrangements and confirm permanent arrangements with each new CHC in due course;
- iv. convene the first meeting of each new CHC;
- v. request early submission of estimates of expenditure from each new CHC and notify approved estimates to the CHC and DHA;
- vi. in relation to existing CHCs which are to continue, proceed at the appropriate time with arrangements for the necessary appointments from 1 September 1982;
- vii. pass five copies of this Circular to "shadow" District Health Authorities.

From:

Children's Division D  
Alexander Fleming House  
Elephant and Castle  
London SE1 6BY

Tel. 01-407 5522 Ext 6162

CHC/57

Further copies of this Circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

## ROLE OF COMMUNITY HEALTH COUNCILS

1. The statutory duty of CHCs, as set out in the NHS Act 1977, is to represent the interests in the health service of the public in its district. The Secretary of State confirms that he sees CHCs as local bodies, representing the interests of their local populations. He does not propose to issue detailed guidelines on this role, but the following paragraphs are intended to confirm or clarify certain points which were raised in the consultative paper "Community Health Councils in England".

### RIGHTS AND DUTIES OF CHCs IN RELATION TO DHAs

2. The existing rights of CHCs to be consulted and informed by AHAs will be retained in relation to DHAs, and the Secretary of State will expect DHAs to make every effort to consult CHCs in good time on all matters of interest to them. CHCs will retain their right to have proposed closures or changes of use of health buildings referred to the Secretary of State, in cases where they object and have put forward a detailed and constructive counter-proposal.

3. Each CHC will have a duty to publish an annual report, and the matching DHA will be required to publish a reply. The DHA will also be required to arrange a meeting with the CHC at least once a year.

4. CHCs will have the same right to send observers to meetings of their matching DHAs as they have now in relation to AHA meetings. Further guidance on this is contained in HC(81)6, Appendix 4, Paragraph 8.

### VISITS TO HEALTH SERVICES PREMISES

5. The current arrangements whereby, subject to certain safeguards in respect of premises used as residential accommodation or for the provision of family practitioner services, CHCs have a right to inspect health services premises controlled by AHAs, will be continued in respect of premises under the control of DHAs. It will be for the DHA and the CHC to agree between them (or in the absence of agreement, for the RHA to determine) arrangements for access. These should take account of the pressures on medical and nursing staff, and ensure that visits are fixed for times when they will not interfere with the efficient running of services. The appropriate consultant and nursing officer should be informed beforehand of proposed visits to wards, clinics, hospital departments etc. Staff residential quarters and premises or parts of premises occupied by practitioners for the purpose of providing family practitioner services should not be entered without the prior agreement of the staff or practitioners concerned.

6. CHCs do not have a statutory right of access to private hospitals or registered nursing homes. However, in the case of such premises where NHS patients receive services under contractual arrangements, representatives of the private health sector have agreed that CHCs should have access to appropriate parts of the premises concerned. It will be for the CHC and the management of the private hospital or nursing home to agree between them mutually convenient visiting arrangements.

### COMPLAINTS

7. Giving advice to members of the public on how to go about making a complaint about the health service has become a widely-established feature of CHC work. However, some CHC members and officers are prepared to go further than this, for instance, by acting as "patient's friend" at service committee hearings. The Secretary of State does not see this as a formal role for CHCs, but he sees no objection to individual CHC members or officers providing such assistance if they are asked and wish to do so.

### ATTENDANCE AT MEETINGS OF FAMILY PRACTITIONER COMMITTEES

8. The Secretary of State does not propose to require family practitioner committees to admit CHC observers. However, many now do so voluntarily, and he urges all FPCs to adopt this practice.

## PROCEDURE FOR APPOINTMENTS BY VOLUNTARY ORGANISATIONS

1. RHAs should maintain for each CHC a register of voluntary organisations to be invited to take part in making appointments to that CHC. To bring the register up to date before each round of appointments, they may find it helpful to contact CHCs themselves, DHAs, co-ordinating bodies such as local councils for voluntary service, county community councils, Age Concern or Old People's Welfare Committees, community relations councils, and local authorities. Whether to advertise, and if so where and how, will under the amended Regulations be a matter for the discretion of RHAs.
2. The register should consist of organisations, including those referred to in Paragraph 27 of the Circular, interested in health matters and active in a CHC's district, or with a particular interest in a health service institution within that district (for example, a miners' rehabilitation centre). Political parties should not be included in the register. The appropriate trades council must be included in the register for each CHC. It is not necessary for the office of a voluntary organisation to be situated in the district concerned for it to be eligible for inclusion. It is for the RHA to decide whether to include an organisation on the register, and the Secretary of State expects voluntary organisations to be given the benefit of any doubt by being included rather than excluded. An organisation which applies for inclusion on the register should be informed of the outcome.
3. Once it has satisfied itself that the register is up to date, the RHA should invite the organisations on it to agree among themselves who should make appointments to the places to be filled. Organisations should not be invited to take part in a round of appointments to a CHC if they already have an appointee on that CHC whose term of office does not expire until the subsequent round. Places may be allocated to individual organisations or to organisations acting jointly.
4. It has become established practice in many localities for a local co-ordinating body of voluntary organisations (for example, the local council for voluntary service) to act as agent of the RHA, in the arrangements for making these appointments. Where this is appropriate and practicable, RHAs are encouraged to invite a co-ordinating body to assist in the arrangements. Expenses incurred by a co-ordinating body for this purpose should be reimbursed by the RHA. Arrangements for the approval and reimbursement of such expenses should be agreed at the outset.
5. It is the RHA's responsibility to ensure that all invited voluntary organisations have the opportunity to participate in the choice of which of them will make the actual appointments. In practice this will usually mean organising some form of election, in which all the invited organisations can take part. Detailed arrangements are for local determination, but the voting procedures should ensure that no organisation with more than one branch in the district has thereby any advantage over the others. CHCs and DHAs should take no part in the selection procedures.
6. At some stage during the selection procedure, the organisations taking part should be invited to indicate which method they would prefer for filling any casual vacancies that may subsequently arise. It will usually be convenient for one of two methods to be adopted: either to invite the voluntary organisation or group of organisations which made the original appointment to make the fresh appointment, or to make use of a reserve list of organisations compiled at the time of making the general round. Where voluntary organisations are grouped for the purpose of making appointments, a reserve list for each group may be preferred. Whatever method is used, it may be useful to have a reserve list in case the voluntary organisation which made the original appointment no longer exists, or does not wish to make a fresh appointment.
7. Provided all the invited voluntary organisations agree among themselves within a reasonable period, which could with advantage be fixed at the outset, the RHA has no part to play in establishing which voluntary organisations should make the appointments. However, if unanimous agreement is not reached, it will fall to the RHA to select the organisations which are to appoint members. The selection should take account of such agreements as may have been reached between groups of organisations. In selecting organisations, adequate recognition should be given to the needs of priority groups within the community, and to the need for a proper balance between voluntary organisations with a general interest in health services, those which seek to influence policies and those concerned with providing a service to the NHS. The RHA should also take into account the claims of organisations with special interests in particular institutions.
8. When the appointing organisations or groups of organisations have been unanimously agreed, or in default of agreement selected by the RHA, the organisations so selected will be free to make their appointments. They should notify the RHA of the names of the persons appointed.



## DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: **Regional Health Authorities** )  
**Area Health Authorities** ) for action  
**Boards of Governors** )

**Family Practitioner Committees** )  
**Community Health Councils** ) for information

April 1981

**HEALTH SERVICES MANAGEMENT**  
**HEALTH SERVICE COMPLAINTS PROCEDURE**

**SUMMARY**

This Circular introduces a Memorandum of guidance upon which health authorities should base their arrangements for dealing with suggestions and complaints other than those relating to family practitioner services. The Circular and annexed Memorandum amplify, but do not replace, the guidance contained in HM(66)15, and the letters to hospital authorities of 9 December 1966 and 27 July 1970.

**INTRODUCTION**

1. A consultation document on the initial handling of complaints was issued with Health Notice HN(78)39 in April 1978 for comment by health authorities, community health councils and a wide range of staff, professional and other organisations. From the response it appears that the consultation document was well received in the main. A great deal of comment was sent to the Department, including much of a detailed nature that is appropriate to local arrangements rather than to broad central guidance. There is general agreement that the Department should advise on simple, easily understood, basic procedures; and this Circular and accompanying Memorandum seek to provide such a framework in the light of comments received. In addition the Memorandum incorporates a procedure which has been agreed on a trial basis with the Joint Consultants Committee for handling complaints relating to the exercise of clinical judgement by hospital medical and dental staff.
2. Untoward events affecting patients that may require investigation sometimes come to light other than from complaints (for example, accidents involving hospital services, such as in operating theatres, or in other hospital departments; or unexplained injuries to a patient who - by reason of illness or otherwise - may be unable to make a complaint). Such events should be investigated in accordance with the principles of the guidance contained in the Memorandum.
3. The investigation of serious complaints or incidents that cannot be satisfactorily resolved by the authority's officers is covered by HM(66)15, Paragraph 7(iii) (supplemented by the circular letters of December 1966 and July 1970). This guidance remains in force.

**MEMORANDUM ON HANDLING PATIENTS' COMPLAINTS**

4. The annexed Memorandum has been prepared for use in hospitals. It does not deal with complaints about family practitioner services covered by the service committee procedures. Part I of the Memorandum is intended for all staff who are in regular contact with patients; Part II is intended for senior staff who may be expected to investigate complaints or incidents involving patients, other than those involving the clinical judgement of hospital medical and dental staff. Complaints as to clinical judgement would be referred to the consultant in clinical charge of the patient (see Part III).
5. In operating the guidance special consideration should be given to the needs of those patients who for a variety of reasons may be unable to complain on their own account. The aim should be to apply the same general principles as far as the particular circumstances of these patients permit.

6. Authorities should consider how the general aims of Parts I and II of the Memorandum can best be applied to services provided by the authority outside hospitals (but excluding family practitioner services); and should make local arrangements accordingly.

#### INFORMATION FOR PATIENTS

7. The importance of communication is given prominence in the Memorandum and good communication depends crucially upon everyone, both patients and staff, knowing who is responsible for giving information. Information booklets should be given to hospital in-patients including, where possible at some suitable time, those admitted through accident and emergency services. These "hospital booklets" should also be available to patients, on request, in hospital out-patient departments. Suggested paragraphs for inclusion in hospital booklets are given in Appendix 1 to the Memorandum. Copies of the leaflet "Health Service Commissioner for England" (obtainable from the Commissioner's office) should be available on request. The Department is preparing a leaflet of guidance on aspects of the complaints procedure dealt with in the annexed Memorandum.

#### MONITORING COMPLAINTS

8. Authorities should introduce a systematic and effective method of reviewing complaints to identify significant trends which could enable them to make improvements.

#### ACTION

9. Much of the procedure described in the annexed Memorandum is already in practice; authorities should bring the remainder into operation from 1 September 1981. Authorities are asked to make available guidance for the staff concerned on the basis of the Memorandum, and to include suitable information for patients in "hospital booklets" (paragraphs for this purpose are suggested in Appendix 1).

#### From:

Health Services Division 2D  
Hannibal House  
Elephant and Castle  
London SE1 6TE

Tel. 01-703 6380 Ext 3120

CPL/1

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HEALTH SERVICE COMPLAINTS PROCEDURE  
MEMORANDUM ON HANDLING PATIENTS' COMPLAINTS  
PART I - COMMUNICATIONS AND COMPLAINTS

(Note: this part is intended for all staff who are in regular contact with patients)

1. The attitudes and comments of patients and their relatives show clearly that they are mostly grateful to staff concerned for the treatment and care they provide. Formal complaints arise from only a tiny fraction of the vast number of contacts between NHS staff and members of the public, although not all dissatisfaction is expressed as formal complaints. Doctors, nurses and other staff are able to reassure patients (or their relatives or friends) about many matters that cause them concern; when misgivings are expressed, an immediate sympathetic response frequently solves the problem. In the relatively few instances where a formal complaint is made - whether by a patient, or by a relative or friend of a patient - it should be dealt with promptly, as set out in this Memorandum.

IMPORTANCE OF GOOD COMMUNICATION

2. Problems of communication between patients and health care staff can lead to confusion and sometimes to dissatisfaction: many complaints by patients have their roots in failures of communication. Difficulties may arise, for example, because of physical handicap, such as deafness, which may go unrecognised, or because of language or cultural barriers. Anxiety, fear, psychological withdrawal, and inarticulateness also create barriers to effective communication. These present a challenge to staff who often work under pressure and may find it difficult to devote as much time to overcoming such impediments as they would wish. Staff no less than patients experience frustration when communication is difficult, but a sick person, in an environment which is probably unfamiliar and often daunting, is particularly vulnerable to lack of information about what is happening to him. The responsibility for establishing effective communication with patients rests with nurses, doctors and other health care staff: members of the professions concerned accept this in principle and recognise that a conscious and continuing effort is required to translate the principle into practice.

3. Almost all patients would like to have, as often as is reasonable, brief explanations of what is happening to them and why. Some patients are reluctant - or feel they lack a suitable opportunity - to approach senior staff: for example it is not easy for some patients to ask a consultant questions or communicate intimate information when he is on a formal ward round. Junior medical staff and ward sisters play a valuable role in providing information and giving explanations to patients; but a patient who wants additional information about his medical condition and treatment should ideally have - and know or be told he has - an opportunity to discuss the matter in private with the consultant or with a senior member of the consultant's team.

HANDLING OF MINOR CRITICISMS

4. Many matters that trouble patients can be dealt with as they arise. For example, minor criticisms about waiting time in an out-patient department, about meals or some aspect of nursing care on the ward, or some misunderstanding about arrangements for nursing services at a patient's home, can often be cleared up to the patient's satisfaction on the spot. Any comment or misgivings voiced by patients, even those which appear trivial, should be listened to sympathetically. It will frequently be possible for the member of staff to whom these are expressed, or the person in charge at the time, to provide an acceptable answer or explanation there and then. Where remedial action has been or is to be taken, its nature should be explained to the complainant. Most minor criticisms are dealt with in this way and, where this is so, and the complainant has expressed himself satisfied, no record of the matter need be kept at ward or department level, unless for any reason the member of staff who handles the complaint and sees the complainant feels that it would be desirable to do so.

PROCEDURE FOR REPORTING COMPLAINTS

5. A formal complaint, which may be written or oral, is one which the complainant wishes to have investigated by senior staff and on which he wishes to have either a written reply from the authority or an oral explanation from the senior member of staff concerned. If a patient wants to make a formal complaint (where there may be any doubt, he should be asked) the following action should be taken (but see Paragraph 6 below where he wishes to complain in writing to the health authority):

i. nurses and other non-medical staff should report the matter to the ward sister (or charge nurse, or equivalent person in a hospital department) who will inform the appropriate senior officer and tell the patient this has been done. Any clinical aspects of the complaint should be referred by the senior officer to the consultant concerned. In any case the senior officer should inform the consultant of *all* formal complaints about the treatment and care of patients in his charge.

ii. medical and dental staff should report the matter to the consultant concerned, telling the patient that they are doing so.

The subsequent handling of complaints by senior officers and consultants is dealt with in Parts II (for non-clinical complaints) and III (for clinical complaints) of this Memorandum. Some complaints will contain both clinical and non-clinical aspects: in each such case it is necessary to determine at the outset which part of the complaint shall be handled according to Part II of the Memorandum and which according to Part III: this should be done by the consultant and district administrator (or officer designated as in Paragraph 13 below) together, bringing in other senior officers as necessary. The arrangements which have been made for handling the different elements of the complaint should be explained to the complainant.

6. A patient who wishes to make a complaint in writing to the health authority should be advised to write to the Area or District Administrator\* at ..... (address). Information about making complaints is given in the "hospital booklet", a copy of which is given to all patients admitted to hospital and should also be available on request in hospital out-patient departments. Formal complaints should normally be made within a year of the complainant becoming aware that he has a cause for complaint.

\* or in the case of hospitals managed by Boards of Governors the Secretary to the Board

## PART II - INVESTIGATING PATIENTS' COMPLAINTS (OTHER THAN THOSE RELATING TO THE EXERCISE OF CLINICAL JUDGEMENT BY HOSPITAL MEDICAL AND DENTAL STAFF)

(Note: This part is intended for all senior staff who may be expected to investigate complaints made by patients or on their behalf.)

### MAIN PRINCIPLES

7. The investigation of formal complaints is the responsibility of senior staff. Staff at ward sister (and equivalent) level or below, and junior medical and dental staff, should not be expected to investigate and reply to formal complaints although they may be asked to assist in an investigation by the senior member of staff responsible.

8. The following principles should apply to the investigation of *all* complaints:

i. All complaints should be investigated thoroughly and fairly and as quickly as circumstances permit. It should be remembered that the unsatisfactory handling of a complaint may become the cause of further complaint.

ii. A member of staff investigating a complaint should keep the complainant and any persons complained about fully and promptly informed of reasons for unavoidable delay in resolving the issue.

iii. Any member of staff involved in a complaint should be fully informed of any allegations at the outset and given an opportunity to reply. He should be advised of his right to seek the help and advice of his professional association or trade union before commenting on a complaint.

9. Legal advice should always be sought (preferably from the legal adviser to the regional health authority) when dealing with complaints which may lead to litigation. In particular, advice should be sought on matters to be investigated and in what form, so as to minimise the risk of prejudicing any civil proceedings. Legal proceedings or the likelihood of legal proceedings should not deter the authority from undertaking any immediate investigation that may be necessary, eg to uncover faults in procedures and prevent a recurrence.

### ROLE OF HEALTH SERVICE COMMISSIONER

10. A complainant who remains aggrieved may refer the matter to the Health Service Commissioner who may investigate any complaint within his jurisdiction provided that the health authority (in practice, the senior member of staff dealing with a complaint) has been given a reasonable opportunity to reply. There may be only one opportunity for the health authority to investigate and reply to such a complaint before the Commissioner is brought in. It is important, therefore, that all complaints should be investigated at the appropriate level and the reply carefully considered before it is sent to the complainant.

### ORAL COMPLAINTS

11. A senior member of staff to whom a complaint is referred in accordance with Part I of this Memorandum should consider whether he may be able to resolve it by discussion with the complainant. He should make a note of any such discussion and its outcome, even if the complainant appears satisfied (in case the complaint is subsequently taken further). The note should be retained with the patient's records.

12. If discussion fails to resolve the matter to the complainant's satisfaction, or if the senior member of staff concerned considers that the complaint is one that should be put into writing, then

*either* i. the complainant should be advised to send a written complaint to the Area or District Health Authority at . . . . . (address)

*or* ii. *if the complainant is not willing or able to send a written complaint but wishes the matter to be pursued*, the senior member of staff dealing with the matter should arrange for a record of the complaint to be made and for the complainant to sign it. A complainant should be given a copy of any statement he is asked to sign. The complaint should then be dealt with in accordance with the principles set out in the following paragraphs.

## WRITTEN COMPLAINTS TO THE AUTHORITY

13. Investigation of complaints made in writing to the authority should be co-ordinated by the district administrator\* (or other senior officer designated by the authority). The Chairman (or other designated member of the authority) should be informed in good time of any complaints that the authority under local arrangements has decided may require to be considered by the authority itself.

14. All complaints should be referred to the appropriate senior member(s) of staff (eg consultant, nursing officer, or head of department concerned) for investigation and report. The principles set out in Paragraph 8 above should be followed in all investigations.

## ACTION FOLLOWING INVESTIGATION

15. Following an investigation, any action to be taken and the reply to the complainant should be agreed between the district administrator (or other senior designated officer) and senior member(s) of staff concerned: if such agreement cannot be reached, the matter should be referred to the district management team who should agree a reply or refer the matter to the authority.

16. The reply should be sent by the district administrator on behalf of the authority unless a departure from this practice has been agreed by the authority and set out clearly in standing instructions. Where complaints raise matters of serious concern, the Chairman of the authority may on occasion wish to reply to them personally. The reply should explain any action taken or recommended or explain why no action is appropriate. It should be sympathetic in tone and avoid technical terms which the complainant may not understand. All members of staff involved in the complaint should be informed of the outcome.

17. If the complainant remains dissatisfied he should be advised to refer the complaint to the Health Service Commissioner unless the matter is clearly outside the Commissioner's jurisdiction.

\* In the case of Boards of Governors, by the Secretary of the Board.

**PART III - COMPLAINTS RELATING TO THE EXERCISE OF CLINICAL JUDGEMENT  
BY HOSPITAL MEDICAL AND DENTAL STAFF**

**FIRST STAGE**

18. As explained in Paragraph 5 of Part I, a complaint may initially be made, and dealt with, orally or in writing. Complaints concerning clinical matters may be made direct to the consultant concerned, or to a health authority or one of its officers. In either case it is the responsibility of the consultant in charge of the patient to look into the clinical aspects of the complaint. This must be the first step in handling the complaint at the *first stage*.

19. If another member of the medical <sup>(1)</sup> staff is involved, the consultant should discuss the complaint with the doctor concerned, at the outset and at all later stages in this procedure. It may be helpful to discuss the complaint with the patient's general practitioner. The consultant should try to resolve the complaint within a few days preferably by offering to see the complainant <sup>(2)</sup> to discuss the matter and seek to resolve his anxieties. If there is any delay, he should get in touch with the complainant and explain the reason. When the consultant sees the complainant, he should make a brief, strictly factual, record in the hospital notes.

20. Where a complaint is made which involves hospital medical staff other than consultants, the consultant in charge of the patient and the doctor concerned should both be involved in the handling of the complaint at all stages.

21. If the consultant feels the risk of legal action is significant, he should at once bring the matter to the notice of the district administrator. Where there are non-clinical aspects to a complaint made direct to a consultant, the consultant should inform the district administrator, who will arrange for these aspects of the complaint to be considered by an appropriate member of staff.

22. Where a complaint which has a clinical element is made to the authority or one of its officers, the district administrator should show the complaint to the consultant concerned and refer the clinical aspects to him.

23. The normal practice will be for the district administrator to send a written reply to the complainant on behalf of the authority. Any reference to clinical matters in the reply, whether interim or final, should be agreed by the consultant concerned. Sometimes it may be appropriate to confine this to mentioning that the clinical aspects had been discussed between the consultant and the complainant. On occasion, the consultant may wish to send the complainant a written reply direct covering the clinical aspects.

**SECOND STAGE**

24. Where a complainant is dissatisfied with the reply he has received at the first stage, he may renew his complaint either to the authority, one of its administrators or to the consultant. In any case, if he has not so far put his complaint in writing, he should now be asked to do so before his complaint is considered further. The next step, *in this second stage*, is for the Regional Medical Officer (RMO) to be at once informed; this should be done by the consultant, informing the district administrator that he has done so. The RMO will discuss the matter with the consultant.

25. At this point, the consultant may indicate to the RMO that he also wishes to discuss the matter with his professional colleagues. After these discussions, he may consider that a further talk with the complainant might resolve the complaint. If this fails, or if the consultant feels that such a meeting would serve no useful purpose, the RMO should discuss with the consultant the value of offering to the complainant the procedure - outlined more fully below - whereby the RMO would arrange for two independent consultants to see the complainant jointly to discuss the problem. If in the light of his discussion with the consultant and - where necessary - the complainant, the RMO considers it appropriate, the procedure of the *third stage* should be set in motion.

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(1) In this Memorandum the terms "medical" and "doctor" include "dental" and "dentist" in appropriate cases.

(2) The doctor's first responsibility is to the patient, hence this Memorandum is concerned with complaints made by patients. It applies also to complaints made by parents or guardians of minors, and relatives of those patients with physical or mental disability limiting their competence to deal with the matter themselves, and of deceased patients. The term "complainant" is used to cover all such cases.

### THIRD STAGE - INDEPENDENT PROFESSIONAL REVIEW

26. The procedure at the third stage is intended to deal with complaints which are of a substantial nature, but which are not prima facie (and in the light of legal advice where appropriate) likely to be the subject of more formal action either by the health authority or through the courts. The procedure is intended for use in suitable instances as an alternative to the inquiry procedures provided in HM(66)15, though these will remain available for use when necessary. It would not be appropriate if legal powers such as subpoena seem likely to be required. Nor is it intended that the new procedure should be invoked for complaints of a trivial nature.

27. Arrangements should be made by the RMO for all aspects of the case to be considered by two independent consultants in active practice in the appropriate specialty or specialties. They should be nominated by the Joint Consultants Committee. At least one should be a doctor working in a comparable hospital in another Region. These "second opinions" should have the opportunity to read all the clinical records. They should discuss the case with the consultant concerned and any other member of the medical staff involved as well as with the complainant. The meeting between the two independent consultants and the complainant should be in the nature of a medical consultation. The consultant who had been in charge of the patient at the time of the event giving rise to the complaint should not be present at the meeting, but should be available if required. The complainant should, if he wishes, be accompanied by a relative or personal friend and might wish to ask the general practitioner to be present.

28. "Second opinions" should discuss the clinical aspects of the problem fully with the complainant. In cases in which it is their view that the clinical judgment of the medical staff concerned has been exercised responsibly, they should endeavour to resolve the complainant's anxieties. The view they have reached and the outcome of the discussion with the complainant should be reported to the RMO on a confidential basis.

29. In other cases the 'second opinions' might feel that discussion with the medical staff concerned would avoid similar problems arising in the future. When they had held such a discussion they would inform the complainant and would explain to him, as far as appropriate, how it was hoped to overcome the problems which had been identified. They should not provide a detailed report for the complainant but they should report the action they had taken to the RMO. The "second opinions" would also consider whether there were any other circumstances which had contributed to the problems in the case and on which they could usefully make recommendations, which they would include in their report to the RMO. These might include matters requiring action by the health authority, for example the workload carried by the medical or nursing staff.

30. In exceptional cases it may appear to the "second opinions", at any stage of an investigation, that the particular case is not appropriate to the second opinions procedure and that the complaint would be best pursued by alternative means. In this event they should report to the RMO accordingly.

### CONCLUDING ACTION BY THE HEALTH AUTHORITY

31. The district administrator will, on completion of the review by the "second opinions", write formally to the complainant on behalf of the authority, with a copy to the consultant. The district administrator will, where appropriate, explain any action the authority has taken as a result of the complaint but, where clinical matters are concerned, he will follow the RMO's advice regarding the comment which would be appropriate. So far as the authority is concerned the matter will remain confidential unless previous or subsequent publicity makes it essential for the authority to reply publicly, in which case comment on clinical matters will be confined to the terms of the district administrator's letter.

### THE HEALTH SERVICE COMMISSIONER

32. Complaints relating to clinical judgment remain outside the responsibility of the Health Service Commissioner. However, it will be possible for him to advise complainants whose complaints contain elements of clinical judgment of the availability of the procedure described in this part of the Memorandum.

**SUGGESTED PARAGRAPHS FOR USE IN "HOSPITAL BOOKLETS" FOR PATIENTS**

If you are seeking information when in hospital, the ward sister will generally be the person to speak to in the first instance. If she cannot help you herself she will put somebody in touch with you who may be able to do so - for example, the hospital administrator or social worker. She will arrange for a doctor to see you if you want to ask questions about your medical treatment - or you can, of course, raise these directly with the doctor when he is on his ward rounds.

**COMMENTS, SUGGESTIONS AND COMPLAINTS**

Our task is to help you, and your views on the care we provide can be very useful in planning improvements. So if you have any comments please don't hesitate to let us know. We are always pleased to have any appreciative comments, which will, of course, be passed on to staff concerned; and any suggestions you may have for improving services will be studied with care.

If you are worried about anything you may like to discuss the matter with the ward sister or senior nurse on duty. Very often she will be able to reassure you or sort out the problem straight away, or bring in somebody else who may be able to do so. If the matter concerns your treatment she will arrange for you to see the consultant or a senior member of his staff.

If you wish to make a formal complaint, you can write to the health authority at . . . . . (address) or, if you prefer, somebody will make a note of your complaint for you to check and sign - the ward sister will be able to make the necessary arrangements. If you do wish to make a formal complaint you should do so without delay. Your complaint will be investigated and a reply sent to you.

Your community health council (insert address) can advise you, if you wish, on how to pursue a complaint. The Health Service Commissioner (the "Ombudsman") may investigate certain complaints (but only after the health authority has been given a chance to deal with the matter). The health authority or community health council will supply, on request, leaflets that explain the role of the Health Service Commissioner and other aspects of the complaints procedure.

## COMPLAINTS THAT MAY INVOLVE CRIMINAL PROCEEDINGS

### CALLING IN THE POLICE

1. If arising from a complaint it appears or is alleged that a criminal offence may have been committed, the matter should be reported immediately to the district administrator who, in consultation with district management team colleagues, should either call in the police or report the matter to the Chairman of the authority. The Chairman of the authority should decide what action to take in the circumstances, in the light of advice from the DMT. Where the police are to be brought in, they should be notified promptly. The authority should be informed in all cases where the police are called in.

### CONCURRENT INVESTIGATION

2. In its investigations, the health authority should take care not to prejudice police enquiries or court proceedings. This does not mean, however, that it should suspend investigation of related matters which are not prejudicial to police enquiries or court proceedings.

3. If there has been a criminal offence there may be defects in organisation, procedures or staffing that have made this possible. These defects should be quickly identified and remedied, to prevent possible recurrence of the offence. If a patient's property has been allegedly misappropriated or stolen, procedures and security precautions should be reviewed to see whether they can be improved. If a patient has been allegedly assaulted, investigation of the related circumstances may show defects of management that should be remedied immediately. Did staff properly report, record and refer the matter to senior officers at the time? Was the alleged assault made possible because of lack of due care or supervision? Answering these and other relevant questions and taking necessary remedial action, should not await the outcome of police enquiries and possible court proceedings.

4. Any member of staff against whom allegations are made and who is involved in enquiries undertaken by the health authority under the preceding paragraphs must be advised to seek the assistance of his professional association or trade union before he comments on any such allegations.

5. If there seems to be any danger that investigations by the health authority into "related matters" may prejudice police enquiries or court proceedings, the health authority should consult the police and their own legal advisers before proceeding. The police should not have a "veto" on investigations that the health authority believes should properly be conducted at the same time as police enquiries. If the authority and the police disagree, however, on the action the former propose to take, the health authority should refer the matter to the Department of Health and Social Security immediately.

### INVESTIGATION FOLLOWING POLICE ENQUIRIES

6. If, having been brought in, the police decide not to institute proceedings the authority must then itself consider what further investigation is needed; for example, whether disciplinary action is necessary. If the police decide not to proceed, it does not follow that the health authority has no need to act. Staff involved in any enquiry must always be advised to seek the advice and assistance of their trade union or professional association.





DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities )  
Area Health Authorities )  
Family Practitioner Committees )  
Community Health Councils )  
Non Metropolitan County Councils ) for action  
Metropolitan District Councils )  
London Boroughs )  
Greater London Council )  
Directors of Social Services )

Boards of Governors

- for information

February 1981

HEALTH SERVICES DEVELOPMENT

HEALTH SERVICES IN ENGLAND

REVIEW OF THE NHS PLANNING SYSTEM - A CONSULTATIVE DOCUMENT

SUMMARY

This Notice gives an outline of the proposed revision of the NHS planning system and invites comments.

INTRODUCTION

1. PATIENTS FIRST said:

"The discipline of planning in both the Department and the NHS has demonstrated its value and is to be retained. It provides the opportunity for the Government's policies and priorities to be reconciled with available resources. It also enables health authorities to appraise systematically their own services and to influence the Government. But existing planning arrangements are over-complicated and bureaucratic. A simpler planning system is being worked out and will be discussed with the Service".

2. The objective of NHS planning is to enable local services to be reviewed in the light of national policies and priorities, and plans and programmes reflecting this to be drawn up. The proposals set out in this paper are intended to simplify the NHS planning system to make it more selective and to adapt it to the new NHS structure and management arrangements (circular HC(80)8). They would replace present planning procedures. The position of post-graduate teaching hospitals will fall to be considered in the light of the report of the London Advisory Group.

MAIN FEATURES

3. The roles of Department, RHA and DHA in the proposed revised planning system would be broadly as follows:

- the *Department* would, as now, promulgate and monitor national priorities and policies, modifying them as necessary in the light of authorities' experience. It would continue to issue annually national planning guidelines giving resource and manpower assumptions, and other planning guidance to RHAs;

- the RHA would promote implementation of national priorities and policies; allocate resources to DHAs; manage the major capital programme co-ordinate and reconcile DHAs' plans; and plan specialist and other services which need to be provided on a regional basis;

- the DHA would be the basic planning unit, providing services within its plans. Planning should start at district level, and as many decisions as possible should be left to local discretion.

4. As at present, the planning system would have 2 main components - *strategic plans* prepared by each district and region normally every 5 years, looking 10 or more years ahead; and *annual programmes of action* for the next 2 years, prepared by each District, consistent with its strategic plan.

5. The following principles will continue to be important for effective planning at district level:-

- a. full and timely consultation with community, staff and professional interests is essential if plans are to command general support;
- b. planning is a collaborative process which must involve service managers and health care professionals at all levels;
- c. there should be joint planning of related health and local authority services;
- d. the needs of medical and dental education should be taken into account;
- e. planning is a part of the management function and should be seen as a continuous process rather than something undertaken once a year or once every 4 or 5 years;
- f. plans must be based on adequate information on the use of existing resources, including the estate, and account must also be taken of relevant local authority, private sector and voluntary provision;
- g. plans must be consistent with the likely future availability of revenue, capital and manpower resources.

## STRATEGIC PLANNING

6. Strategic plans would, as now, look 10 or more years ahead, but would normally be rewritten every 5 years instead of every 4. Both Regional and District strategic plans should present an analysis of the position in the authority at a particular time together with concise plans for major groups of services, the whole would be brought together to form a comprehensive strategy. The plan would draw attention to aspects on which further work or discussion was needed before the strategy could be finalised. Policies and priorities would be developed in consultation with the professions through the advisory machinery in the normal way. Policies would not need to be spelt out in plans if reference could be made to separate standing documents.

7. The strategic planning process would be:-

- a. Each Region would prepare in collaboration with Districts an outline strategy for the region incorporating where appropriate specific district guidelines. This would reflect the plans and policies already agreed within the region and the Department's priorities and policies. The proposed outline is set out at Annex A.
- b. Each District would prepare a district strategic plan within the regional outline. A suggested format is at Annex B. Problems should be discussed between the District and the Region as they arise.
- c. DHAs would submit their strategic plans to the RHA. It would be for the Region to reconcile the DHAs' proposals for capital, revenue and services and to add proposals for Regionally managed services. The aim should be to secure as large a measure of compatibility between districts as possible within the context of the emerging Regional strategy. This would entail taking final decisions if, after discussion, agreement could not be reached with individual Districts on any matter.
- d. Each RHA would prepare and submit to the Department a Regional strategic plan comprising a Regional overview of District strategies and plans for any Regionally managed or supra-District services. The core features of the Regional strategic plan are set out at Annex C. The content may change slightly from one strategic planning round to the next as Departmental guidelines might ask for information on selected aspects of services.
- e. The Department and the Region would discuss the regional strategic plan.

## ANNUAL PLANNING AND PROGRAMMING

8. Districts' annual planning must be consistent with the agreed strategy and take account of the resource assumptions set out in the Department's annual planning guidelines circular. Regions would need to provide comparable guidance to Districts but within this as many decisions as possible should be left to the DHA. Towards the end of each calendar year an annual programme would be prepared by the District in two parts.

8.1 an operational programme for action in the financial year ahead based on the forward programme for that year agreed the previous year;

8.2 a forward programme for the financial year following the one covered by the current programme; this would be formed by selecting items from the district strategic plan and drawing up proposals for implementing them.

The DHA would be invited to endorse the forward programme which would be the subject of local consultation and discussion with the Region after which it in its turn would be revised to take account of later resource assumptions into a further current programme. A suggested format for the programme is set out at Annex D.

#### ANNUAL REVIEW MEETINGS

9. The Region would meet each of its Districts at least once a year to review strategic plans, which should be updated and amended as necessary, and, to settle priorities and action for the future on the basis of the District's forward programme. The Department would hold planning review meetings with each Region once a year to consider progress in the development and implementation of strategy. Formal annual planning reports to the Department by RHAs would no longer be required, though background papers would need to be prepared for review meetings.

#### FORMAL CONSULTATION

10. There should be wide consultation in connection with both strategic planning and operational programming. Professional advisory committees, staff associations, Community Health Councils, and Local Authorities should all be included as well as any other relevant interests. MPs should be kept in touch. For *strategic planning* consultation should take place, as at present, during the preparation of policies and plans for individual services. It would also be necessary as now to consult formally on the district strategic plan as a whole. There would be similar consultation on the *forward* part of the *operational programme* which the District would take into account when it subsequently revised the programme for implementation.

#### TIMETABLE

11. A chart showing the main planning activities during the year is at Annex E.

#### STAFF CONSEQUENCES

12. Planning would be a continuous process rather than an occasional exercise. Strategic plans and annual programmes would be prepared by DHAs as part of the normal process of management and with the close involvement of managers and health care professionals responsible for the provision of services. The main job of designated planners would be to help with the preparation of plans and programmes for individual services and from them to build up the district plan or programme. DHAs would need to take responsibility for planning into account when considering management arrangements (circular HC(80)8 paras 22-32) and the proposed job content of appropriate posts. Even so there is likely to be a shortage of staff with particular experience or training in NHS planning. Regions would need to do what they could to assist Districts, in particular on requests for analytical support in the preparation of strategic plans and in helping in the use, in the planning process, of techniques such as economic appraisal.

#### JOINT PLANNING AND FINANCE

13. The arrangements for the joint planning and joint financing of services in which health authorities and local authorities have a common interest would continue on similar lines as at present (see circular HC(77)17, LAC(77)10) except that some local authorities will now have links with more than one DHA (circular HC(80)8 paras 19 and 20). Regions would include in their planning framework the joint finance assumptions to be made by Districts which would form the basis of planning with the local authority through the joint consultative machinery.

#### GUIDANCE

14. Further guidance would be issued setting out the new arrangements in more detail and covering the transitional period. A replacement for the current NHS planning system manual would be considered in due course.

#### ACTION

15. Comments on the above proposals should be sent within 3 months to Planning and Information Branch at the address below.

#### From:

Planning and Information Branch  
Department of Health and Social Security  
Room A406  
Alexander Fleming House  
Elephant and Castle  
London SE1 6BY

Tel. 01-407 5522 Ext 6823

E3/P347/261

Further copies of this Document may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

**ANNEX A**  
**(HN(81)4)**  
**(HN(FP)(81)4)**  
**(LASSL(81)1)**

#### **OUTLINE STRATEGY FOR EACH REGION**

1. A service by service statement or re-statement of broad policies and priorities drawing attention to local as well as regional problems. This statement would be prepared in collaboration with the DHAs and would reflect national policies and priorities.
  2. Allocation to individual DHAs of responsibility for planning any supra-district services they manage.
  3. Arrangements for regionally managed services and for services managed by one district on behalf of others.
  4. Agreed revenue, capital, manpower and workload assumptions.
- 

**ANNEX B**  
**(HN(81)4)**  
**(HN(FP)(81)4)**  
**(LASSL(81)1)**

#### **FORMAT OF DISTRICT STRATEGIC PLAN**

1. A general commentary on the state of the district, with references to standing policies and plans, to resource assumptions including manpower, and to progress since the last strategic plan.
  2. Concise service by service plans. The Department might indicate in its strategic planning guidelines which services should be covered in all strategic plans. Each service plan would cover present provision and capital stock; surpluses, deficiencies and distance from targets set out in the planning framework; revenue, capital and manpower assumptions; workload assumptions; options; joint planning with the local authority; strategy selected for the next 10 or more years.
  3. A concise commentary on major deficiencies or imbalances and on areas in which national or Regional policies did not seem appropriate or were not being implemented.
  4. An overall plan for district services including the determination of relative priorities (including timing) and a reconciliation with revenue, capital and manpower assumptions.
- 

**ANNEX C**  
**(HN(81)4)**  
**(HN(FP)(81)4)**  
**(LASSL(81)1)**

#### **FORMAT OF REGIONAL STRATEGIC PLAN**

1. A general commentary on the state of the Region and reference to the strategy for the Region.
2. An overview of District plans, identifying exceptional features and offering a broad assessment of expected achievements in relation to the outline strategy.
3. A concise summary plan for each service (including Regionally managed services), in particular those singled out by the Department's guidelines, assessing relative priorities, commenting on major deficiencies or imbalances and on areas in which national policies did not seem appropriate or were not being implemented.
4. A reconciliation of aggregated District (and Regional, for Regionally managed services) proposals with regional revenue, capital and manpower assumptions including a commentary on the progress being made towards achieving comparability between districts.
5. A statement of areas where there was a need for further discussions with the District or other work before a strategy could be finalised, either across the region or in individual districts.

## ANNUAL PROGRAMMES

### PART 1 OPERATIONAL PROGRAMME (for action by the Authority)

- a. A programme of developments and changes for the coming year. These would be the proposals which appeared in part 2 of the previous year's programmes, were consulted upon then, and now being matched with resources and confirmed by the DHA.
- b. Minor capital programme for the coming year.
- c. A revenue budget for the coming financial year based on the latest financial assumptions including joint finance given by the RHA but subject to confirmation in March.

### PART 2 FORWARD PROGRAMME: (for endorsement by the DHA, further consultation with local interests and for discussion with the Region)

- a. Commentary on the development of services, including progress achieved and details of delays, unplanned changes, new initiatives and planning work for the future.
  - b. A list of forward planning proposals in priority order for year 2 and the consequential effects of these proposals in later years.
- 

## ILLUSTRATIVE TIMETABLE FOR PLANNING ACTIVITIES

### A. ANNUALLY

#### AT DISTRICT:

	<i>Possible Timing</i>
Receipt of resource assumptions and DHA specific guidelines.	April/May
Programme development: District to finalise coming year's programme and prepare forward planning proposals.	April/December
DHA endorsement of programmes and planning proposals.	November/December
Submission of forward programme to Region.	December
Consultations with local authorities and other interests on forward planning proposals.	January/March
Review meetings with Region.	January onwards
Policy development and preparation of individual strategies (with Region).	continuing
Consultation on individual strategies and the plan.	continuing

*Possible Timing*

**AT REGION:**

Study of forward programmes and review meetings with DHAs.	January onwards
Receipt of planning guidelines from DHSS.	March/April
Issue of resource assumptions and District specific guidelines.	April/May
Preparation for annual planning review with DHSS.	April/May
Review meeting with DHSS.	May/July
Policy development and preparation of individual strategies (with Districts).	continuing

**B. EVERY 5 YEARS WHEN NEW STRATEGIC PLANS ARE DUE**

DHSS calls for plans and issues guidelines to RHAs (including long-term resource assumptions and checklist of current national policies and priorities).	October
Region discusses outline strategy with Districts.	October/December
RHA issues outline strategy.	January
Districts prepare strategic plans.	January/October
DHAs publish draft plan.	October
Districts consult locally.	October/December
DHAs submit plans to RHA.	January
Regions discuss plans with Districts and prepare regional strategic plan.	January/April
RHAs submit regional strategic plans to DHSS.	April
DHSS discusses plans with Regions at review meetings.	May/October



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities )  
Area Health Authorities )  
Family Practitioner Committees )  
Community Health Councils )  
Non Metropolitan County Councils ) for action  
Metropolitan District Councils )  
London Boroughs )  
Greater London Council )  
Directors of Social Services )

Boards of Governors - for information

February 1981

HEALTH SERVICES DEVELOPMENT

HEALTH SERVICES IN ENGLAND

REVIEW OF THE NHS PLANNING SYSTEM - A CONSULTATIVE DOCUMENT

SUMMARY

This Notice gives an outline of the proposed revision of the NHS planning system and invites comments.

INTRODUCTION

1. PATIENTS FIRST said:

"The discipline of planning in both the Department and the NHS has demonstrated its value and is to be retained. It provides the opportunity for the Government's policies and priorities to be reconciled with available resources. It also enables health authorities to appraise systematically their own services and to influence the Government. But existing planning arrangements are over-complicated and bureaucratic. A simpler planning system is being worked out and will be discussed with the Service".

2. The objective of NHS planning is to enable local services to be reviewed in the light of national policies and priorities, and plans and programmes reflecting this to be drawn up. The proposals set out in this paper are intended to simplify the NHS planning system to make it more selective and to adapt it to the new NHS structure and management arrangements (circular HC(80)8). They would replace present planning procedures. The position of post-graduate teaching hospitals will fall to be considered in the light of the report of the London Advisory Group.

MAIN FEATURES

3. The roles of Department, RHA and DHA in the proposed revised planning system would be broadly as follows:

- the *Department* would, as now, promulgate and monitor national priorities and policies, modifying them as necessary in the light of authorities' experience. It would continue to issue annually national planning guidelines giving resource and manpower assumptions, and other planning guidance to RHAs;

- the RHA would promote implementation of national priorities and policies; allocate resources to DHAs; manage the major capital programme co-ordinate and reconcile DHAs' plans; and plan specialist and other services which need to be provided on a regional basis;

- the DHA would be the basic planning unit, providing services within its plans. Planning should start at district level, and as many decisions as possible should be left to local discretion.

4. As at present, the planning system would have 2 main components - *strategic plans* prepared by each district and region normally every 5 years, looking 10 or more years ahead; and *annual programmes of action* for the next 2 years, prepared by each District, consistent with its strategic plan.

5. The following principles will continue to be important for effective planning at district level:-

- a. full and timely consultation with community, staff and professional interests is essential if plans are to command general support;
- b. planning is a collaborative process which must involve service managers and health care professionals at all levels;
- c. there should be joint planning of related health and local authority services;
- d. the needs of medical and dental education should be taken into account;
- e. planning is a part of the management function and should be seen as a continuous process rather than something undertaken once a year or once every 4 or 5 years;
- f. plans must be based on adequate information on the use of existing resources, including the estate, and account must also be taken of relevant local authority, private sector and voluntary provision;
- g. plans must be consistent with the likely future availability of revenue, capital and manpower resources.

## STRATEGIC PLANNING

6. Strategic plans would, as now, look 10 or more years ahead, but would normally be rewritten every 5 years instead of every 4. Both Regional and District strategic plans should present an analysis of the position in the authority at a particular time together with concise plans for major groups of services, the whole would be brought together to form a comprehensive strategy. The plan would draw attention to aspects on which further work or discussion was needed before the strategy could be finalised. Policies and priorities would be developed in consultation with the professions through the advisory machinery in the normal way. Policies would not need to be spelt out in plans if reference could be made to separate standing documents.

7. The strategic planning process would be:-

- a. Each Region would prepare in collaboration with Districts an outline strategy for the region incorporating where appropriate specific district guidelines. This would reflect the plans and policies already agreed within the region and the Department's priorities and policies. The proposed outline is set out at Annex A.
- b. Each District would prepare a district strategic plan within the regional outline. A suggested format is at Annex B. Problems should be discussed between the District and the Region as they arise.
- c. DHAs would submit their strategic plans to the RHA. It would be for the Region to reconcile the DHAs' proposals for capital, revenue and services and to add proposals for Regionally managed services. The aim should be to secure as large a measure of compatibility between districts as possible within the context of the emerging Regional strategy. This would entail taking final decisions if, after discussion, agreement could not be reached with individual Districts on any matter.
- d. Each RHA would prepare and submit to the Department a Regional strategic plan comprising a Regional overview of District strategies and plans for any Regionally managed or supra-District services. The core features of the Regional strategic plan are set out at Annex C. The content may change slightly from one strategic planning round to the next as Departmental guidelines might ask for information on selected aspects of services.
- e. The Department and the Region would discuss the regional strategic plan.

## ANNUAL PLANNING AND PROGRAMMING

8. Districts' annual planning must be consistent with the agreed strategy and take account of the resource assumptions set out in the Department's annual planning guidelines circular. Regions would need to provide comparable guidance to Districts but within this as many decisions as possible should be left to the DHA. Towards the end of each calendar year an annual programme would be prepared by the District in two parts.

- 8.1 an operational programme for action in the financial year ahead based on the forward programme for that year agreed the previous year;
- 8.2 a forward programme for the financial year following the one covered by the current programme; this would be formed by selecting items from the district strategic plan and drawing up proposals for implementing them.



The DHA would be invited to endorse the forward programme which would be the subject of local consultation and discussion with the Region after which it in its turn would be revised to take account of later resource assumptions into a further current programme. A suggested format for the programme is set out at Annex D.

#### ANNUAL REVIEW MEETINGS

9. The Region would meet each of its Districts at least once a year to review strategic plans, which should be updated and amended as necessary, and, to settle priorities and action for the future on the basis of the District's forward programme. The Department would hold planning review meetings with each Region once a year to consider progress in the development and implementation of strategy. Formal annual planning reports to the Department by RHAs would no longer be required, though background papers would need to be prepared for review meetings.

#### FORMAL CONSULTATION

10. There should be wide consultation in connection with both strategic planning and operational programming. Professional advisory committees, staff associations, Community Health Councils, and Local Authorities should all be included as well as any other relevant interests. MPs should be kept in touch. For *strategic planning* consultation should take place, as at present, during the preparation of policies and plans for individual services. It would also be necessary as now to consult formally on the district strategic plan as a whole. There would be similar consultation on the *forward* part of the *operational programme* which the District would take into account when it subsequently revised the programme for implementation.

#### TIMETABLE

11. A chart showing the main planning activities during the year is at Annex E.

#### STAFF CONSEQUENCES

12. Planning would be a continuous process rather than an occasional exercise. Strategic plans and annual programmes would be prepared by DHAs as part of the normal process of management and with the close involvement of managers and health care professionals responsible for the provision of services. The main job of designated planners would be to help with the preparation of plans and programmes for individual services and from them to build up the district plan or programme. DHAs would need to take responsibility for planning into account when considering management arrangements (circular HC(80)8 paras 22-32) and the proposed job content of appropriate posts. Even so there is likely to be a shortage of staff with particular experience or training in NHS planning. Regions would need to do what they could to assist Districts, in particular on requests for analytical support in the preparation of strategic plans and in helping in the use, in the planning process, of techniques such as economic appraisal.

#### JOINT PLANNING AND FINANCE

13. The arrangements for the joint planning and joint financing of services in which health authorities and local authorities have a common interest would continue on similar lines as at present (see circular HC(77)17, LAC(77)10) except that some local authorities will now have links with more than one DHA (circular HC(80)8 paras 19 and 20). Regions would include in their planning framework the joint finance assumptions to be made by Districts which would form the basis of planning with the local authority through the joint consultative machinery.

#### GUIDANCE

14. Further guidance would be issued setting out the new arrangements in more detail and covering the transitional period. A replacement for the current NHS planning system manual would be considered in due course.

#### ACTION

15. Comments on the above proposals should be sent within 3 months to Planning and Information Branch at the address below.

From:

Planning and Information Branch  
Department of Health and Social Security  
Room A406  
Alexander Fleming House  
Elephant and Castle  
London SE1 6BY

Tel. 01-407 5522 Ext 6823

E3/P347/261

Further copies of this Document may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

### OUTLINE STRATEGY FOR EACH REGION

1. A service by service statement or re-statement of broad policies and priorities drawing attention to local as well as regional problems. This statement would be prepared in collaboration with the DHAs and would reflect national policies and priorities.
  2. Allocation to individual DHAs of responsibility for planning any supra-district services they manage.
  3. Arrangements for regionally managed services and for services managed by one district on behalf of others.
  4. Agreed revenue, capital, manpower and workload assumptions.
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### FORMAT OF DISTRICT STRATEGIC PLAN

1. A general commentary on the state of the district, with references to standing policies and plans, to resource assumptions including manpower, and to progress since the last strategic plan.
  2. Concise service by service plans. The Department might indicate in its strategic planning guidelines which services should be covered in all strategic plans. Each service plan would cover present provision and capital stock; surpluses, deficiencies and distance from targets set out in the planning framework; revenue, capital and manpower assumptions; workload assumptions; options; joint planning with the local authority; strategy selected for the next 10 or more years.
  3. A concise commentary on major deficiencies or imbalances and on areas in which national or Regional policies did not seem appropriate or were not being implemented.
  4. An overall plan for district services including the determination of relative priorities (including timing) and a reconciliation with revenue, capital and manpower assumptions.
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### FORMAT OF REGIONAL STRATEGIC PLAN

1. A general commentary on the state of the Region and reference to the strategy for the Region.
2. An overview of District plans, identifying exceptional features and offering a broad assessment of expected achievements in relation to the outline strategy.
3. A concise summary plan for each service (including Regionally managed services), in particular those singled out by the Department's guidelines, assessing relative priorities, commenting on major deficiencies or imbalances and on areas in which national policies did not seem appropriate or were not being implemented.
4. A reconciliation of aggregated District (and Regional, for Regionally managed services) proposals with regional revenue, capital and manpower assumptions including a commentary on the progress being made towards achieving comparability between districts.
5. A statement of areas where there was a need for further discussions with the District or other work before a strategy could be finalised, either across the region or in individual districts.

## ANNUAL PROGRAMMES

### PART 1 OPERATIONAL PROGRAMME (for action by the Authority)

- a. A programme of developments and changes for the coming year. These would be the proposals which appeared in part 2 of the previous year's programmes, were consulted upon then, and now being matched with resources and confirmed by the DHA.
- b. Minor capital programme for the coming year.
- c. A revenue budget for the coming financial year based on the latest financial assumptions including joint finance given by the RHA but subject to confirmation in March.

### PART 2 FORWARD PROGRAMME: (for endorsement by the DHA, further consultation with local interests and for discussion with the Region)

- a. Commentary on the development of services, including progress achieved and details of delays, unplanned changes, new initiatives and planning work for the future.
  - b. A list of forward planning proposals in priority order for year 2 and the consequential effects of these proposals in later years.
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## ILLUSTRATIVE TIMETABLE FOR PLANNING ACTIVITIES

### A. ANNUALLY

#### AT DISTRICT:

#### *Possible Timing*

Receipt of resource assumptions and DHA specific guidelines.	April/May
Programme development: District to finalise coming year's programme and prepare forward planning proposals.	April/December
DHA endorsement of programmes and planning proposals.	November/December
Submission of forward programme to Region.	December
Consultations with local authorities and other interests on forward planning proposals.	January/March
Review meetings with Region.	January onwards
Policy development and preparation of individual strategies (with Region).	continuing
Consultation on individual strategies and the plan.	continuing

*Possible Timing*

**AT REGION:**

Study of forward programmes and review meetings with DHAs.	January onwards
Receipt of planning guidelines from DHSS.	March/April
Issue of resource assumptions and District specific guidelines.	April/May
Preparation for annual planning review with DHSS.	April/May
Review meeting with DHSS.	May/July
Policy development and preparation of individual strategies (with Districts).	continuing

**B. EVERY 5 YEARS WHEN NEW STRATEGIC PLANS ARE DUE**

DHSS calls for plans and issues guidelines to RHAs (including long-term resource assumptions and checklist of current national policies and priorities).	October
Region discusses outline strategy with Districts.	October/December
RHA issues outline strategy.	January
Districts prepare strategic plans.	January/October
DHAs publish draft plan.	October
Districts consult locally.	October/December
DHAs submit plans to RHA.	January
Regions discuss plans with Districts and prepare regional strategic plan.	January/April
RHAs submit regional strategic plans to DHSS.	April
DHSS discusses plans with Regions at review meetings.	May/October



## DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities - for action

Area Health Authorities	)	
Boards of Governors	)	
Family Practitioner Committees	)	for information
Community Health Councils	)	

January 1982

**HEALTH SERVICE DEVELOPMENT**  
**PROFESSIONAL ADVISORY MACHINERY**

**SUMMARY**

This Circular deals with the establishment and functions of professional advisory machinery in the NHS after 1 April 1982. It also deals with the method of election of consultant and GP members of District Management Teams.

**INTRODUCTION**

1. At a recent conference on management arrangements the Secretary of State recognised the importance of effective professional advisory machinery. He said that the essentials for such machinery were, "that an authority should be able to obtain adequate advice when it needs it and in a suitable form. And, second, the profession concerned should have the absolute right to give advice when necessary, to be consulted on professional matters involving them, and to be satisfied that their advice is properly considered."

**LOCAL ADVISORY COMMITTEES**

2. The Report of the Royal Commission on the National Health Service (Cmnd 7615) recommended that the health departments should consider with the professions concerned the best way of simplifying the present professional advisory machinery. The Government accepted this recommendation and discussions have taken place with four of the professions concerned. The results of the reviews were circulated for consultation under cover of DA(80)20 (dental advisory machinery); DA(81)11 (medical advisory machinery at district level); (DA(81)2 (pharmaceutical advisory machinery); and DA(81)7 (nursing and midwifery advisory machinery). Consultations have also taken place with the optical profession and their views have been incorporated in the advice in paragraphs 27 to 29. Comments on particular aspects of each profession's advisory machinery follow later in this Circular. The Secretary of State is grateful to all those concerned with preparing these reports and to those who have commented on them. Subject to the points referred to below, he accepts the reports as a sound starting point for discussions between the health authorities and professions concerned in the development of professional advisory machinery appropriate to local circumstances.

3. In the case of one of the reviews, that of medical advisory machinery, the report on arrangements at regional level has only recently been issued for consultation. Accordingly, a circular on regional medical and dental advisory machinery will be issued later.

4. The statutory basis of advisory committees is set out in Section 19 of and Schedule 6 to the National Health Service Act 1977, as amended by the Health Service Act 1980 to apply also to District Health Authorities. Under Section 19, committees may be set up in each region and district, representative of the medical practitioners, the dental practitioners, the nurses and midwives, the pharmacists and the ophthalmic and dispensing opticians of the region or district. The Secretary of State has a duty to recognise them if he is satisfied that they are representative of the categories of persons concerned. Such committees are to be called the Regional or District Medical, Dental, Nursing and Midwifery, Pharmaceutical or Optical Committee, as the case may be. The Secretary of State also has a duty under Schedule 6 to the Act to recognise, in a similar way, committees representative of other categories of persons who provide services forming part of the health service, or to recognise a single committee as representative of two or more of any of the categories concerned, where he is satisfied that it is in the interests of the health service to do so.

## FUNCTIONS OF ADVISORY COMMITTEES

5. The Act lays a duty on advisory committees to advise the authorities on the provision by them of services of the kind provided by the categories of persons of whom the committees are representative; and on the authorities to consult the committees with respect to such matters and on such occasions as may be prescribed. The committees are not intended to provide a forum for discussion of issues directly involving the interests of groups of staff such as personnel questions nor are they substitutes for or alternatives to normal arrangements for consultation between management and staff.

## CONSTITUTION AND RECOGNITION OF COMMITTEES

6. Formal recognition of professional advisory committees under the terms of the 1977 Act is a function which will be exercised on behalf of the Secretary of State by RHAs and DHAs, who will be responsible for recognition of regional and district committees respectively from 1 April 1982.

7. In their exercise of these functions, the Secretary of State would like authorities to bear the following considerations in mind:

7.1 It is not a legal requirement to set up professional advisory committees. The Act simply requires their recognition if they are set up and are representative of the professions concerned locally. In relation to medical advisory machinery the report annexed to DA(81)1 concludes that statutory committees are not essential and that there may be simpler, more effective ways of seeking and giving medical advice. This flexible approach is endorsed where appropriate for other professions. It may be that, in the light of local circumstances, DHAs and representatives of other professions locally will be able to identify and agree arrangements which provide a satisfactory source of professional advice and views without the institution of a formal committee requiring recognition under the terms of the statute. Any local experiments along these lines which are generally acceptable to the members of the professions involved will be welcomed.

7.2 If a formal committee conforming to the criteria for recognition is not to be established, the authority should nonetheless satisfy itself that alternative arrangements are adequate to enable professional views to be heard, and should accord the same rights of giving advice and of consultation to such alternative arrangements as would be granted to a formally-recognised committee.

7.3 Any arrangements made for advising DHAs which provide services outside their own boundaries should include locally agreed mechanisms for obtaining the views of the members of the professions concerned with those services.

7.4 Whatever arrangements are adopted should be reviewed within three years by the relevant Authority.

7.5 The establishment of advisory machinery is not without cost and the Secretary of State asks authorities and the professions concerned to consider carefully how administrative and other costs can be limited to the minimum consistent with the establishment of effective advisory machinery.

## MEDICAL REPRESENTATIVE AND ADVISORY MACHINERY

8. The Report on District Management Arrangements, prepared by the Chief Medical Officer's joint working group was issued on 12 January 1981 under cover of circular DA(81)1. The following paragraphs are concerned with the arrangements at district level only.

9. Attention is drawn to the following points which arose from consultation.

### 10. Clinician members of District Management Teams

The recommendation in previous guidance, "Management Arrangements for the Reorganised NHS" (HMSO 1972) was that the clinical representatives be elected by the district medical committee or, in a single district area, the area medical committee. In the Working Group's Report it is recommended that the consultant and GP representatives be elected by a body including all the senior hospital medical staff and by GPs respectively (paragraph 1.14). The Secretary of State has accepted this recommendation as policy, even where it is decided locally to establish a district medical committee (DMC). Thus the consultant and GP members of the District Management Team will now represent their hospital and GP colleagues respectively rather than the DMC as a whole. Their contribution is complementary to the chief officer role of the District Medical Officer, through whom the community medicine and community health advice to the authority will be channelled.

### 11. District Medical Committees

The working group concluded that a district medical committee was not inevitably needed as its functions could be performed in other ways. However, it is apparent that there is considerable support in some localities for its continuation, and it will be for each district health authority and the medical profession in that district

to consider whether or not to set up a district medical committee: in doing so they should have regard to the principle that there should be as few committees as is consistent with the work to be done. Whether or not it is decided to establish a DMC it is important to achieve satisfactory liaison between the three main branches of the profession (hospital practice, general practice and community medicine), and any such arrangements will need to include doctors in training as well as those in the career grades. In the absence of a DMC it may be appropriate to make other arrangements in addition to cross-representation between committees so as to ensure that differences of opinion can be discussed, and if possible resolved, before a medical view is presented to the DMT or the authority. Here as elsewhere the attention drawn by the working group to the need for clear definition of the remit of any committee set up to advise the Authority is underlined.

12. Although the removal of the area tier will generally simplify the task facing doctors in district management, there may be some difficulty where the Local Medical Committee does not correspond to a single health district; in such cases local arrangements should be made to ensure that any administrative and communications problems are minimised.

#### DENTAL ADVISORY MACHINERY

13. The report of the Chief Dental Officer's Working Party was issued in December 1980 under cover of DA(80)20. The following paragraphs are concerned with advisory machinery for district health authorities only, as explained in paragraph 3 above.

14. It is for the district health authority and dental profession locally to decide whether a dental advisory committee should be established. Dental advisory committees should, where established, match the district or districts served by an administrative dental officer. Where appointed, this officer will provide an important source of advice and liaison between the dental services in the districts concerned and he should therefore attend and participate in meetings of any dental advisory committees ex-officio.

15. Suggested management arrangements for dental services after 1 April 1982 are also considered in the report of the Chief Dental Officer's working party and DA(80)20 again makes it clear that it will be for DHAs to decide on appointments of administrative dental officers and arrangements for accountability.

16. The form of dental advisory machinery is a matter for local resolution in consultation with the profession but authorities will be expected to ensure, so far as practicable, that any committees established are representative of all dental interests in the area.

17. The following points should be borne in mind in setting up appropriate dental advisory machinery:

17.1 the need to avoid proliferation of committees and to contain demands on professional time. The present arrangements for advice at area level seem generally to have worked well and it is likely that a similar broad view will be necessary in the future. It may not be possible for this to be provided in every district, especially the smaller ones, and it may therefore be desirable in some instances for a number of districts to make combined arrangements related to the area covered by Family Practitioner Committees and taking into account the arrangements made for management of services.

17.2 The working party's view that committees should be as small as possible, consistent with the representation of all dental interests in the area.

#### NURSING AND MIDWIFERY ADVISORY MACHINERY

18. The Steering Committee representing nurses', midwives' and health visitors' professional organisations, in consultation with the Chief Nursing Officer, has made recommendations on ways of simplifying existing nursing and midwifery advisory machinery, including revised model constitutions and accompanying notes of guidance for district and regional committees which were issued for consultation under cover of DA(81)7 in March 1981. The results of that consultation have been considered and revised model constitutions and notes of guidance will be issued separately for use by health authorities as they wish.

19. There is an inherent difficulty with advisory machinery in a profession that is hierarchically structured and has a clearly defined role for nurse managers. But nursing is a profession requiring machinery for free expression of views and it is particularly important to ensure that advice tendered to authorities is representative of all grades and categories of nursing and midwifery staff within a district or region. As DHAs vary in size and complexity and have wide discretion in determining their management arrangements, it will be the responsibility of the new District Nursing Officers to initiate consultations with the profession locally, and in particular with members of former committees, on the arrangements most likely to be appropriate to local needs for the provision of nursing and midwifery advice.

20. The District Nursing Officer will be responsible for ensuring that, whatever arrangements are made, these will carry out adequately the broad functions of the Area Nursing and Midwifery Advisory Committees, and will normally present their views to the DHA. The DNO should also be responsible for deciding, in consultation with the profession locally, the method of appointing members to a committee.

21. Existing regional committees should continue to operate until the pattern of advice in districts has been established. The Chairman of district committees, or other representatives where there are no committees, will then form the nucleus of the Regional Nursing and Midwifery Advisory Committee and the former Regional Committees will stand down. The new Regional Nursing and Midwifery Advisory Committees will have terms of reference similar to those of the former committees. It is expected that a major part of the committee's work will be undertaken by specialist panels comprised of nurses working in the particular specialties to which the panels relate.

#### PHARMACEUTICAL ADVISORY MACHINERY

22. The report of the Chief Pharmacist's Working Group, concerned with the future of the pharmaceutical advisory machinery in the restructured NHS, was issued in January under cover of DA(81)2. The following points about pharmaceutical advisory machinery should be borne in mind, in addition to the general remarks made earlier at paragraphs 1 to 7 above.

#### 23. District pharmaceutical advisory machinery

23.1 The officer responsible for advising the DHA on pharmaceutical matters (who will in most cases be the officer with responsibility for the managed pharmaceutical services in the District) should play an integral part in the pharmaceutical advisory machinery in each District for which he has a management/advisory responsibility, including attending ex-officio all meetings relating to the preparation and presentation of advice to the DHA on pharmaceutical matters. The status and role of this officer, however, will be for the DHA to decide in accordance with the advice in HC(80)8 although in most cases he is likely to be known as the District Pharmaceutical Officer (DPhO).

23.2 Where it is decided to set up a district pharmaceutical committee the members should, so far as possible, *practice* within that district.

23.3 Advice to the DHA may be channelled through the DMT, provided the DPhO or other nominated pharmacist is given an opportunity to make his views known both to the DMT and to the DHA.

#### 24. Regional pharmaceutical advisory machinery

Regional pharmaceutical officers will have a similar role with regard to any regional pharmaceutical advisory machinery as their equivalents at District level have in Districts (see paragraph 23.1 above).

#### OPTICAL ADVISORY MACHINERY

#### 25. District Optical Committees

In both single-district FPC areas and multi-district FPC areas, a District Optical Committee (DOC) may be formed for each District from ophthalmic opticians and dispensing opticians representative of both the General Ophthalmic Services and the Hospital Eye Service. At present there are no opticians in the Community Health Service. In the case of a single-district FPC area, the members could be the same as the members of the existing Local Optical Committee (LOC). In the case of a multi-district FPC area a DOC may be formed for each District.

#### 26. Regional Optical Committees

In each Region a Regional Optical Committee (ROC) may be formed from ophthalmic opticians and dispensing opticians elected from the members of each DOC in that Region.

27. Consultation with the professional bodies is now proceeding on revised model constitutions for DOCs, ROCs and LOCs and these will be sent to Health Authorities as soon as possible.

#### ADVISORY COMMITTEES FOR OTHER PROFESSIONS

28. As mentioned in paragraph 3, Schedule 6 to the Act provides for the recognition of committees representative of categories of persons other than the five professions specified in Section 19, provided that it is in the interests of the health service to recognise such committees. The Secretary of State does not consider that, at a time of scarce resources, it would be in the interests of the NHS to devote resources needed for direct patient care to the establishment of a formal committee structure for other groups. However, this decision should not inhibit the continuation or establishment of informal arrangements for seeking the views, where appropriate, of other groups.



## ADVISORY COMMITTEES COVERING MORE THAN ONE DISTRICT

29. It is expected that in many cases the most effective pattern of advisory machinery will involve the establishment of committees offering advice to more than one DHA. An advisory committee covering more than one District cannot formally be recognised under the statutory arrangements in Section 19 of the 1977 Act, which refers to committees formed for the district of a single DHA, but despite this such a committee should be treated by the DHAs concerned exactly as they would treat formally recognised committees established on an individual District basis.

## EXPENSES

30. Authorities are empowered to defray such expenses of formally recognised local advisory committee or alternative forms of advisory machinery set up by the Authority as they consider reasonable. These expenses may include travelling, subsistence and financial loss allowances as approved in the National Health Service and Regional Nurse-Training Committees (Travelling Allowances, etc) Determination 1975. Authority for reimbursing expenses in respect of those participating in alternative arrangements is provided by Section 23 of the NHS Act 1977. Such expenses should be paid at the same levels and under the same conditions as those paid under the 1975 Determination to members of formally recognised local advisory committees.

31. Authorities should provide supporting secretarial services and rooms for meetings to enable advisory machinery, howsoever constituted, to function properly.

## CIRCULARS CANCELLED

32. HRC(74)9 and HN(77)50 are cancelled.

## ACTION

33. RHAs are asked to ensure that copies of this circular are made available to "shadow" DHAs. DHAs, in shadow form, are asked to enter into early discussions with local representatives of the five professions concerned to consider what form advisory machinery should take and what arrangements need to be made to establish it.

### From:

Regional Liaison Division 1A  
Euston Tower  
286 Euston Road  
London NW1 3DN

Tel. 01-388 1188 Ext 987

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Further copies of this Circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Haywood, Lancs OL10 2PZ quoting the code and serial number appearing at the top right-hand corner.