INTEGRATION OF HEALTH SERVICES

The Brighton and East Sussex Project

Second Phase
Advisory Group Reports

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THE BRIGHTON AND EAST SUSSEX PROJECT

SECOND PHASE

ADVISORY GROUP REPORTS

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INTEGRATION OF HEALTH SERVICES

The Brighton and East Sussex Project
Second Phase Advisory Group Reports

Origins

The papers in this booklet consist of reports prepared by multidisciplinary advisory groups as part of a project concerned with the integration of health services. This project originated in an application to the King's Fund from the South East Metropolitan Regional Hospital Board for support for a study to see how the proposed unification of the NHS may be made to work at area level. The project was approved by the Fund's Management Committee in December 1970 and a sum of £13,000 was allocated towards the cost of the project over a period of two years. It was to be related to the Brighton and East Sussex area and to be conducted under the direction of Dr P J McEwan, Director of the Centre for Social Research at the University of Sussex.

Objectives

The main purpose of the study was defined as being to bring together those now responsible for the local health, general practitioner and hospital services in the area in order to identify the consequences of any possible unification. Initially, the emphasis was to be laid on:

a) The administrative re-organisation necessary to effect unification and the development of a district organisation if that is thought to be necessary.

b) The organisation necessary to ensure proper medical advice to any area health authority over the whole range of health services, the role of the Executive Committee and the application of the Salmon Report, together with the influence of the Community Physician.

Progress

The project started officially in January 1971, with the appointment of Dr John Powles as Research Fellow, based at the University of Sussex and working under the direction of Dr McEwan, and guided by a steering committee that now consists of the following members:

Dr K R Porter (Chairman)	Senior Administrative Medical Officer, South East Metropolitan Regional Hospital Board
Mr R W Alderton	Group Secretary, Brighton and Lewes Hospital Management Committee
Mr D Allen	Director of Social Services, East Sussex
Mr K Barnard	The Hospital Centre
Mr C Brady	Regional Officer for Health, Department of Health and Social Security (Observer)
Mr M C Hardie	The Hospital Centre
Mr H N Lamb	Secretary, South East Metropolitan Regional Hospital Board
Dr P J McEwan	University of Sussex
Dr J Powles	University of Sussex
Mr J Simmonds	University of Sussex
Dr J A G Watson	Medical Officer of Health, East Sussex

In October 1971 nine advisory groups were convened to consider problems in the integration of services at 'fieldworker' level. The subjects covered by the groups were:

1 Preventive services and the promotion of health
2 Primary health care services
3 Centralised health care services
4 Birth control and maternity services
5 Child health services
6 Services for the elderly
7 Services for the mentally and physically handicapped
8 Psychiatric services
9 The consumer and the health service

This series of advisory groups reported in March 1972 and their reports were published by the Hospital Centre in May (Integration of Health Services, The Brighton and East Sussex Project Advisory Group Reports, THC 72/407).

The reports served as basic documents for a second phase of advisory groups, which were convened in April 1972, to consider the administrative arrangements necessary to secure the effective co-ordination and management of services. There were six such groups:

1 The Area Health Authority
2 Organisation at district level
3 The professions and management
4 Consumers and the health service
5 The organisation of information services
6 The organisation of supporting services

It is the reports of these 'second phase' groups prepared in July, 1972, that are reproduced in this document. (An interim version of the information services report was forwarded to the Secretary of State's Management Study Group, at their request in May).

Subsequent to the preparation of these reports, the Department of Health and Social Security published the report of the Management Study (Management Arrangements for the Reorganised Health Service, HMSO). Whilst that report is clearly more authoritative and systematic, it is hoped that the following reports may be useful on several counts. Firstly, they have been prepared by multi-disciplinary teams comprised of people working at and below the future area level. As such, they represent a kind of 'dry run' for the reorganisation process which is now beginning with the formation of Joint Liaison Committees and their various subsidiary working groups. Secondly, they have resulted from an attempt to apply the general re-organisation proposals to a particular area and have raised and commented critically upon many of the significant issues involved in reorganisation. Thirdly, they include subjects either not covered by the Management Study (for example 'Consumer and the Health Service) or treated only superficially in that study (for example 'The Organisation of Information Services'). It is principally for these reasons that the reports are being reproduced and made available to those currently involved or interested in the reorganisation of the NHS.

EDITORIAL NOTE: To avoid confusion, the terms used in the reports have been modified where necessary to make them compatible with those used in recent documents. The reports are those of the advisory groups themselves and should not be taken as reflecting the views of the project Steering Committee.

SECOND PHASE

ADVISORY GROUP REPORTS

1

Advisory Group Report

on

THE AREA HEALTH AUTHORITY

MEMBERS OF ADVISORY GROUP

The group comprised the following 10 members acting in individual (and not official) capacities and met seven times between April and July 1972.

Mr I G Boon	Treasurer, Central Sussex Hospitals Joint Finance Department
Dr M S Hall	General Practitioner, Forest Row
Mrs H M Hambleton	Chief Nursing Officer, Brighton and Lewes Hospital Management Committee
Dr R E Irvine	Consultant Geriatrician, Hastings Hospital Management Committee
Mr L A Lelliot	Member, Hailsham Hospital Management Committee
Miss J E Moss	Chief Nursing Officer, East Sussex County Council
Mr P F Park	Clerk to the East Sussex Executive Council
Mr T Ryder	Chief Administrative Officer, East Sussex County Health Department
Dr J A G Watson	Medical Officer of Health, East Sussex
Mr A C Wright	Secretary, Hastings Hospital Management Committee
Dr J Powles	Research Fellow, acted as Chairman to the Group

1.1 Within the proposed new administrative structure for the NHS, the Area Health Authorites are the lowest tier of formally responsible authorities. On them will rest the prime task of achieving the effective integration of services. They will have greater responsibility and opportunity for furthering co-operation between the different elements of the NHS and between health and related services than either the district tier below them or the regional tier above.

2 THE AREA, REGION AND CENTRE

2.1 Formally, the area authority will relate to the regional authority. It is likely that there will be no formal line relationships between officers at area level and their counterparts at region.

2.2 The resource allocation that an area receives will be principally determined by the total allocation to the NHS and by the Area's success in competing with other areas for resources from the region. It is DHSS policy to progressively increase the degree to which allocations from the centre to the regions are related to population, age structure and other indicators of "need". A complex formula is being developed and it is intended that allocations to the region should be almost entirely based on this by 1981*. This will naturally reduce the scope for bargaining between the regions and the centre.

2.3 Whilst the group accepts the principle involved in relating resources allocations to objective indicators of need, we are particularly concerned to protect the interests of the less privileged areas within the more privileged regions. As, for example, the Metropolitan regions are levelled down (relative to less privileged regions) over the next 9 years it is important that the position of East Sussex, where hospital expenditure per capita does not appear to be above the national average and where the age structure creates additional demand, should not deterioate relative to national trends.

2.4 Competition for regional funds between areas containing teaching districts and other areas could be regularised by dividing NHS expenditure within teaching districts into that required to provide standard health services to the population (which should be comparable to per capita expenditure in other areas) and the additional allocations required for teaching and research.

2.5 There is a danger that the regional tier will not be sufficiently representative of the full range of interests involved in the provision of medical and related services. For these reasons extra effort should be taken to achieve as much balance as possible in the representation of interests at regional level. In staffing the new regional authorities, care should be taken to include sufficient senior officers whose prior involvement has not been limited to the hospital sector.

* Annual Report of the Department of Health & Social Security for the Year 1972. Cmnd 5019, Para. 6.103

3 AREA, DISTRICT AND FIELDWORKERS

3.1 The district officers for functions which are basically operational at a district level will be responsible through the District Management Team to the Area Health Authority. The district officers for functions which are operational on an area-wide basis - ambulance services might be a good example - will be responsible to the corresponding area officer.

3.2 Members of the District Management Team should, on issues that are not highly specific to their professional skills, be corporately responsible to the Area Health Authority.

3.3 The Community Health Councils which will be organised on a district basis should relate primarily to the Area Health Authority and not to the District Management Teams. They should play a positive role in presenting the views of consumers on the future development of services.

3.4 There will be a need for effective and continuous contact between the area and district headquarters.

4 THE AREA HEADQUARTERS

4.1 Where feasible the area headquarters should be located in the county town. This has the following three advantages:

(1) It will aid the establishment of cross-links to the local authority.

(2) It may not be the centre of any proposed health district and is therefore more neutral than any town which is.

(3) It is probable that many district headquarters will be linked to hospitals and is therefore all the more important that the area headquarters is seen to be independent of hospitals.

4.2 The importance, with respect to the object of integration, of having all headquarters staff under one roof cannot be over-emphasised. Whilst it is difficult to estimate the office space required for the area headquarters it will be clearly be substantial. There will be neither the capital sums, nor sufficient time available to construct new buildings. Existing NHS office buildings will not be suitably located or on a sufficient scale to serve as area headquarters or may no longer be available for NHS purposes. Further, the rental of new office accommodation on this scale may prove very difficult. For example, the new Social Services Departments have not been able to find such accommodation in Brighton or Eastbourne.

4.3 Having considered three alternatives for the performance of the executive functions at area level (a chief executive officer, an executive staff or the Area Health Authority chairman) the group is in favour of a chief exective officer as this would ensure that one officer could be held accountable for the overall functioning of the authority.

4.4 In order to further integrations, the senior administrative officer of the Family Practitioners Commitee should be a member of any executive staff grouping at area headquarters.

4.5 It is difficult to envisage, in any detail, the internal organisation of the area headquarters, but on the basis of the Management Study Group's appendix to the White Paper* it may be expected to contain three elements. Firstly, there will be professional groups such as specialists in community medicine, nurses and para-medical workers: secondly there will be the secretariat of the Family Practitioners Committee, and thirdly a series of departments. The following departments have been suggested: finance, planning and information, personnel, administrative support, management services and technical services.

4.6 Chief officers who are not members of the executive staff should be responsible to one of the officers who is. The following should be responsible to the chief administrative officer: personnel officer, management services officer, technical services officer. The following should be responsible to the chief administrative medical officer: chief dental officer and chief pharmacist. The planning and information officer and the chief ambulance officer should be accountable either to the chief administrative officer or to the chief administrative medical officer.

4.7 It will be important to maintain co-operation between the health services and local government. The following cross-linkages could be envisaged:

a) At member level

i) Membership on the AHA for "some" nominees of the county.

ii) Co-option to the County Social Services Commitee for some nominees of the AHA.

iii) Nomination of half of the members of the community health councils by the (local authority) district councils.

b) At officer level

i) Chief Administrative Medical Officer to be medical advisor to the County Council.

ii) Director of Social Services to be Social Service advisor to the AHA.

iii) Community physicians as advisors to the district councils on environmental health.

* National Health Service Reorganisation: England, Cmnd: 5055 August 1972 Appendix III.

5 POLICY FORMULATION WITHIN THE NEW STRUCTURE

5.1 The Area Health Authority will have to operate within resource and policy constraints determined at central and regional level.

5.2 Central and regional policies should concentrate on broad service objectives. They should have more to say on the problems that need to be tackled than on the precise way in which they should be tackled. Budgeting procedures should be such as to allow flexibility in planning at area level. Unless the AHA has a clear and significant measure of latitude in policy formulation, then its alleged relative independence will be largly mythical and it will fail to attract individuals of sufficient calibre to cope with the very difficult problems that the management and planning of health services involves.

5.3 The process of policy formulation should be cyclical. When new policies are implemented, it is important that their effects should be monitored so that the policy may be reviewed and altered as necessary.

5.4 The area policy formulation process will take place against a background of ongoing consulations with the District Management Teams. A balance will need to be achieved between the relative influence of the many interests involved - particularly the area headquarters staff, the members of the authority, the community health councils and the professional advisory committees.

5.5 The area should handle its own capital projects except those of major proportions (such as the construction of new hospitals). Architectural services will be required to deal with these small and mediumscale projects, but it is not expected that architects will be employed within the health service below regional tier. The area should be able to either employ the services of the regional architects department or to gain the services of private firms after consultation and agreement with the region or to gain the services of the County Architect.

5.6 So that the Area Health Authority will be able to consult readily with the relevant professions, professional advisory committees will need to be established at area level.

5.7 As clinicians - consultants and general pratitioners - are not organised hierarchically they can only be represented within the new management structure. Such representatives cannot be held fully accountable for their colleague's work.

5.8 On the general practitioner side, the local medical committees are already organised on a scale roughly comparable to that of the new areas. The successor to the local medical committee will relate to the Family Practitioners Committees on issues related to contracts and conditions of service and to the Area Health Authority as a whole on the general management and development of services. On these latter issues, general practitioners should relate in the first instance to the District Management Team.

5.9 On the consultant side, existing committee structures correspond roughly to the future district and regional tiers. It will be necessary to develop an area tier to relate consultant advice to decision-making at area level.

5.10 The interests of the para-medical staff should be given more recognition than they have received in the past. They should have a clear channel of communication to the District Management Team.

2

Advisory Group Report

on.

ORGANISATION
AT DISTRICT LEVEL

MEMBERS OF ADVISORY GROUP

The group comprised the following 12 members acting in individual (and not official) capacities and met six times between April and July 1972.

Mr R Aspden	Administrative Officer, Brighton County Borough Health Department
Dr I M Brown	Consultant Geriatrician, Eastbourne HMC
Mr J Barry	Principal Nursing Officer, St Francis Hospital Haywards Heath
Mrs E Beith	Chief Nursing Officer, Brighton County Borough Health Department
Dr N M Cole	General Practitioner, Hailsham
Dr J L Cotton	Medical Officer of Health, East Sussex United Districts
Mr C R Dyte	Group Secretary, Eastbourne HMC
Mr W Holden	Clerk, Brighton Executive Council
Miss M J Lilley	Midwifery Tutor, East Sussex County Health Department
Mr A A G Mitchell	Group Secretary and Treasurer, Hailsham HMC
Miss N Mustard	Chief Nursing Officer, Hastings HMC
Dr K O A Vickery	Medical Officer of Health, Eastbourne
Dr J Powles	Research Fellow, acted as chairman to the group

1.1 The health district is the basic unit of organisation within the proposed new management structure for the NHS. An important objective of the district level of organisation will be to ensure the effective co-ordination of health and related services provided to persons within the district.

1.2 The health districts will be based on the catchment areas of the district general hospitals. They may therefore be expected to have populations in the range 150,000 to 300,000. The local government districts will tend to be smaller than this. Where possible health and local government district boundaries should be made to coincide - for example, by regarding some health districts as the sums of two or more local government districts. Such a resolution of the potential disparity between health service and local government boundaries will be possible in East Sussex but there must be many areas where it will not be so easy. Such disparity may make difficult the co-ordination of heal th and related local authority services.

2 THE DISTRICT HEADQUARTERS AND THE FIELDWORK OF THE HEALTH SERVICES

2.1 It has been proposed that management at district level should be in the hands of a District Management Team comprising a district community physician, district nursing officer, district administrator, district finance officer and one representative of the general practitioners and one of the consultants*.

2.2 It has further been proposed that the work of the health service within each district should be divided up according to the target populations or need groups involved with a multidisciplinary health care team responsible for the services to each group. The following groups have been suggested: child health, elderly, maternity, mental illness, and the handicapped. There might also be groups for preventive, primary care and acute specialist services.

2.3 Each health care team might, according to these proposals, be made up of the following: a community physician, a consultant, a GP, a nurse, an administrator and (where appropriate) a representative of the social services department.

2.4 The advisory group finds these proposals generally acceptable and believes them to be workable. A number of their implications however, need to be explored.

2.5 There will be a number of difficulties to be faced in designing arrangements to further co-operation between the primary care and hospital sectors. First, existing committee structures in general practice (the local medical committees) generally relate to geographic areas that are closer to the future areas than to the future districts. It will usually be necessary for general practitioners to develop a lower tier committee structure within each district in order to nominate their representatives to the District Management Team and the health care teams. Secondly, the location of the Family Practitioners Committee at area level may

*National Health Services Reorganisation: England. Cmnd. 5055 HMSO. August 1972 Appendix III.

tend to focus general practitioners attention at that level. In practice general practitioners may not differentiate between those concerns that relate to their conditions of service - which are to be discussed with the Family Practitioners Committee - and those concerns that relate to the general management and planning of health services - which are intended to be discussed in the first instance with the District Management Teams. Clear examples of the latter types of issue are the attachment of nurses and health visitors and the development of health centres. The development of district general practitioner committees - as the point of first contact for general practitioners - is thus critical to the effective working of the district management structure.

2.6 Two kinds of links may be envisaged between primary care and the district headquarters. Firstly, there will be the representative of the general practitioners on the Dsitrict Management Team. Secondly, working relationships will be established between primary care fieldworkers and certain members of the district headquarters staff. A community physician will liaise with the general practitioners, the district nursing officer and her representative with nursing staff involved in primary care and the district administrator or his representative with those involved in practice administration (especially in health centres).*

2.7 The district community physician or his representative should be responsible for providing medical advice on environmental matters to the new (local government) district councils. The relative responsibilities of the chief public health inspector and the community physician will need to be carefully worked out. Information on environmental hazards to health ought to be fed in to the health service information system. The district council's environmental health service could provide a valuable service function to the health service by monitoring the sanitary conditions of hospitals and hospital kitchens.

2.8 In general the immunisation programme ought to be carried out within the primary care sector. This is being encouraged by the development of computerised call systems. The role of the community physician would be to monitor coverage and to provide specialist advice. As the incidence of many infectious diseases declines it will become increasingly difficult for community physicians at the periphery to remain clinically skilled in this area. Such specialist skills could well be organised at regional or national level within the new structure.

2.9 The community physician should co-ordinate health screening activities - for example, by the development of computerised call systems for the pre-school screening of children in the primary care sector.

2.10 The health education function will be operational at district level and an adequate service would require a health education officer, deputy and 2 to 3 assistants for an average district. The service could be responsible to the District Management Team through the preventive services team and (on specific professional matters) to the area health education officer. As well as conducting health propaganda to the public it should endeavour to "teach the teachers". This

*Pressure of time has prevented us from looking further into the specific needs of the other family practitioner services - dentistry, pharmacy and optical services.

includes all health workers who come into contact with patients. For example chiropodists could be a valuable means or providing health education to the elderly. In determining the objectives of such a service, the area health education officer, community physicians and health education fieldworkers should all play a part. There will be a need for effective links with the Education Department, the Social Services Department, the birth control service and voluntary organisations.

2.11 There is another group of functions which are currently organised largely within the hospital sector and which should in future be organised on a district-wide basis. They include the investigatory services (pathology and X-ray), chiropody and physiotherapy.

2.12 Two alternatives exist for oganising the health care of school children. Firstly, this could be made the responsibility of the child health team. Secondly, such care could be made the responsibility of the district community physician.

3. ORGANISATION AT DISTRICT LEVEL

3.1 Members of the District Management Team with the exception of the clinicians will be working in close physical proximity to each other at district headquarters. For them the implications of working on a day to day basis as members of a team are fairly clear. The representatives of the general practitioners and the consultants however, will only be participating in group decision-making on an intermittent basis - principally at formal team meetings. For them "acting as a member of a team" will be intrinsically more difficult. On top of this they will have a politically difficult role to play as representatives of their fellow clinicians.

3.2 Clinician members of the District Management Teams should be given adequate practical support in the form of office space at district headquarters and secretarial assistance.

3.3 Relations between the District Management Team and local authority services (for example environmental health services, social services, education) will be complicated by the fact that the health district boundaries will not as a rule be coterminous with the local authority district boundaries. Where possible the health district should be regarded as the sum of 2 or more local authority districts (as suggested in para 1.2 above). Thus, in relating to social services, the District Management Team may have to establish links with two or three social service (geographic) units (presuming that these will be organised on the basis of local government district boundaries). It would be helpful if all social service offices within a health district would combine together for the purpose of liaising with health services. The same could apply to education. In the case of environmental health services the district community physician would have formal responsibilities to each (local government) district council.

3.4 The District Management Team should be corporately resonposible to the Area Health Authority. However, for services that are organised on an area-wide basis the district officer will be responsible to his counterpart at area headquarters. Thus if the ambulance services were to be so organised, with central control at area level, the district ambulance officer would be responsible to his area counterpart.

3.5 It will be the function of the convenor of the District Management Team to call meetings, and distribute the appropriate papers for consideration.

3.6 Some members of the group felt that the district community physician should act as a co-ordinator of the health services provided within the district. He should exercise a watching brief over the general quality and content of the services provided and initiate such action as the circumstances indicated. This view was contested by other members of the group.

3.7 The view of the Hunter committee that the grade for district community physicians should be the same as that for community physicians below the area medical officer at area level and that both of them should be comparable to the consultant grade in the hospital service was noted (para 124 of their report).

3.8 The district nursing officer should have a number of staff each responsible for one sphere of nursing. These might include general nursing, community nursing, midwifery, psychiatry and teaching, but any list will need to be interpreted flexibly. The question arises as to whether they should be located within the district headquarters in order to facilitate integration or, for example, whether the nurse in charge of psychiatric nursing should be located at the psychiatric-in-patient unit and so on. Acceptance of the former proposals would increase the need for space at the district headquarters.

3.9 The district administrator will be responsible for providing a "secretariat" function both to the District Management Team and to the health care team. There will be a very considerable amount of secretarial servicing involved. It will also be the responsibility of the administrator to transmit the decisions of the District Management Team to those responsible for carrying them out, (except decisions affecting the colleagues or staff or another member of the team which would be transmitted by the individual concerned). Other responsibilities will include general co-ordination and acting as a clearing house for requests and demands coming from within different parts of the health service and also from individuals and agencies outside the health service.

3.10 In an average health district with a population of 200,000 there may be some 2,500 health service employees. There will thus be a good deal of "personnel" work, and many appointments will need to be made at district level. There should be a district personnel officer, providing a service to the whole district while being ultimately responsible to the administrator.

3.11 There should be a single office for members of the public to enquire about health matters within each major centre of population within the health district. At

least in the most important of these, within each district, it should be possible to have enquiries relating to family practitioner services dealt with.

3.12 The detailed implications of administrative integration at district level need to be explored further. Some functions that will clearly be involved are finance, records and domestic and portering functions.

4 THE HEALTH CARE TEAMS

4.1 According to the proposals now current these teams will be responsible both for the day to day co-ordination of services to particular need groups and for the planning of future services for these groups.

4.2 The co-ordination of services by regular multidisciplinary meetings is now a well-established practice. While some of this co-ordination could be achieved by telephone contact with other officers, maximum co-operation of all involved is best gained by means of multidisciplinary meetings. Authority derives from the consensus of opinion at these meetings and there is little need for more formal executive powers.

4.3 The involvement of the health care teams in the planning of future services may raise some difficulties. If planning does not take place within known financial and policy constraints, time may be wasted in the preparation of plans that will never be implemented. This will lead to frustration and loss of interest in team meetings. Secondly, if all team meetings are formal and minuted there will be an enormous quantity of notes generated within each district. Team members could become swamped in committee literature.

4.4 Negotiations for resource allocations to different services within the district should be conducted against background norms (or yardsticks) for the provision of different services. This may serve to protect the interests of the less influential services.

4.5 The health care team will be responsible to the District Management Team for carrying out proposals for its services that are incorporated into the district plan.

5 PLANNING WITHIN THE NEW STRUCTURE

5.1 The implications of current proposals to involve both the District Management Team and the health care teams in regular, detailed planning cycles need to be further explored.

5.2 For such planning processes to be effective there will be a need for a considerable amount of servicing from area headquarters - particularly in the form of information services and in costing alternative policy proposals.

5.3 Planning decisions should not be solely determined by the "balance of influence" within each district. Services should be compared with those provided in other districts both within and without the area (see also 4.4 above).

5.4 Planning should take place within explicit constraints negotiated with the area and there should be continuous liaison between district and area so that district plans do not become irreconcilable with area policies.

3

Advisory Group Report

on

THE PROFESSIONS AND MANAGEMENT

MEMBERS OF ADVISORY GROUP

The group comprised the following 12 members acting in individual (and not official) capacities and met six times between April and July 1972.

Mr A Brown	Consultant Surgeon, Group Accident and Emergency Department, Brighton and Lewes HMC
Mr S F Butchart	Deputy Group Secretary, Hastings HMC
Mr R B Charter,	Dentist, Lewes
Mrs D I Dale	Superintendent Health Visitor, Eastbourne
Mr C K Fenton-Evans	Chief Dental Officer, East Sussex County Council
Mr D Jackson	Ophthalmic Optician, Hove
Mr R G Mumford	Pharmacist, Lewes
Dr M P F Marshall	General Practitioner, Eastbourne
Dr W S Parker	Medical Officer of Health, Brighton
Dr E P Quibell	Medical Administrator and Consultant Paediatrician, Chailey Heritage, nr Lewes
Miss G Rudd	Principal Nursing Officer, Eastbourne HMC
Dr D M Watney	General Practitioner, Crowborough
Dr J Powles	Research Fellow acted as chairman to the group

1.1 It is an objective of the proposed integration of the NHS to achieve greater co-operation and co-ordination between all those involved in providing health services. In recent years there has been a growing awareness among both general practitioners and consultants of the need for increased co-operation. Opinion on this issue is changing rapidly and a close inter-relation between the present hospital and community sectors of the health service may be expected to continue developing over the next decade.

1.2 The increasing development of health centres and proposals for the development of community hospitals should help create the conditions for close co-operation between the present sectors of the service. The strong preference for working in health centres expressed by young doctors entering general practice and the rise of land values will both serve to strengthen the trend to health centres.

1.3 On the hospital side there is a growing realisation that if the best use is to be made of expensive hospital facilities, hospital staff will have to develop closer links with those engaged in care in the community.

1.4 The group welcomes and supports these trends.

2 PROFESSIONALS AND THE NEW STRUCTURE

2.1 The NHS is an organisation of great complexity and it is no easy task to envisage exactly what its administrative structure will look like after 1974. The work of the NHS may be divided up along three different dimensions:

i) According to the skills used, e g consultant services, acute nursing services, general practitioner services etc.

ii) According to the place in which the skills are deployed e g hospital services, health centre services etc.

iii) According to the group for whom the services are provided, e g child health services, psychiatric services, or indeed, services for a whole district population.

2.2 The division of work by the third of these dimensions best serves the objective of integration. Within this approach multidisiplinary teams may be considered to be responsible for providing services to a specified population with specific needs. Proposals for the reorganisation of the service, as outlined in the White Paper National Health Service Reorganisation: England (August 1972) involve the development of such teams - for example health care teams and district management teams. (see paras 3.1 to 3.5 below).

2.3 Within the proposed new structure, consultants will retain their clinical independence and general practitioners their status as independent contractors. Because clinicians (with the eception of junior medical staff in the hospitals) are not organised hierarchically they can only be represented within the

management structure. Such representatives have no power over their colleagues and cannot be held accountable for their colleagues work. This is the fundamental difference with respect to professional advice to management between clinicians and other health care workers.

2.4 It is likely that much of the early discussion on issues of direct concern to clinicians (for example postgraduate education and research) will take place within the professional advisory committees. If the purpose of integration is to be furthered however, it is important that all major issues should be considered and resolved within multi-interest settings.

2.5 Care should be taken to avoid the development of committee procedures which are not strictly necessary and which threaten to absorb the time and energies of valuable staff. Adequate secretarial services should be made available to all committees.

2.6 Where possible informal alternatives to committee meetings should be developed where services might be reviewed and new working relationships established. The post-graduate medical centres have provided a valuable stimulus in this direction.

2.7 Regular (but not necessarily frequent) conferences could be held to review the provision of services in different spheres. It may be possible, for example, to hold within each district an annual conference to review services for the elderly. All those involved in the care of the elderly could be invited. This may lead to a better appreciation of current problems and to the formulation of better policies than would have been the case if sole reliance were placed on formal committee procedures.

2.8 Where appropriate other arrangements should be developed to reduce the potential burden of committee work. Meeting together over meals or socially may be a more effective menas of developing co-operation than the more formal measures upon which a committee is likely to rely. There may be a case, for example, for opening hospital canteens and social facilities to those working on the community side of the health service. Such facilities could also be provided in association with centres for post-graduate education.

3 THE PROPOSED NEW MANAGEMENT STRUCTURE

3.1 The White Paper (Command 5055, August 1972) proposes the establishment of Area Health Authorities. These will be coterminous with the proposed new counties and would constitute the lowest formally responsible authorities within the new structure. The chairman would be appointed by the Secretary of State and the authority might have 14 other members - some nominated by the corresponding local authority but most by the regional health authority. It is important for the purposes of this report to note the intention that members should be selected on the basis of their general ability and not as representatives of the community or as representatives of those involved in providing the

service. Separate community health councils are proposed to represent consumer interests and professional advisory committees to represent professional interests. However the White Paper does propose that the membership should "always include doctors and at least one nurse or midwife." (para 99).

3.2 The White Paper also proposes that the area should be divided into health districts - largely based on the catchment area of one or more district general hospitals (para 45). The proposed East Sussex Health Authority might be divided geographically into three districts - corresponding roughly to the catchment areas of the existing Brighton and Lewes, Eastbourne and Hastings HMC's.

3.3 Appendix III of the White Paper gives the views of the Management Study set up by the Secretary of State to make recommendations on the future management structure.

It outlines proposals for:

i) A possible area management team at the headquarters of the area health authority comprised of the chief adminstrative officer, chief financial officer, chief administrative medical officer and chief nursing officer (para 21).

ii) A district management team at each district headquarters comprised of the district community physician, district nursing officer, district administrator, district finance officer and one representative of the consultants and one of the general practitioners (para 17).

iii) Establishing within each district, multidisciplinary teams to manage services for particular groups such as services for the elderly, psychiatric services, services for the handicapped and services for mothers and children. There could also be teams for preventive, primary care and specialist services. These teams might be comprised of a community physician, consultant, general practitioner, nurse, administrator and a representative of the local social services department (paras 10 and 19).

3.4 The special purpose multidisciplinary teams within the districts should not meet more frequently than is necessary in order to ensure co-operation and co-ordination in the provision of services and the carrying out of a yearly planning cycle. They should basically be "sleeping committees" with the formal meetings serving to establish links which can then be re-activated on an informal basis as required.

3.5 Professionals will participate in the future management of the service via two inter-related pathways.

i) By participation in multidisciplinary service-based teams (e g district management teams and health care teams). The main focus for participation of this kind will be at district level.

ii) By means of committees representing separate professional interests. These will include successors to the group medical advisory committees (within the hospital service) and the local medical, dental, pharmaceutical and optical committees.

4 MULTIDISCIPLINARY TEAMS

4.1 There has recently been a significant development of the multidisciplinary team approach both within the hospital service and within general practice. On this basis, it may be expected that such teams (for example, district management teams and health care teams) have the potential to provide both acceptable and effective means of managing services. For them to work well there should be:

i) a mutual recognition of roles between the members

ii) good secretarial servicing by the district headquarters

iii) good information servicing (the community physician could be responsible for providing "medical intelligence" and the administrator general services and personnel information - both of them drawing on the resources of an area information unit)

iv) reasonable budgeting procedures for the team to work within

4.2 It is critical to the future role of these teams that the consultants and general practitioners agree to be represented on them. The current proposals for the district management team would require that the consultants within a district agree to have their interests represented by a single colleague (roughly corresponding to the current chairman of the medical executive committees) and that the general practitioners do likewise. The alternative of having more than one representative would almost certainly produce a team too large for the purposes of day-to-day or week-to-week management.

4.3 Consultants are already moving towards the establishment of effective representative machinery at the equivalent of district level and further developments in this direction may be expected. The aim should be to ensure a ready flow of information between the constituents (all the consultants working in the district), their committee (the successor to the current medical executive committee) and their representative on the District Management Team (the successor to the chairman of the medical executive committee).

4.4 General practitioners have much further to go in developing machinery for representing their opinions on the development of the health service at district level. So far their committee structure has been based on the local medical committees which have been principally concerned with conditions of service within general practice. They have also usually been organised on a geographic scale that is larger than the proposed new districts - and which corresponds more closely to the proposed new areas. (The future role of the general practitioners committee at area level will be considered further in paragraph 5.3 below).

4.5 At district level, there is a need for general practitioners to begin developing a committee structure to serve as an effective channel of communication between the constituents (all general practitioners working within the district) and their representative on the District Management Team. Only by this means, can the general practitioners assure themselves of a voice in the development of the whole range of health services within a district. An effective committee structure will be necessary to help the single representative keep in touch with those whom he represents.

4.6 Issues of concern to general practitioners which do not relate to their conditions of service (for example, the development of health centres, the attachment of ancillary staff and hospital admission and discharge policies) should be raised through their committee structure at district level.

4.7 Members of the District Management Team who are not clinicians will actually have their offices at the district headquarters. For them being members of a team carries two obligations: firstly, that in performing their day to day management tasks they should act as members of a management group and not as individuals and secondly that they should seek to resolve important issues in group meetings. The clinical representatives will only be able to spend a small proportion of their time atdistrict headquarters - mostly in relation to group meetings.

4.8 Clinician members of the District Management Teams should receive compensations for the time devoted to those responsibilities - either as a notional number of sessions for consultants or a notional number of patients on a general practitioners list. They should have offices at the district headquarters and adequate secretarial assistance.

5 PROFESSIONAL ADVISORY MACHINERY AND THE AREA

5.1 On the hospital side the most significant change from current practice will be the inter position of a new tier between the current equivalent of the district (the hospital group) and the region. This will require the development of consultant advisory committees at area level both on a specialty and overall basis. Thus, consultants will have to develop a new tier at area level just as general practitioners will have to do at district level (para 4.5 above).

5.2 In the establishment of professional advisory committees at area level, the districts could form the constituencies.

5.3 According to the White Paper, committees representing family practitioners at area level will relating to two bodies:

i) On conditions of service and the administration of contracts to the Family Practitioners Committee

ii) on general issues and on the future development of health services (e g health centres, group practices and attachment schemes, hospital service planning), to the Area Health Authority (paras 68 and 70).

5.4 There have been proposals - for example in the Scottish Home and Health Department Working Party report, Doctors in an Integrated Health Service - that the professional committee structure for both consultants and general practitioners should be integrated at district level. This could be achieved, for example, by the formation of general practitioner divisions within an overall "cogwheel" structure. A careful balance in the number of constituent divisions would need to be maintained between the hospital and community sides.

5.5 General practitioners may well fear that a fully integrated medical committee structure would be too vulnerable to domination by the hospital side. The most viable arrangement, which would still ensure the bringing together of general practitioners and consultants at both district and area level, would be for both general practitioner and consultant committees to be regarded as sub-committees of an encompassing medical advisory committee.

5.6 The community physicians should be closely involved in the work of these committees. They should have a special responsibility to act as a link between these committees and an area information service so that the committees' deliberations could be well informed. If the community physicians throughout an area divide their responsibilities functionally (according to health care teams) as well as geographically then they could also be associated with the work of relevant specialty committees at area level.

6 DENTISTS, PHARMACISTS AND OPTICIANS

6.1 The contracts of dentists, pharmacists and opticians will in future be administered by the Family Practitioners Committee which will succeed the Executive Councils. These professionals will relate to the new committee through area-wide successors to the existing dental, pharmaceutical and optical committees. The group foresees no difficulties in these proposals. However, if the objective of integration is to be furthered, additional arrangements should be made at district level in each of these services.

6.2 The dental service is currently a tripartite one comprising:

i) general dental practice

ii) local authority dental services

iii) hospital dental services

As most dentists are generalists there is considerable overlap in the work done in each sector and a need for improved liaison. Diseases of the teeth and supporting structures were second after mental disorders in one review of HNS expenditure by disease categories.* Despite this little has been said at an official level about the future development of dental services within an integrated health service.

* The Costs of Medical Care, Office of Health Economics, 1964.

6.3 Dental Liaison committees should be established within each health district representing each of the three branches and looking into issues such as the following:

i) The effective average of "at risk" groups, for example school children. If these are to continue to be screened by salaried dentists then liaison will be necessary to ensure effective follow up.

ii) The provision of an emergency dental service. Currently there is no such service - not even in a major accident and emergency centre. (It may prove difficult to find sufficient dentists to be rostered onto such a service).

iii) Co-ordination with the hospital sector, e g in arranging anaesthetists.

iv) Co-ordination with the area and district health educationists.

6.4 Pharmacy is currently a bipartite service with a salaried hospital service and a family practitioner service. The latter practitioners would generally prefer to work solely as professional pharmacists but renumeration from this is insufficient to provide an income in itself and must be supplemented by counter sales of cosmetics etc. A recent example of this problem arose from the plans to provide a professional pharmacy within a new health centre in Horsham. It was apparent that it would be grossly uneconomic to establish a professional pharmacy within the health centre. There is however scope for including existing style chemists shops within health centres and this is planned in Newhaven.

6.5 A liaison committee between the hospital and family practice branches of pharmacy could attend to issues such as:

i) The rostering necessary to provide a 24 hour service

ii) The co-ordination of workloads. Currently hospital pharmacies are understaffed and they are occasionally forced to close suddenly. This may throw a sudden burden on outside pharmacies who might not have the stocks to cope with it.

iii) The encouragement of generic prescribing by doctors (where this is consistent with the relevant regulations).

iv) Arrangements for rural areas.

6.6 There are three croups of professionals involved in the provision of ophthalmic services:

i) Ophthalmic opticians

ii) Dispensing opticians

iii) Ophthalmic medical practitioners

Past arrangements for regulating conditions of service in relation to Executive Councils have worked well. There is however room for improved liaison between the family practitioner and hospital sectors in such matters as referral policy and waiting lists.

7 OTHER MATTERS

7.1 This report has been principally concerned with those health professionals who are not organised hierarchically because their relations to the new management structure pose the most challenging problems.

7.2 Those health professionals who are organised hierarchically (e g nurses, physiotherapists, radiologists) may also feel a need to have recognised professional committee structures, particularly at area level. They may well feel that their own professional pyramids within the health service do not constitute a sufficient channel for relating their particular professional views to management and to the authorities. Pressure of time has not permitted us to explore these problems further.

7.3 This report has focused on organisational problems in the relations between professionals and management within a reorganised health service. The provision of medical services is now based on a highly complex and inter-dependent organisation - the National Health Service - and there is unfortunately no simple way to ensure that the best possible service is being provided to the community. However, an individual professional is less likely to be concerned with formal committee structures than with his own working relationships with those administering the NHS. Nothing in this report should be taken as implying that we have failed to recognise this as the critical link in the relationship between professionals and management.

4

Advisory Group Report

on

CONSUMERS AND THE HEALTH SERVICE

MEMBERS OF ADVISORY GROUP

The group comprised the following 14 members acting in individual capacities and not as representatives of the organisations with which they are associated. The group met nine times between April and August 1972.

Miss M K Bagnall	Group Head Medical Social Worker, Hastings HMC
Mr P D Baker	Rye and Bexhill Conservative Association
Mr H Brogden	Member, Brighton and Lewes HMC
Mr H Gaston	Hospital Secretary, Newhaven
Mrs B Jefferis	County Organiser, Old People's Welfare, Age Concern
Miss Lewis	Isfield nr Uckfield (Red Cross)
Mr C H Mobbs	Eastbourne Constituency Liberal Association
Mrs Morris	Saltdean
Mrs A Peacock	Brighton Women's Royal Voluntary Service
Mrs A Tate	Piltdown (East Sussex Federation of Women's Institutes)
Mr W Trend	Kemp Town Constituency Labour Party
Mrs R Wallace	Home Help Organiser, Hastings Social Services Department
Mrs F Ward	Brighton and Hove District Association for Mental Health
Rev W Webb	Buxted (British Legion)
Dr P J M McEwan	Director of the Centre for Social Research acted as Chairman to the Group

We wish to state in the strongest possible terms that the management of a health service differs in many critical respects from the management of a commercial enterprise. It would be a grave mistake to view consumer participation in the same light as, say, shareholders in a public company. Everyone in the population is a potential consumer (i e patient) and there are many aspects of the National Health Service which the consumer has a right to be involved in, even on occasion in matters of an executive nature. If Community Health Councils are to have neither teeth nor adequate financial support, they were better not to exist at all. Bearing in mind the information available to us through government documents and ministerial statements, we are firmly of the opinion that our recommendations describe the lower limit of what should be accomplished in this field.

As it is understood that the Report will be considered in conjunction with the Report of the First Phase Group in the preparation of a final comprehensive report to be prepared by the research team, this purpose may be best achieved by tabulating our major conclusions.

1 The Group met on 9 occasions between the 26th April and 7th August. In addition one public meeting was held.

2 Terms of reference were "to consider all problems relating to consumer representation in the Health Service under the revised structure." It was recognised that this meant that our discussion should be focused on two major themes, the proposed Community Health Councils and the question of consumer representation in determining national priorities. Accordingly, the major part of our deliberations have been concerned with the former and, unfortunately, the importance of this subject together with its complexities and uncertainties, did not allow as much time as we would have liked for considering the latter.

3 Throughout our deliberations we have assumed that the only firm decisions already taken regarding CHC's were:

i) that each Council will comprise between 20 and 30 members

ii) that the composition would be one half local authority and one half representatives from voluntary bodies

iii) that each Council will have its own secretary, paid from funds provided by the AHA

iv) that each Council would appoint its own chairman

v) that there will be one CHC for each health district

4 FUNCTIONS

In order to be effective, the CHC's must have channels of communication with those yielding executive power. This is absolutely essential; without it, the

wheels of management would grind unheedingly, the system would be in full control and the new Health Service would change only in its organisational flow charts. Accordingly, each CHC in turn should elect one of its members to sit on the AHA and elected members should meet quarterly on a regional basis in order to exchange information and experience.

Furthermore, it is important that there should be a national association of CHC members which would hold annual general meetings with the power to pass resolutions which could be forwarded direct to the minister and be given wide publicity.

The functions of the CHC's should in our opinion include the following:

i) To disseminate information about the working of the health service to the community, and to be the clearing house for all literature concerned with the improvement of "patient-doctor-institution relationships".

ii) To act as an intermediary between local administrators and AHA's in the matter of complaints, forwarding to the AHA's full details only when they were not satisfied that the complaint had been satisfactorily dealt with.

(It was recognised that local administrators would not be responsible to the CHC's, who would not employ them, but it was agreed that this mediating function was a most important one, particularly in view of the demise of Hospital Management Committees).

It was recognised also that the councils would have no executive power and therefore their strength would depend upon the publicity given to their activities and to their success in developing an appropriate image of themselves among the public.

All complaints concerning the hospital service whether from patients or staff, should be referred to the appropriate CHC., in those cases when the complainant had not received satisfaction from the relevant administrator to whom any complaint should be at first addressed.

Regarding complaints dealing with quality of care in general practice, the group believe that if it is to be a truly unified service, the CHC's must be the reipient of all complaints. Within the CHC's, complaints would be considered by respected and interested members of the public, free from other commitments or loyalties within the health service. Furthermore, this was thought desirable in order to produce and maintain the necessary image of the CHC's as public watchdogs. All complaints of a personal nature would need, of course, to be treated in strict confidence.

iii) To share responsibility with the DHSS in the preparation of a booklet to be given to all patients entering hospital, or, in the case of those seriously ill, to their next of kin. The main text should be prepared by the DHSS indicating appropriate details for the patient's life in hospital and incorporating a note about the procedures to be followed for the

making of suggestions and the lodging of complaints This booklet should include two or three pages at the end for matters of local significance and to allow for local variation, which would be the responsibility of the CHC's to compile. It should also be one of the responsibilities of the CHC to ensure that this booklet is distributed in all the hospitals in its district.

iv) The referral of patients to voluntary organisations who may be able to help them is a task likely to be performed by salaried workers within the health service but the CHC's might also have a role here. To perform this task adequately, it will be necessary to maintain a register of voluntary organisations acting in the district, or, where relevant, at national level and the CHC's should be responsible for the compilation and updating of this register.

v) To have the right of visiting all clinics and hospitals in the designated district; to oversee the welfare of patients both in "practice" and in clinics and hospitals; to be consulted in the initial stage of any new project, including the siting of new hospitals.

vi) Although perhaps in itself not a function, we feel that if theCHCps are to have any sort of function at all, they must have the best possible publicity. They should therefore obtain press coverage for their activities and time on local radio and television stations.

5 ORGANISATION

The organisation of the CHC's, including their elections, channels of communication and finance, have been considered by us in detail. With regard to the appointment of members of the CHC's. we recommend the following:

i) Public notices should be displayed inviting all voluntary organisations in the community to nominate their own representative for election to the local CHC

In addition, a responsibility of the DHSS should be to nationally advertise electoral procedures and functions and to circularise secretaries of all national organisations alerting them to the first round of elections.

ii) The election of representatives of voluntary organisations would then take place for the given number of available places, each nominating organisation having one vote for each available place.

iii) One third of all places would be open to re-election each year, with sitting members able to offer themselves for re-election.

iv) The responsibility for organising the first elections (i e during the first year of their existence) should be invested in the Area Health Authority, but, in succeeding years, responsibilities should be invested in each CHC secretary, working in foliaboration with the chairman of the CHC.

v) Before the first elections, a clerical assistant to the CHC should be appointed by the AHA Thereafter, this appointment should become the responsibility of the CHC.

vi) Each CHC must appoint its own secretary, responsible to the council through its chairman. Without this arrangement, the authority of the Area Health Authorities (and hence 'management') would be overwhelming and the voice of the public effectively crushed.

vii) The chairman of each CHC should be elected by its own members for the period of one year No chairman should hold consecutive office for more than three years (although he may be appointed for a further period after an interval has elapsed).

Considerable thought was given to the question whether all voluntary organisations in the community should be eligible to submit a representative or whether such organisations should be limited to those with an existing interest in the health field. We decided in favour of giving the widest possible connotation to voluntary organisations on the grounds that, in principle, this was the only true form of democracy and for practical considerations because of the difficulty of reaching agreement on any circumscribed list. It was also recognised that, although leaving the field wide open presented initial administrative difficulties, these would not be insurmountable. Furthermore, such an arrangement would ensure that all voluntary organisations interested in having a representative on the CHC's would have the opportunity of entering the election.

It is important that committee members should have the opportunity for training as health service consumer representatives.

6 STAFFING

With regard to staffing, it is of the utmost importance that the CHC's should appoint their own secretaries who must be people of highest executive calibre. Although it is recognised the Area Health Authorities will have to approve all salaries, a minimum of £3000 - £4000 per annum would be necessary (bearing in mind that we are speaking of 1974 and beyond). Such a person must have clerical support, and to these costs must be added members' expenses and office rental.

7 ACCOMMODATION

We envisage that each CHC would require modest office accommodation or perhaps two rooms, but these should not be in hospitals since this might inappropriately reflect a relationship between the hospital services and the councils which did not exist.

(In the course of our deliberations letters were sent to 117 voluntary and professional organisations inviting their comments on any aspects of the consumer and the health service. A number of constructive recommendations were submitted to us and all those have been carefully considered).

5

Advisory Group Report

on

ORGANISATION OF

INFORMATION SERVICES

MEMBERS OF ADVISORY GROUP

The workshop comprised the following 15 members acting in individual (and not official) capacities. It met five times between April 12 and May 17, 1972 before agreeing to the interim report and has subsequently met on three further occasions before agreeing this final report.

Chairman:

Mr K Barnard	Research Officer (Health Planning), King's Fund Hospital Centre

Deputy Chairman and Rapporteur:

Dr J Powles	Research Fellow to the Project

Research Assistant:
Miss Shelagh McConnell

Other members:

Mr P R Bailey	Statistician, South East Metropolitan Regional Hospital Board
Dr R G Brims Young	Deputy Medical Officer of Health, East Sussex
Mr R Borley	Assistant Director (Research & Development) East Sussex Social Services
Mr A C Burgess	Chief Management Information Assistant, Central Sussex Hospitals Joint Finance Department
Mr A F Duc	East Sussex County Planning Department
Dr P Gentle	Assistant Senior Medical Officer, South East Metropolitan Regional Hospital Board
Mr R N Humpherson	Secretary, Royal Sussex County Hospital
Mr S Israel	Research Associate, Guy's Hospital Medical School
Mr R Noble	Senior Systems Analyst, Treasurer's Department East Sussex County Council
Mr G A Peakman	Deputy Clerk of East Sussex Executive Council
Dr P A Shave	Deputy Medical Officer of Health, Brighton
Miss F E Stevens	Group Medical Records Officer, Brighton and Lewes HMC

SUMMARY

The purpose of this report is to prepare guidance for those who will be responsible for determining the nature and scope of the information function at Area level and how it will relate to other functions with the AHA Executive, to the constituent Districts, and to other interested parties.

The report discusses initially the nature of information and practical issues and problems surrounding the development of the information function. It moves on to examine the purposes for which information may be collected, stored and disseminated and the kinds of information which could serve those purposes, leading to a suggested classification of required information under the headings of need, resources, services and results. A description of existing (quantitative) information follows together with an assessment of quality, gaps and limitations. The report then discusses the relation of the information function to other functions, identifying various requirements, problems and opportunities; in particular the information function is examined in relation to medical intelligence and planning and the case is developed for giving the information function operation autonomy so that it enjoys the same relation to all user-functions. The Report concludes with a discussion of the organisation and staffing of the information function.

CONTENTS

I INTRODUCTION

The quality of health and related services after the NHS and local government reorganisation in 1974 will depend in large part on how well the new services are informed. An effective health information service is therefore, a prerequisite for the improved quality of care that is hoped for in the future. Before commenting in detail on the information requirements of the reorganised health service, two preliminary issues need to be clarified.

1 Components of the information function

The information function is composed of 2 inter-related parts:

i) Information system
This term is used to include the design and operation of data handling machinery. Activity under this heading is in a service relation to -

ii) Information service
This is concerned with the content of information and with the process of relating information to decision-making.

The emphasis in the following report will be on "information services".

In considering our remit, we have been careful not to limit ourselves to too precise a definition of information, in particular we have avoided regarding information as a synonym for statistics and also we have been concerned to range beyond the variety of epidemiological material which is sometimes regarded as medical or health information. This broad interpretation of information will become clear in our report and where we are concerned with a specific area of information, this will be made clear by the text.

2 Assessment of the external constraints under which an information service will have to be developed

a) Money: Within the broader limits likely to be operating, the gains in effectiveness and efficiency that will be made possible by an improved information service that is positively related to the decision-making process may be expected to outweigh its costs. This being the case, financial constraints should not be allowed to depress the development of information services whose costs will in any case only represent a very small fraction of health service expenditure.

b) Skilled manpower: The special skills required for information systems may well prove to be a limiting resource. This is a factor favouring the centralisation of this component to regional level.

c) Facilities: The issues involved in the formulation of a "computer policy" are beyond the competence of this group. It ia understood that the DHSS is currently determining such a policy. The group acknowledges that the need to make the most efficient use of such expensive facilities may well favour their location at regional level. What needs to be ensured, from the Area's point of view, is ready access to such facilities. There should in any case be personnel at Area level and conceivably below who are sufficiently familiar with computers and their applications to know how and in what ways these facilities can be used.

From this review of resource constraints, it is inferred that the "information systems" component may be best located at regional level. In the event of such a proposal becoming official policy, full weight must be given in its implementation of the needs of the Area including the following:

a) The need for effective links to other "blocks"of information, e g Social Services and County Planning.

b) The need to ensure as large a measure of operational independence of the Area as possible in order to avoid undue and unnecessary centralisation - in keeping with the official policy of allowing maximum delegation downwards.

c) The need for familiarity with local conditions if system designs are to be appropriate and effective. (This point could be met by the out-posting of systems analysts from Region to Area levels).

3 The inertia of existing patterns of data capture and flow

We were very much aware that there were already existing patterns of data capture and flow in the various branches of the existing health service and related local government and, being established patterns, they displayed a certain inertia which means that it would not in any event be an easy task to radically alter them. However, it is widely recognised that much existing information is of little value, particularly in an area of critical concern to community physicians - that of 'need'.

There is, therefore, a strong case for directing a major effort to identifying afresh the information needed and to working out how it might be collected. We would hope that sufficient resources of manpower and money could be made available for this task. However, it cannot be ignored that it will take considerable time and money to implement new methods of data collection and, in the meantime, every reasonable effort should be made to ensure that best use is made of existing information. It was clear to us that the failure to better inform the decision making process in the past has not only been due to the lack of relevant information but also to the failure to make best use of what existed.

However in reflecting on the lack of achievement in the past and its causes, we must be careful not to give the impression that one major effort to correct errors will be sufficient in itself. An information service of the kind we envisage will be dynamic, evolving, concerned to be ever relevant to the organisation of which it is part. An initial effort to set up this service is clearly needed, but thereafter it must always be adaptive and responsible to user-needs.

II INFORMATION FOR WHAT?

The objectives of the reorganisation of the NHS could be stated, with respect to their implications for information services, as the achievement of the following:

1 More effective patterns of operation

2 Better planning for development of services

3 Improved husbandry in the use of resources

4 Improved job satisfaction for health care workers (to aid the achievement of (1) to (3)).

The major information needs under each of these heads are as follows:

1 More Effective Patterns of Operations

i) More accurate and immediate information about patients at the time of treatment, including better cross-agency transfer of information

ii) More accurate information about current and potential workloads, deriving both from:

a) professional assessment of needs, and
b) consumer-generated demand

iii) Information on effectiveness of current patterns of operations; for example, rate of breakdown in cross-agency transfers and indicators of consumer satisfaction. (This information needs to be complemented with assessment of the impact of health care services on the health status of the community - see "medical intelligence" below).

2 Better Planning and Development of Services

i) Information to aid and develop the policy-making process amongst all who take part - members of authorities, headquarters staff, consumer representatives, clinicians and other health care workers. (Ultimate responsibility for policies will rest with members of the Area Health Authority).

ii) Information to enable better planning, including:

a) effective preparation for predictable futures, and
b) maximum flexibility in order to cope with changed circumstances.

3 Improved Husbandry

i) Measures of "value for money" (e g cost/effectiveness).

ii) Norms of good practice, including cost-saving techniques.

iii) Measures of staff performance (where appropriate). (Note links, for items under this head, to management services function).

4 Increased Work Satisfaction

As indicated by:

i) Personnel records.

ii) Wastage rates (for health care workers in training and turnover rates).

iii) Sickness and absenteeism rates. (Note links, for items under this head, to personnel function).

III WHAT INFORMATION?

1 Categories of Information

There is as yet no professional consensus as to how information relating to health services can most usefully be categorised and it may well be that different forms of categorisation are appropriate for different purposes. The simplest pattern may

be to see information relating to either planning or operations or evaluation. We feel, however, that for both practical and analytical purposes, the most useful classification is as follows*:-

i) Need

- a) Demographic, social+ and environmental background.
- X - b) Assessment of the medical task (technical aspects).

ii) Resources

- a) Capital stock
- b) Manpower
- c) Revenue expenditure
- d) Costs and benefits external to the health service

iii) Services

- a) Routine descriptive data
- X - b) Monitoring and evaluation (technical aspects)

iv) Results

- X - a) Improvements in health
- b) Consumer satisfaction

The categories marked "X" are those that relate most closely to the medical intelligence function as it is defined below. Thus it will be observed that not all health service information is health information or medical intelligence. This points out clearly the need for regarding the work of the community physician specialising in medical intelligence as being distinguishable from, yet part of, the broader functions of an AHA information service.

* For other classifications of health service information see:
Israel, Stephen, Health Service: Data Inventory, mimeo, Department of Community Medicine, Guys Hospital Medical School (in draft).
Edwards, B. and Walker, P.R. Profile for Change, mimeo, The Nuffield Centre for Health Service Studies, The University of Leeds.
Bispham, Kay, Thorne, Susan and Holland, W.W. "Information for area health planning" in Gordon McLachlan (ed), Challenges for Change, Essays on the Next Decade in the National Health Service, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1971.

\+ By the term 'social' we would wish to include a variety of information which should bear on formation of policies for health services in a given geographical locality. This information would include economic characteristics such as wage rates, pattern and distribution of industry, unemployment levels, as well as traditional social indicators - such as housing and family structure.

2 Existing Quantitative Information

i) Patterns of capture and flow

An attempt has been made (Appendix A) to map existing patterns of information capture and flow in each of the three sectors of the health service. Flows both from the periphery towards the central Department and from the centre towards the periphery have been investigated. The first step in the construction of any new information system relevant to both the organisational structure introduced for the new service and its links with local government and to real information needs, will involve a full comprehension of existing information, and their flows. We therefore wish to draw attention to Appendix A as being an attempt at laying out the existing situation in as simple a fashion as possible while yet demonstrating the enormous complexity of information flow and the size of the task involved in devising a new flexible system.

ii) The content of existing information

An attempt has been made to order existing information under the headings given under III 1 above (Appendix B). We feel that Appendix B demonstrates that it is possible to develop a better comprehension of existing information and that despite limitations and inadequacies, it could, at least during a transition period to a new information system, be possible to improve the quality of policy and planning decisions by making better use of current information.

3 The limitations of existing information*

These may be appreciated under the following heads:

i) Gaps

This is a relative concept as the quantity of desired information may become enormous. Existing information is however particularly weak in a number of areas - for example that required for assessing need. This has been well revealed by the experience of local authorities in meeting their obligations under the Chronic Sick and Disabled Act 1970. (See further discussion of this issue under "medical intelligence").

* In this section and in the following two sections (4, 5) we have identified and attempted to classify a number of important issues. In organising our thoughts we have not felt obliged to strive for consistency in our classification but to make our points forcibly, which includes the use of duplication.

ii) Unreliability

The following are examples of items of information that are currently of poor reliability: Hospital In-Patient Enquiry, Hospital Costing Returns, Institute of Municipal Treasurers and Accountants published reports.

iii) Low Validity

Many current items do not provide valid measures as desired. For example, waiting lists are not valid measures of need and clinical activity rates are not valid measures of morbidity.

iv) Not fully relevant to identified purposes

Information on hospital geriatric waiting lists, for example, is only of partial relevance if the objective is to provide increased community care.

v) Few adequate measures of effectiveness and outcome

More and better measures are needed for both short-term and long-term outcomes. New measures need to be devised and an increasing amount of measurement needs to be done.

vi) Information is frequently out of date

For example Hospital In-Patient Enquiry analyses are often not available until 3 years after the year to which the data refers.

vii) Information is frequently not inter-related

Information on hospital activities relates to events and not to persons. It is currently very difficult to relate effort expended to results obtained, principally because in many cases resources deployed do not serve identified population.

4 Information that is Currently Not Available

i) Information that could be collected if it were so decided, and deemed politically possible.

ii) Potential information, the development of which is limited by the inadequacy of current techniques. In other words areas where current information frequently does not meet the criteria of validity and reliability - for example, comprehensive health status indicators and population projections.

5 Non-quantitative Information

This needs to be further developed and where possible and appropriate systematised, particularly in the three following areas:

i) The transfer of information on planning intentions between related services - for example Social Services, County Planning, housing, transport, environmental services. Once plans become "hard" then they become part of the quantitative information discussed below.

ii) Assessment of need and effectiveness. The medical aspects of this will be considered under the future role of medical intelligence (below).

iii) Information on political and social attitudes having a bearing on health service policies and programmes, including information on consumer satisfaction and expectation. (This does not of course preclude the possibility of quantitative information on these matters, e g opinion polls and other surveys).

IV RELATION TO OTHER FUNCTIONS

1 Information systems and information services

In its supporting relation to the information services function, the information systems function should satisfy the following:

i) Be capable of all manipulations and analyses that can be reasonably asked of it and be capable of performing these within an agreed time period. There should be close and continuing consultation between the information systems and information services functions to ensure full awareness of information user's requirements.

ii) Be compatible with the other information systems. This will involve both "vertical" compatibility in relation to the health service "centre" and "horizontal" compatibility in order to ensure the ready transfer of information between related services - especially Social Services and County Planning.

iii) Ensure security of confidential information*. There are two aspects to this. Firstly, the intentional transfer of information between health service agents+ should be such as to respect adequately the degree of confidentiality of the information. Secondly, unauthorised access to confidential information needs to be guarded against. In practice a balance will on occasion have to be struck between measures intended to improve the effectiveness of the service and measures intended to protect confidentiality.

* The Report of the Younger Committee was published too late to be taken into consideration. In any event the Government will be issuing a White Paper in due course which will make known their views in the light of Younger and their own review of privacy and the public sector. The Workshop also noted a press report that the British Computer Society had started a survey of 40 major users of computers to see how they protect the privacy of stored information. The society was quoted as saying "There is very little real evidence on this subject, but there are a lot of alarmist rumours."

+ This is construed to include staff or other (non-health) agencies who are involed with health staff in the care of patients.

2 Information services and other functions

This is the most significant interface in the field of information for the value of information is criticially dependent on the degree to which it is effectively related to decision-making processes. Optimum effectiveness, in this regard, requires the following:

i) A clear profile on the information needs of user functions. This will involve continuing close liaison between the information service function and such user functions as planning, medical intelligence, consumer representation (CHC), institutional services, supporting services. The relations with planning and medical intelligence are considered further below.

ii) The timely transfer of the appropriate information to the appropriate decision-makers.

iii) The transmission of information in such a manner as to make its significance and meaning as clear as possible. Even if information is reliable, valid and relevant, it may have little impact on decision-making unless its content is clearly visible to the decision-makers. The information unit therefore have got to be aware of many other qualities of the users besides merely knowing what information they are asking for. They should know for example, which users will appreciate the significance of complex statistics and which would be better served by simple graphic presentation, which users will understand a technical report and which will needs a layman's translation, a full text or a digest.

iv) Flexibility in the local use of quantitative information to the extent compatible with regional and national obligations. It should be possible to mount ad hoc studies within an area, given ready specialist support from the "information systems" function.

The information service should also be involved in the provision of library services. Library services have hitherto been largely undeveloped in the health services, although some growth has been evident recently. Given the heavy involvement of health services in professional education and training, a major expansion of library services at some stage is inevitable. When this happens it is important that all staff involved in the organisation, management and planning of services are aware of the help that library staff trained in information handling can offer, not least in tracking down and obtaining material not immediately at hand. Much non-quantitative material could be provided by a library service which would have a bearing on planning, medical intelligence and other functions as well.

The AHA should appoint a public information officer* whose task would be not only to inform the public on the activities of the health service but also to sense public reaction to the services provided. Such an officer should be associated

* We were in some difficulty in finding an appropriate title for this post: our concern was to raise the idea of such an appointment for further scrutiny.

with the information service. Further consideration should be given to the proposal that he should collaborate with the officers responsible for Health Education.

The Community Health Councils should be regarded as users of the information service. They should have access to the same basic information as the various provider interests, so that when plans and policies are being considered by the different parties involved, the discussion takes place against a shared set of background information. It may be that consumer representatives will also be interested in different analyses of basic data to those requested by other information users. They may also be interested in collecting different basic data. It would not be appropriate for a unit at Area headquarters to become too involved in such consumer advocacy and it may be that the CHCs should perform some of these functions themselves.

3 Relation of Information to Medical Intelligence and to Planning

The information service function at Area level ought to have a single focus in order to co-ordinate and control information flow. It will provide a service to a number of user functions, amongst which should be included medical intelligence and planning.

One argument for separating the medical intelligence function is that a service function (information) should not be seen to be linked with a single executive function (community medicine). Otherwise it could come to be suspected that the information function was having an excessive degree of influence with the medical headquarters staff, or that the medical headquarters staff were exercising an excessive influence on the information function. Similar arguments apply in the case of the planning function.

4 The Medical Intelligence Function

In view of the clear distinction we draw between medical intelligence and the broader concept of information, the following paragraphs expand on the nature of medical intelligence and how the medical intelligence function might be discharged. This function includes the following:

a) Assessment of medical need. There are considerable conceptual and technical problems to be faced in determining needs and the resolution of these should be an early major responsibility of the first generation of community physicians. Need may be assessed in highly specific or highly aggregated terms. On the one hand an attempt may be made to estimate with reasonable accuracy the number of persons with a single condition so that a programme for the treatment of that condition may be worked out in quantitative terms. Alternatively an attempt might be made to identify the major reservoirs of potentially tractable ill health in the population

and to rank them in a roughly quantitative manner, both according to disease groupings and according to the social groups affected, e g age-sex and social glass groupings. This latter type of analysis using highly aggregated information has an important role to play in informing decisions on overall priorities within the health service.

b) Review of current medical care practice within the area.

c) Review of relevant medical care practice external to the area (for example by literature scanning).

d) Review of current performance. Clinical performance will, in the first instance, be assessed by clinicians. Their findings will then become part of the subject matter of medical intelligence.

e) Assessment of the impact of medical activity on the health status and quality of life of the community.

It is considered very important to develop an assessemnt of the medical task within a given community that is not biased by the possession of any particular clinical skill. A community physician carrying out the medical intelligence function will be in a better position to assess the overall health problems of the population served by the area authority than any other doctor. All too often in the past, resources have been awarded to those medical activities whose practitioners have the most professional and public prestige instead of to those activities which meet the most important needs. It is also the case that clinicians are not necessarily the best judges of their own effectiveness in improving health. To assess the overall effectiveness of medical interventions it is necessary to perform studies on populations, not on individuals; it is the skills of the epidemiologist and not those of the clinician that are required.

Although the community physician performing the medical intelligence function will be on the staff of the Area Medical Officer, it is important that his need for relative independence is recognised. Those community physicians engaged principally in liaising between clinicians and other fieldworkers and between clinicians and headquarters staff will find it difficult to sustain a detached view of the work of the health service in their area. That will be the separate task of the medical intelligence function.

V ORGANISATION OF THE INFORMATION FUNCTION

Without having firm detailed proposals on the future management structure of the Area authority, and without being very confidence as to the constraints that will be placed on the development of as information service at Area level, it is only possible to make general recommendations. These will have to take into account both the principles that should govern the relations between information services and other functions (as discussed above) and the work that will be under the control of an

information service.* This work with information will include: collection, processing, retrieval, collation, analysis, interpretation (within agreed limits) and dissemination.

The organisation of the information function will have to meet two potentially conflicting requirements:

1 That the information service sould be in a service relation to its user functions.

2 That the information should be integrated and effectively related to decision-making processes.

As noted above, the critical link lies in the relation of information to decision-making. This has been a point of failure in the past To overcome this the information service should have capable leadership and innovative and creative capacity in relation to its advisory and service function

An information service therefore requires its own organisational focus to co-ordinate, control and develop information services within the health service. It should be the responsibility of the information unit to co-ordinate the collection and flow of all information within the health service. For example, even if the natural flow of certain financial information is from, for example, the hospital to the treasurer's department, it should be so set up in advance that if the medical or personnel functions are tapping into it, the form in which the information is captured is agreed by all parties so that once the treasurer has it he lodges it with information unit and it is stored there and then passed on+ Those whose task it is to collect information at the "shop floor" level should not have to prepare several returns, each in a slightly different format, when these returns all cover the same general field of information.

As noted above there must be effective and continuing liaison between the information service and its user functions. Firstly there is a need for an information advisory panel made up of the heads of information user functions. The head of the information service could act as convenor. This panel would review the work of the information service and be responsible for recommending information policies for the area. The following functions might be represented - medical intelligence, planning, finance, personnel, management services and technical services. The possible participation of a representative of the Community Health Councils needs to be explored.

* We also refer to the information unit: these terms are intended to be synonymous within this report.

+ We have used the word "lodge" in order to emphasise the central and formal role of the information unit in this process. Whether this would necessarily involve physically lodging the information or whether it would be appropriate for the unit to take note of what is being stored elsewhere, is a matter for further consideration.

Secondly, in its day-to-day operations the information service will need working links with user functions. Nominated information liaison officers within the user functions could serve as points of first contact for the information service. They would usually be subordinate to the heads of the user functions who would be serving on the advisory panel.

As noted earlier, information services, medical intelligence and planning should be regarded as three separate functions. However, if the Area headquarters is to be organised into a limited number of departments, it may be necessary to group some functions together. Planning and information, along with medical intelligence, could be grouped into one department providing the operational independence of the information function is respected. There should be separate planning and information officers, if both functions are to be discharged effectively.

Staffing the Information Service

In the DHSS Management Study Group's "Discussion Draft" it is proposed that a formal planning process should be extended down to district and patient need group levels of administration. The implementation of these proposals will generate a very considerable amount of work for the Area information service if it is to service the planning process for so many bodies at and below Area level. The significance of this will be realised when it is remembered that servicing the planning process is only part of the work of an information service.

The information service will need to be adequately staffed if it is to meet these challenges. The head of the information service should be an able and influential member of the Area headquarters staff. He should be on the next rung below the chief officers. He might come from a wide range of parent disciplines including statistics, systems analysis and general administration.

If the inflows of information from the periphery to the Area information service, and the flows downward from Area level are to be systematised, then the skills of a systems analyst will be required at Area level. (As noted above such a person could be out-posted from an information systems function at Regional level). Statisticians will also be required. The technical staff in the Area unit will require adequate clerical assistance.

It should also be emphasised that the quality of the output of the area information unit cannot exceed the quality of the raw data it receives from source. For this reason due attention must be given to the provision of adequate staff at "shop floor" level for the preparation and transfer of material to Area level to ensure that this is not regarded as an additional and marginal task by some already over-worked clerk. When additional ad hoc enquiries are to be undertaken, the necessary extra staff should be made available by the Area information unit. The capability for mounting ad hoc studies is a factor which must be taken into account in fixing staffing levels and will require further thought.

Those who collect information should be aware of the reasons why it is collected and of its potential importance in the running of the NHS. Information which is seen as being useful at the level at which it is collected will probably be collected with greater care than information which appears only to be of use to remote bureaucrats. Those working in medical records units should be encouraged to feel that they belong to an Area information service. In this context we note the growing school of thought which argues for employing staff at gradings which reflect the importance of the work involved.

The group is convinced that money spent on an effective information service is money well spent. Area information services should be developed rapidly in accordance with their potential value. For the forseeable future there may be a shortage of the relevant skills within the health service and therefore persons possessing these skills should be attracted into the service. Workers with relevant skills who are currently within the health service should be given every encouragement to develop them further.

Conclusions

Although this is notionally a 'final' report, we are conscious as members of the workshop that we have only been able to point the way for those who will be responsible for setting up and developing the information function. We feel confident that our analysis and the principles we have evolved are broadly correct, but are not the last word, and much modification may be necessary in turning ideas into practice.

for members of the workshop:

K Barnard, Chairman
J Powles, Rapporter

(Copies of Appendices A and B are available on request to the Project, Centre for Social Research, University of Sussex, Falmer, Brighton BN1 9QN).

6

Advisory Group Report

on

ORGANISATION OF SUPPORTING SERVICES

MEMBERS OF ADVISORY GROUP

The group comprised the following nine members who gave their views as individuals rathan as representatives of their employing authorities. Six meetings were held between May and July 1972.

Mr J Cashmore	Regional Supplies Officer, South East Metropolitan Regional Hospital Board
Mr J Chadwick	Deputy Group Secretary, Hailsham Hospital Management Committee
Mr K J Dixon	O & M Work Study Officer, South East Metropolitan Regional Hospital Board
Mr W J Limb	County Ambulance Officer, East Sussex County Health Department
Mr W Pelling	Group Building Supervisor, Hastings Group HMC
Mr E Tarbuck	Chief Administrative Assistant, Eastbourne County Borough Health Department
Mr R Wellby	Group Engineer, St Francis and The Lady Chichester Hospital and Mid-Sussex HMC
Mr A R Whittingham	Chief Pharmacist, Brighton General Hospital
Mr P Evans	Group Secretary, St Francis and The Lady Chichester HMC (acting also as chairman)
Dr J W Powles	Research Fellow for the Project, attended all meetings of the group

1 INTRODUCTORY

The subject matter with which the Group was concerned was divided as follows:

General and Pharmaceutical Supplies

Building and Engineering Project design and maintenance

Ambulance and general transport services

It was appreciated that the range of subjects considered could have been extended while still being appropriate to our terms of reference but the limitation on time would have prohibited thorough consideration.

The headings above are used in Section 3 of this Report.

2 AIMS

The Group sought to identify only those changes which appeared to be significantly different as between existing and proposed structures, particularly where a shift in control was considered to be either likely or desirable.

We found that care was needed to avoid an invariable assumption that the new service must be hierarchically structured so that every interest is represented at every level regardless of whether staffing or line requirement was being fulfilled.

Arising out of our intention to pick out only the differences we have not attempted organisation charts of the new structure or any parts of it since we should easily have fallen into the trap of omitting a great many staff, particularly those who provide specialist services and will be integrated with their parent department into the appropriate level of the new structure.

A second difficulty, not of great significance in this Group, has been to avoid the implication that all services as now constituted are good and that change will only bring about their devaluation. We have therefore tried to adopt a critical and exploratory approach but we hope that in doing so our report will not appear to denigrate any of the services now given by officers and departments of the various health authorities.

3 SUBJECT CONSIDERATIONS

3.1 General and Pharmaceutical Supplies

3.1.1 General and Pharmaceutical supply services should not be integrated with each other. Co-operation between two parallel but different services should therefore be established.

3.1.2 Area 44 was thought to be too large for the creation of a single purchasing entity for pharmaceutical requirements, since the range of items (running into thousands) was often best satisfied by local purchasing arrangements. Relatively few items (probabaly less than 100) need be dealt with regionally, most of the remainder being purchased within the area, possibly through call-off contracts arranged by two* "Sub-Area" Pharmacies.

3.1.3 The structure for pharmacy staffing proposed in the Noel Hall Report was considered adequate to encompass the professional requirements of this specialty provided that a Regional Pharmacist was available for advisory purposes, particularly in connection with standardisation and Regional/National contracting arrangements.

3.1.4 The general supplies service was seen in Area 44 as an organisation existing at all levels but with a concentration of resources at area level and with only non-line representation in the districts. A regional officer would provide administrative co-ordination and general oversight of contractual arrangements in the region, as well as a consultative role in national contracting ventures.

The bulk of contract work would be organised and executed at area level in association with emergent area stores/depots. This was the point at which purchasing expertise would be centred.

In the districts,administrative personnel on the staff of the district teams would carry out a limited supplies function and it was hoped that recruitment into a supplies career might be encouraged in this way. Such staff would be responsible to the District Management Team rather than to the area supplies department.

3.1.5 The hospital membership of the Group expressed some reservations over the following points:

a) Flexibility and thereby some freedom of choice should be encouraged in respect of occasional purchases and non-contract items

b) The intention to establish area stores/depots should be preceded by careful examination of the cost implications of re-transportation.

c) That budgetary control should be retained as an administrative responsibility (albeit with some delegation to officers in a line relationship to the administrative team) so that, by definition, service agencies such as supplies would have no separate mandate for the commitment of funds.

3.2 Project Design and Management

3.2.1 It was assumed that the Regional Board would offer an architectural and engineering advisory service to the areas in respect of projects in the medium range of expenditure (i e say £20,000 to £200,000) and would control only capital and planning programmes in the higher ranges. Minor projects should be conceived and executed by the District Management Teams always allowing that the consequential revenue expenditure could be contained within the district budget.

* These are identified with the "Area" Pharmacies described in the Noel Hall Report.

3.2.2 Cyclic and Planned Preventative maintenance programmes should be evolved by the district technical officers relating to one, five and ten year periods and should be subject to area approval.

3.2.3 Global budgets should be allocated to District Management Teams as a means of encouraging flexible programming of non-routine maintenance items and minor capital projects. This was not thought to be incompatible with the further view that maintenance and capital should be separately funded since capital schemes would always require the prior approval of the area authority.

3.2.4 Preliminary project work and assessments of need should be undertaken initially by District Management Teams rather than by area planning teams.

3.2.5 An early and adequate assessment must be made of buildings and enterprises which are to be relinquished to the new health authority so that the dangers of underassessment from the maintenance and management points of view can be avoided. Building Supervisors and Group Engineers would need additional staff well before 1974 in order to undertake specific assignments of this type.

3.3 Ambulance and General Transport Services

3.3.1 Policy control and co-ordination should be carried out at area level by an Area Ambulance Manager who would control both ambulance and all other road-going vehicles.

3.3.2 This officer would need to have considerable experience in the management and operation of an ambulance service.

3.3.3 Control over vehicles other than ambulances might be delegated by the Area Ambulance Manager to an assistant Area Manager or to District Ambulance Officers.

3.3.4 Vehicle servicing facilities should be provided for fleets of not less than 50 vehicles and controlled by the Area Halth Authority. These facilities should be looked after by a consortium comprising the Ambulance Manager/Engineer/Supplies Officer. Day to day maintenance would be carried on at district level.

3.3.5 The permanent allocation of vehicles to units or departments within major premises might be justified following enquiry which would demonstrate continuous usage.

3.3.6 The routing of vehicles is traditionally under-managed outside of the ambulance service. Area Ambulance Control might be extended to provide a 'network linkage' for all vehicles in order to maximise the number of useful journeys which general purpose vehicles undertake and also to establish a rota for night emergency calls. Responsibility for this work could be delegated to the District Ambulance Officers in liaison with the Area Ambulance Manager.

4 GENERAL CONCLUSIONS

This group has been concerned only with those specialised services to which its terms of reference relate, but it has been appreciated that none of these has an end in itself.

The real aim - of providing a first class health care service to the community as a whole - is however dependent on the quality of its component parts and the management skills which are applied in bringing these together, and it is recognised that specialist requirements overall may have to be modified in order to achieve co-ordination.