CABINET

REORGANISATION OF THE NATIONAL HEALTH SERVICE IN WALES

Memorandum by the Secretary of State for Wales

1. I propose to publish a White Paper on National Health Service (NHS) Reorganisation in Wales complementary to that proposed by the Secretary of State for Social Services in respect of England. A draft is attached. It has been cleared by the Home and Social Affairs Committee.

2. NHS reorganisation in England and Wales will be dealt with under the same Bill and will be effective from the same date, 1 April 1974. The administrative pattern will be essentially the same in Wales as in England after allowing for the smaller scale which makes it unnecessary to interpose a Regional Health Authority between the eight Area Health Authorities (AHAs) and the Welsh Office. An all-Wales National Health Service agency (Welsh Health Technical Services Organisation) will carry out specialist executive and management functions including design and execution of major capital works but it will not be responsible for general oversight of AHAs' planning and operations. It will be appointed by the Secretary of State for Wales and, like the AHAs, will be directly accountable to him.

3. In all this, the draft White Paper reaffirms the proposals of the Consultative Document on NHS Reorganisation in Wales issued in June 1972 following discussion in the Social Services Committee and the Cabinet (CM(71) 19th and 24th Conclusions). The Welsh proposals reflect those for England as regards the scope of the reorganised NHS, the composition of AHAs, the payment of chairmen and the setting up of Community Health Councils and professional advisory machinery. A proposal in the Consultative Document to set up a new advisory Welsh Health Council has been dropped in favour of continuing to rely as necessary on the existing Welsh Council. There may be a need for review when the Commission on the Constitution reports.
4. As noted last year, the proposals imply some increase in the number of Civil Servants but should make a better use of overall public manpower. Additional short-term administrative costs arising out of the reorganisation have been provided for in Cmnd. 4829.

5. I seek the Cabinet's agreement to the publication of the White Paper in early August.

PT

Welsh Office

14 July 1972
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Introduction

This White Paper describes the Government's proposals for reorganising the administration of the National Health Service in Wales. The proposals take into account comments received on the Green Paper issued by the previous administration in March 1970 and on the Consultative Document of June 1971. Well over a hundred written comments were received on each occasion and over the past year discussions have been held with a number of the principal interested bodies. The Government have now reached firm decisions on the main administrative structure for a reorganised health service. These decisions can be seen as a logical development from the ideas which were outlined in the proposals of the previous administration and which have since been tested and refined in the light of widespread discussion. Some important modifications to the original proposals, concerning the membership of the new health authorities and the means of ensuring that they are responsive to those they serve, are designed to increase the efficiency of the health service in the best interests of the people. Study of the detailed arrangements for management organisation within the new structure is proceeding. They will be mainly a matter for subordinate legislation and administrative guidance which will follow the passage of the main legislation.

That there is need for such a reorganisation is widely accepted. The present institutions have served well, but the time has come when they should be welded together into a unified whole so that in the planning and allocation of resources and in the day to day responsibility for providing health care the service may respond in a balanced and coherent way to the overall needs of those whom it serves. Much has been done already, by goodwill and co-operation between authorities and individuals, to overcome the administrative barriers between the three present arms of the service but further progress will best be secured by removing them altogether.
3 In November 1970 the Government announced their intention to introduce legislation to bring about unification of the service on 1 April 1974, simultaneously with the reorganisation of local government. This legislation is now in preparation. The Government's plans provide for the new health authorities to work closely with corresponding local authorities in co-ordinating the development and operation of their inter-related services. At the central government level the Secretary of State for Wales already discharges his responsibilities for both groups of services through the unified organisation of the Welsh Office.

Services within the National Health Service

4 Reorganisation of the health service will bring together, under eight Area Health Authorities matching the boundaries of the proposed new counties, the family practitioner services now administered by the Executive Councils, the hospital and specialist services now administered by the Welsh Hospital Board and the Hospital Management Committees, the school health service and the personal health services now administered by the local authorities. These latter include epidemiological work and general surveillance of community health; vaccination and immunisation; medical, nursing and other arrangements for the prevention of illness and for care and after-care; health visiting, home nursing and midwifery; maternity and child health care; ambulance services; family planning; and the provision of health centres. The new health authorities will also become responsible for the registration of nursing homes.

5 The Government are satisfied that the future of the school health service will best be safeguarded by bringing it within the National Health Service: there would be a risk of problems arising from professional isolation if it were separately administered from all other personal health services. Area Health Authorities will provide local education authorities with necessary medical, dental, nursing and allied resources and advice to enable them to discharge their continuing responsibilities for identifying and meeting the special educational needs which disability or handicap may bring as well as for school
hygiene and health instruction. There will be arrangements for joint planning and co-ordination (see paragraph 6) and there is no reason why the teaching and health professions should not continue to work harmoniously together within the school regimen. Area Health Authorities will also work in close co-operation with the local education and social service departments of the new county councils in the provision of a co-ordinated child guidance service.

Collaboration with Local Government

6 A major reason for the decision that each Area Health Authority should match a new county council was to facilitate close collaboration between them and between the Area Health Authority and the councils of the new districts which each county will comprise. As foreshadowed in the Consultative Document, a working party covering England and Wales and broadly representative of local government, the NHS and central government is studying how best to promote such collaboration.

7 The working party has already made a number of important recommendations and although consultations on them with the interested local authority and health organisations have not yet been completed it is evident that there is a mutual will to ensure joint identification of needs of common concern and full co-operation in determining and pursuing the best ways of meeting them. Subject to these consultations it is proposed that health and local authorities in Wales, as in England, should be placed under a general obligation to collaborate and should be given wide powers to provide each other generally with goods and services. It will be a part of the responsibility placed by the Secretary of State on Area Health Authorities to provide all necessary medical and allied services and advice to local authorities in the fields of education, personal social services, environmental health and other services, and to make available medical officers to carry out certain specific statutory functions of local authorities. Conversely AHAs will need help from local authorities. For example, whatever the outcome of the review of the future of hospital social work which is currently proceeding they will need the advice and help of staff of the social service department of the county councils. Health and local authorities will also need to co-operate in the field of health education, for which both will have powers.
8 The working party has recommended that statutory joint consultative committees should be set up in each area to advise the authorities on the planning and operation of services of common concern. One such committee, containing county council and health authority representatives, might be concerned with school health and with co-ordination of health and personal social services; another, including representatives of the Area Health Authority and of each district council, with co-ordination between the NHS and environmental health and housing. The committees would be supported by groups of senior officers. Local authorities would also be recommended to co-opt to their relevant committees members or officers of the AHA; AHAs themselves will always include members of the matching County Council (see paragraph 15). To underline the importance of joint consultative committees it is proposed that there shall be statutory provision for them.

9 The working party is continuing its study of the details of the arrangements and is to remain in being to advise on guidance to the new authorities.

PART II DIRECTLY ACCOUNTABLE AREA HEALTH AUTHORITIES:

MEMBERSHIP, FUNCTIONS, ORGANISATION AND SUPPORTING STRUCTURES

Functions of Area Health Authorities
10 There must be a strategy for health for Great Britain as a whole and, consistently with this, a strategy for Wales for which the Secretary of State for Wales will be responsible. But this broad strategic framework should itself be built up from the advice of those with direct experience of health problems and responsibility for meeting them. Within it, an integrated health service can best be provided if real responsibility for planning and running it is carried out by a unified administration as close as possible to the people being served. The Secretary of State will look directly to the eight Area Health Authorities to secure these aims. They will have the key role. Assisted and complemented by professional advisory bodies they will, through the formulation of their own planning proposals and through
regular central consultations at both chairman and officer level, contribute fully to the development of the pattern of health services for Wales as a whole. They will be direct agents of the Secretary of State answerable to him for the efficient planning, organisation and administration of integrated health services within their areas and will carry a prime responsibility for the quality of the health care provided for the people they respectively serve. In some expert and technical fields it is clear that a degree of centralisation will make the most effective use of available resources and for this a central supporting agency will be created; and there must be overall co-ordination, leadership and ultimate control by the Secretary of State who is accountable, through Parliament, for the provision and efficient running of the health service in Wales. While there must be flexibility to respond over the years to experience of the most effective way to administer the services in the interests of the Principality, the Government will make sure that the authority and status of the AHAs is maintained by giving them all the responsibility which they can reasonably exercise. In this way they will best attract and retain men and women of vision and ability to lead them as members and as senior officers; and by this means they will best serve their communities.

Direct Delegation: No Intermediate Tier

11 Both the Consultative Document and the Green Paper of March 1970 proposed that as the number of Area Health Authorities in Wales would be small enough to permit it, they should be directly responsible to the Secretary of State without the interposition of an intermediate all-Wales authority. There has been debate on this. Some have argued that if an all-Wales authority were introduced which was responsible for strategic planning and co-ordination and for supervision or monitoring of AHAs it would put the efficiency of the Area Health Authorities to the test and ensure better planning and the adoption of better standards of service. Others are convinced that an intermediate tier would be to the detriment of the service. They see such an institution as too remote from the people and areas to be served, as interposing an unnecessary tier between the Secretary of State who has overall responsibility to Parliament and
the people and the Area Health Authorities who have the responsibility of planning and running the service. They also suggest that there would be problems of blurred and overlapping responsibilities and that the reduction in status and responsibilities of Area Health Authorities would adversely affect their ability to attract and retain members and staff of high quality.

12 The decision that Area Health Authorities shall be directly accountable to the Secretary of State for planning and running their services has been taken after careful consideration of these contrasting views. The Government readily acknowledge that the policies and standards of service in the National Health Service should be open to serious examination both from within the Service and from outside. But this does not require the introduction of a special body between the Area Health Authorities and the Welsh Office. It can be effected by giving strength to the Area Health Authorities and to the advisory machinery, and by constructive examination by the Welsh Office on behalf of the Secretary of State. Moreover there is wide agreement that the interests of patients and communities will best be served by arrangements designed to enhance the quality and responsibility of local management where the voice of the public will be directly heard through the Community Health Councils (see paragraphs 19-22). It is with these considerations in mind that the Government have decided that it would be better not to create an intermediate tier but to put the AHAs in direct relationship to the Secretary of State.

13 This decision in no way implies criticism of the Welsh Hospital Board. The Government pay tribute to the valuable service which the Board has given and the energy and dedication which its chairman, members and officers have throughout brought to their tasks. But the circumstances have changed since the Welsh Hospital Board was set up as one of a number of regional hospital boards accountable to a single health Minister for England and Wales. The transfer of ministerial responsibility for the conduct of the health service in the Principality to the Secretary of State for Wales gives effect to the view that ministerial concern with and accountability for the service in Wales should be closer and more
direct than had been practicable under the former arrangements. This principle would be difficult to reconcile with an administrative system in which the central responsibility for overall co-ordination of planning, for allocating resources and for monitoring the performance of operational authorities was delegated to an agent authority. In the different circumstances of England an intermediate tier is appropriate. In Wales reorganisation of the service should recognise the smaller scale and turn it to advantage.

Membership of Area Health Authorities

14. The health service is a complex enterprise. Each Area Health Authority will employ a large staff and administer an annual budget running into millions of pounds. Good management is essential to make the best use of these resources for the benefit of patients and the community; and this must be the dominant consideration in determining the composition of Area Health Authorities. To work effectively they must be compact and their membership must combine relevant experience, power of analysis, judgment and leadership and vigorous concern for making the service work well. A proper balance of these personal qualities can best be ensured if most members are chosen after appropriate consultations, rather than serving as representatives reflecting the views of particular interests.

15. The Area Health Authority will normally have about 15 members. Its chairman will be appointed by the Secretary of State. Four members will be appointed by the matching County Council to help foster close links with their related services. Two in South Glamorgan and one in each other Area will be appointed by the Secretary of State on the nomination of the University of Wales to ensure representation of the Welsh National School of Medicine. The remaining members will be chosen and appointed by the Secretary of State after consultation with appropriate organisations, including those representing the main health professions; where an Area has significant working links with another medical school this will also be reflected in the consultations. In all Areas some of these members will be chosen from the healing professions and although the proportion will not be prescribed, and may vary with
time and place, it is intended that there shall always be doctors and at
least one nurse or midwife in the membership of each Authority. Though
they will be entitled to the usual allowances members will as now be
volunteers serving in an unpaid capacity, but because financial
considerations might impede chairmen from meeting the heavy demands
which will be made on their time, legislation will make it possible to
remunerate them on a part-time basis; the same financial provisions will
apply to the chairmen and members of the Welsh Health Technical Services
Organisation and any other health authority which may be set up for
particular functions (see paragraph 40).

Medical and Dental Teaching and Research
16 The close partnership between the health service and the medical and
dental schools of the University of Wales will continue and the importance
of the facilities provided in support of medical and dental teaching and
of associated research will be recognised. The extent of the specialised
services provided by the University Hospital of Wales for patients from
each part of the Principality will be reflected in the allocation of
resources to South Glamorgan Area Health Authority. As already indicated
(paragraph 15), the University will nominate two members to this Authority.
In addition the Secretary of State will ensure that members with teaching
hospital experience are among those members chosen and appointed by him.
Total membership of the Authority will need to be greater than that of
other AHAs to reflect the special teaching functions. The Welsh National
School of Medicine is, of course, already represented on the recently
formed Welsh Committee for post-graduate medical and dental education,
which in the continued discharge of its functions will maintain close
contact with the Welsh Office and with AHAs. There will similarly be
links between Welsh Office, AHAs and professional bodies and committees
concerned with nursing and other training.

Professional Advisory Machinery
17 The administrative structure of the health service exists to
enable the healing professions to bring their skills to the people in
the most effective way. It cannot work properly without the expert
advice of the professions. Although members of the healing professions will be included in the membership of Area Health Authorities they will be there in a personal capacity rather than as spokesmen of the collective views of the professions. Each Area Health Authority will therefore require strong professional advisory machinery, which the professions will be invited to set up and which will be statutorily recognised. It will enable the professions to participate in the formulation and implementation of policy, offering a regular channel through which expert advice on matters of principal and of detail can be proferred and sought.

18 The detailed arrangements will be worked out with the individual professions and will vary from one to another. They will include provision for successors to the present local medical, dental, pharmaceutical and optical committees, to carry out statutory functions in relation to the family practitioner services, including appointment of members to the Family Practitioner Committee (see para 28). It is very desirable that they should also enable the advice of those working in general practice and those working in hospitals to be concerted. The arrangements should build on the best of existing experience - for example on the means by which consensus medical views emerge within the hospital service - and so far as possible there should be a representative structure at district level (see paragraphs 24 and 25) as well as at area level. Doctors, dentists, nurses and midwives, pharmacists and opticians are already considering these matters.

Community Health Councils

19 It is important that Area Health Authorities should act in full understanding of the views and wishes of the people they serve and that there should be effective representational machinery to this end. The previous administration proposed that this should be achieved by looking to members of the AHA to act in a representative capacity and through the creation in some Areas of district committees combining AHA members and local people and playing some undefined part in managing the service. The Government believes that this would have led to confusion. It is better to set up bodies which specifically represent local views and can bring these views to bear on management.
20 Each AHA will therefore be required to set up one or more Community Health Councils for this purpose. Where services are administered through health districts one must be set up for each such district, with discretion for more if local circumstances point to the need. Membership will normally be between 20 and 30, half being appointed by the related local government district councils, most of the remainder on the nomination of local voluntary bodies concerned with the service and some after consultation with other interested local organisations. Councils will appoint their own chairmen.

21 The Council will have powers to secure information, the right to visit hospitals and other institutions managed by the AHA, and ready access to the Authority and its senior officers in the district and area. Councils will be free to arrange their affairs so that particular members take a special interest in individual localities and hospitals. The AHA will consult the Council on its general development plans and particularly on important proposals to vary the pattern of the service, including changes in use, or closure, of hospitals. Apart from regular informal meetings, the full AHA will formally meet representatives of all its Community Health Councils at least annually. Each Council will be expected to publish an annual report and the AHA to publish a record of its consideration of the issues raised in it. The AHA will provide accommodation and secretarial staff and will meet expenses of the Council and its members.

22 These arrangements will give Community Health Councils every opportunity to represent effectively the interests of the local people. It is expected that they will adopt a positive role in reviewing the adequacy of local services and making recommendations for their improvement. Given a constructive and realistic approach they will exert strong influence on the AHA's policies and practices and will play an important part in helping to make a better service.
The Organisation of Area Health Authorities

23 The Consultative Document promised a study into the best managerial arrangements within Area Health Authorities. It was started last year by a study group working under the direction of a Steering Committee which includes members from the three present arms of the service and from the Welsh Office. Tentative ideas have been formulated and embodied in a document distributed widely at the end of April among those working in the health service in Wales. These ideas are now being developed and modified as necessary in the light of a series of discussions throughout Wales designed to produce recommendations to the Secretary of State which take account of the circumstances of the various prospective health areas. Recommendations are expected in the late summer. They will be mainly matters for administrative guidance and decision. Before final decisions are taken on them there will be formal consultations with representative bodies.

24 The closer to the patient that management of the integrated service can be brought the better the prospects of getting the right care at the right time and in the most effective way. The Area Health Authority is the smallest unit which can effectively carry responsibility for integrated planning, in collaboration with corresponding local authorities; and there will need to be close contact and joint planning between neighbouring authorities, since patients will often cross administrative boundaries for particular forms of care. Many day to day decisions on how care can best be provided and organised will be taken very much closer to individual patients - eg by general practitioners and by clinicians, nurses and administrators working in hospitals and in the community. But at this level there must inevitably be some specialisation of function and, though there are already arrangements to help them fit their services together, more formal and comprehensive management co-ordination must be carried out on a rather larger scale in order to achieve full integration in the deployment and operation of services. In some cases this may need to be done on a full Area basis because of the physical pattern in which one of the components - the hospital service - is already set. But in others the main health needs of the majority of the population are met within two or more localities smaller than the
Area itself. Where appropriate it is proposed that Area Health Authorities shall operate their services on the pattern of these health "districts", which will be served by general practitioners, community health services and a district general hospital or one or more major acute hospitals carrying out nearly equivalent functions; the preliminary work of the management study has already sufficiently demonstrated the potential advantages.

25 Health districts will not be a separate formal level of authority below the Area Health Authority; rather they will be decentralised units of its administration exercising, at officer level, substantial delegated management responsibilities for the operation of the service. They cannot be wholly self-sufficient and will be actively controlled and co-ordinated by the AHA and its chief officers to secure consistency of standards and effective and economical use of resources.

26 The ideas now under examination by the Steering Committee contemplate that Area Health Authorities would manage their services through chief officers acting together as a co-ordinated team. Where day to day administration of services was through two or more health districts there would be delegation to district teams. The nucleus at each level would be a medical officer, a nursing officer, a finance officer and administrator; clinicians would also play a direct part in management, through the inclusion of members of the representative medical committee on the district team. Other heads of services would join team meetings when their services were involved and would have the same access to the Authority on professional matters. Subject to reserving to itself the key decisions on policies, plans and resource allocation and to exercising overall control the Authority would aim at the greatest possible delegation; responsibilities and accountability at all levels would be closely defined.
27 Area Health Authorities will appoint and employ all their own staff. This will include consultants and other senior medical and dental staff for whom the appointment procedures will be on the lines of those now operated in the hospital service. The clinical freedom of individual members of all the healing professions will of course be fully preserved.

Family Practitioner Services

28 General medical and dental practitioners, ophthalmic medical practitioners, opticians and pharmacists will continue to provide their services as independent contractors. Each Area Health Authority will be required by statute to set up a Family Practitioner Committee to enter into and administer contracts with individual practitioners in accordance with nationally determined terms of service and unchanged statutory disciplinary arrangements. The Committee, which will appoint its own chairman, will have 30 members, 11 appointed by the AHA (including at least one member of the AHA itself), 4 by the County Council and 15 by professional committees for the area. Of these professional members 8 will be doctors, 3 dentists, 2 pharmacists, 1 an ophthalmic optician and 1 a dispensing optician.

29 On matters concerning the contracts of practitioners the Committee will deal direct with the Welsh Office. But for the full benefits of integration to be achieved, matters involving other parts of the services must be the responsibility of the Area Health Authority. These will include, for example, arrangements to enable family doctors to have access to hospital diagnostic facilities and to be associated with the provision of hospital services and preventive medicine; general arrangements for nursing and other skilled staff employed by the AHA or by the local authority to work with family doctors; and the planning of health centres and of other changes in the pattern of services. The AHA will of course consult the Family Practitioner Committee and the professional committees fully in these matters before making decisions.
Staff serving the Family Practitioner Committee will be employed by the AHA, appointments of senior staff being made after consultation with the Committee. Some staff may make this work their career; but others will benefit from the opportunities for wider experience and the flexibility will enhance the Committee's prospects of attracting the right people to its service.
PART III CENTRAL ORGANISATION

The Secretary of State and the Welsh Office

31 The Secretary of State, acting through the Welsh Office, will provide AHAs with central policy guidance, determine national priorities, co-ordinate area plans into a coherent overall plan and allocate resources between the different areas. This will include provision for particular AHAs to administer the blood transfusion services and the rarer specialities such as radiotherapy or cardiac and thoracic surgery, which need to be planned on an all-Wales basis. Complements of scarce categories of staff will need to be controlled to ensure that they are suitably deployed. The Secretary of State must also maintain general financial and cost control and satisfy himself that the AHAs, as his agents, are providing acceptable standards of care in accordance with agreed plans and in collaboration with local authorities and that they are managing the service efficiently and humanely.

Participation in Central Decisions

32 Reference has already been made to the importance which the Secretary of State attaches to securing that the health service participates effectively in the central processes of policy making and decision and to ensuring that his central control is so exercised that it does not undermine the authority and responsibility of AHAs. There will be a very close, continuing relationship between AHAs and the Welsh Office with flexible arrangements for regular discussions at chairman and officer level; expert panels will be brought together as necessary for consideration of particular problems. AHAs collectively will be fully associated with formulation of the principles on which resources will be allocated from year to year. Within agreed policies and overall plans AHAs will have wide discretion to take account of local circumstances and needs. Similarly in the development of a central intelligence and management information system to assist AHAs in discharging their management responsibilities effectively and in
evaluating alternative means of meeting needs, it is expected that they will both contribute initiatives to the centre and be positively associated with decisions.

33 It is intended that monitoring by AHAs of their own performance and overall monitoring by the Secretary of State shall progressively be based on the systematic collection and analysis of statistical and other management information to assess performance against agreed plans, themselves systematically conceived and expressed. For this, improved financial information systems are being developed and more effective yardsticks of need and performance will need to be worked out. They will take time to perfect. There will always be a close need for personal contacts and visits by AHAs within their areas and Departmental officers will similarly need to have personal knowledge of problems. Visiting and advice by central auditors and by the Hospital Advisory Service will also continue to play a valuable part. But as more systematic management information is developed such arrangements will increasingly be seen in their true context of supporting the AHA in its own management role.

34 Reorganisation will bring about changes in the role of the Welsh Office which will have implications for its staffing and internal organisation. It must support the Secretary of State in his new accountability for the administration of services transferred from local authorities. It will also be discharging major functions of co-ordination and resource allocation (but not largely executive functions - see paras 39-41) which, for hospital services, are currently delegated to the Welsh Hospital Board. The direct Welsh Office concern with the problems of AHAs and the intimate links which it will maintain with them will require some increase in its staff resources. At the same time it must ensure that its own approach to AHAs fully reflects the integration which reorganisation of the service is designed to achieve. The prospective staffing and structure requirements of the Welsh Office are being examined so that the appropriate changes may be made. In any
necessary augmentation of its staff the Welsh Office will seek to draw to the fullest extent practicable on staff at present serving in the Health Service. These matters and terms of transfer will be discussed with the staff associations and with the Staff Commission (see paragraph 49).

35 The health service in Wales cannot effectively be planned and operated in isolation. Neither patients nor the health professions wish to be confined by administrative boundaries; and Wales can benefit greatly from the additional strength, knowledge and experience which comes from participating in arrangements which cover England and Wales, or Great Britain, as a whole. Broad health policy will therefore continue to be conceived, and pay and conditions of service for staff and practitioners to be settled, on a national basis with Welsh participation; similarly there will be common policies in staff training and joint staff advisory machinery. Financial, statistical and management information and control systems will also be closely compatible and there will be co-ordination of research of all kinds and sharing of its results; supplies will be organised on a national basis where this is advantageous. In all such respects the Welsh Office will continue to operate in close consultation with the Department of Health and Social Security.

Central Professional Advice

36 Just as Area Health Authorities need the expert advice of the professions, so does the Secretary of State. In the formulation of national policies he will, jointly with the Secretary of State for Social Services, have the advice of the Central Health Services Council and its expert Standing Advisory Committees whose constitution will be adjusted to meet the needs of the reorganised service. In the application of national policies to the circumstances of Wales he and his officers will look for professional advice to committees representative of the main health professions in Wales. The arrangements for this will also be worked out with the professions, who are already looking at the
considerations. For example, in the medical profession the all-Wales advisory Committee will need to reflect a balance of the interests of general practice, school health and community work, and hospital specialities including the rarer ones; it must also cover the interest in medical manpower and medical education and research.

Advice from the Welsh Council

37 The Consultative Document suggested that for strategic advice on general health matters in Wales the Secretary of State should look to a new Welsh Health Council reflecting a wide range of health interests in all parts of Wales. This proposal met an indifferent response. Doubts were expressed whether the creation of such a body was justified. The proposal has been reconsidered in the light of these comments and of the development of the proposals for the involvement of the health professions and the Area Health Authorities in central processes. The arrangements will be fully adequate to ensure that the Secretary of State receives informed advice reflecting these viewpoints; there remains the question of ensuring that health policies are considered against a wider background. The Welsh Council has represented that its own concern with general questions of economics, transport, planning and the environment - and particularly its concern with social service matters - places it in a better position to provide such a perspective than a body whose remit was confined to the health service alone.

38 The Government accept the force of these arguments. Subject, therefore, to review in the event of any substantial change in the character and role of the Welsh Council following consideration of the recommendations of the Commission on the Constitution the Secretary of State will continue to seek strategic advice from the Welsh Council which already has a Health and Social Services Panel, rather than from a separately constituted body.
Welsh Health Technical Services Organisation

39 In all the main areas of planning and decision the Government are satisfied of the advantages of very substantial delegation to Area Health Authorities. But for a number of specialised and technical supporting tasks the balance of advantage will still lie in the increased efficiency which can be secured by a degree of centralisation. These will include the design and execution of major capital works; the systematic evaluation of contracting arrangements for supplies, the negotiation of central contracts where the Secretary of State judges them appropriate and the provision of expert advice to the supplies officers whom AHAs will themselves employ; a computer-based central management information service and such other specialist management services as are judged appropriate from time to time.

40 A Welsh Health Technical Services Organisation (WHTSO) will be created to carry out functions of this kind. Its role will be complementary to that of AHAs and the Welsh Office. For example its central computer service will provide comparative statistical material to augment the management information which each AHA itself produces and will also be used by the Welsh Office in support of its central intelligence and monitoring functions. In its technical fields WHTSO will be responsible for guiding AHAs on behalf of the Secretary of State and for providing him with expert assessments of current arrangements. Study of the extent to which WHTSO should be charged with particular functions on its inception is still proceeding. It may be advantageous to bring the work of the Welsh Joint Pricing Committee under the wing of WHTSO with arrangements to safeguard the interests of chemists and doctors; this will be discussed with the bodies concerned. Approval and pricing of dental estimates will continue to be carried out on an England and Wales basis by the Dental Estimates Board.
The function of WHTSO in relation to the design and execution of capital works will be of major importance. The AHAs will develop their plans for capital programmes year by year for the approval of the Secretary of State. But the detailed planning, design and execution of any substantial capital work calls for expert teams of scarce specialists who require a continuity and span of work and experience which cannot be provided on an area by area basis. It is proposed that these skills shall be concentrated in WHTSO. It will be responsible directly to the Secretary of State for major works but responsibility for less complex works of defined types, for which there is adequate central guidance material on design and cost, will as far as possible be delegated to AHAs who will make use of the expert staff of WHTSO as necessary. The precise arrangements are still under study. There will be provision for AHAs to make use of design capacity which local authorities may make available and for continuing use of private consultants consistently with efficient employment of the central team.

The Welsh Health Technical Services Organisation will be headed by a small Board consisting of a chairman and some 5 to 7 members appointed by the Secretary of State. It is envisaged that the Board would be concerned primarily with the management of its own organisation and its internal efficiency and with ensuring that it keeps abreast of the latest technical developments and is able to meet demands. The detailed work on individual projects would fall to its professional officers who should be given the maximum freedom to work in direct relationship with officers of AHAs and the Welsh Office. The staffing structure of the organisation is under study.

Financial Administration

Finance for the reorganised service will come almost entirely from central government; charges to patients for certain services will continue to meet a small part of the overall cost. The relief to local authorities of expenditure on transferred services will be taken into
account in the calculation of grant to them. The Secretary of State will allocate revenue and capital funds to Area Health Authorities, with provision for separate funding of payments to family practitioners. Provisional forward financial ceilings will be notified together with provisional approvals for capital schemes so that AHAs may prepare rolling plans on a realistic basis. Allocations will take account of special responsibilities and of services provided to patients from other areas; generally, they will seek progressively to promote good and comparable standards of care for all the people of the Principality. Finance will be provided directly to the Welsh Health Technical Services Organisation for the capital schemes for whose execution it will be responsible and also for the cost of common services, eg from the central supply unit and the computer unit, provided equally to all AHAs. For particular calls on its services there will be provision for individual AHAs to bear a charge in appropriate cases.

Though the Secretary of State will wish to be satisfied, through the examination of plans and estimates, that the general balance of provision between particular patient and community groups and between therapeutic and preventive services fairly reflects the balance of needs and is consistent with approved strategic policies, the aim will be to leave AHAs as much discretion as possible in the distribution of their resources. As previously indicated (paragraph 33) improved financial systems are being developed to assist in budgeting, financial monitoring and overall management control.
PART IV THE STAFF OF THE SERVICE

The new opportunities

45 The health service works through its staff and to them must go the main credit for its very real achievements over the years since 1948. The administrative changes which this White Paper foreshadows are designed to provide a more effective framework for the release of their skills and energies. There will be new opportunities to take a wider and more coherent view of health care. For example medical administrators, as specialists in community medicine with a vital role in planning and managing the unified service, will be concerned not only with developing preventive and domiciliary health services and with the provision of medical advice and help to local authorities, but also with the overall assessment of health needs and the most effective ways of meeting them, and with promoting functional integration within the service and close planning and working links with related services. For them and for nursing and other administrators the changes will open new horizons. For those in clinical work the removal of administrative barriers will mean greater ease in fitting together complementary services: for example more effective mechanisms will be possible to co-ordinate services for vulnerable groups like the mentally ill, the handicapped and the elderly, whether given at home or in hospital.

Training

46 The new perspectives will call for retraining. A series of special courses for senior staff has already begun and there will be local arrangements for helping other staff to understand the purpose of the forthcoming reorganisation and its meaning in their everyday work. Within the unified service, management training at all levels will complement professional and occupational training as part of the very important function of personnel management. It is proposed, in consultation with the interested bodies, to create a number of linked staff advisory committees to build on and extend to other groups of staff the work which the National Staff Committee has done for administrative and clerical staff and the National Nursing Staff Committee has done for nurses and
midwives. It is also proposed to establish an NHS Training Council to work with them. All these bodies will cover both England and Wales. The Welsh Office, as part of its responsibility for promoting consistent personnel policies throughout Wales, will co-ordinate the training activities of Area Health Authorities and relate the work of the national advisory machinery to the training programme in the Principality.

47 Staff will be encouraged over the years to take advantage of the greater flexibility which will be possible within Area Health Authorities so as to gain varied experience. Arrangements for staff interchange between AHAs, the Welsh Health Technical Service Organisation and the Welsh Office, as part of the career training process and to help to knit closer links between them all, will be studied in consultation with staff interests. Such arrangements will be particularly desirable for the provision of the medical and nursing advice which the WHTSO will require in relation to its building and other functions. Doctors and nurses employed by the particular AHA which will have the responsibility of operating a new hospital or other building will be associated with WHTSO architects and other specialists in the team which designs it. But while their experience as users of the facilities will be important they will not necessarily have the wider comparative experience of design problems and developments which comes from regular involvement in a major building programme and which is also important in producing effective and economical solutions. The central WHTSO organisation will therefore need to include doctors and nurses with this experience and since a career in a primarily technical organisation may not seem attractive to members of these professions it is proposed that the necessary advice shall be provided by officers of Welsh Office and of AHAs, probably on medium-term or part-time secondment.

The NHS Staff Commission for Wales

48 Reorganisation of the service will not affect the clinical responsibilities or working circumstances of doctors, nurses and members of other healing professions who are engaged in the care of patients. Their contract for employment, or for services, will normally pass over
to the new authority for the place where they work. This too will be the only immediate change for most other staff: they will carry on working at the same hospital, ambulance station, health centre etc on the same kind of duties as before. But for some, particularly among those who are engaged on administrative work, there will have to be changes in duties and places of employment. There will be problems of redeployment and of the selection of people for senior posts. An NHS Staff Commission for Wales has already been appointed - in the form of an Advisory Committee pending the passing of the legislation - to advise on procedures to ensure the utmost fairness and to safeguard fully the interests of staff.

**PART V OTHER MATTERS**

**Voluntary help for the Service**

49 There has always been generous voluntary support of the service to supplement its staffing and financial resources. Members of the health authorities are themselves unpaid volunteers and the service owes them a very great debt. But, besides this, many voluntary organisations and good-hearted individuals bring help, friendship, comforts and extra amenities to patients at home and in hospital, making life better for them in more ways than can be mentioned here. The Government sets the greatest possible store by this help and will seek actively to encourage it. Unification of the service and close co-operative working between Area Health Authorities and matching local authorities will make it easier for voluntary organisations to see how they can best develop their services to help families, individuals and groups over the whole range of their needs and membership of Community Health Councils will deepen their understanding of the service as well as influencing the way it works. For their part Area Health Authorities will support the voluntary organisations in their efforts to co-ordinate and increase their activities.

**Gifts and endowments**

50 Voluntary organisations also help by local fund-raising efforts and these too will be encouraged. The new authorities, like the present
hospital authorities, will also have power to accept gifts and bequests, which have been so valuable both in enabling extra amenities to be provided and in supporting research into new forms of care. Endowments now held and administered by hospital authorities will be transferred to the new authorities, with arrangements to safeguard local and special purposes of bequests: for example a bequest to a Hospital Management Committee for general use in its services will be used for the same group of hospitals as before and for health services associated with them and a bequest relating to a particular hospital will be used only for that hospital. An appropriate share of the Hospital Endowments Fund, to which many endowments given in England and Wales before the passing of the National Health Service Act of 1946 were transferred, will be available to Area Health Authorities in Wales for hospital and associated purposes.

Patients Complaints: the Health Service Commissioner

Like existing authorities, Area Health Authorities will be expected to maintain satisfactory arrangements for investigating complaints from individual patients. Arrangements for complaints concerning hospitals will be reviewed in the light of the recommendations of an independent committee currently sitting under the chairmanship of Mr. Michael Davies Q.C. To enable complainants to seek independent help where they remain dissatisfied with the results of investigations by the AHA, the legislation will (as already announced) provide for the appointment of a Health Service Commissioner for Wales. The Commissioner will not be concerned with complaints which relate only to the way clinical judgement has been exercised, nor with complaints against family practitioners where existing Statutory investigation procedures will continue and he would not normally pursue a complaint which could be taken to a tribunal or to the courts. Subject to this, any complaint by a patient of injustice or hardship through maladministration or through failure to provide necessary treatment or care may be taken to the Commissioner if recourse to the AHA does not resolve it. Complainants will have direct access to this "ombudsman", or their case may be taken up by someone else on their behalf.
Preparation for reorganisation

In addition to preparatory training and the preparation of guidance on management organisation and processes in the new health authorities, much preparatory work must be done before April 1974 to ensure a smooth changeover. The new authorities in "shadow" form, together with their prospective chief officers, will be appointed as soon as possible after the necessary legislation has been passed and it will be for them to prepare definitive proposals on the development of their services, on the pattern of organisation each wishes to adopt and on its staffing and accommodation implications. Time will be short and their task will be greatly eased if as much preliminary work as possible is done beforehand by existing authorities working in co-ordination, for example preparation of statements about existing staff and services and developments in progress or currently planned; and about endowments, rights, property and liabilities (including local authority loan debt) which may need to be included in arrangements for transfer to the new authorities. Informal joint liaison committees of existing authorities are being set up in the new areas for these purposes. Their work will be guided and co-ordinated by a similar committee for the whole of Wales in which the Welsh Office and the Welsh Hospital Board will join.

PART VI CONCLUSION

Administrative reorganisation is designed to benefit all who use the National Health Service by enabling it to use those resources more effectively. The Government believe that the changes outlined in this White Paper will secure this objective. Through bringing all personal health services together under Area Health Authorities they will provide the framework in which fully integrated services can be developed in the right balance with each other; no one form of service will dominate another and the Government hope that between now and April 1974 local authorities will continue the present development of the health services for which they are now responsible in the assurance that their importance will increase in the unified service. The matching of AHAs with the new counties and the forging of planning and working links between AHAs and local authorities will help to promote the complementary development of
health and related social services. The direct and close relationship between the Secretary of State and the 8 AHAs will allow the fullest possible delegation of responsibility to them for the planning and operation of their services. and will provide for their effective participation in central decision making; this, matched by clear accountability for their stewardship, will fit them better to serve their communities. Particular supporting functions will be provided by the Welsh Health Technical Services Organisation. The Community Health Councils will ensure that Area Health Authorities are responsive to the local needs and professional advisory machinery will bring them the strength of expert knowledge. The Secretary of State, acting through the Welsh Office and with the advice of professional and expert committees and of the Welsh Council, will guide and co-ordinate the work of the health authorities, leading them in the search for a better and more efficient service.

In these ways the reformed administrative structure will help the service to respond to the challenges of the coming decades.