The administrative structure of the health and personal social services in Northern Ireland.

GOVERNMENT OF NORTHERN IRELAND

The Administrative Structure of the Health and Personal Social Services in Northern Ireland

BELFAST
HER MAJESTY'S STATIONERY OFFICE
1969
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THE ROYAL SOCIETY
FOR THE PROMOTION
OF HEALTH
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CHAPTER 1

The Background

Introduction

1. This Paper reviews the present administrative structure of the health and personal social services in Northern Ireland and makes tentative proposals for change as a basis for public discussion and consultation with representative bodies. These proposals are not a statement of Government policy but the necessary prelude to such a statement, which will be made only after full account has been taken of the views expressed on them.

Developments in Great Britain

2. Changes in the administrative structure of health and personal social services are now under consideration in Great Britain. Green Papers containing tentative proposals for an integrated administrative structure for health services under specially constituted Area Boards were issued by the then Minister of Health last July and more recently by the Secretary of State for Scotland.[1]

3. Further, the Report of the Seebohm Committee[2] on the organisation of local authority and allied personal social services in England and Wales, presented in July, 1968, recommends the establishment of comprehensive social service departments whose responsibilities would include the personal social services—such as child care, welfare of the elderly and of the physically or mentally handicapped, home help and educational welfare—at present provided by a number of separate local authority departments. The recommendations of the Seebohm Committee are still under consideration by the Government at Westminster. But the not dissimilar recommendations contained in a White Paper[3] published by the Secretary of State for Scotland in 1966 have already been translated into legislation—the Social Work (Scotland) Act, 1968—providing for the establishment of comprehensive social work departments by local authorities in Scotland. Finally, two Royal Commissions are reporting on the future structure and functions of local government in England and Scotland respectively, and the re-organisation of local government in Wales is under separate consideration.

Implications for Northern Ireland

4. It might seem prudent for Northern Ireland to await the outcome of these developments in Great Britain before considering what changes might be made in the present structure of health and personal social services here. But there are two arguments against such a course. Firstly, the Government considers that the case for review of the administrative structure of these services is as strong in Northern Ireland as elsewhere in the United Kingdom. There are

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1 Ministry of Health: Administrative Structure of the Medical and Related Services in England and Wales. H.M.S.O. 1968.
Scottish Home and Health Department: Administrative Re-organisation of the Scottish Health Services. H.M.S.O. Edinburgh 1968.

2 Report of the Committee on Local Authority and Allied Personal Social Services. Cmnd. 3703 H.M.S.O. 1968.

3 Social Work and the Community. Cmnd. 3065 H.M.S.O. Edinburgh 1966.

therefore advantages in promoting early discussion of the subject with a view to settling not only the basic principles but the practical arrangements best suited to the somewhat different circumstances of this country.

5. Secondly, the process of re-shaping local government in Northern Ireland is under separate consideration, and the Government has set 1971 as the target for its completion. Simultaneously with the publication of this Paper, a White Paper[1] is being presented to Parliament containing further proposals for the re-shaping of local government. The White Paper proposes that local government should take the form of a single tier of 17 Area Councils providing the local physical and environmental services. It is now necessary to reach as soon as possible decisions on the future administrative pattern for the major social services, including health and welfare services, at present provided by local authorities. In this respect, the present Paper is an essential corollary to the Government's White Paper on local government.

6. In the following chapters the structure of the health and personal social services is examined, and consideration given in particular to whether the unified administration of all or part of them would be a desirable and practicable means of furthering their development. The much smaller compass of Northern Ireland and the urgency of the timetable for local government reform have prompted fuller treatment of the detailed issues than the Green Papers issued in Great Britain could provide. Account has also been taken of criticisms levelled at the Minister of Health's Paper in particular. These have related less to the principle of an integrated administrative structure, which seems widely accepted, than to the specific proposals to this end (a single tier of 40 to 50 Area Boards with an average population of about one million has been widely criticised as creating bodies too large for management but too small for overall planning) and to the implied separation of health from personal social services. The Secretary of State for Social Services has announced that the proposals will be reviewed and that the possibility of establishing a two-tier system will be explored.

7. The remaining major social service—education— is not dealt with in this Paper. The administration of the service is at present based on the county and county borough councils and the re-shaping of local government is likely to mean that the structure will have to be changed. There would clearly be administrative and other advantages if a similar pattern could be adopted both for the health and personal social services and for the education service. There may, however, be compelling reasons for different structures. The Government still has to consider the future structure of the education and public library services. It will be advantageous for this review to be undertaken in the light of the public discussions and consultations relating to the tentative proposals for the structure of the health and personal social services set out in this Paper.

[1]The Re-shaping of Local Government: Further Proposals. H.M.S.O. Belfast 1969.

CHAPTER 2

Review of the Structure of Health Services

The present structure

8. The Ministry of Health and Social Services is responsible for the promotion in Northern Ireland of a comprehensive health service, and for providing or securing the effective provision of services in accordance with the provisions of the Health Services Acts. The structure of these services in Northern Ireland, as in Great Britain, is broadly described as tripartite. **Hospital services** are administered on behalf of the Ministry by the Hospitals Authority, and day-to-day management is in the hands of 29 Hospital Management Committees, some of which have Hospital Committees for individual hospitals. **General health services** are the responsibility of a single General Health Services Board, with which individual practitioners—doctors, dentists, chemists and opticians—have contracts for the provision of services. **Personal health services** are provided by 6 County and 2 County Borough Councils as health authorities, acting largely through Health Committees.

9. Certain allied local authority functions and services should also be mentioned. Health authorities in Northern Ireland provide the **school health service** under the Education Acts, which in England and Wales is a function of education departments. Health authorities have also under various enactments **public health** functions, the chief of which are the control of communicable diseases, the control of food hygiene and composition, and in appropriate cases port health. In addition, county borough, borough, urban district and rural district councils have as sanitary authorities a wide range of environmental health functions which include the abatement of sanitary nuisances, the control of unfit housing, refuse collection, sewage disposal, and the control of air pollution.

10. Considerable sums of money are expended annually on health services £52 million is to be spent on them during the financial year 1969-70 (£34.6 million on the provision of hospital services, £14 million on general health services, and £3.4 million on local health authority services). These figures include capital expenditure of £4.5 million, very largely for hospital building. The health services are also large-scale employers. The present numbers engaged or employed are approximately* as follows:

Hospital and specialist services .	20,750
Local health services . . .	1,750
General health services . . .	2,250
	24,750

These estimates give an indication of the scale of operation involved, and emphasise the importance of ensuring that the administrative structure is

*The figures include some slight duplication—for example, some general practitioners under contract to the Board also undertake work in hospitals—but the order of magnitude may be taken as correct.

designed to make the best possible use of available resources of finance and manpower.

The case against radical change

11. The administrative structure of the services in Northern Ireland is certainly much less complex than that in Great Britain, in the sense that fewer bodies are involved. In the hospital service proposals to reduce the number of Management Committees, with the object of aligning the clinical and administrative patterns of organisation, are under discussion. Teaching hospitals are within the main hospital framework in Northern Ireland, whereas in England and Wales—though not in Scotland—they are at present separately administered by Boards of Governors. Northern Ireland has also been fortunate in having a single Board for the general health services, which in England and Wales are administered by 134 Executive Councils. There are only 8 local health authorities. If the number of hospital management groups were materially reduced, the existing structure might be considered to have been rationalised as effectively as possible, given the 'tripartite' basis of operation.

12. Most observers will agree that the services have also considerable achievements to their credit. Since 1948, the Hospitals Authority has effected major improvements in the quantity, quality and availability of hospital services, as the opening paragraphs of the Hospital Plan[1] indicate. Local authorities have expanded the scope and variety of their services, and have in particular built up a body of trained staff in the nursing, health visiting and public health fields.

13. Moreover, there is evidence of increasing co-operation between the separate parts of the service. This is perhaps most evident in the community services, where general practitioners have been making increasing use of local authority facilities, and the attachment of local authority nursing staff to general practices is considered to be yielding real benefits. There has been a recent upsurge of interest in the development of health centres, where such collaboration can be fostered to the fullest extent. Hospital authorities too have been paying more attention to the importance of links with the community services, and examples can be cited of a variety of **ad hoc** arrangements.

14. It can be argued, therefore, that if the growing links between the branches of the services could be strengthened and perhaps formalised, and if a more direct lead on arrangements for co-ordination was given by the Ministry and accepted by the authorities concerned, the existing structure would continue to serve the needs of the public without radical alteration.

The case for an integrated structure

15. The Health Service owes its tripartite structure as much to the historical and political forces attendant at its birth in 1948 as to objective decisions on the merits of this structure in preference to any other. The alternative of a unified administrative structure, in which one authority would be responsible for the provision of comprehensive health services in any given area, has been mooted many times.

16. The basic argument for the integrated organisation of services is that the individual's need for them is not 'tripartite', but should be regarded as a

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[1] Hospital Plan for Northern Ireland. Cmd. 497 H.M.S.O. Belfast 1966.

continuum. During the course of an illness, the patient may need the help of doctors, nurses and a variety of para-medical staff from different services at different stages of his treatment. The administrative structure should be designed to enable him to get appropriate care at each point of time. Merely by reason of the existence in a given area of three different authorities responsible for the provision of services, it cannot be said to be so designed at present. Co-operation is achieved despite administrative barriers, not as a direct result of the structure itself. While the recent developments described above in co-operation are welcome, they are by no means universal or complete.

17. In addition to this need for co-operation in the treatment of the individual case, there is an increasing need for co-ordinated planning of future developments, arising from the inter-dependence of the main branches of the service. For example, hospitals, family doctors and local health authorities are all involved in the care of the elderly, who form an increasing proportion of the population. All are also involved in the treatment and support of mental illness; all are involved in the provision of maternity services. The partial success of liaison committees in some of these fields mitigates the difficulties but does not fully meet the argument for a single authority responsible both for the planning and for the operation of a comprehensive service.

18. Thus, as well as creating problems in day-to-day co-ordination, the present structure does not in itself promote the use of total available resources to the best advantage. Yet rising costs and financial stringency require the most effective possible allocation of limited capital and revenue funds. It is equally important that the skilled human resources in the service, which in some sectors are very scarce, should be efficiently deployed. The disparate responsibilities of the three authorities administering services in a given area make these elementary precepts difficult to implement.

19. Advances in medical knowledge or techniques and the emergence of new needs—such as the development of screening for diseases, and the survival of children with multiple handicaps—also point to the value of overall direction of the services. Resources should be capable of being quickly and effectively redeployed to meet changing circumstances. While co-operation between the services enables this to be done at present with some effort and with varying degrees of success, a single body with responsibility for comprehensive care should be capable of a more rapid and more effective response. It would also facilitate the collection of epidemiological data and the assembly of linked medical records for purposes of research and clinical care.

20. Two other criticisms of the present structure might be mentioned. Since the local authority services are partly financed from local rates, the size of the authority concerned and its rateable valuation are important determinants of the financial resources available for health services. This has undoubtedly contributed to their uneven development, and to a less than satisfactory level of expenditure on community care in some areas. Under an integrated structure financed on a uniform basis not only might community care benefit through the re-allocation of resources, with consequential savings in more expensive hospital care, but it should be possible to reduce disparities in the standard of total care in different parts of the country.

21. The other criticism relates to the hospital service, in which since the passing of the Health Services (Amendment) Act, 1967 the Ministry and the Hospitals Authority both have policy-making functions which cannot easily be

separately defined. Relationships between the Authority and Management Committees in turn, while in theory defined, divorce the planning of services from their management and operation, and have sometimes resulted in dispersal or duplication of effort and difficulties of communication. It is arguable that only two tiers of responsibility instead of the present three—Ministry, Authority and Committees—are needed.

22. The case for an integrated structure might be summed up as follows:-

(a) the present structure is tripartite while the individual's needs for services should be seen as a continuum;

(b) the separate branches of the health services are increasingly interdependent in treatment and care, and the administrative structure should be designed to secure fully co-ordinated planning as well as joint action;

(c) a single authority for each area could more easily secure the most effective use of the financial and human resources available;

(d) advances in knowledge and the emergence of new needs make it desirable that resources can be quickly and effectively deployed to meet new situations;

(e) the different financial basis of the local authority services has presented obstacles to the balanced development of community care;

(f) the three-tier management structure in the hospital service leads to duplication of effort and difficulties in communication.

Towards a new structure

23. Some of the problems outlined above could perhaps be resolved by modification of the existing structure. If, for example, there was thought no longer to be a place for health services in local government, a new Community Services Board could be established, which might also take over the functions of the General Health Services Board, thus integrating services outside hospital. The reduction in the number of hospital groups and clearer guidelines on the respective responsibilities of the Ministry, the Authority and the new Management Committees would make for a more rational administration of hospital services. More liaison committees could be established and more positive arrangements made for collaboration.

24. While solutions of this kind might mitigate present deficiencies in the structure, they would not meet the more radical criticisms. It is suggested that nothing short of a fully integrated administrative system can provide an adequate framework for comprehensive care today and for an effective response to the problems and challenges of tomorrow. This Paper therefore suggests for discussion that health services in Northern Ireland should be administered by **area authorities,** which would replace the Hospitals Authority, Hospital Management Committees and the General Health Services Board, and take over many of the functions of local health authorities.

25. It does not seem practicable to set these area authorities within the framework of local government. County Councils, if they are to remain in being, could not bear any reasonable share of the cost of the hospital and general practitioner services (in 1969/70 about £49 million), and would not as they stand provide adequate areas for their administration. Still less could the re-shaping of local government on the proposed basis of 17 Area Councils provide a suitable administrative structure for health services. Financial considerations apart, the possibility of the new Councils forming a number of joint authorities to run these

services is open for discussion, but seems to contain a number of inherent weaknesses. In particular, such authorities would have no clear identity, and decisions on priorities and other important matters of policy might tend to be made on the basis of conciliating interests in the areas represented rather than on their objective merits. While it might be appropriate for the management of services such as water supply, a system of conjoint boards does not commend itself for the administration of complex and dynamic services like health.

26. Accordingly, there seems no real possibility of making the proposed authorities part of the present or future pattern of local government in Northern Ireland. The new authorities, referred to hereafter as Area Boards, would thus be responsible directly to the Government for the provision of services, but local authorities should have a voice in their administration through representation on the proposed Boards.

27. At this point, it may be asked whether for a population of some 1½ million a **single Board** could not be established for Northern Ireland. This would seem to carry the virtues of simplicity, of ensuring consistency and of providing a base for services which would continue to need to be given on a Provincial basis. There are, however, substantial drawbacks to such a proposal. More especially, a single Board would deprive local interests of an adequate part in determining the provision of these services in their area, and could lose touch with local needs. If an answer to this was sought in establishing a lower tier of administration—in effect Area Committees working to a Northern Ireland Board—a three-tier system would be re-introduced which could scarcely be argued to be necessary in Northern Ireland. Again, a single Board for Northern Ireland responsible for both planning and day-to-day management would be administering a much larger area than seems to be envisaged in Scotland, or indeed in England since, even in the terms of the Minister of Health's Green Paper, the geographical and demographic pattern of an area like Northern Ireland would almost certainly call for more than one Board.

28. While, therefore, a single Board remains a possibility, it has been assumed for the purpose of this Paper that a number of Boards would be needed and that these should form a single-tier system under the Ministry of Health and Social Services, which would discharge both the national functions of the central Health Departments in Great Britain and many of the regional functions which might be allocated to regional planning bodies under the revised proposals now being examined in England and Wales. In an area of the size of Northern Ireland this structure would have the advantages of administrative simplicity, of avoiding duplication and of retaining local interest in the provision of highly personal services. The responsibilities of Area Boards in relation to existing health services are examined in Chapter 3.

CHAPTER 3

Health Services under an Integrated Structure

29. Under the structure suggested, Area Boards would be responsible as agents of the Government for the planning and provision of a single co-ordinated health service for their areas. This would involve their taking over (subject to the exceptions mentioned below) the existing responsibilities of the Hospitals Authority, Hospital Management Committees, the General Health Services Board and local health authorities. It is not, however, intended—nor is it implicit in this system—that patients should be confined to any one particular area for diagnosis and treatment. They would be free to cross area boundaries at need—where, for example, they required treatment under one or other of the regional specialties which will serve Northern Ireland as a whole.

HOSPITAL SERVICES

30. Boards would thus be responsible for the provision and management of hospital and specialist services and would take over completely the present responsibilities of Hospital Management Committees. Some of these services—in particular the regional specialties developing in the major teaching hospitals in Belfast—would certainly need to continue to serve Northern Ireland as a whole. While, therefore, Boards would in general be serving the needs of particular geographical areas, in some respects they would be providing services on a Provincial basis.

Staffing and Remuneration

31. If Area Boards are to exercise a proper measure of responsibility for management, they should appoint and employ staff under the general oversight of the Ministry and with the active support of a Staffs Council and Committees which would operate a system of independent assessors for senior appointments in addition to having responsibilities for management training and administrative staff development. Special arrangements would be needed between appropriate Area Boards and Universities for the continuation of the joint appointment system for medical and dental teaching staff. Further, it would be desirable to maintain, with necessary modifications, the present central advisory machinery on the appointment of consultants, under which representative Appointments Panels (including independent professional assessors) short-list, interview and recommend suitable candidates to the Authority. Such panels would in future advise Area Boards. Central advisory machinery would also be needed on present lines for the appointment of Senior Registrars and other appropriate training grades; and continuing arrangements would be needed for medical staff grading appeals and for appeals machinery in general.

32. The Ministry would assume the Hospitals Authority's present functions of determining remuneration and conditions of service. This would continue largely to be a matter of local implementation of national Whitley agreements, but it could be considered whether local machinery involving the Ministry, Area Boards as employers and staff associations should be established to deal with the

local application of Whitley agreements or with matters which fall outside the ambit of such agreements.

Education and Training

33. It is suggested that the Ministry should assume overall responsibility for securing the provision of appropriate training facilities. This would include standing arrangements for consultation with Area Boards and the Queen's University on the provision of undergraduate teaching facilities and post-graduate facilities for medical and dental education; collaboration with the proposed new Nursing and Midwives Council; general oversight of the adequacy of training facilities in ancillary fields; and collaboration with the Staffs Council on the development of management training. Area Boards would provide training facilities in many fields, and would be represented on the bodies mentioned above.

Central Services

34. Certain clinical services provided centrally, such as the Blood Transfusion and Mass Radiography Services, would need a clinical base for their operations, and could be administered by one Area Board on behalf of all. Arrangements for the discharge under the new structure of other existing functions of the Hospitals Authority—the execution of the capital works programme, central supply services, the disbursement of research funds and advisory services—are considered in Chapter 5 in relation to the services as a whole.

GENERAL HEALTH SERVICES

35. In Northern Ireland, general health services have been administered since 1948 by a single Board to which general medical and dental practitioners, chemists and opticians are under contract. Centralisation on these lines has brought real benefits, particularly in relation to the Board's machinery for the handling of central payments and the maintenance of a central register of Health Service patients. In considering a new structure, care must be taken that these advantages are not dissipated.

Medical Services

36. If the integration of services is to be effective, it seems essential that general medical practitioners, like hospital medical staff, should enter into contracts with the proposed Area Boards. Such an arrangement would not of itself involve any change for general practitioners in their terms of service, which would continue to be determined by the Ministry in consultation with the profession, or in their independent status; but it would give them greater scope for participation in the development of the health services in general, as they would be under contract with the authority providing hospital services and (as suggested below) community health services. In pursuance of this aim, it would also seem appropriate to give Area Boards power to provide health centres (at present a function of the Ministry) where the doctors in contract with them could practise medicine in collaboration with other members of the community team and with hospital services as needed.

37. It would, however, be necessary to maintain central machinery, on the lines at present operated by the General Health Services Board, for the filling of practice vacancies. This machinery might take the form of a Medical Practices

Committee similar to the two central Committees in England and Scotland, a majority of whose membership consists of medical practitioners. Such a Committee would maintain oversight of the adequacy of the total number of doctors engaged in general practice in the light of present and estimated future needs and, in considering practice vacancies or the formation of new practices, it would have regard to the distribution of doctors over the country at large in accordance with its assessment of these needs.

Dental, Pharmaceutical and Supplementary Eye Services

38. Area Boards would also enter into contracts with dental practitioners, chemists and opticians for the provision of services on the basis of standard terms and conditions determined, as hitherto, by the Ministry in consultation with the appropriate professional organisations. The value of the association of these services with other health services will be readily apparent. There would, for example, be opportunities for linking general dental practice more closely with the existing local authority dental service and with hospital dental facilities. Chemists and opticians could benefit from closer association with the body responsible for providing health centres, and perhaps also from closer links with hospitals.

Executive Machinery

39. The General Health Services Board is making increasing use of the Government Computer which at present calculates payments to chemists and produces statistics on prescribing which will be increasingly useful for research purposes; the Computer also deals with payments to dentists and produces some associated statistics; and it is planned shortly to handle payments for Supplementary Eye Services in the same way. Further, consideration is being given to the feasibility of storing the central register of patients on the Government Computer with facilities for immediate access. If this can be done, the way will be open for the full computerisation of the General Health Services Board's executive machinery, including the payment of general medical practitioners.

40. These developments clearly point towards the continued centralisation of this machinery under any new structure. It would be for consideration whether Area Boards might establish a common Executive Board for this purpose, working in close collaboration with the Government's Computer Services Branch, or whether such machinery should be administered centrally by the Ministry, provided that the Ministry's appellate functions in relation to decisions on claims for payment were safeguarded. The alternative possibilities are explored more fully in Chapter 5. In either case, arrangements would need to be made for regular up-dating of information on the size and age-composition of each doctor's total list; for routine checks of dental estimates and eye service claims by professional staff; and for retaining equivalents of the existing Dental Estimates, Drug Pricing and Eye Services Committees of the General Health Services Board through which representatives of the professions concerned have a voice in settling claims and in the administration of these services. Under either alternative it would be possible to maintain the central register of patients, which is used to check entitlement for services and has considerable potential for use in research in conjunction with the development of medical records linkage.

Services Committees

41. Under present arrangements, the General Health Services Board appoints Services Committees which consider allegations against practitioners

of breaches of their terms of service, and practitioners have a right of appeal to the Ministry against decisions of the Board following Services Committee investigations. Under the new structure, it would be unnecessary and undesirable for each Area Board to establish its own Services Committee; together they could establish a central Services Committee under a legally qualified chairman which would ensure both impartiality and consistency of procedure and decisions.

LOCAL AUTHORITY HEALTH SERVICES

Personal Health Services

42. The success of an integrated pattern of care would depend to a considerable extent upon the unified direction of hospital and community health services. Accordingly, the new Area Boards should assume responsibility for the personal health services at present provided by local authorities. These broadly comprise home nursing, health visiting and other services for the prevention of illness, care and after-care; maternity services including domiciliary midwifery; mother and child health clinics; vaccination and immunisation; health education and family planning services.

43. This would, for example, enable the child health service to develop in closer association with hospital paediatric services; it would facilitate the development of an integrated maternity service, giving hospital and local authority midwives a common employer; and it would lay the foundation for the closer involvement of general practitioners with local authority staff in community health programmes. These developments would be of material benefit both to those receiving and to those providing services.

44. If these suggestions were adopted, the staff concerned in the personal health services would transfer to the employment of the proposed Area Boards, and their appointment, remuneration and conditions of service could be governed by arrangements similar to those suggested above (paragraphs 31-32) for the hospital service. (The special position of Medical Officers of Health, who are concerned also with public health, is considered further below.)

School Health Service

45. In Northern Ireland, the school health service is provided by local health authorities acting under powers conferred upon them by the Education Acts. It would seem appropriate that this service should continue to be provided under health auspices, and should therefore be administered by the proposed Area Boards. As with personal health services, the staff concerned, many of whom have functions in both fields, would transfer and would have increased opportunities for collaboration with hospital departments and general practitioners. The possibility of developing a fully unified child health service would emerge. Close liaison would still of course be needed with education authorities.

Public Health

46. The functions of local authorities at county and district level in public and environmental health were outlined in paragraph 9. Broadly, it is suggested that those functions primarily concerned with health and requiring medical control should become the responsibility of the proposed Area Boards, while those primarily environmental in character should remain with local government, becoming in due course the responsibility of the new Councils. Close links would

need to be forged, and in some instances given statutory force, between the medical staff of the Area Boards and the public health staff in local government.

47. Specifically, it would seem essential that Area Boards should be responsible through their medical staff and the Public Health Laboratory Service for the prevention and control of communicable disease, for the medical screening of immigrants and for certain aspects of port health. In discharging these functions, Boards might need to use the services of public health inspectors employed by local government Councils, either routinely or in the event of an outbreak of disease, and arrangements could be made for them to pay for the services so rendered.

48. Environmental services such as clean air, refuse collection, sewage disposal and the control of unfit housing would on the other hand be more appropriate functions for the new local government Councils. In their concern with these functions, public health inspectors should have access to medical advice from the staff of the proposed Area Boards. If it was thought necessary, Area Boards could be put under a duty to provide such advice, and local government Councils to seek it in specified circumstances.

49. It is for consideration where responsibility should lie for control of the safety, hygiene and composition of food under the Food and Drugs Acts. Detailed standards in these matters are laid down by the Ministry, and the routine inspection and sampling of foodstuffs is in the hands of the public health inspectorate. It is arguable that because food safety basically affects health, these matters should be the ultimate responsibility of the Area Boards, which could devolve the work of inspection and sampling to the local government staff. It might in practice be more realistic to give the new local government Councils primary responsibility for the administration of the Food and Drugs Acts, with a duty in specified circumstances to refer matters to and take the advice of the public health medical staff of Area Boards. It may be, too, that the Ministry of Agriculture should have similar responsibilities in food processing premises licensed by them, with a similar duty in relation to the Area Boards.

50. Under the framework suggested, public health inspectors of the future would serve local government Councils in the discharge of their environmental health functions, and the more advanced training in prospect for the profession would strengthen them for this enhanced role. The present local authority Medical Officers would become officers of the proposed Area Boards, thus joining the mainstream of medicine and gaining increased opportunities to use their training and experience in community health. Some might specialise in child health, working in close association with family doctors and paediatricians. Others might specialise in different aspects of the personal health services (such as mental health). Each Board would need an expert in epidemiology and environmental health, including the increasing problems of toxicology and radiation in food and the environment; and public health Medical Officers would be well suited for such posts with appropriate specialist training.

Occupational Health Services

51. The relationship of the Area Boards with occupational health services will require consideration. In their concern with the health of the community, and in view of their component of public health Medical Officers, Boards might well provide a natural focus for the further development of such services in their area.

CHAPTER 4

A Future Structure for the Personal Social Services

The present situation

52. Personal social services are provided under the Welfare Services Acts, the Children and Young Persons Act and the Adoption Act by County and County Borough Councils as statutory welfare authorities, acting largely through Welfare Committees. These services include domiciliary and residential care of the elderly and the handicapped, child care and home help. They are still developing in scale and scope, and in recent years especially their annual rate of growth has been impressive, producing an estimated gross expenditure of £3.7 million for 1969/70. There has also been a significant growth in the numbers of trained social work staff in welfare departments. These advances, which have put Northern Ireland ahead of the general position in Great Britain in relation to proportions of trained staff, must be preserved and strengthened under any new administrative structure.

Implications of developments in Great Britain

53. The trend of events in Great Britain, as outlined in Chapter 1 (paragraph 3), seems likely to be towards the establishment of comprehensive social service or social work departments. Indeed, this is now the statutory pattern in Scotland under the Social Work (Scotland) Act, 1968. This process has implications in Northern Ireland chiefly for local authority welfare departments and for parts of the Special Care Service (which in Northern Ireland is administered by the Hospitals Authority and is responsible for the care inside and outside hospital of the mentally sub-normal), as well as for education and housing departments.

54. Welfare departments are already more 'integrated' in Northern Ireland than is the case in Great Britain since, in addition to the services mentioned in paragraph 52, they are developing community mental health services and accommodation which at present are normally provided in Great Britain by health authorities. Acceptance of the Scottish pattern and of the Seebohm Report[1] would involve their assuming responsibility for social work in schools (absorbing in the process the education welfare service) and for child guidance; for the social care of the mentally sub-normal, including the provision of hostels; and for providing social work services to housing departments. (On the Scottish analogy, the concentration of social work services in this way would also include the probation and after-care services.) On the other hand, education authorities would take over from the Special Care Service responsibility for junior training centres (to be re-named special schools) for mentally sub-normal children.

55. The Government is currently examining the implications of these interrelated developments, and it would be premature to express views in this Paper upon the ultimate scope of the responsibility to be carried by welfare depart-

[1] Report of the Committee on Local Authority and Allied Personal Social Services. Cmnd. 3703 H.M.S.O. 1968.

ments. The Government is, however, satisfied that the unified administration by single departments of general welfare, child care and home help services has been of real benefit and should be retained under any new administrative structure. It can therefore be assumed for purposes of discussion that the social service departments of the future will have at least as wide a range of responsibilities as existing welfare departments, and considerable potential for development. Indeed, the trend is not only towards the grouping of separate personal social services within a single social work department, but towards the evolution of a comprehensive social welfare service, with preventive as well as remedial functions, which would seek to identify needs wherever they may arise and to take or promote appropriate action to meet them. While this will be a gradual process, the administrative structure of personal social services must clearly be such as to facilitate this broader, emergent approach, not merely adequate for the present day.

The re-shaping of local government

56. In Scotland, comprehensive social work departments are to be established within a revised local government structure, and this may also be the framework in England and Wales. The Minister of Health's Green Paper recognises that any conclusions reached on the structure required for medical services will have to take into account the social work services, but leaves the solution of this problem for further consideration in the light of the recommendations of the Seebohm Committee and of the Royal Commission on Local Government.

57. The situation in Northern Ireland is different in that the future pattern of local government put forward in the Government's White Paper[1] on this subject—a single tier of 17 Area Councils—does not provide a solution for the future organisation of personal social services, which by virtue of their growth in scale and scope increasingly need larger, not smaller, bases of operation. Belfast apart, the proposed local government Area Councils could not provide now or in the future the financial and other resources which such services need; and they would constitute far too restricted units for the development of a trained social work staff with increasingly specialist skills. It would be possible for the Area Councils to form joint authorities to run personal social services, but the arguments outlined in paragraph 25 against this form of administration of health services apply in some degree also to welfare services, which though still much smaller than the totality of health services are similarly dynamic and increasingly call for long-term planning in association with, and on a time-scale appropriate to the health services.

58. If County Councils are to remain in being, the possibility would be open of their extending their welfare departments to administer the full range of personal social services. This would entail the administrative separation of these services from health services with consequent disadvantages in relation to the increasing need for co-operation between them. At this juncture, however, decisions on the future of County Councils have still to be taken in the context of local government re-shaping and in relation to their other functions as, for example, education authorities. For purposes of this Paper, therefore, the possibility of their administering personal social services can only be left open for further examination if County administration is to have an assured future.

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[1] The Re-shaping of Local Government: Further Proposals. H.M.S.O. Belfast 1969.

Meanwhile, it is necessary to consider the situation which will arise if the reshaping of local government necessitates the transfer of personal social services to new authorities. It would seem logical that new authorities established for this purpose should be statutory Boards related to the Boards proposed for the administration of health services. Several possible approaches are open for consideration on this basis.

Separate Boards

59. The first is that separate Boards should be established to administer personal social services for the same areas as those of the proposed Boards for health services. This form of organisation would give explicit recognition to the fact that the fields of interest of the health and personal social services overlap but do not coincide, as social needs often arise independently of, or extend beyond, the need for medical care. It would recognise the growing identity of social work as a professional sphere distinct from medicine, its desire to consolidate this professionalism in an independent setting, and the specific management requirements of the personal social services which are elaborated in paragraphs 66 and 67. The obvious need for close links with health, education and housing authorities could be met at Board level by cross-membership and at field level by the attachment of social workers to health centres and hospitals, to schools and to housing departments.

60. The establishment of independent Boards for personal social services has, however, certain disadvantages when viewed in a wider setting. It would, for one, formally separate the administration of social services from health services just at a time when the need for co-operation and joint planning is becoming increasingly recognised on both sides. It would disrupt the existing unity of the Special Care Service, which in both its institutional and community aspects is administered on an integrated basis. Again, it would add another set of authorities to a situation in which the general need is for a reduction in the number of administrative bodies involved in a relatively small area like Northern Ireland. Moreover, separate authorities would need their own administrative staff and supporting professional and other services, and would be competing for them against larger and better equipped organisations such as the proposed Boards for health services. In organisational terms, it might be argued that completely separate Boards for personal social services may not be large enough to constitute economic and self-sufficient units of administration, even allowing for their continued growth.

Linked Boards

61. A solution to these problems might be sought in establishing in each area two independent Boards—one for health and one for personal social services—with a shared secretariat and supporting services for administration, works and supply. An analogy can be found in the present pattern of the local authority services, where separate Health and Welfare Departments operate under the aegis of the County or County Borough Council, sharing in most cases a secretariat and supporting services. Such a system would seem to secure the professional identity of the two services under separate Boards while avoiding duplication of supporting staff. It would, on the other hand, present organisational problems in that, without a common body acting as the equivalent of the County Council, shared staff would have to be appointed and controlled either through some joint machinery or by one Board acting for both, and in the latter case especially could well experience conflicts of loyalty in trying to meet

the competing demands of the two Boards. A possible variant on this approach would be to set up separate Boards for personal social services which would rely for logistical and other forms of support upon a central services executive as outlined in paragraph 86 following. This solution too is not without its difficulties, though it might solve some of the problems inherent in a wholly autonomous welfare structure.

62. Another difficulty in a system of linked Boards is the extent to which it might leave the important task of co-ordinating the two services to the common administrative staff, who could scarcely be expected to achieve the necessary degree of co-operation between them without support at Board level. If the joint machinery suggested as a possible means of arranging the appointment of shared staff were also to exercise co-ordinating functions in the field of policy, the real power would seem inevitably to come to rest in the joint machinery rather than in the separate Boards. The importance for co-ordination of interlocking Board membership is thus clearly apparent, not only if separate Boards are to be established for health and personal social services but also if the equally important aspects of co-ordination with education, housing and other services are to be adequately covered.

Single Boards

63. Some of the problems of organisation presented by separate Boards would be resolved if in each area a single Board were established to administer both health and personal social services. Under it, two Committees could be established, one for health services and the other for personal social services, with overlapping membership. Within this framework, a separate social work department would be directed by a Chief Officer responsible directly to the Committee concerned with personal social services and to the Board.

64. This third suggestion would also appear to be the most practicable means of tackling the deficiencies in co-operation and joint direction of services earlier adduced as an important objective in the recasting of the administrative structure. Residential care for old people, for example, is an important part of the total spectrum of services for the elderly, ranging from geriatric provision in hospitals to domiciliary care, which are complementary and need to be planned as a whole. In the community care of the elderly and the handicapped, health and social needs can seldom be neatly segregated, and require to be jointly met. Provision of home helps is related to medical as well as social needs. Much remains to be done in community mental health—for example in the provision of hostels and the development of child guidance services—which would receive fresh impetus from the establishment of comprehensive authorities responsible for both health and social care.

65. Consideration has also to be given to the future administrative framework for the social work services at present operating within the health service. Major general hospitals and all psychiatric hospitals have social work departments staffed mainly by trained social workers, and the Special Care Service employs social workers in the community care of the mentally sub-normal. There would be clear advantages in the integration of these with other social work services in a single department under a professional Chief Officer. This could, it is suggested, be achieved more easily, and with less risk of disruption in the service, within the framework of a single Board than by their transfer to an independent Board responsible only for personal social services.

66. In considering the feasibility of establishing single Boards to administer health and personal social services, however, account must also be taken of the differences in the type of direction each requires. While both call for long-term planning and management of resources, and both require the involvement of the community in decision making, the emphasis falls on the latter for personal social services in general and for child care in particular. Deprived children, for example, are in no position to speak for themselves or defend their rights, and therefore require a special degree of protection. Thus, the powers of welfare authorities in relation to children in care include full parental responsibility; there is closer supervision by central government than with other services; and there is judicial intervention in many cases. Along with the continuation of these provisions goes a need for the body responsible for the service to take a direct and continuing interest in the children and families concerned.

67. Moreover, while future development may well lead to more comprehensive social services with stronger emphasis on preventive powers—like those in the new Children and Young Persons Act—other important differences in the nature of management of health and personal social services seem likely to remain. In child care, for example, intervention in individual cases may be unwelcome to the individuals concerned, and where it is necessary the right course of action may involve judgements which contain other than purely professional elements. Again, to a much greater degree than in the health service, the solution of problems in personal social services often lies in the use of services from other sources—education, housing, employment and supplementary benefits. For such reasons, the personal social services need an efficient management which will ensure that the personal nature of the service is maintained; a management involved with the local community and fully responsive to the attitudes of society, which will promote co-operation among all the statutory and voluntary bodies concerned with social welfare in the broadest sense.

Conclusion

68. The alternative systems of administration outlined above for personal social services present difficult choices for which an ideal solution is not easily found. But the balance of argument suggests that the best framework for the continued development of personal social services is to be found in their coming into some form of partnership with health services. If this is to be done through separate Boards with common administrative and technical support, means will need to be found to secure the equitable deployment of common staff and the necessary degree of joint planning and day-to-day management in fields of common concern. If a combined Board for health and personal social services is considered on balance to offer the best all-round solution, an essential condition of this arrangement would be the making of provision within the structure to maintain the independent identity of the personal social services. The appointment of separate Committees and separate Directors is suggested above for this purpose; these and other provisions, such as an earmarked budget for personal social services and the establishment of separate local consultative machinery, are further discussed in Chapter 6 on the operation of Area Boards.

CHAPTER 5

Organisation of Services under a new Structure

69. The preceding Chapters examined the scope of services which might be administered on integrated lines under a new structure of Area Boards, and concluded that the Boards might with advantage be responsible in their areas for the provision of a comprehensive health service and for personal social services. The organisation of services within such a framework is now considered. In this and the following Chapter, the discussion is framed generally in terms of the setting up of combined Boards for health and personal social services, but the same considerations would apply with minor modifications to the situation if separate but linked Boards were established.

How many Area Boards?

70. In considering the number of Boards required, certain basic principles should be kept in mind. The area administered should be large enough and should contain sufficient resources in terms of buildings and staff for the Board to provide a comprehensive range of services (with the exception only of certain specialised provision which requires a Provincial basis) and to make an efficient unit for management purposes. On the other hand, areas should not be so large that Boards would forfeit the benefits of local participation in the administration of these essentially personal services, and so become remote from the needs of the community which they serve. Clearly, the delineation of areas should also be related to main centres of population and their natural catchment areas, so that as far as possible each administrative unit is responsible for providing services for a population with a community of interest. Finally, if separate Boards with common supporting services were to be established for personal social services, it would seem essential that their administrative areas should be the same as those for health services, and that both should be aligned as closely as possible with the areas of other major social services and of the new local government Councils.

71. On these criteria, it is suggested that there should be a maximum of **five** Boards in Northern Ireland, centred on Antrim–Ballymena, Craigavon, Londonderry, North Down and the greater Belfast area. These centres represent the main future concentrations of population, and will each also contain one of the proposed area hospitals so that each Board would be able, as seems essential, to provide comprehensive hospital services for its population. Decisions on the number of Area Boards, however, and on the lines of demarcation between them are by no means simple. The difficulties can be illustrated by further reference to the hospitals service—though this is only one and not necessarily the predominant factor in the situation. If five Boards were established on the principles outlined above, East Belfast (which is served by the Ulster Hospital, Dundonald) would come under the Board for North Down, whereas on other grounds there is much to be said for the unified administration of services in the whole Belfast area. In the planning of community services in particular, it seems desirable that the needs of Belfast should be viewed and provided for on a comprehensive basis. Various solutions might be considered, though none is without some drawback.

East Belfast could, for example, be administered by the Board responsible for the remainder of the greater Belfast area, which would then perhaps leave too small a population to justify a separate Board in North Down. Another possibility would be to link the City Hospital in Belfast with the Ulster Hospital, Dundonald, and the Ards Hospital to provide a nucleus of hospital services for an Area Board embracing not only North Down but a large segment of the greater Belfast area. This would have the disadvantage of dividing Belfast in two for the purpose of community care, and of keeping the two main teaching hospital complexes under separate management; but it would make for a better balance of size and resources among Area Boards. A third possibility would be the unified administration of services by a single Board for the whole Belfast area and North Down. There would then be **four** Boards serving roughly the north, south, east and west of the Province, but one of them would greatly outweigh the other three in terms of population and resources. A better balance would be achieved if there were only **three** Boards in all—the Board for Greater Belfast and North Down; a Northern Board for an area roughly comprising Londonderry, County Londonderry and most of County Antrim; and a Southern Board comprising Counties Fermanagh, Tyrone and Armagh and South Down. But the problem might then be increased of aligning these areas with the new pattern of local government and with other major social services.

72. These various approaches serve only as illustrations of the problems involved in the delineation of areas for the administration of health and personal social services, which will be one of the most important issues on which detailed consultations are required. The provisional conclusions reached above are that between three and five Boards might be established under a new structure. In reaching decisions, the various possibilities will have to be measured against the criteria of efficiency and local involvement mentioned above, and account must be taken of the boundaries of the new local government areas. The areas of administration for health and personal social services and for local government should clearly be as closely aligned as possible in view of the links envisaged between them in the field of public health; the need for co-operation with housing and education authorities; and the participation of elected representatives of the new local government areas in the administration of the health and personal social services.

Area boundaries

73. Consideration would also have to be given to the method of delineating the spheres of responsibility of Area Boards. In the hospital service, for example, the responsibility of Management Committees relates to a group of clinical services, not to precise populations or geographical areas. In community health and personal social services, on the other hand, responsibility relates to specific areas, and it would seem important to retain this system particularly in the field of public health. To draw geographical boundaries for the proposed Area Boards would create minor problems, for example, in the administration of general medical services, since many doctors would have patients resident in the areas of two Boards, and the attachment of nurses and social workers to cover their practices as a whole might give rise to some difficulties. But these problems already exist in part under the present structure and have not proved insuperable.

74. It would thus seem feasible and in some respects desirable to give the proposed Boards responsibility for the provision of services for a given area, and to resolve any demarcation problems which might arise by co-operation

between them. An alternative approach would be to give Boards responsibility for a group of hospital services and for contracting with the family doctors and other practitioners within their hospital catchment areas. Each Board would then provide personal health and social work services for the patients on these doctors' lists, which would make arrangements for the attachment of community staff to general practice simple and effective. Where, as in the field of public health, relationship to local government areas was needed, arrangements could be made to link each Board with a number of local government areas which would look to that Board for public health advice. Similar arrangements could be made with education authorities for the provision of school health and social work services.

The organisation of central services

75. The disposition of services which are at present provided centrally either by the Hospitals Authority or the General Health Services Board requires consideration under these proposals. Three broad possibilities are open for discussion:-

(a) such services could be provided by one Area Board on behalf of all;

(b) a central executive Board could be established, which would provide common services for all Area Boards;

(c) appropriate services could be provided locally by Area Boards and centrally by the Government.

76. It has already been suggested (paragraph 34) that the first solution seems appropriate for those services which need a clinical base for their operation such as the Blood Transfusion and Mass Radiography Services. Central machinery is considered essential for the executive functions of the General Health Services Board (paragraphs 39 and 40), as also for the proposed Staffs Council mentioned in paragraph 31, which might provide a focus for the Appointments Panels on consultant hospital appointments and for the Medical Practices Committee mentioned in paragraphs 31 and 37 respectively. The organisation of works, supplies and various other executive and advisory services has now to be examined.

77. **Works Services.** Responsibility for the execution of capital works in the hospital service is at present undertaken by the Hospitals Authority (with some devolution of minor works to Hospital Management Committees), the Ministry of Health and Social Services exercising a supervisory role. Building schemes for the community services—chiefly old people's homes, health clinics and health centres—are executed by individual Health and Welfare Committees, again under the supervision of the Ministry which controls standards and costs. (The General Health Services Board is also involved in the provision of certain health centres in the Belfast area.) Welfare Committees also build children's homes under the aegis of the Ministry of Home Affairs.

78. Under the proposed structure, Area Boards would need their own maintenance staff, and should be empowered to undertake and execute, under the guidance of the Government, capital works within an approved annual budget which would enable them to accept responsibility for the building of residential homes, clinics and health centres, and for certain hospital schemes also.

79. The execution of major hospital building schemes, on the other hand, clearly calls for a central organisation. In an area of the size of Northern Ireland, it would be inefficient and wasteful to establish separate Architects' Departments in the proposed Boards. They would not have a broad enough base on

which to develop their expertise, and the flow of work would be uneven, especially since the hospital building programme is likely in future to contain fewer but much larger schemes. To attract professional staff of high calibre and to concentrate skill and experience in the increasingly sophisticated sphere of modern hospital building, a central unit would be needed. This could be provided jointly by Area Boards through a central executive, or based within Government. Since the first alternative would still require an architectural staff in Government to supervise the building programme as at present, there could be advantages in developing a single works department at this level. Such a department, staffed by architects, engineers and quantity surveyors, would work in collaboration with Area Board staff in the planning and design of all major schemes, executing some and contracting out others as resources permitted. It would also form a focal point for collecting information on building matters for the health services, which is already abundant and needs to be collated and applied.

80. **Supply Services.** A two-tier system would be needed for purchasing supplies under the proposed new structure. Area Boards would have responsibility for the day-to-day control, through a Supplies Officer and a separate department, of supplies required over the whole range of their activities. This should in itself achieve useful economies through the rationalisation of present arrangements and the development of specialised knowledge in the supply field. It would not, of course, preclude the local purchase of day-to-day requirements, for example for children and old people in residential homes.

81. A central organisation would also be needed, however, to make central contracting and purchasing arrangements in certain major fields, such as are in use and likely to be extended in Great Britain. Responsibility for this service could again lie with a central executive established by Area Boards or with a Supply Division located in Government. In view of the proposed strengthening of Supply Divisions in the central Health Departments in Great Britain, there could be advantages in establishing a parallel organisation at Ministry level in Northern Ireland to handle the development of central contracting in liaison with its counterparts in Great Britain.

82. **Ambulance and other Transport Services.** The ambulance service is at present administered centrally by the Hospitals Authority and is managed by the Authority directly in the Belfast area, and by Management Committees elsewhere. Under the proposed structure there would be advantages in Area Boards running their own transport services, comprising not only ambulances but other forms of transport (for example, for handicapped people), in the interests of prompt and efficient operation. The central supply organisation could make central purchasing and maintenance arrangements if this was found to be desirable.

83. **Legal and other advice.** Dealings in land, which form a major part of the legal work at present falling on the Hospitals Authority, could be handled under the new system directly by the Ministry, in which hospital property is now in any case vested. Area Boards would need legal advice on a variety of other matters, and could engage solicitors part-time for this purpose. Alternatively, in order to ensure consistency of advice and procedure, a central legal department could be established with full-time staff to serve all the Boards, provided that it could give prompt and informal advice as needed, for example, by social work staff in the specialised field of child care and adoption proceedings. In view of the appellate functions of the Ministry of Health and Social Services, such a department could hardly be located within Government, but it might form part

of a central executive Board or be housed within one Area Board while serving all.

84. On other matters such as catering and laundries, advisory staff could appropriately be based centrally, in a common executive Board if one were established, or possibly in Government. Work study could also be an appropriate field for a central unit.

85. **Statistics and Research.** It is already clear that a central unit is needed in Northern Ireland to collate and disseminate statistical information on the health and personal social services, and to direct research into the operation of the services as a basis for planning. Such a unit should operate in close collaboration with University Departments and the Registrar-General in Northern Ireland, with the corresponding units in the central Health Departments and other bodies in Great Britain, and under the new structure with statistics and research units at Area Board level. It could also assume responsibilities, under appropriate direction, in the field of clinical research, with a view to co-ordinating and fostering developments within Northern Ireland. Such a unit, it is considered, should be located within Government since its functions would be closely related to the central planning of the services.

86. **Summary.** Of the arrangements for central services suggested in paragraph 75, therefore, it is proposed that services related to clinical practice should be provided by one Board (probably that serving Belfast) on behalf of all. For many of the others, it might be feasible to establish a joint executive Board consisting of representatives from each Area Board. Such an organisation could administer, for example, the executive machinery for the general health services, the Staffs Council and related functions mentioned in paragraph 76, central supply services and certain advisory services on a common basis. Area Boards could decide what other services could best be provided in this way, and transfer them to the central executive. In so far as such an executive carried substantial sectors of work, however, it might constitute an additional tier of administration which in some respects would come between Area Boards and the Government. It would also be responsible for a heterogeneous collection of activities bearing little relation one to another, and might therefore have problems both of staffing and management. Concurrently, the Government would in some sectors of this work need its own organisation in view of its ultimate responsibility.

87. Perhaps, therefore, the question is not whether a separate executive machine is feasible but whether it is necessary. The foregoing outline of the problem suggests that some at least of these executive functions—more especially Works, Supplies and Statistics and Research—could be discharged more effectively by the Government, with devolution where desirable to Area Boards. It might be held that Government should not engage in executive functions in the health or personal social services, but should maintain a purely supervisory role, dealing with the formulation of broad policy and issuing advice and guidance on the operation and development of services to Area Boards. In principle, such a separation of functions between the Government and Area Boards has much to commend it: in practice, it might be hard to achieve completely in an area the size of Northern Ireland except at the cost of some duplication of work or sacrifice of efficiency.

The role of Government

88. Under the proposed structure, it would continue to be the duty of the Government to promote the establishment of a comprehensive health service, and for that purpose to provide or secure the effective provision of services. If

the personal social services were to be transferred to the new structure, a broadly similar duty would presumably be laid upon the Government, which would also retain its existing powers and responsibilities—for example, under the Children and Young Persons Act—in relation to these services.

89. Even if the Government were itself to undertake, as suggested in paragraph 87, a number of executive functions, its main role would still be the formulation of broad policy in consultation with Area Boards, which would plan and manage services in their areas. The Government would allocate financial resources among the Boards, co-ordinate arrangements between them, and offer advice and guidance on the operation and development of their services. It would formulate the capital works programme through a 'rolling' ten-year plan such as is already in operation for hospital building, drawn up in collaboration with Area Boards. It would as earlier suggested (paragraphs 31-33) have oversight of staffing, terms of service, and the provision of training facilities.

90. Two principles should be established in the formation of a new structure on the lines suggested. Firstly, it would largely frustrate the purpose of the new framework if the Government, beyond laying down broad lines of policy, interfered with the management of services and their direction of development in particular areas. It would therefore be the intention to give Area Boards as much freedom from detailed control in the planning and operation of their services as was consistent with the overall responsibility of Ministers to Parliament.

91. Secondly, and as a corollary, it would be essential to establish the principle of partnership as the basis of the relationship between the Government and Area Boards. It would be unrealistic to suggest that differences of view would not arise, but it should be the aim of all concerned to resolve them harmoniously. The establishment of effective liaison machinery would be necessary, under which the Minister or Ministers concerned, Board members and the administrative and professional officers of the central Department or Departments and Area Boards, as appropriate, would meet regularly to discuss general policy and problems of immediate importance. Through such channels, the Government would involve Area Boards closely in the formulation of central policy, and major decisions would be taken only after consultation with them. Further, the present advisory machinery available to Government—in the form, for instance, of the Standing Medical Advisory Committee—would need to be enlarged not only to provide Government with expert advice, where appropriate, on the discharge of its wide responsibilities but to involve the community at large in the process of decision-making and so counter any tendency towards excessively bureaucratic control.

Finance

92. Under the Social Services Agreement between the British and Northern Ireland Governments, the pattern of finance to be established for the new structure in Northern Ireland would depend to a considerable extent upon the future arrangements made for financing the appropriate services in Great Britain. There would be no financial problem in transferring the hospital and general health services, already financed by the Exchequer, to the proposed Area Boards. Important financial issues would, however, arise in the transfer to Area Boards of services at present administered by local authorities and partly financed from rates. In 1968/69 the gross cost of local authority personal and school health services was about £3.3 million, and of welfare authority services about £3.4 million; the notional charges on ratepayers for these services (after deduction

of receipts, Government grants and the General Exchequer Contribution) will each be just over £1 million. If the Government assumed responsibility for financing some or all of these services, account would have to be taken of the resultant reduction of the rate burden in the financial arrangements between central and local government. Under these circumstances, the assets and liabilities of local authorities in respect of the appropriate services would be transferred to the central Government. While on the analogy of the British Green Papers compensation would not be payable for assets transferred, the Government would, it is suggested, assume responsibility for servicing outstanding loans and would provide direct finance for further capital development.

93. Under a centrally financed system, the sums required would derive from Estimates submitted to and voted by Parliament, and the Votes would be accounted for as at present. The accounts of the proposed Area Boards would be audited by the Government under arrangements similar to those at present operating in relation to the hospital service; and their financial arrangements would be subject to regulations.

94. Transfer of administrative responsibility to the proposed Area Boards would not in itself substantially affect the level of expenditure on the health and personal social services. Administrative costs might be increased initially in the process of transfer, and a temporary increase in central Government expenditure would result from the transfer of responsibility for the financing of capital works suggested in paragraph 92. Once the new arrangements were established, however, the reduction in administrative machinery and the opportunities arising for the more rational deployment of resources under an integrated structure could be expected to result in the more effective use of the money available to finance the services.

CHAPTER 6

Membership and Organisation of Area Boards

Membership

95. In view of the important and exacting task which members of Area Boards would be called upon to undertake as agents of the Government, it would seem essential that appointments should be made by the Minister concerned, after consultation with a wide range of interests. The choice of Chairman and Vice-Chairman should also rest, it is suggested, with the Minister concerned, as in the case of the present statutory boards. If Area Boards are to deal with both health and personal social services, they might be composed of, say, about twenty to twenty-four members, though smaller numbers would be appropriate if separate Boards were set up for these services. One of the main functions of members would be to settle area policy and allocate resources on the advice of their chief officers within the broad framework laid down by the Government, entrusting the management and operation of services in accordance with their policy to their chief officers. While this distinction could not always be precisely preserved, its broad observance should enable Boards to discharge their responsibilities without undue encroachment upon the time or energies of members. Indeed, any larger number than is suggested above would, it is considered, work against cohesiveness, concentration on broad policy, and clarity of decision. Regard would be paid to the need for continuity of administration in the transition to the new system. As in the case of existing statutory bodies, appointments would be for a fixed term on a rotational basis, with provision for reappointment.

96. The composition of Area Boards would require very careful consideration and is one of the subjects on which views would be welcomed. It is important that members should be chosen, as in the present statutory bodies, not in a strictly representative capacity but because of the breadth of knowledge and experience which they as individuals can contribute to the planning and management of the services. Nevertheless, the total membership must be such as truly to reflect the community which the Boards will serve: to represent, in the broadest sense, not only the professional aspects of the services but the needs and views of the community at large—in short, of those who use the services.

97. Accordingly, it is clearly desirable that members of the new local government Councils, as the elected representatives of their area, should participate in the administration of the services. This could be arranged, for example, through the appointment of a proportion of members after consultation with local authorities in the area, which is broadly the present principle of appointment to the statutory bodies, and is appropriate to a centrally financed service for which Ministers would be ultimately responsible to Parliament. It would also be desirable to appoint an adequate number of members with broad professional knowledge of the services, not (again) to represent special interests but because of their experience of the practical problems involved and the personal contribution which they can make to the task of remodelling patterns of care. Indeed, the participation of professional persons in the work of the statutory bodies in the health service is a well-established principle. In relevant instances,

members would also be appointed after consultation with Universities. The overall balance of membership should be such as to ensure a preponderance of laymen over professional persons, as in the present statutory bodies, and the Chairman would be drawn from the lay members.

Internal organisation and staffing

98. If combined Boards were established, separate Committees for the planning and operation of health services and of personal social services would be desirable, for the reasons given in Chapter 4. Such Committees would have some members in common to achieve co-ordination, which would be furthered if the Chairman of the Board were also Chairman of the two Committees. Additional members might be co-opted to each Committee to assist in the specialised tasks which each would face.

99. The first task of the Board and of its chief officers would be to weld the health services together in day-to-day operation and in forward planning, and to do likewise for the personal social services, co-ordinating the two at all appropriate points. The Board would have to ensure from the outset that resources were fairly allocated and that one element of the services did not dominate the new organisation. This problem could obviously arise, for instance, in relation to the hospital service, by far the biggest component of the new structure in terms of finance and staffing. While Boards should be given as much freedom as possible to settle their internal priorities, there might be some advantage, in the early years at least, if the proportion of their total budgets to be devoted to personal social services were earmarked by the Government for that purpose, so as to ensure that each main service received its due. At the outset, the existing elements of each of the two main services would inevitably remain distinct in some degree, but the process of co-ordination and joint planning should bring about a gradual lowering of barriers and create real opportunities for integration and full co-ordination in the interests of the public.

100. Careful thought would need to be given to the internal organisation and staffing of the proposed Boards, and it is worthwhile to outline at this preliminary stage some possible approaches. Since the primary aim of establishing the new structure would be to provide comprehensive care, there would be no point in building back into the new Boards the existing divisions, for example in the health service between hospital, general practitioner and community care. Such divisions might to some extent persist in the operation of particular units, but the headquarters structure should clearly be designed to promote a comprehensive approach.

101. To promote integration there should preferably be a clean break from the present divisions. Any standing committees appointed by the Board should cover all parts of the health services or all parts of the personal social services, as indicated in paragraph 98. The principle of promoting integration should similarly be applied to the constitution of any advisory body or bodies which Boards might wish to establish, so that they would be able to advise as far as possible on a range of services—for example, mental health or maternity services —rather than on the existing separate components of such services.

102. There are broadly two alternative systems of internal organisation which might be adopted by Area Boards. Each would need separate departments under the two main Committees to deal respectively with the planning and organisation of health and social work services, co-operating with each other to work out fully co-ordinated programmes in all fields of common concern. But this

division need not be carried through the whole organisation; indeed, as far as possible the supporting departments should be common to both services. Thus there might be departments dealing with the staffing of all services; with logistics (works and supplies); with finance; and a secretariat. Each of these departments would be staffed by administrative and professional officers accountable to a director, and these directors might form an Executive collectively responsible to the Board for providing advice and management. For example, the Chief Administrative Officer would direct the secretariat and preside over the Executive; the Chief Medical Officer would direct the department dealing with planning and operation of health services; and the Chief Welfare Officer or Director of Social Work would direct the department dealing with the planning and operation of social work services.

103. This sketch of a possible system is not meant to be exhaustive. Other chief professional officers, for example a Chief Nursing Officer and a Chief Dental Officer, would need to be appointed who would attend meetings of the Executive, where appropriate, and put a professional view to the main Committee or to the Board. With the addition of the department dealing with the planning and operation of social work services, it is broadly the system of organisation outlined in the Ministry of Health's Green Paper (paragraph 63 onwards).

104. A possible alternative to this system might be as follows. The Secretary or chief administrator of the Board could head an administrative department with several divisions—a secretariat; a staffing and establishments division; a finance division headed by a Chief Financial Officer; and a supplies and works division. The Chief Medical Officer, or Director of Medical Services, could head a department responsible for the planning and operation of health services within which professional and administrative staff would be responsible for hospital medical administration; community health; staffing, in co-operation with the establishments division; statistics and research; and other matters. Within this department would be other professional staff, including a Chief Dental Officer and a Chief Nursing Officer. If personal social services were to be administered by Area Boards, a parallel department would be established, as suggested above, headed by a Chief Welfare Officer, or Director of Social Work Services, responsible for the planning and operation of welfare services. A formal Executive of departmental heads might not be necessary, but the chief officers would need to meet regularly, and the chief administrator and his department would have key responsibility for the co-ordination of the Board's activities.

105. A distinction in the roles of chief professional officers should be noted. The Chief Medical Officer's role would be primarily advisory in relation to hospital and general practitioner services, but executive in relation to community health. The Chief Welfare Officer would advise his Committee and the Board on social work policy, and would also be the executive head of the social work services. The Chief Nursing Officer would advise on nursing matters and be responsible for the management of the Board's nursing and midwifery services, organised in divisions on the lines recommended by the Salmon Report[1] on hospital staffing structure.

Local administration

106. If three to five Area Boards were established to administer the health and personal social services in Northern Ireland, it would be unnecessary and

[1] Report of the Committee on Senior Nursing Staff Structure. H.M.S.O. 1966.

undesirable to form a lower tier of management in the form of local Committees with executive powers. Area Boards should be in close enough touch with the services to administer them directly. There would however need to be considerable devolution of executive responsibility to local units. It would probably be necessary, for example, to base an administrator and a finance officer on major hospitals, though in an integrated service their field of work would often extend beyond the hospital. They would be responsible to headquarters but would have as much freedom of local action as possible. The community health and welfare services would need to be organised in local units on the lines of the existing Divisional system, but often in association with hospitals. As health centres develop, they might become the basic units for the operation of community health services, enjoying functional and other links with the hospitals in the locality. It would be an important and challenging task for the new Boards and their chief officers to forge such links at all appropriate levels between services which are at present administratively separate.

Community participation

107. There are at present many forms of co-operation between the health and personal social services in Northern Ireland and voluntary organisations. In personal social services in particular, voluntary organisations have made a major contribution by providing accommodation and services under agency arrangements which have been of real benefit to all concerned, and this should be maintained and fostered under any new structure. One means of doing so would be through Community Services Committees representative of statutory and voluntary agencies, which already in some areas have proved a useful means of developing co-operation and encouraging joint action.

108. In addition to co-operating with voluntary organisations, Boards should, as already stressed, maintain contact with and be responsive to public opinion in their areas. The appointment of a proportion of members drawn from local Councils would help to secure this end. But it must be recognised that the number of people who participate in a voluntary capacity in the management of health and personal social services as members of existing boards and committees would be substantially reduced under the proposals outlined in this Paper. While the proposals are justified in the interests of efficient management, the fund of goodwill and practical experience built up over the years by these public-spirited people drawn from all walks of life need not be dissipated.

109. Consideration must therefore be given to ways in which the community at large can continue to contribute. One possible solution might be the formation of local consultative committees which could advise the Board and the Board's officers employed in the district on the operation of services, drawing attention to shortcomings and acting as a type of consumers' council. In order to maintain a direct contact with the Board, one or more members of the Board might be associated with each such committee, and it would be for consideration whether separate or combined committees of this kind for health and personal social services were needed.

Complaints

110. Effective machinery would also need to be established for the handling of individual complaints. A detailed procedure already exists for investigating breaches of terms of service (for example, where a doctor fails to visit a patient when he ought reasonably to have done so) on the part of self-employed persons

like doctors and dentists who are under contract to the General Health Services Board. This procedure would require only minor modifications to suit the changed circumstances. But the position in the hospitals service is less clearly defined, as also in the present local authority health and welfare services. In devising any new procedure for these services, it would be necessary to distinguish errors or negligence in running the services from policy decisions which, in the last resort, must be challenged or defended in Parliament. Further, any new arrangements should not in any way affect or reduce existing remedies at law (such as for negligence). Lastly, the extent to which any new procedure could cover complaints on matters involving clinical judgement would require careful definition.

111. Subject to these limitations, there is much to be said for establishing machinery for the impartial investigation of complaints. In Great Britain, it has been suggested that the relevant activities of Area Boards might either be brought within the ambit of the Parliamentary Commissioner for Administration or be investigated by a specially appointed Health Commissioner. In Northern Ireland there is a third possible course which must be considered—namely, to make use of the machinery which the Government proposes to establish to deal with complaints against local authorities and other public bodies.

112. In such ways it is intended to provide that in the planning and organisation of services Area Boards should take full account of the needs of particular communities, using humanity no less than efficiency as a criterion of operation, and having available to them a network of consultative bodies as a sounding-board of public opinion; and further, that effective machinery should be established over the whole spectrum of services for impartial investigation of complaints and appropriate action upon them.

CHAPTER 7

The Way Ahead

113. This Paper is intended to set the scene for full discussion of the future structure of the health and personal social services. It has dealt with several aspects in some detail in order to focus attention on the issues involved. The suggestions which it makes have been cast deliberately in a tentative form, and the Government is not committed to their implementation. The views of the bodies at present administering the services and of the main professional and staff organisations concerned will now be welcomed, as will the comments of other organisations and of individuals on these matters. All such comments should be sent to the Ministry of Health and Social Services, which will circulate them as necessary to other Departments concerned.

114. Parliament too will be given an opportunity to debate the issues. The Government will then decide, in the light of these consultations and of progress in the re-shaping of local government, on firm proposals for restructuring the health and personal social services. At that stage, fuller consideration will have to be given to many of the issues posed in this Paper and to others—such as arrangements for the adequate protection of the interests of staff affected by the proposals, and arrangements for the future administration of hospital endowments—which could not be discussed within the limits of the present document. A White Paper would then form the basis of the major legislation needed to bring about the proposed changes.

115. In conclusion, two notes of caution should be sounded. Firstly, it must be recognised that any re-casting of the structure on integrated lines would have wide repercussions on a scale unknown since the early years of the services. The mechanics of the change would not basically affect the work of the professions in the field, but senior administrative staff in particular would have to face a period of major upheaval and re-adjustment. It follows that such a step should not be undertaken lightly.

116. Secondly, integration of the administrative structure would only be effective if all concerned were prepared to make it a success. To this end training in management for administrative and professional staff in the new service would require high priority. The professions involved would also have to be prepared to examine critically their current attitudes and practice in the light of the new situation, since the purpose of administrative integration could be frustrated in the absence of parallel developments in clinical and related spheres.

117. Considerations of this kind should be realistically faced, but the problems which they pose are not insuperable. As they develop in quantity and quality, the health and personal social services of Northern Ireland are becoming increasingly skilled, sophisticated and expensive, and the need to make the fullest use of total resources is increasingly recognised. It is of prime importance, therefore, that the administrative structure of these services, viewed as a whole, should provide the most suitable framework for their overall management and

future planning in the best interests of the community which they exist to serve. It is against this criterion that the suggestions put forward in this Paper need to be judged.

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