amended if necessary to make clear beyond any doubt that they have the power to do so.

The Ambulance Service in Scotland

674. Under section 16 of the Scottish Act of 1947 the duty of providing an ambulance service in Scotland is placed upon the Secretary of State. In the regulations setting out the functions of Regional Hospital Boards the provision of an ambulance service is included among the duties which these Boards perform on behalf of the Secretary of State. In practice however the ambulance service is provided on behalf of the Regional Hospital Boards by arrangement between the Secretary of State and a Joint Committee representing the Scottish Branch of the British Red Cross Society and the St. Andrew's Ambulance Association, the whole service being known as the Scottish Ambulance Service.

675. In table 54 we show for each of the years 1950–51 to 1953–54 (Scotland) the total mileage run; the number of patients carried; the average number of miles per patient; the cost per patient; and the cost per vehicle mile.

TABLE 54

The Ambulance Service in Scotland, 1950-1 to 1953-4*

Financial Year	Mileage Run	Number of patients carried	Number of miles per patient	Cost per patient	Cost per vehicle mile
1950–1	7,788,797	520,700	15·0	15s. 9d.	1s. 4d.
1951–2	8,382,101	690,028	12·1	18s. 5d.	1s. 6d.
1952–3	9,072,483	769,713	11·8	17s. 1d.	1s. 6d.
1953–4	9,628,768	956,935†	10·1	15s. 7d.	1s. 7d.

* Capital expenditure is excluded from the figures of cost. All figures quoted in this table are approximate.

† Some part of this increase is due to a different method of computation introduced at the beginning of 1953.

676. Although in Scotland the ambulance service is provided on behalf of the Regional Hospital Boards these Boards have not, until changes made fairly recently, taken part in the administration of the service. As in England, one of the difficulties of controlling the use of the service is that it has been largely provided by one authority and used by other agencies; the main user being the hospital service whose demands represent about 75 per cent. of ambulance journeys as against 25 per cent. for general practitioners.

677. In order to bridge the gap between the provider and the users, the Department of Health asked Regional Hospital Boards, towards the end of 1954, to form Regional Ambulance Committees composed of representatives of the Regional Boards, the Scottish Ambulance Service, general practitioners in the Region, and the Women's Voluntary Services (who run the hospital car service); and having the following functions:—

(*a*) To keep under review arrangements for the transport to hospital of all patients who are unfit to travel by public transport. The Committee will thus have within their purview the Road Ambulance Service, the Hospital Car Service provided by the Women's Voluntary Services, the Air Ambulance Service and any other forms of transport such as the provision of hired cars in place of ambulances.

(*b*) To bring to the notice of Regional Boards and Local Medical Committees, on the basis of local experience, the need for, and suitable methods of, impressing on all who order ambulance transport the importance of strict criteria in considering whether it is necessary.

(*c*) To assist the Joint Committee to ensure, subject to the need for limiting expenditure to what is necessary for the well-being of patients, that the ambulance arrangements in the Region provide a comprehensive and efficient service. This includes consideration of the distribution of ambulance vehicles and arrangements for co-ordinating journeys.

(*d*) To consider any cases of apparent misuse of the ambulance service and to make appropriate representations to whatever authority (Regional Board, Joint Committee, or Local Medical Committee) is in a position to take corrective or remedial action.

678. An adjustment in the financial arrangements relating to the Scottish Ambulance Service was also made at the same time. Previously finance had been dealt with exclusively between the Department of Health and the Joint Committee, the Regional Hospital Boards having no financial responsibility. The Boards are however now given monthly statements showing the expenditure on the service in their Regions. These statements distinguish (*a*) changes in expenditure that result from changes in operating costs, which will continue to be the concern mainly of the Joint Committee; and (*b*) changes that result from changes in demand for ambulances in the Regions, which will form the basis of much of the work of the Regional Ambulance Committees. It is understood also that Regional Hospital Boards are to be consulted in the preparation of the Estimates for the Ambulance Service. The Department of Health hope that by these means the increase in ambulance use will be arrested and mileage reduced. It is of course too early yet to judge the efficacy of the new arrangements.

PART VI

WHITLEY COUNCIL MACHINERY

Background history

679. The National Health Service inherited from local authorities, National Insurance Committees, and the governing bodies of voluntary hospitals a complex and elaborate structure of staff grades covering some 400,000 people. Only for some of these grades, notably nurses, were nationally recognised rates of pay and conditions of service already in existence. Outside this group, remuneration was determined in a wide variety of ways. Whereas the rates of pay of employees of local authorities had a relatively common standard, those of employees of voluntary hospitals showed very considerable variation. Many salaries in voluntary hospitals, for instance, were personal to the holders of the post rather than to the office itself.

Moreover, the provision of a Health Service for all residents of Great Britain curtailed for many doctors and dentists, and other professional people in related fields, the scope of private practice upon which they had hitherto either wholly or partially depended for their remuneration. Henceforward, as employees or contractors, they were to be increasingly dependent for their livelihood upon remuneration derived from work under the National Health Service.

680. The National Health Service made possible, and indeed necessitated the establishment of uniform terms and conditions of service and uniform rates of remuneration throughout the whole of Great Britain; and the Minister of Health and the Secretary of State for Scotland made it clear during the debates on the respective Bills in Parliament that suitable negotiating machinery would be set up for this purpose.

At the outset of the Service the Ministry of Health and the Department of Health for Scotland held a series of meetings with the interested employing authorities on the one hand and with the representative trade unions and professional associations on the other; and as a result of these preliminary discussions ten Whitley Councils for the Health Services (Great Britain) were set up.(1) They comprise a General Council and nine Functional Councils, which determine conditions of service and rates of pay for nearly all the kinds of staff employed in the Health Service.

How the Whitley Councils work

681. The nine Functional Councils determine the rates of pay of the grades of staff with which they are concerned, and any conditions of service peculiar to those grades. The General Council's function is to determine conditions of service and other matters (apart from remuneration) which are of general application to all staffs, e.g., appeals machinery, travelling expenses, etc. All the Councils operate broadly within the framework of a main constitution drawn up by the General Council, but each Functional Council is autonomous and has its own constitution to govern its activities. The composition of each Functional Council is set out in its constitution and cannot be varied except by the agreement of each Side.

682. The General Council consists of 27 members on the Management Side and 29 members on the Staff Side. The Management Side includes persons drawn from the various hospital authorities (Regional Hospital Boards, Boards of Governors and Hospital Management Committees), the local authority associations of England and Wales and Scotland, the Executive Councils and the Health Departments (including the Welsh Board of Health). The Staff Side consists of representatives of eight of the Functional Councils; the Dental Whitley Council, which at present deals only with local authority dental officers, is not represented.

The titles of the nine Functional Councils are:—

- Administrative and Clerical Staffs.
- Ancillary Staffs.
- Dental (Local Authorities).
- Medical.
- Nurses and Midwives.
- Optical.
- Pharmaceutical.
- Professional and Technical "A".
- Professional and Technical "B".

The titles of the Functional Councils, except for the Ancillary and the Professional and Technical Councils, indicate generally the grades of staffs with which they are concerned. The Ancillary Staffs Council is concerned primarily with domestic staff of all kinds, and with ancillary staff in various departments, e.g., laundries, farms and gardens, and also with certain tradesmen and craftsmen. The Professional and Technical "A" Council covers certain grades commonly known as medical auxiliaries, e.g., almoners, physiotherapists, radiographers, psychiatric social workers and dietitians, as well as certain other grades such as biochemists and physicists. The Professional and Technical "B" Council covers other professional and technical grades, such as architects, engineers, clerks of works, medical laboratory technicians, dental technicians, dark-room technicians and medical photographers.

(1) A Whitley Council is a joint negotiating body comprising two Sides, one representative of employers and the other of those employed.

683. The Management Sides of the Functional Councils consist in the main of representatives of the various hospital authorities, the local authority associations and the Health Departments. Alterations in this pattern occur in a few cases, e.g., where local authorities are not represented or where Executive Councils have representation. The number of seats varies from 16 to 27. The Ministry of Health provides the Management Side secretariat.

684. The Staff Sides of the Functional Councils consist of representatives of organisations catering for the grades of staff concerned. They include both trade unions and professional associations. The number of seats varies from 18 to 41. Each Staff Side provides its own secretariat.

685. Each Council appoints annually a Chairman and a Vice-Chairman. When the Chairman is a member of the Management Side, the Vice-Chairmanship is held by a member of the Staff Side, and vice versa.

Some Councils have set up autonomous committees to deal with particular groups of staff within their purview. The Ancillary Staffs Council, for instance, has a Builders Committtee which deals with the rates of pay, etc., of building operatives. In the case of the Medical Council there are separate committees for hospital doctors and for doctors employed by local authorities, which conclude their own agreements. The constitutions of the individual Councils also provide as a rule for the appointment of Committees for special purposes, with such powers as the Council may decide to confer on them.

686. The General Council meets quarterly and the Functional Councils as a rule more frequently. It is not always essential for a Council to meet to take a decision on incidental matters or matters of minor importance. Such questions as, for example, the application of Council agreements in a particular type of case, are often settled by discussion between the Secretaries of the two Sides.

687. In Whitley Council negotiations, the two Sides meet round a table and endeavour to arrive at decisions on rates of pay and terms and conditions of service. Decisions are reached by agreement of both Sides, there being no voting as between Sides, though there may be voting within Sides. In the case of staff employed by hospital authorities and Executive Councils, any agreement which may be reached is transmitted to the Minister of Health and the Secretary of State for Scotland for Ministerial approval. This is formally given for hospital staffs under the respective Remuneration and Conditions of Service Regulations and for Executive Council staff under the respective Executive Council Regulations. The Ministers have the right to withhold approval although in practice they have never yet done so. When the Ministers have approved an agreement, hospital authorities and Executive Councils are required to put it into operation. Rates of remuneration so fixed are binding on all the employing bodies concerned, which must pay the approved rates—neither more nor less. In the case of local authority staff the Whitley Council agreements are sent direct to the employing local authorities, who in practice observe them.

688. There is no special arbitration Tribunal for the National Health Service; but a dispute between the two Sides of a Council may be referred for arbitration to the Industrial Court or to the Industrial Disputes Tribunal. Recourse to the Industrial Court requires the consent of both Sides while reference to the Industrial Disputes Tribunal may be made unilaterally. In practice, disputes arising on the Ancillary Staffs Council are taken to the Industrial Disputes Tribunal; disputes arising on other Councils have been referred to the Industrial Court for settlement. If the Industrial

Court award in favour of a revision of the existing arrangements the Council concerned gives effect to the award by embodying it in a Whitley Agreement in the usual way. Awards of the Industrial Disputes Tribunal, although binding in themselves, are also embodied in Whitley agreements.

689. The Minister of Health and the Secretary of State for Scotland still have to settle the rates of pay for certain types of staff. These consist in the main of grades not covered by any of the Whitley Councils, e.g., dental staff (the Dental Whitley Council deals only with dental officers employed by local authorities) and hospital chaplains.

The Ministers also have power to vary the standard Whitley rates in individual cases to meet unusual circumstances (e.g. where an officer is carrying out duties over and above those usually expected of his grade) which are not provided for in the Whitley agreement itself.

POINTS RAISED IN EVIDENCE

690. We have heard a great deal of criticism from our witnesses about the Whitley Council machinery with particular reference to:—

(i) the rigidity of Whitley Council scales of remuneration;

(ii) the unbalanced composition of the Management Sides;

(iii) the lack of consultation with hospital managements;

(iv) delays in reaching agreement.

We now go on to consider these criticisms under the four headings listed above.

Rigidity

691. It is clear that many of the people concerned with the management of the hospital service still tend to resent the loss of the power—which many of them enjoyed before the Appointed Day—to fix the salaries and to determine the terms and conditions of service of all the persons whom they employed. There remains considerable irritation, therefore, that employing authorities are not allowed greater discretion to determine rates of pay in the Health Service (e.g., within "salary ranges" agreed centrally); to reward staff for outstanding efficiency; and to make bonus payments to employees for whom there is no available promotion outlet.

692. Whilst appreciating the difficulties which may arise from the application of centrally negotiated agreements to a nation-wide service, we cannot ourselves agree that this problem would be solved by increasing the discretion of hospital authorities to determine the salaries attaching to individual posts or to particular officers. In any national service there must be some form of national machinery for agreeing centrally the salaries and gradings of the staff employed, and the Whitley system, although capable of improvement in detail, seems to be generally appropriate for this purpose. The loss of the local autonomy formerly enjoyed by hospital authorities in this field is an inescapable result of the introduction of a National Health Service.

693. We do not wish to suggest, however, that the Whitley Council agreements themselves need always be rigid and inflexible in their terms. On the contrary, we agree that provision should be made for a certain measure of flexibility to meet local variations whenever the need arises. This is a problem which has been faced and solved by many large-scale undertakings in the country. Some provision has already been made, too, in the National Health Service itself, e.g., by way of inducement payments and mileage allowances for general practitioners, increased salaries for mental nurses, etc.

What we do maintain is that the provision for flexibility should be built into the national agreements themselves and not left to the discretion of individual managing bodies who might be tempted to compete between themselves, through the exercise of this discretion, for the limited manpower available in the country.

The disfavour with which the Whitley system is regarded in some quarters would seem to arise largely from the rigidity of the national agreements; and if the agreements could be made to take more account of local variations than they now do, there would be considerably less criticism from hospital managements. It is not for us to discuss in detail the terms and conditions of service of employees in the Health Service; but we are of opinion that the Management Sides and the Staff Sides of the Whitley Councils might profitably explore the methods which have been used by other large-scale undertakings to introduce flexibility into national agreements, and should consider whether something more might be done in this way to increase the flexibility of Whitley Council agreements. In seeking out ways and means of introducing more flexibility, the Management Sides will need to consult with the people who are directly concerned with hospital management. There will, of course, always remain a proportion of "individual variations" which cannot be incorporated into a national agreement and we presume that, in appropriate cases, these will continue to be dealt with, as now, by variation orders authorised by the Minister under the Remuneration and Conditions of Service Regulations.(1)

The Composition of the Management Sides

694. We have received a number of suggestions for improving the composition of the Management Sides of the Whitley Councils, e.g.:—

(*a*) that the representation of the hospital employing authorities should be increased so as to provide a greater proportion of members on the Management Side with direct experience of hospital management who would be able to appreciate the full implications of the decisions taken by the Whitley Councils. At present, there are four members for the Regional Hospital Boards in England and Wales and Scotland, two for the Boards of Governors of teaching hospitals in England and Wales, and one for the Hospital Management Committees—i.e., on those Whitley Councils where hospital authorities are represented;

(*b*) that the representation of the local authority associations should be reduced. Their representation varies at present from ten members on the General Whitley Council to one on the Pharmaceutical Whitley Council, according to the interests covered by the individual Councils;

(*c*) that the number of seats occupied by officers of the Health Departments (eight on each Whitley Council) should be reduced.

695. We do not propose to examine, or to comment in detail on, the composition of each and every Whitley Council. The membership of these Councils was only agreed after long discussion and bargaining; and we should need to have heard a great deal more evidence on this subject than we have in fact received before making detailed recommendations for a revision of the membership. In general terms, however, it does seem to us that the employing authorities in the hospital service are under-represented on the Whitley Councils, particularly in comparison with the Health Departments; and we

(1) S.I., 1951, No. 1373.

therefore recommend that the representation of Regional Hospital Boards and Hospital Management Committees be substantially increased. This will have the dual effect of bringing greater experience of hospital management to Whitley Council discussions and also of helping the Management Sides to carry the hospital managers along with them in implementing their decisions.

If it is felt that there would be serious objections to increasing appreciably the total membership of the Management Sides, consideration might be given to a reduction in the number of official representatives of the Health Departments. Normally the Ministry will have only one official view to put forward to the Management Side, while the hospital authorities themselves may have a number of differing views; and we imagine that some of the members representing the Departments must already be serving more in the capacity of advisers than spokesmen. We would see no objection to their continuing to do so (i.e., as advisers without an official seat on the Management Side) if it were found desirable to cut down the official representation. The Health Departments' representation would then consist of a smaller number of "official" members with such additional "advisers" as the Departments might consider to be necessary in any instance.

Consultation with Hospital Managements

696. Whilst appreciating that arrangements are already made for consultation between the Management Sides and hospital authorities on many matters relating to the hospital service, we note the absence of any formal machinery in the Whitley system for ensuring that the people directly concerned with the management of the hospital service are consulted by the Management Side when major salary claims (or other important matters relating to terms and conditions of service) are being considered. The increased representation of employing authorities on the Management Side, which we have already suggested, should be of help; but this should not be regarded as a substitute for prior consultation. We recommend, therefore, that the Health Departments should review the present arrangements for consultation with Regional Hospital Boards, and should invite Regional Hospital Boards to review their arrangements with Hospital Management Committees, in order to make certain that the Management Sides of the Whitley Councils are as fully aware as possible of the views of these authorities before decisions are reached on matters which will affect them.

Delays

697. Another major cause of concern about the operation of the Whitley system is undoubtedly the long delays frequently experienced in reaching decisions in the Functional Councils, and in obtaining the Ministry's authority for (or refusal of) variation orders under the Remuneration and Terms and Conditions of Service Regulations. It is no doubt the resulting irritation which has led many employing authorities to press for more discretion locally in applying salary scales to their staff.

Our evidence has suggested that these delays are due in part to defects in the Whitley machinery and partly to the immense burden of work which has fallen on the Whitley Councils since the Appointed Day. It should be remembered that, in the early years of the Health Service, few Management or Staff Side members had any great experience of national wage agreements and negotiations; and yet they had to deal with an enormous problem in sorting out the wide range of differing grades of staff and rates of pay which had been inherited from the pre-National Health Service days. As the burden of work decreases, as further experience is gained, and as the consultative machinery becomes more effective, we are hopeful that the Whitley system

will be able to operate more smoothly and speedily in the future than it has done in the past. If further provision can be made in national agreements for local variations to meet local needs, a considerable amount of work may be saved and frustration avoided—and this in turn will help to make the Whitley machinery more efficient and more acceptable to the people operating the Service than it has been in the past.

698. In conclusion we should perhaps mention the criticisms we have heard of the practice whereby the Health Departments are required to consult the Treasury in advance about the financial commitments arising from proposed increases in salary scales. Whilst appreciating the reasons for the criticism, we do not consider that the Departments can divest themselves of this requirement since the National Health Service is financed out of moneys voted by Parliament. In the last resort, the decisions reached in Whitley Council procedure must be acceptable to the Government if they are to be approved by Ministers for general application throughout the Health Service.

PART VII

GENERAL

Proposed Research and Statistics Department

699. In the section of our Report dealing with hospital statistics and other measurements of efficiency, we made our first reference to a proposal which we regard as one of major importance, i.e., that the Ministry of Health and the Department of Health for Scotland should set up a Research and Statistics Department which would devote the whole of its time to statistical investigation and operational research in general.

700. We are of the opinion that the knowledge at present available about the working of the National Health Service is inadequate and should be considerably extended and improved, since it is only on the basis of such knowledge that the right decisions can be made for the future development of the Service. We need to know more, for example, about the economics of hospital management, e.g., what is the most economical size of a hospital to undertake any specific functions; about the nature and causes of differences of morbidity in different Hospital Regions; about the changing patterns in the use of drugs in the National Health Service, and also about their cost; about the incidence of charges on particular sections of the community, (revealing, for example, the extent to which demands have been postponed or abandoned and the effect which this will have on the future pattern of supply); about the relative costs of institutional and domiciliary treatment; and so on. Again, as existing hospital waiting lists are notoriously unreliable, some careful study is required to assess more accurately the extent of the unsatisfied demand on the hospital services. These are only a few examples of the many fields which would be worthy of more detailed investigation in future years.

701. It is with these objectives in mind that we recommend the Health Departments to set up a Research and Statistics Department whose main task would be to consider what information is now lacking as to the working of the National Health Service and how this information might best be produced. We have already welcomed the fact that the Ministry of Health has appointed a statistician earlier this year; but we regard this as only the first step towards the formation of a separate Department within the Ministry. We see no