**Final report of the Committee on Hospital Supplies.**


MINISTRY OF HEALTH
CENTRAL HEALTH SERVICES COUNCIL

# Final Report of the Committee on HOSPITAL SUPPLIES

*LONDON*
HER MAJESTY'S STATIONERY OFFICE
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# COMMITTEE ON HOSPITAL SUPPLIES

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From Broadbent Report - 1954.

# CENTRAL HEALTH SERVICES COUNCIL
# COMMITTEE ON HOSPITAL SUPPLIES

# FINAL REPORT

## I. INTRODUCTION

*Terms of reference*

1. For convenience, we quote below our terms of reference which have already been mentioned in our Interim Report:

> "To investigate and report on the organisation of all forms of hospital supplies, including their purchase, storage and issue throughout the National Health Service."

*The Committee's Interim Report*

2. Our Interim Report of June, 1956, was subsequently adopted by the Council and referred to the Minister of Health who arranged for its publication.* Copies of the Report were sent on 14th March, 1957, to all hospital authorities under cover of a Ministry circular† in which the Minister asked all Boards of Governors and Hospital Management Committees to review their supply arrangements, in the light of the advice given in the Report, and to inform him of the result by 30th September, 1957.

3. We do not propose to repeat in this Report what we have already said in our Interim Report, but we shall refer to it from time to time when necessary.

*Questionnaire to Hospital Authorities*

4. As promised in paragraph 8 of our Interim Report we attach (as Appendix A) a copy of the questionnaire which we addressed to Boards of Governors and to Regional Hospital Boards, for completion in the case of the latter by representative Hospital Management Committees within their Regions. We do not propose to attempt to provide a summary of the information received as a result of the questionnaire; it would be difficult to present the information in a concise form and, in any case, we do not consider that a summary would be helpful to readers of this Report except to illustrate the existing variety in hospital supply arrangements. From our point of view we have found the information received to be most helpful in giving us a general picture of the form of supply arrangements and of the kinds of differences which exist, and we are grateful to hospital authorities for the trouble they took in replying to our request.

*Evidence Received*

5. We also attach (as Appendix B) a list of the bodies and associations who have given formal evidence to us or to our sub-committees. In addition to those listed we are indebted to many others both within and outside the hospital service who have provided useful information informally and

* Published by H.M.S.O. in 1957.
† HM(57)25.

indirectly. We have been considerably impressed by the keen interest which has been taken in so many quarters in our work and by the help and co-operation which we have received.

*Procedure of the Committee*

6. In all we have now met 23 times. In addition there have been a number of meetings of our three sub-committees. Sir Basil Gibson, Alderman Bradbeer and Mr. Parker have been mainly responsible as Chairmen for the work of the sub-committees dealing respectively with (i) textiles and other common user items, (ii) drugs and dressings, and (iii) provisions; and we are grateful to them for undertaking this responsibility.

7. The work of the Committee has covered what might seem to be the lengthy period of over three years, but this period has been divided by the publication of our Interim Report which covered what we felt to be the most urgent questions before us, and we are now able, in presenting this our Final Report, to take account of the results of the Minister's request to hospital authorities to review their supply arrangements in the light of the advice previously given by us.

*The Form of our Present Report*

8. In paragraph 3 of our Interim Report we mentioned how the questions before us seemed to fall naturally under three main headings, i.e., (*a*) the level at which hospital supplies should be bought, (*b*) where primary responsibility for buying should rest, and (*c*) what arrangements should be made for delivery, storage and issue. We have accordingly allotted three separate parts of this Report to detailed consideration of these questions, preceded by some general comments and followed by a part dealing with miscellaneous questions connected with supplies organisation, and finally some general conclusions and recommendations.

## II. GENERAL COMMENTS

9. In approaching our work we have considered the Report of the Committee on Internal Administration of Hospitals* and, in particular, paragraphs 205–221 dealing with supplies organisation. There are, however, certain other paragraphs in this Report from which we quote below which seem to us to be particularly relevant.

These are:

Para. 4 on the effects of the grouping of hospitals:

> "The grouping system has, however, not only thrown up a large number of problems but has itself made it almost impossible to produce to most of those problems answers which would be definite and more or less universally applicable. The variation between individual hospitals is immense—their size, the type of patients they serve and the nature of the services they provide, their traditions, their geographical location and so on. Without grouping, this variation would make general recommendations on patterns of administration difficult enough. But when these so varied hospitals are combined into groups which themselves vary almost as much—from the compact and homogeneous urban

* Published by H.M.S.O. in 1954.

group to the group of many different sizes and types of hospitals scattered over hundreds of square miles of country and the so-called functional group (of special hospitals) covering an area even wider—the variations seem almost to become as large as the total number of groups and it is possible to find scarcely two which are wholly comparable."

Para. 5 on the need for variety and flexibility in administration:

"Moreover we regard it as vital to remember that the National Health Service is not static. The development of the hospital service is or should be an organic development, rooted in the historic past but nevertheless still in its initial stages. The great step forward of grouping hospitals for administrative purposes was necessarily taken at one time but further changes in organisation, more particularly as they affect individual hospitals, each with its own traditions, customs and methods, should be made only after the most careful consideration of all the factors in each instance. We have approached our task bearing firmly in mind that throughout the service the administrative pattern must be and remain flexible, so as to fit not only the different circumstances of different groups but also the different circumstances of the same group at different times. There is more than room, there is a genuine need, for originality and experiment throughout this field and universally to impose or even to recommend any one rigid pattern of administrative organisation would be fatal. It is for this reason that many of our recommendations will be found to be expressed tentatively or hedged about with qualification."

Para. 245 (2). Tripartite administration:

"Hospital administration should be regarded as tripartite (medical nursing and lay). The conception of partnership should determine the lines of all future development."

Para. 245 (3). Position of the chief administrative officer:

"At group level there should be one chief administrative officer, with co-ordinating functions extending over the whole range of the group's activities."

Para. 245 (38). Relations of the chief administrative officer with principal specialist officers:

"All principal specialist officers at group level should be responsible to the governing body through the chief administrative officer."

We should also quote at this point one paragraph from the part dealing with supplies organisation. This is paragraph 205 on supplies organisation as a whole:

"The question of centralising group services arises most acutely on the organisation of hospital supplies. The importance of this department is clear from the fact that something like 25 per cent of a hospital's total expenditure goes on consumable goods. But it is a large and amorphous subject in which a complicated variety of factors play determining parts; the most economic machinery will vary widely according to the nature of the hospital group; different considerations apply to the supply of

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partially linked for supply purposes with the local hospital group for the area where the unit is situated. Similarly, some groups may be so small that it would be reasonable for most, if not all, of their supplies to be obtained through a larger nearby hospital group on an agency basis. Again there seems no strong reason why greater use should not be made in suitable cases of joint contracting with local authorities for supplies in common use.

To sum up, the organisation should not be parochial in its outlook or limited by hospital group boundaries or interests.

(c) *The organisation must vary according to different kinds of supplies.* We have been struck by the vast differences which exist between the various kinds of hospital supplies as regards sources of supply, the numbers of the various industries which enter into the hospital supplies field, and the varying traditions, customs and methods which operate as between buyers and sellers in various parts of that field. It seems to us to be inevitable that in any hospital supplies organisation both the form of the organisation and the methods used must vary according to the kind of supplies which is being bought.

(d) *The organisation must be subject to the authority of the responsible hospital group.* It also seems clear to us that from whatever source supplies may be bought, whatever form of organisation is used in buying them and whatever may be the detailed methods used, the customer, i.e., the hospital group who pay the bill, must retain final responsibility for quality and price. This does not necessarily mean where supplies are bought on a wider basis than by the group, that the group should concern themselves with the details of the transactions, but simply that, as in any other principal and agent relationship, the group as principals must retain the right to control what is being done on their behalf and should take full responsibility for the actions of their agents within the authority delegated to them.

An important exception arises in the case of the Minister of Health who, as the ultimate principal in all such matters, must reserve to himself the right to decide to what extent buying powers should be delegated to his sub-principals or agents, the hospital authorities. We will, however, deal with this point further in Part III of our Report.

(e) *The ultimate responsibility for group supply arrangements at the officer level must be that of the chief administrative officer.* We consider that supplies organisation is primarily the responsibility of the lay administration of the hospital group as distinct from the other two partners in hospital administration, the medical and nursing staff. This does not, of course, mean that doctors and nurses are not vitally concerned with hospital supplies, but we regard their interest more in the nature of expert advisers.

The evidence which we have received from organisations representing supplies officers and officers responsible for specialist departments (i.e. pharmacists, catering officers and engineers) follows a rather similar pattern to that received by the Committee on Internal Administration of Hospitals. It is claimed that these officers have a

special or direct responsibility to their authorities for supply arrangements either as a whole in the case of supplies officers or so far as supplies for their departments are concerned in the case of heads of specialist departments. As a matter of principle we do not feel that we can accept such claims. In our view the chief administrative officer of a hospital authority must remain the lay officer to whom the hospital authority mainly look for guidance and advice, and that officer should in turn be prepared to take ultimate responsibility to the authority for all matters relating to supplies. In the discharge of these functions, the chief administrative officer should, of course, fully consult with the senior officers concerned. On the other hand, specialist officers in addition to supplies officers should be invited, if their hospital authorities wish it, to attend at meetings of sub-committees where supplies matters affecting their departments are directly involved, in order that they may give information and advice on the work of those departments.

(f) *The success of any hospital supplies organisation largely depends on co-operation at all levels.* It might perhaps seem unnecessary to stress this point, but it does seem that in the hospital field there is greater need for co-operation than elsewhere because of the fact that, as we see it, there can be no set pattern of organisation or uniform allocation of functions. We have already referred to this point in our Interim Report in connection with joint contracting and we will deal further with it under Part IV of this Report which covers responsibility for buying.

## III. LEVEL AT WHICH SUPPLIES SHOULD BE BOUGHT

*Introductory*

12. Hospital supplies are bought

(*a*) under central arrangements by the Ministry;

(*b*) by two or more hospital groups acting jointly (i.e. joint contracting), or

(*c*) by individual hospital groups (i.e. group buying);

(*d*) by individual hospitals (i.e. hospital buying).

In paragraphs 15–36 we consider these methods in detail and a possible alternative.

13. Some idea of the annual expenditure on hospital supplies can be gained from the statement (attached as Appendix C) showing the amount chargeable to the Ministry of Health Vote in the financial year 1956–57 for hospital maintenance under various sub-heads. The amounts shown largely consist of expenditure on supplies bought by hospital authorities or under central arrangements by the Ministry.

14. We also attach (as Appendix D) a memorandum prepared by the Supplies Division of the Ministry of Health describing their work and showing the value of the contracts placed centrally for hospital supplies

during the same period. It will be seen that in terms of money the cost of such supplies was about 8 per cent of the whole.

*Central Supply Arrangements by the Ministry*

*Evidence*

15. We were told in evidence that there are still some misgivings amongst hospital authorities and their officers about the possibility that the administrative and overhead costs of the Ministry's central supply arrangements might be so high as to outweigh the saving in prices achieved by central buying, in spite of the statement in the Report of the Committee on Internal Administration of Hospitals that the Committee had received no evidence " that over the service as a whole the Ministry's policy for central purchase is uneconomic ". It seems clear that without information on this matter doubts will persist about whether or not these arrangements are truly economical in all cases.

16. There appears also to be some feeling that decisions on these arrangements might be influenced or determined by reference to broad considerations of national policy and not by reference to the needs of the hospital service. It has been suggested to us that the Ministry should inform hospital authorities, from time to time, of the policy reasons governing decisions on central supply arrangements.

17. Apart from these two general criticisms most of our evidence, at least from the hospital service, acknowledges that, in the main, the Ministry's arrangements are working satisfactorily in the field of " special " supplies such as the new and expensive drugs or equipment in limited supply or for which direct negotiation between the Minister and suppliers is clearly necessary, e.g. X-ray, blood transfusion and laboratory equipment and glassware, appliances, hearing aids and batteries, etc.

18. It is regarding supplies in the " domestic " or common user category that criticisms in the hospital service seem fairly general. These relate to such matters as delays in delivery and in dealing with complaints, deficiencies in quality and unsuitability for hospital purposes. It has been suggested to us that the use of agency departments by the Ministry, whereby certain hospital requirements are included with those of the public service, leads to supplies being provided which are below a reasonable standard and not designed to meet the particular needs of the hospital service. The main example of this put to us is the supply of stationery through the Stationery Office. It is also asserted that the agency arrangements accentuate the difficulties of ensuring that goods delivered correspond to the quality contracted for, of getting complaints dealt with expeditiously, and of securing good maintenance services from suppliers.

19. The need has been urged for closer consultation between the Supplies Division of the Ministry and their hospital authority customers, coupled with the suggestion that some sort of advisory committee might be set up. It was also suggested that the Ministry might help hospital authorities by a greater use of central negotiations to secure higher discounts for hospital authorities on a national basis on standard articles sold on price list terms.

20. The replies given to us by the Supplies Division of the Ministry on the foregoing points are:

(a) *The economics of central supply*

No type of supply is included under central supply arrangements unless it is clear that a substantial saving in cost will result. The incidence of overhead and administrative costs of the Ministry and of agency departments taken over the whole field of central supplies for hospitals is very small. This is supported by detailed figures produced to us which show that this "oncost" is of the order of 2 per cent.

(b) *"Domestic" or common user supplies*

The Supplies Division inform us that delays in delivery and deficiencies in quality of deliveries as against specification are now exceptional as the result of the constant efforts made to improve the central supply arrangements since they were first introduced. They acknowledge that the time taken to settle complaints may be increased because of the fact that the contracting authority, under central supply arrangements, is not the hospital authority using the supplies but point out, on the other hand, that this is inevitable in any form of central supply and that better quality control can be secured by central contracting through an authority with the necessary skilled organisation and technical staff with special experience in the type of supplies concerned.

As regards complaints about unsuitability for the Hospital Service we understand that, with the exception of most kinds of stationery, central supplies are the subject of special orders placed to specifications drawn up specially to meet hospital requirements. As regards stationery supplies the Supplies Division agree that there may be some force in the suggestion that quality is not as high as some hospital authorities would wish. Stationery supplied for general purpose use is normally of the same quality as that supplied to the Civil Service and, for reasons of national economy, is not to-day as high as it was before the war. The Supplies Division say that it remains, however, adequate for its purpose and the prices are much below those obtainable by individual hospital groups for supplies of similar quality.

(c) *The need for closer consultation*

The Supplies Division point to the arrangements outlined in paragraphs 2 and 3 of Appendix D and to the close relations maintained with hospital authorities through their contacts with Supplies Officers.

(d) *Extensions in the use of central negotiations to secure larger discounts for hospital authorities on a national basis*

The Supplies Division say that in view of recent developments in connection with the setting up of the Monopolies Commission and the passing of the Restrictive Practices Act, it has been necessary for the Ministry to refrain from pursuing this matter for some time in case the Ministry might seem to be endorsing what might be regarded as restrictive practices. The matter is, we understand, now under active reconsideration.

*Our Views*

21. Having considered the various points raised in paragraphs 15–19 and the replies given to us by the Supplies Division, the following are our conclusions:

(a) *The economics of central supply* (Paragraph 15)

As regards the question of overhead costs, we think that as the costs are so low it is reasonably clear that over the whole field of central supplies, there is little possibility of high overhead charges offsetting ostensible economies. We should, however, point out that the figure quoted is an average figure (it is impracticable to arrive at separate figures for each category of central supplies) and that the inclusion of a few items of comparatively high cost (such as special drugs, X-ray apparatus, films, etc.) may well have the effect of producing a figure below that applicable in other cases.

(b) *National policy* (Paragraph 16)

We consider it is only right that, in matters of importance, considerations of national policy should outweigh other considerations. We agree, however, that where appropriate, the Ministry should inform hospital authorities of the policy reasons governing decisions on central supply arrangements.

(c) *" Special " supplies* (Paragraph 17)

With regard to " special " supplies, we have given further consideration to these, but remain of the opinion stated in paragraph 28 (*e*) of our Interim Report that " . . . As matters stand at present it is right that central supply arrangements should remain on the present limited scale, i.e., that they should be substantially confined so far as value is concerned to those categories of drugs or equipment or other special supplies which necessitate central supply arrangements owing to the inadequacy of available supplies or to the limited sources of supply which are available."

(d) *" Domestic " or common user supplies* (Paragraph 18)

On the whole, we feel that the criticisms are somewhat exaggerated and we have received no suggestion that quality for quality supplies in this field (apart from the occasional " job lot ") could be regularly bought more cheaply by hospital authorities themselves. We also consider that economic considerations should be regarded as of prime importance and that should the opportunity arise (as we understand it has done once or twice since our enquiries commenced) of securing supplies of suitable quality for the Hospital Service in any particular line at prices which are substantially below those currently paid by hospital authorities, there should be no hesitation in placing supplies in this field on central supply. We consider, however, that with the developments in joint contracting which are taking place, the position may be reached sooner or later where hospital joint contracting committees might be able to buy similar supplies without any appreciable financial disadvantage. If this proved to be possible, we would favour supplies of this kind being handed over to joint contracting committees in view of the greater convenience which we think might result. We recommend, therefore, that the Ministry should review the scope of its purchases in this field in the fairly near future and consider whether it might not be possible to devolve part of this work.

*The Case for Large Scale Bulk Buying by a new form of Central Supply Organisation*

*Evidence*

22. It has been put to us in connection with the supply of provisions (although the suggestion is capable of wider application) that responsibility for the supply should be entrusted to a central organisation consisting of a small number of highly skilled and highly paid employees who would buy provisions in bulk for delivery to regional depots from which provisions would be distributed to individual hospitals as required. It is claimed that such an arrangement (which would be rather similar to that in use for the Forces) would be more efficient and lead to substantial economies.

23. As against this it appears that amongst large organisations in the hotel and catering industry (which bears some resemblance to hospital catering) local buying, at least of perishable foodstuffs, is fairly general and that central buying by experts tends to be selective and confined to particular classes of commodities largely in the non-perishable category.

*Our Views*

24. As we see it, the form of organisation proposed would need to be financed by the Minister and would act under his general directions. In its relations with hospital authorities it would presumably act as a buying agency on a semi-commercial basis, charging its customers prices based on cost, including an allowance for overheads and interest on capital. Hospital authorities would probably be required to buy solely from this organisation, or possibly the organisation might be required to supply in competition with private industry.

25. We have no hesitation in saying that such an arrangement would be unsuitable for the hospital service, as at present constituted, for the following reasons :

(*a*) It is most important that responsibility for provisions supplies (as indeed for all supplies) should rest primarily with the Hospital Management Committee or Board of Governors, and the officers of the group or hospital. This would encourage the essential feeling of local interest and responsibility, to which we attach so much importance. Reliance on an independent source of supply without any choice or local responsibility for price and quality is a potential danger which may lead to friction between the supply organisation and the consumer, and to a less keen sense of responsibility on the part of the latter, with a resultant loss of efficiency.

(*b*) We are not convinced that financial economies would result. No evidence in support of this has been produced and we have had no estimate of the cost of setting up regional depots complete with cold and other stores, transport and equipment or of the cost of maintaining and running such depots. Both the initial cost and running costs must be substantial, and the ultimate financial savings, if any, a matter for speculation in the absence of the commercial tests of competition and the profit element. Even if such an organisation were required to supply in competition with commercial firms, there seems no guarantee that they would be able to operate competitively and it is even

less likely that a case could be made out in such circumstances for a considerable expenditure of public funds on setting up an organisation the results of which would inevitably involve risks of losses of one kind or another. In our view it is preferable for such risks to be borne by private industry which possesses the necessary capital and other resources and the specialised organisation to conduct ventures of this kind.

26. Although we discard upon present evidence the proposals for central supply of provisions (or indeed of any other kind of supplies) by an organisation of this kind, we recognise the value of specialist buyers, and we consider that with the development of joint contracting it will be possible to encourage specialisation by individual officers in the technique of buying different kinds of supplies.

### *The Case for the Small Supplier*

*Evidence*

27. It has been put to us by several organisations representing suppliers that a further development of central buying or of joint contracting by hospital groups would prove no more economical, less efficient and generally less satisfactory to hospitals. It is suggested that buying on a wider scale than at present would tend to squeeze out the smaller supplier, who would be unable to tender for the larger quantities required ; and that even if more competitive prices were to be obtained from larger suppliers the Hospital Service would be the loser in the long run by being deprived of the better service which it is claimed is now being provided by small suppliers.

*Our Views*

28. We are not recommending any general extension of central supply arrangements by the Ministry and, as we see it, joint contracting by hospital groups does not necessarily imply that the field of tendering will be limited to large firms, that a contract for the whole of the requirements of a joint contracting committee should be placed with a single supplier, or that smaller suppliers should not be given an opportunity of tendering for part, if not the whole, of such requirements. In our view, intelligent buying demands that there should not be rigid adherence to a single source of supply, that smaller suppliers who are often well placed to meet customers' needs with greater speed and efficiency should not be excluded, and that the quality of the service provided by the supplier should be taken into account, together with price and quality, when awarding contracts. We have no doubt that joint contracting committees will bear these points in mind.

29. We think therefore that this fear of loss of business is exaggerated. None the less, we do acknowledge that with some types of supplies the further development of joint contracting may well result, in many cases, in changes in the sources from which hospital supplies have previously been bought and in some loss of traditional custom and friendly business relationships of long standing between suppliers and individual hospital customers. We would regret such a development, but we feel that it may be inevitable if hospital authorities are to buy as cheaply as possible while having due regard to maintenance of reasonable quality and satisfactory service ; this they are clearly bound to do in a service financed from public funds.

*Joint Contracting*

30. The Ministry have made available to us information about the results of the review of supply arrangements which the Minister asked hospital authorities to undertake in March, 1957. We have studied this information with the object of showing the different types of supplies for which joint contracting arrangements are now in being, or are proposed or under consideration. We attach as Appendix E a broad summary of the replies which we think would be of interest and assistance to hospital authorities.

31. We are greatly encouraged by the response made by hospital authorities (both by Hospital Management Committees and by Boards of Governors) to the recommendations in our Interim Report and are impressed by the wide variety of supplies now covered, or likely to be covered, by joint contracting arrangements. This confirms our opinion that there is wide scope for arrangements of this kind which might well become the principal method in the future of buying most types of hospital supplies.

32. The possibilities of joint contracting in any particular area and for any particular type of supplies should however be considered entirely on their merits and the advantages or disadvantages of this method should be frequently reviewed.

33. We would also urge, as already suggested in paragraph 11 (*b*), that hospital authorities should bear in mind the possibility of joining with local authorities in buying supplies in common use. There is a large fund of experience and expert knowledge in the buying departments of local authorities which would be of assistance to hospital authorities and, even in cases where joint buying with local authorities might seem to offer no immediate advantages, arrangements should still be made to maintain close and informal contact between the officers concerned. We have no doubt that both hospital and local authorities would be ready to co-operate in this or in any other way.

*Group and Hospital Buying*

34. Whatever the extent of supplies for hospital groups covered by joint contracting at any particular time, there will always remain some items (and in some cases many items) which can more effectively be bought at the group or hospital level. It is impossible to define these except in very general terms as so much depends on individual circumstances, but we attempt in paragraph 36 to give some general guidance regarding certain types of supplies based on the evidence we have received.

35. We should, however, record one general impression we have formed. We have been struck by the number of cases in which hospital buying continues for types of supplies which would seem more suitable for group purchasing or joint contracting. We acknowledge that in some of these cases there may be good reasons for this, but we feel that only in the most exceptional circumstances should group requirements be bought piecemeal by individual hospitals and that, with certain possible exceptions which we mention in the following paragraph, group buying or joint contracting should be the general practice.

36. (*a*) *Provisions*

This simple heading covers a vast field, and provides a good example of the existing variety in hospital supply arrangements and of the difficulties of evolving any uniform system. This situation is only partly attributable to the diversity inherent in the Hospital Service ; it also springs from the wide variety in customs, methods and procedures within the different industries or trades which comprise the provisions field. It should therefore be borne in mind that when, in this Report, we refer to " provisions ", " perishables " or " non-perishables ", these terms embrace a large number of separate commodities, arrangements for which are fundamentally different.

We cannot emphasise too strongly the extreme importance of efficient supply arrangements for provisions. The supply of food for hospital patients (and staff) is not only extremely costly (one-third of the total bill for hospital supplies) but is an integral part of the whole process of hospital services in which catering plays such an important part in the treatment and care of patients and in the well-being and comfort of staff. This category of supplies is also one in which there are special difficulties in ensuring that supplies of satisfactory quality and that value for money is being obtained, and in which it is perhaps even more necessary than with other supplies to bear in mind that the value of an article cannot be judged solely by reference to its price, but that quality is of equal importance.

We have regarded our terms of reference as confining us to the supply of provisions and not extending to the succeeding stages of food preparation and service of meals.

In paragraph 29 of our Interim Report we said that we felt there might be room for joint contracting for certain categories of non-perishable foodstuffs. As the result of further evidence we have since received and from the analysis contained in Appendix E, we now feel that there is even wider scope than we previously thought for the use of joint contracting, even possibly for certain items of perishable foodstuffs. Subject to this we favour the use for perishables of group contracting or of hospital contracting as seems best having regard to all the circumstances of the group.

There seems to be a tradition in some hospital authorities that provisions, like most other supplies, should be bought as the result of competitive tendering on period contracts of up to a year ahead. This practice which has the advantages of simplifying buying procedures and of facilitating administrative and financial control is satisfactory where it is possible to ensure that supplies of standard type and quality can be obtained under the contract and that the contract prices are reasonable. It is, however, often difficult to do this because of the absence of generally accepted standards or because of inevitable fluctuations in quality and quantity of available supplies and in market prices. It is possible to meet these difficulties to some extent in one or more of the following ways:

(i) *By improved specifications*

More precise definition of type and quality of the supplies required has been found possible in some cases following negotiations between trade associations and representatives of hospital authorities, fostered by the Supplies Division of the Ministry.

(ii) *By placing contracts for shorter periods (e.g. three months) or by inclusion of a " break " clause*

This protects both buyer and seller against unforeseen fluctuations in both quality and market prices.

(iii) *By relating contract prices to current market prices*

In some areas there are weekly price lists published by official or semi-official bodies connected with various sections of the provisions trade which can be adopted as the basis for the prices to be paid under running contracts. When tendering, suppliers are asked to quote a rate of discount or surcharge to be applied to the recognised prices. We understand, for example, that one of the Manchester groups places contracts in this way for eggs, butter and bacon. Similarly, the practice of relating milk contract prices to a discount off current maximum retail prices fixed by statutory order is fairly widespread.

(iv)) *By placing orders on daily or weekly competitive quotations through experienced buyers*

The practice has been growing in recent years of allowing greater flexibility and increased delegation to experienced officers who buy from day to day or weekly requirements of perishable foodstuffs on competitive quotations. This procedure may be combined with visits to markets where the quality and prices of available supplies are ascertained before purchase.

We consider that in present conditions of free competition and considerable fluctuation in market prices, the use of one or other of the four methods, as appropriate, should prove reasonably satisfactory for most types of provisions, and we recommend that hospital authorities should review their supplies arrangements for provisions to see whether any improvement might be effected.

(b) *Staff Uniforms and Clothing*

*Patients Clothing*

As a sub-committee of the Standing Nursing Advisory Committee of the Council is at present considering the design and materials of nurses uniforms, we do not propose to comment on supply arrangements for nurses uniforms. As regards other kinds of uniforms and clothing, there is obviously scope for the use of standard materials and joint contracting. In both cases, laundering qualities are a matter of importance on which expert advice should be taken.

In all cases, the financial advantages to be gained from standardisation must be weighed against the psychological value of individual preference.

(c) *Drugs and Dressings*

We agree in most respects with the following conclusions of the Council's sub-committee on the Hospital Pharmaceutical Service as shown in their *Report from which we quote below :

"58. (2) Only a strictly limited number of drugs are used in sufficient amount, or involve sufficiently great expenditure to make it economical to buy them nationally ; where this is done, contracts should be negotiated, but the goods should not be taken into store for redistribution.

(3) Apart from these, a small number of additional drugs may be usefully bought by groups by means of competitive tenders.

(4) The great majority of the items used in the pharmaceutical department should be bought at current prices or by competitive quotation as required from suppliers selected by the pharmacist. For these no elaborate form for contracting or ordering is necessary. The custom of trade, which is to rely on warranty and on good relations between buyer and seller, is sufficient.

(5) In every group consultations should take place between the pharmacists with a view to pooling orders wherever it is advantageous to do so.

(6) Neighbouring groups may find similar consultations useful."

Since this report was published there have, however, been extensive developments in joint contracting by numbers of groups within several regions and we think that this method should be used generally for drugs in common use which are not already bought under Ministry contracts. Group purchasing or contracting should be adopted for items which are unsuitable for joint contracting.

As regards dressings, joint contracts are already being placed in several Regions (and Wales is supplied under Ministry contracts) and joint contracting seems the best method.

(d) *Medical and Surgical Appliances and Equipment*

Ministry contracts particularly for X-ray equipment and materials account for a substantial part in value of these purchases. As regards the remainder it should be one of the functions of Medical Advisory Committees to advise on essential medical needs. There does not appear to be much general scope for joint contracting, except for individual items where some degree of standardisation is possible Buying at group or occasionally at hospital level thus appears to be the best course.

(e) *Cleaning Materials*
*Furniture and Fittings*
*Hardware and Crockery*
*Bedding and Linen*
*Printing and Stationery, etc.*

* Published by H.M.S.O. in 1955.

These headings broadly come into what we have described as the field of " common user or domestic " supplies. In all these cases, subject to the Ministry's central supply arrangements, there seems ample scope for joint contracting. Where this offers no advantage group purchasing or contracting should be adopted.

We should mention here a development which appears to be becoming popular and that is the use of printing departments at the group or occasionally at the regional level. These departments are used for large scale printing or reproduction of reports, standard forms, etc. which it is claimed can be produced more economically than by private contractors. While we think that there is still great scope for standardisation of forms in common use and that this is a matter which should be encouraged by Regional Hospital Boards we are only in favour of these and other bulk printing requirements being produced in this way, if it can be clearly shown that material savings can be achieved after taking into account all elements of cost including overheads and after making allowance for depreciation and interest on capital invested in machinery and other equipment. The results of such departments should be reviewed from time to time to ensure that they are continuing to operate on a competitive basis.

In this connection we agree with the views recently expressed by the Select Committee on Estimates

> " that it might well benefit the Hospital Services if other facilities of the Stationery Office through which savings could also be made, such as printing and the supply of publications, were available to them ".

We understand that enquiries made by Supplies Division of the Ministry of Health have shown that the quantity of individual publications would be insufficient to justify central supply arrangements but that investigations into the possibility of greater use of the Stationery Office printing facilities are still proceeding.

(f) *Fuel Supplies*

Our enquiries on the purchase of coal and coke show as regards the former that under the present methods of charging by the National Coal Board for supplies at standard pit head prices and with standard tariffs for rail transport, the suppliers margin to cover local delivery costs and profit is comparatively small. It follows that the scope for competition as between suppliers is correspondingly limited. We are also advised that, although buying on a larger scale than at group level might be practicable in some instances, there would be danger of the loss of the local knowledge and service which can be provided by local suppliers.

Although the pricing system within the industry differs in the case of coke the general position seems to be very much the same as with coal. We understand, however, that in one or two areas there may be scope for savings in cost by joint contracts.

On the whole, we do not consider that there would be much to be gained by joint contracting in this field, but we recommend that joint contracting committees and their parent hospital groups should look into the question in the light of local conditions and current costs of supplies, taking into account also the technical facilities offered by many suppliers for advice on fuel utilization and the grade of coal best suited for hospital plant.

With regard to petrol and fuel oil we understand that the scope for competition is limited but that special terms are available to hospitals in discounts for quantity and similar arrangements, and we recommend that contracts should be arranged so as to secure the most favourable terms.

As regards fuel supplies generally, we consider that at whatever level supplies may be bought and however limited the response may seem in particular areas hospital authorities should continue to invite tenders or quotations in competition. We mention this because we understand that in one or two cases this practice has been discontinued because of the limited number of suppliers.

## IV. RESPONSIBILITY FOR BUYING SUPPLIES

37. It was stated in an early Ministry circular* that normally it was expected that Hospital Management Committees would require amongst other senior officers a "Supplies Officer whose duties will be to arrange for the acquisition, maintenance and distribution of equipment and supplies."

38. There have, however, been later references in Ministry circulars of the functions of certain specialist officers which bear on the responsibilities of a Supplies Officer. These concern:

(*a*) Pharmacists in circular R.H.B.(50)7/H.M.C.(50)7/B.G.(50)6, which stressed the need for pharmaceutical advice before obtaining pharmaceutical supplies.

(*b*) Catering Officers in circular R.H.B.(50)18/H.M.C.(50)18/B.G.(50)16, from which we also quote below:
". . . The duties of the catering officer include the day-to-day purchase of food (subject to the general policy of the buying department where there is a supplies officer); . . . the management and control of food stores . . ."

39. On 31st March, 1957, there were in England and Wales out of 423 Boards of Governors and Hospital Management Committees, 188 groups in which there was a full time Supplies Officer, 202 groups in which the post of Supplies Officer was combined with some other post and in 33 groups no Supplies Officer had been appointed. In addition there were a few teaching hospital appointments of stewards which for most purposes can be regarded as Supplies Officer appointments.

40. Full time Supplies Officer posts are mainly with the larger "general" hospital groups and are relatively uncommon in the case of mental hospital and teaching hospital groups.

* R.H.B.(48) 13/H.M.C.(48) 2 para. 4.

41. It is thus clear that many hospital authorities have not found it necessary to appoint a full time Supplies Officer presumably because they have considered that the work entailed in the supplies arrangements of their groups would not justify a full time post. Where the post of Supplies Officer has been combined with another post, the latter is invariably some other administrative post. In referring to a "Supplies Officer" in the rest of this part of our Report we mean full time Supplies Officers.

42. The appointment of a Supplies Officer usually implies the existence of a separate Supplies Department responsible to the Supplies Officer, but there can of course be a Supplies Department without a designated Supplies Officer. Our evidence shows that the scope of the duties of such Departments or of Supplies Officers in general varies considerably. There are many cases where the responsibility for buying supplies for their own departmental needs is entrusted in varying degrees to heads of specialist departments, i.e. pharmacists, catering officers and hospital engineers.

43. Associations representing heads of specialist departments claim that responsibility for buying supplies for these departments should be vested in the heads of the departments. We will now consider these claims and the opposite views held by associations of Supplies Officers and others.

*The case for Departmental Buying*

44. The case put to us in support of buying by the head of a specialist department is generally based on the technical complexity of the supplies used which is said to necessitate the choice of the article to be purchased, the source of supply, agreement of price and other contract terms, delivery and storage arrangements being left with the department concerned. It is claimed that it is undesirable and wasteful of effort for the supply of the articles or materials to be divorced from the subsequent technical processes involving their use. Direct responsibility to the appropriate committee of the hospital authority is claimed with right of access to meetings in order that the departmental head can advise the committee direct on all aspects of the specialist function of the department. The special position of the Chief Administrative Officer is acknowledged as comprising general responsibility for co-ordination of the work with other group activities and likewise the Finance Officer of the group is recognised to have overall financial responsibilities in relation to the work of the department. No useful purpose is said to be served by the existence of Supplies Officers or of centralised group supply arrangements in relation to the work of a specialist department of this kind.

45. In practice these claims tend to be modified and not pressed to extreme limits. The Pharmacists, for example, now rest their case on the conclusions of the Council's sub-committee on the Hospital Pharmaceutical Service from whose Report we again quote:

> "58. (1) Responsibility for pharmaceutical supplies is a normal and important function of the pharmaceutical department: by responsibility is meant choice of and decision upon materials and sources of supply.

(7) So long as the selection of the material and the source of supply and the control of receipt and storage is in the hands of the pharmacist and he is free to place his orders without delay, there may be advantages in using the services of the supplies department for other stages of the purchasing process. It will aid the smooth working of joint arrangements if it is understood that the method of resolving any difference of opinion between the two departments is for both the pharmacist and the supplies officer presenting their views to any committees concerned and eventually if need be to the governing body."

Similarly, the case put to us on behalf of the Catering Officers while claiming that "Catering Officers should be empowered to purchase provisions for their departments either in the open market or within an existing contracts scheme" qualifies this by saying that this should apply "only where the Catering Officer can submit proof of ability and satisfactory experience of purchasing in previous employment" and continues "Where the Catering Officer had insufficient experience to undertake . . . all buying . . . he or she should be allowed the purchase of perishables, i.e. fruit and vegetables, fish and meat—if necessary within an existing framework of purchasing control."

Again, the hospital engineers' case as put to us in evidence did not go quite so far as that stated in paragraph 44.

These were the three main claimants for supplies autonomy, as it might be described, within the hospital group.

*The opposite views*

46. The views expressed to us on behalf of Supplies Officers may be summarised as follows:

(*a*) that the organisation of hospital supplies arrangements is a function requiring the employment of officers with special training and experience;

(*b*) that for this reason the supplies arrangements of all hospital authorities should be under the control of a designated Supplies Officer with the necessary qualifications and operated by a separate supplies department;

(*c*) that all hospital supplies should therefore be bought by the Supplies Officer who would be responsible for consultation with the heads of specialist departments as necessary;

(*d*) that the Supplies Officer should have right of access to the appropriate committee of the hospital authority and be responsible for advising them on all matters relating to hospital supplies;

(*e*) that where the size of a hospital authority was too small to justify the appointment of a Supplies Officer the supply arrangements for that authority should be under the control of a Supplies Officer in a neighbouring group.

47. The scope of the duties of a Supplies Officer and of his department is more fully expressed in the memorandum of evidence put to us by the Joint Committee of Supplies Officers of the four Metropolitan Hospital Regions from which we quote below:

> " In organising his department, the supplies officer must, therefore, take into account the following main factors, all of which are part of the overall function of supplies :
>
> (*a*) The ascertainment of the right quality or standard of goods and equipment to be acquired.
>
> (*b*) The purchase of all requirements at the best price, having regard to the ethics of public purchasing.
>
> (*c*) The provision of essential services such as laundering, window cleaning and the undertaking of funerals.
>
> (*d*) The storage and distribution of large and varied stocks of expendable stores.
>
> (*e*) The repair and maintenance of furniture and equipment.
>
> (*f*) Control of productive departments, such as printing shops, work rooms, etc.
>
> (*g*) Control and maintenance of transport.
>
> (*h*) Condemnation of unserviceable materials and equipment.
>
> (*i*) Disposal or sale of waste materials and surplus or obsolete equipment."

and again :

> " Supplies officers regard it as a prime consideration to ensure that all purchases are of the right quality or standard. Goods and equipment should not be less than that quality, but equally they should not be above the quality necessary for the purpose for which they are acquired.
>
> " The Joint Committee does not regard the supplies officer as being the sole repository of all knowledge in this matter, and, therefore, believes that full account should be taken of the views of the user departments before deciding type and quality to be purchased. It is, however, the experience of the Joint Committee that there are conflicting opinions on type and quality of equipment held in departments performing similar functions. In such circumstances, the supplies officer conceives it to be his job, not merely to obtain the article which suits the individual customer, but, because his customers have differing views on standards, to bring about agreement on what may be broadly described as similarity of standard. It is not intended to imply that an unimaginative uniformity is the objective. Where agreement cannot be reached with departments or units, the governing body should be acquainted wth the facts in order that they may make the necessary decision.
>
> " It may well be commented at this stage, that it is difficult to appreciate how even a rough similarity in standard can be maintained between departments in those groups where departments purchase independently of one another.

" Supplies officers have experience of considerable reluctance on the part of departmental heads to test under competitive conditions brands and sources of supply other than those to which they have become accustomed. There are, of course, groups where departments invite competitive tenders for their requirements. It will be realised that it needs staff to do this. It is interesting to note that before purchasing was centralised by many local authorities, there existed what has been described elsewhere as a " phantom army " engaged on purchasing in their various departments.

" A central supplies department eliminates the duplication and overlap inevitable in such arrangements. It makes possible the employment of persons experienced in the various fields of purchasing who can use on behalf of individual departments not only their intimate knowledge of the trade, but experience in many other departments and hospitals, thus making for the greatest degree of efficiency.

" In view of the foregoing, the Joint Committee is firmly of the opinion that in those groups where departmental purchasing still continues, economies could be made by setting up a supplies department."

*Our Views—Introductory*

48. Before considering these apparently irreconcilable points of view it seems necessary to describe briefly and simply the various stages normally involved in the supplies function up to the point where supplies are brought into use and the work which is entailed within a hospital authority.

(a) *Assessment of Needs*

*Allocation of Funds*

As a part of the annual estimates procedure it is necessary for estimates to be prepared well in advance of the financial year showing the anticipated requirements of each hospital or department within the group for supplies for the coming financial year. These estimates are usually fairly approximate but necessarily involve some degree of pre-estimation of type, quality and quantity of the supplies needed and of prices. Eventually, after scrutiny and discussion within the group, these estimates are submitted to the hospital authority and later the estimates are approved or revised in the light of the funds which are made available for hospital maintenance and sums are allocated under the various subheads of expenditure within which purchases can be made for each department.

(b) *Decisions on what to buy, when and where to buy it and by what method*

The next step is to decide for each department what type and quality of supplies are to be bought, to what extent these are to be bought under a single contract, by a series of contracts during the year or from time to time as required, what sources of supply are to be used and what method of purchasing is to be adopted, e.g. after competitive tenders, on competitive quotations or otherwise.

(c) *Invitations to submit tenders or quotations*

(d) *Listing tenders or quotations received*

(e) *Examination of tenders or quotations and making recommendations regarding selection*

(f) *The selection of tenders or quotations*

This is either done by the appropriate sub-committee of the hospital authority or may be carried out under delegated powers by officers.

(g) *Placing contracts*

(h) *Ordering*

(i) *Checking quantity and quality on delivery*

(j) *Certification of suppliers accounts.*

(k) *Storage and issue.*

(l) *Settling any disputes with contractors.*

49. If we examine these various stages we find that departmental heads are clearly concerned in varying degrees with the following items:

(*a*) the assessment of needs.

(*b*) the decisions to be taken on the purchasing programme, sources of supply and purchasing methods.

(*e*) and (*f*) examination of tenders or quotations and either recommendations on selection or actual selection.

(*i*) checking quality on delivery.

As regards the following items :

(*c*) the actual invitation of tenders or quotations ;

(*d*) the listing of them ;

(*g*) the issue of contract letters or documents ;

(*h*) ordering ;

(*i*) the checking of quantities on delivery ;

(*j*) the certification of accounts ;

(*k*) the control of storage and issue ;

(*l*) the settling of any disputes with contractors ;

these are all matters which do not necessarily involve any active participation by the departmental head or which form something of a common pattern or which involve routine or semi-routine procedures. The function of the departmental head in these matters seems largely confined to the form of specification to be used in invitations to tender, etc., to any special contract conditions, to control of the ordering and storage of special types of supplies for which it is necessary he should be personally responsible (e.g. the pharmacist in relation to dangerous drugs and poisons) and to participating in any discussions or negotiations connected with disputes where technical knowledge as well as contractual knowledge or experience is involved.

As regards this second group it seems clear that the work included in these stages is mainly of a character which is common to supplies for all departments.

*Our views on the question of responsibility for buying*

50. We reach the general conclusion that responsibility under the hospital authority for the most important decisions involved in hospital supplies arrangements cannot be assigned solely to departmental heads. It would be as wrong for a departmental head to reach any important decision in this field without full consultation with his administrative colleagues as it would be for an administrator to ignore the advice of his professional partner.

51. This situation obviously calls for a high degree of co-operation and friendly relations between officers and a suppression of any individual desire to seek personal prestige. Disagreement there is bound to be at times, but differences of opinion should usually be capable of being resolved without reference to the hospital authority, who are entitled to expect that their officers should normally be able to reach agreement among themselves and give co-ordinated advice on matters of supplies policy.

52. What one might describe as the executive aspect of supplies arrangements and all the routine, or semi-routine, procedures seem clearly to lie on the administrative side, together with similar detailed arrangements which can be much better handled centrally within the group than split up over a number of hospitals or departments. It is, however, important that the specialist head should play a full part in any aspects of this work which require specialist knowledge or advice.

53. Applying these general principles to the three cases for departmental buying we conclude as follows:

(a) *The Pharmacists:* We agree with paragraph 58 (1) of the Report on the Hospital Pharmaceutical Service with, however, the qualification that "choice of and decision upon materials and sources of supply" is not solely a matter for the pharmacist. He must carry his administrative colleagues with him on all matters of importance.

As regards paragraph 58 (7) of the same Report, we regard it as essential that for the matters referred to in paragraph 52 above the supplies machinery of the group should normally be used. The ordering and storage arrangements should, however, where necessary, be under the control of the pharmacist, but questions which have a general administrative background such as the volume and control of stocks are matters in which the group administrators necessarily have an interest. With regard to the proper procedure for settling differences of opinion, we consider that pharmacists and Supplies Officers should, in the first instance, refer these to the Chief Administrative Officer in the hope that the matters in question can be settled at officer level. It is only in the case of differences on matters of extreme importance that a final decision by a sub-committee of the hospital authority, or by the authority itself, should be sought.

(b) *Catering Officers:* As the evidence for the catering officers implies, we understand that there is at present—owing to recruitment difficulties—a shortage of catering officers in the hospital service, and particularly of catering officers with experience in buying provisions. It may thus be difficult in many areas for catering officers to play

as effective a part as they might in the buying of provisions and it seems necessary for hospital authorities to take into account, when deciding on their supply arrangements for provisions, not only such variable factors as the location of their hospitals and accessibility of markets and other sources of supply, but also the training and experience of their catering officers.

In paragraph 36 (*a*) we mentioned under (i) to (iii) (page 18) various improvements to the normal method of placing period contracts as having been found suitable for the purchase of different types of provisions. Many hospital authorities have found or will find the period contract with these improvements satisfactory and well suited to their individual needs and we see no reason why in such cases supply arrangements should not be made through the Supplies Department or other branch of the group administration working in close collaboration with the catering officers.

Method (iv) is however essentially different in that it requires a high degree of expert knowledge and buying experience without the use of formal contracts. This is a method which seems to us to be particularly suitable for the purchase of perishables where the necessary skilled buyers are available and local conditions are favourable and we recommend it as a method which will become increasingly popular with the recruitment or training of the necessary staff. Catering officers are of course well fitted for this work provided they have had the necessary experience. We should add that this method should only be used under delegated powers from the authority which should be strictly defined and include proper administrative control and financial safeguards.

Responsibility for storage of perishable foodstuffs should normally be that of the catering officer. The storage of non-perishables seems largely a matter for local arrangement, as it may be more convenient to include such stocks in a group central store or a hospital general store.

(c) *Engineers:* The position of the engineer is similar in some respects to that of the pharmacist, as the purchase of the supplies which he needs usually involves a considerable degree of specialised knowledge regarding type, quality and sources of supply. We consider that engineers also should not seek to create a self-contained buying unit within the group largely independent of the normal administrative and supplies machinery of the authority. The views which we have expressed regarding pharmacists apply in general to hospital engineers.

54. It will be seen that in our comments on responsibility for buying from paragraph 48 onwards we have referred in general to the relations between the administrative side of a hospital authority and the departmental heads and have not specifically mentioned Supplies Officers.

55. This we have done for two reasons :

(*a*) because we regard the work of a Supplies Officer as essentially administrative in character, although work in which special experience and training are essential and,

(*b*) because in many hospital groups there is no separate Supplies Officer post, the duties being combined with, or covered by some other administrative post.

56. It follows, therefore, that we have largely considered the claims made by Supplies Officers to buying responsibility in discussing in the preceding paragraphs the position of the administrator vis-à-vis the departmental head. We have, however, the following general comment on the scope of the Supplies Officer's responsibility as described in paragraphs 46 and 47. As we see it, the crux of the matter is the manner in which the Supplies Officer and the departmental heads collaborate in deciding on type and quantity of supplies and on sources of supply. In our view the Supplies Officer is quite entitled to suggest to departmental heads that a particular type or quality of article or material should be bought, or that tenders or quotations should be invited from particular sources, or in cases such as that of a pharmacist to question, if necessary, the selection of type, quality and source of supply proposed by the departmental head and to make counter suggestions. In no circumstances, however, do we consider that he should have the last word or be authorised to overrule the wishes of the departmental head without the matter being referred to the Chief Administrative Officer and, only in the last resort, to the appropriate sub-committee of the hospital authority. The Supplies Officer should regard himself as a member of a team but with special responsibility to co-ordinate the (occasionally conflicting) requirements of departmental heads and to ensure on behalf of the group administration that there is no extravagance in quantity or quality, that the fullest possible use is being made of standardisation and to give the benefit of any experience he may have gained as regards possible sources of supply. The more direct responsibility of a Supplies Officer, as we see it, is in relation to the executive responsibility for giving effect to agreed decisions on supplies policy.

57. The function of the Supplies Officer in relation to choice of supplies and of supplier is a highly important one but it does not amount to " responsibility for buying " which, as we have already explained, is essentially something to be shared with departmental heads in partnership. It seems to us to require administrative ability to which, like any other administrator, the Supplies Officer adds the special experience gained in the course of time in matters of a technical nature.

58. Where the work of a Supplies Officer seems to demand special experience and training is in the techniques of buying in the public service, tendering and contract procedure and the general procedures required in connection with delivery, storage and issue of supplies.

59. In relation to the assessment of needs, decisions on the purchasing programme, types and quality of supplies, sources of supply and the policy to be adopted regarding purchasing methods, we thus regard the Supplies Officer as providing the services to be expected from a responsible administrator who has gained special experience in this aspect of administration. On the executive action following these decisions the Supplies Officer brings to bear expert knowledge in which training and experience have a particular advantage.

60. As to the need for the appointment of a Supplies Officer in any particular group, we think that this is entirely a matter for decision by the hospital authorities concerned. In reaching a decision the authorities will need to take into account the volume of purchasing, the location of their hospitals, accessibility to markets and other sources of supply, the ability and experience in buying of their other senior officers, and other local factors.

We would, however, suggest that there seems to be a case for such appointments in large general groups, as it is in such groups that there is clearly greater need for devolution by the Chief Administrative Officer of the major burden of administrative responsibility for matters of supplies policy and of executive responsibility for group supply arrangements. The case for the appointment of a Supplies Officer seems considerably strengthened where the group takes an active part in joint supply arrangements and provides representatives on the joint contracting committees. The Supplies Officer seems well fitted to act in this connection, both in his administrative capacity and as an expert on supplies and contracting arrangements in general.

61. Finally, as we regard the work of a Supplies Officer as requiring both administrative ability and specialist experience and training, we recommend hospital authorities and new entrants to the hospital service, and indeed Supplies Officers themselves, not to regard supplies work as necessarily leading to a separate career distinct from hospital administration in the narrow sense. We have been favourably impressed by many of the Supplies Officers we have seen in the course of our inquiries and we would like to see them and their assistants given better opportunities for progression in the career of hospital administration as a whole. Like others who have studied various aspects of hospital administration we regret the fact that through specialisation this has tended to become divided into watertight compartments resulting in the limitation of career prospects and the discouragement of interchange between senior administrative posts.

## V. DELIVERY, STORAGE AND ISSUE

*Introductory*

62. We have combined the above three phases in supply arrangements because we regard them as inter-related.

63. Delivery arrangements with suppliers can involve delivery either to

(*a*) a group central store, from which deliveries are later made by the group themselves when required to

(i) a hospital store when the supplies will remain on charge in stores ledgers until the supplies are subsequently re-issued for use ;

(ii) user departments for early consumption or use (i.e. no longer remaining on charge). In this case supplies are treated as expenditure, but certain non-consumable items of relatively high value are recorded in inventories ;

(*b*) a hospital store ; or

(*c*) user departments.

64. It is clear that suppliers' prices should normally be lower if delivery of a group's requirements can be made in bulk to a group central store, rather than to individual hospitals or departments. Similarly, prices should normally be lower if supplies can be delivered in bulk, say, yearly or quarterly, whether to a group store or a unit hospital store, rather than at more frequent intervals. This is due to the saving of packing, handling and transport costs to the supplier and possibly in the second case to a saving in manufacturing costs through production in greater quantity.

65. As against this, bulk delivery to a group or unit hospital store of greater quantities than are needed to maintain group stocks at a reasonable minimum level results in the locking up of more capital in excessive stocks and the use of additional storage accommodation, which may outweigh these price advantages.

*Evidence*

66. The evidence we have received shows that while certain types of supplies, such as perishable foodstuffs, fuel, oxygen and anaesthetic gases and certain building materials are best delivered to individual hospitals there is a wide range of supplies which can be delivered in any one of the three ways mentioned above. The type of supplies, the location and size of the hospitals in the group and the availability of storage accommodation will all affect the storage arrangements.

67. Subject to these governing factors, the evidence before us suggests that delivery to group central stores is considered to be the most efficient and economic method in the case of relatively compact groups. The advantages and disadvantages in this method are set out in the following extract from the memorandum of evidence submitted to us by the Institute of Hospital Administrators :

> ". . . we have sought to obtain information on the comparative costs of different types of group supplies organisation, but the information obtained has not proved as helpful as we should have liked. It is, however, our view in general terms that in relatively compact groups with adequate stores accommodation available at the main hospital, the most economical form of purchasing organisation is that based on group purchase combined with central storage. From the point of view both of purchasing and of storage and issue this form of organisation carries with it very substantial advantages, administrative and economic. With one delivery point the best possible terms can be obtained from suppliers. The work of ordering, of paying accounts, and of maintaining stores accounts and records is kept to a minimum. The task of checking and examining goods received and of testing for quality is simplified and can be more efficiently carried out under the direct control of the supplies officer. Proper and economical methods of storage can be better ensured and storage space reduced to a minimum. There can be closer control over the distribution of stores and of stock levels, and total stocks, and therefore the amount of money locked away in them, can be kept to a minimum. Waste resulting from the accumulation of obsolete goods can be better prevented and articles becoming obsolete for one hospital are more likely to be found a use in another. The collection and disposal of surplus and scrap materials are facilitated. Stock-taking and the estimating of requirements for the purpose of the annual estimates are simplified and simplification of requirements and standardisation of common user items are also more readily encouraged. Better qualified staff can be employed than would be available at individual hospital stores. Against these advantages must be set the costs of distribution which are entailed, and it is obvious that if the maximum economic advantage is to be secured from group purchase with central storage there must be an efficient organisation

of distribution to the consumer units. The maintenance of unit stores at the individual hospitals offers a means of reducing distributive costs by permitting less frequent distribution than would otherwise be necessary, but the maintenance of such stores also means that the economies and other advantages appertaining to central storage are reduced. If a central stores system is to be operated to the maximum advantage the maintenance of unit stores should as far as possible be eliminated."

*Our Views*

68. We agree that supplies of the kind mentioned in paragraph 66 are by their very nature only suitable for delivery to a hospital store or department. These items comprise a large proportion both in value and in bulk of hospital supplies. As regards the remainder of hospital supplies, delivery should normally be made to the individual hospitals or departments where they will be consumed or brought into use. Delivery should as far as economically possible be in such quantities and at such intervals as will maintain a minimum working stock with a reserve for emergencies.

69. When it would be uneconomical for delivery to be made by suppliers to an individual hospital, owing to its location, the size of its requirements, or lack of storage accommodation the requirements of that hospital should be met by the nearest hospital with suitable facilities for storage and delivery, or from a group central store.

70. The question whether a group central store should be established (or remain in operation if already in use) for any category of supplies should be considered primarily on economic grounds by comparing the savings which would result in suppliers prices and in costs at unit hospitals by bulk deliveries to a central point with the costs entailed in central storage including in particular transport and additional handling. Interest and depreciation on the capital cost of the store and on the capital value of the average stock holding should also be taken into consideration.

71. In a relatively compact group there is much to recommend group stores, especially where a frequent and regular transport system can be economically made available so that supplies can be issued from the group store to a unit hospital without going through the unit hospital's stores account.

## VI. MISCELLANEOUS

72. Our enquiries and the evidence we have received have covered a wide field and there are many other matters connected with the organisation of hospital supplies on which we might have commented. These matters are, however, mainly questions of comparative detail or involving procedure within the hospital group. Having regard to the inevitable variety in the organisation of hospital groups to which we have referred so frequently both in this Report and in our Interim Report, we have felt it best to confine our Final Report to matters of general principle.

73. There are, however, two subjects of particular importance at the present time which we think worthy of special mention. These are financial control and the related question of stores accounting. We are indebted to two of our members for a memorandum on the former subject and to the Institute of Public Supplies Officers and the Association of Chief Financial Officers in the Hospital Service for a joint memorandum on stores accounting.

74. We think these memoranda would be helpful to hospital authorities and their officers and we accordingly attach them as Appendices F and G respectively.

75. We have no special point to make on these memoranda except to point out that in both cases it is assumed that there is a Supplies Officer for the hospital group. As will be clear from Part IV of our Report, the need for such an appointment is in our view a matter for decision by the hospital authority concerned in the light of all the relevant circumstances. With this reservation and bearing in mind our general view that the supplies organisation of any hospital authority must be designed by the authority concerned to fit the circumstances of the authority, we commend these memoranda as a general guide.

## VII. CONCLUSION

76. We have described this as our Final Report and so far as our work as a Committee is concerned, we have now completed our task. There can, however, be no finality in this field of hospital organisation. As with the Hospital Service as a whole, there are frequent changes in needs which affect the hospital supplies organisation; these call for a high degree of flexibility. Moreover, there are constant changes in sources of supply and buying conditions; these also demand a constant review of the supplies organisation and of buying methods not only by individual hospital authorities and their joint contracting committees but also by Regional Hospital Boards and by the Ministry.

77. In this latter connection, we have been impressed by two points in the course of our enquiries. The first of these is the vast amount of detailed information which is available in the Ministry of Health and in particular to the Supplies Division of the Ministry about suitable sources of supply, trade conditions, and prices. Second, there seems to have been something of a natural inclination both on the part of Regional Hospital Boards and of the Ministry to refrain as a general rule from intervening in the field of arrangements for those supplies not covered by Ministry central arrangements and for which individual hospital authorities remain responsible. We feel, however, that the time has now come for both Regional Hospital Boards and the Ministry to take a more active part in encouraging individual hospital authorities and their joint contracting committees by co-ordinating their activities and pooling information on matters of common interest to authorities engaged in buying supplies of the same kind. This we give as our final recommendation and we consider that it is for the Ministry of Health, Regional Hospital Boards and other hospital authorities to review existing arrangements in this respect with the object of linking as effectively as possible the necessarily diverse and numerous purchasing authorities in the Hospital Service.

## VIII. SUMMARY OF RECOMMENDATIONS

The following summary is added for convenience of reference but should not be regarded as representing fully the recommendations we have made.

78. The adoption of joint contracting arrangements as described in paragraph 28 (*c*) of our Interim Report is generally recommended, subject always to the important qualification that such an organisation must be adapted to

serve the needs and resources of the authority concerned and must not be limited by hospital group boundaries or interests (paragraph 11 (*a-b*)). It will also need to be varied to suit the different kinds of supplies (paragraph 11 (*c*)). Greater use should be made of joint contracting with local authorities (paragraphs 11 (*b*) and 33).

79. Whatever the form of organisation used it must remain subject to the authority of the responsible hospital group (paragraph 11 (*d*)).

80. The ultimate responsibility for group supply arrangements at officer level must be that of the Chief Administrative Officer (paragraph 11 (*e*)) and that co-operation at all levels is essential for the success of any hospital supplies organisation (paragraphs 11 (*f*)).

81. In matters of importance national policy should outweigh other considerations though hospital authorities should be informed, where appropriate, by the Ministry of the policy reasons governing decisions on central supply arrangements (paragraph 21 (*b*)). It is right that central supply arrangements should remain on the present limited scale (paragraph 21 (*c*)) and the Ministry should review the scope of its purchases of domestic supplies with a view to devolving part of this work (paragraph 21 (*d*)).

82. The proposal for a new central bulk buying organisation, staffed by highly skilled buyers, is discarded but the value of specialist buying is recognised and specialisation by individual officers in the technique of buying different kinds of supplies should be encouraged with the development of joint contracting (paragraph 26).

83. Smaller suppliers should not be excluded from tendering for the whole or part of particular hospital requirements as they may be in a good position to meet such orders with speed and efficiency (paragraphs 28-29).

84. Group requirements should not be bought piecemeal by individual hospitals and in most cases group buying and joint contracting should be the general practice (paragraph 35).

85. There is wider scope for joint contracting for certain items of perishable foodstuffs but in the main group contracting or hospital contracting for these commodities is favoured. In present conditions of free competition and fluctuation in market prices hospital authorities are urged to review their arrangements for acquiring provisions bearing in mind four stated methods (paragraph 36 (*a*)).

86. As regards drugs and dressings joint contracting by numbers of groups seems to be the method which should be used if practicable (paragraph 36 (*c*)).

87. The purchase of medical and surgical appliances and equipment is carried out chiefly by the Ministry and other purchases should be made at group or occasionally hospital level (paragraph 36 (*d*)).

88. Where arrangements are not made by the Ministry joint contracting would seem to be the best method for " common user or domestic " supplies (paragraph 36 (*e*)).

89. The results of the operation of printing departments should be reviewed from time to time to ensure that they are operating on a competitive basis (paragraph 36 (*e*)).

90. As regards solid fuel supplies the position should be examined by contracting committees and their parent hospital groups in the light of local conditions, current costs of supplies, technical advice offered by suppliers and the grade of coal required. Petrol and fuel oil contracts should be arranged to secure the most favourable terms (paragraph 36 (*f*)).

91. Responsibility for important supplies decisions cannot be assigned solely to departmental heads, such as Pharmacists, Catering Officers and Engineers. A high degree of co-operation at all times and at all levels is essential and while a lot of the work can be dealt with on the administrative side full advantage must be taken of specialist knowledge and advice (paragraphs 50–52).

92. The position of Supplies Officers is considered vis-à-vis the departmental heads and the administration. Supplies work should not necessarily lead to a separate career distinct from hospital administration. The fact that specialisation has led to the discouragement of interchange between senior administrative posts is regretted (paragraph 61).

93. Both Regional Hospital Boards and the Ministry should take a more active part in encouraging individual hospital authorities and their joint contracting committees by co-ordinating their activities and pooling information on matters of common interest to authorities engaged in buying supplies of the same kind. It is for the Ministry of Health, Regional Hospital Boards and other hospital authorities to review existing arrangements in this respect with the object of linking as effectively as possible the necessarily diverse and numerous purchasing authorities in the Health Service (paragraph 77).

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94. Finally, we wish to pay tribute to the staff of the Ministry of Health to whose expert help, advice and hard work we are greatly indebted ; in particular, we should mention the staff of the Supplies Division of the Ministry and, of course, our Secretary, Mr. L. B. Jacques.

(Signed) FRED MESSER (*Chairman*).
COHEN.
A. F. BRADBEER.
P. H. CONSTABLE.
*B. GIBSON.
F. S. STANCLIFFE.
A. HOWARD.
H. LESSER.
G. MARTIN.
T. E. PARKER.
J. E. STONE.

L. B. JACQUES.

May, 1958.

* Signed subject to the following Reservations.

## Reservations by Sir Basil Gibson, C.B.E., J.P.

1. I am not in accord with my colleagues on the Committee upon the duties of the Catering Officer and the status and duties of the Supplies Officer.

2. I refer to paragraph 53 (*b*) on Page 27 of the Report with regard to Catering Officers. The Committee's view is that the duties of these officers if and when fully qualified by training and experience should include the buying of provisions, and of perishables in particular. My view is that the work of the Catering Officer should be discharged within the hospital, and broadly should consist of receiving and accepting the food supplied when he is satisfied with its quality, responsibility for storage whilst it is in his custody, its preparation for and its cooking, and its service to patients and staff. The full and complete exercise of these duties is paramount and essential to the well-being of the hospital, patients and staff and I consider that the food service is bound to suffer if the duties of the Catering Officer include the purchase of supplies of food involving as it does his absence from the hospital to visit markets and suppliers, and further his power to refuse supplies on the ground of quality is hampered. The reputation of a Catering Officer is built up by the excellence of the food and its service to patients and staff, and adds greatly to the repute of the hospital.

3. I refer to paragraph 55 on Page 28 of the Report, the last sentence of paragraph 56, paragraph 57 on Page 29 and paragraph 61 on Page 30 with regard to Supplies Officers.

4. The paragraphs I have referred to appear to me to denigrate the status of a Supplies Officer though this is not the intention of the Committee. My experience of these officers is limited to those in the service of the larger Hospital Management Committees, and perhaps I ought to make it clear that I have never suggested that every Hospital Management Committee should have a Supplies Officer on its staff, but I do consider that one should be available for consultation. This can be secured by a number of Hospital Management Committees combining for the purpose of joint contracting.

5. I concede at once that a great deal of the work of the Supplies Department is administrative—that appears to be a common factor in the duties of all professional officers. In the case of the Supplies Officer this administrative work is largely discharged by his staff of administrative and clerical grade officers. His personal work is predominantly of a professional character and his ability to discharge it requires long and arduous training and great experience. I do not think the post of Supplies Officer should be compared with the posts of Chief Pharmacist or Catering Officer—the salary scales clearly indicate that these posts are not comparable, and further these scales also show that there are few senior administrative posts in the Hospital Service carrying a larger remuneration than the post of Supplies Officer and that the career of a Supplies Officer is well worth pursuing. The Hospital Service needs the services of first class Supplies Officers.

6. Normally, I do not make adverse comment upon the report of a committee on which I have served. In this case I feel I must, in order to correct any impression a reader of the Report may receive that the views I have expressed on many public occasions when advocating joint contracting in the Hospital Service on the two points mentioned in this note have been modified by the work of this Committee. On the contrary they have been strengthened.

(*Signed*) Basil Gibson.

# APPENDIX A

## Questionnaire sent to Regional Hospital Boards and Boards of Governors with Explanatory Note

*Note :*

(*a*) Where there are separate arrangements for different classes of supplies please give details applicable to each class listed in explanatory note.

(*b*) Where procedure is not clearly indicated by the answers to the questions, please give further details.

(*c*) In the case of Hospital Management Committees brief details should be given of any individual circumstances or special features of the hospitals included which affect the supply arrangements.

*Requisitioning*

1. What officers are responsible for issue of requisitions?

2. What subsequent officer or committee approval is required before goods are supplied from stores or ordered from outside suppliers?

*Ordering*

3. What officers are responsible for ordering supplies?

(*a*) Direct supplies?

(*b*) Supplies to replenish stores?

(Where departmental officers or hospital officers other than the supplies officer are permitted to buy their own requirements give precise scope of delegated powers.)

*Contracting*

4. What method of purchasing is adopted (e.g. fixed quantity contracts, period contracts, spot buying) and in what circumstances are price variations and determination clauses included in contract conditions?

5. What officers are responsible for arranging contracts or spot buying? To what extent is committee authority required?

6. Where joint purchasing arrangements are in operation what other authorities participate?

*Supplies Officer*

7. What duties are assigned to the Supplies Officer (if appointed)?

8. Does the Supplies Officer hold any other office in the group?

9. To whom is the Supplies Officer responsible?

10. What numbers and categories of staff are subject to the control of the Supplies Officer (or other officer responsible for supply arrangements)?

*Storage and Issue*

11. How many stores are in operation in the group and what staff are employed?

(*a*) Central Stores.

(*b*) Hospital Stores.

12. To whom are stores staff responsible?

13. What method or methods are used for requisitioning and issuing?

(*a*) Central Stores.

(*b*) Hospital Stores.

14. Where central stores and hospital stores are maintained, in what manner is the work divided?

15. What system is in use for recording by quantity and/or value the receipts, issues and stock levels of each class of supplies held in stores. What officers are responsible for maintaining these records?

16. How are stock levels controlled and how often are they reviewed and by whom? What steps are taken to ensure a regular turnover and to prevent over or under-ordering or requisitioning?

17. How often is obsolete stock condemned and by whom?

18. How often are the costs of operating central stores and hospital stores ascertained and what are the results?

*Statistics*

19. Please complete attached form.

*Standards and Quality*

20. To what extent have joint or central purchasing or contracting arrangements resulted in standardization or simplification of the types and patterns of goods purchased?

21. Where British Standards have been published, are they specified in contracts or orders and, if so, to what extent?

22. Are arrangements made to test deliveries of goods for quality as well as quantity and to check them against specification or sample?

*Comments of Committee or Board*

23. Have the Committee or Board any views on any of the general questions mentioned in the report of the Committee on the Internal Administration of Hospitals as requiring further consideration, e.g.

(*a*) the possible scope for further extension of central purchasing or contracting ;

(*b*) the relative advantages and disadvantages of central purchasing compared with central contracting ;

(*c*) the merits and demerits of central stores.

24. Have the Committee or Board any comments on the Ministry's central supply arrangements under which certain supplies are at present obtained through Ministry stores or under Government contracts negotiated by the Ministry or by other Government Departments acting as agents of the Ministry?

25. Are there any other matters within the scope of the Committee's terms of reference on which the Committee or Board wish to comment?

## SUPPLIES AND STORAGE STATISTICAL INFORMATION

*Authority*.....

| | Class of Supplies | | | | |
|---|---|---|---|---|---|
| | Provisions | Drugs | Dressings | Uniforms | etc. etc. |
| | £ | £ | £ | £ | |
| A. PURCHASING | | | | | |
| *Annual value of supplies obtained* | | | | | |
| (a) From Ministry (excluding free issues) ... ... ... ... | | | | | |
| (b) Under joint purchasing with other Groups ... ... ... | | | | | |
| (c) Under joint contracting with other Groups ... ... ... | | | | | |
| (d) Under Central purchasing ... ... ... ... ... | | | | | |
| (e) Under Central contracting ... ... ... ... ... | | | | | |
| (f) Direct purchase by Hospitals ... ... ... ... ... | | | | | |
| (g) Other methods (e.g. arrangements for supply by Local Health Authorities) ... ... ... ... ... ... | | | | | |
| TOTAL ... ... ... ... ... ...£ | | | | | |
| B. STORAGE | | | | | |
| *Annual value of supplies* | | | | | |
| (a) Delivered to Central Stores ... ... ... ... ... | | | | | |
| (b) Delivered to hospital stores— | | | | | |
| (i) by Central Stores ... ... ... ... ... ... | | | | | |
| (ii) by Suppliers ... ... ... ... ... ... | | | | | |
| (c) Delivered direct to hospital without going through a store... | | | | | |
| TOTAL ... ... ... ... ... ...£ | | | | | |

*Note:* Goods delivered to Central Stores and also passing through Hospital Stores should be entered at both (B) (a) and (b) (i) if records of receipt and issue are maintained at both stores.

1. Where reference is made to classes of supplies in the questionnaire, the individual classes in respect of which information is desired are:

Provisions.
Drugs.
Dressings.
X-ray apparatus and materials.
Medical and surgical equipment and supplies.
Staff uniforms.
Patients' clothing.
Fuel, light and power.
Building and engineering materials.
Furniture and furnishings.
Hardware and crockery.
Bedding and linen.
Cleaning and chandlery.
Printing and stationery.
Supplies for canteens and shops.
Occupational therapy equipment and supplies.
Supplies for farms and gardens.

2. The questionnaire (except Question 24) relates only to supply arrangements made by hospital authorities themselves and excludes arrangements made by the Ministry.

3. The terms "joint purchasing", "joint contracting", "central purchasing" and "central contracting" in the questionnaire have the meaning attached to them in the Report of the Committee on the Internal Administration of Hospitals. This is:

*Joint Purchasing*
*Joint Contracting*

Arrangements between two or more Hospital Management Committees or Teaching Hospital groups under which the participating groups combine their requirements in joint contracts of the kinds mentioned below.

*Central purchasing*

Arrangements within a Hospital Management Committee or Teaching Hospital group under which the total requirements of hospitals in the group are combined in contracts providing for orders to be placed by the group for delivery of goods either (*a*) to a group store or sub-store or (*b*) direct to an individual hospital.

*Central contracting*

Arrangements within a Hospital Management Committee or Teaching Hospital Group under which the group negotiates contracts providing for orders to be placed by individual hospitals independently within the terms of the contracts.

## APPENDIX B

List of associations, organisations etc. who have given evidence, orally or by submitting memoranda to us or our sub-committees.

Regional Hospital Boards.
Boards of Governors.
Hospital Management Committees (mostly as selected by Regional Hospital Boards).
Ministry of Health Supplies Division.
Association of Chief Financial Officers in the Hospital Service in England and Wales.
Association of Hospital Management Committees.
Association of Hospital Matrons.
Birmingham and Midland Hospitals Pharmacy Committee.
British Dental Association.
British Standards Institution.
Department of Health for Scotland.
Federation of Surgical Instrument Manufacturers.
Guild of Public Pharmacists.
Hospital Catering and Diet Committee of the King Edward's Hospital Fund for London.
Hospital Caterers Association.
Institute of Hospital Administrators.
Institute of Public Supplies Officers.
Institution of Hospital Engineers.
Joint Committee of Supplies Officers of the Metropolitan Hospital Regions.
Medical Superintendents Society.
Middlesex County Council.
Ministry of Power.
National Coal Board.
National Federation of Meat Traders Associations.
National Federation of Ironmongers.
National Association of Hospital Management Committee Group Secretaries.
National Association of Wholesale Grocers and Provision Merchants.
National and of Local Government Officers Association.
Purchasing Officers Association.
South West Metropolitan Hospital Pharmacists Committee.
Surgical Instrument Manufacturers Association.
Teaching Hospitals Association.
Textile and Clothing Contractors Association.
White Fish Authority.

In addition to the above mentioned many individuals, group of individuals and a number of selected hotel and catering organisations submitted evidence for the Committee's consideration.

## APPENDIX C

## Analysis of Gross Hospital Maintenance Expenditure for the year 1956–57 (England and Wales)

| | £ |
|---|---|
| Provisions ... ... ... ... ... ... | 37,123,048 |
| Staff uniforms and clothing ... ... ... | 1,903,472 |
| Patients' clothing ... ... ... ... ... | 1,665,963 |
| Drugs and dressings ... ... ... ... | 11,738,637 |
| Medical and Surgical appliances and equipment | 10,393,428 |
| Furniture and fittings ... ... ... ... | 3,234,484 |
| Hardware and crockery ... ... ... ... | 1,113,157 |
| Bedding and linen ... ... ... ... ... | 2,326,807 |
| Cleaning and chandlery ... ... ... ... | 1,641,441 |
| Printing, stationery, etc ... ... ... ... | 2,272,643 |
| Canteens and shops ... ... ... ... ... | 2,365,356 |
| Farms and gardens ... ... ... ... ... | 1,438,922 |
| Occupational therapy ... ... ... ... | 486,990 |
| Fuel, light and power ... ... ... ... | 19,196,575 |
| Maintenance of buildings, plant and grounds ... | 12,858,267 |
| Total | £109,759,190 |

## APPENDIX D

## Notes on the Ministry's Central Contracting and Supply Arrangements

1. *Functions of Supplies Division*

The Supplies Division of the Ministry has four main functions:

(*a*) Production responsibility for medical supplies, involving the sponsorship of the medical supply industries, allocation of materials subject to control, advice on import licence applications, import programming, export trends and other duties related to Government economic policy generally.

(*b*) Purchase of medical supplies required by the Armed Forces and by Government Departments generally.

(*c*) Organisation of supply and purchase of reserves of equipment and supplies needed for the Ministry's civil defence services.

(*d*) Central contracting and purchasing of medical and domestic supplies for the hospital service.

The production and purchasing functions under (*a*) and (*b*) above were transferred to the Ministry from the Ministry of Supply at the end of 1947. The remaining functions have been added since the establishment of the National Health Service in 1948.

2. *Selection of fields to be covered by the Ministry's central supply arrangements for the hospital service*

The fields of supply at present covered by the Ministry's central arrangements for the hospital service were selected for a number of different reasons. Some were originally suggested by hospital authorities, some by advisory bodies

such as the Medical Supplies Working Party and others by the Ministry. Many suggestions have been rejected after investigation because there was no apparent financial or other advantage in Ministry contracting.

The general policy has been to concentrate on the common-user goods needed by all hospitals in much the same form, to establish and maintain reasonable standards of quality and so to secure the full advantages of large-scale purchasing and contracting wherever practicable.

When preliminary examination of a suggestion has indicated that there may be advantages in central supply arrangements, it has generally been the practice to advise hospital authorities that the possibilities are being explored and to ask for information about their existing supply arrangements (prices paid, qualities and sizes purchased, delivery quantities, annual requirements, etc.). Central supply arrangements have then been made only when it is clear from analysis of this information that there will be overall financial advantages in Ministry contracting or purchasing.

In the case of some drugs—mainly new antibiotics, cortisone, A.C.T.H., and B.C.G., economy is not necessarily the primary consideration. It has been the policy, wherever possible, to restrict the distribution and use of new and potent drugs while they are still in the development stage and little is known medically about them—and incidentally, they are very expensive. As medical knowledge increases and the drugs become more freely available, they may be released for general use but, so far as hospital use is concerned, may remain under central contracts which generally show some financial advantages. This pattern has been followed in the case of penicillin, streptomycin, chloramphenicol, aureomycin, terramycin and tetracycline (all antibiotics), cortisone and A.C.T.H., and B.C.G.

3. *Selection of items and qualities*

The selection of items and qualities covered by the Ministry's central supply arrangements results, in the main, from the views expressed and the information supplied by hospital authorities themselves. This is particularly evident in the arrangements for supply of (*a*) cleaning materials, hardware, brushware, etc., and (*b*) paper, office machinery and office requisites, which are under continuous review by working parties comprising representatives nominated by the Association of Hospital Management Committees and the Teaching Hospitals' Association. Selected hospital Supplies Officers with particular experience in these fields also assist these working parties. By this means, the types, patterns, sizes, etc., commonly needed are determined and reviewed, although in the case of paper and office requisites, it is necessary also to integrate supplies with those provided by the Stationery Office for the Crown Services generally.

In the case of X-ray apparatus and of laboratory equipment, the Ministry relies upon the advice of the various Groups of the Medical Supplies Working Party, which consists largely of consultants in the specialities concerned.

In other fields, e.g., mattresses, spectacles, the items and qualities covered generally select themselves and there is little need for consultation.

4. *Central purchasing* v. *central contracting*

In making Ministry arrangements for hospital supply, the policy throughout has been to provide, so far as possible, for deliveries to be made direct to hospitals by the contractors, the hospitals themselves placing orders on the nominated contractors and settling their accounts at notified contract prices. Many of these contracts are for fixed quantities of goods to be delivered by the contractors during a defined period, which never exceeds twelve months. In the event of the full contract quantity not being taken up by hospitals, the Ministry may, therefore, be obliged to purchase the balance, thus converting central

contracting into central purchase (and, incidentally, supplying one of the reasons why independent purchasing by hospitals of similar goods is inadvisable, since it can lead to duplication of expenditure.)

The main classes of goods dealt with in this way are:

(*a*) X-ray films and paper.

(*b*) Spectacles.

(*c*) Theatre and ward rubber goods.

(*d*) Mattresses.

(*e*) Antibiotics and Hormones.

(*f*) Drugs and dressings (Scotland only).

(*g*) Drugs (Wales only).

(*h*) Cleaning materials, hardware, brushware, etc., (contracts placed by the Ministry of Works)

Central purchasing, which generally involves delivery to Government stores for re-distribution to hospitals, is mainly confined to six classes of goods. These are:

(*a*) Hearing aids and batteries—the aids being distributed from store only to hospital hearing aid centres and the batteries to battery-issuing hospitals.

(*b*) Blood transfusion equipment—distributed from store to the blood transfusion centres.

(*c*) Laboratory apparatus and glassware—distributed from store to any hospital laboratory, monthly indents being sent to the Ministry.

(*d*) Paper, office machinery and office requisites—distributed from Stationery Office depots, orders being sent by hospitals quarterly to the depots.

(*e*) Special drugs when first available and in short supply.

(*f*) X-ray apparatus—generally distributed direct to hospitals by contractors but apparatus may sometimes be taken into store (e.g., to replace apparatus supplied from stocks).

Payment of the contractors for these classes of goods is made by the Ministry or by the Department placing the contract on behalf of the Ministry (Post Office for hearing aids and batteries and Stationery Office for paper, etc.). No charges are made to hospitals for (*a*) hearing aids and batteries and (*e*) the special drugs, but the cost of (*b*) Blood transfusion equipment, (*c*) Laboratory apparatus and (*f*) X-ray apparatus is notified to hospital Boards and Committees and is thus reflected in their accounts. In the case of (*d*) paper, etc., payment is made by hospital Boards and Committees direct to the Stationery Office.

5. *Services provided by other Departments*

As already indicated, the Ministry itself negotiates the contracts for the supply of medical supplies to hospitals but does not, as a rule, contract for the supply of domestic and other goods. Other Government Departments already possess the purchasing machinery and the technical staffs needed to place contracts in the non-medical fields and it has accordingly been the policy to invite these Departments to undertake the contract work. The major examples of this are hearing aids and batteries (Post Office), cleaning materials, etc. (Ministry of Works), paper, etc. (Stationery Office) and textile goods (Ministry of Supply). These arrangements work smoothly and make the best use of the available Government purchasing machinery.

6. *Obligation to comply with Ministry arrangements*

The Ministry has advised Boards of Governors and Hospital Management Committees where central supply arrangements have been made by the Ministry, that they should not enter into contracts for the supply of equipment and stores under central supply, but although the use by hospitals of the central purchasing and contracting arrangements is not compulsory, in fact, only occasionally is it reported that hospital authorities invite tenders or place contracts for the supply of the same goods. The undesirability of this and the danger of duplicating Exchequer expenditure, apart from the necessity to maintain faith with contractors who have tendered in competition for the Ministry's contracts, are then pointed out.

One central purchasing scheme is completely optional. This is the supply of laboratory equipment and glassware to hospital laboratories, which started during the war with central supply of these goods to Emergency Medical Service Hospitals and has continued ever since. Actually, hospitals find the service and the prices so satisfactory that the number of hospital pathological laboratories coming to the Ministry for supplies has increased from about 200 in 1948 to 861 in 1957.

One scheme applies only to Scotland. For some years, contracts have been placed by the Ministry on behalf of the Department of Health for the supply of drugs and dressings to hospitals in Scotland. The items covered are selected by the Department of Health in consultation with their hospital authorities but the scope of the scheme has been gradually widened as it became apparent that a satisfactory service could be provided and money saved. Similar arrangements in respect of drugs only have been made since 1954 on behalf of the Welsh Regional Hospital Board.

7. *Control of Quality*

Detailed specifications are written in to practically all contracts and there is very little purchasing and contracting solely by reference to tender samples although samples are often required in addition. The specifications are made available to hospitals when necessary. If there is a published British Standard for any article, it is the practice to specify that it shall be made to that Standard.

As in the case of Government purchasing generally, inspection of contract goods is generally undertaken at manufacturers' works, samples then being taken for analysis as necessary. In the field of medical supplies, this inspection is undertaken by qualified technical officers on the staff of Supplies Division who are also responsible for technical development work, drafting of specifications, etc. Similar arrangements are made by the other Departments placing contracts on behalf of the Ministry.

As such inspection cannot be complete when goods are moving direct from contractors to hospitals, arrangements are also made for any hospital criticism of quality to be reported to the Ministry. In addition, selected hospitals send samples of current deliveries (e.g., cleaning materials, soap, etc.), periodically for analysis and check.

These arrangements generally suffice to ensure that the goods supplied meet the specifications. Rejections are not infrequent but it is rarely necessary to determine a contract on the ground of persistent failure to supply goods of the quality specified.

The development of Standards by the British Standards Institution throughout the hospital supply field is actively supported by the Ministry. Supplies Division provides technical and other representatives for over 70 committees of the B.S.I.

8. *Purchase of prototype and experimental equipment*

The Ministry's central purchasing arrangements provide also for the development and purchase of new and experimental equipment for technical examination and clinical testing. Most but not all of this work stems from the recommendations of the various Groups of the Medical Supplies Working Party, the particular fields in which activity has mainly been concentrated being equipment for treatment of poliomyelitis and respiratory conditions, X-ray apparatus and laboratory apparatus.

9. *Annual value of contracts*

The approximate annual values of the contracts placed by the Ministry and by other Departments on behalf of the Ministry during 1956 for the supply of goods to hospitals (excluding purchases for Civil Defence reserves) were:

| *Class of supply* | *Annual value* £ |
|---|---|
| *Ministry Contracts* | |
| Blood transfusion equipment, laboratory apparatus and glassware | 230,000 |
| X-ray apparatus and mass radiography units | 1,350,000 |
| X-ray films and paper | 3,100,000 |
| Spectacles | 124,000 |
| Theatre and ward rubber goods (including latex foam mattresses) | 313,000 |
| Mattresses, interior spring and hair | 43,000 |
| Antibiotics | 1,217,000 |
| Cortisone, Prednisone and A.C.T.H. | 782,000 |
| Dextran | 50,000 |
| Other special drugs (including B.C.G., Old Tuberculin, Anti-Anthrax and other sera) | 28,000 |
| General drugs (Scotland only) | 97,000 |
| General drugs (Wales only) | 52,000 |
| Dressings and Sanitary Towels (Scotland only) | 190,000 |
| Breathing apparatus | 10,000 |
| Hearing Aids (non-electric) and Ear Moulds | 17,000 |
| Miscellaneous (including experimental equipment) | 4,000 |
| *Contracts placed by other Departments* | |
| Cleaning materials, hardware, brushware, etc. (Ministry of Works) (England and Wales only) | 580,000 |
| Paper, office machinery and office requisites (Stationery Office) (England and Wales only) | 405,000 |
| Hearing aids (electric) and batteries, spares and repairs (includes supplies for Scotland and Northern Ireland) (Post Office) | 724,000 |
| N.H.S. Reserve Uniforms, Blood Transfusion Service Uniforms, etc. (Ministry of Supply) | 48,000 |

10. *Ministry meetings with Supplies Officers*

Periodical meetings between Supplies Division and hospital Supplies Officers from each Region and from teaching hospitals have been held since 1951. The Supplies Officers (generally one from each Region) are nominated under arrangements made with R.H.B. Secretaries and with the Teaching Hospitals Association. The purpose of these meetings is to provide a forum for discussion of day-to-day supply problems; and these frank and informal discussions have brought to light many difficulties of a practical kind resulting from the operation of the Ministry's central purchasing and contracting arrangements for the hospital service and in this respect they are undoubtedly of value both to the Ministry and to Supplies Officers. Many improvements in and modifications of the Ministry's arrangements have resulted from the meetings, which are, however, in no sense confined to this subject. There have also been useful discussions, for example, on such widely different subjects as meat, milk and margarine supplies, contracting for provisions generally, quality of electric lamps, substitution of rayon for cotton, floor treatments, use of detergents and many other matters quite unconnected with the Ministry central supply arrangements. Notes of all meetings, which often contain useful information, are circulated to all those attending the meetings; Secretaries of R.H.Bs. get copies and the information is generally disseminated through Regional meetings of Supplies Officers. In this way, there is a link between Supply Officers generally and the Ministry which not only secures a large measure of co-operation but leads to more efficient hospital supply services.

## APPENDIX E

## Joint Contracting

## Summary of the replies received from Regional Hospital Boards and Boards of Governors to the request for a review of supply arrangements by Hospital Authorities contained in H.M. (57) 25

*Note:* The information given takes into account joint contracting schemes not only in full operation but in various stages of development and investigation.

*Regional Hospital Boards*

1. In our Interim Report special reference was made to existing joint contracting schemes for the purchase of drugs and dressings and of textiles and certain other common user supplies. It is, therefore, perhaps not surprising that the greatest progress in developing joint contracting schemes has been made in these fields. The following is the latest position as regards Hospital Management Committees shown in the replies to the Minister's circular, but it is quite likely that since these replies were received further progress has been made;

(*a*) *Drugs*

In all the 13 English regions (Wales is already covered by Ministry central supply arrangements for similar types of drugs) joint contracting for a substantial part of the drug supplies not covered by Ministry contracts has either been or is likely to be adopted by all or some of the Hospital Management Committees in each region. Over 100 groups are already participating and many more are likely to do so.

(*b*) *Dressings*

Participation in joint contracts is almost as widespread.

(*c*) *Textiles etc.*

In nearly all regions the adoption or extended use of joint contracting is reported in varying degrees and for a wide variety of categories of supplies. A list of the miscellany of the items said to be covered by or under investigation for joint contracts in different areas is given below:

Antiseptics.
Detergents.
Sodium Metasilicate.
Laundry Bleach.
Surgical Sundries.
Needles, Sutures etc.
Sputum Containers.
Clinical Thermometers.
Crockery and Glass.
Cutlery.
Holloware.
Patients Clothing.
Dress Materials.
Boots and Shoes.
Uniforms: Coats.
Protective Clothing.
Textiles.
Sheets: Shrouds.
Drawsheets.
Sheeting.
Pillow Slips.
Towels, Towelling.
Maternity Pads.
Sanitary Towels.
Napkins, Paper Tissues.
Blankets.
Counterpanes.
Matches.
Coke–Coal.
Fuel Oil–Petrol.
Electric Lamps.
Electrical Goods.
Hardware.
Engineering Supplies.
Fire Extinquishers.
Leather.
Paint.
Printing.
Furniture; Floor Coverings.
Insulated Cables.
Printed Forms, Paper, X-ray Envelopes.
Funerals.

(*d*) *Provisions*

When submitting our Interim Report we did not anticipate that much scope would be found for joint contracting in this field except possibly for certain categories of non-perishable food stuffs. We are, therefore, interested to find the extent to which arrangements have been made, or experiments are in progress on a limited scale in most regions. These cover such items as:

Bread.
Flour.
Cocoa.
Cordials and Minerals.
Eggs.
Fish.
Fresh Fruit and Vegetables.
Margarine and Fat.
Meat.
Bacon.
Milk.
Poultry.
Tea.
Sugar.
Butter.
Cheese.
Jam, Syrup etc.
Canned Food.
Ice Cream.
Soft Drinks.

*Boards of Governors*

2. In the case of provincial Boards of Governors there has, with one exception, been close co-operation with other hospital authorities in the regions

concerned. As a result, in many cases Boards are participating in joint contracts with Hospital Management Committees.

3. In the London area although there are a number of cases of joint contracting between the London teaching hospitals and nearby groups of Hospital Management Committees the recent major developments have taken a different form. There are three experimental schemes for joint contracts for general drugs, textiles and provisions (canned goods, fats and other commodities) in which most, or a substantial number of the London teaching hospitals are either taking part or are considering doing so.

## APPENDIX F

## Memorandum on Financial Control

The efficient purchase of supplies is but one aspect of the important subject of hospital supplies, financial control of such supplies is another of equal if not greater importance if regard is had to the fact that supplies are merely cash in another form—a form easy of misuse and misappropriation—and they should therefore be subjected to the same rigid control as is employed in the case of cash. Moreover, the introduction of departmental accounting into the hospital service on 1st April, 1957, invests the whole subject of hospital supplies with an added importance in view of the need to make a correct charge to departments of goods issued.

Financial control in connection with hospital supplies would seem to fall logically into three divisions—(I) Policy ; (II) Organisation ; (III) Accounting. Policy is a matter for the governing body operating through a designated Committee or Sub-Committee which will lay down the rules and regulations which are to operate in the purchase and control of supplies. (See Section I.) Organisation includes the routine processes of ordering, receiving, custody, issuing and stocktaking. This function may operate through a supplies or other officer designated for the purpose. (See Section II.) Accounting includes the routine processes of recording cost of purchases ; payment of accounts ; cost of issues, and ultimate charging to subjective accounts and departmental accounts, and reporting costs, etc. (See Section III.)

The point is that there should normally be a complete record of all the transactions connected with supplies from the ordering of the goods through to their ultimate issue for consumption or use. In this connection it will be realised that the organisation of a particular group may have a considerable effect upon the method of control to be introduced. The existence of a central stores, no matter where situated, often gives rise to entirely different procedures to those obtaining at a hospital possessing its own stores. Under the former arrangement it is possible that supplies are requisitioned in bulk by the unit hospitals for re-distribution within the hospital and the central stores has no knowledge of the ultimate destination of the issues. Stores ledger accounting, therefore, is dealt with at group level but departmental analysis can only be provided at unit hospital level where, it is suggested, control should also be exercised. No difficulty arises where central stores are issued direct to departments within unit hospitals.

It will be realised also that in any system of supplies control there must necessarily be a double aspect, viz.:

(i) The requirements of the officer responsible for the physical custody, issue and replenishment of supplies,

(ii) the requirements of the officer responsible for accounting for supplies in terms of money and for both subjective and objective accounting records.

In the case of the former time is very much " of the essence of the contract ". He must know at frequent intervals, perhaps daily and at the most weekly, the current position in order that stock levels may be maintained, queries as to the availability of supplies answered with knowledge as to the advisability of " buying-in " when markets are favourable. Against this, the finance officer's requirements may well be met by monthly or even quarterly figures. This may lead to a duplication of records to an unnecessary degree. Indeed it has already done so in a number of hospitals. A solution of the problem may be found along the lines of the finance officer producing figures promptly for the use of the supplies officer.

## SECTION I: CONTROL OF SUPPLIES BY COMMITTEES

The Committee will outline the general organisation of the supplies activity which may or may not be the responsibility of a separate department and lay down specific regulations to cover at least the following aspects of the subject:

1. Kind of supplies to be purchased by tender and contract.
2. Kind of supplies which may be purchased outside tender and contract, e.g. on quotation alone.
3. Arrangements for examination of tenders and quotations, e.g., ad hoc supplies sub-committee.
4. Officer(s) authorised to purchase and have custody of supplies.
5. Limitations as to amount which may be spent outside contract—without prior approval of designated Committee or officer.
6. Officers authorised to requisition supplies from stores (*a*) Group; (*b*) Hospital.
7. Officer(s) responsible for maintenance of Stores Accounts.
8. Treatment of (*a*) supplies issued from group stores to hospital stores, and (*b*) bulk supplies received direct at hospital.

## SECTION II: CONTROL THROUGH ORGANISATION

*Ordering*

Official order forms essential. Number of copies to be made, e.g., to finance officer for subsequent checking of invoices; storekeeper to arrange for receiving, etc.

*Receiving*

Examination (*a*) quantity correct; (*b*) quality. Certifications. Delivery Notes. Returns of goods received to supplies officers and finance officer.

*Custody*

Wherever possible all goods should be taken into a physical store. Number of stores, supplies delivered direct to a department, e.g., X-ray films, coal, etc. to be regarded as stores until accounted for. Officers responsible for control of stores accommodation. Minimum and maximum stocks to be held.

*Issues*

Only on properly authorised requisitions. Fixed days for issues. Standard issues and specific requirements. Type of requisition—pre-printed, blank, or single item slips. Summary of issues for (*a*) Reports; (*b*) Costing.

*Receiving Invoices*

To be received direct by finance officer; compared with copy of order and supplies received returns; checked against contracts and quotations (by finance officer or supplies officer). Stores Accounts under control of Finance Officer.

*Payment of Accounts*

Generally monthly but more promptly to obtain better discounts. List to Finance Committee. Examination of Accounts by Committee, if necessary. Signing of cheques.

*Charging Accounts*

Control (subjective) accounts in General Ledger. Departmental accounts in Cost Ledger.

## APPENDIX G

# Memorandum on Stores Accounting submitted by the Institute of Public Supplies Officers and The Association of Chief Financial Officers in the Hospital Service

Sir Frederick Messer, C.B.E., M.P., J.P.,
Chairman of the Committee on Hospital Supplies.

Sir,

### STORES ACCOUNTING

1. You will recall that last autumn delegates of the Institute of Public Supplies Officers were afforded an opportunity of giving oral evidence before your Committee, and of dealing with a questionnaire which the Secretary of your Committee submitted to the Institute on the 1st November, 1956.

That questionnaire contained the following question:

> Have the Institute any views on the best method of recording receipts and issues for central or other stores, having regard to the recent developments in Hospital costing?

2. It was subsequently suggested by yourself and your Committee that it would assist your deliberations if this Institute considered the question in conjunction with the Association of Chief Financial Officers in the Hospital Service in England and Wales, and submitted an agreed memorandum.

3. Our two organisations have welcomed the opportunity thus afforded us of collaborating on a matter in which both are closely concerned in practice, and this Memorandum sets out the agreed views of the Institute and the Association on this question.

*General*

4. The introduction of central stores and developments in Hospital costing do not affect the basic principles of stores accounting and control; but will invariably necessitate an extension of the analysis and pricing of issues, with probably some modification of forms in use.

5. There is no " best method " as such ; the best method of recording stores receipts and issues must depend largely on such factors as local circumstances, the type and size of stores, the frequency with which particular commodities are issued and the extent of the analysis of issues required.

*Basic Principles*

6. Every system of recording stores receipts and issues should incorporate the following basic principles :

(*a*) Stores are equivalent to cash and they should be no less rigidly controlled. Therefore, adequate and satisfactory stores accommodation, which can be properly secured, is essential for proper control. Access to the Stores should be allowed only to bonafide members of the Stores Staff, but a duplicate key, the issue of which should be strictly controlled and recorded, should be available for use in absolute emergency.

(*b*) The Stores and Supplies Organisation must be on a sound basis, and the various responsibilities covering the ordering, custody and distribution of stores, and the return of unused stores, should be clearly fixed on particular individuals ; and the authorised signatories to all documents should be clearly defined.

(*c*) In our opinion there are circumstances in which it is not economic to maintain detailed stores records. Constant supervision should nevertheless be exercised and consideration might with advantage be given to the use of the imprest system in these cases. The determining level is not necessarily related to the size of the hospital, but to the quantity and value of the stores held.

(*d*) Stores records are necessary as a measure of control, and particularly for

1. security against loss ;
2. a check on the level of stores, (i) to indicate when re-ordering is necessary, and (ii) as a safeguard against over-provisioning ;
3. Departmental accounting.

(*e*) Quantity records (bin cards) kept in the Stores form an essential part of any system to enable a Storekeeper to accept responsibility for his physical stocks, and to facilitate control and independent checks.

(*f*) In designing a stores system, unnecessary duplication of records should be avoided, e.g. it is not of primary importance *where* the Stores Ledger is maintained, provided it is not in the Stores nor kept by the Storekeeper and that the records are readily available for the use of the officers concerned.

(*g*) Stores items must be clearly defined in each Hospital Authority, and additions or deletions from the list of approved stores should be made only with the approval of the Supplies Officer.

(*h*) Inefficient condemning procedures can lead to considerable financial loss. Both organisations in their main memoranda have commented on this point at length.

Applying these fundamental principles to the various aspects of Stores Accounting, and the matters raised in your Committee's question, our organisations make the following submissions to your Committee :

*Procedure for Ordering and Receipt of Goods—Issues from Stores, Returns to Stores and Primary Documents*

7. Replenishment of stores should be carried out in the light of current stock balances, pre-determined levels and contemplated usage. Purchases should always be against an official order signed by the Supplies Officer or other officer designated for that purpose.

8. On receipt, all goods should be entered in a Goods Received Record, which at a minimum should contain the following information:

Date of Receipt.
From whom received.
Order Number.
Description of commodity.
Quantity (in units of issue).
Entered by .....

The following data also may be usefully included in the Goods Received Record:

Materials Catalogue number
Delivery note number
Carrier
Price and value
Goods checked for (*a*) quality
and (*b*) quantity by . . .
Date invoice passed for payment.

All sheets in the Goods Received Record should be numbered consecutively, and written up immediately on receipt of the goods. The Storekeeper should post from this to his Quantity Records (bin cards) at the time of receipt.

The office copy (copies) of the Goods Received Record should pass from the Storekeeper as soon as possible after completion, and in any event not less frequently than once a week.

9. Documents requisitioning goods from a Store should contain the following information:

Description and quantity required
Signature of officer requisitioning
Signature of officer authorising the issue and his designation
Quantity actually issued
Signature of recipient
Signature of storekeeper.

Work may be reduced and simplified by

(i) the use of pre-printed requisition and issue forms containing the description and code numbers of goods in regular demand; and

(ii) designing the requisition form to act also as the issue note so that, with the necessary carbon copies, it may be used through all the various stages of the stores issue transactions.

Differently coloured forms for the various "routes" documents have to follow are also of considerable value.

10. The foregoing principles apply to:

(i) a Central Store or Hospital Store, where no Central Store exists; and

(ii) to any issue from a Central Store to a sub-Store or Hospital Store, but the forms may need modification.

11. Transfers between Stores must be authorised by the Supplies Officer, and should be recorded in the Goods Received Record of the receiving hospital. A transfer note should be issued by the issuing hospital and takes the place of the suppliers' invoice in the Stores procedure.

12. Stores returned to suppliers must be recorded, and the supplier advised.

13. Goods returned to Store should be accompanied by an advice note from the department concerned, be entered in the Goods Received Record and taken on charge in the Stores Ledger if serviceable. Unserviceable items should not be allowed to accumulate but should be subjected immediately to the system for condemning.

14. We would emphasise that time spent on good form design is amply repaid.

*Materials Catalogue*

15. A Materials Catalogue should be prepared for all items on Stores charge, showing for each article :

Code Number

Classification and/or description

Unit of issue.

This catalogue should be varied only with the approval of the Supplies Officer.

For any commodity issued from a Central Store, the unit of issue must be standard for all Hospitals served from that Store (the unit being small enough to meet the requirements of the smallest consumer) ; but each Hospital Store may have its own unit of issue to take account of local requirements.

The appropriate Materials Code Number should appear on each prime document recording the movement of that commodity.

*Pricing of Stores Issues and Returns*

16. The stores accounts may be kept in quantity and value ; or in quantity only subject to the pricing of issues to costed departments or hospitals.

The main advantages of keeping stores accounts in quantity and value as opposed to quantity only are to provide an up-to-date record of the value of stores in hand and to enable the stores accounts to be linked with and controlled by the financial ledger.

Which method is adopted is a matter for local determination, but it seems to us that a full system of Stores Accounting in quantity and value cannot be justified if it involves the employment of staff additional to those required for the alternative of pricing issues only.

Priced stores issues are necessary to ascertain and ensure that the appropriate objective or cost accounts bear a proper share of the cost of stores used, but it is not necessary to keep the stores records in quantity and value, nor to price each individual issue, in order to ascertain the correct charge to each department or hospital. This may be achieved by :

(*a*) summarising the quantities issued to any accounting point over a period, and pricing out the total issues of each commodity, or where not practicable—

(*b*) pricing out issues (or summaries of issues) to all but the major user, leaving the balance of expenditure to be charged to the major user ; or

(*c*) a combination of the methods of (*a*) and (*b*).

17. Returned unused stores should be brought back into Store at their issue price which may, or may not, be the current stores price.

18. Four methods in general use for assessing the price of issue were examined :

(a) *Average Price*

The price is recalculated after every receipt at a price different from the current average, and issues are then valued at the new average price. Pricing differences are reduced to a minimum.

The main disadvantage of this method lies in the necessity to re-calculate the average on each change of purchase price, but this work can be much reduced by the use of mechanical devices.

(b) *First In, First Out*

All stores are charged out at the price that was paid for them, and they are issued in strict order of receipt. One issue may have items at more than one price, and stocks held may also have several prices.

Although the cost of purchases is recharged exactly, the work of Stores Accounting is increased, and such a complex method creates difficulties in a mechanised system but would be simple in a manual system.

(c) *Standard Price*

A standard price is fixed for each article and issues are made at that price for a period, irrespective of cost or replacement price. The method has attractions but tends to be inaccurate. Unless prices are steady or the standard is constantly revised large pricing differences may arise which periodically have to be charged or credited to the user accounts.

(d) *Replacement Price*

Issues are charged out at the cost of replacing them. In a period of rising prices surplus balances must arise and the method is considered unsuitable for Hospital use.

The balance of advantage for most stores would appear to lie in the use of the average price method, and where circumstances justify the price used for any commodity should be the same at all the Stores maintained by a Hospital Authority.

*Stores Ledger*

*Receipts*

19. Debits to the Stores Ledger arise from purchases, returns to Stores and transfers from other hospitals or manufacturing departments and gifts. All should be entered in the Goods Received Record which is the medium for posting the receipts side of the Ledger. This may be done manually or mechanically, and where the Stores Ledger is kept in quantity and value the total value of stores received in each Store or Sub-Store should be reconciled periodically with the corresponding totals in the Stores Control Account/s in the financial ledger.

Returns to suppliers should be dealt with by a reversal of the receipts procedure.

*Issues*

20. The Stores Ledger credits will be posted either from the original stores issue notes or from summaries thereof (see also paragraph 16 on pricing). The total value of the issues in the Stores Ledger should agree with the total value of the issues charged as expenditure in the financial and cost accounts and be posted to the Stores Control Account/s in the financial ledger.

Items returned to Store in an unused condition should be dealt with by a reversal of the issues procedure.

*Balances*

21. The detailed stores accounts will show the quantity and, where kept in quantity and value, the value of each item of stores in hand, and in some systems

the current issue price. The Stores Control Accounts show only the total value of all stores on charge.

22. Used stores which are on charge at a reduced value should be accounted for in a separate section of the Stores Ledger and on separate Quantity Records (bin cards).

*Conclusion*

23. We have refrained from recommending any particular system of Stores Accounting. Hospital Authorities are responsible for devising their own internal accounting system and the best method of recording stores receipts and issues will depend not only on the factors already referred to, but also the system used for recording the other financial transactions of the Authority.

A variety of systems—mechanical and manual—are in use. Each, dependent upon local circumstances, will have its own particular advantages and disadvantages which have to be weighed against the wider background of the general accounting arrangements.

We would, however, mention that where punched card Stores Accounting is in operation or contemplated, the costing requirements for an extended analysis and pricing of stores issues mean that more effective use can be made of the equipment involved, and may in fact justify its employment in preference to an existing alternative system. In this connection, the pricing of stores issues can be greatly facilitated by the use of electronic equipment.

Should your Committee require further information or evidence on any of the matters set out in this Memorandum, our organisations will be ready to assist.

We have the honour to remain, Sir,

Yours faithfully,

J. COVILL,

*President, Institute of Public Supplies Officers.*

E. A. HALL,

*Chairman, Association of Chief Financial Officers in the Hospital Service in England and Wales.*

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