**Sixth report from the Select Committee on Estimates : together with the minutes of evidence taken before sub-committee D and appendices, session 1956-1957: Running costs of hospitals.**


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# SIXTH REPORT
FROM THE
# SELECT COMMITTEE ON ESTIMATES

TOGETHER WITH THE MINUTES OF THE EVIDENCE
TAKEN BEFORE SUB-COMMITTEE D
AND APPENDICES

Session 1956—57

**RUNNING COSTS OF HOSPITALS**

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*Ordered by* The House of Commons *to be Printed*
*10th July 1957*

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# SIXTH REPORT

FROM THE

# SELECT COMMITTEE ON ESTIMATES

TOGETHER WITH THE MINUTES OF THE EVIDENCE TAKEN BEFORE SUB-COMMITTEE D AND APPENDICES

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Session 1956—57

## RUNNING COSTS OF HOSPITALS

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*Friday, 7th December,* 1956

*Ordered,* That a Select Committee be appointed to examine such of the Estimates presented to this House as may seem fit to the Committee and to report what, if any, economies consistent with the policy implied in those Estimates may be effected therein, and to suggest the form in which the Estimates shall be presented for examination.

*Ordered,* That the Committee do consist of Thirty-six Members:—The Committee was accordingly nominated of Mr. Burke, Miss Burton, Mr. Cole, Sir Henry D'Avigdor-Goldsmid, Sir Eric Errington, Mr. George, Mr. Gibson, Mr. Green, Mr. Gresham Cooke, Mr. Hamilton, Mrs. Hill, Mr. Hobson, Mr. Holt, Sir Ian Horobin, Mr. Cledwyn Hughes, Mr. MacColl, Mr. Malcolm MacPherson, Commander Maitland, Major Sir Frank Markham, Mr. Mulley, Mr. Nicholson, Sir Ian Orr-Ewing, Mr. Osborne, Brigadier Prior-Palmer, Mr. Proctor, Mr. Randall, Mr. Robinson, Mr. Shepherd, Mr. Slater, Mr. Sparks, Sir Spencer Summers, Mr. Tomney, Mr. Vaughan-Morgan, Captain Waterhouse, Mr. Paul Williams, and Mr. Willis.

*Ordered,* That Seven be the Quorum of the Committee.

*Ordered,* That the Minutes of the Evidence taken before Sub-Committees D. E and F, appointed by the Select Committee on Estimates in the last Session of Parliament, which were laid before this House on the 5th day of November last, be referred to the Committee.

*Ordered,* That the Committee have power to send for persons, papers and records; to sit notwithstanding any Adjournment of the House; to adjourn from place to place; and to report from time to time.

*Ordered,* That the Committee have power to appoint Sub-Committees and to refer to such Sub-Committees any of the matters referred to the Committee.

*Ordered,* That Three be the quorum of every such Sub-Committee.

*Ordered,* That every such Sub-Committee have power to send for persons, papers and records; to sit notwithstanding any Adjournment of the House; and to adjourn from place to place.

*Ordered,* That the Committee have power to report from time to time the Minutes of the Evidence taken before the Sub-Committees and reported by them to the Committee.

*Wednesday, 23rd January,* 1957

*Ordered,* That Mr. Malcolm MacPherson be discharged from the Select Committee on Estimates; and that Mr. Hannan be added to the Committee.

*Friday, 25th January,* 1957

*Ordered,* That Mr. Vaughan-Morgan be discharged from the Select Committee on Estimates, and that Vice-Admiral Hughes Hallett be added to the Committee.

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The cost of preparing for publication the Shorthand Minutes of Evidence taken before Sub-Committee D was £252 4s. 9d.

The cost of printing and publishing this Report is estimated by H.M. Stationery Office at £1,953 0s. 0d.

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# SIXTH REPORT

THE SELECT COMMITTEE appointed to examine such of the ESTIMATES presented to this House as may seem fit to the Committee, and to report what, if any, economies consistent with the policy implied in those Estimates may be effected therein, and to suggest the form in which the Estimates shall be presented for Examination;—HAVE made further progress in the matters to them referred, and have agreed to the following REPORT:—

## RUNNING COSTS OF HOSPITALS

### INTRODUCTION

1. Your Committee referred Class V, Vote 5, of the Civil Estimates (National Health Service, England and Wales), so far as it relates to the running costs of hospitals, to Sub-Committee D. The Sub-Committee took oral and written evidence from a large number of witnesses[1]. They enquired into many topics relevant to the running costs of hospitals, and they obtained many columns of financial and statistical data relating to the costs and work of the service. They studied the reports of various committees and working parties, in particular the Report of the Committee of Enquiry into the Cost of the National Health Service[2] (the "Guillebaud Report") and the Eleventh Report from the Select Committee on Estimates of the Session 1950–51 on Regional Hospital Boards and Hospital Management Committees[3]. A full description of the organisation and financial administration of the service is set out in the principal Memoranda submitted on behalf of the Minister of Health[4], and the principal statistics are collected together in Appendix 1 to the Minutes of Evidence[5].

2. The running costs of National Health Service hospitals in England and Wales (other than hospitals directly administered by the Minister of Health) make up Subheads B and BB of the National Health Service Estimate. The Estimate for 1956–57 was £320,556,000 and that for 1957–58 is £335,058,000, against which must be set certain Appropriations in Aid (chiefly superannuation contributions, and income from pay and amenity beds). The rise in the actual net running costs of hospitals from £189 million in 1949–50 to £293 million in 1955–56 is shown in detail in Table 12 of Appendix 1[6]. These sums finance a public service administered by Boards and Committees, composed of voluntary members, who are entrusted annually with the expenditure of public money advanced under one of the biggest single subheads of the Civil Estimates. There is only general and necessarily indirect Treasury and Ministerial control over this expenditure[7].

3. The total load borne by hospitals has risen during this period. Detailed figures are given in Tables 3 and 4 of Appendix 1[8], but the following table shows the increase in the amount of work performed since the early years of the Service:—

| | *1949* | *1955* |
|---|---|---|
| *In-patients* (all hospitals) | | |
| Average daily bed occupation ... | 397,570 | 426,047 |
| Discharges and deaths ... ... | 2,936,980 | 3,651,978 |

[1] pp. xix–xxi. [2] Cmd. 9663. [3] H.C. (1950–51) 261. [4] Evidence, p. 1.
[5] App. 1, p. 355. [6] App. 1, p. 371. [7] Evidence, pp. 5, 45. [8] App. 1, pp. 356–9.

| | *1949* | *1955* |
|---|---|---|
| *Out-patients* (all hospitals) | | |
| New patients ... ... ... ... | 6,147,825 | 11,635,886 |
| Total attendances ... ... ... | 36,109,208 | 39,584,241 |

4. The combined effect of this rise in expenditure and rise in the volume of work is reflected in the costs per in-patient per week published annually by the Department. Details showing the rise in the costs per in-patient per week in different types of hospital are given in Tables 14 and 15 of Appendix 1[9]. It will be seen that, after adjustments have been made in respect of increased wages and prices, the real cost remained almost steady between 1950–51 and 1953–54, and, indeed, fell in the case of teaching hospitals. But in almost every instance it rose slightly in 1955–56 as compared with 1954–55, due to extra expenditure authorised for building maintenance and domestic repairs which had been deferred in the earlier years.

5. Officers of the Ministry explained that £69·2 million of the increase in total hospital expenditure of £103·8 million, between 1949–50 and 1955–56, was due to increases in pay, increases in prices, and other unavoidable increases. The remainder, £34·6 million, was the net effect of developments and improvements, offset by savings due to economies[10]. It seems, therefore, that as costs per in-patient per week have not risen greatly in real terms, the major part of the £34·6 million must have been devoted to developing and expanding the hospital service to enable it to carry its increasing burden. Furthermore, as it seems that the standard of hospital service to the patient has risen[11] (Q. 375, 435, 1443, 1876, 2776), and as it appears that this has been achieved at little extra real cost per in-patient per week, this increase in standards of service must have mainly been financed by economies resulting from increased efficiency, skill, and individual effort. Indeed this is shown, to some extent, by the improvement in bed occupancy and turnover, and in administrative staff ratios, at many hospitals in Regions whose Boards submitted evidence to the Sub-Committee.

6. Your Committee are satisfied, therefore, that there is no evidence of declining efficiency on the part of hospital authorities in spending the money allocated to them; indeed all the evidence suggests the contrary. Nor do they believe that there is much, if any, gross inefficiency or obvious waste. But they are convinced that there is scope for bringing about true economies in the service, in the sense that better value can be got for the money spent. Expansion and improvement are no doubt most urgently needed, but that does not mean that unlimited expansion, either now or in the future, should be the basic assumption of those responsible for expenditure within the service. Therefore it is essential that all in the hospital service should recognize that if expansion is to take place in one sector, a standstill, or even contraction, may be involved elsewhere. Everyone in the service must be convinced that whenever he is able to achieve some saving he will be enabling someone else (if not himself) to carry out some improvement in the service that might otherwise be deferred. Your Committee believe that through such a sense of mutual benefit from economies the true efficiency of the service is best ensured; the question is whether such a sense is universally present today.

[9] App. 1, pp. 374–5. [10] Evidence, p. 9. [11] Cmd. 9663, para. 724; Evidence, p. 129.

## THE RESPONSIBILITIES OF THE MINISTER

7. In fulfilling his duty under section 3 of the National Health Service Act, 1946, to provide hospital and specialist services throughout England and Wales to such extent as he considers necessary to meet all reasonable requirements, the Minister of Health should, Your Committee believe, be primarily concerned with planning and guiding the development of the service from a national standpoint and with advising hospital authorities regarding the parts they can play in this national plan. Your Committee agree with the Guillebaud Report that the Regional Boards should be responsible for both planning and co-ordinating the development of the hospital and specialist services[12], and for exercising a general oversight and supervision over the administration of the hospitals in their Regions[13]. It is the Management Committees' duty to administer the service in the individual hospitals of their groups.

8. If Parliament is to be satisfied that the money voted is being spent as economically as possible, while such a complete degree of local autonomy is retained, four requirements must be met:—

(*a*) Those responsible for administering the service, both as members of Boards and Committees, and as administrative officers, must be of the highest calibre and ability.

(*b*) The limited financial resources must be allocated in such a way as to ensure that, in accordance with the national and regional plans for development, the current service can be maintained at the determined level, and that development and improvement can be financed where it is most needed.

(*c*) The Minister and the Regional Boards must do all they can to ensure that hospital authorities employ the most efficient and up-to-date methods of administration and financial control.

(*d*) The available resources must be concentrated on those sick people whose needs can only be met by hospital treatment.

9. Your Committee have set out these points as a convenient framework on which to construct the more detailed comments they wish to make. But before considering these they feel obliged to state one general conclusion. The Minister is responsible to Parliament for the expenditure of money on the hospital service, and it is the activities and attitude of the Ministry that are therefore of particular interest to Your Committee. They consider that, as the Ministry's opportunities of direct control are so limited, it is essential, in the interests of the national hospital service, that they should use their powers of planning, guiding and advising, and in particular of allocating money, to do all they can to guarantee that the limited resources are made available, as smoothly as possible, where those resources are most needed, and to ensure that those resources are expended as efficiently as possible. These obligations can only be met satisfactorily if the Ministry act with vigour and foresight. Your Committee are not satisfied that they have always done so. They were, in particular, disappointed to find that few conclusions had been reached by the Ministry on some of the cardinal problems affecting the service, such as the lack of a career structure for administrative staff, how to bring about greater co-operation between Management Committees over purchasing and various services, how to avoid the unnecessary use in some cases of hospital facilities, and other matters referred to in the following paragraphs of their Report.

[12] Cmd. 9663, para. 168.

[13] Cmd. 9663, para. 212.

## BOARDS AND COMMITTEES AND THEIR STAFF

*Membership of Hospital Management Committees*

10. Your Committee are struck by evidence of difficulties experienced in obtaining suitable people for service on Management Committees in the Oxford Region (Q. 813), in the S.E. Metropolitan Region (Q. 1621, 1627–35) and elsewhere[14] (Q. 1884). The Chairman of the S.E. Metropolitan Regional Hospital Board suggested that there has been too general a tendency to appoint members of Management Committees because of the interests they may represent (Q. 1628–35). It is interesting to note that Manchester Regional Hospital Board have not had any difficulty in obtaining the services of people of sufficient calibre (Q. 696–9), possibly because that Board are always "looking for the person with a business training and background, and not necessarily a person with direct experience of hospital administration" (Q. 658). The prime task of Management Committees is to administer the hospitals in their group, and only secondarily to represent local interests. Your Committee recommend that Regional Hospital Boards, when appointing members to Hospital Management Committees, should have regard to their general experience and ability, as well as to the interest or local body that they may represent.

*Administrative staff*

11. The Guillebaud Committee reported that "a proper career structure" for administrative staff "is a matter of the utmost importance for the well-being and efficiency of the service, but evidence that we have received makes it clear that the present position is by no means satisfactory"[15]. Your Committee are in complete agreement with these comments which were re-inforced by all the witnesses who appeared before the Sub-Committee, but there is nothing new about this. The service came into being nine years ago, and the dangers inherent in the absence of a satisfactory career structure, or of national recruitment, training, and promotion schemes, must have long been apparent. But only recently have the Ministry taken positive action. Your Committee welcome the reference of this problem to Sir Noel Hall, the new training schemes, and the initiative that has been shown by some Regional Boards in seeking a solution (Q. 700–24).

12. Your Committee are particularly concerned with methods of appointment, especially of the senior administrative staff of Management Committees. By that term they mean, principally, the secretary and the finance officer. Evidence was received from Manchester Regional Hospital Board and Oxford Regional Hospital Board of the inadequate quality of some of these senior officers (Q. 675, 815), and that "appointments which are seriously open to question, have been and continue to be made"[16]. Oxford Regional Hospital Board gave evidence that they were "very unhappy" about the appointment of certain officers, especially where "the local boy has been appointed because of pressure of the local group" (Q. 820, 826). On the other hand, the Chairman of the S.E. Metropolitan Regional Hospital Board considered that the present holders of senior posts with Management Committees are, by and large, satisfactory, although the service was not attracting the right type of recruit (Q. 1666), and the Permanent

[14] App. 12, p. 403. [15] Cmd. 9663, para. 395. [16] App. 7, p. 390.

Secretary to the Ministry of Health did not believe "that there have been any substantial numbers of obviously bad appointments of senior lay staff" (Q. 2712).

13. While there is no suggestion that the majority of appointments are bad, if some bad appointments are made it is worth considering whether the system is as good as could be devised. In the opinion of Your Committee a proper career structure for the administrative staff of the hospital service cannot be established unless Regional Boards are given at least the opportunity to advise upon the appointment of the senior officers of Management Committees. In the first place the wider experience of the Board would give greater guarantees against parochial appointments being made. In the second place it would enable the Board to exercise its function of planning and co-ordinating the development of the Region as a whole, by pooling Regional resources so that the best men can go where they are most required in the interests of the Region and where they will be able to broaden their experience.

14. Two suggestions would retain for Management Committees the right to appoint, while enabling the Board to give advice. Oxford Regional Hospital Board consider that the establishment of Regional Advisory Appointments Committees would be in the interests of the service as a whole[17] (Q. 820–3), and this suggestion appeared to be favoured by the Secretary of the Manchester Regional Hospital Board[18]. Opinion on this subject was divided, most other witnesses, including those from the Department (Q. 2710), being opposed to it, although sometimes for conflicting reasons. The simpler alternative to this advisory procedure is to establish the practice, already fairly common, of inviting representatives of the Board to "sit in" on Management Committees when senior administrative posts are being filled. Your Committee also considered whether these appointments could be made by the Regional Boards themselves. This would give them complete control, but would cause grave distress to Management Committees, who regard their right to appoint their own staff as an important element in the discharge of their responsibilities of management. This idea was opposed by most witnesses (Q. 628–9, 1678, 1933, 2244, 2388).

15. For the reasons given, Your Committee consider it important that Regional Boards should be associated in some degree with the appointment of senior administrative staff of Management Committees, and they are disappointed by the negative attitude of the Department (Q. 2706–56). They do not consider, however, that the Management Committees should be deprived of their responsibilities for the actual appointment. They think that the appointment of yet another committee should be avoided if possible, and they doubt whether an Advisory Appointments Committee would be as helpful here as it may be for senior medical appointments, because the qualifications required are less well defined and the variations in the type of man required are more pronounced. Finally, they consider that the advice of Regional Boards would be more willingly heeded if given directly to Management Committees at the time candidates are actually being interviewed and their merits compared. Your Committee therefore recommend that representatives of Regional Hospital Boards should always be invited to attend meetings of Hospital Management Committees when group secretaries or group finance officers are being appointed.

[17] App. 9, p. 392.

[18] App. 7, pp. 389–91.

*Salaries of administrators*

16. The salaries of group secretaries, finance and supplies officers, hospital secretaries, matrons, chief male nurses, and of the deputies of all these officials are based mainly upon the numbers and types of beds of their group or hospital[19]. It has been suggested that in this and other ways "the whole service . . . is geared to move only one way—towards expansion"[20]. Other witnesses have made the point that it is wrong to base salaries so extensively on numbers of beds when other factors such as clinics for outpatients, casualty departments, training schools, and the existence of laundries, bakeries, farms, etc., can form part of the responsibilities of chief officers. Evidence was given of the cramping effect this rigid basis for salaries has on Management Committees who wish to reward administrators for efficient work, or perhaps to discourage a good man from leaving the service[21] (Q. 2262–3, 2369, 2421).

17. Your Committee are in sympathy with these criticisms, which are also made by the King Edward's Hospital Fund when they write "salaries of administrators and of many other grades of staff in hospitals are too closely governed by the number of beds in commission, at a time when the closest attention should be given to reducing rather than expanding the number of beds"[22]. As far as possible salaries should be commensurate with qualifications and overall responsibility, and Your Committee consider it desirable to reduce the close correlation between salaries and the number of beds. In their opinion there are other important factors relevant to the responsibility of the officer, which if taken into consideration, could well give him additional incentive to make his group or hospital more efficient. Your Committee recommend that formulae should be devised to enable other objective criteria, in addition to the number of beds, to be given greater weight when assessing the salaries of hospital administrators.

*Establishment control*

18. Your Committee appreciate that direct establishment controls, although somewhat arbitrary and rough, were probably necessary in 1952 when expenditure had rapidly increased, when financial control was still largely untried, and before hospital authorities had really determined the pattern of their requirements. Because the number of medical staff employed is closely associated with the Minister's and Regional Boards' plans for the development of the hospital service, Your Committee consider that the present establishment controls should be retained for them. But in their opinion the ceiling control over nursing and midwifery staff and other staff, and the detailed control over administrative and clerical establishments, are no longer valuable. In many cases numbers fixed in 1952 are unrealistic today. Indeed, where present figures are below establishment (as they often are in nursing, technical and some domestic grades), increases in numbers may be positively encouraged by a belief that the hospital ought to recruit up to its establishment. Furthermore, the imposition of these direct controls from above can cause a sense of frustration and, possibly, antipathy between authorities. The evidence indicates that budgetary control would now be sufficiently effective (Q. 850, 1513–9, 2544–8). It is very important that all hospital authorities, aware of the advantages that can accrue to the service from economies, should be encouraged to determine for themselves in which grades extra staff may be most required, and in which grades numbers could

[19] App. 2, p. 376.
[20] Evidence, pp. 275, 296.
[21] App. 11, pp. 399–400.
[22] Evidence, p. 296.

be reduced, without regard to establishments imposed from outside. Your Committee therefore recommend that the controls at present exercised by the Minister and by the Regional Hospital Boards over the administrative, nursing and other non-medical staff establishments of hospital authorities should be withdrawn.

## FINANCIAL CONTROL

19. The Minister of Health is responsible to Parliament for his allocations of money on revenue account to Regional Hospital Boards and Boards of Governors. The allocations to Regional Boards are made in one sum. In recent years about 99 per cent. of the national total has been for the purpose of maintaining the existing level of services. The remainder has been in respect of what are called "developments and improvements," which Your Committee comment on later[23]. The maintenance allocation is based on the amount the Regional Boards spent in the previous year. It will be seen that hospital expenditure is thus linked to an "inherited pattern" (Q. 529–30). In this way while a check is kept on unrestricted growth, inefficiency or lack of proper economy may go unchecked (Q. 475), and variations in costs as between Region and Region may also tend to become entrenched. The Minister's policy is to reduce these variations (Q. 449, 2686), and Your Committee are glad to note that they have been reduced from a total variation of 35 per cent. in 1951–52 to a total variation of 20 per cent. in 1955–56[24]. However they are still too wide. It should be the object of the Minister to break away from this inherited pattern, and to find some method of taking efficiency into account when making his annual allocations.

*Hospital costing*

20. There are no wholly reliable tests of efficiency, although factors such as bed occupancy, bed interval, length of stay, rate of turnover, and staff ratios, may provide valuable contributory evidence of the efficiency or inefficiency of a hospital or Region. But the chief criteria of financial efficiency must remain the costing statistics. The difficulties of assessing these, as published, and their well known and admitted limitations, are recognised by Your Committee. These figures will be valuably supplemented when the results of departmental costing become available. In the opinion of several witnesses, including those representing the Minister (Q. 2684–5, 2780–2), these new statistics will enable valid comparisons to be made between hospitals, and will serve to throw much more light on the reasons for variations in costs. They should also bring about better preparation of hospital budgets, by enabling estimates of expenditure to originate in the various departments, and this should have the further merit of encouraging cost consciousness among heads of departments. It is essential that every advantage should be taken of these new costing returns, which will, incidentally, be expensive to produce. Your Committee accordingly recommend that the fullest use of departmental costing should be treated as a matter of the highest priority, and that as soon as these returns are available the Minister should take them and other criteria for measuring efficiency into account, when making his annual allocations to Regional Hospital Boards in respect of developments.

*Organisation and Methods Service*

21. Even with the new objective costing, difficulties of interpretation will emerge because of variations in circumstances—nature of area, type of building, availability of staff, and particularly type of case treated—which

[23] App. 4, p. 378.

[24] App. 3, p. 378.

cannot be evaluated. These can only be considered subjectively by experts, medical and lay, in hospital administration. If hospital statistics are to be properly understood they must be considered in the light of such independent judgment. Consequently the efficiency of the service (both in individual hospitals and in Regions) can only be accurately assessed if such examinations take place. The experimental use of Ministry of Health O. & M. teams appears to have been very successful, for most of their recommendations have been accepted (Q. 2858–60). Your Committee believe that this Service should now be put on a permanent basis and expanded. Such a development would, they are sure, be welcomed by hospital authorities at all levels. The teams would normally be called in by Regional Boards at the instance of Management Committees. Hospital authorities should also be encouraged to call in the services of methods study experts when they consider that their assistance might lead to more economical methods. Economies discovered by one authority in one hospital are of limited benefit to the service as a whole unless knowledge of them is rapidly disseminated. Your Committee recommend that the Ministry of Health Organisation and Methods Service should be established on a permanent basis, and expanded so as to enable it to cover the hospital service as a whole.

*Virement and expenditure on developments and improvements*

22. Your Committee were disquieted by evidence which suggests that hospital authorities may sometimes be managing to develop the services in their Regions or groups, by the exercise of virement, in a way which may be contrary to the intentions of those responsible for planning national and Regional development. In 1956–57 Oxford Regional Hospital Board, considering that the amount included in their allocation in respect of developments and improvements (£32,000) was insufficient to enable them to carry out certain projects they desired (to the total of £150,000–£180,000), financed the balance by a form of virement, which consisted of reducing the initial allocations to Management Committees by deferring maintenance and renewals (presumably of domestic items) (Q. 955–7). " Deferring maintenance ", said the Secretary, " has been one of the ways in which money has been found to pay for improvements and developments in the service " (Q. 957) and this appears to have been their regular practice[25] (Q. 960).

23. Your Committee realise that there is nothing financially improper about such action by the Boards as no part of the allocation is specifically earmarked for a particular purpose (except that earmarked for building maintenance)[26] ; and they appreciate that it is intended that the money allocated in respect of developments and improvements may be " supplemented by savings which hospital authorities are able to make in their existing services "[27]. Nevertheless such a practice is undesirable for three reasons. In the first place, although he did not specifically state the fact in making the allocation, the Minister did not plan that this Region should develop to the extent of £150,000. If he had done so he would have made provision for it in his allocation. In that they developed on a scale so much greater than that planned they partially vitiated his policy of evening up the varied costs of Regions by a controlled redistribution of development money[28] (Q. 449). In fact, in this case, one of the higher cost Regions managed to develop their services (and so possibly their recurrent costs) still further. In the second place this extra development was not financed from genuine savings

[25] Evidence, p. 88.
[26] App. 9, p. 393–4.
[27] App. 4, p. 381
[28] Evidence, p. 5.

## MATTERS IN RELATION TO WHICH THE MINISTER CAN GIVE GUIDANCE AND ADVICE

*The domiciliary consultative service*

28. The growth of this service from 175,504 visits in 1951 to an estimated 270,618 visits in 1956 has been described in evidence[37]. Your Committee appreciate the merits the service has in reducing the demands on hospital beds, but they are concerned about the possibility that the service may be abused. There appears to be some laxity on the part of general practitioners in unnecessarily asking for domiciliary visits (Q. 1842, 2155–9) and particularly about attending domiciliary consultations (Q. 1839). They were surprised to learn that out of 2,627 visits made by whole-time consultants in the S.E. Metropolitan Region between November, 1955, and December, 1956, the practitioner was only present in 38 per cent. of the cases[38]. It appears that the requirement of the Terms and Conditions of Service for Hospital Medical Staff is not being complied with in this respect, as they include the provision that the general practitioner should normally accompany the consultant on domiciliary consultations for which a fee may be paid[39]. Your Committee recommend that the Minister should institute an enquiry into the domiciliary consultative service to determine the extent, if any, of misuse, and to recommend what controls, if any, are required to prevent abuse.

*Drug expenditure and " cost-consciousness "*

29. The estimated hospital expenditure on drugs rose by £1·01 million from £6·70 million in 1953–54 to £7·71 million in 1955–56, despite the fact that the price of drugs fell between the two years by about 13 per cent.[40]. It appears that there has been a general increase in this expenditure even after allowing for the special factors referred to by the Department and the increase in the number of patients treated. Your Committee wonder whether such growing expenditure is justified by its therapeutic effect, at a time when all sectors of the hospital service are short of money. The Department and hospital authorities are themselves worried about the rising drugs and dressings bill and have taken steps to supervise prescribing or to enlist the co-operation of the medical profession. One of the most effective ways of doing this is for Management Committees and Boards of Governors to place the responsibility for keeping down a hospital drug bill upon the medical staff of that hospital collectively, through the medium of the Medical Staff Committee. At the same time Your Committee cannot entirely accept the view that the control of drug expenditure must be left exclusively to the doctors.

30. Your Committee believe, however, that true economy in this field can only be achieved when doctors are fully cost-conscious, and appreciate the advantages that can accrue to the hospital service as a whole by a strict avoidance of extravagance in the use of drugs. Witness after witness before the Sub-Committee—medical as well as lay—referred to the lack of cost-consciousness among doctors (Q. 871–3, 1022, 1314, 1775, 1780–3, 1877), although the representatives of Guy's Hospital were not so critical (Q. 2070, 2084, 2090) and the Royal College of Physicians thought that the situation was improving (Q. 2211–3). The Ministry have been aware of this problem for several years, and since 1950 have taken steps to inform doctors in the hospital service, and, since 1953, in medical schools, of the costs of drugs.

[37] App. 5, p. 387; App. 10, pp. 396–7.
[38] App. 10, p. 395.
[39] App. 5, p. 386.
[40] App. 6, p. 388.

The profession should also be aware of the financial state of the service through their representatives on Boards and Committees.

31. Apparently this has not been enough. Your Committee believe that the problem can only be solved at the source—by ensuring that no medical student qualifies as a doctor without being made aware of the financial responsibilities of his position in the Health Service, and of the costs of the treatments he will have to prescribe. They were therefore disappointed to note the opinion of one distinguished medical witness that he did not "really think it is possible to make a student cost-conscious. They are much too busy learning medicine to get through their examinations" (Q. 2072). The Chairman of the Board of Governors of Guy's Hospital said that instruction designed to make students cost-conscious "is the sort of thing which I think it is no good putting in a syllabus . . . If you put it in a syllabus it tends to get rather forgotten" (Q. 2071). As potential patients Your Committee are alarmed by the implications of this statement. They do not consider this attitude satisfactory. In the interests of economy throughout the Health Service they recommend that the Minister should urge upon all medical and dental schools and teaching hospitals that medical students, before qualifying as doctors, surgeons or dentists, should be required to satisfy their examiners that they have a proper knowledge of the financial structure of the National Health Service, and of the costs of treatment for which they may be responsible.

*Amenity beds*

32. Your Committee wish to draw attention to the limited use made of amenity ("section 4") beds by paying patients in many hospitals. In 1955, for all hospitals, only 46 per cent. of these beds were so occupied although 33 per cent. were occupied by other patients[41]. The Sub-Committee received evidence of considerably less use in some hospitals. They consider that higher percentage occupation by paying patients might be achieved if the benefits of these beds were better advertised. They recommend that the Minister should call upon all hospital authorities who have beds designated under section 4 of the National Health Service Act, 1946, to do all they can to encourage the use of these beds by paying patients.

*Centralised contracting and centralised services*

33. The Sub-Committee heard evidence about group, joint group, and Regional purchasing and contracting, and also about the organisation on similar bases of laundry, transport, maintenance, storage, and advertising services. As these matters have been the subject of extensive study elsewhere Your Committee do not intend to comment in any detail. However they are disappointed by how little such measures of co-operation for the mutual benefit of the authorities concerned have been adopted in the nine years of the hospital service's existence. In particular it is clear that great economies could be achieved by further joint-group contracting. Such methods are indispensable for any sound modern business organisation, with similar problems of ensuring that separate units can benefit by their common membership of a large concern. Your Committee would have expected that spenders of public money would not, perhaps for reasons of local prejudice and habit, have lagged behind.

34. The Manchester Regional Hospital Board gave evidence of economies that they have achieved by Regional purchasing schemes, and also by co-ordinated service arrangements such as Regional control of advertising[42].

[41] App. 1, p. 360.

[42] Evidence, p. 60; App. 8, p. 391.

Other Regions have done less (Q. 882–3, 905–9, 1765–8). If one Region can save money in these ways by initiating co-operation between autonomous Management Committees, there appears to be little reason why all should not do the same. But the Minister also has a part to play by guidance and advice and persuasion. Your Committee appreciate that he has done more in these respects than the results would indicate, and that he has no powers of compulsion, but there is much more to be done and they recommend that the Minister should make still greater efforts to encourage the adoption by hospital authorities of joint-contracting and service arrangements where these appear economical.

## THE LOAN BORNE BY THE HOSPITAL AND SPECIALIST SERVICE

35. Lastly Your Committee wish to make a few comments on what is undoubtedly one of the most difficult (and least satisfactory) aspects of the whole National Health Service. In the interests of the hospital service the Department should do all they can to ensure that expensive hospital facilities are only devoted to those sick people who are truly in need of them. There are five main problems. First, Your Committee have evidence of patients attending as out-patients for specialist clinics, who could well have been examined and treated by general practitioners. Secondly there are cases of patients being unnecessarily retained as out-patients, for treatment by consultants, who could (with greater convenience to the patient himself) have been referred back to their general practitioners for treatment. Thirdly there are cases of people being admitted as in-patients for observation who could have attended as out-patients if facilities (such as a rest room) had been available[43]. Fourthly there are a certain number of chronic sick being retained in acute wards (where costs are higher) because of the shortage of chronic beds. Although the number is not thought to be large overall, this is a serious problem in some hospitals[44] (Q. 2184–6, 2357, 2363). Lastly, and most tragic, there are those patients in chronic sick beds who cannot be discharged because other suitable care and accommodation are not available (approximately 4,500 in 1955), and the 10,000 old patients in mental hospitals whose degree of mental health is such that they could appropriately be discharged if there were someone to care for them.

36. The problems are known, but the solution is far from simple. It appears that formal consultation between the three branches of the Health Service at the periphery has not really succeeded[45] (Q. 2361–3, 2860–1). The answer, undoubtedly, lies partly in extending such services as the maternity and child welfare services, the home nursing service, the use of mental welfare officers, and the provision of home helps, as well as an expansion of certain types of hospitals and wards. But eventually hospital authorities, the general practitioners, and the local authorities must all work together if the limited resources of the hospital service are not to be wastefully employed on the care, attention, or treatment of those who are not truly in need of them.

## CONCLUSION

37. It is not within the province of Your Committee to pass a verdict upon the hospital service as a whole. It is clear to them, however, that if full value is to be obtained for the large sums of public money that are spent every year, there must be more time and attention devoted to long term planning. They have been impressed by the devotion and enthusiasm that prevails

[43] App. 12, p. 404.
[44] Evidence, pp. 130, 257; App. 11, p. 399.
[45] Evidence, p. 277.

throughout the service. But they have also been depressed by the apparent lack of vigour with which some fundamental problems are being faced by the Ministry.

## SUMMARY OF RECOMMENDATIONS

38. Your Committee have made the following recommendations:—

(1) Regional Hospital Boards, when appointing members to Hospital Management Committees should have regard to their general experience and ability, as well as to the interest or local body that they may represent (paragraph 10).

(2) Representatives of Regional Hospital Boards should always be invited to attend meetings of Hospital Management Committees when group secretaries or group finance officers are being appointed (paragraph 15).

(3) Formulae should be devised to enable other objective criteria, in addition to the number of beds, to be given greater weight when assessing the salaries of hospital administrators (paragraph 17).

(4) The controls at present exercised by the Minister and by the Regional Hospital Boards over the administrative, nursing, and other non-medical staff establishments of hospital authorities should be withdrawn (paragraph 18).

(5) The fullest use of departmental costing should be treated as a matter of the highest priority, and as soon as these returns are available the Minister should take them and other criteria for measuring efficiency into account when making his annual allocations to Regional Hospital Boards in respect of developments (paragraph 20).

(6) The Ministry of Health Organisation and Methods Service should be established on a permanent basis, and expanded so as to enable it to cover the hospital service as a whole (paragraph 21).

(7) Regional Hospital Boards, by their exercise of the power of sanctioning virement, should not incur recurrent expenditure by permitting developments or improvements to be undertaken in excess of the sum envisaged by the Minister in his initial allocation, without financing such extra developments or improvements by savings whose effects are equally recurrent (paragraph 25).

(8) Until the standards of non-teaching hospitals reach a significantly higher level, the allocation of development and improvement money to teaching hospitals should continue to be strictly limited (paragraph 26).

(9) The definition of capital should be relaxed to enable Hospital Management Committees to finance small revenue saving projects out of savings in running costs (paragraph 27).

(10) The Minister should institute an enquiry into the domiciliary consultative service to determine the extent, if any, of misuse, and to recommend what controls, if any, are required to prevent abuse (paragraph 28).

(11) The Minister should urge upon all medical and dental schools and teaching hospitals that medical students, before qualifying as doctors, surgeons, or dentists, should be required to satisfy their examiners that

they have a proper knowledge of the financial structure of the National Health Service, and of the costs of treatment for which they may be responsible (paragraph 31).

(12) The Minister should call upon all hospital authorities who have beds designated under section 4 of the National Health Service Act, 1946, to do all they can to encourage the use of these beds by paying patients (paragraph 32).

(13) The Minister should make still greater efforts to encourage the adoption by hospital authorities of joint-contracting and service arrangements where these appear economical (paragraph 34).

10*th July*, 1957.

## APPENDIX

The following persons or bodies submitted Memoranda to the Sub-Committee:—

The Ministry of Health.

Her Majesty's Treasury.

Manchester Regional Hospital Board.

Oxford Regional Hospital Board.

South-East Metropolitan Regional Hospital Board.

Board of Governors of Guy's Hospital.

Board of Governors of St. Bartholomew's Hospital.

Reading and District Hospital Management Committee.

Springfield Hospital Management Committee.

Physician Superintendent, Queen Mary's Hospital for Children, Carshalton.

Association of Hospital Management Committees.

Association of Municipal Corporations.

British Medical Association.

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King Edward's Hospital Fund for London.

Royal College of Nursing.

Royal College of Physicians.

Teaching Hospitals Association.

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In the Minutes of Evidence a row of asterisks indicates that an answer or a part thereof, or a question and the answer thereto, or several consecutive questions and the answers thereto have not been reported.

# MINUTES OF EVIDENCE TAKEN BEFORE SUB-COMMITTEE D OF THE SELECT COMMITTEE ON ESTIMATES

TUESDAY, 29TH JANUARY, 1957.

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Members present:

Mr. Nicholson, in the Chair.

Sir Henry D'Avigdor-Goldsmid.
Mrs. Hill.
Mr. Holt.
Vice-Admiral Hughes Hallett.
Captain Waterhouse.
Mr. Willis.

**Memorandum submitted on behalf of the Minister of Health.**

## HOSPITAL RUNNING COSTS

*Introductory*

1. The Minister has a duty under Section 3 of the National Health Service Act, 1946, to provide hospital and specialist services throughout England and Wales to such extent as he considers necessary to meet all reasonable requirements. Hospital and specialist services include:—

(*a*) in-patient and out-patient treatment in all types of hospitals, including hospitals which are wholly or mainly acute, long-stay and chronic hospitals, maternity accommodation, mental and mental deficiency hospitals, sanatoria, infectious diseases units, and convalescent homes ; and

(*b*) the provision of consultant advice in the patient's home, where necessary.

For these purposes hospital premises and equipment need to be provided, medical, nursing and other staff employed, necessary drugs and medical and surgical appliances made available, and in-patients maintained while being treated in hospital.

*Administrative arrangements*

2. The Minister's duty to provide these services is executed generally through the agency of Regional Hospital Boards, Hospital Management Committees and Boards of Governors. The constitution of these bodies is laid down in general terms in the Third Schedule to the Act of 1946 and in more detail in the Orders and Regulations setting up the Boards.* Certain services are however provided directly by the Minister, such as the direct administration for the time being of certain ex-Ministry of Pensions' hospitals, and of the arrangements for providing artificial limbs and mechanically propelled invalid vehicles. In addition the responsibility for nurse training, under the Nurses Act, 1949, is vested in Committees answerable to the General Nursing Council.

3. The control of the non-teaching hospitals is shared between the Regional Hospital Boards and the Hospital Management Committees (Section 12 (1) and (2) of the Act of 1946). Of the former, there are 14 each covering an area which ensures that the Boards' services can conveniently be associated with a university having a School of Medicine (Section 11 (1) of the Act of 1946). The Chairman is appointed by the Minister, who also appoints the members after consultation with the associated university, organisations representative of the medical profession in the Board's area or generally, local health authorities in the area and such other organisations as appear to the Minister to be concerned.

4. With the Minister, and in collaboration with the Boards of Governors, Regional Hospital Boards plan and administer a co-ordinated hospital and specialist service for their respective regions. Included in their responsibilities are:—

(*a*) the appointment and dismissal of senior medical and dental staff (subject to the Minister's approval of their establishment), and approval of Hospital

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* In relation to the Boards first set up S.R. & O. 1946/2158, 1947/1297 and 1298. S.I. 1948/656 and 979. Orders 1948/108,020 and 108,109. Further Orders have been made from time to time making minor alterations to areas or constitutions of particular Boards.

Management Committees' staff establishments in broad categories (see para. 24 below);

(*b*) the allocation between themselves and their Hospital Management Committees of the sum provided by the Minister to meet the current costs of running the hospitals in their Region, the approval of the Committees' estimates of expenditure, oversight of current expenditure and follow up of auditors' reports;

(*c*) making contractual arrangements with institutions outside the service for the provision of additional beds; and

(*d*) running the blood transfusion and mass radiography services.

5. In accordance with a scheme approved by the Minister each Regional Hospital Board appoints local Hospital Management Committees, one for each large hospital or group of hospitals forming a reasonable unit for local administrative purposes. The members are appointed by the Board after consultation with any local authority whose area is served by the group, the Executive Council(s) in the area, the senior medical and dental staff in the group and such other organisations as appear to the Board to be concerned. The Committees undertake the day-to-day management of the hospitals on behalf of the Regional Boards. There are in England and Wales 388 Management Committees.

6. The 36 Boards of Governors control the teaching hospitals of the country. The Minister appoints the Chairman and members of each Board of Governors, subject to the nomination of certain proportions of the members by the university with which the hospital is associated, by the Regional Hospital Board and by the teaching staff of the hospital, the remaining members being appointed after consultation with such local health authorities and other organisations as appear to the Minister to be concerned. A Board of Governors is responsible directly to the Minister for the management and control of the teaching hospital or hospitals in its group and is required to provide for the university with which the hospital(s) are associated such facilities as appear to the Minister to be required for clinical teaching and research (Section 12 (3) of the Act of 1946). They appoint their own staff, subject to the Minister's approval of establishment in broad categories (see para. 24 below).

7. Boards and Committees may appoint committees and sub-committees consisting wholly or partly of non-members except that the finance committee or sub-committee must consist wholly of members.

8. Service on the Boards and Committees is voluntary and unpaid but provision is made under Regulations made by the Minister to pay for loss of remunerative time and for travelling and subsistence expenses. The staff appointed by the Boards and Committees are not Civil Servants (Section 14 (1) of the Act of 1946).

*Development of the Service*

9. The main figures illustrating the growth of in-patient and out-patient work and showing the numbers of staff employed in the Service are contained in Appendix 1*. Tables 1 and 2 show the number of hospitals, bed complement, average beds available and occupied, discharges and deaths by type of hospital at September, 1956. The classification of hospitals by type is explained in Table 11. As there have been a number of changes in this classification over the years it is not possible to give comparable figures for earlier years; comparable figures for each year from 1949 to 1955 inclusive are, however, given of in-patients by specialty (Tables 3 and 4), out-patients by specialty† and numbers of amenity and private beds (sections 4 and 5 of the Act of 1946—see para. 10 (*b*) (iv) and (v) below) (Tables 5 and 6). Tables 7 and 8 show the total numbers of staff employed in each year from 1949 to 1955 inclusive divided into the main sub-divisions, while Tables 9 and 10 give an analysis of nursing staff over the same period according to type of hospitals (though for the reason given above these are not strictly comparable).

* App. 1 pp. 355-67. † Table not reported.

*Finance of the Service*

10. Hospital maintenance expenditure falls wholly upon the Exchequer subject to the following qualifications:—

(*a*) Boards and Committees have varying amounts of income of their own from endowments, gifts, etc., which are generally referred to as non-Exchequer funds. These funds may be divided into:—

(i) those which were in existence on the Appointed Day, 5th July, 1948, and

(ii) those which have been received since the Appointed Day under Sections 59 and 60 of the 1946 Act.

The endowments in category (i) relating to teaching hospitals were vested in the Boards of Governors and freed from existing trusts. Subject to minor exceptions, the endowments of all other hospitals in the same category were freed from existing trusts and vested in the Minister who established a central fund, the Hospital Endowments Fund; after the discharge of certain existing liabilities of hospitals the value of the securities in the Hospital Endowments Fund at the Appointed Day was approximately £20m. Half of the income from this Fund is distributed to Regional Hospital Boards (who in turn may either distribute sums to Hospital Management Committees or retain them under their own control) and half direct to Hospital Management Committees.

The use of funds received after the Appointed Day may be limited by the terms of the trust on which they are held but, subject to such trusts, hospital authorities are free to use their non-Exchequer funds for any hospital or research purposes they think appropriate. They are commonly used to provide amenities for patients and staff but they may also be expended on items for which Exchequer funds might be used if they were available and the Minister has been careful not to discourage such use. Although he has issued guidance from time to time on appropriate uses for non-Exchequer funds, the Minister has not thought it practicable to attempt to draw up an exhaustive list of such items.

(*b*) Charges may be made for:—

(i) appliances which at the request of the person supplied are of a more expensive type than the prescribed type or in respect of the replacement or repair of such appliances—see 3 (2) of the National Health Service Act, 1946.

(ii) Dentures (except at some dental teaching hospitals) and glasses supplied to outpatients—National Health Service Act, 1951.

(iii) Certain appliances (surgical boots and shoes, wigs, abdominal supports and elastic hosiery) and drugs supplied to outpatients (with some exceptions)—National Health Service Act, 1952.

(iv) Accommodation in single rooms or small wards, subject to the needs of the Service. Patients undertake to pay the cost of this accommodation as determined under Section 4 of the Act of 1946. The charges originally prescribed were a maximum of 2 guineas per week for a bed in a single room and 1 guinea a week for a bed in a small ward; these charges were increased from 1st June, 1952, to 4 guineas a week and 2 guineas a week respectively (see Appendix 1, Tables 5 and 6).

(v) Accommodation set aside under Section 5 of the Act of 1946 for patients who undertake to pay prescribed charges designed to cover the whole cost of accommodation and services provided including an appropriate amount in respect of overhead expenses. Occupants of these beds may make private arrangements with doctors of their choice and pay them individually at rates not exceeding specified maxima (see Appendix 1, Tables 5 and 6).

(*c*) In accordance with Section 37 of the National Insurance Act, 1946, contributions towards the cost of the National Health Service as a whole are

payable out of the National Health Insurance Fund. The amount of the receipts is based on the number of contributions payable by insured persons during the year.

(*d*) In accordance with the financial provisions of the National Health Service Act of 1946 superannuation contributions paid by employing bodies and officers employed in the Service are paid into the Exchequer and used towards the cost of the Service; while, on the other hand, superannuation benefits falling due for payment are charged to the National Health Service Vote and met by the Exchequer.

(*e*) Payments due to be made by car users and insurance companies under the Road Traffic Acts are recoverable by hospital authorities under Part I of the 10th Schedule to the Act of 1946. The maximum amounts recoverable are £50 for inpatient treatment and £5 12s. 6d. for outpatient and emergency treatment.

(*f*) Part of the cost of maintaining an inpatient who is remuneratively employed outside the hospital may be recovered under Section 28 of the National Health Service (Amendment) Act, 1949.

11. Income of the various types described in paragraphs (*b*), (*c*), (*d*), (*e*) and (*f*) appear as Appropriations-in-Aid of the Vote. The transactions of the Hospital Endowments Fund are annually summarised, examined and certified by the Comptroller and Auditor General and presented to Parliament in accordance with Section 56 of the Act of 1946. A note on income and expenditure relating to non-Exchequer funds generally is included with the foreword to the Summarised Hospital Accounts presented to Parliament each year (see paragraph 13 below).

*Financial Structure*

12. The financial structure of the Service is based on a system of approved annual budgets followed by audited annual accounts. Each Hospital Management Committee is an accounting unit empowered to incur expenditure on the services for which it is responsible within the framework of a budget approved by the Regional Hospital Board before the commencement of the year in which the expenditure is to be incurred. The Regional Hospital Board in turn must contain, both its own revenue expenditure and that of its Hospital Management Committees within a total sum determined by the Minister who also approves the detailed estimates of the Boards' own expenditure. Provision is made for budgets to be adjusted for wage and price changes (subject to approval by Parliament of any necessary supplementary estimate) and also for revision of estimates later in the year to which they relate, provided that the total sum for the region determined before the commencement of the year (adjusted as necessary for changes in salaries and wages and in prices) is not exceeded. Each Board of Governors is similarly responsible for keeping its expenditure within the total of a budget approved by the Minister. The power to approve transfers between subheads (which is normally done at the revised estimates stage) in the case of Hospital Management Committees was restored to Regional Hospital Boards from the year 1952-53, with the proviso that the total sum available for the region was not to be exceeded, and Regional Boards are responsible also for approving formally the detailed estimates of the Management Committees. The Minister is responsible for approving the budget of each Regional Hospital Board and Board of Governors, and any transfers between subheads, in the same way. The detailed procedure for the submission and approval of estimates of running costs is described in paragraphs 14 to 23 below.

13. The Service is financed by monthly advances of cash to the Regional Hospital Boards, who in turn advance money to the Hospital Management Committees, and to the Boards of Governors. The amounts debited in the Ministry's Appropriation Account (Class V.5) are the cash advances to the Boards. The accounts of hospital authorities (which are on an income and expenditure basis) are audited by auditors appointed by the Minister. An annual summary of these accounts is transmitted by the Minister to the Comptroller and Auditor General who examines and certifies them and lays copies, together with his report thereon, before Parliament.

*Measures of Central Control*

14. It has, from the outset, been the policy of the Minister to allow a wide measure of independence to hospital authorities, subject to central guidance on matters of major policy and necessary measures for controlling expenditure. The main instruments of that control are now:—

(1) *Determination of Funds to be Provided and Approval of Estimates*

15. Under the current procedure (which has developed since the early years of the Service), Regional Hospital Boards and Boards of Governors are asked to provide a forecast of expenditure for the forthcoming financial year showing:—

(*a*) the amount required to maintain services at the level they are likely to reach by the end of the current financial year, and

(*b*) the amount required for urgent improvements and developments, of which details are requested.

16. These forecasts are scrutinised and discussed by the Ministry with the Treasury, and, after Ministers have decided the total amount to be included for hospital running costs in the National Health Service Estimate, each Board is told in February how much the Minister proposes to allocate for the forthcoming year for the services for which it is responsible, subject to the ultimate approval by Parliament of the total provision included in the National Health Service Estimate. It is told at the same time that, except for wage or price changes not covered by the allocation, for which if necessary a supplementary estimate will later be presented, all expenditure, from whatever cause, must be contained within the allocation.

17. The principles on which allocations are made to Boards have varied according to the circumstances of the time but in recent years allocations have been based on estimates of the amount necessary to enable Boards to maintain during the coming year the level of services expected to be reached by the end of the current year. Provision for new developments in the coming year has been made in various ways:—

(*a*) each Regional Board has been allocated a sum based on their estimates of the additional expenditure expected to be incurred on new capital developments:

(*b*) special arrangements have been made for dealing with sums intended to be used for particular purposes, e.g., for 1955–56 additional funds were provided to enable the standard of building maintenance to be improved and arrangements were made to see that proportionately larger sums were allocated to Boards whose expenditure on this service was low; similarly for 1956–57 additional money was made available to improve the standard of feeding in mental and mental deficiency hospitals and proportionately greater sums were allotted to Boards where the standard of feeding was specially low;

(*c*) any sum available for general improvement has been distributed generally in such a way as to give a slight advantage to Regional Boards with the lowest ratio of expenditure per head of population. (Boards of Governors have been dealt with specially.)

A small reserve has been retained centrally to meet contingencies and to enable additional allocations to be made during the year to Boards of Governors which have incurred additional expenditure from the completion, and bringing into operation, of new capital developments.

18. Each Regional Hospital Board, after any necessary discussion with its Management Committees, decides what part of the regional allocation to keep for its own services and how much to allocate to each Committee; and then asks each Committee to prepare, for the Board's approval, detailed estimates within its own allocation. Each Regional Board prepares detailed estimates for its own services for the Minister's approval, as does also each Board of Governors.

19. The Estimates of Boards of Governors are approved by the Minister under the following headings:

*Expenditure*

1. *Administration*—central expenses of the Board.

2. *Hospital Maintenance.*

Salaries and Wages.

(i) Medical.

(ii) Nursing.

(iii) Works and Maintenance.

(iv) Other Staff.

Provisions.

Uniforms and clothing.

Drugs, dressings, medical and surgical appliances and equipment.

Fuel, light, power, water and laundry.

Maintenance of buildings, plant and grounds.

Domestic repairs, renewals and replacements.

All other expenses.

*Less*

Direct credits.

3. Other expenditure.

*Income*

20. The estimates prepared by Regional Hospital Boards in connection with their own services are approved by the Minister under the following headings:—

*Expenditure*

(1) Central administration expenses of the Board.

(2) Blood Transfusion Services.

(3) Mass Radiography.

(4) Payments to Specialists and Registrars.

(5) Payments under contractual arrangements.

(6) Other expenditure.

*Income* (if any)

21. It is left to Regional Boards to determine the amount of detail to be submitted to them by Hospital Management Committees in connection with their estimates and although the headings under which the Boards approve the estimates follow generally those set out in paragraph 19 above there are local variations.

22. Most Regional Boards initially retain varying sums as "regional reserves", which they do not issue to Management Committees until later in the year, when it becomes clear what additional expenditure needs to be incurred. The procedure for issuing sums from these reserves is within the discretion of the Boards themselves, but generally they ask their Management Committees to submit revised estimates in the autumn, and in approving those revised estimates both authorise transfers between subheads and then give effect to issues from the reserves in so far as they have not previously done so. The Minister requires both Regional Boards and Boards of Governors to furnish revised estimates of their own expenditure under the approval subheads when submitting their forecasts for the forthcoming year.

23. Since 1955–56, in view of the importance of maintaining the assets of the hospital service, the Ministry have, when notifying each Board of the total allocation for the services for which it is responsible "earmarked" the amount to be spent during the year on building maintenance (whether carried out under contract or by the hospital authorities' own staff). Savings on this earmarked amount may

not be used for other purposes, though savings under other headings may, subject to the necessary approvals, be used for building maintenance work.

(2) *Control over Establishments*

24. Before making any increase in the establishments of staff (other than administrative and clerical) as they existed at 5th December, 1952, all hospital authorities are now required to seek the approval of the next higher authority: that is, the Minister (in the case of Regional Hospital Boards and Boards of Governors) and the Regional Hospital Boards (in the case of Hospital Management Committees). For this purpose, the staffs concerned are grouped into four categories:—

(*a*) senior medical and dental staff (down to the grade of registrar);

(*b*) other medical and dental staff;

(*c*) nursing and midwifery staff;

(*d*) all other staff (i.e., other professional and technical staff, domestic staff, maintenance staff, etc.).

25. Hospital authorities were also asked at the end of 1952 to review their establishments to effect any possible reductions within these categories generally and so far as possible to counter-balance any necessary increases in staff by effecting reductions elsewhere.

26. Administrative and clerical staff were excluded from these arrangements because, at the time when they were introduced, individual reviews by small teams of experts were already well advanced. As a result of these reviews, the Minister was enabled to authorise an appropriate establishment of administrative and clerical staff for each authority. These establishments can now be increased only with the approval of the next higher authority.

27. The Committee of Enquiry into the Cost of the National Health Service (the Guillebaud Committee), whose report was published in January, 1956, recommended that the arrangements for the control over establishments of staff, other than medical staff, should be relaxed. Consideration of this recommendation has been deferred.

(3) *National Determination of Pay and Conditions of Service*

28. One General and nine Functional Whitley Councils have been set up to settle the rates of pay and conditions of various categories of staff. The agreements reached by the Councils require the Minister's approval before they can be put into effect. Under regulations made under section 66 of the Act of 1946, where agreements have been approved by the Minister, hospital authorities are required to apply the approved rates and conditions to the staff concerned, and may not (without the Minister's agreement) adopt terms which are either less favourable or more favourable. For staff not covered by Whitley agreements—a very small minority—the Minister is empowered to give directions to the hospital authorities on the remuneration and conditions of service.

(4) *Monthly progress reports on Expenditure*

29. Hospital Management Committees are required to submit to the Regional Hospital Boards monthly statements of their expenditure under the approval subheads, together with any necessary explanations. Regional Boards are thus enabled to watch the rate of progress of expenditure and if necessary to discuss with the Management Committees in good time measures to keep it in check. The Regional Boards furnish the Minister with a summary of the Committees' returns and a note of any action taken. They also submit monthly returns of their own expenditure for examination by the Minister, as do the Boards of Governors.

(5) *Audit of Accounts*

30. The accounts of all the hospital authorities are audited by auditors appointed by the Minister in accordance with Section 55 (2) of the Act of 1946. A total of 15 auditors and 240 other audit staff, stationed at convenient centres throughout the country, is engaged on the audit of the accounts of these and other National

Health Service authorities. The hospital audits are concurrent, the accounts of each financial year usually being the subject of examination at three visits, but this number may be reduced or increased according to circumstances.

31. On the conclusion of each visit, the Auditor submits a report to the Minister if there are any matters he considers it desirable to bring to notice (e.g., defects in financial organisation or control, non-conformity with statutory requirements, errors in accounts, overspendings, losses, irregularities, etc.). A copy of each report is sent to the authority concerned. In the case of a Hospital Management Committee, a copy of the report is sent also to the Regional Hospital Board, for them to undertake any necessary follow-up and to report the result to the Minister. Exceptionally the Minister reserves the right to initiate action on a report. A Board of Governors is asked to send its comments on an audit report direct to the Minister.

32. Under the Act, the Comptroller and Auditor-General may examine the accounts of hospital authorities and any reports made by the Minister's auditors; in fact, all such audit reports are seen by officers of his Department, and in addition, some hospital authorities are visited, and their accounts examined by his officers.

(6) *Central Purchase of Supplies*

33. (*a*) Some goods are purchased directly by the Minister or by other Departments acting as his agents and distributed to hospitals through Government stores or direct from contractors if necessary, the cost being met by the Minister and not recharged to hospitals. Examples are hearing aids, mass radiography units and vans, artificial limbs and invalid vehicles.

(*b*) Other goods are purchased and distributed in a like manner but, although no payment is made to the Minister by hospital authorities for these supplies, pro forma invoices are issued in respect of them for inclusion in the hospital accounts. Examples are X-ray apparatus, laboratory and blood transfusion equipment. Payment for paper supplies is made direct by hospitals to Her Majesty's Stationery Office.

(*c*) There are for other goods central Government contracts under which hospitals may order and obtain direct from the contractors the goods they require. Examples are X-ray films, spectacles, rubber goods, mattresses, cleaning materials and hardware, surgical footwear and appliances.

Hospital authorities are asked not to obtain central supply goods from other sources. They have, however, been asked to consider the advantages of joint contracting by groups for articles which are not covered by the central supply arrangements but which might be suitable for such joint action, such as textiles, footwear, cutlery, etc. A number of schemes of joint contracting have now been developed on these lines.

Towards the end of 1954 a committee on Hospital Supplies was appointed by the Central Health Services Council set up to advise the Minister by the Act of 1946. The terms of reference of this Committee are as follows:—

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

An interim report by the Committee is expected to be published shortly.

(7) *Other matters*

34. Other ways in which the Minister seeks to influence and guide the hospital authorities are through:—

(*a*) The issue of memoranda containing guidance on matters of general policy or in connection with the introduction of new administrative or financial arrangements, revision of earlier arrangements, or in amplification of existing procedures.

(*b*) Regular periodical conferences between officers of the Ministry and Chairmen and principal officers of the Regional Hospital Boards.

(*c*) Meetings between officers of the Ministry and representatives of individual hospital authorities to deal with particular problems.

(*d*) Visits by specialist officers of the Ministry (medical, nursing, engineering, catering, etc.) to advise or report on hospital services.

(*e*) Attendance of the Ministry's Regional Officers as observers at meetings of hospital authorities, whose circulated papers they also receive.

(*f*) The establishment by the Minister of an experimental O and M service, which is available to investigate any aspect of an authority's arrangements (at the authority's invitation) and make suggestions for more efficient management.

(*g*) Publication of documents of comparative statistics and costs. Hospital costing is dealt with in more detail in paragraphs 36-41 below.

*Growth of Expenditure*

35. Appendix 1, Table 12*, summarises (under the approval subheads) the growth of total hospital expenditure in each year from 1949-50 to 1955-56. The main factors in this growth of expenditure (with rough estimates of the amount each has contributed) are :—

| | £m. |
|---|---|
| Increases in Pay ... ... ... ... ... ... ... ... | 33·8 |
| Increases in Prices ... ... ... ... ... ... ... | 25·7 |
| Transfer of new services to hospital service (e.g., certain ex-Ministry of Pensions hospitals) ... ... ... ... ... | 1·3 |
| Other unavoidable increases, such as salary increments ... ... | 8·4 |
| Net effect of developments and improvements, offset by savings due to economies ... ... ... ... ... ... ... | 34·6 |
| TOTAL | 103·8 |

Appendix 1, Table 13†, breaks down for each year by types of hospital most of the expenditure shown in Table 12.

*Hospital Costing*

36. Hospital costs are calculated separately for each of the types of hospital. These types are the same as those adopted for statistical classification. An exception to this was made in 1953-54 ; the definitions of hospital types for statistical purposes were changed for the calendar year 1953 and were expected to be and indeed were changed again for 1954. In order to preserve comparability of costing results the old definitions continued to be used for the purpose of the 1953-54 costing returns.

37. The detailed cost figures are published annually by the Minister, the non-teaching hospitals in each category being grouped together for each Region, and the teaching hospitals in each category all being grouped together (except that those in London are shown separately from those in the Provinces). Regional and national averages are shown wherever appropriate.

38. The present system of cost analysis is based on the subjective headings of the accounts. The costs at each hospital are, under this system, calculated under between 40 and 50 headings. The aim has been to provide a figure of " the total inclusive net cost per week of maintaining an in-patient " at the hospital. For this purpose, the heads of expenditure are divided into two types : those which tend to vary directly with the number of patients (provisions, drugs and dressings, etc.)—Running Charges—and those which tend not to vary much with normal variations of occupancy (salaries and wages, fuel, light and power, etc.)—Standing Charges. From the total of Standing Charges are deducted certain receipts (direct credits). From the total of Running and net Standing Charges an attempt is made to eliminate the effect of outpatient expenditure (at present not separately ascertained) by assuming that five outpatient attendances represent the costing equivalent of one inpatient day and adjusting the total accordingly so as to arrive at " the total inclusive net cost per week of maintaining a patient ". For certain types of hospital the 1955-56 Costing Returns also show the average cost per case, which is calculated by multiplying the weekly cost by the average stay per case.

* App. 1 p. 371. † App. 1 pp. 372–3.

39. Certain headings of expenditure relate to both patients and staff and costs expressed in terms of patient-weeks may therefore be misleading. Under the present subjective analysis it is not possible to correct generally for this factor but in the case of provisions an attempt has been made to do so by including a separate column showing the average weekly cost of provisions per person fed, based on the numbers of both patients and staff fed.

40. Appendix 1, Table —*, shows the detailed national average costs for the main types of hospital for the year 1955-56, as shown in the published Costing Returns for that year ; and Tables 14 and 15† the national average inpatient costs for the main types of hospital for each of the years from 1950-51 to 1955-56. These latter Tables show in addition the estimated inpatient costs for 1953-54 for each type of hospital in terms of wage and price levels obtaining in 1950-51 and the estimated inpatient costs for 1955-56 in terms of wage and price levels obtaining in 1954-55. It is not possible to make comparisons of this kind between costs in 1955-56 and costs in 1950-51 because of the changes which took place at the beginning of 1954-55 in the definitions of hospital types for classification purposes.

41. Notwithstanding the limitations of the present costing scheme, the Minister has taken the view that the published returns can give useful pointers to differences in cost which ought to be investigated by the hospital authorities and so help to promote economy and efficiency. Arrangements have now been made for the introduction, with effect from 1957-58, of a more informative costing system. This will be based on the Report of a Working Party on Hospital Costing, published in 1955, which recommended the introduction, by stages, of a full departmental and unit costing system, which would show not only on what items expenditure was being incurred but also to what extent the different departments were contributing to that expenditure. Outpatient expenditure will, under this system, be separately calculated for the first time. Initially the main scheme is to be operated in some 200 hospitals—principally acute or mainly acute—with an annual expenditure of £150,000 or more. Other hospitals will operate a simpler scheme which is in essentials an improved version of the existing system. They will produce unit costs for certain departments based on the principal direct expenses (e.g., salaries and materials) of those departments and no attempt will be made to bring in overhead costs, on a departmental basis. The first figures to be published nationally under the new system, and showing comparisons between the costs at different hospitals, will not be available before the latter part of 1958. But hospital authorities have been asked themselves to get out interim cost statements at frequent intervals during the year for purposes of internal management. Great importance is attached to the prompt production of these interim statements and to the follow up action which should be taken locally when the statements reveal anomalies in costs. Both the Committee of Public Accounts and the Guillebaud Committee have expressed themselves in favour of the introduction of the new system.

*The Guillebaud Committee*

42. Reference has been made to certain of the recommendations of the Guillebaud Committee (see paragraphs 27 and 41). This Committee was appointed in May, 1953, by the Minister of Health and the Secretary of State for Scotland, with the following terms of reference :—

> "To review the present and prospective cost of the National Health Service ; to suggest means, whether by modifications in organisation or otherwise, of ensuring the most effective control and efficient use of such Exchequer funds as may be made available ; to advise how, in view of the burdens on the Exchequer, a rising charge upon it can be avoided while providing for the maintenance of an adequate Service ; and to make recommendations".

The Committee made no recommendations for major changes of policy or administration but made a number of detailed recommendations, including those mentioned.

* Not reported. † App. 1. pp. 374-5.

**Examination of Witnesses.**

Mr. J. E. PATER, C.B., Under-Secretary for Hospitals and Specialist Services, Mr. A. S. MARRE, C.B., Under-Secretary for Finance and Accountant General, Mr. M. REED, Under-Secretary, Health Services Remuneration and Staffing Division, and Mr. J. F. HUNT, a Deputy Accountant General, Ministry of Health, called in and examined.

*Chairman.*

1. I thought we would just prepare the ground by going through this Memorandum which, no doubt, you have in front of you. With regard to paragraph 1, could you elaborate a little about the phrase " all reasonable requirements ", which is rather a key phrase? ——(Mr. *Pater.*) I am not sure that I can elaborate this very helpfully. This is, I think, precisely quoting the words of the Act of 1946, and, so far as I know, successive Ministers have always interpreted it as meaning in practice that their obligation was to provide such services as they reasonably could in the circumstances obtaining, financial and otherwise.

2. In fact, it really means very little. It is just a phrase?——It is imprecise. (Mr. *Marre.*) It ought perhaps to be read in the context of the Minister's obligation under section 1 of the Act to secure the provision of a comprehensive health service.

3. With regard to paragraph 2, will the ex-Ministry of Pensions hospitals continue to be directly administered by the Minister?——(Mr. *Pater.*) The position there is that certain of these hospitals have already been transferred to the administration of the appropriate Regional Board and Hospital Management Committee. There are at present still four of these hospitals directly administered by the Minister. In the Government White Paper issued at the time of the transfer of functions from the Ministry of Pensions, it was said that it was the intention, as time went on and as circumstances permitted, to bring the administration of these hospitals within the National Health Service. That, in fact, is what has been happening. As the war pensioners' demands on these hospitals has fallen it has been thought appropriate to transfer their administration to what has in effect become the major user, that is the local Regional Hospital Board or Hospital Management Committee.

4. And it is a permanent arrangement?——Yes.

Mr. *Willis.*

5. Might I ask, in addition to that, does that also apply to the provision about artificial limbs and invalid vehicles?——No.

6. It is not proposed to transfer those? ——That question has not yet arisen.

*Chairman.*

7. In paragraph 3 you use the words " conveniently be associated with a university having a School of Medicine ". How are the Regional Boards' services associated with the Schools of Medicine; what collaboration is there between the Boards and Schools of Medicine?—— There, I think, the picture differs considerably as between London and the provinces. In taking as a random example the Birmingham region, shall we say, one tends to find that the hospital services of that region focus naturally on the Birmingham teaching centre. One finds, for example, that certain highly specialised forms of treatment for the whole region will be provided at the teaching hospital centre. There are links of other kinds. The membership of the Regional Hospital Board includes medical and other people from the university concerned, and, conversely, the governing body of the teaching hospital includes members nominated by the Regional Hospital Board. So at what one might call the formal administrative level, the management level, there is interlocking membership, and at the level of the actual provision of services there is an interlocking between the teaching centre and the non-teaching hospital services provided by the Regional Hospital Board, with the teaching centre providing a sort of natural focus for the hospital services for the region as a whole.

8. But that is not so in London?—— In London the position is rather different, because there are so many teaching hospitals, both under-graduate and post-graduate, and there is not, I think, the same close link between any particular teaching hospital and a particular region in which it happens to be, though there is, it is probably fair to say, an increasing

tendency for the flow of traffic to a teaching hospital to correspond more closely with the area of the region in which it is situated. That process has not gone a very long way.

9. There is very little interlocking in London?——There is inter-locking of membership, but not to the same extent for perfectly practical reasons. Whereas in Birmingham it is perfectly easy to secure interlocking, for the reason that the Regional Hospital Board nominees on the Board of Governors of the teaching hospital can all be members of the Regional Hospital Board, it is quite impossible in London where, for example, one has as many as ten teaching hospitals in one region and the Regional Hospital Board could not possibly get all its nominees from among its own ranks for all those ten boards.

10. What sort of people are appointed to the Regional Boards? For instance, are members of the Management Committees ever members of Regional Boards?——Yes.

11. What sort of people are the chairmen of Regional Boards, and how many people are there on the Boards?——If I may take the numbers first. The numbers are laid down in one of the Orders referred to in the footnote to paragraph 2. The numbers vary from 22 to 31, I think; the average is, therefore, about 25 or 26. As to the kind of members, to some extent that is laid down in the Third Schedule of the 1946 Act itself, which, although it leaves it entirely to the Minister to decide who he shall appoint, does enjoin him to consult various groups of people before he makes his selection. He has, for example, to consult the university concerned, the organisations of the medical profession, the local health authorities in the area, and he has also made a practice of consulting Hospital Management Committees in the area, executive councils, and various other bodies.

12. Is he enjoined to keep a particular balance?——No, not on Regional Hospital Boards; no balance is laid down.

13. How many members of Regional Hospital Boards are members of Management Committees, would you say in the average Board?——I would have said something of the order of a quarter to a third, perhaps, in some cases.

Mrs. *Hill.*] It does vary quite considerably. For instance, on my own Hospital Committee I have two members of my Committee on the Regional Hospital Board, but it does not necessarily mean every other Committee has.

*Chairman.*

14. Is the witness satisfied there is adequate liaison between the Committees and the Boards?——I would have thought so. The liaison between the Regional Boards and the Management Committees, I would have thought, was much more a matter of day to day working on particular problems between officers and perhaps between chairmen of Regional Boards and the chairmen of Management Committees.

15. How often does the average Board meet?——That varies a good deal.

16. I am talking of a full Board?——I would have said most of them were meeting monthly.

Captain *Waterhouse.*

17. Is there a university School of Medicine in each of the Regions?——Yes. There is one in each of the provincial regions; in the four London regions there is more than one in each.

18. Would I be right in thinking that this particular Board we are discussing now is really the key of the whole organisation, and that on them rests, to a large extent, the decision as to whether or not the Service is economically run; would you look upon the Regional Board as the key of the whole thing?——From that point of view, yes; I think my colleagues would agree with me on that.—(Mr. *Marre.*) We have gradually built up the financial responsibilities of the Regional Board for the expenditure in the Service.

19. Would you feel that some of the members of the Regional Boards are appointed because it is hoped that they will keep a special eye on the economy of the regions?——(Mr. *Pater.*) That is one of the factors.

*Chairman.*

20. I want you to elaborate that, if you would. Are there any members appointed for that purpose rather than for their hospital or medical knowledge?——I am not sure what you mean by " medical knowledge ".

21. Appointed for the expertise in the subjects they deal with?—(Mr. *Marre.*) There are businessmen, for example, appointed. Mr. Pater will know. There may be people with legal qualifications. —(Mr. *Pater.*) The Minister's basic approach to this is to appoint someone he thinks can make a personal and individual contribution to the successful running of the Service, and people come from all walks of life for this particular purpose, including businessmen, bank managers, lawyers, people drawn from every possible source.

Captain *Waterhouse.*

22. Would you say that some members are appointed to these Boards because it is hoped they will have a special eye on the economy of the Board, or on the efficient working of the Board?——Yes, I can certainly think of occasions on which that has been the influencing factor in picking a particular person as a member.

23. When you say " on occasions ", do you mean there are certain occasions over the whole of the country out of the 13 Boards, or that there are occasions on each Board when a man or a woman is picked because of his or her knowledge?——I was only meaning that I could at the moment think of one or two persons that came to my mind. I would not wish to imply they were the only one or two persons.

24. Generally speaking you would not say the Minister recommended certain people in each Board because it was hoped that those people would watch the economic efficiency of the running of the Board?——I am not sure how conscious the process is, but I think the way in which it works out is that there are in fact people selected for that reason, and there are members of each Board who discharge that function.

25. You consciously put people on the Boards because of their hospital knowledge, but do you consciously put anybody on a Board because you think they are more likely to get value for the money that is spent than other people? ——May I put it this way? These appointments are, of course, always made by the Minister, and Ministers personally have always taken a very close interest in the choice of members of these Boards. Undoubtedly there have been occasions when a particular individual has been selected by the Minister because he was regarded as somebody who would pay particular attention to the financial running of that particular region.

26. You have to look into your mind and pick out particular instances of such an appointment. You would not say there is a general rule for every Board that there would be a certain proportion of them whose primary duty would be to look at the cash side?——I think that is so.

Mr. *Holt.*

27. With regard to the Chairmen of the Regional Hospital Boards and the Chairmen of the Hospital Management Committees in the big hospitals, am I right in thinking that those two positions take up a great deal of time, very much more than just part-time work? In other words, in regard to the Chairmen of the Regional Hospital Boards and the Chairmen of the Management Committees in hospitals in big towns, they are perhaps not full time jobs, but very nearly?——I would think that that must vary a good deal according to the Management Committee group in question. So far as the Regional Hospital Board is concerned, my impression is that most chairmen would give two or three days a week to it.

*Chairman.*

28. Full days?——Yes.

Mr. *Holt.*

29. Has the Minister found any difficulty in getting suitable people able to do that work, for which I think they are not paid although they can get some expenses?——So far as the Minister is concerned, he is concerned only with the chairmanship of the Regional Boards and the Boards of the teaching hospitals, not of the Management Committees. I would have said the Minister had not found any difficulty so far in finding suitable people for the chairmen of the Boards.

*Chairman.*

30. Regional Boards?——Or indeed the hospital Boards.

31. Has he had reported to him whether there is any difficulty on the part of the Regional Boards in getting chairmen of the Management Committees?——I am not aware of difficulties which have arisen.

Sir *Henry D'Avigdor-Goldsmid.*

32. Could you tell me where the staff of the Regional Boards are recruited.

Are they recruited through local government, or through the Ministry of Health?——(Mr. *Reed.*) They are recruited by public advertisement.

33. I mean do they form part of the medical services or local government services?——They form part of the National Health Service. They are employees both in law and in fact of the Regional Hospital Board. They are not civil servants, and are in no way connected with or employed by the Ministry of Health or local government.

34. Therefore, they are not liable to transfer from one region to another?——No. They can, and in practice do, transfer voluntarily, but are not liable to be moved about.

Vice-Admiral *Hughes Hallett.*

35. If I may ask this. As I understand it from the two paragraphs we have been discussing, there are really three tiers of management: the Regional Board, the group Management Committee, and the Boards of Governors?——(Mr. *Marre.*) No; those are not three tiers.

Vice-Admiral *Hughes Hallett.*] That is what I want to get at. Are the functions normally separate and laid down anywhere, or do they overlap?

*Chairman.*] The Boards of Governors deal only with teaching hospitals. There is a clear distinction. There are the Management Committees of hospitals and Regional Boards.

Vice-Admiral *Hughes Hallett.*

36. Then there is a group committee between?——The group committee is the Hospital Management Committee. If we are dealing with non-teaching hospital committees now, the bodies concerned are the Regional Hospital Boards and the Hospital Management Committees, each Hospital Management Committee being responsible either for a group of hospitals or sometimes for a single hospital.

37. Is there such a thing as an organisational diagram which one might look at to see who does what?——We will gladly put one in.

Sir *Henry D'Avigdor-Goldsmid.*

38. Inside the Hospital Management group there are house committees which deal with individual problems of the individual hospitals concerned.——(Mr. *Pater.*) The practice varies, if I may say so, from group to group.

*Chairman.*

39. Would you be good enough to put in a note?——Yes.*

Mrs. *Hill.*

40. Is it not true that in some instances the chairman of the Regional Hospital Board is also the chairman of the teaching Hospital Board as well?——That is true in two instances, Manchester and Liverpool.

Mrs. *Hill.*] Yes, I rather thought so.

*Chairman.*

41. Coming on now to Boards of Governors. What collaboration or liaison is there between Regional Boards and Boards of Governors? Who allocates a patient to a teaching on non-teaching hospital? Who decides the total allocation of beds in teaching and non-teaching hospitals?——The allocation of patients depends first on what is wrong with him, and second on the views of his general practitioner, and thirdly which teaching hospital we are thinking of. If we are thinking of the teaching hospital in Birmingham, shall we say, I think whether a patient is referred to the Queen Elizabeth Hospital, a teaching hospital in Birmingham, or to Selly Oak, a non-teaching hospital in Birmingham, will depend on what is wrong with him, where he lives, and what his general practitioner thinks the best thing to do with him.

42. It must be so, I suppose, but teaching hospitals in general are more costly, are they not?——Yes.

43. What is the meaning of the words in paragraph 4 "in collaboration with the Boards of Governors"?——That is related to the planning and administration of the Service for the region as a whole. In Birmingham itself, I think I am right in saying, the Regional Board and the Board of Governors have a sort of standing committee which considers on behalf of both bodies problems of planning of the hospital services of the Birmingham region.

44. Is that peculiar to Birmingham?——No; it exists also in other areas.

45. In every area?——I am not sure it does in every area. The particular method of carrying out this task does vary from region to region.

* Not reported

46. You would agree, would you not, that it is clearly a very vital task?——Yes.

47. I am a little surprised that you are implying there is no formal collaboration laid down, because it would look as if where there is not much collaboration the teaching hospitals are rather on their own. Would that be an unfair deduction?——Yes, though I think that again one must distinguish between London and the provinces. In the provinces I think the co-operation between the Regional Board and the teaching hospital is much easier to effect than it is in London, and is therefore more effective. In London it is very difficult because of the existence in London of 26 teaching hospitals and four Regional Boards, and it needs a much greater effort to secure that kind of planning and co-operation. I am not aware of any standing committees in London, but of course there is free consultation between the parties concerned on any planning question which affects them both.

48. I do not think you have answered my question as to who it is who decides the total allocation of beds between teaching and non-teaching hospitals?——In the last resort I suppose the Minister must determine that.

Captain *Waterhouse.*

49. Are there some possibilities that they could take many more beds than they have got now?——Only with new building. Perhaps I have not understood your question.

50. I think it was meant the allocation of beds in the existing buildings. Are all available beds open for occupation? Are there not some possibilities that beds are closed because of lack of staff, and one thing and another?——Yes, certainly, but I do not think I have followed this question.

*Chairman.*

51. Who decides that such-and-such a proportion of the hospital accommodation shall be teaching hospital and such-and-such shall be non-teaching?——That was decided by the Minister of Health under the terms of the 1946 Act at the outset of the Service. Certain hospitals used for teaching purposes were designated as teaching hospitals. That is how it was done.

52. Expansion or contraction of those hospitals is quite another matter?——Yes.

53. Done independently?——That is a matter of future planning and future expenditure, and so on.

Mrs. *Hill.*

54. Any major changes would be considered by the Minister, would they not, in the case of teaching hospitals, because they have a closer liaison with the Ministry than do the Regional Hospital Boards; they have closer access than the Regional Hospital Boards?——Certainly, yes.

*Chairman.*

55. Turning to paragraph 5, Management Committees. Who nominates them?——They are selected and appointed by the Regional Board for the region in which the Management Committee is situated.

56. Do they appoint on much the same basis as the Minister to the Regional Boards?——Yes. Again, the 1946 Act in its Third Schedule gives some guidance by mentioning various bodies to be consulted by Regional Boards in making their selection, but the final selection, of course, is left to the Regional Board itself.

57. Does that selection have to be approved by the Minister?——Not in any way, no.

58. So the Regional Board is really the head of a completely autonomous body?——Completely autonomous in this task of selecting and appointing members of Management Committees.

59. Do they appoint people with management and business experience to act as watch-dogs? Roughly how many people are there on an average committee?——The number, I think, tends to be rather smaller than Regional Boards, but, there again, it varies considerably. I would have thought the average number was about 20 members.

60. They break up into committees and sub-committees in some way?——Yes.

61. How are Boards of Governors appointed?——Appointed by the Minister, but here the Act requires nomination by the university, the Regional Hospital Board concerned, and the medical and dental teaching staff of a certain proportion of the members, not more than one-fifth in each case.

62. Would you say a Board of Governors on the whole is more what I might call "medically" constituted than the Regional Boards?——I think it is true that it tends to have a large proportion of medical members because there are several sources from which they are likely to come. Not only, of course, the medical and dental teaching staff, but also very frequently the university, and sometimes the Regional Hospital Board will nominate medical men for membership of the Board of Governors.

63. Would it be fair to say that the technical membership rather outweighs the "practical affairs" membership, so to speak?——I do not think one could find a case in which there was a majority of professional members. It is a high proportion, but not, I would have thought, a majority.

Mrs. *Hill.*

64. Is there not a tendency or suggestion at the present moment—I am speaking particularly of Hospital Committees—to restrict or reduce the number of medical members on some of these Committees?——Yes. The Minister has recently issued a circular making it clear he proposes in future to adopt as a working rule the recommendation of the Guillebaud Committee that medical membership of Regional Boards should not exceed 25 per cent., and has asked Regional Boards to adopt the same working rule in appointing Hospital Management Committees. He did, however, in that circular make an exception in the case of Boards of Governors, about which the Guillebaud Committee in fact made no recommendation.

*Chairman.*

65. What is the total membership of Boards of Governors?——The total membership is 20 to 30.

Mr. *Holt.*

66. May I ask, following up my previous question, whether the Minister has been informed of any difficulty in filling the vacancies on the Hospital Management Committees with a variety of people?——I am not aware of any, but I am not sure the Minister would necessarily hear about it because this is entirely the Regional Hospital Board's functions and I am not sure it would come his way.

67. Surely if the Regional Hospital Board could not fill their Management Committees they would have to take some action, and if they had to run the hospital without a Hospital Management Committee they presumably would have to get permission from the Minister, but there has been no information to the Minister?——I am aware of none.

*Chairman.*

68. You said you agreed they broke up into committees and sub-committees in Regional Board Committees or Boards of Governors. What powers can they delegate to committees—have they power to delegate anything? Are the committees plenipotentiary in some respect?——They can delegate . . . . (Mr. *Marre.*) They can certainly delegate the right to authorise expenditure to the Finance Committee.

69. Without limit?——I am not sure. (Mr. *Hunt.*) Without limit, yes.

70. So far as money is concerned, the Finance Committee of a Management Committee is the sole spending authority?——(Mr. *Marre.*) The Committee would certainly expect to be kept informed, and is kept informed, of the progress of expenditure.

Captain *Waterhouse.*

71. The Minister who has to provide all the money has no direct representative on any of the Hospital Management Committees?——By "direct representative" you mean a civil servant?

72. The Minister does not appoint?——The Minister does not appoint, no.

73. He has no civil servant, obviously, has he?——Serving on the Committees, no.

74. He has no direct representative either appointed, much less a permanent official on any of these Management Committees?——Yes. Perhaps I ought just to add that our principal Regional Officer, an officer of the department outstationed in each region, is able to, and does attend meetings of Regional Boards of Governors and Management Committees as an observer. Not all meetings, but so far as he can.

75. He has a right to go to any meeting?——Yes.

76. But no right to speak?——No right to speak, no. If asked, obviously he would speak.

77. If he objected to any particular item of expenditure, he could not speak up but would have to go back to his region and make a report there, would he?——I think that if he really objected to a particular item he would make his views known at the meeting.

78. Has he a right to?——I do not think the point has arisen. I have never heard of any practical difficulty.

Miss *Hill.*

79. He is not specially appointed to the hospital service?——No. His main functions are liaison with the various bodies of the National Health Service. He is an administrator.

80. He has many other tasks besides hospitals, has he?——He has other tasks. The tasks include liaison with executive councils, who are bodies which administer the general practitioner services, and certain functions in connection with the civil defence responsibilities of the Minister.

*Chairman.*

81. He is the only link, and when I say "he" I understand there are about 13 of them, is that the case?——There are actually 10, I think.

82. These ten gentlemen are the only direct link between the Minister and the spending bodies?——I am not sure what you mean by "link" there.

83. The only way the Minister has a chance of making his voice heard before the expenditure is undertaken?——You mean on a particular item of expenditure.

84. Yes?——On a detailed item of expenditure that would be so.

85. The Regional Boards are on the same footing as the Management Committees *mutatis mutandis*, are they; they have Finance Committees to which they delegate the expenditure and who are plenipotentiary?——Yes.

Mrs. *Hill.*

86. May I ask one question? It is true is it not, that the Boards' Management Committees submit their estimates which have to go to the Regional Boards for vetting, the Regional Board then send them on to the Minister after they have vetted them and considered all the items that the Management Committee are asking should be included, and that it sometimes happens that Regional Boards, indeed, prune those requests before they come to the Minister?——Of course, we are getting on to the later parts of the Memorandum here. It is the case that a Hospital Management Committee before the beginning of the financial year will submit to the Regional Board an estimate of its requirements for the following year, and the Regional Board will scrutinise that estimate and will afterwards reduce it if it thinks right. It will submit that forecast as part of a summary of the forecast of the whole region to the Minister, and the Minister, after various steps which are set out in this Memorandum have been gone through, will say how much is available to the region to spend for the forthcoming financial year. The Regional Board will apportion that between itself and its Management Committees, and those allocations are the limit of the expenditure of the different bodies, subject to provision for wage and price increases. The Minister's policy has always been, within that broad sort of financial structure, to leave financial autonomy to local bodies.

Mr. *Holt.*

87. May I ask one further matter? When the Minister appoints people to the Regional Boards, can he have anything in consideration other than a person's general ability to assist in the working of that Board?——(Mr. *Pater.*) No, Sir. I think that puts very plainly the principal reason for the Minister's choice in each case.

88. May I then further ask: is it unrealistic to think that anyone could be appointed to a Board specially to undertake to direct the activities of that Board in a certain direction, as he will only, in fact, be one of that Board, and so I suggest that the fact the Minister might in fact appoint somebody with a reputation for parsimony is not something the Minister could countenance, is it?——May I put it like this? Successive Ministers have always chosen the members of these Boards on the grounds of their personal ability and the contribution which they can make as members,

and not upon their representative function, if I may put it that way: not because they are members of this, that or the other, or have been proposed by this, that or the other body. But I would suggest that in some cases the Minister may well decide to choose and appoint A rather than B becuase of A's financial ability through his experience in business or financial management.

89. Was that all, in fact, you meant when you replied to an earlier question that you knew of one or two cases that had been made?——That is what I was thinking of.

Mr. *Holt.*] So that you did not mean to imply that such a person was put on a Board by the Minister with the idea of carrying out an economy drive on the Board?

*Chairman.*

90. I think we are going a little far from the Memorandum. I think it is quite clearly understood that the idea is to have a balanced form of committee, and in your view that is being achieved? ——Yes.

Vice-Admiral *Hughes Hallett.*

91. One question about which I am a little confused: who is what I would call the accounting officer at each level of this—who actually has the financial responsibility to see that the money is spent?——(Mr. *Marre.*) That is the Board's or Committee's responsibility.

92. But you have got to have an individual responsible for a thing like that, have you not?——They have, of course, a staff working subject to their directions. They have a secretary, a senior administrative medical officer, and a treasurer —I am talking of the Regional Hospital Boards at the moment.

*Chairman.*

93. They are whole-time people?—— Whole-time officers, yes.

Mrs. *Hill.*

94. There is usually a finance officer, and deputy finance officer on Regional Boards, and Hospital Management Committees have a finance officer as one of their officers, generally speaking?—— Generally speaking, that is so. Sometimes the duties of finance officers are combined with those of the secretary.

*Chairman.*

95. Are the auditors independent firms or Ministry auditors?——The auditors are appointed by the Minister; they are officers of the Ministry, civil servants.

96. Who are continually going round doing that work?——That is so.

97. Are they connected in any way with the Comptroller and Auditor General?——No, they are quite a separate audit service whose function is solely to undertake the audit of the accounts of hospital authorities and other National Health Service bodies. When I said they had no connection, that perhaps was going a bit too far. All their reports are made available to the Comptroller and Auditor-General and the Comptroller and Auditor-General can in addition, and does sometimes, undertake local test examinations of his own.

98. Are their auditors mainly to check the correctness of the book-keeping and finance, or are they advisory in their function as well, and critical? ——The audits are as much concerned with waste and extravagance as with the accuracy of the figures.

99. To whom do the criticisms go? ——Those criticisms are submitted in a report to the Minister. The Minister then sends a copy of the report, if it is a non-teaching hospital, to the Hospital Management Committee, and to the Regional Hospital Board whose function it is to follow up a criticism with the Committee.

100. Is it exceptional or usual for every auditor's report to contain a good many items of constructive criticism? ——It varies enormously. There will be some reports which have no criticism of any kind. There will be reports which have one or two criticisms, which may be quite minor or may be major. At the other extreme you get a report which contains quite a large number of criticisms.

101. You have not quite answered my question. Do you normally expect in a report to find criticism, or do you normally expect to find no criticism: is it exceptional for there to be many criticisms?——(Mr. *Hunt.*) I would not say it would be exceptional to find constructive criticism in an auditor's report. I think possibly in rather less than half of the auditors' reports received there

is some criticism of the Board or other hospital authority.

102. You would say that auditors have a pretty wide experience of different types of hospitals and hospitals of the same type to make comparisons between one hospital and another?——They have that experience.

Mrs. *Hill.*

103. Is that also so with regard to teaching hospitals?——(Mr. *Marre.*) Yes. In those cases audit criticisms are followed up direct by the Ministry with the Board of Governors.

Sir *Henry D'Avigdor-Goldsmid.*

104. In the case of the non-teaching hospitals, what power resides with the Ministry to make sure the auditor's criticisms are in fact taken note of and remedied—I am not referring to imputation of dishonesty, or bad book-keeping, but the more general criticisms? ——(Mr. *Hunt.*) The Regional Hospital Board in the first place is charged with the duty of following up the auditor's report with the Hospital Management Committee, and is expected to report to the Minister on the action taken on that report. If that action were not satisfactory, the Minister would take it up with the Regional Hospital Board.

105. These answers have all been conditional. Can the witnesses tell us from their knowledge that the procedure is in fact followed that when criticisms are made they are taken up and if satisfactory replies are not received action is taken?——I can give that assurance.

*Chairman.*

106. Paragraph 10, endowments. Did each teaching hospital keep its own endowments, or not?——(Mr. *Pater.*) The endowments of the hospitals designated by the Minister as teaching hospitals were kept by the Board of Governors of the hospital or group that was formed from those designated hospitals.

107. They were not pooled?——They were pooled to the extent that if the hospitals were put into the same group under the same governing body they were pooled to that extent, but no further.

108. On what basis is the income from the Endowment Fund—I am not talking of teaching hospitals—distributed between Regional Boards and Management Committees: what is the basis of distribution? ——(Mr. *Marre.*) At the moment the income of the Endowment Fund is sufficient to enable an annual distribution totalling——

109. I want the basis on which they are distributed?——On the basis of beds.

110. That is the same all over the country?——Half the total is distributed to the Regional Boards in proportion to the beds in the Region; the other half is distributed to Management Committees in proportion to the beds which they control.

Sir *Henry D'Avigdor-Goldsmid.*

111. In both cases without reference to the previous endowments to the hospital in question?——That is so.

112. Can subsequent endowments now be accepted for the Endowments Fund? ——No.

113. It would have to be accepted for the Amenities Fund?——The individual hospitals may accept endowments now, but the Endowments Fund set up by the Act is now, as it were, complete.

*Chairman.*

114. What is the present income of the Endowment Fund?——The present income of the Hospital Endowment Fund is £700,000 a year.

115. How much of that is post-1948? ——None is post-1948.

116. Post-1948 does not come into the Fund?——No.

Captain *Waterhouse.*

117. Does that include any teaching hospital?——No.

118. What sort of amenities do they get spent on?——(Mr. *Pater.*) That varies considerably from hospital to hospital. It may be almost anything, from T.V. sets to easy chairs for the nurses.

*Chairman.*

119. They are only spent on amenity? ——No, Sir; they may be spent on any hospital purpose, or on research.

Mrs. *Hill.*

120. A new waiting room could be paid for out of it, if necessary?——Yes, certainly. Large numbers of small

capital schemes have been paid for out of these funds.

*Chairman.*

121. In many cases they are regarded as a source of income outside Parliament's or the Minister's control which the organisation in question is free to spend as it likes?——On hospital purposes or on research. The Act prescribes the broad purposes on which they must be spent, but——

122. To what extent does the Endowment Fund enable the Exchequer grant to be reduced?——I think the answer to that, Sir, would be not at all. The intention of Parliament, as I understand it, was in 1948—and since as carried out by the successive Ministers—to allow these Endowment Funds to be used by the hospitals as they think fit to supplement the Exchequer funds available.

123. With regard to paragraph 10 (*b*), you are referring there to charges. How do the amenity bed payments compare with the actual extra cost incurred?——(Mr. *Marre*.) I do not think anybody has ever assessed the extra cost of these beds by comparison with other beds in the same hospital.

124. It is notional?——Yes. I think it would be probably an almost impossible task to do.

125. How are the Section 5 bed charges calculated on a local or regional or national basis?——Those are calculated on the basis of the costs of the pay-beds at the hospital itself where that cost can be separately ascertained, as when the pay-beds are in a separate block; or where that cannot be separately ascertained it is based on an arbitrary formula taking the cost of an ordinary bed in that hospital and adding a percentage to allow for the fact that the cost of a bed in a single room or a small ward is more expensive.

126. It is less notional than amenity beds, but still to some extent notional?——Still to some extent notional, yes.

127. Turning to 10 (*d*), what does that really mean? Does it really mean that there is no real superannuation fund at all?——There is no real superannuation fund at all. The superannuation contributions are used in relief of the Exchequer, and in return the Exchequer meets all benefits that become due.

128. Why is that? Is that laid down in the original Act, or is it an administrative practice?——No, that is the effect of the 1946 Act, and it follows the pattern of the teachers' superannuation scheme where again contributions are used in relief of the Education Vote and benefit paid out of the Education Vote.

129. That is a precedent for it?——That is a precedent for it.

Mrs. *Hill.*

130. What is the amount of contribution?——At the moment, employers and employees, about £26 million.

131. What percentage of that amount does the employee pay?——£26 million is the amount of the contributions paid by all employing bodies and officers in all parts of the Service, and not simply the hospital service. Hospital service contributions are about £17 million out of the £26 million. The employers contribute 8 per cent. of remunerations, the employees 6 per cent., except for domestic staff, where the contributions are 6 per cent. and 5 per cent. These are exceptions.

*Chairman.*

132. Turning now to paragraph 12, at what moment in the year are the Committees' budgets approved by the Boards?——Could I give you the timetable from the beginning, if I may? At the end of September Hospital Management Committees submit their forecasts to the Boards. The Boards collate those forecasts, discuss them with the Committees as necessary, and submit to us a regional forecast at the end of November. Our aim is, after examining those forecasts, after discussing them with the Boards and discussing them with the Treasury——

133. May I interrupt? You are just dealing with the Regional Boards at this time?——At that time we are only dealing with the Regional Boards. We do not deal direct with the Management Committees at all on this. The Regional Board's forecast for the whole region comes to us at the end of November, we examine those forecasts, discuss, if necessary, with the regions, discuss with the Treasury, normally reference to Ministers is then made and Ministers decide the total. At the beginning of February we inform the Regional Board how much is available for their region for the forthcoming financial year. They

then divide the money up between themselves and their Management Committees and notify the Management Committees before the beginning of the financial year. They ask the Management Committees to submit to them detailed estimates by subheads which, I suppose, they would get at about the beginning of the financial year.

134. It leaves them a little short of time for the early part of the financial year. They cannot plan quite soon enough, can they?——There is not a lot of time for the Management Committee, no, before it receives its allocation. We have tried our best to cut down the time-table. We have not really succeeded.

135. The Estimates are revised, possibly, in the beginning of the current financial year?——Just about that time.

136. It seems to me rather pinched? ——It is so. The estimates reach the Regional Boards in September—they are forecasts really—and that is six months before the beginning of the financial year. To achieve any earlier time-table we should have to ask for the estimates to be sent to the Regional Boards earlier still, and they are not much use if submitted even before September.

137. I see that. May I go back to paragraph 10 (*f*) on one point? Roughly how much is recovered from employed in-patients?——Roughly £200,000 a year.

138. Going back to the budgets, what happens if the total sum determined for the group is exceeded?——If the Hospital Management Committee exceeds its allocation, do you mean?

139. Yes?——As far as the Ministry is concerned, we allocate a total sum to a region.

140. I quite understand that?—— What the Regional Board does with the Management Committee we do not concern ourselves with, provided that the total for the region is not exceeded. Our concern is to ensure that the total regional budget is adhered to.

Captain *Waterhouse.*

141. What happens if the regional budget is exceeded?——It depends, obviously, on the reason for the excess. One goes into it with the regional board. A relatively small excess may be quite understandable and justifiable. A larger excess may indicate bad planning. I do not think we have in recent years had on hospital maintenance any excesses that were so large we thought they indicated bad financial planning.

142. Can you under any circumstances make a surcharge on the Board?——No, we have no power of surcharge.

*Chairman.*

143. Is there ever an unspent balance of cash returned?——The accounts are on an income and expenditure basis.

144. Perhaps "cash" is the wrong word, then?——Do they sometimes under-spend?

145. Yes?——They do sometimes under-spend by varying amounts. In recent years the under-spendings have been, on the whole, very small indeed.

146. If they do under-spend, it comes back?—If that is so, it simply means the money to meet that expenditure has not had to be provided. It remains unspent.

Captain *Waterhouse.*

147. Are they congratulated, or given a "rocket" for not spending?——I do not think either happens, normally.

Vice-Admiral *Hughes Hallett.*

148. I have two questions. The thing starts off with the Management Committee submitting its budget?——Yes, submitting a forecast.

149. Yes. Is no indication given to it in advance of how much money is liable to be available?——Not at that stage, no.

150. That is the answer to my first question. My second question is this. I notice these words in paragraph 12, "Provision is made for budgets to be adjusted for wage and price changes", etc., etc. Are we to understand from that that these people are in the fortunate position of being insured against inflation in advance, and that they can disregard rising prices—their income will be stepped up *pro rata*?——That is substantially so. I ought, perhaps, to give the Committee a little of the history here. Some years ago the practice was to include provision for things like wage increases and price increases in the initial

allocations. The Public Accounts Committee a year or two back took exception to that, and expressed the view that no provision of any kind should be made for unforeseen wage increases or price increases, and also expressed the view that instead the right course should be to cover those later on by a Supplementary Estimate, and that is now the practice.

*Chairman.*

151. Towards the end of paragraph 12 you say ". . . Regional Boards are responsible also for approving formally the detailed estimates of the Management Committees". What does that mean, "formally"?——That means they do not send them up to the Minister. The responsibility rests with the Regional Board itself.

152. What does that sentence mean? ——The word "formally" could easily have been omitted.

Captain *Waterhouse.*

153. Does that mean that the Management Committees are really responsible and all the Regional Boards say is "Very nice"?——Not really, no. It was the practice in the early years of the Service for the Minister to approve the Management Committee estimates.

Mr. *Holt.*

154. Is it not the case the Management Committee do, in fact, decide their own expenditure within a total figure, and are these words not exactly what describes what happens?——We would not expect the Boards to give it formal approval, if that means someone saying "Very nice". We would expect the Board to examine those estimates and satisfy themselves that, by and large, they presented a reasonable picture of the expenditure plans before giving approval.

155. Does the Minister expect Regional Boards to examine in detail their forecasts, and, for instance, possibly send them back and say, "You are spending too much on food and not enough on mops and buckets"?——Not normally, not unless the general picture was unsatisfactory.

*Chairman.*

156. You do sometimes disapprove? ——We are in the position that we do not really control the actions of the Regional Boards.

157. You know what is happening; you know what the practice is?——There is no need for them to tell us so long as they keep within their regional total. That is our main concern. The Select Committee of some years ago expressed the view that consideration should be given to allowing the Regional Board greater responsibility. That is what we have been doing.

Mrs. *Hill.*

158. Principally, the Hospital Management Committee is charged with the job of the day to day running of the Hospital?——That is so.

159. They forecast the amount that is necessary for running from the previous year, with any additions for work which might be put to that group. The Finance Officer helps you with that, and that forecast is sent to the Regional Board. It is not unknown for that to come back and for them to say "Look at this, that or the other"?——That, I am sure, quite frequently happens.

Captain *Waterhouse.*

160. The Regional Board does not take any part in the Management Committee estimate of their expenditure?——Oh, yes. I think that perhaps we are not referring to quite the same stage. The forecast comes into the Regional Board at the end of September. At that stage the Regional Board will examine all those forecasts in some detail.

161. Pausing there, will they take them together and examine one hospital against another in a comparative way item by item, category by category?—— Whether they will do it quite in that form is for them—they will certainly examine each forecast in as much detail as is provided with the forecast, and it is certainly not unknown at that stage for the Regional Board to go back to the Management Committee and say, "Your forecast is high, we must do something about it".

162. You say "not unknown". It is obviously very exceptional?——No, I did not mean that to be implied. I have been rather cautious in my choice of words simply because this is left in the hands of the Regional Board and they do not normally tell us what they do. It has to be something quite exceptional for them to come to us and put something on record. They do not normally feel it necessary to do that.

163. Does not your officer to whom you referred a little time ago at this stage keep in very close contact with the Regional Board?——I think it is very difficult for him to do so, because this is a period of very intense activity. A Regional Board which is dealing with the estimates of up to 30 or so Management Committees is working under very severe pressure and strain, and really has not got time for outside discussions at that point.

*Chairman.*

164. To be quite frank about it—these are very technical matters—I suppose the actual members of the Regional Boards cannot go into them in detail in person: it must be their professional staff, really, who do it?——They must rely very heavily on their professional staff, but the Finance Committee or a specially appointed sub-committee would have to devote a good deal of time to this examination.

Captain *Waterhouse.*

165. You say they "would have to". Do they to your knowledge actually devote a great deal of time?——They do to our knowledge devote a great deal of time to it.

166. To the detailed examination of the hospital estimates?——Yes.

167. But your own Ministry representative leaves it to them, and does not at this stage materially interfere?——That is so.

*Chairman.*

168. In paragraph 17 you talk of "allocating per head of population". Are you satisfied with that?——We have not been able to devise so far any more satisfactory method of distribution.

169. A very important question: how are the claims of the Boards of Governors balanced against Regional Boards when allocating the money for general improvements?——It is done on a somewhat arbitrary basis. You are talking about item (*c*) only?

170. I am talking of the whole paragraph, (*c*) mainly?——The sum which is left for general improvement is usually a comparatively small sum after the other sums have been taken out.

171. The total being roughly what?——Something possibly of the order of £1 million out of £300 million.

172. We will leave that, then. Every pound is important, I quite understand. It is not as important as I thought?——It is quite important to the authorities themselves.

Vice-Admiral *Hughes Hallett.*

173. This is a very small carrot?——This is a very small balance of what is available.

174. It is a small carrot to encourage them to be economical?——I do not follow what you mean by that.

175. It seems to go up with the ratio of expenditure?——Yes.

Captain *Waterhouse.*

176. The lower the ratio the higher the grant?——Yes.

*Chairman.*

177. The Boards of Governors get very little out of that, on the whole?——Out of this the Boards of Governors would get a very small share, and it would be, roughly, rather less in proportion to the total expenditure.

178. On an expenditure basis?——Yes. We earmark a small part of this sum for the Boards of Governors.

Captain *Waterhouse.*

179. You say a million pounds has been distributed under (*c*)?——It varies in total, naturally. In the last year I think that worked out at about £1 million.

180. Something like £100,000 per region?——After you have taken off the shares of the Boards of Governors, it would be an average of about £70,000 per region. It is a very small part in the total budget.

181. It is a lot of money, though?——Oh, Yes.

*Chairman.*

182. Paragraph 18. Have you anything to say about the method of allocating the regional allotment between Committees, or have you already covered that?——This is something we like to leave entirely to the Regional Board itself to settle.

183. Is any pressure brought, when allocating money, on a Committee with high costs to reduce them?——By the Regional Board?

184. Yes?——I do not think we know the extent to which that happens. I am quite sure it does happen.

185. That is part of your decentralisation?——Yes.

186. And you are satisfied, are you, that inducements are made to the low-cost Committees to keep on with the good work?——When you say "inducements" are made, it is not too easy to decide how inducements should be given.

187. In fact, you leave that entirely to the Boards?——We think we give inducements to the Regional Boards simply by giving them a regional total, and to the extent economies are found in the region during the year they have something saved to be used for other purposes.

Mrs. *Hill.*

188. Is it the usual practice of a Regional Board to retain a sum to see how the money is panning out over the year?——It is usual for Regional Boards to retain reserves, as we call them, of varying sizes to see how things go during the year.

*Chairman.*

189. Paragraph 19. What does "provisions" cover?——Simply food and drink.

190. What does "other expenses" mean?——(Mr. *Hunt.*) "All other expenditure" will include expenditure on rents and rates, farms, gardens and canteens, etc.

191. Quite a healthy sum, £16 million this year with the Regional Boards?——(Mr. *Marre.*) If you would like us to we could give you a break-down of that figure.

192. We should be very grateful if you would. Altogether it is quite a healthy sum?——It covers quite a lot of items, some offset by the direct credits.

193. What are they, sales of flocks and herds?——With regard to direct credits, the greater part, I think, consists of payment by staff for board and lodging or for meals, but in addition direct credits include receipts from farm produce, receipts from leasing of accommodation to local authorities, offsets to expenditure.

194. Then there is "other expenditure" which Regional Boards estimate at £6 million this year. What does that cover—it is in paragraph 19, item 3? ——Perhaps you would allow us to give you a break-down of these figures.*

*Chairman.*

195. Thank you. Turning to paragraph 20, what specialists and registrars are paid by Regional Boards, under item 4 of "Expenditure"?——All. "Specialists" is a collective noun covering consultants, senior medical officers, and with regard to registrars there are two separate grades of registrars, all of whom are employed and paid by the Regional Boards.

196. You mean that all registrars are paid direct by the Regional Board?——Yes, their pay is not part of the Hospital Management Committees' own expenditure.

197. What are payments under contractual arrangements?——(Mr. *Pater.*) They are payments made by Regional Hospital Boards to hospitals outside the National Health Service in which they hire beds.

198. Then again you have "other expenditure" up there. You will give us a break-down of that?——(Mr. *Marre.*) Yes, we will.

199. And the income is from various odds and ends, is it?——The scope for a Regional Board to have income is not quite so great as it is with a Hospital Management Committee or Board of Governors.

200. They do not have farms?——Income covers income from pay-beds and amenity-beds which are not direct credits but is accounted for separately as income.

Captain *Waterhouse.*

201. That goes to the Regional Boards?——No, it goes to the Board of Governors or Hospital Management Committee. The Regional Board does not have the same opportunity of getting income as the others have.

202. I am not quite clear how they come to get any money at all?——I think from rents, sales of surplus equipment, oddments like that.

203. Inkpots or things of that sort? ——Yes.

* Not reported.

204. It has not got any beds or medical stores?——No.

*Chairman.*

205. Paragraph 22. When you talk about the regional reserves, are they all necessary? Are all revised estimate revisions upwards? Could there not be more accurate original estimating? Are they always used? Are they always needed?——They are, I think, almost always used. As you will gather from an earlier paragraph, we provide a sum which is meant to cover both the maintenance of existing services and to provide for a limited amount of development. The Regional Board will keep back the whole or part of the development element in that money, because developments just do not materialise as you expect them to.

206. Can you give any indication of the amount of the Regional reserves? ——(Mr. *Hunt.*) I do not know.

207. You see their accounts, do you not?——(Mr. *Marre.*) The reserves have disappeared by the time the accounts come in. It is quite reasonable that a reserve should be kept.

208. You want to keep something up your sleeve, I know.——I would hazard a guess, perhaps £100,000 possibly, it might be a little bit more, it may be £200,000—out of a budget of £20 million, something quite small.

209. On paragraph 24, why are staff establishments based on December, 1952?——(Mr. *Reed.*) This machinery for control of manpower was introduced in December, 1952, as a measure of economy which in the financial circumstances of that time appeared especially necessary.

210. Just a convenient date?——It is the date at which this system of control started. (Mr. *Marre.*) It was the date of the issue of the circular.

211. Paragraph 29, with regard to these returns. What can the Minister do to check any overspending revealed by the returns? Are they just for information, or have they a real value?—— The Minister cannot do a great deal more than exhort and ask for explanations, but I think I am right in saying that there has not been any real need, certainly not in recent years, for the Minister to do anything because by and large the monthly returns have shown a satisfactory position.

212. Are similar returns made by the Boards of Governors?——Similar returns are made by the Boards of Governors, yes.

213. Turning to paragraph 34 of the memorandum, are the memoranda issued to Management Committees direct?—— Yes, simultaneously with the Regional Boards.

214. Are they ever published?—— They are all published, I think. There may be a confidential civil defence one, but apart from that they are all published.

215. You refer in (*b*) to periodical regional conferences. How often are they held and do they cover finance? ——These conferences take place either every month or every two months. They are conferences between the Permanent Secretary of our Department and the Chairmen of the Regional Boards; our Chief Medical Officer or his Deputy with the Senior Administrative Medical Officers; Mr. Pater here with the Secretaries of the Regional boards; and, normally, Mr. Hunt with the Treasurers of Regional Boards. They are between all the principal officers and their opposite numbers at the Ministry.

216. Going back to paragraph 25, were any reductions effected?——(Mr. *Reed.*) Yes, they were, Sir.

217. Substantial?——Quite substantial reductions were effected, yes.

218. In paragraph 34 you refer in (*f*) to the O and M service. Have they been fully used, and have they achieved economies?——They are kept very busy. The principle on which they work is that they take on a subject at the invitation of the hospital authorities.

219. Only by invitation?——Only by invitation.

Mrs. *Hill.*

220. Could a hospital engage some other body experienced in these O and M investigations?——It has been done once or twice, but not to any great extent.

*Chairman.*

221. Paragraph 41. You have already referred to the Report of the Committee of Public Accounts of 1955. Are these

costing returns useful in reducing running costs—are they used, in fact?——(Mr. *Marre.*) We think they are useful, and we think they are used. We do call for reports from Regional Boards on the use made of the costing returns, because we expect them to follow up with their Management Committees, and from the reports which they make it is quite clear that they are found useful in producing economies in all sorts of different ways.

222. You will remember that the Committee said this: "Your Committee cannot understand why so many Boards of Governors of teaching hospitals should have considered comparisons of costing returns to be of little or no use"?——It is perfectly true that the Boards of Governors do not find the returns so useful as do the Regional Boards.

223. What you mean is that they do not pay so much attention to them?——They feel they are not of so much value to them, partly because of their admitted deficiences—admitted deficiencies of the returns—and party because of the fact Boards of Governors feel their own functions are so different that it is not easy to compare them on the basis of costing returns with other hospitals, even other teaching hospitals.

224. Would you say that the comments made in this Report have brought about changes in the administration or attitude? Would those same comments be made again today?——I rather think a good many Boards would still make those same comments today. I rather think a good many Boards of Governors would still feel the same way today, despite those comments. You do understand that we are altering the basis of the costing returns in the future in improving them and that should go a long way to remove one of the difficulties which these Boards have felt.

Mrs. *Hill.*

225. What sort of difficulties have the Boards felt?——The main difficulty in our present costing returns is that it does not separate out-patient expenditure. If you look at the individual items in the costing returns you will find that out-patient expenditure is not eliminated at all from them, and when you get to the final cost per in-patient you will find it eliminated by a somewhat arbitrary formula which might not be appropriate for all hospitals.

Vice-Admiral *Hughes Hallett.*

226. You referred to O and M services. Are there any regular standing teams who visit from the Treasury?——No. (Mr. *Reed.*) Some of the Ministry of Health O and M inspectors are in fact seconded by the Treasury.

227. Does nobody visit the hospital service and inspect it, working with the direct authority of the Chancellor?——No. (Mr. *Marre.*) When you say "visit" no-one goes there with the object of——

228. I meant visit and inspect in exactly the same way as Treasury officials descend?——No. We do arrange for visits by the Treasury for their education.

229. In the general forecast of expenditure over the period the National Health Service has been running as a whole, is allowance made at all for the fact that if the Health Service is working efficiently the health of the country should improve and consequently the expenses of the hospitals should go down on that account, no matter that there may be other matters tending to make them go up?——That is a wide question, I would only like to say this. We have always found it very difficult to connect directly the rising cost of the Health Service with a general improvement in the health of the people.

*Chairman.*

230. Do Regional Boards have regional conferences with their Management Committees?——Yes.

231. Regularly?——I do not know how frequently. I think the more usual form they take is that the chairmen meet the chairmen, otherwise it would be an enormous job.

232. You mean getting them all together?——Yes. Or it will be a case of principal officers meeting principal officers.

233. Do the Regional Boards have relations with the Boards of Governors at all, liaison?——(Mr. *Pater.*) Yes; I think I mentioned earlier that I know examples of joint standing committees of a Board of Governors and a Regional Board.

234. You said that was in Birmingham?——I know there is one in Birmingham. I happen to know that one. There are other similar arrangements in other places too.

235. They are not in two watertight compartments?——No; it is very difficult for them to be in completely watertight compartments because of the interlocking membership in any case.

236. Which you said did not apply to London?——The contact is less close in London simply because of the numbers concerned.

*Chairman.*] Thank you for your helpful evidence. We will continue the enquiry next week.

## TUESDAY, 5TH FEBRUARY, 1957.

Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | Captain Waterhouse. |
| Vice-Admiral Hughes Hallett. | Mr. Willis. |

Mr. J. E. Pater, C.B., Under Secretary, Hospitals and Specialists Division, Mr. A. S. Marre, C.B., Under Secretary for Finance and Accountant General, Mr. M. Reed, Under Secretary, Health Services Remuneration and Staffing Division, and Mr. J. F. Hunt, a Deputy Accountant General, Ministry of Health, called in and further examined; Mr. H. Wilkinson, C.B.E., Controller of Supplies, Ministry of Health, called in and examined.

*Chairman.*

237. Mr. Wilkinson, I understand you will answer with regard to paragraph 33 of the Memorandum. My first question is this. What is the value of the stores purchased directly by the Minister?——(Mr. *Wilkinson.*) For the hospital service in England and Wales, £8,264,000.

238. That is in the last financial year, is it?——That is actually in 1955-56. It is related to the accounts for that year which you have in this memorandum.

Mr. *Robinson.*

239. Could we have the rough proportion of the whole expenditure?——I should say that the proportion of the total hospital expenditure on goods is between 11 per cent. and 12 per cent.

*Chairman.*

240. Is much stored in Government stores?——Very little. Practically all the goods available under the Minister's arrangements move direct from the contractor to the hospital.

241. Where are these stores?——They are in various parts of the country. There are seven or eight stores. We do not ourselves run to stores. The stores are Ministry of Works stores operated for us on an agency basis.

242. There is very little in them?——Very little movement of goods into store and re-delivery from store to hospitals.

Mrs. *Hill.*

243. Could I ask what sort of goods would be kept in those stores?——The goods actually handled through stores are laboratory equipment, glassware, and also hearing-aids. Those are the main categories of goods handled through stores.

*Chairman.*

244. Were you only referring to goods covered under sub-paragraph (*a*)?——Yes, with regard to some of the goods

delivered to stores. The main categories mentioned in 33 (*a*), are hearing-aids, mass radiography units and vans, artificial limbs and invalid vehicles.

245. What is the value covered by paragraph 33?——I cannot give you a value for each of these paragraphs separately, I am afraid.

246. Your figure was an overall figure? ——An overall figure of the actual value of the contracts arranged by the Ministry or by other departments on behalf of the Ministry.

247. As described in these three sub-paragraphs?——Yes; total value.

248. Whether distributed by the department centrally, or obtained directly by the hospitals under central Government contracts?——Yes, that is so.

249. Why are not more of the standard goods purchased under central contracts? ——That is a question of Ministerial policy. The arrangements have been extended from time to time, but for the time being, in view of the appointment of the Committee on Hospital Supplies, a halt has been called to extension of the arrangements.

250. Why is that?——Because this Committee is examining all questions of organisation of hospital supplies.

251. But up to the date of the appointment of the Committee what factors governed the decision only to purchase 11 per cent. or 12 per cent. centrally? ——It was a question of economic or other advantages in making central arrangements for supply. That was all that was considered, the economic or other advantage.

252. But, surely, central purchase is bound to lead to economy: is it a question of distribution, or what?——Not necessarily. There are many items where there would not be any advantage at all in central arrangements.

253. What about tinned goods, or blankets, or drugs?——We have not touched foodstuffs or provisions at all.

Mr. *Robinson.*

254. On the question of drugs, surely the biggest field for saving could be not only by central purchase, but by rationalisation of product because we all know the extraordinary proliferation of new drugs coming in not only from manufacturers in this country but from manufacturers abroad. Has not the time come for some kind of rationalisation and, if necessary, tendering could be embarked on by the Ministry with a view to making very considerable economies?——It has, of course, been embarked upon by the Ministry for Welsh hospitals and has been embarked upon by certain Regional Boards for their own areas.

255. I was thinking on a very much larger scale, on the scale of the whole of the United Kingdom?——I do not think it would be practicable to arrange contracts centrally for the whole of the United Kingdom. It would have to be on a regional basis. That is, in fact, what is being done.

256. Are drugs being considered by the Committee to which you refer?——Yes.

*Chairman.*

257. What are the main savings effected by central contracts?——They are savings which result very largely from the fact that you are committed to purchase a stated quantity of goods in a stated period. That quantity of goods is always, of course, quite large in relation to the requirements of any individual hospital, or indeed any individual Hospital Management Committee. Therefore you get a very much better price.

258. I quite see that, but why should those considerations only apply to 11 per cent. or 12 per cent.?——As you probably realise from the figures, half the hospital expenditure on goods—very roughly —is for provisions. Most of those provisions are perishable goods.

259. Leaving out provisions, it means that you only purchase under a quarter of your total requirements centrally?—— Yes.

260. I ask you the same question: why do those considerations not apply to the remaining threequarters?——There are, of course, many items like uniforms, clothing of all kinds, where individual preference must be regarded, and unless you are going to standardise, and indeed rationalise, the whole thing it would not be practicable to undertake the central arrangements.

261. Could you assure the Committee that the maximum possible is purchased centrally?——No. I should not have thought it is the maximum possible. There are other things which possibly could be tackled.

262. With resultant savings?——With resultant savings.

Mrs. *Hill.*

263. When the Ministry makes a contract is it always the same price which will be available to all Management Committees for a given article, or does it sometimes happen that there might be one or two different prices at which a Management Committee may eventually have to take their goods even though on Ministry contract?——Practically always there is one price. There have been, I think, one or two cases where it has been necessary to split a contract between two suppliers at different prices.

264. I should have thought there were more?——There are very few, actually.

265. Does the Ministry have special arrangements with some contractors whereby those goods they purchase from the contract are free of purchase tax? ——No, there is no special arrangement. It is normal in government contracting that the government contract does not attract purchase tax. In other words, the goods purchased under government contract are not subject to purchase tax.

*Chairman.*

266. The Management Committees or Regional Boards are not debited with the purchase tax?——No.

Mrs. *Hill.*

267. Would the witness think that that does cut out, possibly, other suppliers where Management Committees go to tender for their goods, that it places other firms in a very difficult position, and that their price might even be lower than the Ministry price if the purchase tax did not have to be added to it?——Yes, I think that follows, that if a Management Committee purchases independently the goods which are already available under a central contract and under that contract the price does not include the purchase tax, then as the Management Committee would have to pay the purchase tax on the goods it buys completely independently there will be a difference of price.

*Chairman.*

268. That is another argument in favour of central purchase?——If you look at it in that light, yes. Take, for example, the purchase tax on hospital mattresses. That purchase tax is not paid under the government contract for the supply of mattresses to hospitals, but if a Management Committee bought the same mattress independently not under the Minister's arrangements it would have to pay the purchase tax on that mattress.

269. Do Hospital Management Committees do that very much?——Very little.

270. I think you said you did not think the maximum possible was done by central purchasing. Does that imply you think there are economies which can be made but which have not yet been made?——The Select Committee on Estimates last year considering the Stationery Office Estimates recommended, for example, that we should consider making central arrangements through the Stationery Office for the supply of books to hospitals. That is now being investigated.

271. I was going a lot further than that, because that is not a very great sum, is it?——We do not know.

272. Do you feel there is room for further central contracting?——In some ways, yes. There could be room, particularly, I think, in the bedding and linen field.

273. What has prevented it happening up to now?——Nothing really, except that most hospitals have already made very good arrangements themselves, and there is very little additional advantage now in making——

274. You do not think there is a great deal of room for savings in that direction?——There may be some. It is difficult to say how much until it is investigated.

Mr. *Robinson.*

275. When you have made extensions in this field of central purchase, have you found you have met resistance in the first instance on the part of Regional

Boards and Boards of Governors?——Yes, in the first instance.

276. But you have usually got over that with not very much difficulty?——We find most of them now welcome it.

Mrs. *Hill.*

277. What would be the problem supposing you did purchase bedding and linen centrally: would it mean that every hospital would have exactly identical linen throughout the whole country?—Not necessarily, no.

278. May there be variations?——There are already, of course, standards for blankets.

279. I know that there are standards, but I am thinking rather of counterpanes, things of that description?——I am sorry. I was thinking rather of towels, pillow-cases and blankets rather than counterpanes. Counterpanes are obviously items where the hospital ought to have some individual choice.

*Chairman.*

280. Are there many group contracting schemes operating?——A very large number.

281. Under your purview?——No.

282. You officially do not know about them?——We know about them. There are both group contracting schemes and joint group contracting schemes, that is to say schemes covering a considerable number of hospital groups.

283. Do you encourage them in any way?——We do, very much.

284. How do you encourage them?——By circular to the hospital authorities They have been encouraged in two circulars.

285. Do the auditors comment on that at all?——That is so, I believe, but auditors' comments are outside my field.—(Mr. *Marre.*) I would not have thought the absence of a joint group contract scheme would necessarily evoke comment from the auditor. I think that if a group did not have a contracting scheme but each individual hospital bought at different prices for itself the auditor might well comment on that sort of case.

286. I see that the Public Accounts Committee commented on that in the last Session in paragraph 41 of their Report. The Report referred to the fact that "At one group of teaching hospitals, the United Manchester Hospitals, the Ministry's auditors had for a number of years reported on the independent purchasing of supplies by the individual hospitals for which the Board of Governors is responsible. Year after year the auditors have encountered the same refusal to interfere with House Committee policy, although different prices have been paid by the three major hospitals in the group for similar items of provisions and a comparison of these prices with those paid by other hospital groups suggests that some economies might be effected by group purchasing". No doubt you are familiar with those words?——Yes.

287. Has anything been done?——In that particular case, yes. The Minister did, of course, take the matter up with the Board as he had done previously but fortified now by the views expressed by the Public Accounts Committee, and they have now got an arrangement which is a distinct improvement providing for group purchasing of—I was going to say all—at any rate a large proportion of the group's requirements.

288. Has similar resistance been met in other quarters?——From time to time resistance has been met. It is exceptional.

289. Does the Minister act by moral suasion or has he any sanctions?——The Minister seeks to act always by moral suasion.

290. You have just told us that it was not effective for some time, why did he not apply some sanction?——I am not quite sure what sort of sanction you have in mind.

291. I was only asking you what sanction he could apply?——I am not sure he could apply anything, except replace that particular Board of Governors when their offices fell vacant.

292. Surely he has financial sanctions he can apply, has he not?——The result of applying a financial sanction might not be the result desired

293. I suppose one might say in this case there was unnecessary expenditure?——Yes.

*Chairman.*] Which might, perhaps, be extravagance. Surely he has some weapon in his armoury beyond moral suasion in a case like that.

Mr. *Robinson.*

294. Has he not got the power of direction?——There is a power of direction. I do not know whether it could be applied in this type of case. (Mr. *Pater.*) Yes, I suppose theoretically the Minister could have directed the Board of Governors to place contracts in a certain way, but it has been the policy of successive Ministers to treat these Boards as responsible with a full measure of independence.

*Chairman.*

295. If they are lacking in that respect, should they not cut the allocation?—— It seems to me that cutting the allocation would only mean worse care for the patients in hospital, and it would not, as far as I can see, have very much effect on the Board itself.

296. I think you are underrating the intelligence of a Board. If they are accused of extravagance and their allocation is cut pro rata, they would take steps to mend their ways in that direction, would they not?——That is possible.

Mrs. *Hill.*

297. Does this situation arise more in the teaching hospital groups?——(Mr. *Wilkinson.*) I have no information to answer that.—(Mr. *Marre.*) I believe generally both among teaching and non-teaching hospitals group purchasing is the normal practice. It is only rather exceptionally that you get into difficulty, particularly where for reasons of its own the Board disagrees with the Minister's view that there is a field for economy there.

298. The point which I wanted to get at was this. Is it thought that that applies more to teaching hospitals than to hospitals under Regional Hospital Boards, because they seem to have a greater independence than hospitals under the purview of the Regional Hospital Board?——I do not think myself that there is much difference of opinion at all on this particular topic of group purchase.

*Chairman.*

299. The Minister has to approve the estimates, has he not?——Yes.

300. Are you telling the Committee that the Minister approves the estimates which he knows indicate expenditure he thinks extravagant or unnecessary?—— When you say the Minister knows it, there was in that particular case a difference of opinion between the Board and the Minister. The Minister felt there was scope for saving there; the Board disagreed. I do not know quite what you would expect the Minister to do on receiving the Board's estimate in a case of that kind. There is no possibility of measuring the extent of any possible saving until group purchasing had been put into operation and it could be seen whether the Minister was right or the Board.

301. You used the expression "the Minister felt". Presumably the Minister holds a strong opinion on the matter. I should have thought it was the duty of the Minister if he has to reach a conclusion that seems to him sound to try and enforce it where the expenditure of public money is concerned?——The Minister's policy in these matters is always to try to persuade rather than to compel.

302. Perhaps to the detriment of the public purse?——On occasion that might be so.

Vice-Admiral *Hughes Hallett.*

303. As I understand it, food represents about 50 per cent. of all purchases, and is entirely decentralised; did I understand that correctly?——(Mr. *Wilkinson.*) It is not subject to any arrangement made by the Minister. It represents about half the total expenditure.—(Mr. *Marre.*) Mr. Wilkinson did say that, but I think the proportion would be rather lower, about a third of expenditure on goods or services.

304. It is a substantial proportion. What I want to ask is this. Because there is no central purchasing of that, are we to understand that the Ministry exercises no supervision whatsoever as to what goes on with regard to catering in the hospitals, and that that is entirely decentralised?——(Mr. *Pater.*) I am not sure I take the point, but the Minister

has on his staff advisers in catering and dietetics who visit the Hospital Boards on request—and without being requested—in order to help them in their catering arrangements. To that extent, certainly, the catering is supervised and advice is given about diets and dietaries, menus, and so on, as well as in the organisation of kitchens and use of kitchen equipment, matters of that kind.

Mr. *Robinson.*

305. Would it not be true to say the maximum autonomy is given not only to the Regional Board and Management Committee but to individual hospitals in the field of catering?——(Mr. *Marre.*) And in other fields too. That generally has been the policy of all the Ministers ever since the scheme started.

Vice-Admiral *Hughes Hallett.*

306. I want to come back to the cost side. If you find there are discrepancies in the charges being incurred the reasons for which are not immediately obvious, what action then is taken by the Ministry?——If you are thinking of non-teaching hospitals, first of all we expect the Regional Board to follow up any such discrepancies with their own Hospital Management Committees and find out if there is a good reason for those discrepancies, and, if not, to persuade the Committee, if there is extravagance, to mend it ways. It may well be that the discrepancy is due to the fact that in some particular hospital or hospitals the standards are too low and that they ought to be increased, and we would expect them within the available funds to encourage that to take place. If you are thinking of teaching hospitals with which the Minister has dealt direct, the Minister has for the last year or two had an investigation set on foot into the costs of food, fuel, and drugs and dressings at selected teaching hospitals, those which apparently had relatively high expenditure on these items and those which had apparently low expenditure on these items. As a result, advice has been given to those particular Boards at whose hospitals the costs were investigated, and in the case of food it has been found possible to draw up some general points of guidance which have been circulated to all teaching hospitals.

Mr. *Robinson.*

307. Is it not correct to say that in the absence of any single investigation of that kind there is no conceivable way in which the Minister can tell from figures whether there is extravagance in food or not, because the expenditure relies to a very large extent on the standards of catering, which vary from hospital to hospital?——That is so; I agree with you.

308. Therefore, you must have an investigation of a particular hospital or group of hospitals to ascertain whether there is extravagance in buying of food or in catering generally or not?——That is what the Minister felt, and why those investigations were undertaken.

Vice-Admiral *Hughes Hallett.*

309. On this question of food, I am very surprised there should be no central purchasing, because if you compare hospital catering with catering in the Army, for example, it is not all that dissimilar, is it? The Army has always found it pays to buy certain categories of food centrally and to decentralise the perishable food. Has it never been suggested any of the foodstuffs should be purchased centrally?——(Mr. *Wilkinson.*) No, not to my knowledge.

*Chairman.*

310. Why?——Because I think food has not been regarded as a suitable item for activity centrally.

311. I again ask why?——Well, if, for example, you selected butter you would be involved in buying butter in bulk and in distributing it through stores. You could not avoid, I think, distribution through stores if you buy in the sort of quantities needed by all the hospitals in this country. There would be no advantage at all in buying butter merely to get the contractor to deliver it direct to the hospital.

312. What about tinned goods?——With tinned goods, it is possible, but, again, I think you would be involved inevitably in handling it through central stores.

313. Is there rooted objection to handling it through stores?——No.

314. Surely it is an investigation worth pursuing?——It adds very considerably to the overheads.

315. Has it been gone into very carefully?——No.

Mrs. *Hill.*

316. What size of staff have you for considering these contracts? You must have some staff engaged on that?——I have 50 per cent. less than I had when the Health Service started. The total number at the moment is about 300.

317. So every additional item of any quantity that would have to be bought centrally would rarely involve additional staff to deal with it?——It would involve additional staff. I should add that of that 300 in terms of man-hours, approximately 60 per cent. only are engaged on National Health Service work.

318. How many people do you employ to check up the goods for which you have contracted to see they are in fact as per sample or as per specification? ——Total technical staff, excluding technical staff engaged in work for the disabled on vehicles, artificial limbs, and so on, engaged in connection with the supply of goods to hospitals is 30.

*Chairman.*

319. Is there any good reason why careful consideration should not be given to the advisability of centrally contracting for non-perishable provisions?——I should prefer to leave that till we know what this committee which is at present investigating this whole question has to say.

320. When will the interim report come out?——The interim report is due almost immediately. It is with the printers.

321. Will it be published?——Yes.

322. Will it be out within a month or so?——I do not know. (Mr. *Pater.*) I would have thought within a couple of months. I do not know the exact position. (Mr. *Wilkinson.*) I know it is with the printers. I do not think the interim report will help in this matter of purchase of food.

323. Perhaps I can ask you this question then: what stands in the way of consideration of central purchasing of non-perishable provisions?——We would prefer to wait, and I think the Minister would prefer to wait, until he knows what this committee recommends.

324. The National Health Service has been in operation now for some years, and the hospitals have been the responsibility of your Department for some years, and I cannot help feeling there must be some good reason standing in the way of central contracting for non-perishable food and provisions, and I was wondering what those considerations were?—— (Mr. *Pater.*) I think that the fundamental point here is that of ministerial policy. If I had to sum up the policy of Ministers since 1948, I think I would say that it has been to advance slowly in the field of central purchasing of supplies step by step as in each case it appeared that a reasonable case had been established for a financial advantage in purchasing a particular kind of goods in this way. So far as such supplies as provisions are concerned, again the Ministerial policy has been not to advance in that field, but rather to encourage joint action by hospital authorities and joint contracting over the field of several groups.

325. There must be some classes of item, such as tinned goods, where substantial savings could be arranged by a very large contract. You have told us that such-and-such has been the policy of the Department or of the Minister; you have not said they have carefully gone into those questions, or why they reached the conclusions they did?—— The reason why any particular item has been selected for central purchase has, I think, been the demonstration of an anticipated saving.

326. The reason why something has not been selected for central purchasing is what?——The reason why something has not been selected for central purchasing is because Ministers have in this matter preferred to go slowly.

Mr. *Robinson.*

327. Would it also be true to say that you have tended to concentrate on central purchasing for those items not in regular consumption at hospitals? In other words, perhaps the difficulty of regular distribution may have been a factor in deciding what should be purchased centrally and what left to local purchase?——(Mr. *Wilkinson.*) No, I would not put it quite like that. I think the policy has been rather to concentrate on the types of goods which are commonly required by hospitals in the same form.

328. That would be true exactly of tinned foods, would it not?——Yes, but in the same form in circumstances in which no question of preference arises for one brand or one pattern of goods rather than another.

Vice-Admiral *Hughes Hallett.*

329. There is an analogy between the National Health Service problem of provision of food to several thousand scattered hospitals and the fighting services in feeding a large number of scattered establishments. There is a long history of experience in the fighting services as to the variations between centralisation and decentralisation in this regard. Has the advice and experience of the directors of victualling in the great service victualling departments ever been sought?——It has been sought only in respect of specifications used by the services for certain foods such as butter, margarine, and other perishable goods of that kind, where hospital authorities have come to us and asked us for advice about specifications.

*Chairman.*

330. Not on the overall merits or demerits of central purchasing?——No.

331. Do you think we could have a note giving us fuller details of what is done at present?——Yes, surely.*

*Chairman.*] And if you could add to it anything that may be of interest to us in this connection we should be very grateful, because it seems to us to be an important point where there may be possible savings, and I would remind you the *raison d'être* of this Committee is to suggest possible savings.

Mrs. *Hill.*] Could it also be stated as to whether it would be the intention to have central stores for this, or whether it would be the intention, as is done with such things as brushes, and so on, to decide whether they should be obtained from a particular contractor, because my own view is that if we are going to set up lots of central stores to store these goods we are not going to save anything if the drive is intensified to buy specifically on contract, because some buy extremely well and very nearly under the Ministry figure.

* Not reported.

Sir *Henry D'Avigdor-Goldsmid.*

332. Would the witness say whether this unwillingness to touch central purchasing for foodstuffs could be associated in any way with the natural desire of Regional Boards to support their local contractors?——Not at all.

333. You would rule out completely as having any bearing on this subject the natural feeling of Regional Boards in favour of their local contractors?——Yes, I think so. The local contractor would be given an opportunity to tender in precisely the same way as a large national firm if he wishes to have that opportunity.

334. But the point to which I am addressing myself is that if these goods were in fact supplied centrally the local contractor would not have the opportunity of tendering, and therefore I would take into account the natural desire by the Regional Board to arrange their affairs in such a way that the local contractor should have a chance. I am asking you to say whether you would discount that variation entirely as having any bearing on this?——I think that I should like to deal with that in the note. It is rather an involved question to the extent to which a preference should be given to a local contractor merely because he is local.

*Chairman.*

335. I suppose when one uses the term central purchase or central contracting, one does not necessarily mean a contract goes to one individual. There may be a series of contracts?——There are a very large number of contracts.

Mr. *Robinson.*

336. May we have a preview of the sub-committee's report?——(Mr. *Pater.*) I can see no reason at all, apart from the availability of copies. Perhaps we could look into that.

*Chairman.*] May we now come on to Tables 1 to 4 of the Statistical Appendix.*

Vice-Admiral *Hughes Hallett.*

337. Taking Table 1, the difference between bed complement and available beds is very marked in isolation hospitals, for example. What is the reason

* App. 1, p. 355.

for these differences?——The average daily number of available beds is the number of staffed beds available on average throughout the year for use straight away. The bed complement is the total number of beds in the hospital, which is in some cases to some extent a fictitious figure. If I may put it this way, a particular number of beds may be associated with a particular hospital as being the number of beds which that hospital contains, regardless of the fact that owing to re-spacing of beds or some reason of that kind another may be the real number of beds, and quite apart from that there may well be beds within the complement which are empty because of wards being decorated, or they may be empty because there is no nursing or domestic staff available to serve them. There may be, particularly in the case of isolation hospitals, a pool of unstaffed beds held deliberately as a reserve in the event of an epidemic to which staff would be rushed, as it were, to deal with that emergency.

Mr. *Robinson.*

338. Is it the bed complement figure to which salaries are attached, and is that its main importance?——(Mr. *Reed.*) I think it is, yes.

Vice-Admiral *Hughes Hallett.*

339. Why should it be that, as opposed to the bed availability figure?——It is a very varying figure, bed availability.

*Chairman.*

340. It is like a paper army in that case?——The total number of beds does involve the provision of overhead services throughout the hospital, even if the beds are temporarily not available, and in many instances the difference between the two is not very great.

Vice-Admiral *Hughes Hallett.*

341. It is very great in some cases. If you take the isolation hospitals, for example?——(Mr. *Pater.*) The isolation hospital one must regard as a special case. It is very largely a reserve of beds kept as against an epidemic.

342. But still the salaries are based on the complement even in the isolation hospitals?——(Mr. *Reed.*) Yes.*

* But see App. 2, p. 376.

Mrs. *Hill.*

343. They are usually very lightly staffed?——Yes. (Mr. *Pater.*) In the Ministry's Annual Report the table at the end does, in fact, give the build-up of the number of the bed complement at the end of 1955. This is a September, 1956 figure. It is not exactly the same. It is very roughly comparable and the difference between the available beds and the unavailable is beds unused for lack of staff, some 16,000; emergency fever reserve beds, 1,600; beds out of action because of major structural alterations nearly 2,800; and beds unused for other reasons, some 5,500.

*Chairman.*

344. What is the total?——The total bed complement was 507,000. The total out of action was 25,000 to 30,000.

345. Approximately 5 per cent. are out of action?——Yes.

Captain *Waterhouse.*

346. So 16,000 are out of action, through lack of staff?——Yes, through lack of staff. That is the main item.

Vice-Admiral *Hughes Hallett.*

347. Can we compare the next two columns, that is to say the difference between the beds available and beds occupied? I would like to ask why is it the occupation figure is comparatively low in the case of some hospitals, and in some types of hospitals, notably the convalescent and pre-convalescent, children's (acute), and T.B. chest, to give examples of the difference being rather big?——I think one of the answers is that this is the September quarter which covers the months of July, August and September when the occupancy is not as high as it would be—particularly in some of the classes you mentioned—in January, February and March. The T.B. and chest figure on my arithmetic is about 83 per cent. The T.B. chest and isolation figure is 66 per cent. I think the difference there is due to the inclusion of isolation beds. These are very often fever hospitals which have in part turned over to the T.B. or other chest work. There is still a section held for fevers, and it will be that section which reduces the occupancy of that group to 66 per cent. You will notice

that much the lowest occupancy is the isolation figure, where it is 43 per cent.

Mr. *Robinson.*

348. Does the Ministry feel there may be now a slight over-provision of T.B. beds and children's beds in the country? ——The information we have is, of course, that the need for T.B. beds is falling. The number in use has fallen for the last two or three years, and the ones that are suitable are increasingly being turned over to other uses, particularly other chest diseases. As to children's beds, again in most parts of the country there does, in fact, seem to be a fall in the demand for children's beds.

349. There is always a time lag between the emergence of that fall and the actual closing of wards or transferring of wards for other purposes?—— Yes, and, if I may say so, it is this fall in the demand for beds for children which partly explains the low figure of occupancy for convalescent beds. Again, the demand for convalescent beds for children has undoubtedly been falling for the last three or four years.

Sir *Henry D'Avigdor-Goldsmid.*

350. Would the reason for load over occupancy be the fact that when there is an epidemic of an infectious nature most hospitals are obliged to close their wards for the admission of children's surgical cases because of the epidemic? ——That does happen, of course. It is a risk that is greater in the children's hospital than many others which causes closing of the beds.

Mr. *Robinson.*

351. Is it not also due to the improving health of children in the country?—— Yes.

Mrs. *Hill.*

352. Would it not be better if you had a comparison of a heavier quarter?—— I would have thought that a better picture would have been given by Table 3, which are the figures for the whole of 1955.

Vice-Admiral *Hughes Hallett.*

353. A question on this seasonal variation. What surprises me is that it is not bigger than it is when you consider that as being the summer quarter. Is that a thing that is watched, the seasonal variation; has it varied at all since the Health Service started?——That I am afraid we cannot answer because these figures on a quarterly basis have not been collected for very long and their reliability, if I may say so, is now increasing.

354. There are no teaching mental hospitals, I observe?——There is one teaching psychiatric hospital, which is not technically a mental hospital.

355. That is just a historic fact, I suppose. There never have been any? ——I think that is so.

Mr. *Robinson.*

356. I presume you refer to Maudsley and Bethlem?——Technically it is not a mental hospital. The patients are not treated under the Lunacy and Mental Treatment Acts.

357. Not at Bethlem?——I think not. I am not sure. In any case it is in this table included under "Other hospitals" at the bottom. That is why it does not appear under mental illness.

Vice-Admiral *Hughes Hallett.*

358. Why is it that the teaching hospitals have a higher bed occupation, apparently, than the non-teaching ones? ——Partly, Sir, I think it is the type of hospital, but partly I think it is because the teaching hospitals for the most part tend to attract a great many customers and pressure on their beds tends to be heavy.

359. There appears also to be a higher rate of turnover in the teaching than in the non-teaching hospital. Is there any explanation of that? Is it because people avoid sending chronic cases to them?—— Yes, I think it is. According to my arithmetic the turnover in the acute teaching hospital is 5·4 in the September quarter compared with 5·1 in all acute hospitals. That is patients treated per bed during the quarter.

Mrs. *Hill.*

360. You cannot compare teaching hospitals, surely, with the all-over picture of the other hospitals, for the simple reason that the teaching hospitals do not have chronic beds, or if they do they are in small numbers. The chronic beds

are practically all in hospitals under the Hospital Regional Board?——Yes, that is so. I was looking not at the figure of total for all hospitals where the turnover is much higher in teaching hospitals because they are for the most part acute hospitals. I was looking at the figure for the different types of hospital. If you take the first line of each of the two tables, that is the total for all hospitals, there the turnover for teaching hospitals is 5, compared with 1·9 in non-teaching, and that is undoubtedly because of the very large number of non-teaching hospitals which are chronic, and mental where turnover is very low. Looking at the next one, which is acute hospitals only, there the comparison is 5·1 for all hospitals, 5·4 for teaching hospitals.

Vice-Admiral *Hughes Hallett.*

361. Even if you compare the chronic ones, there is a very marked difference between the teaching and the non-teaching?——Yes, but I think there is no doubt there that the two hospitals are not doing the same kind of job. The chronic beds in the teaching hospitals are small in number and are for the most part patients who are being turned over and got out somewhere else. In the non-teaching hospitals they are not—many are permanent residents.

362. Could we turn to Table — out-patient statistics?* What is the explanation of the rather striking increase in the number of out-patients since the Service began? It is particularly dramatic under one heading, accidents, which appear to have gone up by over a million. The numbers as a whole have been rising the whole time, and in some cases by quite a dramatic amount. The casualty heading has gone up from ten million in 1949 to very nearly eleven and a half million in 1955, and during the same period it is true the population has gone up by the best part of a million, but they cannot all have been casualties. What I am asking is for your view on these very high attendance figures, one in five of the entire population over a year?——I am not sure it would be really very reliable to compare the earliest years' figures with the latest because the basis on which these figures are collected has differed somewhat from year to year, and I would not be too confident that that is a true increase. In recent years the figures have been, I think, rather more reliable; the figure is much more stable. For example in 1953 the casualty attendances were 11,445,000, and in 1955 were 11,478,000, and no doubt in between there was a drop. I think the thing is now much more settled, and, as I said, I would not myself place too much reliance on the earlier figures.

363. Your brief answer is to say that you do not accept the figures?——Yes.

364. Is there any reason why the teaching hospital out-patients appear to make more visits per annum than the ones in ordinary hospitals?——The number per new patient is higher in the teaching hospital, I think that is the point, is it? There is very little in it, I think, just under four in both cases.

*Chairman.*

365. The figures are roughly 3·75 visits per patient in teaching hospitals, and 3·5 in non-teaching, a very slight difference. Have you any comment to make?——No.

Mrs. *Hill.*

366. Would it be because in the teaching hospitals they very often have specialist services which some of the non-teaching hospitals do not have. Would that account for more out-patients?——That may well be so. The attendances of the casualty out-patients are lower than those of the consultative out-patients and that may well be the reason for the difference, the higher proportion of special cases.

Mr. *Robinson.*

367. I should like to ask some questions on Tables 5 and 6 section 4 and 5 beds. There is still a fairly low total occupation of section 5 beds, under 70 per cent. in the last year for which figures are provided. Do you not think more use could be made of these beds by non-paying patients, are you satisfied that Regional Boards are exercising sufficient pressure on the hospitals in their region to do this, and what encouragement is coming from the Ministry?——This is a point that is from time to time taken up with the Boards. It has been the subject of Ministerial circulars in the past as a point to

* Not reported.

which their attention is from time to time drawn.

368. What do you regard as satisfactory occupancy of a section 5 bed, overall?——I think it is very difficult to say because one has to remember that in many hospitals the section 5 beds are in very small packets, it may even be one bed in a hospital, and in those circumstances it is very difficult both to lay down a reasonable standard of occupancy and to maintain any real standard of occupancy, if you have only one bed to play with. If you are lucky you get an occupancy of 100 per cent.; if you are unlucky it may be 40 per cent.

369. But in hospitals which have a substantial number, would you agree there is in certain hospitals considerable resistance to putting non-paying patients in section 5 beds?——I am not sure we have evidence of considerable resistance.

370. General reluctance, then?——I would have thought it was perhaps lethargy.

371. We have noticed that there has been a falling off in the use of section 4 amenity beds. Can you say why this is, and is the Ministry satisfied that sufficient publicity is given to inform patients as to the existence of amenity beds?——This again is a question which we have brought to the attention of Boards more than once and suggested to them methods of making the existence of these beds known and asked them to advertise them.

372. In particular in teaching hospitals occupancy is very low indeed, particularly occupancy by paying patients?——Yes.

373. Is there not some signficance in that fact?——There again, Sir, it is very difficult, I think, in a sense to organise the use of these beds. Section 4 beds are not set aside in the same way as section 5 beds. They may be needed urgently for a non-paying patient, but it may well be that a greater effort could be made to make better use of them.

374. There is no reason why the overall occupancy of a section 4 paying bed and non-paying bed should be any less than the overall occupany of the hospital as a whole?——I would not have thought so, unless the question of small numbers came into it.

*Chairman.*

375. May we now turn to Tables 7 and 8, Appendix 1. We notice that except with the administrative and clerical staff in Hospital Management Committees and Boards of Governors the number of staff has gone up considerably. All these staff figures show increases, do they not? Can you account for that?——(Mr. *Reed.*) Generally speaking, the staff figures have gone steadily up. The number of beds has also gone up, and I think it is fair to say that if the ratio between staff and patients increases that is an index of the improvement in the quality of service provided.

376. That is what one would hope would be the answer. Is there any way of keeping a check on that?——I think it is impossible to devise any objective index or objective standard which could be taken as an ideal of staffing in relation to services provided.

377. In teaching hospitals the number of patients attended by each consultant and other medical staff has risen. How do you account for that—you have a different trend in the different types of hospitals?——I think that is probably because they started with a higher staff ratio, and the consultants on the staff of teaching hospitals ever since the beginning of the service have tended to be given contracts with non-teaching hospitals as well.

378. I do not quite understand that answer. You do accept the fact that the number of in-patients attending for each consultant and other medical staff has risen. It does not seem to have risen in the other hospitals. On the other hand, when you get to administrative staff the number of in-patients for each member of the administrative staff in the teaching hospitals is very small?——As distinct from non-teaching hospitals?

379. Yes. In 1955 there were 4·62 in-patients per administrative staff in teaching hospitals, according to my figures. That seems a very low number of patients per staff. Does the administrative staff in teaching hospitals, for example, cover medical schools, or something like that?——No.

380. How do you account for it? Perhaps you would look into that and let us know?——I will do that.

Mr. *Robinson.*] Is it not inevitable that the level of administrative staff on a Board of Governors must be much lower than that of a Regional Hospital Board which copes with a very large number of hospitals?

*Chairman.*

381. If that is the answer we would very much like to have it?——(Mr. *Marre.*) I thought the comparison was between the Board of Governors and the Management Committee here.

382. Yes?——(Mr. *Pater.*) What is the figure that is being quoted? The number of in-patients?

383. Per administrative staff in non-teaching hospitals?——That is in-patients admitted, is it?

384. Beds occupied. I think you might let us have a note of that?——Yes.*

385. I suppose that it is natural that teaching hospitals should employ four times as many doctors per in-patient, and there is nothing extraordinary about that. Is it really necessary?——A much higher ratio is, of course, necessary, partly for their teaching purposes, partly because of the research done——

386. You think that is an adequate explanation?——And partly it is there where the primary post-graduate teaching of the doctor is undertaken.

387. You are satisfied in your own mind that that is adequate?——I am not sure that anyone has the information to enable them to say whether it is an adequate explanation, but it is an explanation.

388. We have not any information at our disposal to show that it is inadequate. I am asking whether you are satisfied. I am puzzled why teaching hospitals employ twice as many maintenance and domestic staff and nearly twice as many nurses?——(Mr. *Reed.*) I think it is partly that those categories of staff, nurses and domestics, are all categories in which there are shortages, and that, teaching hospitals being more attractive, they tend to go there. (Mr. *Pater.*) I think there is another point which may be leading us astray. If those figures are all in terms of staff per occupation of bed one must appreciate that the type of bed of which we are talking is very different in the two groups. The number of medical staff, for example, required, shall we say, in the mental hospital or mental deficiency hospital is much less than in the acute hospital for the acutely ill, and, broadly speaking, the teaching hospitals tend to be acute hospitals only where the ratio of staff anywhere in the country is the highest. One must take that into account.

Vice-Admiral *Hughes Hallett.*

389. One question on staff. Has anybody ever carried out, if so, do they often carry out, time and motion study investigations into the hospitals, or, alternatively, do the Treasury O and M teams ever visit hospitals?——(Mr. *Reed.*) A certain number of the Treasury O and M staff are at the moment seconded to the Ministry of Health and do carry out visits to hospitals at present at the invitation of any hospital. The number is limited, so it is done on that basis. The Treasury as such does not send O and M people to visit hospitals. Time and motion study, in the strictest sense of the word, is not being done by the Treasury O and M people on our staff. A small number of hospitals have made limited experiments in getting outside firms to do that kind of work.

Mr. *Robinson.*

390. In reply to an earlier question I think Mr. Hunt said you had no means of knowing whether the ratio of doctors per patient in teaching hospitals was excessive or not. I would like to know what means the Ministry, or indeed any hospital authority, has of knowing the actual hours that a consultant, for instance, has to put in, or does put in, at the hospitals to which he is appointed. Is there any way of finding out at all? In default of that information, can you ever say whether a hospital is over-staffed or under-staffed medically?——The consultant has a certain number of hours in his contract which will include travelling time.

391. You never know whether he puts in that number of hours?——You do not make him clock in.

392. I would like an answer to my specific question. I know that you do

* Not reported.

not make him clock in. Do you have no way of finding out whether he does, in fact, put in that time or not?——That is so.

*Chairman.*

393. Looking now at paragraph 35, I see you put down £33·8 million as increases in pay. It includes the increase in numbers, does it not?——(Mr. *Marre.*) No. That is simply increases in pay, using the numbers in posts in 1949-50.

394. The numbers come in where?——The additional staff numbers come in the last item.

395. In the £34·6 million?——Yes.

396. How is that figure broken down?——About £20 million of that figure is for additional staff, the rest for non-staff expenditure.

397. How do you break down the non-staff expenditure?——I do not think I could give you any break-down at this moment. Our index does not enable us to break it down any further than that.

398. You must have some figure for savings due to economies?——We have no separate figure for savings due to economies. This is the balance of the increased expenditure which is attributable only to the combination of all these factors.

399. Is that quite satisfactory, do you think?——It is inevitable.

400. You cannot help us any more than that?——No.

Vice-Admiral *Hughes Hallett.*

401. One very broad question. Looking at these increases in another way, has any attempt ever been made to distinguish the growth of costs due to rises in prices, pay scales on the one hand, and the growth due to the fact there are more patients going in and out of the hospitals on the other hand?——The growth of expenditure due to treatment of an increased number of patients is one of the elements included in this last item of £34·6 million.

*Chairman.*

402. The expenditure on uniforms and clothing has been static more or less. Can you account for that—I am referring to Table 12?——I do not think there is any special explanation for that, Sir. I think it is simply that hospital authorities have found that they have been able to manage——

403. No special answer?——No special reason for that.

404. The expenditure on drugs and dressings has risen a great deal as between 1954–55 and 1955–56. Is there any reason for that?——There might be two main reasons or perhaps three main reasons. One is the effect of any increase in prices; another is the introduction during this period of new drugs which tend when they are first introduced to be expensive.

405. There was a particular introduction of new drugs in that year, was there?——There always is an introduction of new drugs.

406. But if you go back over the previous three years, it remained more or less static and then leapt ahead in the last financial year?——Yes. I am not sure whether in this particular year there was a particular new drug.

Mrs. *Hill.*

407. Cortisone?——I would have to look into that. I am not sure it was in this particular year cortisone.

408. I am referring to the various derivatives of cortisone?——I am not sure that is included in this year's expenditure.

*Chairman.*

409. Would you look into that and let us know?——Yes.*

Mr. *Robinson.*

410. Would it not be largely the use of tranquillising drugs?——I was going to say that a third reason for the rise over the whole period is treatment of additional numbers of patients.

*Chairman.*

411. I was asking you why there was the particular jump of £1,600,000 in one year, whereas in the previous two years there had only been a rise of under £300,000?——We will see whether there was any special reason for that.

Captain *Waterhouse.*

412. You might also have a look at the difference between 1949-50 and 1950-51 where there is a similar jump?

* App. 6, p. 388.

——We will see whether that took place because of any special reason.

Mrs. *Hill.*

413. May I ask a question on the fluctuations with regard to maintenance of buildings, and domestic repairs?——Would that be for the last three years?

414. Yes?——I want to make one caveat here. This is not the total expenditure on maintenance of buildings, plant and grounds. It does not include the salaries of maintenance staff employed directly by the hospital authorities. Their salaries are included in the "Other" category in heading one. But there is a particular reason for the fluctuations over the last three years in the total in item 6. It was that in 1954-55 the sum provided for the hospital service proved, as matters turned out, to be very tight indeed, and hospital authorities found that they could only keep their expenditure within their allocation by cutting down rather heavily on building maintenance.

Vice-Admiral *Hughes Hallett.*

415. One more question of maintenance. You mentioned that part of maintenance is paid for by permanent staff as opposed to being done by contract?——That is so.

416. Can you say roughly what the proportions between the two charges are?——Very roughly, about the same.

417. They spend as much money on permanent staff as they do on contract, do they?——Very roughly, perhaps not quite so much. I think it is very roughly the same, but if I find I am in the wrong I will let you know.*

Mrs. *Hill.*] Costs per in-patient week, cost of provisioning: why are they so much more expensive in teaching hospital than non-teaching?

*Chairman.*

418. This is item 2 of the table*?——I would suggest that item 1 is a better figure to look at for this purpose. Item 2 is subject to the defect I described last time. Item 2 is arrived at by taking the average cost of provisions in any week and dividing it by the number of patients during that week. In a hospital which is for any reason heavily staffed the staff has got to be fed, of course, as well as the patients, and you therefore get a distortion of the picture. The teaching hospitals are heavily staffed; if you divide the cost of provisions for patients and staff by the number of patients only you obviously get a distorted picture. Item one attempts to eliminate that particular distortion by dividing the average weekly cost of provisions by the number of patients and staff.

Mrs. *Hill.*

419. Are we not comparing the same elements in the various amounts along that same line on line 2, £2 2s. 9d., for instance, £2 4s. 0d. and £3 15s. 7d.?——You are not really comparing the same elements there, no. You are looking at T.B. and chest and isolation hospitals with your £2 4s. 0d. figure?

420. Yes?——There are few out-patients treated there; not a very large number at that type of hospital—little staff required for that work. Therefore, the figure is bound to be fairly low. On the other hand, teaching hospitals with a wider range of services and treating large numbers of out-patients have large numbers of staff and the figure becomes comparatively high. You have got to feed all that staff, but you are dividing only by the number of in-patients. The truer comparison figure we use ourselves in making comparisons of relative costs of food is that given in item one.

*Chairman.*

421. Does the same apply in drugs and medical appliances in administration and fuel?——It does—not necessarily the same particular point, but there are other factors affecting those.

422. With regard to drugs it does not, does it?——With regard to drugs, you have an out-patient complication. At a teaching hospital you provide drugs for in-patients and out-patients, of which there is a large number, and you divide that weekly figure by the weekly number of in-patients. You are bound to get a fairly high figure because you have out-patient drug expenditure also included. In many of these other types of hospital there is less out-patient expenditure; in some none at all.

* Not reported.

Mrs. *Hill.*] Why has there been a general rise in real costs since 1955?

*Chairman.*

423. By "real costs" we mean calculated back to the original price? ——We are turning to another table, are we, now?

424. Table 15?——I think the answer to this lies largely in what I said before. The year 1954-55, which is the first of these two years, was an artificially low figure, when expenditure on such items as building maintenance was deliberately cut down because otherwise hospital authorities could not keep within their allocations.

425. You are not laying it all to the charge of building maintenance?—— That was the main thing which was cut down—not the only thing.

426. You have not much to play with there, have you?——Quite a considerable sum when you think of the limited amount available in any year for development of the hospital service.

427. What I mean is that out of the total costs of the hospital scheme, the increase in maintenance charges does not give you much to average out, does it, over these increases?——1954-55 was artificially low on that item, and also on domestic repairs which is another item where you can cut down on a short-term basis temporarily. In 1955-56 Parliament decided to vote extra funds to help hospital authorities make good, as it were, the short-fall on building maintenance and domestic repairs in the previous year and to improve the standard. I think that accounts for a very large part of the increase in that particular year. I have no other reason I can put before you.

428. On the whole question of regional variations, how do you explain them? ——With regard to regional variations in the cost per in-patient week at different types of hospital?

429. Yes; I am looking at the table we sent you.* The variations strike the layman as extreme really. Oxford is by far the most expensive, and it looks as if the Newcastle region spends a good deal less. The difference is sometimes several pounds per in-patient. Is there any broad method of accounting for that? ——I think there are a number of factors contributing to these figures. Undoubtedly one of the main factors is the fact that even before the Health Service started in some parts of the country hospitals had developed their services to provide a higher standard of care than in other parts of the country.

430. Your answer, briefly, would be that the standard of care, and, possibly, the efficiency of the hospitals, vary considerably?——I did not say efficiency, Sir. I said the standard of hospital care. That difference was one of the main factors. There are other factors which certainly contribute to this. A region which finds it more difficult to recruit staff has its costs lower than a region which is more fortunate.

431. You would accept as desirable that the standards of the hospital service should not vary from region to region, would you not?——I am sure I would accept it, that a high standard is desirable everywhere.

432. I did not say that. I said you would accept that there should not be such marked variations?——I do not know quite what you mean by that. If you mean that the standards of hospitals which are at present more adequate than others should be reduced in order to provide a better service in the other regions, all I can say on that is that it has not been the Minister's view that that would be a reasonable thing to do.

433. I think perhaps you are putting words into my mouth, and I may be putting words into your mouth. What I am trying to get from you is a statement that variations are undesirable? ——I do not think it is a question I could answer in that form.

Vice-Admiral *Hughes Hallett.*

434. On what evidence do you base the suggestion that the higher priced hospitals are giving a higher standard of service, because that is contrary to the finding of the Guillebaud Report?—— I was not aware the Guillebaud Report had found anything on that particular point.

435. My recollection is that there was a paragraph somewhere in that Report that they did not think big variations

* Not reported.

in cost revealed variations of standard of service?——Undoubtedly, one of the main reasons is a higher standard of staffing, more staff per patient, and I base my statement of a higher standard of local care largely on that, that there are relatively more staff in the hospitals in the regions which show a high cost.

*Chairman.*

436. You did not like my use of the word "efficiency". Would you say from the medical point of view that the medical results in the higher-spending regions are markedly better than the medical results in the less high-spending regions?——I am not sure what you mean by medical results. Do you mean they discharge their patients more quickly?

437. Or cure more people?——I could not say. I do not think we have got any evidence, nor am I sure how you could get evidence that a high cost per in-patient week necessarily means that you can discharge your patient more quickly. It is certainly true sometimes, but certainly not always.

438. I know it is very difficult. Surely there must be some way of getting efficiency, some way of knowing whether you are getting good value for money? ——We have not found any real criterion yet for judging, any decisive criterion. (Mr. *Pater.*) I am not sure I can say anything very useful on this. The Minister's officers, like other people, have tried to use yardsticks like occupancy, or turnover, or whatever it may be, to measure efficiency. I am not sure anyone has gone very far along the road of being able to do it. All that one can say is that on subjective tests I do not think that any Minister has ever had any evidence that the expensive and most highly staffed hospitals are providing a standard of service that is unreasonable or even necessarily adequate.

439. I know that this is very difficult to go into, but it occurs to one when you get these rather striking variations, when you find all the lower costs in the north of England and the higher costs in the south of England, and I am sure that the Ministry notice all those things. What deductions do they draw?——Very often this is a reflection, as I think Mr. Marre has said, of the ease or difficulty of recruiting necessary staff.

440. You mean in Manchester, Liverpool, Newcastle, Leeds and Sheffield you find more difficulty than in Oxford and the London regions and south-western regions?——They certainly on the figures appear to have greater difficulty in attracting the same numbers.

Mr. *Robinson.*

441. Of medical staff or nursing staff?——I was thinking particularly of nursing staff.

442. It is true of medical staff too, is it not?——That is certainly true of London. I am not so sure about some of the provincial areas.

443. Are the variations in general diminishing?——That I think is so (Mr. *Marre.*) We have undertaken a recent examination with that very object in view, to see how far our efforts to bring the standards of the lower-cost regions nearer the standards of the others. We have a table which perhaps I might be permitted to put in to the Committee.*

444. Yes, thank you?——What we have done is to take, starting with 1951-52, a representative selection of hospitals, and we have priced, as it were, that same representative selection of hospitals according to the costs of each region. We have arrived at a figure for each region for the running costs of that same representative selection.

445. A sort of "weighted Gallup Poll" idea?——That is the general kind of picture. On the analysis we have made in 1951-52 the national average weekly cost of running that notional selection of 100 beds was £775 (that is the weekly cost), and the variation of regions from the national average was between 21·8 per cent. above the national average to 12·9 per cent. below the national average.

446. A variation of nearly 35 per cent.?——Yes. In 1955-56 the same exercise produces a national average weekly figure of £987.

447. These are actual figures, not weighted—not reduced to corresponding

* App. 3, p. 377.

costs?——Not reduced, no. These are actual expenditure. £987 is the national average cost for running that representative selection of hospitals. The variation from the national average was 9·8 per cent. to 10·2 per cent. below.

448. 20 per cent. instead of 35 per cent.?——That is so.

449. The Committee will be pleased to hear that. Would you say that that improvement—and I am sure you would call it an improvement—is the result of action by the Ministry largely?——Certainly at least partly ; I hope largely. It has been the Minister's policy all along, within what funds were available, to give some preference to the lower-cost regions.

450. By means of the allocations. So there is an inducement?——Yes.

Captain *Waterhouse.*

451. Have you any system of sending inspectors or examiners round to the hospitals to do a prolonged inspection, not a cursory inspection? The Board of Education have a system of examining the public schools and they send round a body of wise men who stay there a week or a fortnight, go through the schools, and issue a report. Have you anything of that sort?——I think the nearest parallel we have today is these teams of O and M people that Mr. Reed was describing, who I think do not normally go down for a prolonged inspection of the whole of the hospital arrangements, but simply to inspect one or two aspects of administration.

452. You were saying that it was difficult to find a criteria to compare the efficiency. The only way would be through a wide examination of that sort by a group of experts?——I was thinking when I said that of objective criteria. I think that would be rather a subjective test.

453. I am not sure what you mean by that definition?——I mean it was nothing you could establish on facts and figures. It would be the opinion of certain individuals whom you trusted to form a judgment.

454. Do you think there might be value in that?——I am not sure. The scope of a hospital is so enormous and I do not know whether you could find a suitable team whose views would really command respect.

*Chairman.*

455. You would get some comparative benefit if the same team visited different hospitals?——What I think you would need to do if you did anything of this kind would be to have a large number of different teams inspecting or examining different aspects of the hospital's arrangements. We did have teams centrally organised, for example, to look into the administrative staffing arrangements of hospitals. That was found to be both a very large and a long job when undertaken centrally and the Minister came to the conclusion that, anyway, it was the sort of job that ought not to be undertaken centrally and ought to be the responsibility of the Regional Boards.

Captain *Waterhouse.*

456. He did think there might be something in that. He thought they might discover some useful information?——I am not sure those particular teams went as far as you had in mind. They were primarily to look at the adequacy of a particular number of staff of a particular class. (Mr. *Reed.*) May I add to that that they were primarily interested in fixing establishments, and were able to effect over the service as a whole quite significant reductions. But it was establishments in particular with which they were concerned.

Vice-Admiral *Hughes Hallett.*

457. Are you most worried about the standard of the hospitals or the costs of the hospital service as a whole? Why I asked that is that it appears to me those teams went round more with the object of seeing whether the standard should be raised, which leads me to ask whether you are concerned with the rising costs of this service or not?——(Mr. *Marre.*) Which teams are you thinking of now?

458. The ones you have been thinking about?——That was not their primary object. Their primary object was to see whether the establishments of a particular class of staff was or was not adequate, and on the whole their recommendations resulted in some reductions, not the other way round. (Mr. *Reed.*) Very rarely the

5 *February*, 1957.] Mr. J. E. PATER, C.B., Mr. A. S. MARRE, C.B., Mr. M. REED, Mr. J. F. HUNT and Mr. H. WILKINSON, C.B.E. [*Continued.*

other way round. (Mr. *Marre.*) I do not think I can answer your other question further than to say that our concern is to encourage hospital authorities to provide the best possible service within the funds provided.

*Chairman.*

459. It surprises me that under the heading of " acute " the smaller hospitals seem to be less costly. Is there some obvious explanation to that? I should have thought the overheads would be the other way round?——I think the obvious explanation is that generally in a small acute hospital you would not find the same range of services provided as you would in a large acute hospital.

460. And the extra overheads do not out-balance?——The extra overheads are more than outweighed by the cost of providing a much bigger range of service.

*Chairman.*] Thank you very much.

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WEDNESDAY, 13TH FEBRUARY, 1957.

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Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | Mr. Willis. |
| Vice-Admiral Hughes Hallett. | |

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**Memorandum submitted by H.M. Treasury.**

## CONTROL OF HOSPITAL RUNNING COSTS

1. Provision for the running costs of the Hospital Service is made in the B. and BB. Subheads—Advances to Boards (Revenue Account)—of the Vote for the National Health Service (England and Wales)—Class V, 5. The amount appropriated in the current year so far is £306,300,000. A Supplementary Estimate has just been presented, including £13,342,000 for this service. The receipts of the Hospital Service appropriated-in-aid of the Vote (chiefly superannuation contributions and income from pay and amenity beds) are included in Subheads Z (*b*) and (*c*). Appendix A to the Estimate gives an approximate subjective analysis of the estimated expenditure from the B. and BB. Subheads, sub-divided between Regional Hospital Boards and Boards of Governors; Appendix B provides an estimate of numbers of staff to be employed by hospital authorities; and Appendix C gives particulars of scales of pay.

2. The principal Treasury control exercised over this expenditure is through the Annual Estimate, but the Treasury is consulted on many other matters during the course of the year.

### ANNUAL ESTIMATE

3. The way in which the estimates of the hospital authorities are prepared has already been described in paragraph 15 of the Memorandum by the Ministry of Health (D. 56-57, M1). The Treasury do not see the estimates of individual hospital authorities; nor do they take part in the allocation of funds available as

between these authorities for the forthcoming year. These matters are left to the Ministry, and the Treasury's operations are conducted in respect of a single total for all the hospitals in England and Wales. In outline the method adopted is to calculate first of all the cost of carrying on the Hospital Service in the forthcoming financial year at the same level of activity as is likely to obtain towards the end of the financial year coming to a close, and to add thereto a sum for developments and improvements.

4. The calculation of the cost of carrying on the service at the same level in the coming year as it is likely to reach by the end of the current financial year is not done by considering separately the revised cost of each subjective heading (medical salaries, provisions and drugs, for example), but by adding to the forecast out-turn for the current year additional amounts where these are inevitably incurred without any change in the level of the service. Taking these items in more detail:

(*a*) The basic figure to which all the following additions are added is the forecast out-turn for the current year. This figure is arrived at by making the best possible forecast of actual expenditure in that year in the light of the cash advances already made and the estimates of the hospital authorities themselves. This forecast is adopted for purposes of building up the estimate for the following year, but only so far as it is within the total originally laid down for expenditure in that year, as supplemented in the way explained at paragraph 7 below.

Then to this out-turn figure the following additions are made:

(*b*) The extra cost of wage and salary awards already known or firmly expected to issue before the beginning of the coming financial year; that is to say, the excess of the full year cost of such awards over and above the amount provided for them in the year coming to a close.

(*c*) The extra cost of wage and salary increments, taking into account the saving through staff retiring when high up on their scales and being replaced by staff lower down on scales.

(*d*) The extra cost of price increases in respect of the non-staff expenditure of the hospitals as measured by the Ministry's Hospital Price Index.

(*e*) The extra cost of developments and improvements begun in the financial year coming to an end; such developments and improvements are introduced from time to time during the financial year, and their cost in a full year therefore exceeds their cost in the year of their introduction.

(*f*) Special factors which affect hospital service expenditure, such as re-valuation for rating, the incidence of extra pay days in a Leap Year, or an increase in national insurance contributions.

(*g*) Necessary adjustments and transfers, to cover such eventualities as the absorption into the Hospital Service proper of units formerly under the direct control of the Ministry of Health, or the transfer of clinical research from the National Health Service to the Medical Research Council.

Generally, economies in running costs accrue to the hospitals. The total thus arrived at represents the cost of carrying on the hospital service in the forthcoming year at the level it will attain towards the end of the current financial year.

5. A decision is then taken by Ministers as to the amount to be provided in addition to the total referred to above for all improvement and development of the hospital service on revenue account. In reaching their decision Ministers would take into account on the one hand the commitments of the service (such as bringing into use new buildings) and the need for its further development, and on the other hand the exigencies of the prospective budgetary situation; bearing always in mind that the amount allowed for development in any year has a greater effect in the following year.

6. With one exception, the Treasury does not seek to control by means of the Estimate how the total thus provided shall be spent. In other words the global total provided is not divided by the Treasury into subjective headings of approval, such as appear in Appendix A of the Estimate. Accordingly Treasury consent for virement between Subheads is not required. The exception mentioned is that the

Ministry of Health, in agreement with the Treasury, have in the past two years earmarked a specific minimum sum for the maintenance of hospital buildings, which is not available for other purposes. The hospitals keep their accounts on an income and expenditure basis, and all the foregoing operations are conducted in terms of income and expenditure. In order to calculate the amount of cash to be provided from the B. and BB. Subheads consideration is given to whether any change in the level of stocks of cash balances is necessary, and adjustment is made for these changes and other minor items in arriving at the total for the appropriate Subheads.

7. There is an understanding between the Ministry of Health and the Treasury that the Treasury will normally ask Parliament to make supplementary provision to enable the hospitals to meet the cost of wage and salary awards and of increases in prices as measured by the Hospital Price Index so far as not provided for in the original estimate. (This arrangement also provides for the downward adjustment of the hospital running cost allocations in the event of decreases in salaries and wage rates or in prices.) If necessary, a Supplementary Estimate is sought for this purpose in February.

### Other Matters

*Establishments*

8. The control over establishments exercised by the Ministry of Health and the Regional Hospital Boards is described in paragraphs 24-27 of the Ministry's memorandum (D. 56-57, MI). The Treasury does not exercise in addition a control over the manpower numbers to be authorised by the Ministry of Health, but the control of the latter would not be relaxed without Treasury agreement.

*General*

9. The Ministry of Health is required to consult the Treasury on certain accounting and allied matters, and in practice consultation takes place before guidance to the hospital authorities is issued on any change of policy having a financial effect. The Treasury was consulted, for example, about the introduction of improved hospital costing arrangements, to which importance was attached, and this was taken into account when the provision for hospital running costs to be included in the Estimate for 1957–58 was settled.

## Examination of Witnesses.

Mr. F. F. Turnbull, C.B., C.I.E., an Under Secretary, and Mr. R. L Workman, a Principal, H.M. Treasury, called in and examined.

*Chairman.*

461. We would like to ask you questions based on this Memorandum. It really all turns, to my mind, on the question of how much Treasury control there is over the current expenditure on the Hospital Service, whether you think it is adequate. It appears to me, at first glance, that the method of preparing the Estimates implies that there is very little possibility for the Treasury to exert pressure in the direction of economy. Do you think that is a fair summary of the situation?——(Mr. *Turnbull.*) I think that is a fair summary of the situation if you are thinking of how to get the best value for the money which is provided.

462. I do not suppose the Treasury, any more than this Committee, has a yardstick by which that might be measured, has it?——No, there is no very good yardstick at present.

463. Am I right in thinking that the basis of the whole thing is the expenditure by the various hospitals, and so on, as it was when the scheme was first started, plus certain increases?——Yes.

464. Therefore, is it true to say the Treasury can exert next to no influence once granted that the original basis is accepted as immutable?——I think if we felt that by and large the Hospital Service was over-lavishly provided we should take steps to reduce the provision, but our general judgment is that taking the service as a whole there is a case for some limited expansion of the amount of money which should be provided from year to year. That arises partly

from the fact that Ministers have authorised a building programme for the hospitals. That means that there are additional buildings coming into operation over a period of time, and that additional money has to be provided to start them and run them.

465. That is rather a different category, is it not? What I want to arrive at is whether you agree that the Treasury is faced with a certain annual bill to which there may be certain inevitable additions springing from rises in cost of living, or whatever it may be, and that you have no means at your disposal to see that the basis on which that bill is compounded is sound?——Yes, I think that is so, apart from such lay criticism as we can exercise on the details of this in our usual function of laymen criticising experts.

466. What steps do you take, or can you take, to confound your criticisms? ——All we can do is to ask questions of the Ministry and see whether we think the answers are adequate.

467. What sort of questions?——We should ask whether increases in staff are necessary and on what grounds, what the case is for any expansion element at all in any given year, and we should be told on what it was intended to spend additional money.

468. All your questions of criticism would be related to increases?——Yes.

Mr. *Robinson.*

469. How far down the organisational ladder do you go in criticising expenditure? Do you take individual Hospital Management Committee estimates, or do you go below Regional Board level in querying the estimates put up to you by the Ministry of Health?——What we have from the Ministry of Health are combined summaries of the Regional Boards' estimates. We cannot go below that level; we can see what the composition of the total of Regional Boards' estimates is by heads of particular kinds of expenditure but that is all.

470. You do not get any further breakdown in considering annual maintenance estimates than each Regional Board's estimate broken down in the sub-heads for the region?——We do not see the Regional Board's estimate. We see a global total broken down by items of expenditure.

Mrs. *Hill.*

471. May I ask what happens with regard to teaching hospitals?——We do not see those separately either.

Mr. *Robinson.*

472. That is also a global sum for all the teaching hospitals?——Yes.

*Chairman.*

473. Would you say there is a good deal less control by the Treasury than in the case, say, of the Service Departments?——Yes, certainly, there is less.

474. Is there any control by the Treasury over virement?——No.

475. Is it true to say that an uneconomical hospital authority is under no pressure to produce the same standard of service at a lesser cost since it can be assured of being allocated at least the same sum in the forthcoming year as it had in the past year?——It can happen that if a given hospital authority is in a position in which it could make savings and does not it is still possible within our control for it to go on receiving money in the same way.

476. It is very unlikely, in fact, that it will not go on?——They have the inducement that if they can make economies within their total funds they can also make improvements in the service out of the proceeds, at any rate within their region.

477. Do you consider that satisfactory that there is no pressure you can exert to make an uneconomically run hospital more economically run?——No. I think we should like to see a system under which the maximum possible pressure is put on the hospital authorities to achieve economies within the existing rate of expenditure.

478. Have you any idea what such a system might be?——The general policy—I think that the Ministry have already explained this to you—is that having regard to the nature of these authorities it is desirable to proceed to the maximum possible extent by exerting a moral pressure and persuasion on them, rather than by issuing directions. We would like to see, I think, a system developed by which the allocation of the money as between different hospital authorities was, at any rate, influenced

by the standard of expenditure in relation to the service provided. The difficulty about this, of course, is that there are substantial differences, so far as one can see from existing statistics, in the cost per patient in different hospitals, and there is a whole range of reasons to which this might be attributed. There may be differences in the kind of standard of medical treatment provided in two different hospitals of the same broad category, and one may cost more than the other. There may be differences in the nature of the diseases treated which make it more expensive, but there may also be differences in efficiency, or in the standard of food, or other things provided, which are out of line with the general average.

479. Do you envisage the possibility of having a system that would give the Treasury greater control?——We think the control would have to be exercised by the Ministry as the spending department acting through its agents. We would have thought that when the new costing system, which is about to be introduced is developed it should be possible to make much more accurate comparisons between one hospital and another.

480. When you say "hospital" you mean hospital and not hospital board, do you?——I meant comparison between one hospital and another, and between one part of a hospital and a comparable part of another hospital, by which you could develop some sort of rough standard on which you would test whether the expenditure was reasonable, and if it did not appear to be reasonable it ought to be investigated.

Mr. *Robinson.*

481. Would you agree, broadly speaking, that whatever system of control of expenditure could be devised it would not be one which could be exercised by the Treasury, at least so far as maintenance is concerned?——Yes.

Vice-Admiral *Hughes Hallett.*

482. May I refer to paragraphs 3 and 4 of your Memorandum, and ask you whether that, in fact, represents an accurate description of the method whereby the budgets are framed?——They are a description of the way in which we arrive at the annual total which we think ought to be provided.

483. In that case, within the machinery as laid down here how could the cost ever come down?——I think that in theory it could come down if there were no grounds for any improvement or expansion of the Service, and that standard overall were too high. In that case there might be a decision providing less in one year than in the preceding year, but that has not so far happened.

484. I would like to press this matter. Where in this procedure do we find the sub-paragraph which will enable you to reach this opinion that one of the hospitals is being too extravagantly run?——I did not mean if we thought one hospital was being too extravagantly run we should take account of that in doing this, but if the situation did come later on when it was felt by the Government that the standard of the Hospital Service, by and large, was adequate and satisfactory, there was no need for any expansion or development, and if prices were stable, then you might decide to provide the same figure in one year as in the previous year, or you might even provide less. It would be open to us to do it.

Mr. *Robinson.*

485. There have been years in which if one discounts increases in salaries and wages—and perhaps I might add prices —there has been a cut in the overall cost of the Hospital Service?——I think within the last four or five years there has always been some amount of development.

Mr. *Robinson.*] I was thinking of rather before that.

Vice-Admiral *Hughes Hallett.*

486. May I turn to paragraph 6 on this point? Do the Treasury regard it as sound in principle that virement should be permitted without Treasury sanction?——In dealing with civil departments we should be consulted. Here we are dealing with something which is really *sui generis.*

487. What does that mean in English?——It is of a special kind ; it is not on all fours with local authority expenditure, because these authorities have no source of income of their own ; they are not elected and do not raise rate revenue ; they spend 100 per cent. Exchequer money, except endowment funds. On the other hand, they are not like army commands part of government

service ; they are statutory agents set up to work on behalf of the Minister, and people who serve in them give their time voluntarily. Therefore, we do feel there is a case for dealing with this Service in a rather different way to direct Government expenditure.

*Chairman.*

488. It is the taxpayer's money just the same, of course?——Yes.

489. Does that mean you feel you can deal with it less stringently, or should deal with it less stringently?——There is another point I would like to make. There is very great practical difficulty in dealing with this expenditure as if it were a government department, and saying that each Regional Board or each hospital authority must submit an estimate broken down by sub-heads to the Ministry, that the Ministry must reduce those estimates in detail, under each sub-head to a figure they think reasonable, that that must then be put to the Treasury and discussed with them for approval on each sub-head, and that the result must then be put back to the Regional Boards and the Management Committees for implementation. We do not think we could get that process completed in the time available between September and the end of January. It is not very easy even now on this system to get a decision taken in time to give the hospital authorities reasonable time to plan their expenditure for the coming year.

Vice-Admiral *Hughes Hallett.*

490. This arose from my question about virement. I would like to continue the subject of virement for a moment. Do I understand from your earlier answer that you attach material importance to the fact the Boards are composed of people working voluntarily and that has to do with your agreement to allow virement without approval?——Yes ; we think, particularly in view of the nature of these authorities, that we must have a system which it is reasonably practical to work and which enables them to have some discretion, subject to the Regional Board's approval, to switch money from one head to another within a global total which must not be exceeded.

491. One other question arising from that. Supposing the members of the Regional and Management Boards were paid, shall we say, on the same scale as the Electricity Authority, what would be the percentage effect on the total cost of the hospital bill. Would it be appreciable at all?——(Mr. *Workman.*) I think they would then become servants of the Minister.

492. I am asking what appreciable effect it would have on the bill?——I think, as at present constituted, the Minister, previous Ministers of Health and the Government have desired to give a large measure of delegation to hospital authorities so that they can, as far as is consistent with parliamentary control, run their own affairs, and if the unpaid members were transformed into highly paid civil servants they would almost be bound to come under more direct control of the Minister, and the Treasury and the Government would intervene much more deeply in the carrying out of the Hospital Service, and there might then be an opportunity to change the financial provision.

Vice-Admiral *Hughes Hallet.*] That was also in my mind, but I still would like to press my question as to whether, in fact, it would have any appreciable effect on the global cost of the Hospital Service.

*Chairman.*] I should like to put an answer into your mouth, Mr. Turnbull, that it would cost quite a lot of money, and is really a policy question outside our terms of reference.

Vice-Admiral *Hughes Hallett.*

493. With respect, one of the reasons given for this very loose control is that we were getting the management "on the cheap". The point I am trying to make is that the cost of paying the management would be a negligible fraction in the sums with which we are dealing here?——(Mr. *Turnbull.*) I think that it is a bigger point than getting the management "on the cheap". We are getting the management by what were thought when the Act was framed to be the right kind of people to manage this service.

*Chairman.*

494. I think that we have to accept the set-up to that extent as it is. I should like to go back to one of your previous answers. You did reply that there might be a slight change of system so that you could exert pressure in individual instances, did you not?——Yes.

495. Did you mean on Regional Boards or down to the Management Committees?——I think as between the Ministry and hospital authorities it would have to be on the Regional Boards, but it does not seem to us impossible that the same process should be operated by a Regional Board in relation to a Management Committee.

496. In the present set-up from where do you see the urge for economy proceeding? You have already indicated that there is very little outside pressure exercised on an uneconomically-run hospital to bring about an economy. I think you indicated that there is encouragement in the sense that any economies accrue to the hospital in question—I think you said that, did you not? ——Yes.

497. Taking the other side of the picture, with regard to a really high standard hospital, is there any way in which you could see it could be encouraged to accept a slight lowering of standard to enable the standards of other hospitals to be raised?——I think this can only be done through the annual distributions of money, and that to a very slight extent over the last five years there has been a distribution of the total funds slightly away from the more expensive hospitals, or the ones which appear to be more expensive in that in-patient costs are higher.

Mr. *Robinson.*

498. Has that been done at the instance of the Treasury or the Ministry? ——It has been done by the Ministry.

499. Would it be true to say the Treasury is not in a position to exercise any control of economy on individual Hospital Management Committees or Regional Boards, but only in so far as global totals are concerned, and that economies on a more specific basis must be the function of the Ministry of Health; would that be correct?——Yes, I think that is correct. It is the normal practice of the Treasury that we operate through departments, and departments are responsible for securing the efficient and economical use of the moneys.

500. Compared with the War Office this is a very weak system?——It is indeed. At the War Office you are dealing with a government service down to the roots, and you can have financial advisers in Army Commands who are able to report to the Secretary of State.

Mrs. *Hill.*

501. Would I be right in saying it is the Ministry of Health that decides on the sort of standard of Health Service it wants to give to the public?——To some extent, I think, this is decided by the past pattern. The Ministry of Health in 1948 took over control of the hospitals as they then were. They are, I think, trying gradually to produce more uniform standards. But the question whether this process could be achieved to a greater extent by taking away from the people with high standards already in order to improve at the bottom is a very difficult one because you have to have some effective instrument for judging the reasons why the cost is high, and they may be medical reasons in part. What we would like to work towards is the development of an improved costing system which will throw up the places where the expenditure is high, not merely by hospitals but by departments of hospitals, so that you could compare like with like to a much greater extent than now, and having compared like with like to investigate where the cost appears to be high and find out the reasons.

*Chairman.*

502. Some very interesting questions emerge from that. Firstly, is such a costing system going to come about in the near future?——A new system is being introduced in 120 to 150 large hospitals.

503. Introduced by whom?——Introduced by directions from the Ministry of Health. This has been under consideration for some time. It was favoured by the Public Accounts Committee and the Guillebaud Committee, and we have been asked this year to provide money for this purpose, and are doing so because we feel it is important.

504. Assuming that you have this new costing system universally applied the Treasury would still be out of the picture and would not apply any stimulus? ——I agree. The stimulus would have to be applied by the Ministry.

505. What stimulus would you apply to the Ministry in those circumstances? ——We can ask them for reports as to what they are doing, what the statistics

show in particular regions, to what extent particular regions have been investigated because their costs are high, and what the results have been.

506. Do you do that?——We do not do that now. The existing costing arrangements make it very difficult to do this.

507. In fact, you do not question the Ministry to any marked extent, at all?——(Mr. *Workman.*) We have in fact seen some of the reports which the Regional Hospital Boards send to the Ministry each year and the action which they have taken after the existing form of costing return has been made available to them so that they can see where they ought to take up cases of apparent high cost, and we do argue with the Ministry about these, indeed I think press them to take more account of the costing statistics in making the regional allocations from the estimate we provide.

508. Do you see the reports of each Regional Board?——No.

509. Why not?——I think it is not primarily our function to see each Regional Board is doing its duty. It is our function to see that the Ministry is doing its duty.

510. How do you set about that?——By discussion and argument with them, and by looking at such of these reports as they send us, to see they are taking action.

511. You have nothing very much to discuss and argue about, have you?——We have the existing costing figures.

512. Do you take any interest in the fact that the variation in cost per patient has decreased, that there was a variation of something like 33 per cent. or 35 per cent., and that now it is something in the neighbourhood of 20 per cent.?——I think this is based on a memorandum which we have not yet seen.

513. It said that the variation of the weekly cost of running a notional hospital of 100 beds varied between 21·8 per cent. above the national average to 12·9 per cent. below, which is a variation of 34 per cent.—that is as between 1951 and 1952. Now the variation is a matter of 20 per cent. Is that the work of the Treasury acting on the Ministry of Health?——I think they have prepared this information themselves as a guide in making decisions about the regional distribution. We have also looked at figures of our own. (Mr. *Turnbull.*) I think this result is produced by the fact that even if we give to the Ministry of Health enough money to run the Service in the coming year, at the level it has reached at the end of the last year, plus something for development, that something is so small in relation to the total number of hospitals that they are distributing the total sum to some extent in a way which redistributes the money as between regions and between different kinds of hospitals, and this does press the high cost hospitals to reduce their relative rate of expenditure to some extent.

Mr. *Willis.*

514. Why does it press them to reduce their own expenditure?——If the same amount in real terms as is available in the preceding year is re-distributed rather differently with, say, a slight improvement in mental hospitals, a slightly less large proportion for other hospitals, that will tend to slightly lower the average amount of money available for other hospitals.

*Chairman.*

515. It is only £70,000 per region which they have to play with?——Yes.

*Chairman.*] It does not give much encouragement or discouragement, does it?

Mr. *Robinson.*

516. Do you consider that you have got a control, at any rate, on the money that goes for developments, as opposed to the sort of control you have in regard to capital developments?——I think we have absolute control of what is given for development each year. When you have estimated on the basis set out in the Memorandum what is needed to keep the Service going at the existing level there is then a decision as to how much more should be provided for development, and there is a debate with the Ministry as to what the amount of money they ask for will be used for, and whether those things are really essential, and quite often they get less than they ask for.

517. Does not that money to a large extent depend on the capital schemes

that have been sanctioned in the immediate past?——I agree that in providing development money you have to provide something for the buildings which are coming in, and to that extent it is determined by that factor.

Mr. *Robinson.*] I see; you have very specific control of individual schemes over a certain size.

Vice-Admiral *Hughes Hallett.*

518. With regard to paragraph 7 of the Memorandum, it indicates there that the Service as a whole is completely insulated from any effects of the falling value of money?——Yes.

519. Do the Treasury regard that as sound in principle that public money is being spent?——This is a public service and it seems to us that if in a time of rising prices the standard of the service ought to be reduced then we ought to do that by conscious decision, and not simply by allowing the standard of service to be eroded because in a particular year prices, wages and salaries rose abnormally. That would mean that in a year of that kind the hospital authorities would have to dismiss staff, or cut down on the standard of feeding, or something of that kind, or treat less patients, or close beds, in order to make ends meet. It seems to us that if it is felt that the economic situation is such that a lower standard must be imposed on the hospitals then we ought to do it in the annual Estimate, and tell them in good time that they are to have less money, and let them plan their reductions.

*Chairman.*] You do not mean less money; you mean not more?

Vice-Admiral *Hughes Hallett.*

520. That was really my question. What I am trying to get at is this. Is there any parallel in other forms of expenditure to that with a guaranteed immunity, because that is what it does come down to, a guaranteed immunity from rise in costs?——I think there is a guaranteed immunity, but in practice I think it is the case that in a pure government service if there is a rise in prices or a rise in wages during the course of the year the department will come and ask for a supplementary, and, unless it is felt that the standard of that service ought to be reduced on grounds of economy, they will get it.

*Chairman.*

521. You are not claiming that any other government service is treated in the same way as the Health Service, are you?——I think that is in this respect other government services are broadly speaking treated this way.

Mr. *Robinson.*

522. Do you treat the Hospital Service any differently from the way the Treasury itself has treated the Treasury staff; in other words, are they insulated to the same extent, or to a greater or lesser extent, from increases in salary and costs of one kind and another than the Hospital Service?——Well, if there were a salary or wage award in the civil service in the course of a year, the Treasury would put in for a supplementary to cover the cost of that, unless it were decided by Ministers that the circumstances were such that the number in staff must be reduced in order to try and cover some of the costs.

Vice-Admiral *Hughes Hallett.*

523. That is my point. We are informed that there is at present a drive which, I think, has reduced 15 per cent. of civil servants. Is there any corresponding drive to reduce the expenses of this particular Service by the staff?——Not at the present time, no. The fact, I think, is that the hospital services are staffed appreciably below the establishments approved two or three years ago when there was a review of staffs by the Ministry.

*Chairman.*

524. In actual fact—I am not talking of nursing staff—the headquarters staff of Regional Boards are constantly rising. Is any step taken to see that that does not happen?——(Mr. *Workman.*) I cannot quote the exact facts to you, but I think the Guillebaud Committee refers to the fact that the hospital administrative and clerical staffs were separately investigated. I do not recollect the year exactly, but I think in 1952 the complement was established then and a reduction was called for, and I think this recommendation has since been brought about.

525. I was talking about headquarter staffs of the Regional Hospital Boards. The figures were that there were 256 in-patients per unit of staff in 1950 and

only 214 in 1945?——The Regional Board are responsible for other things apart from what one thinks of as the Hospital Service, such as the Blood Transfusion Service, it may not necessarily mean the actual running of the hospital has absorbed this extra staff.

526. Does the Treasury take any interest in the greater cost of teaching hospitals than other hospitals?——(Mr. *Turnbull.*) We are aware they do cost more. We have, of course, taken considerable interest in what has happened in the Public Accounts Committee on this, but there again, we think this is primarily the responsibility of the Ministry.

527. Where does the taxpayer get his protection if the Treasury really deny most of the responsibility for these startling differences in cost. You do not take direct interest yourselves: do you stimulate the Ministry to take steps, or do you make enquiries of them to see what they are doing about it?—— We certainly have done in connection with the case raised at the Public Accounts Committee.

528. That case at Bart's?——Yes.

529. Have you gone into any other teaching hospital's expenditure?——(Mr. *Workman.*) I think that other similar cases have arisen in the past, individual Boards of Governors have been criticised, but I think we are faced here as elsewhere with an inherited pattern in which the teaching hospitals generally had a much higher standard before the appointed day, and with the limited juggling you can do in allocating money each year it is not very easy to bring about a closer alignment. There are some legitimate reasons for which teaching hospitals would be more expensive.

530. I like your phrase "inherited pattern"; it seems to sum up the position aptly. Am I right in thinking that the Treasury accept this inherited pattern as an immutable inheritance, and do not put pressure on the Ministry to get it modified?——(Mr. *Turnbull.*) We do not regard it as immutable. We have discussed with the Ministry whether they cannot find ways of using costing statistics in distributing the money and make a greater re-distribution than is now made of the total available funds. There has been, according to figures I have here, some slight fall in the percentage of the total money which is made available to Boards of Governors, that is to say, there has been some slight adjustment as between teaching hospitals and other hospitals within the total.

531. I am not so much interested in what has actually been done as in your powers and in the use you make of them, and the impression you have given me is that willy-nilly you find yourself in the position of simply having to dish out money without being able to exercise much control on how it is spent. I hope I am not unfair in saying that?——I think it is very difficult for the Treasury as a department to judge what proportion of the total money made available the hospitals ought to be given to teaching hospitals as against other kinds of hospitals.

Mrs. *Hill.*

532. Are you really saying that you rely on the Ministry of Health, in other words, to keep their house in order to a great extent on this question of costings? ——I think we are bound to. I do not think we can form a better judgment than they can as to what is the proper amount out of a given total to give to Boards of Governors as against Regional Boards and other kinds of hospitals.

533. And auditors audit the hospitals under the Board of Governors in the same way as they do the hospitals under Regional Hospital Boards, do they, and do reports come to you of any excesses or any criticisms that there are at any time?——We do not get the auditor's report, but the auditors do audit.

*Chairman.*

534. Would it be right to say your only auditing contact is through the Comptroller and Auditor-General?—— Yes.

535. And you do not intervene either as of right or as friendly advisers with the Ministry at all?——If any cases come to our notice in which it was alleged that there was necessarily extravagant provision we should certainly take it up with the Ministry of Health, but we have not got any independent sources of information.

536. Do you advise the Ministry, for example, in the way the Regional Boards frame their estimates?——(Mr. *Workman.*) The form of the hospitals' accounts is agreed with the department

and to that extent we are concerned, but in actually building up the figures in those estimates by Regional Boards we are not concerned.

537. Do your Organisation and Methods teams visit the hospitals?——(Mr. *Turnbull.*) There are Organisations and Methods teams run by the Ministry of Health which visit the hospitals, and we have lent them some personnel from our Organisation and Methods branch, and we assist them by training their people.

Mr. *Robinson.*

538. Could I ask the witnesses to express an opinion, on the basis of what they have discovered since looking after the Hospital Service at the Treasury, are there any sub-heads on which they feel that the financial control down the ladder is inadequate? Perhaps I might quote two specific ones. Do they feel the control over expenditure on drugs is adequate; do they feel the control of expenditure on staff is adequate?——I cannot say I am satisfied that control is adequate. I find it very difficult to see under existing costing arrangements how the Ministry can establish that in a particular hospital the expenditure on, say, drugs is too high. If there were costing arrangements which showed that the expenditure on drugs per patient in the comparable hospitals was very much out of line, then I would have thought they would have a strong *prima facie* case for some form of enquiry or investigation to see whether there were particular circumstances which justified it. But I do not think that there is the statistical background or the information to do that now.

Sir *Henry D'Avigdor-Goldsmid.*

539. Could I take this particular reference a little bit further. Do you feel that the general expenditure on grounds, land, agricultural purposes generally which come under the Hospital Service is controlled in any effective way?——There is an investigation, I think, now going on hospital by hospital into the expenditure on farms and gardens, and it is being overhauled and reduced.

Mr. *Willis.*

540. In view of the fact you do not think this costing system is adequate, what are you doing about it now in respect of drugs, etc?——The Ministry have had a working party on costing systems, and about a year ago they came to us for approval for this new departure, and they are going to introduce it after the end of the financial year. We have provided the necessary amount of money.

541. In every hospital?——No; in about 150 large hospitals. It is a fairly elaborate system and it is not certain it would be desirable to extend it to all small hospitals, but it will be applied in the first instance in these 150 to 200 large hospitals spread over the country as far as possible. I think we are going to have at least one or two in each Regional Board. As a result, when those figures are available, it should be possible to do the kind of process that I have been describing.

*Chairman.*

542. You will really have nothing to do with it?——No, the Ministry will do it.

543. Urged on by you?——Yes.

Mr. *Robinson.*

544. Do you think it will ever be possible to control adequately the expenditure on drugs without interfering with the clinical freedom of the doctor to prescribe?——Whether you should or should not interfere with that freedom is a very difficult question.

Mr. *Willis.*

545. You have referred several times to the costing system that is about to be introduced. From your experience is there any other direction in which you think the Treasury control of this expenditure ought to be tightened up; is there anything else you think can be done, or should be done, to tighten up the Treasury control of this expenditure?——We do not think that as the Hospital Service stands now we provide too much money in total for it. We should like to see it better distributed, and we think we should work towards that as fast as we can, and that that will hasten the day when the total cost of the Service rises more slowly.

*Chairman.*

546. When you say better distributed, you mean, do you not, that there should

be a greater margin at the disposal of Regional Boards to give prizes to the good boys and to take money away from the bad boys or the less good boys?——Yes, we should try to work towards an average standard which is more uniform over the country than now.

547. Do you feel there should be a greater sum at the disposal of Regional Boards which will be awarded to hospitals which make efforts at economy and taken away from the hospitals that do not make those efforts?——Yes. I think that if you had a hospital which the Regional Board was satisfied had not made adequate investigation into a *prima facie* case which the Regional Board had brought, that in comparison with other hospitals there was high cost in certain respects, we would then think that that factor ought to be taken into account when the annual money is distributed by the Regional Boards.

548. There is no pressure you can exert to bring that about?——No. We have discussed this with the Ministry, and we have emphasised particularly in connection with this new costing arrangement that when we have these figures they ought to be used in this sort of way. They have not gone further, but they will discuss the possibilities with the Regional Boards when the figures become available.

549. Do you keep up a constant pressure? I see in the special report replying to the Public Accounts Committee last March you say that when the new costing system becomes available it will be fully used as an aid to economic administration. What sort of pressure can you exert to express your concern—merely moral suasion?——I think only moral suasion at any rate in the first instance. In the last resort the Minister has powers, of course, to direct hospital authorities to take particular measures.

Mrs. *Hill.*

550. Are there any other ways in which the money could be allocated to Regional Boards on the lines of the university grants. That might encourage them not to rush to spend their money at the end of the year, if they could have a carry-over?——A block grant for a period of years?

551. Yes, even if only a certain amount was released each year, but if they were allowed to carry-over. Would that be very difficult from the Treasury point of view?——Yes, I think it would. Carrying over from year to year has been discussed in this connection before. I think it was considered by the Select Committee on Estimates in 1951 or 1952, and they advised against it on the ground that carrying-over from year to year is not in accord with the system of parliamentary control. The universities arrangement, of course, is a different thing, but I do not think that in the case of authorities which are 100 per cent. grant-aided and which deal in very large sums of money, and at a time when prices and costs have been rising at the sort of rate that has occurred in recent years, it is feasible to have a block grant for a period of years.

*Chairman.*

552. I really think, Mr. Turnbull, you have told us very nearly all you have to tell us, but there are a few specific questions I should like to ask. What do you think of central purchasing, and central contracting, on a national or regional or group basis, for things like tinned goods, linen, drugs, etc. Do you think the department should go in for central purchasing?——We think that there should be a full examination of the possibilities of bulk buying either on a group, regional or central basis as soon as this report on hospital supplies is available.

553. Are you aware that the Ministry of Health have not consulted with the service departments and other departments on the question of bulk-buying as much as they should have done?——I think it might well be useful, particularly when this report comes out.

554. When will the report be out?——I think they told you it was in print now.

555. We are hoping to get an early sight of it?——We certainly think there are possibilities of economy in this.

556. But the broad position is that, as Mr. Workman said, you are working to an inherited pattern and you have very little *locus standi* in intervening with the the Ministry of Health with a view to getting it modified. You would accept that, would you not?——Yes. I think

I would say we have *locus standi*, but I think that in view of the Ministry's policy of dealing with these authorities by persuasion rather than by direction there are limits to what can be done quickly.

557. Can you advise the Committee as to the lines on which you think enquiry could properly be conducted and continued? We should be glad of your views. We thought of seeing Regional Hospital Boards, Boards of Governors, and some Management Committees. We are interested in the machinery of financial control and how effective it is. Have you any particular view which you would like to give the Committee?——I would think it would be very valuable if the Committee could see Regional Boards and Hospital Management Committees and hear from them how this system works at the various levels, and how far they do, in fact, investigate the hospitals which appear, on the basis of the costing statistics, to be high cost ones in particular respects.

558. Do you feel that Regional Boards have enough expertise at their command to control the expenditure of these large sums of money?——I should have thought they were fairly good authorities for judging what sort of service ought to be provided in the region, and as to whether one of those hospitals is more costly than another.

559. They are all more or less autonomous, are they not? Do you think they have enough expertise and knowledge for their estimating and budgeting, and so on?——I think it probably varies a good deal from one to another.

560. Have you any data at your command to enable you really to answer my question?——No.

561. It was more or less a speculation on your part?——Yes. (Mr. *Workman.*) I have met several Hospital Board officials in the course of my work, and I think it is generally accepted, as Mr. Turnbull said, that there is some variation in the quality of the personnel.

Mrs. *Hill.*

562. Each Regional Board has a Finance Officer of good standing, has it not, a Trade Finance Officer?——Yes. (Mr. *Turnbull.*) Whether they have sufficient staff for this purpose of sufficient quality is a point to which I think would be very valuable to know the answer.

*Chairman.*

563. One final very comprehensive question. What changes, given the present policy, do you think could reasonably be brought about to provide better supervision of the expenditure of Exchequer money?——We think the first thing to be done is to develop the new costing system.

564. Do you think the experimental installation of a new costing system is on a broad enough basis?——I think it is in the first instance, yes.

565. And is being pressed forward with the necessary expedition and urgency?——Yes; we have been told it will be brought in in the coming financial year.

566. When will you get results?——We shall get the first statistics in a year's time, at the end of 1958.

567. What is you next point?——That on the basis of those statistics the Ministry should urge hospital authorities, the Regional Boards, to use the statistics by making enquiries between one hospital and another, and one department of a hospital and a comparable department of another hospital, and by making comparisons between regions to try and identify the places where expenditure appears to be abnormally high.

568. I thought you used the phrase that "the Ministry should be urged": who should do the urging?——We shall.

569. You have enough powers for that, or is it just force of personality—I am sure that will not be lacking?——In the last resort these matters can be taken to Ministers.

570. Apart from that, what changes would you like?——We also think these costing returns should be used within individual hospitals for compiling budgets of expenditure by departments in hospitals to which they should aim to adhere.

571. You mean for example comparing the X-ray department of one hospital with the X-ray department of another hospital?——Not only that. We think that an X-ray department should frame a budget for a year and try to keep

within it, that that budget should be based on examination of what they spent last year, whether any economies could reasonably be made, and whether it is reasonable compared to what other X-ray departments are doing elsewhere.

572. Do you feel you need increased power in dealing with the estimates; do you think there is any hope of your getting them?——I think we have satisfactory control over the total amount of money, and in the normal case that is all that we should ask for. If we could feel satisfied that the hospital authorities under the aegis of the Ministry were making every effort to secure administrative economies and to bring the costs of individual hospitals gradually rather more into line with a common standard, we should be reasonably content with this system.

573. Do you feel throughout the Service that there is a proper appreciation of the need for economy?——We think it is growing.

574. By which I assume you really mean you do not think there is enough, but it is getting better?——Yes.

575. Are there any steps the Treasury or Parliament can take to instil such a spirit?——I think this can only be done by a process of urging the need for economy, by the Ministry exhorting the authorities, by the Ministry finding out ways and methods by which economies can be found, and by the Regional Boards and Hospital Management Committees having adequate administrative staff of good enough quality to get the best results.

576. What role do you see the Treasury playing—constantly prodding? ——Yes.

*Chairman.*] Thank you, that is all we wish to ask.

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TUESDAY, 19TH FEBRUARY, 1957.

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Members present:

Mr. Nicholson, in the Chair.

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|---|---|
| Sir Henry D'Avigdor-Goldsmid. | Vice-Admiral Hughes Hallett. |
| Mrs. Hill. | Captain Waterhouse. |
| Mr. Holt. | |

**Memorandum submitted by the Manchester Regional Hospital Board.**

## RUNNING COSTS OF HOSPITALS

### (1) Description of Manchester Regional Hospital Area

The Board's area covers parts of the four administrative Counties of Lancashire, Cheshire, Derbyshire and Westmorland, and includes 13 County Borough areas. The area, containing approximately 2,700 square miles, extends from Barrow-in-Furness and Windermere in the North to Crewe and Nantwich in the South, a distance of about 120 miles. The area is not more than about 30 miles wide at any point. A map is attached.* The estimated home population of the area on the 30th June, 1955, was 4,379,000 and, in terms of population, it is the third largest hospital area in the country, being exceeded only by the South West Metropolitan (4,672,000) and the Birmingham (4,512,000) Regional Hospital Areas. More than half of the population of the Region live within a radius of 12 miles from the centre of

* Not reported.

Manchester and this part of the region is recognised as the most densely populated part of Europe. North of Preston and South of the Manchester conurbation the area is predominantly rural in character with concentrations of population on the coast round Blackpool, in the vicinity of Lancaster and at Barrow-in-Furness. The hospitals under the control of the Board number 190; in addition, there are 30 ad hoc out-patient clinics of various kinds. The day to day management of the hospitals and clinics is carried out by 33 Hospital Management Committees appointed by the Board. A list of the Committees and of the hospitals for which they are responsible is given in Appendix —.*

**(2) Discharge by Board of their financial responsibilities**

As a general preface to any statement of how the Board discharge their financial responsibilities, it must be said that, in the absence of more complete costing information, the methods employed by the Board for the distribution between the Management Committees of the global allocation received from the Ministry have necessarily had to be based on historical expenditures, adjusted in the light of information which is continuously being gathered by the Board. (Note: A limited costing experiment under Ministry of Health sponsorship is to be introduced on the 1st April, 1957.)

The Management Committees in the Autumn of each year furnish the Board with a forecast of their financial needs for the year commencing on the following 1st April. This forecast or estimate is in the form shown in paragraph (3) below. The Board, after examining these estimates, and paring them where necessary, forward them to the Ministry, together with the Board's estimate of their own requirements. In due course the Ministry, without comment on the estimates of any individual Management Committee or of the Board, advise the Board of the global sum which will be available to them for the maintenance of all the services within the region. This sum is invariably less than the total sum indicated in the estimates supplied to the Ministry. The Board, having deducted from the global sum the amount necessary for their own directly administered services and for certain regional reserves (a further reference to these reserves is later made in this paragraph) then proceed to divide up the balance between the various Management Committees. This they do by reference to the current approved expenditure of each Committee making adjustments up or down to meet development trends and other known factors of unavoidable increases and, of course, prospective savings; also adjustments to meet wage awards, price increases, etc. Further adjustments become necessary and are in fact made at the revised estimates stage, half way through the financial year.

Among the methods employed by the Board for ensuring maximum economy by the Hospital Management Committees are—

(*a*) *The use of Regional Reserves:*

The Board operates a system of regional reserves. The actual amounts of the reserves are related to and dependent on the Board's global allocation from the Ministry and may vary from year to year. They are, however, of the approximate order of—

| | |
|---|---|
| Deferred Maintenance ... ... ... | £175,000 |
| Developments and Improvements ... ... | £175,000 |
| General contingencies ... ... ... | £100,000 |

These reserves are created out of monies temporarily withheld from the Management Committees. They have two virtues. First they enable the Board, acting from a regional standpoint, to apply expenditure in the directions which they consider will produce the maximum advantage; secondly, by limiting the initial allocations to Hospital Management Committees to the amounts necessary to meet essential needs, good housekeeping is stimulated.

(*b*) The issue to all Management Committees of annual cost statements for all hospitals in the region with the object of stimulating self-criticism in relation to comparatively high costs or comparatively low bed occupancy.

* Not reported.

(*c*) The publication quarterly to all Management Committees of statements of provisions costs, showing the cost per capita for every hospital in the region.

(*d*) Discussions between the Board and Management Committees whose costs either generally or in relation to any particular hospital appear to be unduly high comparatively.

(*e*) Very close scrutiny of all applications from Management Committees for approval to the engagement of additional staff and the determination of establishments. In judging these applications the Board have special regard to the general staffing position of the group in comparison with that of other groups and of the regional average.

(*f*) Initiating the centralisation of group services, such as laundries, transport, maintenance departments, etc.; and encouraging the introduction of labour-saving devices.

(*g*) Close examination by the Board's Finance Committee of the monthly statements from the Management Committees showing the progress of their expenditure, and the taking of action thereon in appropriate cases.

(*h*) Taking appropriate action with Management Committees in relation to matters arising out of Audit reports or out of applications from the Committees for Board approval to the writing-off of losses, etc.

(*i*) Examination, in consultation with the Board's Medical Advisory Panel (an all-professional body) of the rising costs of drugs and dressings.

(*j*) For several years the Board have been developing standards for different types of accommodation and equipment, e.g. Operating Theatres, Ward Units, X-ray Departments, Furniture and furnishings. Their sole aim is to secure efficiency without extravagance on the basis that the standards *of quality* which are requisite and proper in one hospital are also requisite and proper in another without imposing uniformity of design or appearance.

(*k*) For some years the Board have operated a system of control over Hospital Management Committee advertisements for Medical and Nursing staffs. The control is aimed at minimising unproductive advertising of which the Board had abundant evidence in the early years. It is difficult to be precise about savings but they are estimated to be between £5,000 and £7,000 a year. (See a further reference to advertising costs in paragraph (9).)

(*l*) Significant savings can be achieved by Hospital Management Committees pooling their requirements, for contract purposes, of goods and commodities in common use. A highly successful scheme has been in operation in the Manchester region since 1954.

**(3) Management Committee Estimates: Sub-heads**

The following is the standard form, devised by the Ministry of Health, in which Management Committees prepare and submit their Estimates—

*Approved Sub-heads*

Gross salaries and wages and employers' contributions to National Insurance and Superannuation.

(*a*) Medical (Category B).

(*b*) Nursing (Category C).

(*c*) Administrative and Clerical.

(*d*) Works and Maintenance

(i) Gardeners and Stokers.

(ii) Others.

(*e*) Other Staff (Category D except Works and Maintenance).

TOTAL SALARIES AND WAGES.

Provisions.

Uniforms and Clothing.

Drugs.

Dressings.

Medical Appliances and Equipment.

Fuel, Light, Power, Water and Laundry.

Maintenance of Buildings, Plant and Grounds.

Domestic Repairs, Renewals and Replacements.

All other expenses

(*a*) Rates.

(*b*) All other expenses.

TOTAL HOSPITAL EXPENDITURE.

*Less* Direct Credits.

NET HOSPITAL EXPENDITURE.

*Add* Central Administration.

Table C Expenditure.

TOTAL.

*Add* Additional Maintenance arising from urgent developments coming into operation—

(*a*) Arising from completion of capital works.

(*b*) Not arising from completion of capital works but involving the opening of additional ward accommodation.

(*c*) Other developments and improvements.

TOTAL ESTIMATE

**(4) Major Developments and Improvements**

Major developments and improvements in the service in recent years include—

(a) *Expansion of the Consultant and Specialist Service*, as shown below:—

| | 1948 | | 1956 | |
|---|---|---|---|---|
| | Numbers employed | Number of sessions | Numbers employed | Number of sessions |
| Consultants ... ... | 307 | 1,846 | 426 | 3,601 |
| S.H.M.Os. ... ... | 205 | 1,216 | 170 | 1,403 |

(b) *Better use of hospital beds*

There has been an increased turnover of 44,000 per year in the beds of acute hospitals. This is equivalent to the building, staffing and equipping of 2,200 additional beds, or four hospitals each with about 550 beds. A typical 550 bed mainly acute hospital costs about £420,000 a year to maintain. This increased turnover, therefore, is equivalent to a revenue saving of nearly £1,700,000 per year not taking into account the saving on capital account.

(c) *Development of the Out-Patient Services*

New Out-Patient Departments have been built in Barrow, Leigh, Withington (Manchester) and Hope (Salford), and major alterations and

extensions have been undertaken in other places. Since the commencement of the Act the Board have spent £375,000 on the capital improvement of the Out-Patient and Casualty Services.

(d) *Pathology*

Every centre now has a comprehensive laboratory service accessible to every general practitioner. The Board have expended £300,000 of capital money in providing 20 new laboratories and generally making good the deficiencies which existed in 1949. Between 1949 and 1952 the number of pathology examinations increased by 38 per cent and between 1953 and 1955 by a further 33 per cent.

(e) *X-ray services*

A comprehensive X-ray service is now available in all hospital centres. Between 1953 and 1955 the number of X-ray examinations measured in terms of units increased by 18 per cent. Every general practitioner in the Manchester Region has access to an X-ray department. The Board have expended £½ M. of capital money on the development of the X-Ray Services, including the provision of 19 new departments.

(f) *Maternity Services*

Maternity homes have been provided in towns where previously none existed, such as Buxton and Northwich. Major improvements have been carried out at Kendal, Burnley, Wigan and Ashton. A minimum of £200,000 has been spent on the development of the maternity services.

(g) *Operating Theatres*

Since 1948 the Board have built 9 single operating theatres and 5 twin operating theatre suites and carried out major alterations to several others. The total capital expended amounts to £360,000.

(h) *Children's Burns Unit*

A special Unit for the treatment of burns and scalds in children was opened at Booth Hall, Manchester in 1953. The Unit serves the whole of the region and deals with approximately one-third of all the burns and scalds occurring in the region including practically all those which are of a serious nature.

(i) *Mental Deficiency*

Between 1948 and 1955, 540 additional beds were made available for mental defectives.

(j) *Mental Health Services*

The Manchester Board is unique in the way it has developed its peripheral psychiatric acute units and in the enhanced facilities provided in general hospitals for psychiatric out-patient services. The value of these units is shown in the fact that since 1954 the number of discharges a year from the mental beds has exceeded the number of admissions and the large mental hospitals are now beginning to show a decline in the number of beds. The number of voluntary admissions has increased from 1,896 in 1951 to 4,057 in 1955. In the same period the number of out-patient sessions has increased from 51 to 103 per week. The number of new cases has increased by 50 per cent and the total attendances by 90 per cent.

(k) *Chronic Sick*

The Board attach special importance to the rehabilitation of the chronic sick and they have appointed no less than 10 Geriatricians for this work. By the appointment of these specialists with a special interest in the care of the chronic sick, the Board are making much better use of their available accommodation and in many areas the waiting lists have been reduced.

There has been much expenditure on the accommodation to improve it and to provide day rooms and rehabilitation facilities. The specialist physicians who have been appointed co-operate very closely with the officers of welfare authorities and voluntary organisations. All cases on the waiting lists are seen before admission and the correct priorities assessed. Patients are fully investigated on admission and later classified. The turn-over in the chronic sick wards has been greatly improved and many more patients are now discharged to the care of their relatives or to welfare hostels than previously.

(5) **Reductions in Current Expenditure**

There have been no significant reductions in current expenditure in recent years or indeed at any time since the commencement of the Act. Further comment is made on this matter at paragraph 9 dealing with the current operation of the service.

(6) **Major increases in establishments**

Appendix —* gives particulars of the main staffing developments (other than medical) approved by the Board since December, 1952. Details of medical staffing are given in Tables — and — of the Statistical information.*

(7) **Fluctuations in Hospital running costs**

Apart from increases in wages and prices there have been no significant rises or falls in hospital running costs in the Manchester Region during recent years and this is illustrated by the attached statement (Appendix —*) setting out the maintenance expenditure of the hospitals under 8 heads for each of the 7 years 1949-50 to 1955-56 and showing the percentage relationship of each head of expenditure to the total. On the subject of hospital running costs, it is interesting to observe that in the latest costing returns published by the Ministry of Health for 1955–56 in which hospitals are classified in 20 different types, the per capita costs of the Manchester Board are shown to be below the national average for no less than 14 types of hospital; in 6 of these 14 types of hospital, the Board's costs are next to the lowest and in three of the 14 types the Board's costs are the lowest for the country. This kind of position has been consistently maintained over the past 5 years.

(8) **Variations in the Board's direct expenditure**

There has been a significant upward trend in three departments of the Board's directly administered services. In the Blood Transfusion Service, expenditure has risen from £55,628 in 1950-51 to £96,682 in 1955-56. This increased cost has, however, been matched by a significant increase in the amount of blood collected from 40,886 bottles in 1950-51 to 60,919 bottles in 1955-56. In the Consultant and Specialist services, expenditure has increased over the last 6 years by £656,214 (from £1,098,305 to £1,754,519). The growth of this service in terms of numbers employed and sessions undertaken is detailed in (4) (ante). The third significant increase occurs in connection with payments to hospitals outside the service with which the Board have contractual arrangements. Between 1950-51 and 1955-56 these payments almost doubled (from £54,350 to £107,867). Some part of this was attributable to increased charges but the beds also increased from 302 in 6 Institutions to 386 in 9 Institutions. A statement showing the expenditure for each item of the Board's direct expenditure is attached as Appendix —.*

(9) **Current Operation of the service**

The Select Committee's letter of the 4th February invites comments on the current operation of the Hospital Service with any recommendations the Board might like to make for greater efficiency or economy in the future. Presumably this point is to be read in with the statement in the second paragraph of the letter that the Committee are interested in any steps that could be taken to reduce the revenue expenditure of the Hospital Service without a lowering of general standards.

* Not reported.

In their Memorandum of Evidence to the Guillebaud Committee the Board expressed the opinion that " the provision of an adequate service must inevitably result in a rising charge on the Exchequer although this might be mitigated by greater efficiency and economies and particularly by greater concentration " on certain aspects of the service, notably the development of the out-patient and domiciliary services with the object of diminishing the demand for in-patient treatment ; also the development of the geriatric services with the twofold object of keeping old people out of hospital and rehabilitating, for early return to the community, those who do become hospital patients. Reference has already been made to these developments in paragraph (4).

It is still the view of the Board that in a service such as the Hospital Service in which there is no foreseeable limit to the amount of money which *could* be spent, there is no possibility whatever, outside a curtailment of the service, of reducing the overall call on the Exchequer. Particularly is this so in an era of continually rising prices. But the rising charge can be mitigated in a number of directions and the following are some of the methods (in addition to those already referred to earlier in this memorandum) which are being practised or advocated by the Manchester Regional Hospital Board :—

(a) *Concentration of beds*

Economy and efficiency have been promoted by concentrating the beds in given specialties in one, or at the most, two hospitals in a group rather than in small units in many hospitals. This process has now been carried to the fullest limit practicable without major capital investment.

(b) *Contracts of Medical staffs*

The Board maintain a special department for keeping under continuous review all medical establishments (both senior and junior) and revision of the contracts of all senior hospital medical staff to meet changing circumstances. With the object of minimising travelling time and travelling expenses, all newly-appointed officers are required to live within reasonable distance of their main hospital.

The foregoing are methods which the Board themselves practise. Below is a note of proposals which the Board advocate :—

(c) *Mental Deficiency*

The development by Local Health Authorities, as rapidly as possible, of Occupation Centres and Industrial Centres for mental defectives, with the object of retaining as many mental defectives as possible within the community and so minimising the heavy capital and revenue costs and the heavy manpower demands involved in the provision of Institutional care.

(d) *Approval of Boards' capital projects by the Ministry of Health*

The Board urge a streamlining of the cumbersome and time consuming procedure for obtaining Ministry of Health approval to capital projects. The position in this matter has recently been considerably assisted by a new arrangement under which Regional Boards are relieved of the obligation to submit to the Ministry for specific approval, the bulk of capital schemes involving not more than £30,000. But schemes outside this category are required to go through a four stage procedure and be subjected to a meticulously detailed examination by Ministry officers. This attachment to detail is the cause of frustrating and costly delays. It is understood that the Ministry are currently considering this matter but in the meantime it is the view of the Board that once the Central Department has satisfied itself as to the need for any capital proposal put forward by a Regional Board, and as to the reasonableness of the estimated cost, then provided the expenditure can be met within the limits of the Board's allocation, the Board should be allowed to carry the scheme through to completion within the approved cost without further reference to the Ministry.

(e) *Advertising Costs*

The cost of advertising has now attained to very high proportions and the amount spent annually throughout the country on staff advertising alone can hardly fall far short of £½m. It is probable that very substantial savings could be achieved if the Ministry of Health were to sponsor the publication and sale of a weekly vacancies bulletin of jobs in the hospital service. As this bulletin would be the only medium by which knowledge of vacancies in the hospital service would be available, it would command a large circulation and would be self-supporting.

**Examination of Witnesses.**

Mr. NORRIS M. AGNEW, C.B.E., Chairman, Dr. F. N. MARSHALL, M.D., B.Sc., D.P.H., Senior Administrative Medical Officer, Mr. J. GIBBON, F.H.A., Secretary, and Mr. J. EMLYN JONES, A.A.C.C.A., Treasurer, Manchester Regional Hospital Board, called in and examined.

*Chairman.*

577. Mr. Agnew, would you like me to start straight away with questions, or have you any preliminary statement to make?——(Mr. *Agnew.*) I do not think we have any preliminary statement, Sir; but there may be one or two slight clerical errors in the memorandum.

578. We will leave them; they do not matter. I will start my questions: how many members are there on your Board?——29 altogether.

579. How often does it meet as a Board?——Once a month.

580. I suppose the committees are constantly meeting?——Yes.

581. How many committees are there, and what are they?——There is the General Purposes Committee, which meets once a month immediately after the monthly Board meeting. Then we have the Planning and Development Committee, which is in charge of all developments for the Board; that meets once a month. The Finance Committee, which meets once a month. The Consultant Services Committee, which advises the Board on medical appointments; that meets once a month. The Establishment Committee which is responsible for advising the Board on H.M.Cs'. establishments; that meets once a month. The Building and Works Committee which meets once a month. The Nursing Committee, which meets once a month.

582. As to the membership of the Board, what sort of experience have they, and what interests do they represent? How many are members of H.M.C.s; what is the medical representation; how many are just plain businessmen? That is the sort of picture I would like you to paint?——I think six members of the Board are actually Chairmen of H.M.C.s. With regard to medical representation, we have two general practitioners on the Board and six consultants—at any rate, it includes two general practitioners, and the rest are consultants.

583. The total membership of the Board is 29; therefore 8 out of the 29 are medical?——They are medical, yes. The rest, I think, are drawn from all quarters. There are representatives of trades unions; we have businessmen——

584. How many businessmen are there?——There are about 19, who are members of an H.M.C., and 6 of them are Chairman, as I have said. You asked what is the general business background?

585. Yes?——There are 7, I should say, with a general business background, and myself, if you can count me—possibly 8.

586. Would you say that there is a good balance on the Board of people who have some knowledge of finance and business administration?——Oh, yes. I should say very much so. The Deputy Chairman of the Board and the Chairman of our Finance Committee, Sir James Lythgoe, is the ex-Treasurer of the City Council of Manchester. I should say the answer to your question is definitely yes.

587. You realise we on this Sub-Committee are mainly concerned with the system of financial control and how the Regional Board imposes its financial views on H.M.C.s—how it budgets and exercises its influence towards economy and so on?——Yes.

588. Particularly since your Board represents a district which is apparently

very efficient and has the lowest cost of any region?——One of the lowest, yes.

589. Yes, one of the lowest costs of any region. Can you say briefly how you have brought this good state of affairs into being?——Well, of course, I suppose like every Board, the H.M.C.s submit their estimates to us. We go through them very carefully, particularly that part of the estimate where the H.M.Cs. estimate what their maintenance requirements will be for developments. We are not so much concerned with what they estimate they will need to maintain the services as they are, because we know that the H.M.Cs. are reasonable.

590. May I pick you up on that point? Is there any way in which you are able to bring about economy in the actual running costs?——Well, yes. I think possibly the main reason for any success which the Manchester Board may have had is that we felt (I am talking about two or three years ago, when this started) that when the Ministry gave us the global allocation, we should only distribute to the H.M.C.s what they required for their minimum requirements, retaining at Board level as big reserves as we can. The amount of the reserves depends upon what the global allocation to the Board is, because obviously we have to give to the H.M.C.s a sufficient amount to run their hospitals as they are. But what we do is that we set aside three very important reserves, having allocated the minimum amount to the H.M.C.s (this is at the beginning of the year). We set up what we call a deferred maintenance reserve, and this we have been doing for about two years. This year and the year before it was £175,000. Now, that maintenance reserve is retained by the Board so that the Board can decide how that money can best and properly be spent.

591. How big a proportion is kept in reserve?——The whole of the £175,000.

592. But what proportion does that represent?——Of the Board's total?

593. Yes?——It is about 1/140th. The total allocation is about £23 million.

594. Out of which you are able to set aside £350,000?——No, Sir; out of which we set aside three reserves.

595. That is, £350,000?——No, £450,000; and one of these reserves is to spend money on buildings where money ought to have been spent years ago. It is deferred maintenance.

596. I cannot believe that such an apparently slender weapon can be the only influence which you can bring to bear. What other influences have you? ——Well, you see, every month the Finance Committee sees in the greatest possible detail what every H.M.C. is spending, where they are overspent and on what particular item they are overspent. We have frequent discussions with H.M.C.s, both at Chairman's level and, more frequently, of course, with the Treasurer and the Finance Officer of the H.M.C. concerned.

Captain *Waterhouse.*

597. Who do you mean when you say "we"? Do you mean yourself, as Chairman, or your officials?——As Chairman of the Board, I myself have quarterly meetings with every H.M.C. Chairman.

*Chairman.*

598. All of them together?——All of them together, at which anything of interest can be discussed, whether it is on the agenda or not. But, dealing with finance, if we see that an H.M.C. is overspending by these monthly statements, we get——

599. You mean spending over their estimate?——Month by month.

600. Yes, of course?——Then the Treasurer will go and discuss things or ask the Finance Officer of the H.M.C. to come and discuss things with the Treasurer and find out why it is overspent.

Sir *Henry D'Avigdor-Goldsmid.*

601. I would like to address myself to the question of underspendings, which particularly come up at this time of the year. What is your attitude, after the 9 months' figures are in your hands, when the Hospital Management Committees report underspending?——Well, we are very pleased if they do, but, generally speaking, it is not often that we find that.

602. No. That leads me to this position, do you not invite requests for drawings on the reserves from the H.M.C.s for money to be spent in the last three

months of the year?——These reserves are being handed out throughout the year as and when development is done, as and when the Board agrees to a capital development being done. We will then hand out from that reserve the money to enable the H.M.C. to do it. We do not keep these reserves back until the last three months.

603. The particular question to which I want to address myself is, do you invite requests from the H.M.C.s for something out of the reserves when it looks as if the reserves will not be spent by the end of the year?——No, Sir.

Mrs. *Hill*

604. Do you keep a programme of requests which you have had from Management Committees, which you review from time to time?——Are you referring to maintenance or capital?

605. Either?——Oh, yes, invariably.

606. From which you can pick out points for which you can allocate money?——And which we can pick out in the order of priority we think, both for capital and other items.

*Chairman.*

607. I am very much interested in the chain of financial responsibility. What staff has Mr. Jones, your Treasurer?——(Mr. *Jones.*) I have a staff of 15, excluding myself and my Deputy.

608. Have any of them professional qualifications?——Yes, I have at present four professionally qualified people on my staff.

609. Who appointed you?——The Board.

610. Was there any obligation on the Board to appoint someone with professional qualifications?——Yes, there was an undertaking that they should be professionally qualified.—(Mr. *Gibbon.*) There was no definite obligation. The Board laid it upon themselves.

611. Yes, quite. Now, going down the chain, each H.M.C. has a treasurer?——(Mr. *Agnew.*) Each H.M.C. has a finance officer.

612. He is appointed by whom?——(Mr. *Jones.*) The Management Committee.

613. Do you have a say in it?——No, Sir.

614. Have many of them professional qualifications?——The majority have—(Mr. *Gibbon.*) Might I qualify that, as to whether we have a say? Occasionally we are invited to assist the Management Committee in the appointment of senior officers, including finance officers.

615. You do not think there is a slight weakness in each H.M.C. having the question of appointments entirely in its own hands?——(Mr. *Agnew.*) If I may say so, that particular matter has been discussed between Regional Board Chairmen and the Ministry. As you probably know, the Regional Board Chairmen meet at Savile Row every second month, and that particular matter has been discussed, as to whether Regional Boards should sit in with H.M.C.s when senior appointments are being made: but no definite conclusion about that has been come to.

616. I was asking for your opinion—not what was being done?——If we did sit in as advisers? I do not think we could expect anything more, because, after all, the H.M.C.s are statutory bodies and have their own responsibilities. I think, at best, it should be by invitation from the H.M.C.s to the Boards, asking a few of their number to sit in as advisers.

617. There is nothing to prevent an H.M.C. appointing someone inadequate for the post?——Actually not, but, as the Board's Secretary has said, quite frequently when H.M.C.s are making an important appointment they do invite the chief officers of the Board to go and advise and help them.

Captain *Waterhouse.*

618. When you say these people are qualified, what qualifications have you in mind, as a rule?——(Mr. *Jones.*) It would be one of the recognised accountancy qualifications—(Mr. *Gibbon.*) With a rather particular emphasis, in this field, on the Institute of Municipal Treasurers and Accountants.

*Chairman.*

619. You have 33 H.M.C.s have you not?——(Mr. *Agnew.*) Yes.

620. And 190 hospitals?——Yes.

621. Who is in charge there? What is the corresponding post in a hospital? ——To a finance officer?

622. You have your Treasurer; each H.M.C. as a finance officer. What is the corresponding post in a hospital? ——None, Sir. A finance officer is in charge of the financial matters of his particular Group, his H.M.C. We have an H.M.C. which consists of one hospital, a 3,000 bed mental hospital. We have others which might have five, six or seven hospitals. But, however many hospitals they have, they have one chief financial officer, and he is called the finance officer.

623. I see that; but my point is that in one of these hospitals there must be a man who is in charge of the day to day financial management?——(Mr. *Gibbon.*) He is called the hospital secretary.

624. Is his a whole time job?——Oh, yes.

625. What qualifications has he?—— None in particular.

626. Who appoints him?——(Mr. *Agnew.*) The H.M.C.

627. They appoint a hospital secretary for each subsidiary hospital?——They appoint all their own senior officers, and they also appoint all the secretaries of each individual hospital in their Group. That has nothing to do with the Board at all. The appointments are made by the H.M.C.s themselves.

628. Do you regard that as satisfactory?——I think so, because, after all, an H.M.C. has statutory duties to perform. They are responsible for the day to day running of the hospitals under their charge, and I think it is only right, if that is so, that they should have, may I say, the main say at any rate in who they appoint as the officers, to whom they can look as their responsible officers.

629. I see that from the point of view of the rights of the Hospital Management Committee, but from the point of view of securing economy and efficiency in running, do you think it produces the results?——I have no grounds whatsoever for saying that if the responsibility of appointing senior officers to H.M.C.s rested with the Regional Boards it would lead to any greater economy.

630. Going down to the hospitals, though, you might have a man with very little business experience appointed to be secretary, might you not?——As secretary of an individual hospital?

631. Yes?——Yes.

632. And he is the man who really spends the money, and sees that the money is spent economically or uneconomically?——I should say not. Of course, you are asking me questions which ought to be addressed to the Chairman of an H.M.C. But I do know the answer. The answer is that the Secretary of an individual hospital really has very little power. He is responsible entirely to the Group Secretary and to the Group finance officer.

633. But you know from your own business experience that the managing director, even of a subsidiary business, is the man who brings about efficiency or inefficiency in the management of the business?——I agree.

634. You are not telling me, surely, that what you call the Group Secretary supervises the day to day running of all his hospitals?——I do not say the day to day running, but you must bear in mind that most of the hospitals in a Group have been so formed that they are all fairly near together. We have only, I think, one Group where the hospitals are really scattered, and that is up in the Lancaster and Kendal area; but, generally speaking, most of the hospitals are fairly near together—I do not say within a stone's throw of each other.

Mr. *Holt.*

635. May I ask you some questions following the alternative line of thought to what has just been put to you. With regard to the Hospital Groups, if the Chairman in charge of those Groups—those people who are giving their services voluntarily were not competent people, then perhaps you would be concerned or you might have cause to be concerned about the management of some of the H.M.C.s, even though the chief administrative officer, the Secretary of the Group, was well qualified and so on. In practice, do you find that you have some H.M.C.s that you are concerned about because there is difficulty in getting suitable types of Chairmen—people who have responsible positions in life and are perhaps retiring and are able

to take on what I believe is a very onerous job, really?——I have told all my H.M.C. Chairmen that in my opinion their job is one of the most important jobs in the whole of the Hospital Service, and I honestly believe it is. But the appointment of an H.M.C. Chairman is in the hands of the Board. The Board appoints the H.M.C. Chairmen; not the Minister. The Minister appoints the Chairman of the Board, but the Board appoints H.M.C. Chairmen.

*Chairman.*

636. How do you set about appointing the Chairman of a Hospital Management Committee?——May I just answer this other point first?

637. Yes?——If I have reason to believe (and sometimes I have had) that things are not running quite smoothly in an H.M.C., the relationship between my 33 H.M.C. Chairmen and myself is such that I can ask them to come in and we can have a real heart to heart talk about things. If, having done that, I still find things are wrong, which I have not found yet, and I do not expect to, there would be no alternative but to report the matter to the Board and for the Board to make an alteration in the Chairmen. Now, Sir, to answer your question, it is possibly one of the most difficult jobs that a Chairman of a Board has to do. Chairmen are appointed for three years, and it so happens that all the Chairmen are up for re-appointment this year. Their time expires on the 31st March.

638. The whole lot?——The whole of the 33. Of course, we do find and we have found this time that some of them, although excellent and have given years of service to the hospital world, are 74, 75, 76, and 77 years of age. In three years' time they will be 77, 78, 79 or 80. This has been a very difficult matter for years past, but we have now decided that unless there are any very exceptional circumstance to the contrary, we do not re-appoint a Chairman or indeed a member of an H.M.C. if, at the time of appointment, he or she has reached the age of 74. That rule having been brought in has meant that I have had to see personally six H.M.C. Chairmen, ladies and gentlemen who have given years of their time, and I have had to tell them as tactfully as I could, "This is awful, but, really, the time is up". Except in one case, they have taken it extraordinarily well. They appreciate that it is time to let a younger person in, and that is what we do. But now you come on to your next point: how do we find a suitable person? Well, that primarily is left to the Chairman of the Board, to make inquiries from whatever source he thinks fit.

639. The appointment is the Board's; not the Chairman's?——No, the appointment is the Board's entirely.

640. And the Chairman is, by tacit agreement, left to ferret out the right person?——Yes, or try to. We have what we call a Nomination Sub-Committee, which is a sub-committee of the General Purposes Committee, and the Chairman of the Board happens to be the Chairman of that Nominations Sub-Committee. The Nominations Sub-Committee asks—not on the Minutes, but informally—the Chairman of the Board if he would make inquiries as to whom he recommends as the new H.M.C. Chairman. I then make whatever inquiries I can from people in whom I have confidence, from my own personal knowledge, sometimes, of the people concerned. I then report back to the Nominations Sub-Committee on the inquiries which I have made, on the recommendation which I make, giving reasons why I make the recommendation. I give the Committee a full description of what the man is, what job he is doing and all about him. Of course, in every case I make a point of seeing the person in my own office privately before any recommendation is made.

641. Surely it is a superhuman task? It is more than should be put on anyone's shoulders. I suppose the same goes for the other members of the H.M.C.s?——Well, in that case, when I took over the Chairmanship of this Board——

642. When was that?——In 1953—I decided that when we came to appoint members of an H.M.C., one of the best people to advise as to whether a person should be re-appointed or not was the Chairman of that particular H.M.C. * * * The difficulty is this: when an H.M.C. meets and passes a resolution as to whether their retiring members

should be recommended to the Board for re-appointment, it is very difficult for that H.M.C. in meeting to say "We do not think that Mr. X's name should go forward", when Mr. X is sitting round the table. So we know perfectly well that when we get a recommendation from an H.M.C., as we invariably do, that they should be re-appointed en bloc. it really means very little.

643. I can see very naturally that the removal of superannuated members weighs very heavily with you and causes you much pain?——It does.

644. But I am really more interested in the original selection. Am I right in thinking that the original selection of the Chairmen is practically entirely your duty, and that as far as recruiting new members for the H.M.C.s is concerned, do you do that yourself or rely on the Chairmen you have already appointed?——We rely to some extent on reports we get from the Chairmen of the H.M.C.s, and we have to have regard to other interests. We know when we come to re-appoint a member of an H.M.C.——

645. I am not talking about re-appointment; I mean original appointment?——(Mr. *Gibbon.*) We are under a statutory obligation under the Act to consult with certain specified bodies or organisations at least once a year when the annual filling of vacancies is taking place. At each annual filling, roughly one-third of the membership retires. The membership of the Management Committees ranges from 15 to 20.

646. They retire statutorily?——They retire because they have been appointed initially for periods of 1, 2 and 3 years; so you get a third retiring each year in rotation. But on the occasion of each annual filling of vacancies, it is the Board's duty to address communications to a wide variety of organisations.

647. Is the balance laid down?——No, Sir, not every body which is consulted by the Board is specified by the Act, but some are.

648. What I meant was, is the balance of interests or experience in an H.M.C. laid down? Is it laid down that you must have so much of this and so much of that?——It was initially. At the initial formation of H.M.C.s in 1947-48, it was administratively laid down by the Minister to give a balanced reflection of certain particular points of view.

649. Could you say very roughly what that balance is?——I think in a typical Committee there might be five local health authority representatives——

650. Local government representatives?——Yes, local government representatives.

651. The Regional Board would choose them, but suggestions would be put up by local authorities?——That is true. Then you might get three senior staff—consultant staff.

652. From the hospitals in question?——From the hospitals themselves within that Group. Then you might get two or three members of the Executive Council.

653. Of what Executive Council?——The Executive Council constituted by the Act to run the General Practitioner Services.

654. They would be medical representatives?——No, not necessarily; they could be medical or lay from the Executive Council, which, in itself, is composed of both medical and lay people. Then initially there would be two or three representatives from the voluntary hospitals which were coming into the Group—the Boards of Governors of the voluntary hospitals.

655. They are time-expired now, of course?——They have disappeared now. That is just a rough idea of the way the original committees were formed. (Dr. *Marshall.*) There is also the consumer element, which is rather important. (Mr. *Gibbon.*) In addition, there is a variety of organisations which have to be consulted, as my colleague Dr. Marshall said, to represent the general consumer interest. In the Manchester Board we do consult the W.V.S., the Townswomen's Guild, Federations of Trades Councils, British Legion, Leagues of Friends of Hospitals——

656. Women's Institutes?——Yes, Women's Institutes—a wide variety of organisations representing, may I say, the man in the street, the consumer, the person who comes into the hospital as a patient.

657. The victim?——The victim, yes.

658. What I am driving at is this. What proportion do you insist on having of people who have experience in running big commercial organisations?——May I add this to what I have already said. I have described how the original Committees were made up; but the Minister laid down certain guiding lines about how the representation of this organisation, that body and that authority should be reflected in the initial Committees. The Board is not bound by that any longer, but they do still try to preserve something like the original balance and reflection of view on each of their Management Committees, and always they are looking for the person with a business training and background and not necessarily a person with direct experience of hospital administration.

659. Do you always insist on having a certain number of what one might call hard-headed businessmen or qualified accountants or people like that?——We do not insist, because sometimes that material is not available to us. As a general rule, we can only pick and choose from the lists of names which are before us on the nomination of the various bodies with whom consultation has taken place.

660. Are you limited to considering the names sent up by the bodies you are charged with consulting?——Definitely not. We can pull them out of the blue. (Mr. *Agnew.*) Generally speaking, in answer to your question, I know what you are trying to get at. If an H.M.C. was lacking in commercial brains or professional brains—a solicitor, accountant or the like—and we could find one or two suitable names to go in, those people would go in.

661. How do you find the good business or professional man—just by using your own intelligence?——Very largely. I did have a case of the managing director of one of the biggest firms in Manchester who was in my house three or four months ago. He said, "Are you wanting the likely kind of type from the business point of view on any of your hospitals?". I said, "Yes". He said, "Would you have any objection at all to Mr. So and So, who acts as private secretary to me, and who is prepared to give his time to do voluntary work?" I said, "Thanks awfully. Would you give me his name and address?" And that man has been appointed on to an H.M.C.

662. Are you satisfied that the Board and the H.M.C.s have enough sound financial representation?——With regard to the Board, I should say yes. With regard to the H.M.C.s I do not think I can quite answer that because I do not know all the members of each of our 33 H.M.C.s.

663. Perhaps Mr. Jones, who must be in close contact with them, could say whether he feels there are people on every H.M.C. who talk the same language as he does?——(Mr. *Jones.*) I think on every H.M.C. there are members who have an intimate knowledge of finance. But Mr. Gibbon probably has a more intimate knowledge of the make up of H.M.C.s.

664. Are there retired bank managers or solicitors, for instance?——Yes, in every case there is one of that type, or with similar experience. (*Mr. Gibbon.*) From time to time the Chairman of a Management Committee may come to me and say, "I am getting a little worried about the financial aspect. Mr. So and So is not getting any younger. Would you mind having it in mind, when the Board next considers appointments, that I personally would welcome someone with financial experience." But, generally speaking, I think it is safe to say that on every one of our Committees there is at least one member with financial knowledge and experience.

665. Who has a bias in favour of efficient financial running?——The Board is very conscious of the need for that type of person on every Committee.

666. It is not necessarily reflected down to the hospitals?——Not the individual hospitals, no, because different Management Committees have different methods and techniques. Some have House Committees for individual hospitals, but not all of them. (Mr. *Agnew.*) In some cases the H.M.C. will not have a House Committee at all, and the H.M.C. does all its hospitals itself.

667. Is that sound?——I personally am in favour of a House Committee under an H.M.C. because I am so frightfully interested and keen on maintaining the voluntary spirit in our Hospital Service.

I think that voluntary spirit can be enhanced by having a House Committee whose job it is to look after its one hospital. That House Committee can then get together its friends and it forms a league of friends for that hospital. That hospital becomes their own hospital, in their own small way, but I think it is very important.

Mrs. *Hill.*

668. Would Mr. Agnew agree, too, that from House Committees they can also co-opt a member on to the Committee, as distinct from the League of Friends, and from among those people very often it is possible to collect some of the sort of people you have been talking about? ——Yes, very definitely. When we come to select an H.M.C., one of the first things we look for is whether there is anyone on the list who has given some of his time to one of the hospitals in the Group; in other words, if a person has been serving on a House Committee for Hospital A for five or six years, I think we are always apt, not to favour that person, but to look upon that person as being the right type to promote from that House Committee on to an H.M.C.

*Chairman.*

669. The point I was trying to establish was that you do feel it is of vital importance that every H.M.C., and, if possible, every House Committee, should have one or more members who are placed there because of their commercial or financial or professional experience? ——I would agree absolutely and entirely with that, but I would place much greater emphasis on the H.M.C. than I would on the House Committee. The House Committee has not got the power to deal with finance.

670. I think you have already answered this before. You are satisfied that each H.M.C. has such a member? ——Yes.

Mr. *Holt.*

671. Would you think there is a danger that if it became generally thought that you had to serve on a House Committee before being appointed to a Management Committee it would make it particularly difficult for you sometimes to promote people from outside? For instance, many of the people you promote to be actually Chairman in many cases must be people who have lived in an extraordinarily busy life until they have retired. Then they find they would like to use their qualities in a hospital, and very often they are the sort of people you would like to make Chairmen. But if this idea got about, people might say, "Why has this person suddenly been made Chairman? We have worked all these years, and this man is being pushed in by Mr. Agnew. It is all wrong"?——I think it would be very dangerous if it got about that appointment from a House Committee to an H.M.C. was automatic, because, in the end, that would mean that the members appointed to the H.M.C. were appointed by the H.M.C. themselves, which is wrong. An appointment to an H.M.C. must be by the Board. But I do say that if we find there is a person giving work and time to a hospital, we look upon that person as being the right type to go on to an H.M.C. But I agree with you that it would be fatal if it got round as being the recognised practice. I do not know whether that answers your question?

Mr. *Holt.*] Yes; thank you.

Vice-Admiral *Hughes Hallett.*

672. Going back to an earlier question that was asked of you concerning the appointment of officers, particularly Treasurers and Secretaries, why do you suggest it is necessary for the H.M.C.s, for example, to appoint their own officers, merely because they are statutory bodies, bearing in mind that a Minister of the Crown, for example, does not appoint the senior officials in his department, or a commander-in-chief in the Army does not appoint his commanding officers in the regiments under him?——My answer to that would be that I do not think I should be very happy if I felt that my senior officers, with whom I have to work very closely and see every day, were appointed by a completely outside body without my knowing.

673. It was found, I think, by Gladstone, to be necessary to introduce what we now call the Civil Service as public expenditure reached bigger levels. Why do not the arguments that led Gladstone to form a regular Civil Service apply with equal force to a great public spending organisation such as the National

Health Service?——Would you suggest that senior officers be appointed by——

674. I am not suggesting ; I am asking why the same kind of argument which led to the Civil Service being set up, with the Treasury, really, as the nominating authority for the key posts, does not apply to the National Health Service? ——I do not know if I can answer why we should necessarily look upon the two things as the same. What I am saying is that I am dealing with the Hospital Service as I know it, and I think it is right for a Hospital Management Committee, which is responsible to us, and we to the Minister, to have some say, at any rate, in the appointment of their own senior staff.

*Chairman.*

675. The danger is, surely, that any Regional Board and its subsidiary bodies can inbreed. I am sure in the case of Manchester it works very well. Surely you would agree that one or two bad appointments as Chairmen of Management Committees might lead to inefficiency throughout the whole Region in the course of time. What would be wrong, I think the Admiral means, in you having a Treasurer or Secretary appointed from outside, rather than from within?——I think it is absolutely essential that the best people should be appointed, and, of course, I am not satisfied that in some cases the highest officers in the Hospital Service are yet quite of the right quality.

676. If you, for instance, had been a very worthy individual but were not much good, and the members of your Board had been at much the same time making a whole series of bad appointments amongst your staff, your lack of experience or faulty judgment would mean the hospitals were staffed with less efficient people, and there would be a decline in efficiency and a great waste of public money?——I would agree that the way of appointment should be the way by which the best people are appointed. I should want to be satisfied that there is a better way of appointing better people than the exising one.

Vice-Admiral *Hughes Hallett.*

677. The point is this. We know, of course, that every Minister and every Colonial Governor always wants to appoint his own officers if he can, and he is never allowed to, and for a variety of reasons, with which we are all familiar, a centrally controlled Civil Service has grown up. But can you point to a fundamental difference between the National Health Service and any other great spending or government organisation in the country which makes the present local method of appointment preferable?——I would only say this. It would seem to me that the Appointments Committee, consisting of representatives of the H.M.C. and probably the Chairman of the H.M.C., at the interview, would know more of what was wanted in that particular Group than a Committee appointed from outside, who knew nothing about local conditions at all. You see, hospitals vary enormously.

678. May I just ask you another question, which is related in my mind, although perhaps not quite so obviously. Who, in your experience, are the people in the National Health Service at working level who really control whether the whole thing is being run economically or not? Is it the doctors? Who are the people you have to watch?——Certainly not the doctors, no.

679. Can you put your finger on any particular function or group?——The department which is mostly responsible for keeping an eye on expenditure is the Finance Committee of the Regional Board, I should say, advised and guided by a number of people ; obviously the Board's Treasurer, helped and assisted by the establishment officers of the Board, with regard to the appointment of staff ; another very important person is the Senior Medical Officer, Dr. Marshall, who is responsible for all consultant contracts and keeps an incessant watch on the contracts to see if they can be varied. I do not think it is one person ; I think the ultimate responsibility must be the Board, based on advice it receives from a number of different bodies.

680. The answer, then, is that it is at Board level?——Yes.

681. And not at working level?—— Yes. When you say " working level "——

682. I mean the people working in the hospitals?——Let me put it this way.

The only thing the Regional Board can do is to make recommendations to the Hospital Management Committee: to advise the H.M.C., and ask the H.M.C. But the spending is done by the H.M.C., and if the H.M.C. does not want to play ball with its Regional Board and wants to kick over the traces, there is no one who can stop them from doing it.

*Chairman.*

683. That is a most significant remark?——I should say it is true.

684. That there is very little the Regional Board can do to pull in the reins, as it were, on an H.M.C. which does not want to play ball?——Excepting this, that, of course, the Regional Board would not grant the allocation of money to it. But if the H.M.C. enters into a commitment which has to be met, as far as I know, there is only one source out of which that money can come.

685. Dr. Marshall, you say, is the key man?——On all the medical appointments.

686. And on what you might call the contracts entered into on the medical side. Apart from the fact that you are public spirited and intelligent, what, besides your own conscience, makes you keep a close watch on the public purse?——(Dr. *Marshall.*) I suppose the same things which guide any chief officer of any organisation. It is a matter of conscience all the time in the promotion of efficiency.

687. It is also a matter of not getting money you ask for if you ask for too much. Does that apply in your case?——Well, of course, it is a matter of balancing the various planes.

688. Perhaps I may help you out. It is up to you to do your best, according to your own conscience and your sense of duty, and there is no sanction that can be applied to you?——No, I do not think so.

Sir *Henry D'Avigdor-Goldsmid.*

689. I wonder if I might come back to the question I raised before: the question of underspending, which aroused so much astonishment in your Treasurer? Do you have examples which you can think of where your H.M.C.s have in fact underspent their estimates on particular items?——(Mr. *Agnew.*) Oh, yes.

690. Do you think those are as frequent as they might be? Let me put it another way: does the underspending in one year not colour very much the estimate for the next year?——No. Now, that is one thing it does not do. We do not let our H.M.C.s think, just because they have underspent this year, that necessarily is going to be their allocation for next year. That we do not do.

Mr. *Holt.*

691. May I just follow up the point the Admiral made about the centrally controlled civil service. The analogy between what he described in the Hospital Service is perhaps not exactly comparable because, of course, the whole of the Regional Boards and the H.M.C.s are volunteers. They themselves are not part of the Civil Service. If the kind of thing suggested in his question were to take place and all the professional appointments were made centrally from the Ministry downwards—secretaries, treasurers and so on—would you say this would completely undermine the authority and perhaps even the interest of the Regional Boards and the H.M.C.s in their work?——I should say the interest, certainly; and I should say if that happened, the Minister would have to set about finding an awful lot of new Regional Board Chairmen.

692. And the reason would be because you would feel there was no real responsibility?——Because there is still in the Hospital Service a certain amount of voluntary spirit—that old spirit which we had in days gone by. I think if you are going to put all the appointments of all the senior staff of all the Hospital Service in the hands of the Ministry, that is not helping that local voluntary spirit.

*Chairman.*

693. There is this point, however. The professional staff are solely employed by one Regional Hospital Board or one H.M.C. There is no likelihood of their being promoted from one Regional Board to another?——Oh, yes. I do not say that my Treasurer would be appointed Treasurer of another Board,

because both jobs are very much alike; but frequently his deputies and Mr. Gibbon's deputies apply for and are appointed to the next grade up, either on the Regional Board or with an H.M.C.

694. In other words, there is, informally, a sort of professional ladder which can be made to work?——Yes, but I should say that the ladder which you talk about is rather more in the staffs of H.M.C.s than in the staffs of Regional Boards.

695. Because they are at the top, you mean?——Because in H.M.C.s they see the doctors in white coats going into the theatres. They feel they are themselves in the Hospital Service, whereas my officers, to all intents and purposes, are outside the Hospital Service as such. They never see a white coat.

Mr. *Holt.*

696. What you have been saying in answer to questions seems to have underlined the vital importance of the high calibre of the Chairman of both the Regions and H.M.C.s and, really, of the other members of those Boards and Committees. If there were any question of difficulty in getting people of high enough calibre, would you agree this would be a matter of great concern?——As members of the Board?

697. And for the H.M.C.s?——As members of the H.M.C.s?

698. Yes. Would it be a matter of great concern?——Of the greatest concern.

699. Do you think we have any reason to be concerned about it now, or do you think we ought to be concerned about it in the near future?——I honestly do not think so. I see no difference or falling off in the quality of candidates for H.M.C.s today compared with those we had three or four years ago. People still seem to come forward.

*Chairman.*

700. As far as administrative and technical staff are concerned, the Guillebaud Committee reported some considerable anxiety. Have you any comment to make on that?——On the technical staff?

701. They said, "A great many of our witnesses who represented the hospital authorities have expressed concern at the unsatisfactory nature of the present arrangements for the recruitment and training of administrative staff in the Hospital Service. Because of the lack of central planning, we were told that it was impossible to determine not only the numbers of administrative staff needed for the Service in the future but also how the recruits to the Service could best be trained to give them the necessary experience for taking on the highest designated posts in the Service. A national recruitment and training plan was needed to expect the Hospital Service to compete with the Civil Service, Nationalised Industries, Commissions and private industry generally for a fair share of the best material available at all levels of entry to the Service".——I agree with that entirely, but I thought that the last question was about the members.

Mr. *Holt.*

702. The purely voluntary ones?——If you talk about a reservoir of suitable applicants for the staffs of the Boards, then I do agree that there is an urgent need for us to get some kind of training scheme together, to train these people up, ready to take on these very important posts these people hold.

*Chairman.*

703. That would mean the creation of a new branch of the Civil Service?——I do not think so. What we are doing in Manchester is this. In addition to being Chairman of the Regional Board, I also happen to be Chairman of the Board of Governors, which is of all the teaching hospitals. So, in Manchester, I have asked Mr. Gibbon and Mr. Cable, the Secretary of my Teaching Hospital Groups, to try and get working our own Manchester scheme for the training of suitable people, to switch them about from the Regional Boards to the Boards of Governors and to the H.M.C.s where they can do something special there.

704. You are about to create you own Manchester Hospital Civil Service?——I would not call it "Civil Service".

705. I have the greatest opinion of the Civil Service; shall we say, Hospital Administrative Service?——It is a scheme to select the best people in the whole of our Region to give them specialised training.

706. Creating a service?——Yes.

707. That is just up to you. Have you any knowledge of any other Regional Boards doing the same?——No.

708. Surely there is a lacuna here, is there not, that it should be left to one Regional Board with sufficient initiative to start this?——(Mr. *Gibbon.*) May I comment on this? This whole subject is a very big one, and is a matter of considerable concern to all hospital authorities and has been for some time past. The Ministry of Health recently, following the publication of the Guillebaud Report, took up the paragraph which you read a few moments ago and issued a circular to hospital authorities on the subject.

709. Do you mean Regional Boards?——Regional Boards, Boards of Governors, Hospital Management Committees, on the need for the training and improvement of prospects of promising young men and women who come into hospital administration as a career. One of the most important paragraphs of this circular deals with the pooling of resources between different types of authority.

710. Within the same Region?——Within the same Region, yes. Indeed, tomorrow we have another committee which will be meeting to consider this very matter, of how we can produce the set of mechanics which will pool the resources of the whole of the Manchester Region, including the Regional Board, the Hospital Management Committees and the Boards of Governors, in relation to vacancies which occur in the administration.

711. Creating a profession which would offer prospects of promotion, which would start with suitable training and emerge into being, as I say, a profession?——That is true. What we are trying to do is this. At the present moment, the hospital authorities in themselves are too small to offer the appropriate prospects to a young man of calibre and ambition, but if we get together and throw all our vacancies into a pool, we will thereby enhance the prospects of promotion to the worthy and ambitious young man, and we remove a lot of artificial barriers which have been created through the development of Hospital Management Committees, Regional Boards and Boards of Governors as water-tight compartments.

712. You are still painting a picture to me of something which is up to the Region to take up or not, according to its wishes; and, even when it has been done, each Region will be in a water-tight compartment?——It is looking rather a long way ahead. We would hope that once we have this Regional pooling, there might be inter-Regional pooling. It might develop even further.

713. But, you see, these are just the sorts of thing this Sub-Committee has to consider, and I am sure you would agree that the efficiency and calibre of the technical and administrative staff has a most important bearing on the financial efficiency, apart from anything else, of the Hospital Service?——I must agree entirely.

714. Perhaps making a difference of millions of pounds. So that it should not be left to the goodwill and capability of individual Regional Boards to do this or not, as they like? I should like your views on that?——(Mr. *Agnew.*) I think we ought to mention this new training scheme which has come in. Manchester University is doing half the training, and the College in London is doing the other half. I think they have only 16 trainees at the moment.

715. What sort of posts would they fill?——They are selected by a Committee. The ex-Vice Chancellor of Manchester University, Sir John Stopford, is Chairman, and they select candidates from far and wide. Half of them get their training via the Manchester University and some come to us and so go to other Boards. It is a three year training period.

716. They would be secretaries and treasurers?——Yes, mostly, I should say. (Mr. *Gibbon.*) They have been picked on the basis that they have sufficient intellectual calibre eventually to reach the top in administration in the Hospital Service.

717. How would you rate "the top" in the Manchester Region? In Hospital Management Committees they would be Group Secretaries?——Yes, precisely.

718. Perhaps they would start as hospital secretaries?——Yes, and perhaps finance officers.

*Chairman.*] I think that point has been made.

Mrs. *Hill.*

719. I have one further question on that. Apart from going to the university, are they going out to separate hospitals as well for practical experience?——(Mr. *Gibbon.*) Yes, there is only one year out of the three which is an academic year. The other two years are entirely in the field. I am not sure exactly how the Administrative Staff College are working their arrangement, but the Manchester University has appointed a peripatetic tutor who visits these students wherever they may be.

*Chairman.*

720. I do not think we can afford the time to explain the scheme. The point is, it is a voluntary scheme and comes from the gumption of the Manchester Board?——(Mr. *Agnew.*) The one which Manchester University is interested in is a national scheme.

721. You have first call on it?——(Mr. *Gibbon.*) It has nothing to do with us at all. (Mr. *Agnew.*) The other scheme will be, if it goes through, a Manchester Regional Board scheme.

722. The more junior posts in the administrative service are just *ad hoc* appointments with no probability of promotion?——That is the point of this Manchester scheme, if I may call it that. It is to give prospects to these younger people who are now, say, on grade D, E or F. It is to give them more prospects and chances of getting out and getting a better job within the Region.

723. It is purely Regional?——(Mr. *Gibbon.*) I think it is just as well to mention this. It is probably already within the knowledge of members of the Committee that the Minister of Health has recently appointed Mr. Noel Hall, the Principal of the Administrative Staff College at Henley, to undertake an investigation of the whole grading and salary structure of the Hospital Administrative Service. Most people connected with hospital administration are hoping that out of this will come a much more attractive service for the intelligent, well-educated and ambitious young man.

724. On a national basis?——Yes.

725. Thank you very much; that has been most interesting. Following up what you said about an hour ago, you said that when you found something was wrong with an H.M.C. . . . What sort of things do you find wrong?——(Mr. *Agnew.*) The Chairman might be having trouble with a particular member.

726. You mean personal relationships?——Yes, mostly.

727. I know it is very difficult to have a yardstick with regard to efficiency in the running of the Hospital Service. What points do you look out for? I am thinking particularly of the financial angle. What points do you look out for in making up your mind whether a hospital is run efficiently?——From the financial aspect we can see it in front of us in black and white. Their statements come in once a month, and we can tell at a glance if an H.M.C. is being run economically.

728. How do you do it? I agree you can see whether they are overspending or not?——If we allocate the money reasonably and fairly, as we really believe we do, then if an H.M.C. badly overspends, I maintain that the H.M.C. is being extravagant.

729. I am asking you whether you have any criteria by which you can judge whether a hospital is run efficiently?——We know from the cost. We can tell at a glance exactly what a similar thing costs in hospital A and in hospital B, 20, 30, 40, 50, 60 or 70 miles away.

730. There has been talk about a new costing system. You have your own costing system, have you?——It is not a costing system, exactly—(Mr. *Jones.*) There is a national costing system in operation at the moment. It is referred to, actually, as the National Hospital Costing Returns, published by the Ministry of Health for every hospital in the country. They are purely comparative figures.

731. Yes, we have those?——The Board examine these each year in great detail and where there are large discrepancies between the costs of a hospital one year compared with another year—or between the costs of one hospital compared with the average costs of its type—they ask the Management Committees why; will they enquire into them, submit to them the reasons, causes and

so on. From that, the Board obtain their view as to whether that hospital is being run efficiently or otherwise.

732. Are there great variations above and below the average in your Region between comparable hospitals?——There are considerable variations.

733. Can you give figures at all as to what is the percentage below or above? ——up to 20 per cent. above; 20 per cent. below.

734. Do you make a comparison horizontally, if I may put it that way, as between one department in a hospital and another department in another hospital?——We regard the hospital as an overall unit, but we do compare heads of expenditure. There are often times when hospitals, otherwise comparative, might have varying costs by reason of the building situation. It might be the incidence of various medical specialities. One hospital regarded as acute might have a great preponderance of surgical beds rather than medical beds.

735. This figure is a very much bigger variation than the overall national figure?——Yes.

736. How do you account for that? ——Because the grouping nationally is a very wide grouping. Acute hospitals are divided into four according to size. One type is the 1-50 bed group and you might have a hospital of fifty beds in that group which is acute in every meaning of the word. You might have another which has only ten beds and which is a general practitioner hospital.

737. Am I right in saying that a variation of 20 per cent. either way is bigger than the national variation?——Not bigger than the national variation. The overall national variation is a variation of Regional averages from the national average, but actually I think it will be found throughout the whole of the country that there is a wide range within each Regional average for hospitals of the same type, that is between the cheapest and the most expensive.

738. I suppose the most rough and ready comparison you can have is the cost per in-patient?——Yes.

739. The Manchester Region is the lowest in the whole country?——Yes, one of the lowest.

740. Have you any reason to think that indicates that the standard of the Service is lower?——I do not think that is really a question for myself or the Chairman. —(Mr. *Agnew.*) If I thought for one moment that because Manchester was usually the lowest or thereabouts that meant the patients in our hospitals were being fed less well than patients in other hospitals, I should be very concerned about it. I have not heard anything of that kind.

741. You believe it was entirely achieved by sheer efficiency?——I honestly believe it is. I believe also that up in our part of the world possibly we are rather more hard-headed than people in other parts of the country.

742. Not hard-hearted?——Not necessarily hard-hearted. I do honestly believe that where the people live and what they have been used to does account to some extent for this.

743. Is there a lower ratio of staff to patients?——Yes.

744. That must have a very important bearing?——(Mr. *Jones.*) Our costs for staff per bed, which are quoted in the National Returns, are lower in 14 out of the 19 or 20 types of hospitals than elsewhere in the country. That is purely for staff.

745. Does that apply to Teaching Hospitals as well?——No, Sir. I am referring to Regional Board Hospitals.

746. You can also answer for the Teaching Hospitals?——(Mr. *Agnew.*) I have not any papers here, but you cannot compare the staffing of a Teaching Hospital with the staffing of a Non-Teaching Hospital.

747. Perhaps I should not have brought that up. What room is there in the Hospital Service for greater efficiency? What lessons can you teach other Regions? There is a good deal in your Memorandum?——There are so many things. Let me give you one example. You all know, I suppose, that each H.M.C. throughout the country does its own bulk buying. We have gone a stage further than that. Two years ago we started Regional buying.

748. This Committee have been enquiring whether with regard to certain classes of goods, national bulk buying might not

be a good thing?——(Mr. *Gibbon.*) It is already done with certain things.

749. Very little is done?——(Mr. *Agnew.*) May I just tell you what our Regional bulk purchasing has resulted in? It only started a year and a half ago. We started in textiles—sheets, blankets and the like. The saving on textiles per annum we reckoned to be £6,967. Then we started on drugs. That saving is estimated to be £18,000.

750. Out of a total expenditure of how much?——(Mr. *Gibbon.*) It is related to the contract figures.

751. I was just wondering what the percentage was?——Certain drug accounts amount, over the Region as a whole, to £73,701, and we estimate that if the drug contract were not running and the Hospital Management Committees were still buying independently, the cost would be another £18,136 for the same amount of goods.

752. Another £18,000?——Yes. (Mr. *Agnew.*) If you take X-ray envelopes, the saving there is £1,204. It is not much, but it all helps. We are now thinking of starting on the Regional purchasing of paint and electric light bulbs.

753. What about provisions—tinned goods and so on?——(Mr. *Gibbon.*) We have not got that far yet. We are only developing this scheme.

754. Would it be possible to let us have a short paper on your contracts scheme? (Mr. *Agnew.*) Certainly.* There is one point I must make about this. Regional bulk purchasing cannot be done unless you have the goodwill and the complete co-operation of your H.M.C.s.

755. It has to be done, I take it, purely by their voluntary agreement? You cannot impose it?——No, and the particularly difficult one was when we came to drugs, because the people at H.M.C. level responsible for this are the supply officers.

756. Who are they?——They are a senior grade of officer with an H.M.C. I forget quite where in the scale they come; I think they are number 3.

757. They are appointed by the H.M.C.?——Yes.

758. Do they have any qualifications? ——(Mr. *Gibbon.*) They have no qualifications. They are appointed by the H.M.C. and they are, of course, in a very responsible post.

759. You do not have a veto of that —your advice is not asked?——No.

760. Have you any complaint of the calibre of your supply officers?——(Mr. *Agnew.*) No.

* * * *

I think many of our H.M.C. Chairmen are really beginning to wonder whether the supply officers are really necessary or whether one, instead of doing one group, could not do two or three groups. That is a thing I think we shall have to go into.

764. Or, possibly, the whole Region? ——I should think it is too big. It goes from Crewe to Kendal. It is a day's journey to get up and down. The point I was making about this group Regional buying is that the co-operation of those people is essential. If it is not given, the scheme will not work at all. The difficulty comes when you start on drugs, because not only have you the supply officers, but the pharmacists as well. Each works in his own little groove, and each is very jealous of the other. Before we could get our drugs group going, I had to have a talk with the supply officers and the pharmacists.

765. It has to be done by private treaty?——Entirely. This scheme which we have started and feel is working very well is not the slightest use unless there is complete cooperation between the Board and the H.M.C.s.

766. What support did you have from the Ministry of Health in the initiation of this scheme?——We did not ask. Obviously, it is the thing to do if you can do it.

767. They never suggested it?——(Mr. *Gibbon.*) It is not quite fair to say that. The Ministry, in a general way, were urging Boards to promote any schemes which would result in the purchase of commodities at a cheaper price. This was the scheme we worked out in Manchester and its great asset is that it has all the virtues and advantages of a centrally controlled scheme without any

* App. 8, p. 391.

Regional machinery controlling it. No new appointments have been made ; not a single junior clerk has been appointed to work this.

Mr. *Holt.*

768. I would just like to put two or three points. In starting this, what criteria influence you in choosing what to buy Regionally? You mentioned textiles and drugs. Why did you pick those? Is it a question of the standardisation of the textiles ; are the sheets the same?——I think I could give a simple answer as to why we picked textiles first. Linked up with the question of bulk purchases was also the question of the marking of textiles to minimise pilfering. The two things were taken up together. It seemed convenient, as we were working out a scheme for the pooling of the textile requirements of the Region, that we might be able to combine with it, in view of the enlarged orders, a scheme for working-in a device which would identify all textiles like sheets and blankets ; and, indeed, that proved highly successful eventually, although there was much heartburning about what form that identification device should take. But eventually a simple device of an unostentatious green stripe was woven into the sheets and the blankets and all the other textiles to identify them as Hospital property.

769. Has it resulted in a very great change in the sources of supply?——You are not buying from the same people from whom the H.M.C.s were buying before? Are you buying from one firm instead of a number?——You mean, has it brought in a number of new sources of supply with whom we did not previously deal?

770. Has it resulted in a bulk purchase from one firm? Lancashire in particular is a mixture of very big combines and a lot of small firms. Has it resulted in any alteration of the trade? Is it something which may have hit a lot of small firms?——(Mr. *Agnew.*) I cannot answer that question. (Mr. *Gibbon.*) I would say the answer is no.

*Chairman.*

771. Some of these questions will be answered in your Paper?——(Mr. *Agnew.*) I do not think we have dealt with that particular point.

*Chairman.*] I think that is a matter which must be ignored. The Committee must view this from the point of view of economy.

Mr. *Holt.*

772. It is an extremely important point involving, possibly, the setting up of monopolies. The third point I would ask is this. Are you really sure that, over a period of years, you have in fact made a saving? You may have actually bought a sheet at a lower price——?——(Mr. *Gibbon.*) At a better specification, yes.

773. At a better specification, and you may have reduced your pilfering?——Yes.

774. Because you have marked sheets ; but are there any other advantages which perhaps have been lost? I would suggest that you cannot answer that now, but if we are having a paper perhaps something might be put into it?——We will bear that in mind when preparing the paper.

Mrs. *Hill.*

775. Are you able to secure all your supplies at one price, or is there any variation in price? Would a Hospital Management Committee have to make the choice of one or two different contracts which you have made because you cannot get all your supplies at one specific price?——(Mr. *Agnew.*) That information can be given in the paper. (Mr. *Gibbon.*) I do not think I quite understood Mrs. Hill's question.

776. My point is this, can you buy for a whole Region in just the same way as you buy nationally? Can you get all your supplies at one price or would you have to have different contractors, who may have different prices?——Do you mean for the same article?

777. Yes, for the same article?——Well, I cannot answer that off hand.*

Vice-Admiral *Hughes Hallett.*

778. Did I understand you to say it is the intention to move forward into the realm of bulk purchase of food?——I said we have not got that far.

779. What is in your mind for the future?——(Mr. *Agnew.*) Much smaller

* *Note by the witness :* The answer is " no."

things. As I said, the main things are things like electric light bulbs and paint, but I do not think we are ready to tackle such a vast problem as food.

Sir *Henry D'Avigdor-Goldsmid.*

780. I am afraid you will find this a rather minor point, but on this question of objective tests of efficiency, if one of your Hospital Management Committees, when putting in estimates, allows so much for a loss on running a canteen, say, would you consider that is reflected on their efficiency?——Oh, yes, undoubtedly.

781. You would regard that as a small objective test in efficiency?——(Mr. *Jones.*) We did have a report that there was a loss on an out-patient canteen, and the Finance Committee of the Board asked the Management Committee to raise its prices in order to cover its losses. The canteen could not be run at a loss to the Exchequer.

*Chairman.*

782. Which they did?——Which they did.

Vice-Admiral *Hughes Hallett.*

783. I have been puzzling over one of your answers when you said you did not think that doctors, as such, had any influence on the economy or otherwise with which the whole Service is run. Surely, in practice, it is the doctor who decides, first of all, whether or not a patient goes to hospital, and when he has to come out again. It is the doctor who prescribes the drugs and decides on the form of treatment. I would have thought that in the last analysis it is on the attitude of the medical profession to this question of economy that the whole problem of whether the Health Service is going to go on getting more expensive ultimately turns?——(Mr. *Agnew.*) I thought you meant as to whether medical gentlemen showed the keenest interest in the question of Hospital expenditure.

784. You do not conceive that it is the doctors?——Yes, it is the doctors. May I give you an example: We noticed this year that drugs are again going up, new drugs are being brought in. We estimate this year that the purchase of new kinds of drugs will cost us £94,000 extra.

*Chairman.*

785. How do you account for that?——A new drug is now costing 382s. 6d. for a thousand units, against an old drug for the same purpose which cost 15s. per thousand units.

786. Which drug is that?——I have not got the name.

787. We would not recognise it anyway?——I did not put the name down because I could not pronounce it!

Vice-Admiral *Hughes Hallett.*

788. The question I wanted to lead on to is this. What in your experience is the attitude of the doctors as a whole towards the importance of conducting the whole thing with great economy; in other words, is the fact that Dr. Marshall pays a very proper regard to economy the exception, or the rule?——No, I will tell you exactly what we did about a month ago when we received this startling news about the cost of these drugs. Obviously, we lay people cannot do anything about it. If a doctor wants to prescribe a certain drug, I am not the person to say he is not to. What we did, was to refer the matter to the Board's Medical Advisory Panel, which is the highest medical set-up in the Board, and we told the Panel what these figures were and asked them to advise the Board as to what they could do about it. I think the only thing is for the consultants to instruct their juniors not always to give these expensive drugs. But in that case, the Medical Advisory Panel did not throw it back and say "We shall do nothing about it". I hope they are going to do something about it, because they are the only people who can.

*Chairman.*

789. They are a Sub-Committee of the Regional Board, are they?——They are a Committee appointed by the Board; they are entirely medical people.

790. It is a matter of conscience as to whether or not they play ball with you in urging economy upon the doctors?——Yes, but I have not the slightest doubt that they will.

Vice-Admiral *Hughes Hallett.*

791. In your capacity as Chairman of the Teaching Hospitals, are the young

medical students taught anything about the cost of the Service? Is the need to run economically urged upon them?——I am being told "No" by the Non-Teaching Hospital staff, and I have not got my Teaching Hospital staff here. (Dr. *Marshall.*) It is not part of the training of a doctor.

792. That is a very important point, if I may say so: it is not part of the training?——(Mr. *Agnew.*) You did ask, can Manchester give a lead in any other way. There are just two other things which we are doing which I can put very shortly. One is the cost of advertising. We noticed that our H.M.C.s—and I do not blame them—were putting in advertisements week after week.

793. For staff?——For the same staff. (Mr. *Gibbon.*) Nursing staff in particular. (Mr. *Agnew.*) Yes, sisters or student nurses. The amount of money being spent was getting very high. We said to the H.M.C.s: "It is no good going on week after week and getting no replies." We limited the amount of advertising by H.M.C.s and they took it extraordinarily well.

*Chairman.*

794. Again, by voluntary persuasion?——Yes; we limited our H.M.C.s. They may put in two initial advertisements. If they do not bring in any replies, they can put in two more. If they do not succeed, they are limited to one a month. Whether or not other Regional Boards do that, I cannot say.

795. You reckon that saved quite a lot?——This is only a rough estimate, but we think the saving would be between £5,000 and £7,000 a year.

796. In the Region?——Yes. Finally, another thing which we do which saves money is the adoption of standards, in new theatres and so on. I do not mean that there is uniformity of cost, but we have brought in a uniformity of standards of material. We do not see why in building a new theatre, one theatre should be so very much bigger than another or should be higher than another. We do not want them all exactly the same over the Region, but we do feel that there should be a certain amount of standardisation, both in nurses' homes and furniture and so on; and that is what we have done.

797. If you did not do that, each H.M.C. would specify of its own sweet will?——I do not say each H.M.C. would. If it is a new capital project it is under the Board, but the private architects who are designing it might have a very free hand indeed. Although this is not a standardisation of cost, it does give us some idea of what a new theatre should cost.

798. What officer handles it?——The architect. We have a fully qualified architect, with three or four assistants under him.

799. He is part of your technical staff?——Yes.

800. He again is your own appointment?——Yes.

801. Does every Regional Board have its tame architect?——The smaller ones might not, but I believe the majority do.

Mr. *Holt.*

802. He does not build?——No, Sir. It is not true to say the Board's technical staff do not do any Regional designing work, because they do; but to a large extent, the bigger jobs are let out to private architects.

803. What influence would your architect have had on the new operating theatre recently built in Bolton?——A very large one. He would discuss the plans with the private architect from the very word "go".

804. And he uses his influence to obtain some standardisation?——Yes, entirely. He would tell the private architect "At the theatre at so and so which the Board approved, the rooms are so and so. Why are you having these rooms so and so. You must cut them down."

Vice-Admiral *Hughes Hallett.*

805. With regard to your maintenance in the Region, when we were hearing evidence from the Ministry of Health, they told us that they thought, in round figures, one third of the money spent on maintenance was money in respect of work let to contract, and the remainder was spent in wages of permanently maintained maintenance staff and on materials used by them. In your Region, may I ask whether those percentages are so, and whether you find it more or less

economical to go to contract?——(Mr. *Jones.*) The salaries and wages of staff engaged on the maintenance of buildings, plant, etc., in the Manchester Region last year amounted to nearly £800,000. The amount spent on materials and contract work was £1,000,000; so actually it would appear that we are spending probably 60 per cent. or more on direct work, as against contract work, as normally, there is a proportion between materials and staff which is something varying between 30 and 40 per cent. and 60 and 70 per cent.

806. Have you any views as to whether that is desirable or not, as to whether you might not achieve economy by going more for contract work?——That is a matter which has been concerning our Board. The Chairman might like to speak on this—(Mr. *Agnew.*) I do not think I can speak on that. There are so many things involved. You mean, from the Board angle, would it be cheaper for us to put all our work out to contract with private architects and consultant engineers?

807. I was thinking more of maintenance?——Of course, we do know there are some H.M.C.s which have a first class maintenance staff governed by a first class chief engineer. In those cases, I think it would be a pity to abolish that staff and bring in private contractors. On the other hand, I think it is quite likely that there are H.M.C.s which have not got a satisfactory maintenance staff. I think it all boils down to the same thing: it depends on the person in charge.—(Mr. *Jones.*) The Board have tested through their Management Committees the odd direct works job as against a private contractor, and where that has been found cheaper they have had the work done by direct labour. Equally, it sometimes follows that the staff of the H.M.C. is not large enough or capable enough to do the project they have in mind, and they must go out to contract. I think the answer is according to circumstances.

808. I only have one final question. I do not know if it would be in order to suggest that it should not be answered now. No doubt you have read the recommendations and conclusions in the Guillebaud Report on the Hospital Service, and I would be interested to know whether you have any comment on the general tenor of them?——(Mr. *Agnew.*) Do you want me to answer that now?

*Chairman.*

809. I do not think it is quite fair to expect you to answer that now?——It is a very big problem.

Vice-Admiral *Hughes Hallett.*

810. I was suggesting something in writing?——Yes, certainly.*

*Chairman.*

811. You have interested us very much, and I fear that we may be asking you to come again?——That is quite all right, Sir.

*Chairman.*] Thank you.

* Not reported.

TUESDAY, 26TH FEBRUARY, 1957.

Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | Captain Waterhouse. |
| Vice-Admiral Hughes Hallett. | |

**Extracts from a Memorandum submitted by the Oxford Regional Hospital Board.**

(1) *Description of Region*

The Oxford region is largely rural in character and has no large urban conurbations. It comprises 3,763 square miles and consists of the whole of the counties of Oxfordshire and Northamptonshire, the greater parts of the counties of Berkshire and Buckinghamshire, and substantial parts of the counties of Gloucestershire and Wiltshire. There are three County Boroughs (Oxford, Northampton and Reading) and a number of Municipal Boroughs, of which the most important are Aylesbury, Banbury, Cirencester, High Wycombe, Kettering, Newbury and Swindon The population of the region at mid-1955 was 1,503,400.

Oxford itself, the administrative centre of the region, is some 28 miles from Reading, 41 miles from Northampton, 23 from Aylesbury, 26 from High Wycombe and 30 from Swindon. Only Kettering, in the north-east, is more than 50 miles away. From Kettering to Pewsey in the south-west of the region is approximately 100 miles and this is the region's longest axis; that from Moreton-in-Marsh in the north-west to Chalfont St. Peter in the south-east is under 70 miles. Throughout the region, at distances of about 5 to 15 miles from the larger towns are many other towns such as Abingdon and Wokingham (Berkshire) and Henley-on-Thames and Chipping Norton (Oxon) with populations of from 3,000 to 20,000, and a somewhat denser belt of similar towns (including Wellingborough with 28,000) running diagonally across Northamptonshire, in the iron-ore area. In the north-west of that county there is the new town of Corby, which has grown up in recent years round the steel works of Messrs. Stewarts & Lloyds, from a population of about 11,000 to one of 25,000 and is to grow still further to about 40,000 within the next few years: while in north Buckinghamshire the population of the small railway junction town of Bletchley is scheduled to grow from 9,000 to 35,000 in a similar period of time.

The principal general hospitals of the region are in Reading and Northampton, those in Oxford being part of the Teaching Hospital Group and not, therefore, under the Regional Board's administration. From the point of view of the Regional Hospital Board this separation of the authority for the central care of service hospitals in the region is not without its disadvantages.

The acute services at Reading are distributed between two main hospitals with some medical beds in part of an infectious diseases hospital: those at Northampton are concentrated in one, with some support from an infectious diseases hospital.

Aylesbury has three hospitals, of which one, the former Ministry of Pensions Hospital at Stoke Mandeville, has within it a large, internationally known spinal injuries centre, as well as a number of regional services.

Elsewhere in the region the building has just begun of a new hospital at Swindon to replace unsatisfactory and inadequate existing ones, and considerable development schemes are being planned for Kettering and High Wycombe. For the rest, the pattern is one of a mixture of hospitals of various kinds and sizes, from small cottage hospitals (of which there are many, especially in Berkshire and Oxfordshire) and somewhat larger ex-voluntary hospitals such as those at Banbury, Cirencester and Newbury, to former Public Assistance Institutions which have for the most

part been considerably up-graded. In addition, there are some specialist hospitals, including the Nuffield Orthopaedic Centre at Oxford, three chest hospitals (one at Peppard, Oxon, and two in Northamptonshire) and several mental and mental deficiency hospitals with various associated premises.

Public transport within the region is not uniformly good. Some parts of it, especially in the Northampton-Nene-Valley-Kettering area, are well served, but large areas are connected with their principal towns only by very infrequent bus services. Although the road links between the several towns in the region and the regional centre at Oxford are good, public transport connections are, on the whole, indifferent ; indeed in some cases they are non-existent. The only fast rail connections are between Reading and Oxford. This inadequacy of public transport raises some special problems, especially in growing towns like Bletchley (already referred to) which has no hospital of its own and relies for the most part on hospitals 17 miles away in Aylesbury, and to a lesser extent on Northampton, which is even further away. It may be noted also that some parts of Berkshire and Buckinghamshire are to a large extent dormitories for London, with which they have excellent rail connections. Because of this many residents in these areas used to look to London for their hospital services, but they do so to a rapidly decreasing extent as the services within the region are developed.

In order to give a more detailed picture of the region and its hospital services the following document is attached :—

(i) a Commentary on the Annual Statistics by the Board's Senior Administrative Medical Officer.

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NOTE ON THE STATISTICAL TABLES FOR THE YEAR 1955.

BY THE SENIOR ADMINISTRATIVE MEDICAL OFFICER, OXFORD REGIONAL HOSPITAL BOARD.

The volume of work throughout the area as a whole continues at a high level. The fall in the waiting list which was noticeable in the second half of the year 1954 has continued, though there are still large numbers of patients awaiting treatment.

The number of new out-patients continues to be high, though there has been a fall from the peak of the second quarter of 1954.

There has been little change in the number of staffed beds, and the discharges and deaths remain high.

As will be seen from the report, there is room for improvement in the turnover interval at some hospitals. The pressure at Kettering General Hospital is still great. With a small decrease in the number of beds, the number of discharges and deaths rose by 10 per cent., having risen by 15 per cent. in the year 1954. The total volume of work as represented by discharges and deaths in some of the other hospitals has shown a slight fall.

Attendances at casualty departments show a general increase. Not all the patients attending these departments are casualties. Patients who attend without a doctor's letter are seen in the casualty department in the first instance.

*United Oxford Hospitals*

The work at this hospital is really the responsibility of the Board of Governors but, as the Board will know, we prepare the statistics for the Board of Governors and we are interested in the work which is undertaken, since although it is a teaching hospital it provides the only service for the City of Oxford and its surrounds. I have not been able to confirm that the U.O.H. does more work than any other hospital in the country but there can be few hospitals that have a higher turnover rate and pass more patients through their beds.

*Regional Position*

We have only 65 per cent. acute beds in general medicine and 75 per cent. in general surgery, and of all kinds of beds only 83 per cent. of the average number of acute beds for England and Wales in 1953.

It is true that we have 12 per cent. more chronic, convalescent and tuberculosis beds than the average number for other Regions, but the evidence is that we make very good use of these chronic and convalescent beds if we are to judge by turnover.

The turnover figures in general medicine in this Region in 1955 were nearly 18, whereas in the country as a whole for 1954 they were just over 14.

In general surgery cases the turnover was 29 per bed, whereas that for England and Wales was just over 23·5.

In gynaecology 33·6 as opposed to 27·7.

In E.N.T. 58 as opposed to 48.

In chronic sick institutions 2·4 as opposed to 1·9.

The corollary of this is that the duration of stay of patients in hospitals in the Oxford Region is a good deal shorter than the average duration of stay for England and Wales as a whole. For instance, in general medicine our average duration of stay is approximately 17 as opposed to approximately 23 days.

In our chronic sick institutions our average duration of stay is some 40 days less per patient than it is for chronic sick patients taking the country as a whole. As the Board will know, taking the position as a whole we are generously supplied with chronic sick beds, particularly in the County of Northampton, though there are shortages in Swindon and High Wycombe. Even though we are more generously supplied with beds our turnover per bed is greater by about 25 per cent. than the average for England and Wales.

In quoting all these figures for England and Wales as a whole the Oxford figures are included, so that the position is slightly better than I am making it.

Our tuberculosis beds are a good deal less in numbers per thousand of the population than the country as a whole—44 to 70. It must be admitted that we are a relatively rural population and the problem in this Region has been a good deal less than in some of the black spots in the industrial north. In 1950 when I came to this Region one of my first tasks was to organise beds in infectious disease hospitals and arrange for them to receive tuberculosis cases. The tuberculosis problem in this Region now is such that there is relatively little difficulty in securing hospitalisation of patients.

On maternity provision we are reasonably well equipped, having the same number of beds as the country as a whole. The percentage occupancy of some of our general practitioner institutions is relatively low, but this appears to be inevitable when the number of beds is small. The average duration of stay in maternity hospitals now is 11 or 12 days—this is rather longer than a little time ago when the birth rate was higher and the pressure on accommodation greater.

The picture so far painted is a reasonably cheerful one, but there are some problems before us. The surgical waiting lists in places like Northampton and Reading are relatively high in relation to the resources available. The gynaecological waiting lists are high too in relation to the number of discharges that take place from beds at any given period.

We are taking special steps in Northampton to provide additional surgical beds, which it is hoped will make some inroad on the surgical waiting list. The Board will also be considering what it can do for the Reading area.

Stoke Mandeville Hospital has proved of enormous benefit in dealing with some of the long surgical waiting lists and has helped out at Oxford, Reading and Northampton. The fall in the waiting list at Northampton from nearly 1,500 to approximately 1,100 is in part due to the ability of the Stoke Mandeville Hospital

to take on some of the surgical work of other areas. It is hoped that increases in provision in Kettering and Reading will also help to lower the gynaecological waiting lists.

*Mental Health*

We have many less beds for the treatment of patients suffering from mental illness than the average for the country as a whole, our provision being only 80 per cent. of the average for England and Wales. The Board will remember that we made a case out to the Minister for special consideration on this account, This has led to our having new building projects at St. Crispin, Littlemore and Fair Mile. Our position so far as beds for mental defectives are concerned is rather less than the average for England and Wales but does not compare so unfavourably.

For the year 1955 the picture has again been one of overcrowding and the position shows no substantial improvement over the year 1954, but the opening of the two new Admission Units at Fair Mile and Littlemore and the two additional villas at St. Crispin has allowed some improvement.

On the mental deficiency side our hope is for continued improvement as more and more beds are brought into use at Bradwell Grove.

*Medical Staff*

As has been mentioned earlier, the total number of medical staff shows little change from the previous year. The total volume of work appears to have continued at a high level. The members who attended the Special Board meeting will remember that the papers circulated, showed that the Oxford Region was second highest in costliness of its senior medical staff.

It seems quite clear that if the number of discharges per bed in this Region exceeds the average for England and Wales, we might come out a good deal better under this particular heading if we used another method of comparison, say the cost per patient treated. At the moment we are working on figures showing the cost per patient treated in this Region compared with other Regions, but we are not sufficiently advanced to be able to quote figures today. More work has got to be done before these figures can be quoted. Such figures as I have seen, however, do lead me to believe in many instances that our relatively high costs on the medical and nursing staff side may be justified by the turnover of patients.

(2) *A brief description of the methods by which you implement your financial responsibilities with special reference to steps taken to ensure maximum economy by the Hospital Management Committees in using their current account allocations.*

The Board's financial responsibilities fall under two main headings:—

(i) expenditure on services administered directly by the Board—on revenue account approximately £1,000,000 p.a., and on capital account approximately £800,000 p.a., and

(ii) supervision of the expenditure incurred by Hospital Management Committees on the running of hospitals—approximately £8,000,000 p.a.

In regard to (i) the Board exercises its financial control through its Finance Committee acting through the Treasurer, whose responsibilities are laid down in Statutory Instrument 1948, No. 1414, supplemented by a number of Ministry circulars.

Approximately three-quarters of the Board's own expenditure of £1,000,000 is on the salaries and travelling expenses of medical staff. This expenditure is watched very carefully at all stages. The Board's Regional Medical Establishment Committee give careful consideration to medical staff appointments of all grades and advises the Board thereon. A decision, for instance, to appoint an additional

consultant is taken only after the most careful review of the needs of the particular area of the region, not only by the above-named Committee but also by the Joint Medical Advisory Committee and its appropriate specialist sub-committee. Recommendations are then made which in turn receive careful scrutiny by the Board's Executive and Finance Committees.

The increased expenditure under the heading of central administration reflects an increase in the Board's architectural department, and is referred to in more detail in the answer to Question 8.

The Blood Transfusion and Mass Radiography Services were, at the Board's own request, recently investigated in some detail by the Ministry's Organisation and Methods Division and certain of the Organisation and Methods team's recommendations have been implemented.

Under the heading of contractual arrangements the increase represents not only an increase in active costs per patient at the various institutions but also an expansion of the numbers of patients covered by these contracts.

The arrangements for (ii) are as follows:—

(*a*) Prior to the commencement of the financial year, the revenue allocation for each Management Committee is determined by the Board, on the information supplied by the Treasurer who has previously discussed the detailed make-up of the figures with the individual Finance Officers. Broadly his proposals are related to the actual expenditure of each Committee in the previous full year, including the salaries and wages of staff actually in post and the rate of expenditure in the current year so far as that is known, after making adjustments for any extra-ordinary and non-recurring items and so far as possible (within the limited sum made available by the Minister, the implementation of Board policy for uplifting standards, e.g. at mental hospitals). Two questions are addressed to all Management Committees—why is more money required next year than this, and what economies are possible in the present rate of expenditure? Each sub-head of expenditure is examined in detail, and further, where overall hospital costs are high, Management Committees are encouraged to meet their proposals for developments from savings in one direction or another.

(*b*) In making their initial allocations to Management Committees the Board, as has been said above, aim at covering the cost of maintaining the services as they exist at the end of a particular financial year. The service, however, is not static: it is continually being expanded to meet the growing demands upon it and it is also undergoing gradual improvement. Notwithstanding that such improvements and developments may have been approved in advance by the Board, the cost of implementing them is not contained within the initial allocation. Instead, the Board make supplementary allocations as these improvements and developments materialise, and find the money from two sources, viz. (*a*) from the amount allocated under this heading by the Ministry, which is usually considerably less than the total of such items included in the forecast estimates; and (*b*) from savings obtained by reducing the initial allocations to Management Committees. In effect this means that the bulk of improvements and developments are financed, not from additional sums advanced by the Ministry, but out of savings under other heads.

As regards nurse recruitment, the Board do retain a small reserve out of which they make supplementary allocations to Management Committees later in the year to meet the cost of extra nurses recruited during the year in excess of the numbers provided for in the initial allocation. In most years the amount retained as a reserve for this purpose has been more than adequate: but in the current year 1956–57 it was barely adequate and there are indications that nurse recruitment may be proceeding at a faster pace than present financial resources allow.

In the early years of the service the Board retained a larger "general purpose" reserve, to be allocated to Management Committees during the year as the Board saw how expenditure was going. This practice was discontinued, however, as Management Committees knew of the existence of the reserve and there was a tendency not to be unduly anxious if the rate of expenditure appeared to be in excess of estimates. The Board have found that they get better results by placing the fullest confidence in their Management Committees, who are given the largest possible initial allocation, the Board only retaining sufficient to finance additional nurse recruitment and approved developments and improvements on the lines already indicated. The Board do their utmost to estimate needs as closely as possible so as to achieve a fair distribution between Hospital Management Committees, and the latter know that they must live within the limits of their allocation.

(*c*) Throughout the year the Finance Committee of the Board receives from Management Committees monthly returns of expenditure showing the actual out-turn compared with the proportionate part of the approved sum for the year. This information is supplied under the established sub-heads. Any apparent over-spendings under these sub-heads are taken up at once with the Committee.

Apart from the estimates procedure outlined above, the following additional arrangements are in force:—

(*d*) Consideration by the Board of the National Health Service Hospital Costing Returns published annually by the Ministry of Health and the observations thereon submitted by Management Committees at the Board's request. Alongside with this practice which has been in existence for three years, the Board's Finance Committee initiate from time to time *ad hoc* enquiries into such items as the cost of provisions "per person fed", the numbers of staff employed in various departments, and the investigation of drugs expenditure as between hospitals of similar types. Discussions take place with members and officers of Management Committees and at all times the Chairman of the Board maintains the closest contact with Chairmen of Management Committees.

(*e*) Audit reports on Management Committee's accounts sometimes bring to light information which may lead to economies (e.g. losses on farms and gardens), and there is a standing arrangement that all audit reports are considered by the Finance Committee of the Board.

(*f*) Another avenue of approach is the interchange of information with Secretaries and Treasurers of other Boards, which is passed on to Management Committees, and (as stated in the answer to Question (9) in more detail), the Board always endeavour to bring about economies and increased efficiency in the service. The following have already been put into effect:— more efficient heating of hospitals; review of catering arrangements and comparisons with outside firms; the introduction of more economical purchasing methods; the installation of laundry equipment to reduce the use of outside laundries; the setting up of a regional printing service; the installation of a regional accounting bureau; and investigations by the Organisation and Methods Department of the Ministry at the Board's invitation. The Board themselves are constantly taking the initiative in studies aimed at reducing expenditure.

Generally speaking, in view of the statutory relationship between Regional Hospital Boards and Hospital Management Committees, effective control depends on the maintenance of good personal relations between the Board and their officers on the one hand and the Management Committees and their officers on the other.

(3) *A list of the heads under which Hospital Management Committees prepare their estimates*

| | £ |
|---|---|
| Salaries and Wages: | |
| Medical ... ... ... ... ... ... ... ... | |
| Nursing ... ... ... ... ... ... ... ... | |
| Administrative and Clerical ... ... ... ... ... ... | |
| Works and Maintenance: | |
| Gardeners and Stokers ... ... ... ... ... ... | |
| Others ... ... ... ... ... ... ... ... | |
| Other staff ... ... ... ... ... ... ... ... | |
| Provisions ... ... ... ... ... ... ... ... ... | |
| Drugs, Dressings and Medical appliances ... ... ... ... | |
| Fuel, Light, Power, Water and Laundry ... ... ... ... | |
| Maintenance of Buildings ... ... ... ... ... ... ... | |
| Domestic Repairs and Renewals ... ... ... ... ... ... | |
| Other Hospital Expenditure ... ... ... ... ... ... | |
| Central Administration Expenditure ... ... ... ... ... | |
| Total of the above ... ... ... ... ... ... | |
| *Less* Recoveries for Board and Lodging, Trading Services, etc. | |
| Total approved net expenditure ... ... ... ... | |

(4) *Some major developments and improvements in recent years*

| Hospital | Scheme | Additional maintenance expenditure | Comments |
|---|---|---|---|
| | | £ | |
| Stoke Mandeville ... | Burns Unit ... ... ... | 12,100 | The Stoke Mandeville Hospital was a Ministry of Pensions Hospital transferred to the Regional Hospital Board. Many of its wards were empty. It houses the largest Spinal Injuries Unit in the country. An additional ward for spinal injuries has been opened since the Board took the hospital over. The hospital also has a Plastic Unit, but had never previously had a Burns Section. A Burns Ward is now available for cases from the whole Region. A Rheumatism Unit was established in an empty ward after the appointment of a consultant physician, who undertakes research which is supported by the Nuffield Foundation. |
| | Rheumatism Ward ... ... | 10,180 | |
| | Additional Spinal Ward ... | 12,100 | |
| Royal Berkshire ... | Conversion of obstetric accommodation into gynaecological accommodation. | 11,700 | As part of the process of integrating the Royal Berkshire and Battle Hospitals (former voluntary and former Local Authority Hospitals) the obstetric department was moved to the Battle and the obstetric accommodation at the Royal Berkshire converted into additional gynaecological accommodation. |
| Battle ... ... ... | Conversion of Maternity Block | 26,000 | |
| Fair Mile ... ... | Admission Unit ... ... | 22,528 | Fair Mile is a large overcrowded mental hospital, on the outskirts of which the Board have erected a new modern Admission Unit for both sexes, housing about 60 patients. The accommodation provided is of an entirely different kind from that in the old building. |
| Littlemore ... ... | Admission Unit ... ... | 18,000 | Here again a modern Admission Unit is being created near to a 900 bed old type mental hospital. The character of the Unit is entirely different from the hospital which is its parent body. |
| Smith ... ... ... | Adaptation to form M.D. Hospital. | 15,000 | This hospital was a disused infectious diseases hospital which has been brought into use as a hospital for uncertified disturbed mentally defective children. As a rule these children are certified as being mentally defective before being admitted to any institution. This arrangement is experimental and is proving successful. |

| Hospital | Scheme | Additional maintenance expenditure | Comments |
|---|---|---|---|
| | | £ | |
| West Stowell House ... | Adaptation to form M.D. Hospital. | 11,572 | This is a large private house purchased and adapted to form a hospital for mentally defective children, run on similar lines to those of the Smith Hospital. |
| Manfield Orthopaedic ... | Introduction of General Surgical Cases. | 6,978 | This orthopaedic hospital had great difficulty in finding nurses so that several of its wards lay empty. A nearby hospital in the same group, the Northampton General, had long surgical waiting lists. Arrangements were made for the Northampton General to staff, with both medical and nursing personnel, a ward in the Manfield Hospital to deal with cases from their waiting lists. This scheme cost nothing in capital, but entailed additional revenue expenditure. It is achieving its purpose. |
| Bradwell Grove ... | Stage III A ... ... ... | 13,535 | This was an ex-American Army hospital which the Board took over to provide accommodation for mental defectives. The colony for mental defectives at Bromham Park before the appointed day served the county of Northamptonshire but has not done so since as it is in another region. The Board were, therefore, hard-pressed to provide accommodation for defectives, and Bradwell Grove has helped to fill the gap, though it is distant from Northamptonshire. It will house at the end of the next stage 320 patients. |
| | III B ... ... ... | 25,460 | |
| | IV A ... ... ... | | |
| | IV C ... ... ... | 28,775 | |
| St. Margaret's, Swindon | Geriatric Ward ... ... ... | 4,870 | Re-arrangement of the orthopaedic services in this area freed a building which was used as a ward in the E.M.S. days, and which had been used as a physiotherapy department under the Health Service. The re-arrangements allowed this ward to be brought into use to provide additional beds for geriatric patients, much needed in this area where provision is less than 1 bed per thousand of the population. |
| Horton General ... | New Out-patient Department... | 1,000 | Out-patient demands at this hospital had grown so that the very primitive facilities that existed before 1948 were utterly inadequate. A new out-patient department which also houses the almoners has been provided at relatively small additional revenue expenditure. |

| | | | |
|---|---|---|---|
| Mass Radiography Service. | Additional Unit... ... ... | 4,000 | The provision of a third M.M.R. Unit in the Region, more mobile than the previous ones, in that it is entirely independent of village halls, resulted in additional expenditure on staff of £4,000 a year. This, however, was achieved without providing an additional Medical Director. |
| Battle ... ... ... | Male Rehabilitation Ward ... | 4,000 | This is an empty ward brought into use after redecoration and minor adaptations as a rehabilitation ward. The idea behind this is that the patient, having received such medical treatment as is appropriate, is got up and about and brought to such a stage that he can deal with the problems which will exist in his own home. |
| Northampton General... | Ophthalmic Department ... | 5,023 | This is an extension of the existing ophthalmic department from 14 to 17 beds. This ophthalmic department provides the only in-patient accommodation for the whole of the county of Northamptonshire. The opening of additional beds has brought with it some additional costs. |
| St. George's, Wallingford. | Conversion of I.D. Hospital to Maternity Unit. | 16,000 | These premises were used for infectious disease but were in fact nearly empty. They were converted into a 17-bed maternity unit to serve Wallingford and the neighbouring area of Didcot. |

(5) *A description of any significant reductions in current expenditure in recent years*

In a period of expanding services and rising prices it would have been impossible to show significant absolute reductions in expenditure under any heads. On the other hand, it can be claimed that in the Oxford region there has been an important move towards increasing and improving services without any corresponding increase in real cost.

The Board have been devoting considerable attention to the study of the trend of costs in relation to services rendered. As an illustration of this two graphs are attached.

While the illustrations attached are concerned with the factors of major importance, there have at the same time been a series of efforts made to reduce costs under specific heads. The following may be quoted as examples:—

*Salaries—Nursing:*

Re-allocation of spells of duty has achieved the following:—

(*a*) at a mental hospital a reduction of overtime worked by nurses; and

(*b*) at a general hospital the opening of an additional 25 beds without increase of nursing staff.

*Salaries—Other Staff:*

Disposal of surplus land and closing of uneconomical market gardens have reduced staff requirements.

Improvements to boiler house equipment including the installation of mechanical stokers and oil firing.

*Provisions:*

The continuous process of examining "cost per person fed" has led to economies of several thousands of pounds per annum.

*Drugs:*

Improved purchasing arrangements and stricter control of issues following the Board's appeal for economy to medical staff.

*Fuel and Laundry:*

Pipe lagging and improved equipment have resulted in better heating, whilst the installation of washing machines and the setting up of group laundries has done much to reduce reliance on outside contractors and therefore to reduce costs.

*Other expenditure:*

(*a*) Stricter control of the use of hospital transport.

(*b*) Installation of automatic telephone exchanges in place of manual ones.

(6) *What major increases in the staff establishments of Hospital Management Committees have there been in recent years?*

To assist in answering this question the table below shows the total approved manpower figures for all Hospital Management Committees in the Region as at the 5th December, 1952, and as at the 31st December in each subsequent year. Totals are shown in respect of each of the Categories of staff recognised by the Ministry for control of manpower purposes. These are:—

Category B. Junior Medical and Dental.

Category C. Nursing and Midwifery.

Category D. Other staff (excluding Administrative and Clerical).

Administrative and Clerical.

FROZEN TOTAL MANPOWER FIGURES OF THE STAFF OF HOSPITAL MANAGEMENT COMMITTEES FROM 5TH DECEMBER, 1952, TO 30TH SEPTEMBER, 1956

| Category | 5th Dec., 1952 | 31st Dec., 1953 | 31st Dec., 1954 | 31st Dec., 1955 | 30th Sept., 1956 |
|---|---|---|---|---|---|
| (B) | 134 | 136 (129) | 138 (131) | 142 (134) | 143 (133) |
| (C) | 4,778 | 4,873 (4,371) | 5,046 (4,532) | 5,141 (4,605) | 5,217 (4,780) |
| (D) | 5,210 | 5,170 (4,828) | 5,192 (4,774) | 5,247 (4,860) | 5,343 (5,043) |
| Admin. and Clerical | 806 | 800 (783) | 813 (784) | 834 (807) | 854 (825) |

NOTE: (*a*) The figures quoted are expressed in whole-time equivalents and include not only staff in post but also casual vacancies.

(*b*) The figures in brackets represent the whole-time equivalent of staff actually in post; they are not available for 5th December, 1952.

It will be noted that there has been no substantial increase in the number of *Category "B"* staff, such increases as have been approved being attributable either to the opening of new departments or increases in the volume of work.

With regard to *Category "C"*, increases have been mainly due to:—

(i) some improvement in the overall recruitment position leading in some instances to the re-opening of wards which had previously been closed for lack of staff;

(ii) the opening of new units, wards and departments. (These include the Admission Units at Fair Mile and Littlemore Mental Hospitals; Bradwell Grove Hospital and West Stowell House (Mental Defectives); Rivermead (Chronic Sick); the Burns Unit and other wards at Stoke Mandeville; and the Corby Diagnostic Centre).

(It should be emphasised that the complement of nurses in many hospital is still substantially below what can be regarded as adequate.)

Under *Category "D"*, increases have been mainly due to:—

(*a*) improvements in standards of catering at mental hospitals, necessitating the employment of more cooks and kitchen staff;

(*b*) the development of occupational therapy and other services in mental hospitals;

(*c*) Management Committees deciding to undertake more direct works instead of placing work out to contract;

(*d*) the engagement of ward orderlies, porters, domestics and other staff in order to relieve nurses of non-nursing duties;

(*e*) increases in the work of out-patient and ancillary departments, necessitating the appointment of more radiographers, physiotherapists, laboratory technicians, etc.;

(*f*) the provision of physiotherapy, occupational therapy and chiropody services at chronic sick hospitals;

(*g*) the enrolment of Nursing Cadets to undertake specified routine duties at hospitals pending acceptance for nurse training.

The increases in *Administrative and Clerical* staff have been due to increases in the volume of work in various departments. This applies particularly to Finance Departments in order to carry out the Ministry's requirements in regard to financial control and to cope with the work arising from Whitley Council awards, etc. Other main increases have been in staffing out-patient departments (e.g. Records Clerks, and Clinical Stenographers) and for the purpose of relieving other staff (particularly nurses and almoners) of clerical duties.

(7) *An explanation of any significant rises or falls in hospital running costs indicated by the costing returns for your Region in recent years.*

The Board has kept the running costs of its hospitals under constant scrutiny and made use of the National Costing Returns to check up its costs with those of other Regions.

In September, 1956, the Board's Finance Committee undertook a special review and considered the running costs of all hospitals in the Oxford Region over the three financial years ended 31st March, 1956. Because the Board is of the opinon that cost per patient week is not by itself a reliable yardstick, calculations were also made of the "cost per case treated". (For the information of the Select Committee a copy of the statement giving the results of this review is attached.)

It will be appreciated that a number of factors influence the results from year to year, and in particular the Sub-Committee's attention is drawn to col. (3) average percentage occupancy of available beds and col. (6) average length of stay per case, as well as col. (7) total in-patient expenditure. The Committee would be able to extract from this table particulars of special cases in which there have been significant changes in running costs. In order to explain what seem to the Board to be significant illustrative cases we comment on the following:—

*Stoke Mandeville.* It is exceptional, in a period of rising prices, to find a fall in total expenditure, though this did happen at this hospital. The explanation is that in 1953-54 there was a large amount of non-recurring extra-ordinary expenditure on maintenance of buildings.

*Northampton General* and *Kettering* are interesting cases and may be compared. In both cases there has, over the three years, been some improvement in the standards of treatment etc. and in the allocations for maintenance. In Northampton there has been no improvement but rather a slight fall in percentage bed occupancy and in the yearly number of cases treated per bed. The result has been that the cost per case (rising from £24 0s. 10d. to £28 13s. 1d.) has risen about in the same proportion (19 per cent.) as the cost per patient week (rising from £16 14s. 11d. to £20 5s. 0d.) (21 per cent.). In the case of Kettering there has been a marked improvement in percentage occupation and in the number of cases treated per bed. Here the cost per case treated has risen by 9 per cent. (from £24 4s. 7d. to £26 7s. 10d.) while the cost per patient week has risen by 19 per cent. (from £16 18s. 11d. to £20 2s. 9d.).

In the case of the *Royal Berkshire Hospital, Reading,* the Committee may note that there has been a marked rise both in the cost per case and cost per patient week. This, however, illustrates one of the many factors which tend to make comparisons difficult. It so happens that for 1955-56 a different classification was adopted in that 65 beds at the Blagrave hospital (a pre-convalescent unit serving the Royal Berkshire) were taken out of the Royal Berkshire returns.

*Swindon Victoria* is another case which calls for special comment and again illustrates the difficulty of making comparison. Here the number of cases treated has gone up from 2,121 to 3,137, the number of cases treated per bed from 22·8 to 34·9, the cost per case treated has fallen from £37 5s. 9d. to £28 17s. 9d., while the cost per patient week rose from £21 2s. 0d. to £25 13s. 0d. The reason in this case was that all E.N.T. cases in the Swindon area which are short-stay cases, were transferred to the Victoria Hospital. (The reverse happened at the Great Western Hospital, Swindon, from which the cases were transferred.)

Generally speaking, the Board is satisfied that the cost of real work done (which means essentially cost per case treated) has not risen disproportionately to the rise in prices and rates of pay. In some cases it has declined, in a few other cases it has risen, but there have generally been special reasons for this (e.g. Harborough Road).

As throwing further light on the general position, the Board calls attention to the following figures taken from the 1955-56 National Costing Returns which, for the first time, publish figures of cost per case.

| *Acute General Hospitals.* | *Cost per patient week* | *Cost per case* |
|---|---|---|
| *301–900 beds* | £ s. d. | £ s. d. |
| Oxford Regional Average ... ... ... ... | 21 16 11 | 40 4 6 |
| National Average ... ... ... ... ... | 17 17 10 | 41 6 3 |

In making comparisons for this class it must be remembered that about one third of the Oxford beds are in Stoke Mandeville which is quite exceptionally expensive owing to the proportion of paraplegic cases treated. (For this hospital cost per case treated is no less than £89 3s. 2d.)

| | *Cost per patient week* | *Cost per case* |
|---|---|---|
| *101–300 beds* | £ s. d. | £ s. d. |
| Oxford Regional Average ... ... ... ... | 19 9 10 | 35 19 1 |
| National Average ... ... ... ... ... | 18 0 11 | 36 7 1 |
| *51–100 beds* | | |
| Oxford Regional Average ... ... ... ... | 21 1 5 | 34 5 4 |
| National Average ... ... ... ... ... | 18 9 4 | 34 18 0 |
| *Under 50 beds* | | |
| Oxford Regional Average ... ... ... ... | 16 0 6 | 32 10 4 |
| National Average ... ... ... ... ... | 16 1 1 | 31 0 11 |

* * * * * * *

(8) *An explanation of any significant variations in your own central expenses in recent years.*

BOARD'S OWN SERVICES—1950-51 TO 1955-56.

*Central Administration.*

The only significant increase was in 1953-54 when architects' etc. fees were charged to revenue (£31,752). In previous years these had been charged to capital, but the Board's capital allocation was so inadequate, having actually been reduced at a time of rising costs, that the Board in this year decided to charge them to revenue, as had been done for several years in another region. The Ministry, however, requested the Board to revert to the previous procedure, which was done in the next financial year, but in order to make the best use of their inadequate capital resources the Board were obliged to expand their own Architect's Department, and the cost of this is reflected in the expenditure of subsequent years. Expenditure under this head also includes an expansion of the machine room staff to deal with regional punched-card accounting.

*Blood Transfusion Service.*

There has been a steady expansion of the Service and the area served has been extended in the western parts of the region. The number of bottles of blood has steadily increased through the period.

*Mass Radiography.*

In 1953-54, a further unit was formed, making three in all. There has been a continual increase in the number of miniature X-ray photographs taken by the units.

*Medical Staff.*

There has been a steady rise in the cost of medical staff and this can be attributed to five main factors:—(*a*) increase in the number of all grades of staff; (*b*) incidence of salary awards and increments in 1954-55; (*c*) increased number of domiciliary visits; (*d*) the rates of payment for travelling expenses have risen several times and the mileage covered has steadily risen; (*e*) in 1951-52 the Board took over payment of senior registrars and registrars from Hospital Management Committees.

*Contractual Arrangements.*

The increase here is mainly due to higher maintenance charges paid for Board patients in these Institutions and Homes.

(9) *The current operation of the service—efficiency and economy.*

We note the following headings, which we could develop in oral evidence. Efficiency and economy have been our constant study. In the nature of the case we have concentrated chiefly on producing better results and fuller services from the sums of money allotted to us. This has been our obvious need, because there have been so many shortcomings to make good (long waiting lists to be reduced, better distribution of consultant services to be achieved, improvement in conditions, especially in our mental hospitals, etc., etc.).

(i) Efficiency and economy depend on the quality and effort of the human beings employed in the service at all levels down to the very bottom. *We need better quality at many levels.* Therefore we attach great importance to creating a better career structure for hospital administrative staff and better rates of pay for key posts. (Refer to the Guillebaud Committee recommendations.)

(ii) Economy and efficiency depend upon everybody being cost-conscious. We need to spread this cost-consciousness to all ranks, to matrons and nursing staff as well as administrative officers. This means that they ought (*a*) to understand and be interested in the financial position ; (*b*) to feel that they have some responsibility for it ; (*c*) to feel that if they can save money they will get some benefit from it by being able to devote savings to very necessary improvements. For this reason we believe in stimulating joint consultation, and in giving responsibility to House Committees, letting them know their budgets, etc., etc.

(iii) One of the most important concrete possibilities would be to save running expenses by better capital equipment (engineering installations, kitchen equipment and design, labour-saving equipment of all kinds). Many of our buildings are most uneconomical to run, though it may perhaps be too much to expect capital to rebuild ; but shortage of capital has been a great handicap to increasing efficiency and economy.

(iv) Some economies should be possible by greater standardisation of different kinds of equipment (domestic textiles, crockery, hardware, etc.). Standardisation, making it possible to place bulk orders—e.g. to give long runs to textile manufacturers—needs to be handled on a national basis. There is still room for the Ministry to give a constructive lead here, though we recognise they have difficulties in combatting the individualism of different hospital authorities.

(v) In other ways the Ministry might give more helpful guidance. Compare what the Ministry of Education with its building section has been able to do—to reduce the cost of school building.

(vi) In many cases greater efficiency and economy could be achieved if we were allowed to pay more so as to attract first class personnel, such as catering officers, etc.

(vii) In order to keep check on our Hospital Management Committees we need much more accurate knowledge of what a given service *ought* to cost if efficiently run. A very great need is to develop knowledge in this field by better cost accounting, etc.

(viii) We believe that, although conditions for running an industry are quite different from running the hospital service, nevertheless there should be much to be learned from the greatly improving industrial techniques which have been developed during the last ten years. We have been in touch with the Work Study Department of Imperial Chemical Industries and we have plans for a pioneer project for exploring the possibilities under this head.

In considering the current operation of the service and a Regional Board's powers to achieve economies and efficiency, it is important to understand the scope of a Board's authority.

The general tendency of policy in the first years of the service was to limit this scope. The Ministry made it very clear that they retained the power to deal direct

with Hospital Management Committees. The Ministry sent down its own staff review teams to Hospital Management Committees and carried out the audit of their accounts without any reference to Regional Boards. There was a school of thought which took the line that Regional Boards were an unnecessary link—a sort of fifth wheel which might well be dispensed with. (The Select Committee has shown in its previous report that it is well aware of this position.)

The Guillebaud Committee's report has killed this idea, having definitely taken the line of recognising the necessity for the Regional Boards' functions and authority. It still, however, remains true to say that Regional Boards have no power to issue orders to Hospital Management Committees. The Minister of Health, speaking on the Guillebaud Committee's report in the House of Commons on 7th May, 1956, referred to this recognition of Regional Boards' authority and used the following words:—

> "Let me make it quite clear that that recommendation does not mean that Boards in relation to Management Committees, or, for that matter, the Minister in relation to Regional Boards, should seek to put them in a straight-jacket of prior approvals or should require them, in any but the most exceptional and restricted fields, to get authority before taking action within the scope of their proper functions.
>
> The conception is rather one of review—and, if necessary, rebuke—after the event, and not one of reference upwards beforehand in order to get approval."

These words are all right as far as they go but they do not cover the point that there may be occasions when a Regional Board may wish to ensure that certain courses are followed by its Management Committees and, as we have already stated, the Board has, in fact, no powers to take the initiative in issuing definite orders. The result of this is that a Board that wishes a certain policy carried through has to achieve its object by consultation and discussion and personal influence. In the Oxford region our relations with our Hospital Management Committees are on a friendly and co-operative basis, so that we have no reason to complain about the results, though sometimes it takes longer to achieve our aims than we think desirable. The point which we really want to bring out in relation to this state of affairs is that it increases the necessity for having the right people in the various positions— the right Chairmen of Management Committees, the right Chairmen of House Committees and the right officers. Their quality at all levels is of supreme importance. (Illustrations of cases where we have had difficulty in getting what we believe to be the right policy accepted can be given orally.)

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**Examination of Witnesses.**

Sir GEORGE SCHUSTER, K.S.C.I., K.C.M.G., C.B.E., M.C., Chairman, Dr. J. O. F. DAVIES, M.D., D.P.H., Senior Administrative Medical Officer, Mr. GEORGE WATTS, F.H.A., Secretary, Mr. C. R. POOLE, F.I.M.T.A., A.A.C.C.A., Treasurer, and Mr. ALEXANDER BARR, Chief Statistician and Records Officer, Oxford Regional Hospital Board, and Mr. R. W. KELLEY, Principal Regional Officer, Oxford and North-West Metropolitan Regions, Ministry of Health, called in and examined.

*Chairman.*

812. I would like to ask a few questions first of all on the document which you have numbered 9.* Before doing so, as to the constitution of your Board, how many members have you?——(Sir *George Schuster.*) 23.

813. What proportion are business men or people with practical experience in running a big organisation from the financial angle?——That is one of our very great problems. Of course, you know we do not appoint the Board. The Minister appoints the Board. I have had to deal with six different Ministers since I have been Chairman, and some of

* Evidence p. 98.

them have consulted us very carefully, others have not. Your last Minister, and the present one that has just come in, although he had been in only a few days did take account of our recommendations. I am glad that you asked me this question because it really is one of the key questions in the Hospital Service. Our great difficulty, and this applies also to Management Committees, which we appoint, is to find the few people who will do more than just attend ordinary Committee Meetings. I mean to get a good Chairman of a Finance Committee, for example, is important. We were in very great difficulty when I first got on to the Board in finding a Chairman of the Finance Committee, and were lucky in getting an old friend of mine from the I.C.S. He has been an extremely good Chairman of the Finance Committee, but he is not very strong and we are rather worried. I think that we have got the Minister to agree to appoint the senior partner of one of the leading chartered accountants' firms in Oxford whom we have been trying to get for some time, and who has just told us that he thinks that now he is retiring and trying to get away from active work he will be able to give a bit of time to board work, and I am looking to him as a potential Chairman of the Finance Committee.

814. Of your Board's Finance Committee?——Yes. He would really be the only straight-out businessman we have got on the Committee.

815. You would agree, then, that from the point of view of financial efficiency, with which, of course, this Committee is mainly concerned that Regional Board is liable to have great weaknesses in structure?——Not necessarily. There is nothing wrong with the structure. The trouble is to find the people, and, of course, it is one of the points I wanted to put before your Committee. It is relevant to one of the points which we have here. I do not want to be unfair to the Service, but we do suffer—and I think I can speak as one who has had experience in running Government financial machines and business organisations—from an insufficient number of good quality administrative officials which means that what I feel is an unduly heavy weight of responsibility is put upon the voluntary members. We are most dependent on having a good Chairman of the Finance Committee on the Boards, we are most dependent on having good Chairmen on Hospital Management Committees, and we are most dependent on having good Chairmen of House Committees. I know that unless I have got a good Chairman of a House Committee in a big hospital I am going to feel unhappy about the administration, and that is because the quality of the hospital secretary as an administrator, the type of man we are getting at the salary we are allowed to pay now, is not up to the responsibility.

816. As far as the permanent staff is concerned, for instance, Mr. Poole and Mr. Watts, the appointment is entirely in the hands of the Board, is it not?——Yes. I am extremely fortunate in Oxford—we will spare their blushes—but we have got a first-class team and it so happens that Mr. Watts is the only one of the Regional Board Secretaries who had had experience of hospital administration before the Boards were set up.

* * * *

818. In what way do you think the quality of the professional staff could be improved?——That is in the long run. We attach very great importance to the recommendations of the Guillebaud Committee, paragraphs 395 and 396. Paragraph 395 says: "A proper career structure is a matter of the utmost importance for the well-being and efficiency of the Service, but evidence we have received makes it clear that the present position is by no means satisfactory". I think that that is about the most important thing they said, and we have been fighting ever since this Report came out to get this question tackled. The Ministry has now appointed an independent investigator to make recommendations on the grading structure in the Service. We think that there are not enough good prizes at the top, and not enough reasonably well paid posts in the middle grades to make the career of a hospital administrator one which would attract the best kind of graduates, and it is vitally important to improve that. But that is not going to make any immediate improvement. All the posts are filled now, and we have to wait until those people fade away.

26 *February*, 1957.] Sir GEORGE SCHUSTER, [*Continued.*
K.C.S.I., K.C.M.G., C.B.E., M.C., Dr. J. O. F. DAVIES, M.D., D.P.H.,
Mr. GEORGE WATTS, F.H.A., Mr. C. R. POOLE, F.I.M.T.A., A.A.C.C.A.,
Mr. ALEXANDER BARR and Mr. R. W. KELLEY.

819. Have you any recruitment and training scheme in your Region on a regional basis?——Yes. We had started one on a small scale and we have been urging the Ministry to start one on a national scale, and as you probably know they have started one now on a small scale with an intake of 16 every year, but we are still running our own scheme. We have got two trainees we are trying to bring on.

820. Is there a regional pool in your region of staff resources and vacancies? ——(Mr. *Watts.*) I think the question is probably: do we pool all the regional vacancies that occur and try to make the appointments within the region? The answer is No. Each Management Committee is an autonomous body, advertises its own posts, and makes its own appointments, although the Regional Board officers are usually invited to assist in the filling of the senior posts. (Sir *George Schuster.*) May I elaborate? Again you have touched upon a very important point. As you know, we have got no power to give orders to our Management Committees, and in the case of making appointments, in a way they have autonomy. But, as Mr. Watts says, in our case they practically always ask for Mr. Watts, the Administrative Officer, or Mr. Poole, the Finance Officer, to attend their Selection Committee meetings, but they need not take the advice of our officers when they go down, and we have had two cases recently where we have been very unhappy about the appointments. There is always a very strong tendency to appoint the "local boy" and to put the No. 2 into the place of No. 1. We have brought this point up several times with the Ministry and have put up the suggestion that there should be a regularised form of Advisory Appointment Committees for the principal posts in Hospital Management Committees on the same lines as the Advisory Appointments Committees for the appointment of specialists.

821. On a Regional basis?——Well, it could be on a regional basis, but it would be better on a national basis. The Advisory Appointments Committees have to have certain local representatives, certain independent assessors, and so on, and we think that something on those lines should be laid down for the principal appointments in Hospital Management Committees, but the Ministry is very unwilling to do anything to interfere with the autonomy of the Hospital Management Committees.

822. Is it your feeling that it will be a good thing if Regional Boards had some power over Hospital Management Committees other than that of moral suasion and good relations and common sense?——That is a difficult question in a way for us to answer. We have got a very happy position in our Region and have very good relations with our Management Committees, and I would in some ways be sorry to have the position more formalised. I would like Mr. Watts to say something on this. But we do have difficulties. Whether it would work better if we had Boards being able to order or not, I cannot say. The sort of thing where we have difficulties, for example, is that we feel very strongly in our Region and we are very great believers in the process of joint consultation. We think that it is vitally important that before any decision affecting the running of a hospital is taken, the matron should have a chance of having her say. We feel very strongly that there should be some regularised procedure by which a matron is always kept in the picture and able to express her views. That is the sort of point on which there is a great difference of opinion, and some of our Management Committees take the view that they do not want to have matrons present at Management Committee meetings, and so on, and some have even resisted for some time the idea of having a special Nursing Services Committee on which the matron would always be present. That is the sort of case where it has taken us a very long time to move to what we consider to be the desired position. Actually, the very last of our Management Committees which objected to having a Nursing Services Committee has now just decided to have one, because the Chairman has been changed. That is the sort of thing we are up against. Whether we should be better off if we had definite powers to give orders is a matter I feel some doubt over. (Mr. *Watts.*) I do not think that

we can altogether judge by what happens in the Oxford region. We started off in the Oxford region having had an experimental few years under the Nuffield Trust, with people getting together from both sides and getting to know one another, and we did have that great advantage in that people knew one another and worked with one another, and we built on that foundation. We have got, I think, throughout the Region a common bond of friendship and trust between the officers of the Boards and Management Committees, and between the members of the Board and members of the Management Committees, but one from one's experience, it is not universally true throughout the country. It is one of those fences which the Guillebaud Committee refused to take, saying that it could be left to the common sense of the Boards and Management Committees to work out their own salvation. I am not at all sure that that was a really wise recommendation.

Mr. *Robinson.*

823. There is apparently some conflict here between the evidence and the memorandum. Do I gather that generally speaking, Sir George and the Board want to give more responsibility to Hospital Management Committees, or to take some responsibility from them, as in the question of engaging staff, and in that way do they think that they will get increased efficiency at Hospital Management Committee level?——(Sir *George Schuster.*) My first reaction to that is that we are essentially "decentralistic" in my Region. We want to decentralise responsibility as much as possible. We want our Management Committees to do it with their House Committees in the same way. So that if I am asked whether I would want to give less responsibility to Management Committees, I should hate to say I did, but there are certain points, as I said, where we find ourselves in a little bit of a difficulty because we cannot direct them to do things. I do not think that that really entrenches on responsibility seriously. When I said that there ought to be some sort of advisory appointments procedure with Management Committees to see they did not appoint the local boy and ought to have a wider choice, to that extent, perhaps, I am seeking to limit their responsibility.*

Mrs. *Hill.*

824. Your Management Committees, surely, are always able to call on the Regional Board's officers to attend a meeting when they are appointing?——They normally do, yes, but they do not always take their advice. Mr. Poole will tell you of cases where has has attended meetings but the Committee did not take his advice.

*Chairman.*

825. I should like to ask Mr. Poole what he feels about this from the technical angle. You have had, perhaps, difficulty in getting the right policy and so forth, no doubt. Can you give us examples, and your general views from the technical point of view, on the alterations which you would like to see in the system in order to get greater financial efficiency, not only speaking as to the Oxford Board, but speaking from the general point of view?——(Mr. *Poole.*) I would like to emphasise, first of all, that I have very good relationships with the Finance Officers and Management Committees in the Oxford Region, but on the financial side I do feel a little more power would be helpful. For example, with regard to accounting systems. We have got 16 Hospital Management Committees and have probably got 16 different accounting systems going on. Uniformity would be helpful, and would obviously lead to some economy. To take that point a little further, I have got at the Board's offices a Power Samas equipment which cost £7,000. We have got some of the Management Committees taking a part in it and some of them not, partly because their own systems have been got going, and partly because they believe in manual methods or some other methods, but, if our power was a little stronger, we could bring them into the system obviously with some economy.

826. Could you say anything about the appointment of the Finance Officers on the Hospital Management Committees?——Yes. As Sir George says, I have attended two or three meetings

* And see App. 9, p. 392.

where Finance Officers have been appointed, but I have not been asked on every occasion. Sir George was referring to cases where I have been invited and I have suggested that "All things in all I suggest that so and so be appointed, and that so and so be second," but the local boy has been appointed because of pressure of the local group.

827. Do these Finance Officers always, or never, have qualifications?——Sometimes they do, but, generally speaking, it is only in the higher flights where the Management Committees are in 50 points or above—the big groups.

828. What do you mean by 50 points? ——Almost the maximum, the big groups where the number of beds is considerable.

829. You would regard it as highly desirable that Finance Officers should have some form of training, and preferably some qualification?——I regard it as essential not desirable, but only in the top flight groups are the salary scales sufficiently attractive to get the type of man required.

830. Do you put down the difficulty in getting the right sort of man mainly to salaries or mainly to the fact that Hospital Management Committees are not fully seized of the urgent necessity of wise and skilled financial control?—— I think it primarily is a question of salaries, in that there are competing demands from Gas Boards, Electricity Boards, and so on, where salary scales are much more attractive at the top, and therefore really keen people will not come to the Hospital Service. I think that alongside that, perhaps, is the fact that some of the Committee members are not sufficiently alive to the necessity of appointing good chaps into the financial field.

831. You feel that if you had more power at the centre you could make them more alive to it?——Yes, up to a point. There is always the difference between members and officers to consider regarding how far one can go in advising.

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Vice-Admiral *Hughes Hallett.*

832. As I understand it, the staffing of the Hospital Service as a whole is not unlike the staffing of the Government Departments before Mr. Gladstone's reforms and the establishment of a central Civil Service. My question is: what are the arguments against having a central Hospital Service in exactly the same way as it was found desirable 100 years ago to establish a central Civil Service?——(Sir *George Schuster.*) I do not know of any arguments against it. I am chiefly concerned with, and am much more interested in, having a career structure to attract the right kind of chap to come in. That seems to me the key point.

833. Would you be in favour of a national system which would naturally ensure that only fully qualified people come in and give a general career structure throughout the country?——I have not considered the point. Offhand I should say it would be an advantage really. (Mr. *Watts.*) There are hospital administrators who believe in that. I have heard that view expressed in quite unexpected places by men who are secretaries of groups. On the other hand the reverse view is more generally held.* (Mr. *Poole.*) I would like to add this. As a first step to what you have in mind, an interchange of officers between the Ministry of Health and Regional Boards and Management Committees would go some way. For example, we are quite convinced in the field that the stream of circulars from the Ministry, which go to over 100 every year, carry implications involving additional work not always understood at the Ministry end. Then there are individual officers dealing with particular angles, and I feel that an interchange of officers would be helpful on both sides. In that way we should know the Ministry's difficul-

* *Note by the witness*: I should like to add that in a Service such as this, so much depends on mutual regard and trust between an officer and the employing authority (and especially its Chairman) that the Board or Committee ought to choose its own officer; but their choice should be restricted to those qualified by training and experience, which could probably best be achieved by having Advisory Appointments Committees to choose the "short-list" of candidates for interview.

ties in getting allocations from the Treasury, and so on, and they would know our difficulties in living on the limited sums we get.

*Chairman.*

834. Would it be fair to sum up this part of our discussion by saying that you feel that efficiency, and therefore economy, would be greatly helped if there were a judicious extension of your powers over Hospital Management Committees?——(Sir *George Schuster.*) I would put that really as a minor point. I would like to put all my emphasis on what I have said already, creating a career structure which will attract enough of the right kind of people. What we have been saying as to powers would help us to prevent stupid appointments being made, and that is all part of the same process.

835. With regard to your Management Committees, do you find difficulties in avoiding finding suitable chairmen?——I regard it as having been a most important part of my job as Chairman. It does mean taking an awful lot of trouble, going round and picking on people, and then it means sometimes handling very awkward personal problems in getting rid of the men or women you want to get rid of. It is proving very difficult to get enough of the people who will do what I said and take on the jobs which mean more than just attending occasional committee meetings. In my region the majority of our chairmen, I think, are women, and we have got some first class women chairmen, and, of course, it is on the whole easier to find women who can give the time to it than men.

836. Do you feel that it casts, perhaps, an undue burden on the Chairmen of the Region to have to fill these very important appointments, and do you feel it is a weakness of the system that so much must depend on the personality and the ability of the Chairman of the Regional Board?——I do not know that that is for me to answer. I should like to feel a great deal did depend on it. I think it does as a matter of fact. We feel, and I think my colleagues agree with me, that the thing you have to do in this national service is to make it human, and I think the humanity of the service does depend very much on the people who are chairmen of Boards or chairmen of Hospital Management Committees.

837. Of course the bias behind my question was the financial one. I was wondering how you thought the Service could be improved from the point of view of economy and expenditure of public money?——I am not quite sure what you mean. Are you suggesting that if the chairmen were paid it would be easier to get good chairmen or what?

838. No. What I am wondering in my own mind is whether too much that is not only human but is also financial does not depend on the luck and judgment of the Minister in appointing the right Chairman for the Regional Board? ——Well I think it does; of course a great deal depends on the luck or the judgment of the Chairman of the Regional Board in getting hold of the right Chairman of a Hospital Management Commitee. One of the things you have to remember is that you have no sanctions. I had one Management Committee which at one early stage said: "Well, if all you are going to give us for the next year is such and such an amount of money, we refuse to put in our estimates on that basis because it is unrealistic and cannot be done". * * * * One has to deal with a situation like that. Actually we were able to deal with it and not only did they accept our figures, but at the end of the year they were underspent by £16,000. That is the sort of position you have to deal with. On the whole now I would say we in our Region have got very good Chairmen everywhere.

839. You would feel safer if you had some sanctions?——I would, but you cannot ask for the impossible. But I think it is one of the things you have got to remember about this Service, and I think that the miracle is that it has worked as well as it has.

Mr. *Robinson.*

840. You are not suggesting it is entirely the responsibility of the Chairman of the Board to provide Chairmen of Hospital Management Committees. Is it not the collective responsibility of the Board?——Yes, but you know there are

certain things involved. Sometimes you get useful suggestions from members on your Board, but there are certain things which want somebody who can give more or less continuous thought to it who has got to take it on. I have got to rely on my officers to help me enormously in finding such people and so on, but I do not think it is exaggerating to say that at least the initiative on any action with regard to seeking the right kind of people must be taken by the Chairman. There are a lot of awkward situations which you have to handle, as I have said, in getting rid of people you want to get rid of, and so on, which can only be done on a personal basis really.

Vice-Admiral *Hughes Hallett.*

841. In one of your earlier answers I rather gathered you were of opinion that at present an undue amount of financial responsibility falls on the members of the Boards owing to the weakness of some of the officials in the organisation. Was I right in thinking that?——Yes, not only on the Board, but right the way through the Service, and I make that point not because I want to suggest that one cannot find the people, but to emphasise how vitally important it is to improve the career structure to get a better class of people in as administrators. Take one of our hospitals, Stoke Mandeville. It is a very difficult hospital to run because we are dealing with a lot of very high grade specialists and difficult specialities there. It is a 600-bedded hospital. All we can pay the administrator there is on the salary scale of £900 to £1,100. The result of that is that in order to keep the peace there and to see that the whole thing runs smoothly, the Chairman of the House Committee has a very heavy burden and that is the sort of thing I have in mind. Unless we had a really good Chairman of the House Committee at Stoke Mandeville we would have an awful lot of trouble.

842. You yourself put a rhetorical question in one of your replies and raised the possibility of paying the Chairman of the Management Committees. What, in fact, would your attitude be to such a proposition?——I thought the Chairman was suggesting that.

843. As it was raised I would like to know your answer on that please?——As a matter of fact I was discussing it yesterday with the Permanent Secretary of the Ministry of Housing and Local Government who has the idea that it would be a good idea, and who feels that it is a good thing in the New Towns Corporations that the members of a Board are paid. I hate the idea myself. I should be very sorry to see it come in, but I suppose one must recognise that there is some possibility that some sort of moderate payment would make it easier for certain people who have got to earn a bit of money to live to perhaps retire from their business a bit earlier and come in.

*Chairman.*

844. That would require legislation out of our scope, but it is interesting that you have brought that out?——I can only say that I personally hate the idea. I think it is a great thing to have it all voluntary.

Mrs. *Hill.*

845. Would Sir George think that the salary structure is very largely at fault, in as much as we cannot recruit in view of the fact that medical superintendents of hospitals got more before the Hospital Service. Do you think that the difference in the amount to be paid to a hospital secretary in comparison with what a medical superintendent was paid before the Health Service is contributory to our not getting the right type of person for a 600-bedded hospital?——I was thinking more of what a House Governor of one of the old voluntary hospitals got. As I see it, one of the most important problems, of which none of these reports, the Bradbeer Report or the Guillebaud Committee Report, have put forward the final solution, is the overall administrative responsibility for the hospital unit. Apart from the question of whether that should be a lay administrator or a medical administrator, there is the question of the overall administrative responsibility. The hospital secretary on his rate of pay now in these hospitals is not the sort of person who can personally take on that overall responsibility, and the Guillebaud Committee quite rightly in one of the things

we think they have been so right about, say in the next paragraph to the one I have quoted before, "As we have indicated earlier in our Report we believe that the hospital secretary holds one of the key positions in the Service, for it is the unit hospital which spends the money, and it is there that economies must be sought out and applied". We hope that when Sir Noel Hall has completed his career structure investigation he will recommend a structure in which there would be a much larger number of reasonably attractive middle grade posts which might be mainly hospital secretaries' posts. (Mr. *Watts.*) It does not matter whether it was the local authority's method of administration with a medical superintendent or the voluntary hospital type of administration with a House Governor, the point is that they were both able to pay first class salaries, and now we cannot. I believe that is true.

Mr. *Robinson.*

846. Following Sir George's expression of view that someone in overall responsibility is required either at hospital or Hospital Management Committee level, has he in mind somebody who would have control over the engagement of staff in the various departments concerned who would have the authority to say to a head of a department: "You do not need extra staff"?——(Sir *George Schuster.*) Yes.

847. Do you consider that that kind of control in the field of staff is inadequate at the moment at Management Committee level?——I was not thinking so much in terms of control of staff as in terms of looking after the whole of the administration, but I think that the control of staff, of course, is an important point.

848. Particularly staff engagements? ——Yes.

Mrs. *Hill.*

849. Do you fix an establishment for your various groups, that X number of people be appointed to a certain group, and any new appointments have to get your permission?——Yes. You have got on to a very complicated question, the establishment question. When the manpower freeze was introduced in 1952, and there was a sort of frozen establishment for certain grades—I could talk at very great length about this, it has created some confusion with our Management Committees, but perhaps I will let Mr. Watts answer that question. (Mr. *Watts.*) Very briefly, we did do what the Minister asked us to do in 1952. We froze establishments at the figure they then were, plus casual vacancies, and from that date onwards the Management Committees have had to come to us if they wish to vary their establishments from those figures. They have to come to us if they want to add to the figures they then had in any way; they must get our consent.*

*Chairman.*

850. How do you implement your decision?——They ask us formally if they may do this, we investigate and we decide whether they should have that change or not, and usually have to tell them they can have it if they have got the money. The other question is the question of financial control. There are two controls. There is the manpower control and control through the Budget. We feel that the control through the budget is the most effective one. The confusion exists because some Management Committees have felt that provided they did not exceed the manpower controlled figure of 1952 they were all right, and could go on recruiting staff, but in fact, of course, they did not always have the money to do it, because the financial control through the budget meant they had only the money for staff actually in post.

851. In a different part of your Memorandum you say that it is possible to transfer money from the maintenance allocation for improvement and development purposes, and that there is a general transfer of money saved on one item to another?——(Mr. *Poole.*) The primary consideration is that the overall budget for a Management Committee is the maximum they can spend, and they cannot engage staff if they cannot pay for it in the overall sum. But the Oxford Board in order to encourage Manage-

* *Note by the witness*: Regional Hospital Boards have to go to the Ministry for permission to add to or vary their own establishments.

ment Committees to do the best they can with the limited sums made available—and for the 1957-58 period they are really limited sums—we allow them almost automatically to take money which might have been wanted originally for X subhead to Y subhead provided the total sum allocated is not exceeded.

852. That is a very great innovation. It means unlimited power of *virement*. Does not it mean that money is often spent for purposes it was not intended?——No, on the contrary. The amount of money required for the Hospital Service far exceeds the amount available. Every penny that can be made available is really needed. Nothing is bought which is not required.

Sir *Henry D'Avigdor-Goldsmid.*

853. On the question of recruiting the right type of people for the important voluntary positions, does Sir George feel that this decentralisation of financial control is partly an inducement to people of high standing to take an interest in the Service they would not otherwise take if they felt their movements were circumscribed to a greater degree?——(Sir *George Schuster.*) That is a very important point. With regard to the Management Committees, to my mind it is one of the most interesting voluntary jobs you can do, because you can *do* something, we give our Management Committees a very free hand as regards spending their money. But I would like, if I might, now that you have given me a chance, to make one of my own favourite points. I would like to carry on the question you have put to the question of the position of House Committees, because we feel that if you want to get economy you have got to get right down to the hospital unit, and we feel it vitally important to get good House Committees in close touch with their hospitals, and you cannot get good people to serve on House Committees if all the House Committees are able to do is to look after flowers, or gardens, and so on. In the early days of this Service it was laid down from on high that they would not have what they called a three-tier system of administration. Therefore, the House Committee's powers were strictly limited. Personally, I found it rather difficult to understand. After all, if you look at the Army, you have many tiers, from G.H.Q. down to battalions, etc. Why there should be something fundamentally wrong in three tiers I could never see. We have rather taken the law into our own hands, and have encouraged our Management Committees to go as far as they possibly could in delegation of powers to House Committees. Where you have a wide scattered area (I understand you will have Reading Management Committee coming before you later, that will be very interesting if you ask them about this), for example, if you take a place like Newbury where there is a very strong local feeling. They have got a first-class House Committee there now, which really takes an interest in their local hospital, because they have been given some powers. They are told their budget, and can watch how the expenditure goes, and although the Management Committee have the overall responsibility yet the House Committee can be given quite a lot of responsibility. In connection with the point that was put they would tell you, I think, that since we got rid of the Chairman who refused to give any power to House Committees and have introduced this system it has worked like a charm.

854. Would you agree, then, in the absence of a very much strengthened administration that the only way the Hospital Service is going to keep this form of limited responsibility is by continuing to devolve this financial responsibility?——Yes, I think it is vitally important, and it is vitally important to get local interest in this.

*Chairman.*

855. I am interested in Newbury, as I live there. I notice that the Newbury Hospital has a remarkable record in keeping its costs steady. Would you put that down to the degree of devolution which has taken place?——I am sure the Newbury House Committee is doing a very good job.

856. Newbury has as good a record as any of your hospitals in consistency?——Yes.

857. What lessons can be learnt by other hospitals from that?——You prob-

ably know more about Newbury than I do.

858. I have nothing to do with the Hospital Management Committee?——(Mr. *Poole.*) I should think it is partly due to the question of local interest. I think it is also due to the fact that they have been using more beds in Newbury Hospital, the medical side as opposed to the Management Committee side, if I may put it that way.

859. Does it mean that there is a very good Secretary there, for example?——(Mr. *Watts.*) They have a good Secretary there; and there is good co-operation with the Management Committee. I would say in answer to your question that it is probably because they have a local committee which does take a great deal of interest in their local hospitals, and have done increasingly since changes were made there which did give them greater delegated powers. In the early days of the Service they were losing interest. That interest has been recovered and I would say a good deal of that is responsible for their steady cost there.

Mr. *Robinson.*

860. If the cost of the odd hospital has remained steady, could it be that the explanation is that the standard of the service to the patient has not improved—I am not saying that it is due to that in this case, but that might answer it?——It could be, but in Newbury the standard has improved. It may have gone down a bit from the pre-National Health Service days as a voluntary hospital, but that has happened often elsewhere.

Mrs. *Hill.*

861. When you speak of the cost being steady, you see that the cost per in-patient week runs at £19 to £20 per week?——(Mr. *Poole.*) From my point of view the reason that the cost has been steady is that more beds are being used. There have been rising prices, and that is reflected in the total expenditure at Newbury Hospital. The figure went from £58,000 in 1953-54 to £65,000 in 1955-56.

*Chairman.*

862. What steps do you take, or do the Hospital Management take, to bring down the higher cost hospitals?——You mean generally, or particularly?

863. Generally speaking. Is it just the result of an improvement of the efficiency of the Hospital Management Committee, or due to steps taken by the Regional Board?——(Sir *George Schuster.*) I think perhaps I had better deal with this. One of our difficulties is to get down to detail, because it is the Management Committee's responsibility, but what happens in these cases where on our analysis of the figures any hospital seems to be going the wrong way, or is unduly high, we are constantly rubbing the noses of our Management Committees into these cost statements. Our great effort is to make them understand their own cost structure, and watch it carefully.

864. Does Mr. Poole do that, or do you?——Mr. Poole does a tremendous lot of it through the Finance Officers. He has very close contact with all the Finance Officers. Sometimes we have to ask Management Committees to come up and talk to either us personally or to my Chairman's Executive Committee. Just now we are going to go through a process of seeing all our Management Committees in this way because our allocation in 1957-58 is going to make us so frightfully tight that we have got to look around everywhere for chances of saving money, and we are now going to send round to our Management Committees a sort of general appreciation of their position, calling their attention to a number of things we have dealt with in this Paper.

865. Do you have a sort of inquiry into a certain hospital's running?——We have had several very elaborate inquiries.

866. Into a specific hospital, or group?——Into a specific hospital, not, if I may say so, critical inquiries because we thought the costs were high, but inquiries in which they collaborated in order to understand just what was affecting costs. There was a firm of consultants on hospital administration, Goddard and Livock. Mr. Goddard has done a lot of investigations for the Nuffield Trust; he is on our Board. We employed that firm to do most elaborate investigations on two of our hospitals, which has helped a great deal to make

people understand where the money goes and what affects the expenditure. (Mr. *Poole.*) In regard to the individual discussions that take place with Finance Officers in an endeavour to cut down the costs of hospitals, one might mention costs per person fed, which is one of the costs given in the booklet. It is true to say that at one Hospital the cost has been brought down from 30s. to 25s. per person fed in spite of rising prices, and that has been due in large degree to comparisons of costs produced for each hospital in the Oxford Region.

867. Are you hampered by the accountancy system which you refer to? ——Not in the production of these figures.

Vice-Admiral *Hughes Hallett.*

868. I think you said, Mr. Poole, that the money available for the Hospital Service was nothing like what it really required?——Yes.

869. Is that a universal view of those in the Service?——I think, Sir, that for 1957-58 it would be a universal view.

870. So long as it is a view, is it not rather difficult to get economy?——Yes, in a sense it is. Nevertheless there are certain avenues available to get economy, for example, with the 30s. a week going out on food. Individual hospitals might be satisfied that 30s. is not unreasonable, but when they compare their figures with hospitals of the same type they can see that 27s. 6d. or 25s. is obtainable.

871. In the first sentence of (ii) of the paper number 9* occurs the remark that economy and efficiency depends on everybody being cost conscious. What I would like to ask is, do you find that the doctors themselves, and particularly the new ones now emerging from training, are cost conscious? Are they taught about the finance of the National Service, do they understand the importance of it?——(Sir *George Schuster.*) Doctors vary. Some are cost conscious and some are very much the reverse. (Dr. *Davies.*) We do plug away at it, at the daily business of cost, just as Mr. Poole keeps plugging at the cost of feeding and circulates to all Hospital Management Committees the costs of all, so do we also act as another spur and circulate to every clinician the turnover and work done.

*Chairman.*

872. What does a clinician mean in that context?——Every doctor.

Vice-Admiral *Hughes Hallett.*

873. Do you think enough is taught to the students when they are first learning about the need for economy?—— My first answer to that is I do not know, but I would be very surprised if it was.

Mr. *Robinson.*

874. Could I ask Dr. Davies what practical steps the doctors can take to reduce the cost of drugs?——Well, in the main our attitude to that kind of thing is to make the people who are using the drugs themselves determine their own priorities, and, within a given sum which may not be exceeded for which they ask, for them to determine the drugs they will not buy.

*Chairman.*

875. In the hospital or group, or what? ——In the Hospital Management Committee as a whole.

Mr. *Robinson.*

876. You are not suggesting that it is possible to interfere with the doctor's right to prescribe what he thinks fit for his patient?——No. indeed, I am not, but you can present the situation to every Hospital Management Committee, whose task is to hand the job on to their Medical Advisory Group, and they are told themselves the sum that can be allocated for this year when one determines the priorities, and it is idle to pretend that there are no priorities. So long as the people on the ground have the task of determining what they want, so long as that responsibility is fairly and squarely placed on them, I think they measure up to it.

877. You try and put the responsibility collectively on the Medical Staff Committee of the hospital rather than on the individual doctors for their own prescriptions?——Yes. As a group they exert more pressure on the individual than the individual will exert on himself.

878. But if you have a considerable increase in the drug bill of an individual

* Evidence p. 98.

Hospital Management Committee, you do know that you have to meet it, do you not?——Yes, but it is always a good question to ask what the interesting reason is that this increase has occurred. (Sir *George Schuster.*) This is one of the headings we are always watching, as we are always watching the heading of the cost of persons fed. May I say something with regard to the general financial position? I think that something possibly the Treasurer said may have created a misleading impression. We have never been in a position where we need not worry about money, but I would not say that until this year we had been in the position of not having enough money to carry on (except as regards capital expenditure; there there is a false economy—we could have saved money). On the whole, the fact that we have been tight has been very good for people; I would not complain about it. But we are worried about the situation this year. Let me give you the sort of problem we are up against now. When we put in our estimate, our basic figure is based on the Service as it is and the bodies that are in position in the various posts, on November in the current year, corrected by estimates to carry it on to 31st March. Then, in addition to that we have to submit under an additional head the extra expenditure we shall incur next year by having to pay for twelve months for various services started during the year which have already been running perhaps for three months or so. Under that heading this year, the figure we put in, which was simply the full year's cost of things we had started, was £255,000, and the Ministry's sum which they have allotted to us to cover that figure is £62,000. That sort of thing is going to put us into very grave difficulties. As regards new developments, the things that are going to come into play next year, they have cut us down from something like £289,000 to £40,000. We do feel now that we are really up against it, and we have got to consider whether there are quite unpleasant things we might have to do, reducing services, and so on, in order to get by. We do not yet know the answer. We have got to thrash this out with our Management Committees between now and the end of March.

*Chairman.*

879. You refer in your Memorandum Number 2 to giving the largest possible initial allocation. How does that square up with the tightness? It says: "the largest possible initial allocation, not giving back a reserve". That is your policy as a Board, is it not?——When I first came on to the Board, there was a practice of keeping back a sort of Regional reserve to have something up your sleeve in case estimates went wrong, and we found that was demoralising, because people felt that the Board had something up its sleeve and thought all they had to do was to ask us to find the money. As a general principle now we find it better to allocate up to the hilt.

880. Other Regions find the opposite policy is best?——(Mr. *Poole.*) Do they? I do not know. Do I understand correctly that other Regions are able to hold back considerable reserves?

881. I am quoting from another Region when it says that it operates a system of Regional reserves. They say: "They have two virtues. First they enable the Board, acting from a Regional standpoint, to apply expenditure in the directions which they consider will produce the maximum advantage; secondly, by limiting the initial allocations to Hospital Management Committees to the amounts necessary to meet essential needs, good housekeeping is stimulated"?——I do not think there is any difference between the Regions. We all keep back a Regional reserve. The other Boards may keep back a little more, but we have found it is better to let Management Committees know where they stand at the beginning of the year, except for developments of the Service which are to take place, where we hold back the money until the developments take place. (Sir *George Schuster.*) Except for new developments and for possible additional nurse recruitment we practically keep no Regional reserves. For nursing recruitment, that was the one thing where we felt it was so uncertain as to what would happen, we thought it was an economy to keep a small Regional reserve.*

* And see App. 9, p. 393.

882. What do you think about standardisation, central purchasing, and what do you think about the role of Supplies Officers? Do you think it would be an advantage to increase central purchasing a good deal on a Regional basis?——We are not an awfully good Board in a way to answer that question, because we have not done I think as much as some other Boards have about central purchasing. I will ask Mr. Watts to tell you about this. He has been specialising on it recently. But I would like to refer to one thing we said in our Memorandum. I do still think that there is room for economy in some ways on a national basis. I go back to my experiences as chairman of the Working Party on the cotton industry. It was astonishing then to realise the vast number of different sizes of sheets, pillow cases and towels being ordered, and I should have thought there is still room for the Ministry to take that up and give long runs to textile manufacturers. There is room for economy on domestic textiles. That is one thing. Then, when you come down to other kinds of articles, we have been going through an interesting experiment in the Oxford Region.

883. Before Mr. Watts answers, I was thinking of this. Why is there not central purchasing of linen and also of certain provisions and various other things? Is it because there is resistance by Supplies Officers? Do the Supplies Officers fulfil a reasonable function? Is there any great room for economy there?——How much room for economy there is I do not know. I think that the Ministry has been rather reluctant to do too much because of the individualism of Regional Boards, and so on, just as we find that when you come down to such things as crockery, and so on, we are up against the individualism of matrons and Supplies Officers. You have got to try to get this done on an appropriate basis for each article. (Mr. *Watts.*) Before I come to figures, might I suggest to the Chairman and the Committee that they might find some very useful answers to this question from the Committee of the Central Health Service Council, which has been sitting for some time on this very question and which I believe will be reporting very shortly. They have gone into it in great detail. As far as the Oxford Region is concerned, it is true that we have not hitherto done too much about for instance joint group purchasing, let alone Regional purchasing. We have not been convinced that there were any substantial economies to be found in that direction in a Region so scattered as ours. We have, as we have said, in our Region no great urban conglomerations. Our main hospitals are thirty or forty miles apart. Their units are scattered and the probability is that you would increase your transport costs even if you were able to buy at lower prices. We have recently had a Committee of Regional Board Officers and Management Committee Officers sitting, of which I have been Chairman, where we have been carrying out an investigation into a selected list of objects including blankets, sheets, pillow cases, tumblers, knives and forks, cups and saucers, articles in every day use, and we have found that by and large prices that are being paid in the Oxford Region by most Management Committee Boards compare fairly favourably, at least reasonably well, with those Regions where joint group purchasing is practised. We asked those Regions to let us have prices and samples and specifications to compare with our own, and we had a meeting where we had all the commodities on the table, at which we went into the thing in the greatest of detail. We found a need to put our own house in order rather than to go in for any extension of group purchasing. We did find that if our Management Committees could exchange information about how prices were comparing with the same articles, it was a great help. For tumblers, we found that whereas one Management Committee had evolved a first class article which was, I will not say unbreakable but a toughened tumbler, at about £5 10s. 0d. per gross, two Management Committees were paying about £9 for what we thought was an inferior article, and one was paying £14 11s. 0d. for something worse still. We thought that if the Supplies Officers could get together and compare the goods they were buying, the prices they were paying and do that more frequently, they would do far more good at this stage than by going into joint contracts, and that they are going to do.

We are extending our enquiries to another series of articles in common use, and I think we shall achieve some substantial economies. We have been trying recently to extend this to drugs. We have been told of certain Regions where Regional contracts have recently been placed where all the Supplies Officers and pharmacists in the region have got together and have achieved quite substantial savings. We have made enquiries and find that the prices some of our Management Committees are paying are at least as favourable as those paid where contracts are placed Regionally. So we have not yet finally found any evidence that joint group purchasing, that is to say getting neighbouring groups of Committees to enter into joint contracts, has anything to contribute in any large way to our Region. But we do think we can improve on this over present methods.

884. With regard to the tumblers, that was surely a very cogent argument in favour of some form of central purchasing?——They will be able to achieve the same result as if it were central purchasing.

885. What will that mean?——They will meet monthly and compare prices of commodities and put into practice what they have learned from their colleagues.

886. Surely everything you say would apply with even greater force to a regional purchasing scheme, would it not?——We have not found that to be so.

887. Are you satisfied with the Supplies Officers? It is not a highly paid post, is it?——It is the third one in the heirarchy of the Management Committee. There is a Group Secretary, the Chief Financial Officer, and the Group Supplies Officer, where they have got one. Not all Committees have a Supplies Officer designated as such, but all the larger ones have, and every Committee has to have some officer responsible for purchasing.

888. Have you had any complaints about the correctness of behaviour of Supplies Officers?——No, we have not. We may have varied opinions about their qualifications and ability. You realise that probably the bulk of the work of a Supplies Officer may not be in actually purchasing the goods, but in looking after and issuing them.

889. He is the quarter-master?——Yes. What we did find was an astonishing number of sizes of blankets and pillow-cases and sheets and towels. Every Committee seemed to be buying different sizes, and even three or four different sizes of the main lines of blankets and sheets, and we think a good deal of standardisation of sizes and some form of arranging longer runs by the manufacturer would be likely to bring about substantial economies.

890. Is that not an argument for a regional scheme?——That is, yes.

891. What about provisions, with regard, for instance, to certain tinned goods?——We have no evidence at all. I was also chairman of a committee of the Institute of Hospital Administrators who investigated the whole question. We had no evidence to show any substantial economy could come about by regional purchasing of tinned foods.

892. We have evidence from another regional board, not about tinned foods but about other things to the effect that regional purchasing schemes, as far as they have embarked on them, have saved a good deal of money?——We know of that particular region. We have got information from them to help us. They were good enough to send us their specifications—if you refer to Manchester?

893. Yes?——They were good enough to send us samples and specifications. We did find we were buying probably as well as Manchester, bearing in mind the difference in the two regions. You have there an area where your transport is not a difficulty such as it is in the Oxford region.

894. And they had a particular knowledge of textiles?——Yes.

Mrs. *Hill.*

895. Would you say that transport is a natural handicap from your point of view as to the question of supplies?——Yes. If you take a group of hospitals 17 or 18 miles away from each other, scattered around as satellites of the main hospital, we would say transport is almost the governing factor.

Captain *Waterhouse.*

896. The point you are putting is that standardisation is undoubtedly good, but bulk purchase is doubtful, is that right? ——(Mr. *Poole.*) For a central store, yes. (Sir *George Schuster.*) Might I say something on that. What I feel is different sort of principles apply to different kinds of articles. I do feel that on the whole range of domestic textiles I should have thought that is the sort of thing that ought to be tackled nationally and on those lines, where you can go to manufacturers and give them really long runs of that kind of thing. You might then effect very substantial savings. There are other things where the same sort of principle does not apply.

897. Have you in mind national specifications or national purchases?—— National specifications.

*Chairman.*

898. What is there to prevent—you may be absolutely right in saying it would be advisable to have it on a national basis. You gave textiles as an example. Do not those same arguments also apply to regional bulk purchases? Why do you insist it must be on a national and not on a regional basis?——First of all, I must say that I have not really been into this yet, but why I say it must be on a national basis for certain articles is because I realise what happens when you are dealing with textile manufacturers. Take Marks and Spencers, for example, who, after elaborate research decided to concentrate on two different qualities of shirting, gave those orders to a particular firm in Manchester, got them to give them 40 per cent. of their turnover and thus got them "out of the red" (this was before the war when the textile industry was in a bad way). On that kind of thing there is an enormous saving in getting long runs, and you are certain to get really long runs if the whole of the hospital domestic textile requirements are handled nationally, and there is no reason why they should not be as to sheets and pillow-cases, and that sort of thing. When you come to tumblers, crockery and tea services you get the question of individual tastes, but for towels, pillow-cases, sheets, blankets, there ought to be, I should say, standardisation, and I should have thought there would be room for some considerable savings.

Captain *Waterhouse.*

899. Sir George is saying standard of specification, not necessarily of purchase? ——They have to be bulk orders, otherwise you would not get advantage.

900. If you had your standard specification would you not be bound to get your bulk orders?——No. You have to tell the fellow "You can run off so many million yards on one run".

*Chairman.*

901. If he knew that every hospital would have the same tumbler or the same sort of pillow-case it would be worth the manufacturer's while to put in a machine to make that same sort of tumbler or pillow-case for everyone? Even though a national standard of purchase might be the optimum, I should have thought there was still room for rationalisation in the region?——There is room for rationalisation in regions in certain things, but it seems that here you have one class of local requirements in very large quantities where there is no reason why there should be difference between the tastes of different hospitals, and so it would be of advantage to handle it on a national basis.

Vice-Admiral *Hughes Hallett.*

902. As I understand Sir George's point, it is that the supplies for the hospitals should be organised on lines more comparable to those of the army; is that what you mean?——I was speaking entirely in terms of things like domestic textiles, but I am sorry to have got drawn into this to such a great extent, because as I said at the beginning I felt this question of standardising and group purchase was one of the things in which our region has not actually taken a lead—I think you would agree with that, Mr. Watts? (Mr. *Watts.*) Yes, I do.

*Chairman.*

903. I was going to ask you about transport. Are you responsible for hospital transport services?——No, Sir; that is the Management Committees' responsibility—is the reference to their own inter-hospital transport?

904. I mean when individuals get taken to and from hospitals?——That is local authorities' responsibility.

905. Is there any room for centralisation of laundry and maintenance services?——(Mr. *Poole.*) Yes, Sir; the answer is quite definitely that we have been doing something in the Oxford region in regard to centralised laundries. For example in Banbury at the present time it is being made possible to take in all the hospitals into this—previously it has been sent out to local laundries and we are achieving fairly substantial economies.

906. You think there is a good deal more room for that, do you?——We are finding out as we go along. There probably is more room.

907. In all these matters, including standardisation of bulk purchase, laundry centralisation, do you find resistance from Management Committees?——Not on a matter of laundries, no. (Mr. *Watts.*) The governing factor has been finance. With so many demands on limited financial resources we have not had enough money to provide equipment which can do this job.

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908. To go back to the tumblers, was there resistance?——No. As soon as they realised what the position was the Supplies Officers themselves said: "This is something we have got to deal with."

909. One other little detail on which Manchester told us they saved a lot of money, a good many thousand pounds, was in regard to the central control of advertising for medical and nursing staff. Have you considered that at all?——Yes, we have. We do, as do all the Boards, have a regional block advertisement in the nursing papers for nurses, and no Management Committee is normally allowed by Ministry direction to advertise outside that block for its nurses. We do not exercise any detailed control over the number of advertisements that a Management Committee may insert. We try to achieve economy by guiding them and bringing to their notice the desirability of doing these things. I happen to know what Manchester have been doing. They have been doing quite a lot of good work in this direction for some years. We have not gone about it in the same way as Manchester, but have tried to apply the Manchester lessons by giving guidance to our Committees, leaving them to effect their own economies in their own way.

910. We are not trying to set one region against another. We are just comparing?——I realise that but I am very conscious of what has been done in other regions.

Vice-Admiral *Hughes Hallett.*

911. May I ask one question with regard to Mr. Watts and his knowledge of hospitals before the war? How do you reckon the costs measured, shall we say, per in-patient per week compare today in terms of real values with the costs of the hospitals before the war?——The difficulty is one of making any comparisons at all there, because one of the large elements in the cost of hospitals today is the cost of medical salaries, and in the kind of hospital with which I was concerned before the war they did not pay their doctors at all; they gave their services. Today you do pay them, and that is one thing. Another is that in those days we paid our staff nurses £60 a year, and exploited our probationer nurses by paying £18 to £20 a year. Today you do not do that. It is difficult to make a comparison with a hospital like the Norfolk and Norwich, where I used to be, where we prided ourselves on running our hospital on about £2 15s. 0d. a week.

912. Leaving out the reasons, but from the purely financial point of view if you multiply—you say it was £2 15s. 0d. per week?——That sort of figure.

913. That has got to be multiplied by three to bring it into modern money, and it is substantially less, is it?——That would be about £9 or £10 a week, and on top of that you have to add the services you did not find then as well as the services we now pay for, which in those days were given free.

914. The figures in these different tables we have now are in effect bigger than before the war?——Oh, yes.

915. Even allowing for the changed value of money?——Yes, and again developments in the Service account for a considerable part of the increased cost. The hospital of 400 beds might have had two pathologists, shall we say,

and two technicians in the laboratory. Today they might have fourteen of one and sixteen of the other due to medical advances.

*Chairman.*

916. Now that we are on costs, it is noticeable that your costs per case are relatively low, but your costs per in-patient per week are relatively high. Two questions arise from that. How has that situation come about, and why do you think the cost per case is a better basis of comparison than the other?——(Dr. *Davies.*) We think the cost per patient week for better or worse is not really a very satisfactory method of comparison. We think costs per case is perhaps a better method of judging, because it puts us in a very much more favourable light. We have, in fact, got less acute beds than the average, for example, in England and Wales with which to do our job, so if we are going to do our job at all we have got to do it more briskly. That is to say our duration of stay in hospital and turnover and absence of turnover intervals, has to be short if we are to measure up to our tasks. Those things do in fact bring our costs per case downwards, and our cost per case is, as you rightly say, a more favourable picture than it is in other regions. But it is in a way the shortage of beds that is the spur. We have, of course, compared with some other regions, undertaken an enormous increase in turnover. In the case of beds you can call acute or non-chronic, for instance, we have an increase of about 40 per cent.

917. On what?——On 1949. In the group of chronic, and that includes mental, M.D. and T.B., where you might think there was not any substantial room for improvement in 1956, on 1949 we have an increase of practically 80 per cent. In discharges and deaths of all types if you care to regard that as your turnover, the two groups I have been talking about, the acute and chronic, we have an increase of 47 per cent. over the beds we had in 1949. That has not been affected by any enormous increase in beds. We have brought beds into use we had not got staff for, and it is true we had one hospital given to us in the shape of Stoke Mandeville, but there I would remind you that we have a Spinal Injuries Unit with a very long duration of stay, so in a way they are counter-balanced, so the turnover rate in our region is relatively high.

918. What puzzles me is this. I will give you full credit for a high turnover rate. I do not see why that should necessarily be linked with a high cost per in-patient per week?——It is in fact linked in that way. We may well have a higher standard of nursing staffing, say, than some of the regions farther north that have not got such a high turnover.

919. For instance, the acute, 301 to 900, is the highest region in the country?——(Sir *George Schuster.*) That is because one third of that is Stoke Mandeville, which is necessarily a very expensive hospital.

920. Your mental one is a very high cost one* ; your maternity is high, but not very high?——(Dr. *Davies.*) In the early days of the Service the Board took a decision that they would have to do something radically with the mental hospital service, and they set aside a relatively high percentage of their capital on the mental hospital service. Our present Chairman two or three years ago led a deputation to the then Minister and presented him with plans of how the mental hospital service might be developed, and we think we have some credit for the development of the mental health service. It is true our consultant staff in mental hospitals is relatively high. Some of the figures I have been quoting to you may be the result of that better staffing. We have sought to get far away from custodial care in places like mental hospitals and to introduce active treatment. There again we have less than the average number of beds for England and Wales. There again, if we are to do our job we have to push patients through relatively quickly ; we have to get them back home rehabilitated, and probably have to re-admit them if need be, and for that purpose we need better consultant staffing.

* *Note by the witness:* The average mental hospital costs in this Region appears high because one of the hospitals is a highly specialised psychiatric unit, quite different in type from the others in this class.

921. In other words, you do claim there is a direct casual connection between the high cost per week and the quick turnover?——Yes.

Vice-Admiral *Hughes Hallett.*

922. We have had given us by the Ministry of Health comparative costs based on the cost per in-patient per week, and I think I am right in saying we had another table based on 100 beds in the hospitals.* You put the case, which I think we all understand, working it out cost per case. What nobody has yet suggested to us is that there would be any interest in looking at the cost per unit number of population in the region. I would like to ask whether you think a comparison on those lines would have any validity at all, and, if not, why not? ——We have not, in fact, worked it out on that basis.

923. I am asking whether you think such a comparison would be of any interest, or do you think the differences in the standard of health you expect to find in different parts of the kingdom are so great as to invalidate a comparison on those lines?——(Mr. *Poole.*) Might I add here that regions do differ considerably, and if one takes the population basis and divides it into the expenditure of the region one will get diverse results. The South-West Metropolitan Region, which is the biggest Region, has the biggest budget, and its percentage of mental beds is quite high. I think if you divide those figures and then went to Oxford one would get results which would not be cery comparable. (Dr. *Davies.*) May I answer that question now? We did, in fact, two or three years ago try and work out a whole lot of comparable figures for that purpose. (We got all the other regions to supply us with figures, and I see that we worked out the cost per thousand of the population. I think that was the question which was asked?

924. Yes?——But we have not ever made any great use of it. That, in fact, was for the domiciliary service, the Home Care Consultant Service. We did not come out terribly well.

* App. 3, p. 377.

*Chairman.*

925. Your occupancy figures are very slightly below the national average. For instance, with regard to acute hospitals your figures are 79·9 per cent. and I think the national average for non-teaching hospitals is 82 per cent.?—— In what groups of hospital are you quoting?

926. Your table 1*?——(Sir *George Schuster.*) May I say something on this? I am sure how we compare with others, but this question of percentage occupancy is one which I think you want to look at from various points of view. If you are working as we are, trying in many of our hospitals to get a very high turnover rate per day, you obviously cannot achieve the same percentage rate of occupancy as if you were just letting people stay there as long as they like. That is putting it rather crudely.

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929. Can you exert any pressure on Hospital Management Committees to improve their use of beds?——(Dr. *Davies.*) We constantly bring this to their notice. Every quarter we have a quarterly table on which you have got an annual report in these papers. Every quarter if we find that a Hospital Management Committee is in fact showing a low occupancy we write and ask for a reason for it, in the same way as every doctor has a picture of what goes on in all the departments like his throughout the region. Every doctor practising gynaecology has a sheet which gives duration of stay, occupancy turnover——

930. A horizontal comparison?—— Yes, of all the gynaecological departments in the region: all the surgeons have the same, all the physicians, and so on, so we are constantly drawing attention of Management Committees as administrative bodies and of individual clinicians to the state of affairs.

Vice-Admiral *Hughes Hallett.*

931. May I come back to your earlier evidence on this comparison on the basis of the cost per case, which, I will say at once, impressed me very much indeed. You pointed out you had managed to

* Not reported.

26 *February*, 1957.] Sir GEORGE SCHUSTER, K.C.S.I., K.C.M.G., C.B.E., M.C., Dr. J. O. F. DAVIES, M.D., D.P.H., Mr. GEORGE WATTS, F.H.A., Mr. C. R. POOLE, F.I.M.T.A., A.A.C.C.A., Mr. ALEXANDER BARR and Mr. R. W. KELLEY. [*Continued.*

increase, I think you said by 47 per cent. since 1949, but that does give rise to a further question, which is: why has it become necessary to have 47 per cent. more people in the hospital since 1949. What would have happened to those people in 1949: would they have died, or been attended in their homes? What actually has been gained by increasing that?——The conception of the National Health Service with free treatment did, I think, bring forward an enormous hidden demand. The fact that it was now readily available brought people forward demanding treatment the need for which previously must have lain hidden.

*Chairman.*

932. Will it go on increasing?——No, Sir. We have in this annual return a graph which does give you, in fact, the kind of national picture, and the demand in certain specialities is clearly falling. This is a picture of our Regional waiting list which I have here, which, as you see, has begun to fall (*indicating on graph*). Our discharges and deaths, which is our turnover, has gone up pretty steadily. The new patients coming as out-patients have also risen up to a peak, so we think now it will probably fall a little from that, and in a few years time the service will, I think, reach a kind of reasonably steady level. This is an enormous back-log really which has been released.

933. According to these figures,* your new out-patients did increase considerably last year?——Yes, Sir, but they are achieving on the whole a steady level. (Sir *George Schuster.*) It has reached a kind of plateau.

934. You went up from 153,000 to 162,000 last year?——I was talking about the number of new out-patients. We do not really believe our new out-patients are likely to increase to any considerable extent now.

935. They have increased steadily over the last six years. Mr. Barr may have the answer?——(Mr. *Barr.*) The number of new out-patients in consultant clinics has only increased by 20 per cent. and has increased slightly from 1955, but nothing significant.

* Not reported.

Captain *Waterhouse.*] They decreased from 1954-55.

*Chairman.*

936. They then jumped ahead by nearly 10,000?——(Mr. *Watts.*) I wonder to what extent Corby Diagnostic Centre may have affected those figures?

Vice-Admiral *Hughes Hallett.*

937. I wanted to ask whether you had made even an approximate estimate of the utilisation of the service from the point of view of age of the patients. In other words, what sort of proportion of the total expenditure is in respect, shall I say, to old age pensioners as opposed to the working population?——(Dr. *Davies.*) Our only estimates have been proportions of patients over the age of 65 going into geriatric establishments and mental hospitals. We have not carried out any investigation into the number of patients over those ages going into acute hospitals.

938. Would you care from your experience to give a very rough guess as to the answer to that question?——I would have very great difficulty in guessing at that, but it is, of course, a substantial number. I could not say anything more than that.

*Chairman.*

939. Why has there been a rise in the whole-time administrative clerical staff employed by the Board and a similar rise in the number of administrative staff employed by Hospital Management Committees? I am referring to section 6*?——(Mr. *Watts.*) Is the question directed to the administrative and clerical increase?

940. Yes?——Part of that increase has been going on *pari passu* with the increase in the technical and architectural staff. In recent years we have had to do more of our own work. We began with just one architect, putting the whole of the rest of our building work out to private architects. In recent years we have increased our architectural department to two, three or four architects and quantity surveyors, and do more of our own work. That has meant more administrative and clerical staff to do

* Evidence, p. 94

work for the department.* I think on my side and your side, Dr. Davies, there has been no increase for many years, but you have had a few increases, Mr. Poole: you have taken on things like departmental costing and you have had to take on one or two more people. (Mr. *Poole.*) The figures in 1956 will reflect a little increase on the financial side in my own department and in accounting staff of H.M.C.s.

941. I ask that question because it has not happened in other regions. My final question is rather a general one. What do you think can be done to reduce the costs of high cost regions to something nearer the national average?——(Sir *George Schuster.*) Treating us as a high cost region?

942. In some respects, not in all?—— There are so many differences in conditions, you know.

943. I quite realise you cannot be compared with Manchester, the pattern is different?——Yes.

944. I would like your opinion on the main ways in which you think you can reduce your costs?——It all depends on what kind of service you are going to give. I am surprised you have not got on to the cost of our medical salaries, which is very high in our region, but it has grown up really from the desire to give good service, to spread consultant service to our hospitals on the periphery, and so on. I think we in our region are giving good value for the money being spent. I think that the quality of service in certain other regions is not as high as it is in ours. If you want us to get our costs down by reducing quality of service you will be putting a very difficult question to us, because, as a matter of fact, the cost of medical salaries having got into the position where it is, we really cannot reduce because we are under a moral obligation not to terminate any consultant's contract without offering him comparable employment elsewhere. If we could streamline our medical services and get rid of some of our uneconomical contracts where people have a tremendous amount of travelling in relation to the work they do, we could save a lot of money on that but when you come to try to do it you cannot do it. Your general question I find very difficult to answer. One wants to know, when you talk about the high cost region, in what respect is it a high cost region.

945. I can see that it is a very difficult question to answer. Have you anything you want to say to the Committee before we conclude, any particular recommendation you want to make?—— I come back to my first general point, that the rate of expenditure efficiency and economy really depends on the quality of people you have got in the various positions, and we have not got at present the quality I think we ought to have and I think that is the most important thing for improvement. Apart from that, you have not referred to the question of capital expenditure. There is no doubt that if we could have more money, the new centralised laundry plans, and so on——

946. That is outside our order of reference. Your main point, as I gather, is the creation of a real career in the Hospital Service?——I think that is vitally important, yes.

947. Just one thing more, we are fortunate enough to have Mr. Kelley, the Principal Regional Officer. Could he say a word about his duties?——(Mr. *Kelley.*) It is rather difficult to say. The glib answer is that we are regarded as the eyes and ears of the Department and of the Minister. Of course, that is far too glib. I suppose it is right to say that we really set ourselves out to become on such terms with the hospital authorities, the executive councils, local health authorities, and welfare authorities, and so on, that these authorities will come to us for any assistance they may want on particular points or cases, and that similarly if the department wants assistance on a particular point or case we use our good offices to that end. Broadly, I think that is the job, but, of course, it really is what one makes it, as I think is the case in all jobs of that sort. It is not in any way a "tramline" job.

* *Note by the witness:* Also, the amount of capital work for which the Board is responsible has grown from about £200,000 to £500,000 annually.

948. Would you describe yourself as a mixture between a spy and a rich uncle, something like that?——I do not think so, Sir. I think the Boards will agree there are occasions when on a particular case we have been able to grease the wheels.

949. General liaison?——That is it, I think, it is very difficult to say, Sir. I hope, and always have hoped, that I am of use not only to the Regional Boards and to other people, but of similar use to the Department. The trouble, of course, is that we all have to cover far, far too great an area, really.

950. You mean a geographical area? ——Yes, too great a geographical area. For instance, I have to cover right from north of Bedfordshire, through Hertfordshire, Middlesex, and then through to Oxford, Berkshire, and into Hampshire and Dorset, which means that it is very difficult to develop that friendliness, I would like to describe it, with the authorities with whom we have to deal sufficiently and frequently. (Sir *George Schuster.*) May I say something about Mr. Kelley? I would like to say that we find Mr. Kelley extremely useful. I only wish that he was listened to more at his Ministry when he got back. I personally think an officer like Mr. Kelley, coming round and keeping us in touch with the Ministry, is a most valuable feature, but he ought to command considerable authority when he gets back to the Ministry in reporting on the things he sees.

951. You feel his recommendations are sometimes ignored or neglected?—— In a general way I would like to feel that Mr. Kelley had bigger guns at the Ministry than he has now.

Captain *Waterhouse.*

952. Are you only the eyes and ears? Are you also the mouth? Do you give instructions?——No, Sir, we are most definitely precluded from attempting to instruct any of our outside authorities. Indeed, I personally feel the confidence we hope we have built up would be destroyed if we in any case did that. Of course, there are occasions when, if an authority really is doing something we think they have not thought about —not, I may say, this particular Board —we feel then we have to say something to them, but always by permission of the chairman.

953. Do you make a report to the Board at the same time as you make a report to the Ministry?——No, we put in reports when we think it is necessary direct to the regional division of the department concerned.

*Chairman.*

954. Sir George has spoken in section 2 of the Memorandum* of transferring money from the maintenance allocation for Hospital Management Committees to improvement and development purposes. That is what I was referring to before. Is there not a danger that money spent on purposes for which it was not approved?——To which sentence are your referring.

955. In section 2 of the Memorandum you say: "The bulk of improvements are financed not from additional sums advanced by the Ministry but from savings under other heads"? ——(Mr. *Watts.*) We had to finance developments and improvements in that year, something like £150,000 to £180,000, and of that we only got £32,000 from the Ministry. We got £26,000 under one heading, and £6,000 towards developments and improvements, capital works coming to fruition, but our actual developments and improvements in that year to the Service totalled £150,000 or £180,000, something of that order. We only got £32,000 from the Ministry. We were able to finance the rest by keeping back a certain amount by reducing the initial allocations to the Management Committees and issuing it to them as the developments and improvements come to fruition.

956. Does it mean you over-estimated their requirements?——No. (Mr. *Poole.*) No, it does not mean that. Year after year the Ministry on account of national econmy cut back on the amounts we request for running the Service and maintaining developments that have taken place, and we only manage to carry the expenditure because up to a point hospital expenditure is

* Evidence p. 88.

elastic—you can do renewals or defer them, but a point is reached when you cannot defer them any longer. Previously we have done this sort of thing and deferred things, but the point has now been reached when we cannot go on deferring any longer. In my view it is not a good thing to defer maintenance for years. It is dictated by——

957. You do not defer maintenance and transfer the money to other heads? ——(Mr. *Watts.*) I think in this case yes, Sir. Deferring maintenance has been one of the ways in which money has been found to pay for improvements and developments in the Service.*

958. I do not mean this offensively, but to some extent that is getting money under false pretences, is it not?——(Mr. *Poole.*) You have to recognise that more than 60 per cent. of hospital expenditure is on salaries and wages and that is not in this *virement* at all. When one talks about moving the things between headings the amount involved is comparatively very small.

959. It is not quite correct, is it?—— (Sir *George Schuster.*) I do not understand "getting money under false pretences", because we put in for the full amount of our development on which we want to spend money. The Ministry only explain the basis on which they have calculated our allocation. They say "You have put in for £150,000 for development, and we can only give you £30,000 for that", but if we can find money under other heads it is not getting money under false pretences because we have complete powers of *virement* between ourselves and the Ministry.†

960. It is a recognised practice?—— Yes.

Vice-Admiral *Hughes Hallett.*

961. In view of the need for national economy what would be your reaction if a Treasury instruction were to be issued that new services and capital expenditure were for the time being to be restricted to those things which when completed would result in an overall economy?——Well, the Ministry has tried to do that to some extent. They have given us under one special head a class of capital allocation for projects which will result in running economies. I should like to make this point. You naturally are concerned with economies. We are given a certain amount of money from the Ministry; we put up our case and we get less than we put up for. Having got that, our job, as we have interpreted it, is to give the best possible value out of that money, not to save on it. I am being quite frank about that. There are so many things we are wanting to do we are struggling all the time to give the best possible service and to make the best use of the money we get.

962. The thing that worries me is this. I do not quite see what safeguard there is against a regional Board authorising a new service by their *virement* process which in ensuing years is going to run the region into a heavy recurring bill? ——I do not see how that could arise, really. (Dr. *Davies.*) It cannot arise, except in the matter of new construction. (Mr. *Poole.*) Is it capital development you have in mind? For example, Swindon's new hospital is going up. That is a substantial development, and in the fullness of time we shall want some extra revenue to run that big hospital. (Sir *George Schuster.*) That is specifically approved by the Ministry. I think that everything that will involve increasing outgoings has got to be approved by the Ministry.

963. What about new bits of apparatus in an existing hospital, for example?—— (Mr. *Watts.*) You are concerned with the fact that I said we had to finance £150,000 to £180,000 of improvements and developments out of savings, and you are concerned about the possible effect of that in future years, as to where the money is coming from.

964. Yes, precisely?——That becomes part of the budget which is put up to the Ministry at the end of that year on which they base their allocation, the costs of running the Service as they are at the 31st March. (Mr. *Poole.*) The point is that in one year we start certain items up—it need not be capital construction, it may be nurse recruitment which is a thing very topical. We may have obtained a number of nurses in one

* *Note by the witness:* The Board, however, have always spent on maintenance of buildings at least the sum prescribed by the Ministry.

† And see App. 9, pp. 393-4.

26 *February*, 1957.] Sir GEORGE SCHUSTER, [*Continued.*
K.C.S.I., K.C.M.G., C.B.E., M.C., Dr. J. O. F. DAVIES, M.D., D.P.H.,
Mr. GEORGE WATTS, F.H.A., Mr. C. R. POOLE, F.I.M.T.A., A.A.C.C.A.,
Mr. ALEXANDER BARR and Mr. R. W. KELLEY.

year ; on the average we have only got to pay them for six months. We will ask the Ministry for the additional cost in the next succeeding full year, which will in this case be six months more. We shall only get a proportion of that. We are then forced to cut back somewhere to bear it. Up to a point that is all right, but a point has now been reached where we cannot go on along those lines. (Sir *George Schuster.*) I see the point of your question, that it may be that things that are not capital expenditure may involve starting an expensive new service.

965. What is the financial safeguard about that?——(Mr. *Poole.*) Have we not reached a point where we cannot take on any more nurses?—(Sir *George Schuster.*) That is another point. If you really wanted to so organise this set-up that there could be no sort of growth started that was not approved by the Ministry, I think it would be a desperate thing to do, but you would, I suppose, have to increase the scrutiny of the Ministry very considerably. They would have to ask over everything you do, " Is this going to involve an increase in expenditure in the future? " (Mr. *Watts.*) Is not the answer this—that the only safeguard that the Ministry can have is to rely on having appointed responsible persons as chairmen and members of Boards. (Sir *George Schuster.*) I do not regard it as part of my responsibility to resist every improvement. In fact, I say quite frankly that we want to use the money we have got in the best possible way to improve the service.

*Chairman.*] I think it is not only touching this particular Regional Board. I think it is a matter of principle we must pursue further with the Department. Thank you for your evidence.

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## TUESDAY, 5TH MARCH, 1957.

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Members present:

Mr. Nicholson, in the Chair

| | |
|---|---|
| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | Captain Waterhouse. |
| Mr. Holt. | |

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**Extracts from a Memorandum submitted by Reading and District Hospital Management Committee.**

(1) *Description of the Group Area and of the Hospitals therein*

The Reading and District Hospital Management Committee group is the largest in the Oxford Region and geographically consists of the majority of Berkshire (i.e. excluding the Windsor Hospital Management Committee group to the East and the Abingdon/Wantage area to the North) and South Oxfordshire, but the catchment area extends into parts of Hampshire and Buckinghamshire.

Hospitals in the group accommodate acute, chronic, maternity, children's, infectious diseases and tuberculosis and chest cases. There are no mental hospitals or M.D. Institutions. The hospitals in the group are situated in Reading, Henley, Wokingham, Newbury, Cold Ash, Wallingford and Peppard. In addition, there are 56 associated properties used as resident staff quarters or occupied under service tenancy or licence agreements.

Further, the Committee have the use of six general practitioner maternity beds at Chiltern Maternity Home, Reading, under contractual arrangements made by the Regional Hospital Board.

Distances from Reading are as follows:—

| | |
|---|---|
| Henley ... ... ... ... ... ... ... | 9 miles |
| Wokingham ... ... ... ... ... ... ... | 7 miles |
| Newbury ... ... ... ... ... ... ... | 20 miles |
| Cold Ash ... ... ... ... ... ... ... | 17 miles |
| Wallingford ... ... ... ... ... ... ... | 19 miles |
| Peppard ... ... ... ... ... ... ... | 8 miles |

Reading is 30 miles from Oxford.

The Hospital Service provided for the community covers all specialties other than Neurosurgery and Plastic Surgery, such cases being referred to Oxford. The organisation of the Service has been developed on a group basis.

The key unit of the group is the Reading Combined Hospitals comprising the Royal Berkshire, Blagrave, Battle and Prospect Park Hospitals, each with separate specialties. This integration and non duplication of facilities is of note when comparing costs.

The population served is approximately 320,000 but attention is drawn to the rapidly expanding population of Berkshire, particularly in the Wokingham/Bracknell, Aldermaston/Newbury and Wallingford/Harwell areas.

Within the group there are three Local Health Authorities, namely Reading County Borough Council, Berkshire County Council and Oxfordshire County Council, and three Executive Councils, namely Reading, Berkshire and Oxfordshire, each of the latter with their respective Local Medical Committees. Liaison and co-operation with all these partners in the Local Health Service is excellent.

The following Nurse Training Schools are in operation:—

| | |
|---|---|
| General Training ... ... | ... Reading Combined Hospitals. |
| Assistant Nurse Training | ... Henley, Newbury, Wallingford and Wokingham. |
| B.T.A. Certificate Training | ... Peppard. |
| Post Graduate Training... | ... Royal Berkshire Hospital (Ophthalmic) and Peppard (Thoracic Surgery). |

* * * * * *

(2) *Description of the method adopted to implement financial responsibilities, with special reference to steps taken to ensure maximum economy in spending the money allocated to the Committee.*

(*a*) The Committee exercise their financial control through their Finance and General Purposes Sub-Committee who are advised on financial matters by the Finance Officer in accordance with responsibilities laid on him by Statutory Instrument No. 1948/1414, as supplemented from time to time by relevant Ministry circulars.

The Finance and General Purposes Sub-Committee consider recommendations received from two channels which are closely co-ordinated, namely:—

(1) *Standing Sub-Committees of the Hospital Management Committee*

(*a*) Medical Advisory Sub-Committee, with component Area Departments for each specialty, Hospital Planning Sub-Committee and Area Records Sub-Committee.

(*b*) Nursing Sub-Committee and component Senior Nursing Appointments Section.

(*c*) Establishment and Appointments Sub-Committee.

(*d*) The Supplies Section of the Finance and General Purposes Sub-Committee. and

(2) *The seven local House Committees*, and their component medical staff committees, where applicable. The Committee wish to emphasise the importance they attach to the controlled procedure which they have adopted in regard to the responsibilities of House Committees and will emphasise the two-way advantages thus derived in oral evidence if so desired.

(*b*) In all their deliberations, the Committee and their subsidiary sub-committees, including House Committees, are aided by strict *budgetary control*. All are aware of the financial position at monthly intervals when comparative statements of expenditure as against proportionate estimate, prepared by the Finance Officer, under main sub-heads of expenditure for each hospital are examined in detail and no decision is taken without specific reference thereto. An example of this is given in the comparative statement of expenditure for the nine months ended the 31st December, 1956. Knowledge of the financial position is not limited to committees, for all unit secretaries, matrons and departmental heads are similarly informed by means of close personal contact with the Group Secretary and Finance Officer. In turn, these officers at hospital level are aware that full cases of need must be established and priorities assessed before expenditure is authorised by the Committee.

(*c*) Particular attention has been paid in recent years to the re-organisation of the purchase of supplies. A small central supplies department has been established. The main " common user " items are being progressively standardised, group contracting extended and greater stock control exercised, with resultant economies in expenditure and reductions in stock holding. The method adopted can be amplified in oral evidence if required. A recent innovation has been the purchase of provisions by group contract, following the invitation of tenders by public advertisement.

(*d*) No increase in any categories of staff beyond the approved establishment are allowed without prior authority by the Committee. Such authority is not granted without a proved supporting case of need and Regional Hospital Board sanction, and even then is subject to the over-riding availability of monies for the purpose. Numbers of staff in post in the various categories are regularly reviewed.

(*e*) Forward planning is encouraged in respect of large scale maintenance works and replacement of expensive equipment so that specific provision can be made in the forecast revenue estimates and planned over a period of years if necessary.

(*f*) Inventories of equipment have been compiled and are maintained. Internal audit is in operation but its scope was limited by a reduction in the establishment imposed by the Ministry's Administrative and Clerical Staff Review Team. However, with the introduction of circular H.M. (56) 85 the Committee have sought the Board's authority for an increase in that establishment so that all required internal audit can be undertaken.

(*g*) Examination of Hospital Costing Returns are continuously made, and examples of the way in which the Committee have done this are to be found in section (6).

(*h*) Allocations to hospitals and their respective sub-heads of expenditure are initially made in the light of both anticipated requirements and data obtained from the Costing Returns which point to any need for adjustment. A similar procedure is adopted at revised estimate stage.

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(3) *Some of the Major Developments during the years 1951/56*

| *Developments* | | *Additional Maintenance Expenditure* |
|---|---|---|
| The functions of the three main Reading Hospitals, Royal Berkshire, Battle and Prospect Park were integrated, and the changes necessary to effect this fusion, and other developments are shown below. | | |
| *Battle Hospital* | | |
| Adaption to provide consultant obstetric service; Maternity, Ante-natal and Premature Infant Unit. | Originally estimated at ... (i.e. 50 Beds at £10 0s. 0d. per week, per bed) | £26,000 p.a. |
| Beds:—Ante-natal 16. Prem. Unit 16. Maternity 32. | | |

| *Developments* | | *Additional Maintenance Expenditure* |
|---|---|---|
| *Royal Berkshire Hospital* | | |
| Maternity Unit closed and transferred to Battle Hospital (see above). Vacated accommodation altered to provide an addition to the existing gynaecological department. | Re-opening of accommodation for 15 Beds. Originally estimated at ... (i.e. 15 Beds at £15 0s. 0d. per week per bed) | £11,700 p.a. |
| *Prospect Park Hospital* | | |
| Medical Beds provided at Prospect Park to accommodate acute medical cases formerly admitted to Battle Hospital | Originally estimated at ... (i.e. 40 Beds at £10 0s. 0d. per week, per bed) (23 only staffed) | £20,800 p.a. |
| *Battle Hospital* | | |
| Transfer of Accident and Orthopaedic department from Royal Berkshire Hospital | | |
| *Battle Hospital* | | |
| Transfer of Casualty Department from Royal Berkshire Hospital. The vacated accommodation providing an extension to the X-Ray Department at the Royal Berkshire Hospital. | Originally estimated at ... Some Casualty Department Staff transferred from Royal Berkshire Hospital. Additional Staff, etc., required to meet increasing work load. | £1,500 p.a. |
| *Battle Hospital* | | |
| Opening of new Nurses' Home (for 25 nurses) | Originally estimated at ... | £1,000 p.a. |
| *Royal Berkshire Hospital* | | |
| Construction of four out-patient clinics for gynaecology, physiotherapy, otolaryngology and ophthalmology. | Originally estimated at ... | £9,025 p.a. |
| *St. George's Hospital, Wallingford* | | |
| Conversion of Infectious Diseases Hospital to Maternity Unit for 27 Beds (17 only staffed). | Originally estimated at ... (for 27 Beds) (actual exp. 55/56—£16,532). | £21,060 p.a. |
| *Battle Hospital* | | |
| Development of Group Chronic Sick services (based on Battle Hospital) involving additional Physiotherapists, Occupational Therapists, Almoners, etc. | Originally estimated at ... | £5,150 p.a. |
| *Battle Hospital* | | |
| Opening of 10 Beds to rehabilitate Chronic Sick Patients. | Originally estimated at ... (Approx. £8 8s. 0d. per week per bed). | £4,377 p.a. |
| *Royal Berkshire Hospital* | | |
| Extension to Area Pathological Laboratory to meet growing demands on that department. | Originally estimated at ... | £1,806 p.a. |
| *Royal Berkshire Hospital* | | |
| Provision of Dental Services Department | Originally estimated at ... | £1,000 p.a. |

| *Developments* | | *Additional Maintenance Expenditure* |
|---|---|---|
| *Battle Hospital* | | |
| Establishment of Central Chest Clinic. 2 separate Clinics in Reading closed. | Originally estimated at ... Additional Staff required to meet increased workload. | £1,200 p.a. |
| *Newbury District Hospital* | | |
| New Out-Patient Department. | Originally estimated at ... | £1,300 p.a. |
| *Wokingham Hospital* | | |
| Opening 3 additional Maternity Beds. | Originally estimated at ... | £1,302 p.a. |

(4) *Some of the Savings made during the period 1951/56*

| | *Saving* | |
|---|---|---|
| *Royal Berkshire Hospital* | | |
| * Dispensing Optician engaged for Ophthalmology Clinic, resulting in the majority of Out-Patients obtaining their glasses through the Hospital instead of outside opticians. | Approximately £2,000 p.a. | |
| Cost of glasses supplied to Hospital Patients via outside opticians are charged to the Management Committee. | | |
| * Dispensing Optician emigrated for New Zealand, September, 1956, and, so far, we have been unsuccessful in filling this post. | | |
| *Peppard Chest Hospital* | | |
| Following a very full investigation by the Hospital Management Committee of costs, reductions in the numbers of staff employed were made. | Approximately £6,100 p.a. | |
| With the disposal of the Farm further reductions in staff were made. | Approximately £2,500 p.a. | Against this saving there should be offset the loss of Farm produce, approx. £7,400. |
| Saving in other expenditure for Farms and Gardens. | Approximately £5,500 p.a. | |
| *Newbury District Hospital* | | |
| In their endeavours to bring down the costs at this hospital, the Management Committee, with the full co-operation of the House Committee, the Medical and Nursing Staff, re-opened 10 Beds in July, 1956, which had been closed prior to 1948, without engaging additional staff. This will reflect in the 1956/57 costs. | Reduction in cost per patient week. | |
| *Battle Hospital* | | |
| In similar circumstances to those mentioned above, 24 Chronic Sick Beds were re-opened during the period August, 1954, to March, 1955, without the engagement of additional staff. | Reduction in cost per patient week. | |

* * * * * *

(6) *The explanation of significant rises or falls in Hospital running costs indicated by the Costing Returns in recent years.*

The report on hospital costing returns for 1953/54, 1954/55 and 1955/56 are attached.

* * * * * *

*Notes on Hospital Costing Statements* 1955/56 *for Annual Report to the Regional Hospital Board*

**Royal Berkshire Hospital**

*Total Net expenditure* for 1955/56 shows an increase of £46,436 when compared with 1954/55. Wages £21,600 (Wage Awards £14,100); Medical and Surgical Appliances £10,000 (including £7,000 new X-ray apparatus); Drugs etc. £3,300; Fuel, Light and Power £4,200 and Maintenance of Buildings £2,650, represent the major increases.
*Cost per patient week.* 1954/55—£18 14s. 1d. 1955/56—£21 9s. 8d.

Comparison with the previous year's costs has been complicated by the fact that the expenditure in respect of Blagrave Hospital has been separated for costing purposes and is now included as a " Pre Convalescent " unit.

However, for comparison, the cost in 1955/56 of the two hospitals combined would have been £20 0s. 8d., an increase of £1 6s. 7d. per patient week, which is more than accounted for by the extra cost of Salaries and Wages.

In making comparisons with the National Average, it should be borne in mind that the figures are not adjusted for the large Out-Patient Cost in individual categories, and, also, the rate of turnover measured in terms of length of patient stay (Royal Berkshire Hospital 10 days, National Average 16 days) increases above average the cost per week, although it reduces the cost of a patient treated to a conclusion.

| | | | | | |
|---|---|---|---|---|---|
| (*a*) *Running Charges:* | Royal Berkshire Hospital ... ... | £6 | 4s. | 6d. |
| | Northampton ... ... ... ... | £6 | 3s. | 8d. |
| | National Average ... ... ... | £5 | 7s. | 4d. |

The extra-ordinary expenditure of £7,000 for X-ray apparatus if excluded would reduce this cost by 9s. 4d. per patient week.

| | | | | |
|---|---|---|---|---|
| (*b*) *Standing Charges:* | *Gross Salaries and Wages* | | | |
| | Royal Berkshire Hospital ... ... | £21 | 14s. | 2d. |
| | Northampton ... ... ... ... | £18 | 3s. | 2d. |

Medical and Nursing Salaries contribute £2 6s. 0d. towards this difference. Although Works and Maintenance Salaries and Wages are 13s. 6d. per week more than Northampton, this is offset by the category Maintenance of Buildings.

*General*

It is felt that costs do not indicate the necessity for special investigation, at this stage, especially as the cost of treating a patient to a conclusion, £31 7s. 8d., is considerably lower than the National Average £41 6s. 3d.

It should also be noted when looking at costs of a hospital of a similar size and nature, the costs compare reasonably, e.g. Royal Hants and Northampton.

**Newbury District Hospital**

*Total expenditure* for 1955/56 increased by only £757 in spite of wage awards which amounted to £2,358 and extra-ordinary expenditure on the purchase of an operating table and binocular microscope £690.

As promised in the 1954/55 report, the Committee have taken every opportunity within their power to ensure that costs were reduced this year.

The cost per patient week in 1954/55 amounted to £20 1s. 0d. and has been reduced in this year to £19 2s. 6d. The factors responsible for reduction in costs were:—

(1) Increased occupancy (from 78 per cent. to 81 per cent.);

(2) Rigid economy by all concerned to achieve lower costs.

*General*

When taking into consideration the size of the hospital together with the Consultant services provided, the average length of stay (12 days) and the cost of treating a patient to a conclusion, the small difference between this hospital's weekly cost and the National Average is considered reasonable.

**Henley and District War Memorial Hospital**

*Total expenditure* for 1955/56 was increased by only £19 despite increased wage awards amounting to £502 and extra-ordinary maintenance expenditure on ward redecoration amounting to £295; these items together account for 18s. 0d. of the weekly cost.

*Cost per patient week.* 1954/55—£19 4s. 8d. 1955/56—£18 14s. 3d.

The reduction in weekly cost is mainly due to increased in-patient workload. Average occupancy rose from 78 per cent. to 81 per cent.

Although the weekly cost is in excess of the National Average, it is felt that the considerable turnover and low cost of a case treated justifies this.

**Wallingford and District Hospital**

*Total expenditure* increased by £1,734, of which Salaries and Wages accounted for £1,700. The cost of wage awards amounted to £472.

*Cost per patient week.* 1954/55—£17 13s. 8d. 1955/56—£20 17s. 10d.

The increase of £3 4s. 2d. is due to increased Salaries and Wages and reduction in average occupancy. Although the cost per patient is high due to turnover, a considerably lower In-Patient Cost per case is still shown compared with the National Average. Although the increased weekly cost looks formidable, it should be regarded in perspective. This cost represents £2,300, whereas this amount would only equal 3s. 0d. of weekly cost in a large General Hospital.

**Prospect Park Hospital**

*Total expenditure* shows an increase of £3,420 over last year, of which almost £2,000 is in respect of Salaries and Wages (Wage Awards amounted to £1,673). Other main increases were Provisions £291; Drugs and Dressings £207; Fuel, Light and Power £747; Extra-ordinary Maintenance of Buildings £460.

*Cost per patient week.* 1954/55—£16 8s. 1d. 1955/56—£17 5s. 7d.

The increase of 17s. 6d. per patient week over last year is accounted for by Wage Awards and general price increases.

*General*

It is very difficult to find hospitals providing similar services under this type, however, reasonable comparison is made with Cuddington (Banstead), South West Metropolitan Region.

**Townlands Hospital**

*Total expenditure* increased by £7,567, of which £5,197 was in respect of Salaries and Wages (Awards £1,980); £1,191 Fuel, Light and Power; £1,154 Extra-ordinary Maintenance (Wards and Maternity Block). The increase in Wages expenditure over and above awards is due to the fact that previously a proportion of this Total Wages expenditure was charged to the Local Authority in respect of Part III residents.

*Cost per patient week.* 1954/55—£10 15s. 5d. 1955/56—£12 9s. 2d.

National Average £13 4s. 4d.

The increase of £1 13s. 9d. above last year's cost is due to the removal of Part III residents for whom the Local Authority bore a proportion of overheads and Wages, and to the Salaries and Wages Awards.

**Sandleford Hospital**

*Total expenditure* increased by £5,378 almost entirely due to Salaries and Wages £5,174 (Awards £2,000) and Fuel, Light and Power £1,162, adjusted by reductions in other sub-heads.

*Cost per patient week.* 1954/55—£8 13s. 3d. 1955/56—£9 18s. 5d.
National Average £11 8s. 6d.

The cost per patient week is well below National Average.

**Wokingham Hospital**

*Total expenditure* increased by £5,368, of which Salaries and Wages accounted for £3,102 (Awards £2,185); Provisions £1,014; and Fuel, Light and Power £964.

*Cost per patient week.* 1954/55—£7 13s. 5d. 1955/56—£8 15s. 7d.
National Average £7 15s. 9d.

The weekly cost is considered to be reasonable when taking into account that this hospital includes a Maternity Unit of 16 beds and has a small Physiotherapy Department.

**St. Mary's Hospital**

*Total expenditure* increased by £3,662—Salaries and Wages £855 (although awards amounted to £1,826); Fuel, Light and Power £672; Furniture and Furnishings £457; Transport £311; Extra-ordinary Maintenance £577 (Part III).

*Cost per patient week.* 1954/55—£8 3s. 6d. 1955/56—£10 2s. 1d.
National Average £7 18s. 7d.

The reason for the increased cost of £1 18s. 7d. is reduced occupancy, which amounted to a loss of 3,996 patient days (nearly 12 per cent. of the in-patient workload). This was due to lack of nursing staff, which forced the closure of 12 beds during the year. Had the percentage occupancy remained as last year, the cost would have been £8 18s. 0d.; an increase of 14s. 6d. over last year, which could be more than accounted for by Wage Awards and price increases.

It is of interest to note that the total net expenditure (H.M.C.) at this hospital has only increased by £1,000 since 1954 (2½ per cent.) although Wage Awards have cost £2,300.

**St. George's Hospital**

*Total expenditure* increased by £2,319 during the year, of which Salaries and Wages were £936 (Awards £623), Fuel, Light and Power £358, Transport £232 (part cost of new vehicle), Medical and Surgical Appliances £105, Laundry £173, Bedding and Linen £139. When considering this expenditure, it should be borne in mind that the total net expenditure has only increased by £302 since 1953/54.

*Cost per patient week.* 1954/55—£21 6s. 1d. 1955/56—£26 6s. 5d.

Inevitable expenditure following a year when an all out effort had been made to bring down the cost by cutting out every item, together with Wage Awards and price increases; and unfortunately accompanied by a substantial loss of workload, has been the cause of this increase over the previous year. The cost per patient week in 1953/54 was £28 1s. 9d.

The loss of occupancy was due to a certain extent to the restriction of admissions due to an acute shortage of trained Midwifery Staff during the latter part of the year.

Some Staff reductions were made during 1956/57 and Chalmore—the separate Nursing Home—was vacated in January 1957. These measures should reduce expenditure in 1957/58 in the region of £1,000.

Due to shortage of Trained Midwifery Staff the average occupancy is not expected to be improved in 1956/57.

**Peppard Chest Hospital**

*Total Net expenditure* shows an increase of £9,412 over 1954/55. Direct Credits were reduced by £13,062; Wage Awards amounted to £4,800; Fuel, Light and Power was increased by £1,652; and Provisions, Drugs, Maintenance of Buildings, Furniture and

Furnishings, etc., were increased by £3,259 in total. Therefore, although expenditure indicated an increase of £22,773, only £9,412 is the actual increase. This is mainly due to the following savings:—

| | |
|---|---|
| Savings in Salaries and Wages ... ... ... ... | £6,726 |
| ,, ,, Farm and Gardens, etc. ... ... ... ... | £5,671 |
| ,, ,, Medical and Surgical Appliances and Equipment | £703 |
| ,, ,, Transport ... ... ... ... ... ... | £595 |
| | £13,695 |

As Farm produce previously realised £7,384, this must be offset against the above saving, making a net figure of £6,311.

*Cost per patient week.* 1954/55—£15 6s. 5d. 1955/56—£15 18s. 9d.

The increase in cost compared with 1954/55 of 12s. 4d. is considered to be due to Wage Awards £4,800, Fuel and other price increases amounting to £3,349. But for the fact that Direct Credits in connection with the Sale of Farm £5,823, reduced last year's costs, they would have been roughly the same as this year due to the savings made.

**Battle Hospital**

*Total Net expenditure* increased by £17,553, of which £11,849 is accounted for by Salaries and Wages (Awards £9,000); Medical and Surgical Appliances £3,128; Maintenance of Buildings £1,296; Provisions £942.

*Cost per patient week.* 1954/55—£15 10s. 2d. 1955/56—£15 2s. 9d.

Although the expenditure increased to the extent of £17,553, a reduction of 7s. 5d. per patient week was achieved. This was due to the increased workload in patient days rom 87,595 to 96,009 (9·6 per cent.), and Out-Patient attendances from 134,481 to 149,126 (10·89 per cent.).

In view of the Chronic Sick waiting list at the time, and as an effort to reduce the cost per patient week, 24 additional beds were opened without additional staff.

**Cold Ash Children's Hospital**

*Total Net expenditure* increased by £1,322, of which Salaries and Wages accounted for £491 (Awards £673); Laundry £615 (not previously re-charged from Sandleford).

*Cost per patient week.* 1954/55—£9 8s. 3d. 1955/56—£10 5s. 1d.

The increase of 16s. 10d. compared with the previous year is almost entirely due to Wage Awards, and the cost of laundry not previously re-charged.

**Blagrave Hospital** (Branch of Royal Berkshire Hospital)

The expenditure for this branch had previously been incorporated with the figures of the Royal Berkshire Hospital.

*Cost per patient week.* 1955/56—£8 16s. 3d.

The weekly cost for this unit compares favourably with the Margaret Spencer Hospital, Northampton, and the Regional and National Average.

**Dellwood Maternity Home**

This unit shows a reduced expenditure when compared with 1954/55 of £134, although Wage Awards amounted to £532. Expenditure of a non-recurring nature in the sum of £466 was charged in the previous year.

*Cost per patient week.* 1954/55—£19 7s. 5d. 1955/56—£19 6s. 3d.

The cost compares favourably with the Regional and National Average.

(7) *Comments on the current operation of the Hospital Services, together with suggestions for greater efficiency or economy in the future*

(i) Experience shows that the standard and amount of service given in this group has increased and in many respects this has been achieved without proportionate increases in staff. It is however becoming increasingly apparent that the workload cannot be further expanded in this way with safety.

(ii) The provision of expanded facilities for treatment invariably produces an increasing number of patients, but as yet no one has been able to determine what is a reasonable standard to provide.

(iii) Although increased efficiency, giving better use of available resources will increase the workload and decrease the cost per patient treated to a conclusion, it must be realised that total expenditure must of necessity increase, together with cost per patient week.

(iv) The amount of accommodation available for Local Health Authority Part III residents either in hospital or hostel is inadequate. The result is that chronic sick beds are blocked with cases medically suitable for discharge, while acute sick beds are blocked with chronic sick cases. In each instance, unnecessary expense is incurred and beds are not put to proper use.

(v) Reduction in revenue expenditure could be assured if a greater allocation of capital monies was forthcoming. Old buildings and uneconomic plant perforce have to be maintained at increasing cost year by year purely to keep them in use.

(vi) The system of controlled House Committee administration in this group is strongly advocated to make the best use of intimate local knowledge and leave the main Committee free of minor detail but still leave them with full powers of financial control, policy formation, development and overall guidance.

(vii) Efficiency and economy depend upon the quality and enthusiasm of all grades of staff employed. To maintain or improve the standard of work recruits of the right calibre must be attracted to hospital administration as a career. Under present salaries and conditions of service there is little likelihood of success.

(viii) The expansion of the hospital eye service would provide definite economies. Through inability to appoint dispensing opticians and consequent necessity to refer patients to the Supplementary Ophthalmic Service for the supply of spectacles, the Committee are faced with an increased expenditure of approximately £2,000 per annum.

(ix) Greater autonomy should be given to Regional Hospital Boards and Hospital Management Committees which would obviate the need for prior reference to higher authority with its attendant waste of time, duplication of labour and sense of frustration.

(x) The issue of Ministry circulars instructing Committees to carry out further work "*the cost to be contained within existing estimates*" is unrealistic and should cease.

(8) *Statement of the numbers, grades and duties of Administrative and Clerical Staff employed as at 31st December 1956*

| *Number* | *Grade* | *Employment* |
|---|---|---|
| *Group Central Administration* | | |
| *Group Secretary's Department* | | |
| 1 | Group Secretary* | |
| 1 | Deputy Secretary† | |
| 1 | G | Administrative Assistant |
| 1½ | D | Administrative Assistant |
| 1 | B | Shorthand/Typist |
| 3 (including 1 temporary) | A | Clerk/Shorthand/Typists |
| 1 | A | Telephonist/Receptionist |
| *Finance Department* | | |
| 1 | Chief Financial Officer | |
| 1 | Deputy Chief Financial Officer | |
| 1 | G | Senior Accountancy Assistant |
| 1 | E | Accountancy Assistants including functional costing |
| 1 | D | Accountancy Assistants including functional costing |
| 1 | C | Accountancy Assistants including functional costing |
| 1 | C | Accounts, invoices and cash |
| 2 | B | Accounts, invoices and cash |
| 1 | A | Accounts, invoices and cash |

| *Number* | *Grade* | *Employment* |
|---|---|---|
| 1 | E | Wages and Superannuation |
| 1 | C | |
| 2 | B | |
| 5 | A | |
| 1 | D | Internal Audit |
| 1 | B | Machine Section |
| 3 | A | |
| 1 | C | Secretarial and Shorthand/Typing |
| 1 | A | |
| *Supplies Department* | | |
| 1 | Supplies Officer | |
| 1 | Deputy Supplies Officer | |
| 1 | B | Supplies Clerk |
| 1 | A | |
| 1 | A | Shorthand/Typist |
| *Hospitals* | | |
| 7 | Hospital Secretaries | |
| 1½ | D | Assistant Hospital Secretaries |
| 4 | C | Administrative Assistants |
| 7½ | B | General duties |
| 15¾ | A | |
| 3 | B | Accounts/Stores/Purchasing |
| †2 | A | Accounts/Stores |
| 1 | B | Patient Transport/Road Traffic Act |
| 1 | A | Appliances |
| 1 | A | Patient Transport |
| *Departmental Allocation in Hospitals* | | |
| 1 | F | Medical Records Officer (Hospitals and Group) |
| 1 | C | Medical Records |
| 6 | B | |
| 20½ | A | |
| 2 | C | Medical Shorthand/Typists |
| 10½ | B | |
| 7 | A | |
| 1 | B | Matron's clerical and Shorthand/Typing service |
| 2½ | A | |
| 4 | A | Almoners' clerical and Shorthand/Typing service |
| 6½ | A | Radiological clerical and Shorthand Typing service |
| 1 | B | Pathology Department |
| 2 | A | |
| 2 | A | Physiotherapy Departments |
| 1 | B | Pharmaceutical Department |
| ‡1 | A | |
| 1 | C | Administrative Assistant—Central Chest Clinic |
| 1 | B | Catering Department |
| 2 | A | |
| 1 | B | Bed Bureau |
| 1 | A | Dental Department |
| ¾ | B | Library Services. |
| Total 160 | | |

* In addition Secretary of Prospect Park Hospital and Dellwood Maternity Home.
† In addition Secretary of Cold Ash Children's Hospital.
‡ 1 Grade A clerk in the Pharmaceutical Department and in the Engineering/Works Departments are employed for functional costing.

* * * * * *

**Examination of Witnesses.**

Mrs. BENYON, C.B.E., Chairman, Mr. F. H. AITKEN WALKER, Vice-Chairman, Mr. G. H. WESTON, Group Secretary, and Mr. J. H. KITCHEN, Finance Officer, Reading and District Hospital Management Committee, called in and examined.

*Chairman.*

966. Would you just explain the functions of each of the witnesses, Mrs. Benyon?——(Mrs. *Benyon.*) Mr. Weston is Group Secretary, Mr. Aitken Walker is Vice-Chairman of the Hospital Management Committee, I am the Chairman at the moment, and Mr. Kitchen is our Finance Officer.

967. What qualifications have they? I suppose you and Mr. Aitken Walker are volunteers?——Yes.

968. And Mr. Weston?——(Mr. *Weston.*) I am a Fellow of the Institute of Hospital Administrators.

969. Mr. Kitchen?——I am a Fellow of the Institute of Hospital Administrators.

970. Do you feel worried about the quality of recruits for your administrative staff?——(Mrs. *Benyon.*) It is a little difficult to say. I think we are, because we are in competition with commercial interests and the atomic stations, of which we have two in Berkshire, and they do absorb an enormous amount of people on their staffs of all sorts and all grades.

971. You seem to have a great many administrative staff, compared with the number of patients. I see you have only 8 patients to each member of the administrative staff. It seems rather a lot. The regional average is much higher: 14·2 occupied beds for each regional staff, whereas you have one regional staff for every 8·5 occupied beds. How do you account for that?——Personally, I could not. I do not know whether Mr. Weston could answer that. (Mr. *Weston.*) I do not think I have the question?

972. You find in Table —* that you have 160 administrative and clerical staff and have 1,356 average daily occupation of beds. The national figures show that there are one unit of staff for every 18 occupied beds, and the regional figure is one staff for every 14 occupied beds?——I take it that that national figure includes staffing of mental hospitals. Our particular group is largely a general hospital group with busy out-patient and casualty departments and therefore with a far greater medical staff than you find in a special hospital or a mental hospital.

973. I am talking about purely administrative staff?——Yes, but that in turn does mean you need far more clerical staff, particularly in so far as medical records and doctors' secretaries are concerned, and if you do look at our break-down of administrative staff, I think you will see there a large proportion of that staff relates to medical records departments, doctors' out-patients departments, and also clerical staff to the ancillary departments, such as physiotherapy, radiography, and pathology, which you have not got in such a large proportion in the special hospitals.

974. I thought that might be the answer. Have you any general difficulty in recruiting other grades of staff, such as junior medical and nursing staff?——Could I go further, and first of all talk about the recruitment of administrative and clerical staff? We are particularly perturbed at the moment at the calibre of recruits coming into the hospital service for hospital administration as a career. We are finding increasing difficulty in getting men of the right calibre, particularly at Hospital Secretary grade, and I feel the main reason for this is that there are no what I might call intermediary grades at hospital level where these embryo Hospital Secretaries can be trained in actual practice and therefore be qualified to be appointed to Hospital Secretary posts as and when they fall vacant. We have only been able to meet that problem in our group up till now by a small internal training scheme which we have had over a period of several years, and have been able to have internal promotion, but we have found that internal training has dried up to a certain extent now. We now find when we advertise a post of that calibre the standard of application leaves a lot to be desired. I think we have a great

* Not reported.

problem in running the Service in the future.

975. Would you welcome a regional career structure?——If by that you mean an interchangeability of posts in order to gain experience, I would welcome that, but would not welcome appointments of administrative staff by Regional Boards so that they would be transferred around the region in some way, for instance, as in the Civil Service. I would prefer to see the appointments left at Hospital Management Committee level.

976. If you want an efficient service, surely you have got to have one with a good many posts in it? Would you not welcome a regional hospital civil service, or whatever you like to call it, a hospital administrative service?——I would very much welcome a regional training scheme, but left in the hands of Hospital Management Committees to appoint the officers they wish to appoint.

977. I was not talking about the appointments. I was wondering whether you would not welcome the whole thing being organised on a regional basis with the hospitals left to choose who they want, with a larger field in which to cast their net, so to speak?——At the moment we do cast our net nationally by virtue of public advertisement, and therefore get applications throughout the country. The posts are filled by competitive application.

978. I understand that when Newbury advertised two or three years ago for a Hospital Secretary they got very many replies?——Newbury District Hospital, when Mr. Part was appointed, yes, I am very well satisfied with our Hospital Secretary there.

979. They got very many replies to their advertisement?——I think there were 69 replies, but of those 69 I would say 50 were very much "young hopefuls".

980. How do you advertise for staff? ——It is dependent on the grade of staff and type of staff. For senior posts, administrative and clerical staff, we advertise in the public press. We restrict it to the "Telegraph," actually, and to the professional journal, which is the "Institute of Hospital Administrators Journal", and sometimes the "Hospital and Social Services Journal". As far as nursing staff are concerned, we advertise in professional journals and in local papers for part-time staff.

981. Do you agree with what has been said, Mrs. Benyon?——(Mrs. *Benyon.*) Entirely, yes.

982. We have heard evidence from one region in which there was central control of advertising. It is an urban region, Manchester, and they have saved a good many thousand pounds a year by a rationalised advertising scheme. Would that be advantageous?——We have tried various things, because we are aware of the amount spent in advertising, but we have come back to the conclusion that the system we have adopted now is the one that does produce for us the most answers, and the most suitable recruits. (Mr. *Weston.*) To add to that, we in our group have centralised the whole of advertising. Obviously, each individual hospital inserting its own advertisement is uneconomical, and has not been done over a period of seven years. We have effected savings as a result of that.

Mrs. *Hill.*

983. Does your Regional Board give you any instructions as to how you should advertise?——Only in regard to nursing staff, and that is done by regional block advertisement. That is the only basis of regional advertising in regard to H.M.C. staff.

*Chairman.*

984. My earlier question, to which I have not had an answer was: do you find it difficult to recruit junior medical and nursing staff?——We do not have the difficulty with regard to junior medical staff now as we did two years ago, except in certain special cases. We have difficulty in getting junior medical staff in anaesthetics and also in the casualty departments. Whether that has anything to do with the proportion of medico-legal actions I am not too sure. With regard to other junior medical staff, we have not had difficulty recently. (Mrs. *Benyon.*) As to nursing, we should always like to have more recruiting. Sometimes we fill our training school, and sometimes there are vacancies, but I think that we should always welcome an addition to our recruits for the nursing side.

985. What do you think of the quality? ——I think the quality is a thing which is

very carefully vetted by our matron of the Royal Berkshire Hospital, who is also in charge of the Group Training Scheme, and she definitely would not accept girls who she did not think capable of taking the training and making good in the nursing profession.

986. Are you below establishment?——Yes, we are. (Mr. *Weston.*) We are approximately 150 short of our establishment.

987. Of how many?——944.

988. You have only got 794?——801 was the last figure—143 short.

Mr. *Holt.*

989. Has the shortage of nursing staff, or the lack of quality, if that exists, resulted in any unfortunate experiences inside the hospitals, mistakes being made at the bedside, people being given wrong drugs, and that kind of thing?——(Mrs. *Benyon.*) I do not think we have had any experience of that sort. I think the matrons of all the hospitals would welcome more staff, especially, of course, in the four former public assistance institutions which we have to administer for chronic sick patients. They have been at times very short there, but not so short in the acute hospitals. But, as you can see from the fact of our being below establishment, I do not think there is any one matron who would not welcome being brought up to the full establishment.

*Chairman.*

990. Would the shortage of staff be reflected in the bed occupancy figures?——We have to close beds, for instance, at Wallingford at St. Mary's Hospital, because they literally had not got the staff. At those hospitals we have to engage a good many part-time nurses, people who live in the town and come in to the hospital, but it is rather extraordinary that for the first time for a very long time—I do not know whether it is up to full establishment—but anyhow we have made up lost ground, and are pretty well staffed there. It has been a great pleasure to us because we can reopen these beds. (Mr. *Weston.*) Through deficiencies in nursing staff we have closed beds in certain of our hospitals.

Mrs. *Hill.*

991. Where do you get your staff from? Are you able to recruit your student nurses all locally, or from where do you recruit them?——(Mrs. *Benyon.*) Everywhere. We get quite a number of girls at times from Northern Ireland, and many of them are very good. We have also had some Colonial girls and they have turned out very well indeed and are very good. Mr. Walker has seen them in the hospitals at work, and will tell you they are very good, I think. (Mr. *Aitken Walker.*) Yes, that is so. (Mrs. *Benyon.*) We have recruited them from everywhere. As to the type of girl we do take, there are obviously those who apply who would not make the grade.

Captain *Waterhouse.*

992. Do you pay your temporary staff or part-time staff the same rates as your permanent staff?——(Mr. *Weston.*) Rates are laid down by the Whitley Council.

993. Is it, in fact, the same?——(Mr. *Kitchen.*) Slightly higher. (Mr. *Weston.*) You did ask have we had difficulties in recruitment of other grades of staff. I would like to mention auxiliary medical staff. We do have difficulty in recruitment and retention of those staff due probably to our geographical position and other factors. We cannot get dispensing opticians. If we could get them it would mean a great saving to the hospital service. At the moment all spectacles have to be dispensed by outside opticians which costs our Management Committee some extra £2,000 or more per annum. That is one point. We do have difficulty in getting pathological technicians, in view of the demands for that grade of staff at Harwell and Aldermaston to which Mrs. Benyon has referred. We do have difficulty in regard to almoner staff due to the national shortage of almoners.

*Chairman.*

994. Passing on to finance, what happens if expenditure exceeds the estimates under any heading in any hospital?——(Mr. *Kitchen.*) When expenditure is exceeding the estimate, the Regional Board are notified, my own Committee are notified first. We anticipate expenditure increasing above estimate by monthly budgetary control, hospital by hospital, approved head by approved head.

995. Does it occur very often?——Overspending?

996. Yes?——It is a difficult question to answer shortly. Overspending occurs mainly due to expenditure, such as wage awards which come in beyond our control. We do get that back from Regional Boards at a later date. However, when we go back to the Regional Board at revised estimates stage and sufficient money is not forthcoming due to their reduced allocations, we probably show overspending. Towards the latter end of the year we are working on a budget which is overspent and looking for economies in an endeavour to bring it down to reasonable level.

997. It is noticeable in these statistics* that on the whole the estimates and expenditure pan out pretty evenly, a very small percentage above or below. Would that imply that hospitals always tend to spend up to the hilt? My next question will be as to under-expenditure. I am surprised there is not more under-expenditure?——You are looking at my statement for nine months, which is one month or two months after the revised estimate stage. We have a chance then of putting our money under different heads. At the revised estimate stage we have covered the present staff and the other expenditure has to be cut down probably lower than we could afford for the rest of the year.

998. Are hospitals encouraged to underspend; are they allowed to keep their savings?——They are not allowed to keep their savings.

999. Do you think they tend towards the end of a financial year always to spend up to the hilt?——No, we have found for the last three years we are pretty desperately deferring items of expenditure to the following year. For at least the last three months of the year we are having to defer expenditure because of overspending.

Sir *Henry D'Avigdor-Goldsmid.*

1000. Do you not find that there are certain items of expenditure which you are prepared to meet in the last quarter of the year which you have previously turned down owing to the funds probably not being available?——That has been a fact probably two or three years ago. For the last two years we have been so desperately near the total budget, and when one considers the payroll is in the region of £850,000 a year, with changes of staff as many as 300 in a quarter that change in the salary expenditure leaves us very little margin. In the face of this fluctuation we have no money to play with, and are at the end of a year before we can mop up any savings.

1001. If I may follow that up, this mopping up of savings is in fact a continuing process. The question I ask is this: is it not really in the mentality of the organisation that there should not be savings? Is it not really almost the business of a Hospital Management Committee to say: "What are the desirable things we need this year? Have we the funds available to get them, and if we have let us do as many as possible?"?——(Mrs. *Benyon.*) Yes. (Mr. *Weston.*) May I underline what the Finance Officer has said? In years gone by there is no doubt whatever we did have at the end of a year an opportunity of buying those things we had had to defer previously, but during the last two or three years that has been absolutely impossible. Our task now at the end of the year is desperate in trying to live within our estimates. We have not the spare moneys available.

*Chairman.*

1002. You see what my point was: I feel that there might be something a little suspicious in the fact that expenditure so closely fits in with estimate?——Could I answer that, to save the blushes of my colleague? It is due to budgetary control.

1003. You see, at Newbury apparently they only spend two-thirds of their estimates for drugs?——(Mr. *Kitchen.*) With respect, they have not only spent two-thirds.

1004. They have underspent?——They have not underspent on the estimate for drugs. There is an out-standing commitment of £5,000 for X-ray equipment. That has been put into their estimate to meet the X-ray bill due now.

1005. Do you mean at the end of the year the thing will balance exactly?——Actually the equipment has been supplied to the Newbury District Hospital, and we are only waiting now for the Ministry's bill, which is an Exchequer service we charge to our accounts without pay-

* Not reported.

ing a cheque over. We are now awaiting that bill for £5,000.

1006. Mrs. Benyon, do you take any definite steps to control the rapidly rising bill for drugs and dressings?——(Mrs. *Benyon.*) There have been great conferences amongst all people concerned regarding this matter. Mr. Walker, I know, would be able to say something of that, being the Chairman of the medical staff. (Mr. *Aitken Walker.*) We have had discussions about this among the clinicians, pointing out the rising costs of drugs. We have had a very intensive discussion between the pharmacists and clinicians generally, methods whereby certain economies could be adopted have been discussed.

1007. Your figures are very much above the national average?——(Mr. *Weston.*) One factor which influences that high cost of drugs is the high turnover of beds as far as the Reading Hospital is concerned in comparison with elsewhere. If a patient has a shorter stay in hospital he has more intensive treatment, and there is extra expenditure incurred on such things as drugs, which does not apply in a hospital where the length of stay is much longer.

1008. I wonder if that answer carries conviction. I am not at all sure. Would the medical profession say there is a direct connection between the amount of drugs pumped into somebody and the stay in bed?——You have a different patient occupying that particular bed and he is, therefore, probably having the same drug as the previous patient had, that is twice the cost.

1009. Are the treatment prescriptions reviewed every few days to see whether it is necessary to go on using a costly drug?——They are reviewed very closely.

1010. At fixed intervals?——I will not say at fixed intervals, no; but, quite frankly, we have every confidence in our group pharmacist, who is effecting a number of economies.

1011. I am not questioning that. What I am saying is this, I am told that at Newbury, for example—I am interested in that because I live near there—every prescribed treatment is reviewed every five days to see whether it is necessary to go on with a particular drug. Would you accept that as desirable?——(Mr. *Aitken Walker.*) That has been instituted at Reading as well. The only thing is that we have not made a special attack on the drug question by asking the medical staff to limit their treatment or to alter their treatment to a cheaper drug, or to do anything other than for the good of the patient.

1012. The theory is that it often happens that an expensive treatment goes on perhaps longer than necessary?——We foresaw that some years ago, and go to the trouble of having our charts marked with what drugs the patients are having with coloured pencils, so that we know at a glance how long they have had it.

Mrs. *Hill.*

1013. Do you make up many prescriptions for people in your out-patient departments, or do your consultants give them a prescription to go off to their local chemists with?——The general trend has been to use the out-patient department as a consultative out-patient department, and to refer the patient to the doctor for continuation of the treatment. There are certain cases where the clinician wishes to observe the case, and he orders the drug through the hospital dispensary.

*Chairman.*

1014. The regional figure of turnover is high, which would lead one to expect, if Mr. Weston's argument was sound, that they would also be high in drugs, on your analogy, but I see that the Royal Berkshire, St. Mary's, Wallingford, and Peppard are above both the regional and national averages for that type as far as drugs, dressings, etc., are concerned?——(Mrs. *Benyon.*) But we are below Hampshire, and Northampton. (Mr. *Kitchen.*) It should be noted at this stage that these figures*, when taken from the individual categories, are not adjusted for out-patients at all. It is a national average which must include a lot of acute hospitals without large out-patients departments. Similarly, with the regional figures. There is a very large out-patient department at the Royal Berkshire, and a large part of that is included in the weekly cost of £1 8s. 6d.

1015. If you go farther down in your page, you see in-patient cost adjusted by notional out-patient expenditure?——

* Not reported.

That is for the total, not for individual categories. You are comparing one category with the national category average and a regional category average, and they are not adjusted at that stage for out-patients, they are adjusted only at the end of the costing statement.

1016. They are still higher than the South Western Metropolitan Regional?——Not the individual hospital, but again in the South West Metropolitan Region average you have also got hospitals without necessarily large out-patient departments. Therefore they must be above those.

*Chairman.*] I realise that statistics can mean anything at all; I am trying to find what they do mean.

Captain *Waterhouse.*

1017. These figures are not comparative?——They are comparative with similar hospitals; like can always compare with like. But we are trying to compare a hospital with a considerably large out-patient department giving an extremely up-to-date service with other hospitals not quite in that fortunate position.

1018. Would not it be an advantage if these figures were prepared making allowance for the out-patient, instead of just the averages?——That has been arranged. From 1st April there will be full functional costing at this hospital whereby we will then work out the proper out-patient cost in departments. At the moment we have only an indication; later on we may have some comparison.

1019. That is being done all over the country, in all regions?——Yes, it is national.

*Chairman.*

1020. Do you encourage the hospitals to make their own economies? I understand that in Newbury they have just finished a trial period of six months using commercially made swabs to save nurses' time, and this has resulted rather unexpectedly in a saving of £3 a week in the hospital. You may say it is trivial, but it is something. Is anything done like that in your Region?——(Mrs. *Benyon.*) Not that particular one. Mr. Weston and Mr. Kitchen attend each meeting of the House Committee. I do not know whether that has been reported. I have not heard it. (Mr. *Weston.*) It has not, with my knowledge. It is a thing I welcome. If that is an example of something which has been proved to be economical, we would, after it being proved economical, adopt it elsewhere in the area. If I may give an example of that, at Sandleford Hospital a water softener has been required, but through money not being available they have not had one, and we agreed with the House Committee that they should experiment and instal a softener on hire, and after an experimental period we had a report from the hospital that economies had been effected.*

1021. Mr. Kitchen and you are the links?——Yes, together with interlocking membership between the Hospital Management Committee and the House Committee. (Mr. *Kitchen.*) On the instigation of savings for drugs and dressings, I can illustrate it by the fact the Chairman of the Medical Committee of the main Hospital invited myself and the Chief Pharmacist to attend a meeting and discuss the cost of drugs. Mr. Walker was present at the meeting. For example, as to the use of antibiotics over a long period, it was agreed it should be limited to a period of four days and that it then had to be re-requisitioned by the consultant concerned.

1022. Do you find, Mrs. Benyon, in your Group that many doctors, or some doctors are cost conscious?——(Mrs. *Benyon.*) I think they vary. I think there was much pressing of this point at all levels, and in the medical staff and Medical Advisory Committee, and so on. I think that most of them have become conscious of it. They do not always all quite play up to costs.

1023. What steps do you take to chase them?——(Mr. *Aitken Walker.*) It is rather left to me, I think. We have not really forced that on the consultant as to the actual details of drug costing. We have rather aimed at giving the best service we could.

1024. You do realise if the cost of the hospital service as a whole keeps on mounting, in the long run the patients will suffer even more. It has come to

* *Note by the witness:* We are now taking similar steps at another hospital in the group.

a critical level in the national finances, and in the interests of the service and patients themselves the utmost value should be got for money?——(Mrs. *Benyon.*) We all appreciate that very much.

Mr. *Robinson.*

1025. Would you say that pressure is exerted by members of the Medical Staff Committee of the hospitals on any individual member of that Committee who is inclined to over-prescribe where very expensive and untried drugs are concerned?——I should not attempt to do such a thing. I know nothing of what it is right to use in medical matters. Mr. Walker, I am sure would be able to answer that question as Chairman of the Medical Advisory Committee?——(Mr. *Aitken Walker.*) I think it is not easy to coerce a consultant in the treatment of his patient. First of all we have to presume, therefore, we are keeping a daily check on what Mr. X, Y or Z prescribes. He is working in a team. His ward is ordering the drugs en bloc; he is not doing them under his own prescription; his house officers are doing it. Secondly, we may be making an effort to investigate the relative advantages of certain treatments. Are we to stop a man using a drug because it is expensive? To take cortisone, for example, are we to stop a clinician using that, which is recommended in the literature as responding well, because we know it is expensive? Are we to limit a man who has ulcerative colitis, whose life is in peril, and in whom cortisone acts as a release? When do we stop it? Those problems come up. I feel against any real control, apart from pointing out the financial implications of these treatments. Linking up with what Mr. Weston has said as to our rate of turnover, we have put on pressure to compete with Northampton, for example. The rate of turnover means that patients who stay in hospital a long time are ill patients costing a lot. They are the ones taking antibiotics, intra-venous drips, etc. Those are the patients costing the Service a large amount of money.

1026. I think we recognise the extreme difficulty of this, but does your answer mean in effect that the Hospital Management Committee can really exercise no control over expenditure on drugs?——I do not think they can really keep an accurate control over it. They can persuade and advise and suggest and help, and that sort of thing, but I do not think they can control. I think that if they do, if that is what the Service is developing into, my colleagues would take a different view of it.

*Chairman.*

1027. There is a halfway house, is there not? You can see all treatments are supervised, all prescription treatment prescribed is looked at by other people to see that it is reviewed at frequent intervals. You can see that a doctor is well aware that he is prescribing a very costly treatment and does it with his eyes open. There is plenty to do, surely?——That can be put into operation.

1028. Ought not it to be?——(Mr. *Weston.*) We have already said the Group Pharmacist does discuss with clinicians the question of the cost of drugs. We said that at the beginning of the evidence. Furthermore, the Hospital Management Committee does exercise an amount of control in so far as the purchasing of drugs is concerned. That is a thing we have gone into very thoroughly in Reading.

*Chairman.*] I was not talking about that at the moment.

Mr. *Holt.*

1029. Might I ask Mr. Walker whether he had any experience before with the voluntary hospital or the hospital run by local authorities as to what steps they took to keep a check on the cost of drugs used by their doctors?——(Mr. *Aitken Walker.*) I am afraid I have only worked at Reading Royal Berkshire Hospital, for the last twenty-three years, and those were the days of the voluntary system. The question of drugs then did not arise quite to the same degree as now, because of the antibiotics and the new types of drugs and treatment used now, but we were starting them in 1937, 1938 and 1939, and as soon as sulphonomides were available, we used them. We were aware then that we should try and keep the prescribing of drugs as low as possible. That is a thing which I, as an older member of the staff, have ingrained in me.

*Chairman.*

1030. May I follow that up? If the Reading Hospital were still a voluntary

hospital, but it had a situation of growing expenditure on drugs, what kind of action do you think would have been taken by the Hospital Committee or by the doctors, or would some different action have been forced on them then than is being taken now?——That is a very hypothetical question.

1031. It may be hypothetical, but it does seem to me we ought to examine it, because at the moment there is the feeling one cannot interfere with the doctor's prescribing for his patients. At the same time there is not an open end at the Treasury?——(Mrs. *Benyon.*) I think Mr. Walker mentioned he has been twenty-three years at the hospital. I have been connected with the Royal Berkshire Hospital for thirty-three years, and I do know what vicissitudes we have gone through under the voluntary system. I think it is a hypothetical thing, but I think that what was the usual custom when anything was desperately needed for the hospital was that we made a public appeal for money.

1032. That must have kept down the drug bill because you did not want to do that?——I do not know that we had any more control over our surgeons and doctors than we have today, over their prescriptions.

Mr. *Robinson.*

1033. Can I ask Mr. Walker whether he feels in his hospital that the responsibility for the expenditure on drugs, which we all agree cannot be to any marked extent interfered with by laymen, is collectively accepted by the medical staff, or is it left purely to each individual doctor to use and prescribe what drugs he thinks fit, without any other consideration in mind?——(Mr. *Aitken Walker.*) It is referred to area departments. Each section of medicine and each department in the clinical work of the hospital forms an area department, of which the clinicians doing that work collect to discuss the problem.

1034. What area?——The Reading area, this Management Committee Group. That department is warned or told that certain costs are rising, and what they can do to increase the control of expenditure.

1035. At whose instigation?——From the Hospital Management Committee.

1036. Who calls attention to the fact costs are rising?——(Mr. *Kitchen.*) I would call the Chief Pharmacist's attention to it. He would find what drug was causing the trouble and it would come back to the Committee for any decision.

1037. The report would come back to you?——We ought to realise, when we are talking about the rising cost of drugs for the Group, that in 1952 the cost of drugs was £60,000 for the year, in 1953 it was £50,000, in 1955 £53,000, and in 1956 £54,000—you are not quite correct when you refer to a very high rising costs of drugs.

*Chairman.*

1038. I agree. This is not a tendentious question but rather for information. I suppose you might say the more you use a very expensive drug the more you are likely to bring the cost down; is that so?——I think so.

1039. Cortisone has fallen a lot?——(Mr. *Aitken Walker.*) They are falling; they always do.

Mr. *Robinson.*

1040. Was the drop between 1953 and 1954 something like 12 or 13 per cent?——(Mr. *Kitchen.*) I cannot give you a reason from the papers I have with me.

1041. You do not know whether it was fortuitous or whether the result of any particular efforts from any quarter?——It would be difficult to say at this time. I feel it was about that time we had a meeting with the medical staff about the cost of drugs. I would like to be able to have a look at my records for confirmation though.

*Chairman.*

1042. Does the dispenser play a great part?——(Mr. *Aitken Walker.*) Yes. (Mr. *Weston.*) One further point which does show we have the co-operation of our clinicians in this matter without any force being brought upon them, and that is that Management Committees are being called upon to meet the cost of more expensive drugs formerly provided free by the Ministry. Our average cost of drugs has not risen excessively over the past year. We are meeting a cost now which in previous years we have not had to meet. (Mr. *Kitchen.*) Had we had knowledge of this question we probably could have come prepared with a story to say how the cost of drugs

has gone down. Penicillin was free, as you know, at the beginning. Cortisone probably cost us £3,000 last year over and above what we anticipated.

1043. I must admit that I was grouping drugs and appliances together.——That, of course, is probably new equipment. We have in hospitals, you know, to replace equipment and charge to maintenance account, and it does vary year by year. In the present 1956 figures which you are looking at, 9s. 4d. patient cost is in respect of the replacement of X-ray machines, £7,000.

Captain *Waterhouse.*

1044. I understand Mr. Kitchen to say that the dispenser has a very material effect?——Yes, he plays a very important part.

*Chairman.*

1045. May I ask my question first on that point. Is it true that at Newbury they have a part-time dispenser who works in a branch of Boots in the town, and who is trained to look at things from a commercial point of view, and perhaps is a bit more conscious of the question of savings compared with some of the whole-time staff in the Hospital Service?——No, I refute that completely. Our Group Pharmacist is a pharmacist who works completely hand in hand with financial control. He is continually talking to the medical staff about the use of drugs, and prepares many of the drugs in his own laboratory to save money. At Newbury the pharmacist comes under the control of Mr. Burton.

1046. That would apply *mutatis mutandis* to the other hospitals, would it?——He is the Group Pharmacist. He buys for them all in the main.

1047. You do a certain amount of central purchasing for provisions, do you not?——(Mr. *Weston.*) Yes. We started that system in November last year.

1048. How do you find it works out? ——It is very early days yet to say, and it is rather difficult to say in view of the fluctuating food prices. I would not like to give a clear opinion at this stage. We are still in the process of reviewing it.

1049. Do you buy everything?—— Every commodity.

1050. Do you arrange the buying of everything?——Yes. Everything is now done by a public advertisement, and tenders are received for all commodities.

1051. Are the hospitals satisfied with the result?——It has been quite a major unheaval, but I must say it has gone through far more smoothly than we anticipated.

1052. They do not say: "We get worse food", or anything like that? ——Again, it is early days to say, but I have not had any more complaints than we had in the days when purchasing was done by one officer alone.

1053. There are no Supplies Officers outside Reading?——No. We have a Supplies Officer.

1054. Only one?——Yes, one.

1055. Did the other hospitals have them before?——Yes; the Royal Berkshire Hospital had a Purchasing Officer before Hospital Secretaries bought at unit level, that is, for general supplies. As far as provisions were concerned, that was done by the Group Catering Officer who is based on the Royal Berkshire Hospital, and she did do buying by means of weekly prices given to her over the telephone and seeing how the market stood. Now we are going out to tender on a set period.

1056. Would you like a regional purchasing scheme?——For what commodity?

1057. As much as it is appropriate to do regionally.——Well, personally I would not, Sir. I have just been sitting on an *ad hoc* Committee formed by the Regional Hospital Board to go into this question of group or regional purchasing. We have gathered a lot of information with regard to purchasing by the various Hospital Management Committees throughout the Region, and find that by comparison of the prices and standard of commodities bought that Reading, being a large Group, is getting the benefit of prices and qualities equivalent to, and in some cases better than, places like Manchester, which had regional buying machinery. I think there is room for more group purchasing. There is room for smaller groups being combined for the purpose of purchasing, but I rather see it in local level, in other words, at the optimum buying level which

we consider to be a 60 point group like us, rather than a remote buying control by Regional Board or by the Ministry.

1058. You say that on the whole you buy better than other Groups. Is there any reason why other Groups should not come up to your standard?——We are hoping they will.

1059. Except at three hospitals, the cost of provisions per patient fed is below the regional and national averages for each type of hospital. Do you put that down to greater efficiency, or what—I am sure you have not a lower standard of feeding?——We have not.

1060. What would the answer to that be; how do you do that?——(Mr. *Kitchen.*) We have spent considerable time on provisions costs to bring the cost down per person per week. That is the real reason.

1061. Looking at the whole Hospital Service, it seems to us that you achieve this measure of efficiency of your own initiative?——I think we are fortunate in having a good catering officer who will listen to Mr. Weston and myself and the Committee, and really go out of her way (*a*) to buy well, and (*b*) to produce a good menu at reasonable cost.

1062. Does the Region constantly chase the Group on catering costs?——Not now, Sir. At one time, when our costs were high it was mainly due to the fact that the formula we used was not always correct.

1063. You mean calories and things like that?——The counting of persons fed. We work on a pointage system, and that, as you will see in some of our reports here, was wrong at one time. The Board have generally discussed provisions costs with the financial officers, and have gone out of their way, without reducing food to patients, to bring our costs down.

1064. I am sure the others have something to learn from you?——(Mr. *Weston.*) One further factor. We have received considerable help from the Ministry of Health Catering Advisors. She has given the Committee the benefit of advice with regard to equipment and layout and planning of menus and diets, and the Committee have gone all out to try and implement the various recommendations she has made.

1065. On standardisation, do you think there is room for standardisation throughout the Region?——(Mrs. *Benyon.*) That is a very debatable subject. Hospitals are so entirely different from each other. These old buildings which we have got——

1066. I meant standardisation of crockery and linen, and things like that?——We do to a certain extent standardise. We allow them some licence with regard to colours where they are bought at the same price. Otherwise I think they are pretty well standardised. (Mr. *Weston.*) The Management Committee have formed a Supplies Section of the Finance and General Purposes Committee, whose responsibility it is to determine the requirements of the various categories for all hospitals, to try and adopt an acceptable standard for the "common user" items, then to place group contracts in order to get proper prices. That has been the principle we have worked on, but we have only effected standardisation in consultation with all the people who really use those articles. There is no doubt whatsoever that benefit is to be gained by this, but it is a question of standardisation on a sensible footing.

1067. On what scale, regional working?——On a group basis we have done it.

1068. Is there any pressure upon you to have it on a regional basis?——No, Sir. Our Regional Board investigating this——

1069. They are investigating it and not pressing it yet?——The latest information is that they feel more can be done on a group basis and joint group basis than it is at the moment, even before any regional buying system is envisaged.

Mr. *Holt.*

1070. Would you agree that any group buying with a view to standardisation of the product is probably only desirable where that product has become fairly traditional itself, and there is not much change being made in the product? For instance, we had one case where they standardised all sheets. If it is a product where one hospital might prefer a new product that is coming out to an old product which might be cheaper but not as good, or slightly better but a little dearer, if you go in for standardisation

you may cost yourself more in the end than you actually have saved, because you do not take advantage of a new product coming along with which you replace the old?——That is what I mean by standardisation on a sensible footing. Any Committee would be foolish if they were not prepared to examine new things.

Sir *Henry D'Avigdor-Goldsmid.*

1071. I was interested to read about your relations with your House Committees. I notice you said that you would " emphasise the two way advantages thus derived in oral evidence ". I would appreciate your enlarging on that?——(Mrs. *Benyon.*) I would like to say that giving House Committees more work to do and more duties to perform really has been going on for three years. Before every small item came to our Finance and General Purposes Committee of the Group, and in consequence the House Committees began to feel a great frustration and really felt that beyond meeting once a month and looking into accounts and wanting certain things and recommending them, they had no real interest, they did not know how much money there was to spend, and they were losing interest, and not really performing the functions I think are so desirable in a House Committee. Now, the system was changed three years ago, and our Chief Officers attend each House Committee.

*Chairman.*

1072. How often?——Once a month. The House Committees are made aware what money there is to spend. They have very close consultation with them, and we expect our House Committees to go carefully into every item before it is brought to the Finance and General Purposes Committee, and is very carefully advised of our Chief Officers' opinion, in their presence naturally, at the House Committee, and very carefully gone into before it ever comes forward for acceptance at the Finance and General Purposes Committee of the Group.

1073. You are successfully attempting to arouse local interest and a local sense of responsibility?——I think that has been one of the big features, and I think all evidence would go to show it has been one of the big features of the very happy relationship between the House Committees and the Group, because there is naturally some sense of frustration when some of the things they would dearly like to have done appear to be impossible. They know now why it is impossible, because they are told of the financial position, that it is impossible for them to have certain things within the money allotted, and they have accepted it, I think, with a very good grace. (Mr. *Kitchen.*) Very good indeed. (Mrs. *Benyon.*) I think all these House Committees, the Chairman of them, are very sensible people who do appreciate the fact that if the money is not there and we have to be economical they must do their best to make the best of what they have got, and personally I would pay a great tribute to all those House Committees for the great assistance they have given to us in vetting their expenditure and needs and wants and discussing it quite freely with our Chief Officers, and bringing their considered applications to us to pass or not, as we have to do according to our financial position.

Mr. *Robinson.*

1074. Did you find that you had to strengthen them administratively, or did not they have to take on extra staff?——No.

1075. The existing staff was qualified to deal with that extra work?——Yes. (Mr. *Weston.*) With the assistance of the chief officers.

*Chairman.*

1076. Do you find it difficult to get enough people to serve on your House Committees?——(Mrs. *Benyon.*) No, I do not think we have got one. We are not only fully up to standard, but I think people take a most tremendous interest.

1077. Who appoints them?——The Management Committee. (Mr. *Weston.*) One-third of House Committees retire annually, and it is the task of the Hospital Management Committee to seek nominations for those vacancies from all local interested bodies. From that pool of nominations one-third of members are elected or re-elected to serve on that, so you have a continuity and at the same time you have a fresh element year by year.

Mr. *Holt.*

1078. Is what you have just said merely a duplication of work?——(Mrs. *Benyon.*) No.

1079. Or have you actually given some authority to the House Committee to decide, not to recommend, but to decide on expenditure, that this shall be spent on that, and not that?——(Mr. *Weston.*) Could I make that clear? The Hospital Management Committee has not delegated executive powers to their House Committee. Furthermore, the Management Committee have retained full responsibility for expenditure. They are the only people who approve expenditure through their Finance and General Purposes Committee. The House Committees know they have powers of recommendation only, but the Hospital Management Committee does rely to a very large extent on the considered opinion received from the House Committee.

1080. Is it not possible to get the real advantage from what you have done by, instead of when those things come up to the General Committee to pass them, as it were, doing it in bulk, provided it comes within the limit of finance you have allowed to that particular hospital? It seems at the moment, from what I understand, these are then considered again?——(Mr. *Kitchen.*) They are not. The Finance and General Purposes Committee ask whether the items concerned can be met within our present expenditure, and are told at the meeting whether any item of an unusual nature is included on a requisition or recommendation. They may discuss a large item ; they may see that it is too small to discuss, but they go through mainly in bulk.

Mr. *Robinson.*

1081. You are not allowed to delegate spending powers?——We are not allowed to delegate spending powers, that is quite true.

Mr. *Holt.*

1082. Has it resulted in these estimates going through quicker?——Mrs. *Benyon.*) Yes, much. That is one of our great points. We used to sit endlessly going through every detail, and the time would not suffice. For instance, we had a long time spent over a wheelbarrow. It was quite fantastic. The obvious place to discuss that was in the House Committee, and having discussed that and said it was necessary for the House Committee to have the wheelbarrow, by all means have it (Mr. *Kitchen.*) If a frivolous recommendation could have been made in the past, it is not made now. We would say: "There is not the money for that ; we cannot do it this year." The recommendation, therefore, does not move from the House Committee ; it stays where it is.

Mrs. *Hill.*

1083. Do you appoint your Chairman of your House Committee from your Management Committee?——(Mr. *Weston.*) No, we leave it to the House Committee itself to appoint its Chairman.

1084. You do not insist that whoever they appoint chairman must be a member of the Management Committee?——No. (Mrs. *Benyon.*) We do it rather in reverse. We hope the chairman of the House Committee will be appointed by the Board on to our Management Committee.

Mr. *Robinson.*

1085. To what extent do people graduate from House Committee to Management Committee?——We have the chairmen or vice chairmen of the principal House Committees on our Management Committee.

*Chairman.*

1086. How many are there on your Management Committee?——(Mr. *Weston.*) 21. We have 20 members at the moment.

1087. I asked you a question before to do with some other evidence we have had. Do you think there is anything in the theory that a reformed system of physician superintendent has a great part to play?——Of what type?

1088. In the old hospitals I understand a lot of the management was done by the physician superintendent?——I quite naturally would talk very hotly against that.

1089. Why?——Well, Sir, I think the management and general administration of a hospital is a skilled job and the man who does that should be properly trained for that work. Without in any way wishing to offend Mr. Walker, who is a medically qualified man, when a man is trained for medicine he has been trained for medicine—he has not been trained for administration, and hospital administration is large-scale business

these days. The two types of training are entirely different. My second point, if I may, is this. In order to get your medical administration working properly I suggest it should be done, as we do it in Reading, by means of a very active Group Medical Advisory Committee with a very active Group Medical Advisory Committee chairman. That is the way you get a democratic way of dealing with medical matters, rather than having one man who, more often than not, if you tried to put him in charge of a general hospital would not have the respect of his colleagues and would not have the authority that an Advisory Committee chairman has.

1099. That, you think, would be the general view of Hospital Management Committees throughout the country?——(Mrs. *Benyon.*) I would definitely think so.

1091. You do not think there may be weaknesses in an administrative structure which relies too much on working through a committee?——(Mr. *Weston.*) I say no sir, if those committees are properly conducted and properly informed, and if there are responsible members of those committees, which we are very fortunate in having in Reading.

1092. The terrible thing about the Hospital Service is it depends so tremendously on the personalities?——It does.

Mr. *Robinson.*

1093. Would not it be true to say laymen are in favour of lay administration and doctors are in favour of medical administration on the whole?——No, I would not say that. (Mr. *Aitken Walker.*) The ideal medical administrator would be ideal, but they are not so easy to find.

*Chairman.*

1094. I am interested in the fact that medical nursing costs per in-patient at the Royal Berkshire are so much above the regional average. Would the large out-patient total account for that?——(Mr. *Kitchen.*) Not completely, Sir. If you would look at Table —*.

1095. May I continue my question? You say that costs—this is on section 6 of the Memorandum†—do not indicate the necessity for special investigation at this stage?——I said medical and nursing salaries contribute £2 6s. 0d. towards the difference between our salaries and Northampton's, which is a comparable hospital and has a large out-patient department—that is a fair comparison. We are more expensive than Northampton and perhaps Mr. Walker can say a few words about that. (Mr. *Aitken Walker.*) We have been encouraged for a long time to get our nursing recruitment up to a high level. Then again we are running certain departments which we look upon as being advantageous, but they are a little extravagant in nursing. We are running a pediatric department (which is the children's ward of the old Berkshire Hospital), and on that we have followed the wishes of our pediatric physician, Dr. Kempton, and he has requested we should have an extra number of nurses there, with two sisters in charge for a ward of 40 cots. That is one of the illustrations. Then again we have several small wards. That is due to the structure of the hospital. These small wards result in a sister being in charge of a ward very often when she cannot be divided between two wards. We are out of proportion there a little bit.

1096. It does not cause you uneasiness?——No. We have moved towards what the matrons want, and have tried to help her with staff. We are still below our establishment.

1097. Your maintenance and works costs are rather above. I do not think we will spend time on that?——(Mrs. *Benyon.*) We have an immense lot of property attached to the hospital. There are old buildings which we have to service.

Mr. *Hill.*

1098. Would you think that the way to economise would be to spend more capital?——(Mr. *Kitchen.*) Undoubtedly. (Mrs. *Benyon.*) If anyone has seen our four old public assistance institutions there could be no doubt about it. They are a terrible headache. We have four, Townlands, Sandleford, Wokingham, and Wallingford. Wallingford is literally falling down, and the money we have had to pour in these places, even to bring them up to a modest standard—nothing like the standard they ought to be! Unfortunately, we had to take over these four,

* Not reported.
† Evidence p. 126.

and with regard to Wallingford I can only call it a deplorable position. We are making the best of it, and I think the patients are comfortable, but it is very difficult for nursing.

*Chairman.*

1099. Two hospitals, Newbury and Battle, have recently opened beds without engaging extra staff, which has had a corresponding and beneficial effect on the figures. Could that be done elsewhere?——I rather doubt it. There were special circumstances. Battle Hospital was concerned with the chronic patients and there was a reorganisation and also an improvement in some of the wards, structural improvements which made it possible to open those extra beds. I think they had been rather liberally spaced before. Now they are quite within the proper number of beds, but we were able to do that to a greater extent through some structural alterations and reorganisation of the department. Battle Hospital was an old public assistance place. It is in Reading; it was the Municipal Hospital. We are now getting quite proud of it. Before we took it over you could merely describe it as "Dickens" in every particular.

1100. Your turnover rates are above the regional and national average. This presumably explains your low cost per case in acute hospitals. How has it been achieved, generally speaking?——(Mr. *Weston.*) I think it first started by examination of the statistical data that was brought to the attention of the Management Committee where occupancy was low, where turnover interval was high, where length of stay was high. That was carefully considered in the first instance by our Group Medical Advisory Committee and the consultants concerned with that department were informed of it, and they were asked whether an increased turnover could be arranged.

Mr. *Robinson.*

1101. Is this statistical information from the Board or from your own resources?——I frankly get it from my own Group Medical Records Office. We supply the information to the Board, and they collate it. It is sufficient for our purpose. That is how it was spotlighted, and after that it was due to the collaboration and co-operation from the clinicians, and also from the help given by the chairman of the Medical Advisory Committee in saying that something must be done about this cost, as well as pointing out how low occupancy affected the hospital costs, and we did then get the co-operation of the medical staff and nursing staff. I would like to make one point which is this: I think we have just about reached the limit. Frankly, I do not think it is humanly possible to go on further than we are at the moment with safety.

*Chairman.*

1102. Is it turnover you are talking about?——Yes. The strain on our nursing staff is important to be considered. It means that if you have a turnover with nursing staff who are working up to capacity the whole time they have not got the convalescent period when the work is not so heavy. It is having repercussions.

Mr. *Robinson.*

1103. This seems a comparison with the drugs. Here again is a matter in which the medical responsibility is being interfered with by a layman, and with the resultant economy to the Hospital Service. After all the length of time a patient stays in bed after an operation is decided by the doctor and here, if I understand the Secretary aright, the statistics department came along and said "if you can cut down the length of stay in bed, it will increase your turnover and efficiency of the hospital." Am I right in saying the doctors did not resent this approach but on the contrary collected together and met it?——Yes, for this reason: they had information regarding their waiting lists and what demands would be made on their beds and knew they would have to reduce that demand.

* * * *

*Chairman.*

1107. Take Newbury which has a rather lower occupancy rate than the Royal Berkshire, for good reasons. I fully accept the reasons. They have a fairly quick turnover rate, do they not? Are you implying that if there is a lower turnover rate the beds would be fuller, that there would be greater occupancy? ——If we kept people in bed much longer we would have a much greater occupancy than if we kept them in a few days.

Mrs. *Hill.*

1108. How long do you keep your maternity patients?——(Mr. *Weston.*) It varies between ten to 14 days. At the moment it is ten days, due to pressure.

*Chairman.*

1109. The same picture persists for several hospitals in your Group, which are below the national average for occupancy, and above for turnover? ——(Mr. *Kitchen.*) We could take it by each individual hospital, and answer on each.

1110. I do not think we have time for that?——There are special explanations for every one. Hospitals are not all the same, of course.

1111. I am glad you have a quick turnover rate. I am wondering what the length of stay is?——(Mr. *Weston.*) Could I put it this way. The only way you can relate your length of stay, turnover and percentage occupancy is this. If you have a quicker turnover it means you have got more patients for that one particular bed. The only way in order to have a complete hundred per cent. occupancy of that particular bed would be to pop the second patient into the bed immediately the first one goes, but that is completely impossible. There has got to be a certain interval and with high turnover these more frequent intervals have a cumulative effect upon percentage occupancy. Furthermore the patient might have been discharged before the bed count, and comes in the following count. (Mr. *Kitchen.*) Another point is the question of emergencies at the Royal Berkshire.

1112. We quite understand the smaller the hospital the greater the proportion of the emergency beds is to the total number of beds. You agree?——(Mr. *Aitken Walker.*) The medical staff are aware of this difficulty of bed occupancy figures, but we have not forced it on them yet. I say yet, because it may have to come that they should keep a patient in longer than necessary in order to keep the bed full till the next patient is ready to come in.

1113. That would be bad?——It would make the figures much easier.

1114. The interesting point is what have you been doing about it to bring about this state of affairs? Whether it is good or bad is irrelevant. How have you been able to interfere with the doctors to that extent?——(Mr. *Weston.*) In consultation and co-operation. That is the gist of it.

Mrs. *Hill.*

1115. Have you long waiting lists? ——There were 4,200 in 1952. They are now down to 2,400.

*Chairman.*

1116. Can you say why Section 4 beds are so little?——(Mr. *Aitken Walker.*) I am responsible for half of Section 4. They are side wards of the main wards, and there are certain cases I must nurse with a certain privacy and those beds are full for those cases. We have had very little request for Section 4 beds.

Mr. *Robinson.*

1117. You are not putting many paying patients in Section 5 beds, of which there are a large number. Could not that overall occupancy be increased above 60 per cent.?——(Mr. *Kitchen.*) That varies. At one time you have more people wanting to come into private beds than we have beds to put them into. At other times there are lulls in people paying privately.

1118. Would you not agree it is important you should get a high overall occupancy, and if it occasionally results in a paying patient having to wait for a bed, after all, he is only doing what a vast number of non-paying patients have to do?——(Mr. *Aitken Walker.*) We have a long list waiting for the paying patient beds. There is a very wide fluctuation there.

1119. It is a very low figure, you agree?——Yes.

*Chairman.*

1120. On quite a different point, do you feel it is a great advantage for a town or district when all the practitioners are connected with the hospital? ——As far as connection with the hospital is concerned, yes.

1121. I understand that in Newbury all 14 practitioners are intimately connected with the hospital. They think it a great advantage. Do you agree?—— Yes, I do in a place like that certainly, because they are all taking part in it.

1122. Is it possible to extend that in other areas?——It is done in other areas, including Reading, except in the main centres as at the hospitals of a big town.

1123. It is impossible there?——There are so many doctors. We have liaison with doctors, and we have a large number of doctors serving in the various departments. We cannot get them all in because that would lead to difficulty administrating medically.

1124. It is only possible in a country town?——Yes, I think so.

1125. Have all the general practitioners got clinical assistantships?——(Mr. *Weston.*) Certain are graded S.H.M.O. Surgeons, and Anaestheticians and paid by the Board; others are graded G.P. Anaesthetists and paid by the Committee; others are clinical assistants to various departments, again paid by the Hospital Management Committee, and, furthermore, all local general practitioners have access to 12 G.P. medical beds for which they are given a share in the staff fund, of £25 per average occupied bed per annum.

1126. You mean they have first call on them?——(Mr. *Aitken Walker.*) They look after their own patients when they are in.

1127. Would those beds otherwise remain empty?——No, they are used by other sections. The surgical side, for instance.

1128. Where are the Section 5 beds? ——Chiefly in the Greenlands Nursing Home, 22 at the Royal Berkshire, and one or two in the other hospitals.

1129. And Section 4 beds?——(Mr. *Weston.*) On paper we have 10 at the Royal Berkshire Hospital, but purely on paper in view of the demand on that accommodation for patients who require admission as an ordinary case, the others are three at Wallingford, three at Newbury District, and one at Henley.

1130. The percentage of Section 5 beds occupied by paying patients is very much above the national average. It is a minor detail. I was wondering why that was? ——(Mr. *Kitchen.*) We did not know it was greater.

1131. We have exhausted most of the things we are interested in. Have you anything you would like to say to us about what lessons do you think other areas could learn from you. What are you particularly proud of?——(Mrs. *Benyon.*) I think from the lay side we are particularly proud of our liaison with people who are doing the work in the different hospitals in our area. In other words, we are very proud of our arrangements with our House Committees because we have seen that it works both ways. We saw what happened when they had no real responsibility for recommendations and going into the day to day works and we have seen the benefits that have arisen since the system was adopted.

1132. Who instigated the different system?——It originally came to us to look at from the Regional Board, from Sir George Schuster, and we adopted it with great celerity because we felt we were losing the interest of our House Committees, and whilst we felt at the same time that everything financial had to come through our Finance and General Purposes Committee of the Management Committee it has given them both a great pride in, so to speak, administering their own hospital within the limits provided.

1133. Is that what they were mainly referring to when they said greater autonomy should be given to the Hospital Board and Hospital Management Committees?——(Mr. *Weston.*) That was only part of it. The other aspect of the need for greater autonomy to the lowest level is that you do eliminate waste of time and duplication of labour and the sense of frustration. If a Hospital Management Committee can be given the responsibility of spending £1,300,000 a year it is surely wrong that that Hospital Management Committee must go to the Board or to the Ministry on trifling matters. Just to instance that: why should a Management Committee need to ask the Regional Board for permission for one of its officers to go on a three day course? Why must the Management Committee go to the Ministry and ask for permission to put an officer on another incremental point of salary? We feel Management Committees are responsible bodies otherwise they would

not be given this wide power of spending public money.

1134. I should like to ask this. You are not urging, are you, that a Management Committee or a Regional Board, as the case may be, should have more power to initiate expenditure, but more powers to allocate their expenditure?——More powers to use expenditure exactly as they wish.

1135. To allocate, not to initiate?——Yes.

1136. Would you submit to stricter estimating or budgeting?——I do not think the present method could be more strict. We have been extremely careful in the submission of our estimates to Regional Boards and are frankly worried as to what is going to happen next year. I say that without, so to speak, blowing a trumpet. It is a fact. I do not see how it could be stricter.

1137. Do you compare notes directly with comparable hospitals in the region, such as Northampton?——Constantly.

1138. Do you go and see them, do they come and see you, or what?——My colleagues and Finance Officers meet at the Board headquarters once a month. (Mr. *Kitchen.*) They have been to us, and we have been to them, and the Group Pharmacist has been to Northampton with me to examine their expenditure on drugs with ours.

Mr. *Robinson.*

1139. Knowing, as you must, your estimates will be cut down, when your allocations are finally agreed to, to what extent do you inflate your estimates to take that into account?——We have put in realistic estimates to the Regional Board. I would like to explain the case of revised estimates this year in which we asked the Board for a sum of money which included our initial allocation together with wage awards and various other things. We were then over-spent by £7,000 on staff due to quicker turnover, more people coming into vacant jobs. We decided we would save that additional cost and did not add it to the revised estimate. However the Region was forced to make a further reduction of £9,000. We literally cannot live now within our estimates.

*Chairman.*

1140. You agree there must be temptation if you want £100 to ask for £110 and be expected to cut down?——That is quite impossible to do now, actually. The estimating system is based in such a way one has got to prepare it by referring to previous years' expenditure, less any savings on non-recurrent items, and add to it things that have gone through, wage awards and the like. It is not possible now to wangle more in the estimate.

Mr. *Robinson.*

1141. What about developments. There is a little scope there, is not there?——No. We put in now complete itemised lists with any developments we want. They are cut at the Estimates stage anyway, because we have not the money to pay for them. Although a project was originally estimated at £26,000 a year. We do not necessarily get that money. We originally estimate the thing not knowing what is going to happen and we do not get that money until we know how we are going to spend the money.

Sir *Henry D'Avigdor-Goldsmid.*

1142. On traffic accidents, do you find you have a satisfactory system for collecting the amounts due to the hospital on traffic accident cases?——I am very satisfied about the system for collection of R.T.A. cases.

1143. I do not know whether we could have a note of that. I am satisfied that is not the common view of all hospitals?——We will let you have that, with pleasure.*

*Chairman.*

1144. Is there enough co-ordination of experience between Management Committees and Boards?——You are talking administratively.

1145. In everything, your method of collecting traffic accident money, the little trivial detail about the experiment with the swabs, and 101 different details which in the aggregate might be important?——We have discussed at Oxford several times the method for dealing with R.T.A. cases amongst all our colleagues. There is a complete exchange of knowledge on these things month by month.

1146. If one hospital gets a tiny way of making an economy is that, after being satisfactorily proved, quickly circulated

* Not reported.

to other hospitals?——We are very quick to notify the Regional Board to get a medal for our chests. They disseminate the information very quickly round the region. (Mr. *Weston.*) I think the relationship and exchange of information in the Oxford region is very good indeed. (Mrs. *Benyon.*) It could not be better. We have all felt the greatest respect and admiration for the officers and the people who compose our regional Board. We have our differences with them sometimes, but I do not think it could be a more happy relationship.

Mrs. *Hill.*

1147. Can I ask this question: I am looking at item 27 of your Report.* You see there "Canteens and Shops", and I notice you have quite a sum of money there. How does that accrue, and is that profit or is that turnover?——(Mr. *Kitchen.*) This is the amount of money received in respect of sales from canteens and shops. We have a large shop at Peppard Chest Hospital where the patients buy requisites. At one time that was making £500 a year for the Special Fund at Peppard. Since it has been transferred the Exchequer benefit from that profit.

1148. Who runs that?——It is run by the Hospital Management Committee.

1149. By a paid staff?——By a part-time paid staff and with part-time assistance from the administration.

*Chairman.*] Thank you very much for your evidence.

* Not reported.

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TUESDAY, 12TH MARCH, 1957.

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Members present:

Mr. Nicholson, in the Chair.

Sir Henry D'Avigdor-Goldsmid.
Mrs. Hill.
Vice-Admiral Hughes Hallett.
Mr. Robinson.
Captain Waterhouse.

**Extracts from a Memorandum submitted by Springfield Hospital Management Committee.**

(1) **Description of Management Committee**

The Management Committee of Springfield Hospital consists of the Chairman, Mr. T. E. Parker, J.P., the Vice-Chairman, County Councillor Mr. D. W. Chalkley, and twelve others, including five women Members. There are two vacancies. The twelve Members include one Consultant (Psychiatric) and one ex-Hospital Matron, but both of these leave the Committee on the 31st March, 1957.

The main Sub-Committees of the Management Committee consist of:—

The House Sub-Committee.

The Works Sub-Committee.

The Farm and Garden Sub-Committee.

The Establishment Sub-Committee.

The Finance and General Purposes Sub-Committee.

All Members of the Management Committee are appointed to sit on any of these main Sub-Committees.

The main Sub-Committees meet once monthly on the second Friday in each Calendar month.

The Management Committee meets once monthly, on the third Friday in each Calendar month.

Other standing Sub-Committees of the Management Committee are:—

The Joint Consultative Committee.

The Educational and Nursing Advisory Committee.

All Members are eligible to serve on an Appeals Sub-Committee and the Chairman of the Management Committee is empowered to appoint an ad hoc Appeals Sub-Committee for each case arising.

Meetings of the House Sub-Committee are attended by the Medical Superintendent, Matron, Chief Male Nurse, Catering Officer and the Church of England Chaplain.

Wards and all parts of the Hospital are visited regularly by Members, so that each part is inspected once every two months.

At the request of Members a fortnightly Visiting Rota has been compiled whereby any two specified Members have a period of a fortnight during which they can, if they wish, visit the Hospital without notice at any time of the day, and submit a report to the House Sub-Committee.

(2) **Numbers, Grades, Duties and Qualifications of Administrative and Clerical Staff**

Group Secretary, Finance and Supplies Officer (Mr. Tarlton—F.H.A.).*

Deputy Group Secretary, Finance and Supplies Officer (Mr. Connor—A.H.A.).*

Senior Administrative Assistant (Miss Fielder).

Senior Supplies Assistant (Mr. Squires).

* By examination.

*General Administrative Office:—*

1 Clerk, Grade D (Mr. Wilson).

1 Clerk, Grade C (Mr. King).

1 Personal Clerk to Group Secretary—Grade C (Miss Free).

1 Shorthand-Typist (pool duties)—Grade B (Miss Rose).

3 Clerical Assistants, Grade AI-2 (Mrs. Flood and Mr. Ludbrook) and Grade AII-1 (Mrs. Rose).

*General Finance Office:—*

1 Clerk, Grade E (Mr. Hatfield).

2 Clerks, Grade C (Mr. Rendle and Mr. Finlayson).

3 Clerks, Grade B (Messrs. Manning and Carter, and Miss Cottrell).

1 Clerk, Grade AII (Mrs. Leary).

*Supplies Department:—*

1 Clerk, Grade AI (Mr. Pullen).

*General Stores:—*

Storekeeper, Grade E (Mr. Withers).

Deputy Storekeeper, Grade B (Mr. Rogers).

4 Clerical Assistants, Grade AII (Messrs. Feldmanis, Dines, Burnagel and Rabbits).

*Building and Engineering Stores:—*

Storekeeper-clerk. Miscellaneous. Grade IV (Mr. S. Hutton).

Clerical Assistant, Grade AII (Mr. Mexson).

*Medical Superintendent's Clerks :—*
1 Clerical Assistant, Grade C (Mrs. Butler).
1 Clerical Assistant, Grade B (Mrs. Brants).

*Psychiatric Social Workers' Department :—*
1. Clerical Assistant, Grade B (Miss Ingleton).

*Matron's Clerk :—*
1 Clerical Assistant, Grade AI (Miss Douglas).

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**(3) Description of the Hospital and of the Types of Patients Admitted**

The Hospital consists of a Main Building, an Admission Hospital, an Infirmary Block, a single ward Male infirmary building partly for T.B. patients, a neurosis centre for twenty female patients, a Nurses' Home and an Annexe at New Malden (7 miles distant) for over three hundred long-stay female patients.

Additionally, there are two separate O.T. buildings, one for each sex, Staff Dining Rooms, extensive Works departments, a pig farm and market gardens.

All types of patients are treated here, part of the Hospital being utilised specially for therapeutic activities, part for convalescent patients, and the remainder for the care of long-stay patients. Research, both clinical and psychological in character, is carried out extensively. All modern treatments are regularly practised.

The admission rate is very high—over a thousand per annum.

**(4) Implementation of Financial Responsibilities**

In the first place the Annual estimates, based on prices and wage rates at 30th September of each year, are prepared with great care and are subjected to scrutiny and detailed discussion in the Finance and General Purposes Sub-Committee.

Once estimates are approved by the Regional Board, a monthly comparison is made between the estimate figures (under the correct allocation headings), and the actual expenditure to date. A table showing in detail any over or underspending is placed before each Meeting of the Finance and General Purposes Sub-Committee. Stock levels are kept down to figures to conform with the Ministry's requirements.

Wherever possible, purchasing is done by competitive tenders. Under to-day's unsettled conditions, period contracts are not of great use. Every opportunity is taken of forward buying when there appears probability of a rise in price of any commodity.

With regard to salaries and wages, every care is taken in assessing correctly each new entrant into the service of the Hospital. Additional staff to the proper establishment is not permitted without reference to, and sanction of, the Regional Board.

There is full accounting procedure for the receipt and issue of goods and monies. Inventories are kept and regularly checked. Duties among office staff and others, are so arranged to give maximum security.

**(5) Major Improvements in Recent Years**

Since 1948, when the Hospital was taken over by the Ministry of Health, most of the leeway in repairs and redecorations left over by the War period, have been taken in hand. Numerous improvements to the Wards, and other parts of the Hospital have been carried out, including redecoration both internal and external, and much rewiring. Lavatories and old fashioned fireplaces have been replaced all over the Hospital, as redecorations have taken place. In addition, floor coverings have been renewed and curtains provided for most windows, particularly on the female side. The lighting of the wards has been improved out of all knowledge by the installation of fluorescent tubes.

The three big kitchens attached to the Hospital have been largely brought right up to date with new equipment, and efforts are being made to improve the means of food transportation. The bakery has been provided with modern machinery while under expert advice, the laundry has been redesigned and re-equipped with new labour saving and drying apparatus. The furniture of the Wards has been replaced so that the old "institutional" look might be eliminated (the Hospital was built in 1841).

The cost of all this work has naturally been considerable, but the Hospital's budget allocation has never been exceeded by its expenditure excepting in one year, when through the use and high cost of a new drug (Chlorpromazine) which gave promising results, the expenditure exceeded the budget total by £2,010. As against this, in an earlier year, when the Ministry of Health called for a special effort in economy, the Hospital returned £10,000 to the Exchequer at the end of the financial year.

Among the larger improvements at the Hospital recently are :—

(1) Conversion of old Army searchlight section hut to Staff Canteen.
(2) Conversion of old farm implements shed to Male Occupational Therapy department.
(3) New dining room for Female Nursing Staff.
(4) New film projectors (35 m.m.), screen, curtaining, and furniture for Main Recreation Hall.
(5) New Occupational Therapy building for Female patients.
(6) Replacing corrugated iron walls and roofs of two large buildings at Malden Annexe with brick walls and corrugated asbestos roofs.
(7) New water-softening plant installed.

Nos. (4) and (5) were the result of grants from the King Edward Hospital Fund for London.

Nos. (3) and (6) were the result of special capital grants from the Regional Board.

(6) **Significant Reductions in Expenditure**

(See answer to (5) above.)

A scrutiny of staff took place, and certain vacancies as they occurred, were not filled. Purchases of new furniture and other replacements were cut to the minimum.

£10,000 was saved.

(7) **Staff Increases Authorised in Recent Years**

1 Assistant Occupational Therapist, April, 1953 (in place of a Sports and Welfare Officer).
1 Clerical Assistant, Shorthand Typist, April, 1956.
1 Clinical Psychologist, 1956.
1 Assistant Occupational Therapist, June, 1956.
1 Assistant Engineer at Malden Annexe, replacing stoker-handyman, 1956.
2 Cooks, September, 1955, and June, 1956.
1 Female Assistant (Catering Staff) June, 1956.
1 Plumber and Mate as a temporary expedient (for 6 months) through illness among plumber staff, 1956.

(8) **Purchasing Arrangements**

*Provisions :*

Purchases made by the Catering Officer. With the exception of Flour and Milk for which we hold Contracts, buying is carried out in the main by competitive quotations.

*Drugs and Dressings:*

*Medical and Surgical Appliances.*

Purchases made by the Pharmacist. Where possible, these are made through the Joint Hospital Contracting Scheme, otherwise bought direct by competitive quotation.

*Domestic Renewals, Clothing and Uniforms, Occupational Therapy, Canteen (Shops):*

Purchases made by the Supplies Officer. Items other than those on Central Supply Contracts are purchased by competitive quotations, with exception of Occupational Therapy and Canteen.

(9) **Significant Rises or Falls in Running Costs**

Few rises or falls of a significant nature have taken place here during the past few years, with the one exception of the heading of "Drugs, etc.". This shows cost increases over the last three years.

| | *1954* | *1955* | *1956* |
|---|---|---|---|
| *Total cost* | 10d. | 1s. 8d. | 2s. 3d. per patient per week. |

The reason for this was extensive use of the newer and more costly drugs, such as Chlorpromazine.

All other changes in cost here have followed the national trend in an upwards direction, whenever salaries or wages increase, or rises in the price of commodities have been announced.

| | *1951* | *1952* | *1953* | *1954* | *1955* | *1956* |
|---|---|---|---|---|---|---|
| | £ s. d. | £ s. d. | £ s. d. | £ s. d. | £ s. d. | £ s. d. |
| Average weekly cost (nett) (per patient per week) | 3 12 5 | 3 17 1 | 4 2 8 | 4 7 9 | 4 14 2 | 5 4 8 |

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**Examination of Witnesses.**

Mr. T. E. PARKER, J.P., Chairman, Dr. H. C. BECCLE, M.B., M.R.C.P., D.P.M., Medical Superintendent, Mr. W. J. TARLTON, F.H.A., Group Secretary, Finance and Supplies Officer, and Mr. M. B. CONNOR, A.H.A., Deputy Group Secretary, Finance and Supplies Officer, Springfield Hospital Management Committee, called in and examined.

*Chairman.*

1150. Your Committee consists of twelve members, does it not?——(Mr. *Parker.*) Yes.

1151. Have they any special local interests?——No, the Hospital does not serve the area where it is situated. Its catchment area is that of the ex-Middlesex County Council Hospital, which originally served before 1948 the catchment areas on the west of Middlesex, Staines, Ashford, Uxbridge, Ealing, but since the Health Service has now lost part of this catchment area and now takes part of Hammersmith, Paddington.

1152. If I wanted to get there, how do I get there?——From here you would go to a Tube station, Tooting Bec Station, Tooting, and get a bus.

1153. It is on the edge of Wandsworth Common?——Yes.

1154. Have you any organisation for arousing local interest, or anything like that?——No, Sir. We have a League of Friends. It is most difficult to raise local interest in a hospital where no patients come from the locality. Therefore, what we have begun to do—it is working quite satisfactorily—is for the relatives of the patients of the hospital to form themselves into a League of Friends, and they do that which one would expect with regard to a hospital with attachments locally.

1155. Do you think that the professional element is over-represented or

under-represented?——We are rather blessed, Sir. It depends which way you look at it. When you say "professional", do you mean women nurses and doctors?

1156. Yes?——A local practitioner was appointed and she found she could not do the job. Normally, I think it is about a reasonable amount of representation we have on the Committee of professional people.

1157. I should like your opinion, as representing a typical mental hospital: do you think that the medical experts should be members of a Hospital Management Committee, or do you think they should attend as expert advisers?——My own feeling would be for the medical members to give expert advice to that Committee.

1158. And not be members?——And not be members.

1159. And the same for nursing?——Yes, I would say for nurses too.

1160. Perhaps you would answer this: would you say that is the general view in Mental Hospital Management Committees?——No, Sir; I am only speaking of my own opinion. I have discussed it with colleagues, and I should say that generally they feel if they could only call in as advisers medical and nursing persons they would feel they would get the advice to guide them in their decisions. (Dr. *Beccle.*) I rather agree. I think medical functions can be best served by an adviser, but it is obviously likely to give rise to administrative difficulties to the Physician Superintendent . . .

1161. You run on the Physician Superintendent system?——Precisely.

1162. Do all mental hospitals?——At present, yes.

1163. You find that it works satisfactorily?——We think so, yes.

Mr. *Robinson.*

1164. Can I ask if Dr. Beccle has as of right a chance to go to meetings of the Management Committee?——I am invited to attend. I do not know that I have a specific right.

1165. Do you automatically attend all meetings?——Yes, it does work like that—all meetings.

*Chairman.*

1166. You have one psychiatric consultant—twelve members, including one consultant psychiatrist?——(Mr. *Parker.*) Yes, appointed by the North-West Metropolitan Regional Hospital Board for liaison between the North-West and South-West Metropolitan Regional Boards. Dr. Blair is a member of the consultant staff of St. Bernard's Hospital, Southall, and comes on to our Committee appointed by the North-West Regional Hospital Board.

Mr. *Robinson.*

1167. It is a fact, is it not, that your hospital takes only patients from the North-West Metropolitan Region?——Yes.

1168. Although you are yourself in the South-West Metropolitan Region?——Yes.

*Chairman.*

1169. I can only ask your personal opinion on this: do you feel that there will be difficulties in the future in getting people for the post of Chairman? What is your opinion as to whether they should receive part-time payment, as Chairmen do on other statutory Boards?——To give part-time payment to Chairmen I do not think would help.

1170. Or whole-time?——Not even whole-time. I do not think a Chairman should be whole-time in a hospital. My feeling is that the present system works quite satisfactorily, and you do find people who are prepared to be Chairman and members of the Committee because of the public work involved.

1171. Do you find you feel anxious about the future?——No. I think the method of selection in the case of Management Committees is a case for Regional Boards.

Mr. *Robinson.*

1172. Can you give some idea as to how many days a week the job of Management Committee Chairman takes up, or how many days per month?——Now a day a week is more than sufficient; I feel at present a day a week is more than sufficient to do the job of the Management Committee. In the early days it was necessary to have two days, but now it is running like a well-oiled machine. The Officers know the

Committee, they know the policy of the Committee, and therefore one day a week is more than sufficient merely to discuss with the Medical Superintendent and the Group Secretary any outstanding point or matters which might require attention in the sittings of the Committee.

*Chairman.*

1173. Am I right in my impression of a mental hospital that it can run more on a routine basis than in the case of the ordinary type of hospital?——Well, Sir, I do not think it is quite like that. I am both a member of a general group and a mental group, and I find that a Chairman of a general group would go into more appointments than I would as the Chairman of a mental group, but, by and large, the duties fall roughly into the same category.

1174. I think you say here that your Committee members can visit the hospital without notice on a fortnightly visiting rota. Do you find that a good thing? Why do you really like that? Why cannot the members of the Committee make a visit at any time?—— They can; but it was thought that it was rather a hit-and-miss sort of affair when it was felt that the members would pop in and out. We felt that if we had a rota it would be better. They can choose any day to go in, of course, and any time, and they submit their reports to the House Committee.

1175. They make a point of doing it? ——Yes, they make a point of doing it.

1176. The idea is to see that the thing is covered?——To see that the job is covered.

1177. What is your function, Dr. Beccle?——(Dr. *Beccle.*) I survey the administrative territory generally. I keep a clinical control over the medical staff, which is necessary at the moment. I deal with a vast and voluminous correspondence.

1178. Would you call yourself the General Manager of the hospital?——It approximates to that, indeed. It is both clinical and forensic.

1179. And administrative?——And administrative, yes, indeed.

1180. You are the General Manager or Managing Director?——Yes; I do not think I ever aspire to those heights, but it is roughly that.

Mr. *Robinson.*

1181. Do you have a clinical responsibility for a number of wards?——Not wards. Legally, I am responsible for every patient in the hospital.

1182. What about out-patient clinics? ——Yes. I myself do an out-patient clinic, as do all the other senior Doctors.

*Chairman.*

1183. Did you climb the ladder in the mental hospital service?——I climbed the ladder in the service. I never practised privately.

1184. It is a regular profession like that?——Yes.

1185. You could have left it at any time?——I could have done. I preferred not to, of course.

1186. Turning to Mr. Tarlton and Mr. Connor, I see they were selected after examination.* What did that mean, quite?——(Mr. *Tarlton.*) It was a time shortly after 1948, when senior officers in the Health Service who had not passed the qualifying examination of the Institute of Hospital Administrators could, by paying the necessary fee, use the letters A.H.A. or F.H.A., depending on their status in the hospital.

1187. The asterisk applies to them as F.H.A. and A.H.A.?——Mr. Connor and I did take an examination. It was not a title which was given to us.

1188. It was not an examination set by the hospital?——No, the Institute of Hospital Administrators.

1189. Not this particular hospital?—— No.

1190. Are you satisfied with the quality of staff under Mr. Tarlton and Mr. Connor?——(Mr. *Parker.*) It is a rapidly changing staff, Sir, and I would say that the type of entry into the service, going on my own observations from before 1948 and since, is that the standard is lower.

1191. Does that apply to all grades? ——What do you mean by all grades?

1192. In the general administrative office, Mr. Wilson and Mr. King.

* Evidence p. 150.

Obviously it does not apply to clerical assistants or shorthand-typists?——Yes; I would say there is a lowering of standard.

1193. What remedies would you suggest?——One springs very easily to my mind, and that is to say more money, but I do not think that is the answer completely to the recruiting of staff. It would mean, I think, that the mental hospital service would have to make itself known, and this would follow not from the clerical aspect but throughout the Hospital Service. The mental hospital service is a service which gives opportunity for promotion within that service.

1194. Are you suggesting that if one formed what one might call, for lack of a better term, a Hospital Civil Service, the mental hospitals should be something apart; because the administrative problems are much the same, are they not?——I should say they are a little different from the general conception of a hospital.

1195. You would not promote from one to the other?——No, I would not. Recently there was an occasion at a hospital in the South-West Metropolitan Regional Hospital Board where an applicant for the post of Group Secretary with no experience in mental hospitals whatsoever was appointed as a Group Secretary. That, from the observations made from people I have met, was regarded as something which would mean those people working and giving all their time to the mental hospital felt that their opportunity for promotion is going to be very, very small.

1196. Surely there is more opportunity for promotion if it is one big service than if you have it in compartments?——You see, the mental service on numbers is far smaller than that of general hospitals.

1197. My point is that if you have them all thrown in together, if there is "cross-promotion", it gives people in the mental service the chance to go into the ordinary hospital service?——I doubt it very much.

1198. Have you ever known a mental hospital Secretary to move into the Secretaryship of a general group?——I have never known it. I can give you an instance of a General Secretary moving from a general group into a mental group, but I have never known a mental Officer going into a general group.

Vice-Admiral *Hughes Hallett.*

1199. Supposing there was a general service for all hospitals, are you suggesting that even if in the course of the man's journey up the ladder he had a certain number of posts in mental hospitals and a certain number in general hospitals the difference would be so great he could not grasp both kinds of work?——I am not saying the person would not be of intelligence to grasp both kinds of work, but it does require in a mental hospital something different from that required in a general hospital. Much of the work is taken up by dealing with patients' pocket money, with patients' pensions to a very large degree, which is different from the position in a general hospital. They are dealing with patients' amenities in a far greater way than in a general hospital. If you made it a general service, I feel that the opportunities for people who devoted the whole of their career to mental hospitals would be jeopardised by virtue of the fact of the difficulty in the service that would mean people would be able to be recruited into and block promotion.

1200. Looking at it from the point of view of somebody joining the service as a young man at the beginning, would that point arise?——If you could make the service interchangeable, I do not see any reason why not, if it could be done. If it could be done, I think it would be good for the service. That would be my own opinion, but whether it is practical is a matter that would have to be gone into very carefully.

Mrs. *Hill.*

1201. Is it the position that we have not yet got the mental hospital out of that compartment where we used to have it even before the Act?——Indeed.

1202. Really it is a matter of understanding that to be mentally ill is no different from illness in some other part of the body, and that is the sort of thing we should try and get people to understand?——By and large that would be so.

1203. That would allow them a greater respect of those people who spent some

time in the mental hospital service?——Yes.

*Chairman.*

1204. Is there an element of vocation in the mental hospital service?——Yes, indeed.

1205. Which grows on people?——Yes. I have grown attached to being a member of a Mental Hospital Committee, and I would prefer, if it was a choice between general and the mental, to take the mental before I accepted the general. There is far more to do, and by and large it is far more interesting.

1206. That is most interesting evidence. What promotion prospects have your administrative staff got outside your hospital?——It has been rapidly changing since 1948. I can think of perhaps twenty or thirty people leaving our service and taking higher posts in other mental hospitals.

1207. Are you up to establishment?——Yes, we are.

1208. Your recruitment difficulties, you would say, are of getting the best type rather than of getting anybody?——Indeed. The best type is the type that will be of importance from the point of view of preparing important statistics both for the Ministry and the Board. They are very difficult to get. We get young people, typists, indifferent typists at that, of course, but we can recruit those reasonably easily.

1209. Is your only main remedy to pay more?——No, I do not think so. I do not think the matter of pay is the answer to the recruitment of better types of people in mental hospitals; I do not think it is the whole answer. I think it is a matter that the mental hospital has got to get better publicity.

1210. More status?——Better status; that, I think, is the whole thing. It is so wrapped up with recruitment of nurses. This thing is not confined to clerical staff. This goes to the whole of the staff employed in mental hospitals, with perhaps the exception of the works, where you have a different story altogether.

1211. How do you get staff?——We advertise in the local papers for general staff or in the national papers for the more senior staff.

1212. How do you get your nurses?——We advertise for nurses and are building up a reputation of having a very excellent school. By the progress of our school we build up a reputation and get people recommended to us by the nurses trained there.

Mr. *Robinson.*

1213. How far are you short of your establishment of nurses?——We are very low indeed. I think, subject to confirmation by the Doctor, I should say that on the female side we are 118 as against an establishment of 160.

1214. And on the male side?——We are 7½ short—130 is the establishment. I think we have 123.

*Chairman.*

1215. This is in Table —,* is it?——Yes.

1216. Do you think it is essential for administrative staff to be recruited and appointed by the Hospital Management Committee?——I do indeed, Sir. The reasons I gave for that are money. I believe that as a result of the selection of officers by a Hospital Management Committee you have the man on the spot and are able to assess his suitability for that particular post. It means a great deal to a Hospital Management Committee. May I give you an instance to explain that? We went to the Institute of British Launderers Ltd. for an investigation of our laundry. There was a bottleneck on the laundry and we wanted to investigate it. They submitted a report to us on the organisation of the laundry. The cost ran into some thousands of pounds which it would have been possible to obtain at the time, two or three years ago, and the officials were able to implement the policy in the Launderers' report. There was a heated chamber of two-floor construction used for drying, which was demolished and replaced by a new Lister Airspeed dryer. This machine was originally supplied to the Government for army use, but was bought by us for £600. This, together with the cost of a drying tumbler giving the maximum load to us, meant a saving of £1,000. This meant an increase in the number of articles from 26,000 to 31,000 articles a

* Not reported.

week without employing additional staff. We felt that it was an economy which was only made possible by the calibre or the efficiency of the officers employed by us.

1217. I do not quite see the connection with the question of whether you should appoint your own officers or whether they should be appointed by the Regional Board, or even on a national basis?——Well, Sir, the persons on Management Committees could very well be in the same position as being members of a Regional Hospital Board. There could be no difference in personnel really. Any one of the members of a Hospital Management Committee could be a member of a Regional Hospital Board, and knowing the requirements of the hospital, the type of people who are going to do the work or the officers whom we are going to employ is an advantage, rather than it being done at the Regional Board Headquarters at Portland Place or any other headquarters removed from the hospital.

Vice-Admiral *Hughes Hallett.*

1218. I am still not quite clear why you should say that. Let us take the Post Office as a parallel. The General Post Office in a great city requires a staff of the highest calibre, but, as far as I am aware, the appointments are not made locally but by the Postmaster-General, are they not?——The difference between the Post Office, if I may say so with respect, and a hospital is that a hospital is dealing with individuals. We appoint people not only for their ability to do the job, but for the personality they may have for the purpose of dealing with those patients in the hospital, as we feel we are the people on the spot and are better judges than people who may be appointed at Regional Hospital Board level, or on any other level.

*Chairman.*

1219. Would it be true to say that at back of your mind is the feeling that you are much more likely to work successfully with people you appointed yourself rather than people wished on you?——Indeed, partly. I am taking it from the point of view of the Hospital Management Committee. Many functions performed by the Regional Hospital Board could easily be performed by the Hospital Management Committee, and if you took away most of the functions of the Hospital Management Committee, apart from your local knowledge of the hospital, it does mean you get people who would probably refuse to go on committees which sit there just for a pleasant afternoon and a cup of tea. If you are going to appoint people to Management Committees there should be trust in those people able to do the job in the best interests of the hospital service. At the moment, if we appoint a senior doctor, we go to the Regional Hospital Board to appoint him. He is quite easily appointable at Hospital Management Committee level.

1220. There is a lot to be said on both sides, of course?——Yes.

1221. Are many of your patients long-term patients?——(Dr. *Beccle.*) A very great number are of necessity long-stay patients because of the nature and quality of mental disorder, but, at the same time, in recent years, with the tremendous therapeutic advances that have gone on, this position is likely to rectify itself very considerably.

1222. There will be always a hard core of "old sweats", as you might say?——Yes, just as there is in physical medicine, irrecoverable physical elements.

Vice-Admiral *Hughes Hallett.*

1223. Is there a mixture of certified and voluntary patients?——Yes.

1224. What is the rough proportion between the two?——It is difficult to say at any one moment. The best figure I can give you is that approximately two-thirds of all admissions are voluntary patients, and they do not tend to linger, for obvious reasons.

1225. Are they segregated inside the hospital from certified?——As far as is humanly possible, yes.

*Chairman.*

1226. You said all admissions. That does not mean all patients?——I said all admissions.

1227. That is quite a different thing? ——Completely different, yes.

1228. Can you distinguish between the two? Am I right in thinking that the voluntary patients are a quicker turnover?——Yes, a much quicker turnover.

1229. Taking your 2,000 odd patients at any given moment, how many are voluntary?——It is very difficult to say.

Mr. *Robinson.*

1230. Would it be as high as a quarter?——Yes, I should say about a quarter.

*Chairman.*

1231. How many of the certified patients have been there years and years and years?——Let us take an arbitrary figure. Ten years or fifteen years.

1232. Yes?——Somewhere in the region of 750, I should say.

1233. That is an appalling figure?——It is an inevitable one.

1234. There is nothing that can be done about it?——At present, no. As I said, this is largely due to the lack of any kind of therapy, say, two or three decades ago.

1235. What sort of research do you do?——Research is both clinical and psychological. The clinical deals with the investigations into the whole host of new medicines about which information floods in constantly. The psychological research is based on a firm liaison we have with the Institute of Psychiatry, that is to say, the Maudsley Hospital.

1236. Does the research cost a lot?——It costs us nothing.

1237. You do it in the course of your daily job?——We do it in the course of our daily job.

1238. You have not a Research Department?——Not specifically as such. It goes on all over the hospital.

1239. As far as modern treatment is concerned, which you refer to in section 3*, that is all the usual things, electro-convulsives, etc.?——Yes, electro-convulsive treatment, deep insulin, various tranquillisers, with which we are experimenting, some of which have proved very successful, and neuro-surgery, of course.

Mr. *Robinson.*

1240. Referring to your earlier answer about nothing being done for long-stay patients, do you think much can be done for them if you had a larger medical staff? Are you up to medical establishment?——No, we are not.

1241. Can you say why you are not up to it? Does the Regional Board——?——That is not in our hands.

1242. They will not appoint up to establishment?——Apparently there are one or two difficulties, but gradually we are acquiring more and more staff. As a matter of fact, I have a consultant coming to me in a couple of months' time, a new man.

*Chairman.*

1243. How many are you below?——We should be 12, officially, and we are 10.

1244. The picture of the hospital for your area is one of 700?——Yes.

1245. If you leave out the hard core, what is your turnover rate for the rest?——Taking the admission rate level, between 1,000 and 1,200, the percentage social admissions—social recoveries—we cannot really speak of complete recovery in psychiatry, it is not possible, discharges in either were between 80 and 82 per cent.

1246. Of the 1,300?——Of the 1,200 or 1,300.

1247. So that the average stay of the 1,200 or the 1,300 is not much over a year?——Oh, no, it is not, and quite often much less. We estimate that an acute psychotic episode, as it is known to us in clinical jargon, would take about eight weeks with modern treatment, as against three months doing deep insulin therapy, and as against seven months when there was no ad hoc treatment at all.

Vice-Admiral *Hughes Hallett.*

1248. Do you experience any difficulty when you wish to release one of the patients who has come in, having been certified, in getting them accepted back in their home again?——It does occur, of course, particularly where the previous history has been bad, and there has been a history of vocational instability or anti-social conduct, etc. Then we do have some difficulty in restoring the patient to his particular milieu, but there again we have other methods of dealing with the situation by After-Care Associations and all the various philanthropic bodies to which we can apply.

1249. Have you an appreciable number at the hospital who, from your point of view, you would rather see discharged but you have got to keep them because you cannot dispose of them?——Only

* Evidence p. 151.

the elderly ambulant folk for whom there is a great need for a different kind of institution or a different system. They are a problem. Otherwise there is no problem.

Mrs. *Hill.*

1250. What sort of proportion would you have among the elderly people where it is really senility and not anything else? ——It is very difficult to say, but I should think that if there were such hospitals or long-stay homes, I think we could discharge somewhere about 100 people.

*Chairman.*

1251. Is there a sort of "boarding out", anything like that?——The drive is to create more and more old people's homes nowadays.

1252. You think you could transfer to them?——I think so, with comparative ease.

1253. They are quite safe, just senile? ——Yes; a number of old people who have been living alone in single rooms and are suffering from malnutrition rather than psychosis. They arrive in hospital, and nursing and good food is all that is required.

1254. This Committee, of course, is interested in finance. Would it be a saving to put them into old people's homes rather than to have them in hospital?——It would not, because small homes are much more expensive to run

Captain *Waterhouse.*

1255. Do patients do a great deal of the work in the hospital?——They do a considerable amount of work on a voluntary basis.

1256. Are they used as much as you can?——From the point of view of the routine tasks in the utility departments we employ them, as I say, if they like to go; otherwise there are quite extensive occupational facilities.

1257. When you say "if they like to go", do you ask them if they would like to?——Yes; for example, in the laundry.

1258. If they refuse and you think they are capable and that it would be better if they did go, have you any means of telling them to go?——No.

1259. Would you like to have some means?——No.

1260. Do you pay them when they work?——Yes.

1261. The normal outside wage, or what?——That would not be possible. The amounts vary between 8s. and 10s a week, something of that sort.

1262. Are you allowed to pay them more?——I think the Management Committee have the prerogative to increase the amounts, but it would not be wise.

1263. If you were able to pay them more you would not like to pay them more, and you do not think you would get more to do the work?——I do not think so, no. In exceptional cases it would be possible, but we find that in a fair number of cases this money is accumulated and then, unfortunately, vanishes.

1264. You are quite content with this particular state of things. You have all the facilities you need?——I think so.

Mrs. *Hill.*

1265. What sort of sum do you have in hand belonging to the people as a result of these payments, or their allotments; is it considerable?——(Mr. *Tarlton.*) I do not think I have a separate figure. It is credited to pocket money; it is part of the general fund; it is quite considerable. (Mr. *Parker.*) Roughly £10,000 in patients' credits.

*Chairman.*

1266. I see your admission rate and bed occupancy figures are high above the national average. Have you any reason for that, or is that just chance? ——I think it is pressure on the beds which we have in the department.

Mr. *Robinson.*

1267. Is there a waiting list for voluntary patients?——(Dr. *Beccle.*) At the moment, no, but there has been. There has been a slight decline in the last month in the number of admissions. We have been able to clear both lists off. Our catchment area is becoming increasingly dense as the years go by. Huge blocks of flats are going up, and that is influencing the admission rate.

Vice-Admiral *Hughes Hallett.*

1268. You referred earlier to the great improvement made in medical technique. Do you expect this to result in a fall in the proportion of our mental hospitals

in the course of the next five or six years?——I believe it is falling. We are now able to give treatment with modern methods in a more effective manner than otherwise. It looked at one time as if we would reach a saturation point, but the rapidity of the turnover and the quality of the treatment has helped us tremendously to cope with this problem.

*Chairman.*

1269. Table —* does not seem to fit in with Table —*. What is the reason for that?——(Mr. *Parker.*) The number you have got in Table — is the number of psychiatric out-patient attendances at the hospital proper. The attendances on Table — include also those out-patient attendances at St. Charles, King Edward Hospital at Ealing plus X-ray, sight-testing, etc., at Springfield.

1270. I knew there was some simple explanation. They as a whole have fallen according to Table —, which is the inclusive Table. Is there any reason for that?——(Mr. *Connor.*) The Ministry changed their minds about working out the number of out-patient attendances.

1271. Changed their mind?——Yes. There is a difference in working out the number of out-patient attendances as in 1953 and in the later years.

Vice-Admiral *Hughes Hallett.*

1272. Calculated on a different basis? ——Yes. I am sorry that I cannot tell you offhand why.

Mr. *Robinson.*

1273. But there has not been any fall in the number of out-patient clinic sessions?——(Dr. *Beccle.*) We have not noticed any fall numerically.

1274. In the clinic sessions?——The number of sessions, no.

*Chairman.*

1275. To turn to financial control, what do you do if the money allocated to you is considerably less than what you forecast is required?——(Mr. *Parker.*) We sit down and, with the aid of our officers, see where we can trim the estimates on the various subheads to come within the required sum that has been allocated to us by the Regional Hospital Board.

1276. What do you do if during the course of the year expenditure is exceeding the estimate?——We have never done it, only on one occasion on drugs, and that was explained to the Regional Hospital Board, who made a special allowance that year for the purpose. But since 1948 we have never overspent, and in fact on one plea from the then Minister of Health we were underspent by £10,000 on the budget allocated for that year. We have never been able to do it since, much as we would like to save money, because of the amount of work in hand at the hospital and the need to give the patients a better atmosphere and better buildings.

Mr. *Robinson.*

1277. If you suddenly found you got the number of nurses needed, you would soon spend your allocation?——Yes; but we have no hope of that. In the South-West Board, with regard to any moneys allocated for nurses' salaries, we are only allowed to use that money for nurses' salaries. That is a rule of the Board, and we are unable to break it. The only concessions which we got on that was in conversations with the South-West Board. They said that if we could point to the introduction of labour-saving devices, thus saving nurses' work, they would then perhaps consider making a grant for the money we are underspending on nurses' salaries.

Vice-Admiral *Hughes Hallett.*

1278. You have two-thirds of the number of female nurses you should have?——Yes.

1279. Can it be said that the service given by the hospital is suffering as a result of that, or would you say that the full establishment would be unduly generous?——I think that the service is strained. We are using in the wards staff nurses, or student nurses, or an assistant nurse, for the purpose of taking charge of a ward. That is the only way we can spread our staff over.

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Mr. *Robinson.*

1281. Can you give any idea how much you pay in overtime for nurses in the course of a year?——We keep the overtime for nurses, particularly with male nursing staff, at no more than the normal establishment laid down. That

* Not reported.

is to say, if there are 123 they have sufficient man-hours to cover the additional seven male nurses, bringing them up to 130. On the female side it is much less indeed.

1282. It does not amount to a great deal?——It does not amount to a great deal, as I previously said.

*Chairman.*

1283. A number of answers which you have given gave me the impression that you were compelled to cut your coat according to your cloth?——Yes.

1284. Does not that suggest that sometimes your demand for "cloth" is more than you really need?——No, not really. The point is that we were required to do certain things by the Regional Hospital Boards. I have a number of reports here where the Committee have from time to time taken steps to cut various estimates and do without those things which we felt, when preparing the estimates, were really necessary. For instance, at the present moment we are in the process of taking out toilets which were installed 100 years ago for mental deficients. Then we would say: "It is very vital to take them out, but we were cut in our estimates this year on the budget. We shall have to let them go for another year." That is the sort of thing we should have to cut out.

Mrs. *Hill.*

1285. That would be capital expenditure, would it?——No; we take it as ordinary maintenance, because it is a replacement of existing toilets, and we have stretched the maintenance to put an additional toilet in where necessary. Of course, it is very necessary in a mental hospital.

Vice-Admiral *Hughes Hallett.*

1286. I would like to come on to the question of the nurses. At the present, if you were required to make up to establishment you would have to have an increase of no less than 50 per cent. on your existing number. If the total theoretical number is really the correct number to run the hospital, I would have thought it would have been impossible to run at two-thirds of the number. Is it not possible that a more realistic complement of nurses would be perhaps something between the two?——No. If I were to tell you, for instance, that on night duty you would have one night superintendent, one night sister and three trained staff to cover the whole hospital of 1,800 beds, it is stretching it to a very fine degree. In one case I know the superintendent was sitting on a "powder keg" almost to stretch the staff on night duty to that extent.

1287. What I am querying is the enormous discrepancy between what you have and the theoretical complement?——The thing which must be remembered is that there are a large number of assistant nurses and other untrained or semi-trained staff who are doing, or trying to do, the duties of trained staff. When we say the complement of nurses is half of what we should have, it must be remembered that it is made up by untrained staff doing duties which should be performed by trained staff.

1288. Your actual bodies are not quite so short?——Our actual bodies are not quite so short as it may appear.

*Chairman.*

1289. When you are compelled to, you can make do with less than your establishment?——We can, we have done that. We cut our building and maintenance staffs very drastically some three or four years ago.

1290. Very often you fall below your estimates slightly or largely?——We keep it that way.

1291. Do you always return savings, or have you any power of virement?——No, Sir; we underspend and start afresh on 1st April.

1292. You are always endeavouring to underspend?——We always try to be on the right side. That is to say, we like to be not overspent, but we like to spend up to—I think we were within £32 of our estimates.

1293. This Sub-Committee would like to hear that you are always trying to save money and return as much as possible?——The money that is allocated is not sufficient to allow us to save. The total allocation from the Regional Hospital Board means that we always have to cut when we get the budget back somewhere.

1294. Human nature being what it is, is that not difficult?——No, Sir. The

Regional Board have this thing to a fine art. They have the average for a number of years of actual expenditure. Therefore we are not able to pad the estimates to that extent, because the Regional Board have got it to such an art. We are not able to pad them in any way.

Mrs. *Hill.*

1295. Do you get your £10,000 restored?——No.

1296. So your estimates are reckoned without that £10,000?——Yes.

*Chairman.*

1297. As to the improvement and development money, is that allocated?——Capital development?

1298. Yes?——Capital development is allocated by the Regional Board. Non-recurring items are allocated as special items on special approval by Regional Board. Malden Annexe, situated 7 miles from my hospital, consisted of tin huts, and something had to be done about it. They have been rebuilt with brick, the existing wards and buildings.

1299. The drug bill having gone up a lot, can you account for that. Is that this chlorpromazine?——(Dr. *Beccle.*) Yes.

1300. That accounts for it?——Yes, almost entirely—these modern tranquillisers.

1301. Will that be recurrent?——I do not think so. One firm has a monopoly of chlorpromazine and can charge what it likes. That is one of the difficulties. This happens to be May & Baker. They have manufactured this drug, and it is expensive.

Mrs. *Hill.*

1302. Is it one of their products?——Yes, and it goes under the name of Largactil.

*Chairman.*

1303. You are not implying that they are overcharging?——No.

Mrs. *Hill.*

1304. They gave research to it?——Yes. They did give us 250,000 50 milligramme tablets to start with, free.

Vice-Admiral *Hughes Hallett.*

1305. May I refer to section 9*? That summarises the general financial result from the point of view of the cost per in-patient per week, and it shows that from 1951 to 1956 the cost has risen, according to my calculations, by 44 per cent. The total cost of living over the same period has gone up about half that amount, about 22 per cent. Am I right in thinking that the reason for your figure being much higher, the general average, is because your costs are dominated by wages and salaries?——(Mr. *Parker.*) Indeed, largely; and again there has been over the years from 1951 a larger allocation to the mental hospitals. There has been a larger allocation—when I say larger, I do not mean in hundreds of thousands of pounds, but in some thousands there has been a larger allocation by the South-West Board for those much-needed improvements in the mental hospitals.

Sir *Henry D'Avigdor-Goldsmid.*

1306. Is it not correct that there has been a desire to raise the standard of service in mental hospitals, the standard of food?——Yes, indeed. There is a limit to how far we can go in that. We have risen with our provisional costs very rapidly in comparison with other costs because the standard of feeding in a mental hospital was very poor. There is a limit to how much we can spend there, because, as soon as we begin to give the patients, say, an evening meal as such, we then come into the realm of employing more cooks, more porters to distribute it, staff staying on later to serve it, with the result that the cost really would go very high.

Vice-Admiral *Hughes Hallett.*

1307. None the less, is it not correct that these figures indicate that the rise in food costs has not in fact outstripped the average rise in the cost of food over the same period?——Very nearly. I would not say quite that there is a better standard in Springfield. At Springfield the standard of feeding is better than it was in 1948.

Sir *Henry D'Avigdor-Goldsmid.*

1308. Could you tell me how this came about? Did this come by directive from

* Evidence p. 153.

the Ministry of Health through the Regional Board, or from a desire on your part?——What we did was this: we allocated a larger proportion of our budget. We were free to allocate budget for provisions and start increasing the amount we gave to the buying of provisions for patients' feeding.

*Chairman.*

1309. You would say that the increase in the average cost of food per patient is partly deliberate?——Yes. We have scrapped other things in the hospital for the purpose of buying that additional food for patients.

1310. It is a very striking increase from £3 12s. 5d. per week to £5 4s. 8d.?——There were a number of salary increases for ancillary nursing staff.

Vice-Admiral *Hughes Hallett.*

1311. Is a certain amount of capital improvements buried away?——I can say that since 1948 the amount of capital improvements we have had at Springfield have been about £6,000 in all, no more than that. We have no new buildings, except one new building provided for us by the King Edward Fund in London for the Occupational Therapeutic Department, and also a restaurant. If I may amend that figure, £7,500 would be the total which we have received since 1948 for capital development.

Mrs. *Hill.*

1312. Would you think more money spent on capital development would help you to save in other ways?——No, I would not say that. What I would say is that we have endeavoured to contain within our budget those improvements which are necessary for the welfare of the patients. We would like new buildings, we would like a new Preliminary Training School. But we can go along without it, and our results are quite excellent. We finance out of current estimates the wiring of the hospital, for example, which is falling to pieces, and we have to, as I say, out of our current estimates replace that wiring each time we decorate a ward. If we did not, the risk of fire is becoming more dangerous every day.

*Chairman.*

1313. May I return to drugs? Your costs are above the national average. I am wondering what steps the Committee take to ensure that there is all possible economy in the use of drugs?——When we watched these drugs move up we received from our Physician Superintendent as a Committee a report on the use of drugs, and steps were taken that these drugs could only be used on the authority of a senior doctor, that is to say, the Physician Superintendent and his deputy, so that the drugs could be watched by those two very carefully.

1314. Would you say that the medical staff is cost-conscious?——No, I would not. I exclude my Medical Superintendent. He is always a member of the Committee and could not but become cost-conscious. (Dr. *Beccle.*) I am very much so.

1315. Do you chase the staff and try and make them cost-conscious?——Indeed. I keep a firm, tight watch on things by means of a simple arrangement. When the prescriptions become unduly large or irregular in any way, my pharmacist telephones me.

1316. Are prescriptions reviewed constantly?——Regularly.

1317. How often?——By the weekly check I have installed with the pharmacist.

1318. It does not happen that an expensive drug continues on and on?——No, we do not permit that.

1319. As far as purchasing is done, drugs and appliances are purchased through hospital joint contracting schemes?——(Mr. *Parker.*) Yes.

1320. How much of your domestic items, bedding and linen, are purchased centrally through central contracts?——When you say central contracts, do you mean joint contracts with other Hospital Boards or through the Ministry?

1321. Either?——The Ministry, as you are well aware, I am sure, have not gone into blankets, sheeting, pillowcases, things of that kind. We take all the goods which are centrally purchased through the Ministry, our soaps and cleaning materials. But we have endeavoured to start discussions with other groups in the neighbourhood for common items.

1322. Was that on your initiative?——Yes.

1323. On Springfield's initiative?——Yes.

1324. Would you welcome a regional purchasing scheme?——Yes, I would, Sir, because I am on the Committee which has been set up by the Minister for going into the supply position in the Service, and I feel that joint contracting between hospitals for common user goods is a very useful way of buying the large quantities, without becoming too large and therefore having the risk of storage.

1325. You are aware of what Manchester has done in the field of textiles?——Indeed.

1326. Would you like to see that in your Region?——I can see no reason why it should not be.

1327. Would you go further: would you accept a national arrangement?——No, Sir; if I may judge the standards by the commodities now supplied by the Ministry, no, I should not.

1328. You would not suggest a national textile purchasing policy?——Do you mean by that it should be regional?

1329. No, national?——But split up regionally to go to various manufacturers regionally.

1330. If you like?——I can see no reason against it.

1331. Would you accept greater standardisation in crockery and so on?——Yes, I would. I can see no reason why there should not be greater standardisation in crockery.

1332. What about greater standardisation in the use of drugs?——(Dr. *Beccle.*) The routine drugs of the Aspirin or Disprin type is an example, yes; there is no reason why not. It is only when we get into the realm of the more exotic drugs that we get into trouble financially.

1333. Your drug chlorpromazine: was that your idea at Springfield or was it being tried at many hospitals?——We started it to begin with, and we were followed by Dorchester and one other hospital. We were the first in the field.

1334. Do you exchange information with other mental hospitals?——Actually we did not. We worked out the technique in the form of two separate bases of research.

1335. Is there any means by which the experience of different mental hospitals can be pooled in treatment and drugs?——Yes, there have been innumerable papers in the various medical journals.

1336. There is no exchange committee, as you might say?——It is a difficult matter. It sometimes becomes a matter of pride to the individual hospital to get in ahead of the others with a piece of research

1337. Do not you think that is harmful to the efficiency of the service?——In my opinion it is a little immature.

1338. Rather childlike?——Exactly.

1339. It is most understandable, but you feel, in other words, that you could have greater pooling of discoveries and information?——I feel that the inter-hospital rivalry from the point of view of clinical research is childish and petty.

Vice-Admiral *Hughes Hallett.*

1340. Could I ask a question about maintenance of buildings? What are your views with regard to maintenance by means of your own permanent staff in comparison with maintenance by contract?——(Mr. *Parker.*) We are in favour of the work being done by our own maintenance staff. There are a number of reasons. The first one is the inconvenience of taking in outside contractors. We have to empty a ward perhaps of 60 people. We have to overcrowd already overcrowded dormitories and have to have the place cleared.

*Chairman.*

1341. Is that because it is a mental hospital?——I should say that in a mental hospital you have a problem of overcrowding which is not always apparent in a general hospital. The second point is the standard of work is not always that which we require, in as much that our wards will only be redecorated perhaps once in 15 years, and, therefore, when we do the work it has got to be done very properly, and very thoroughly, and if we were to insist on the sort of things we wanted from an outside contractor I am afraid the cost would be far greater. In fact, we do have a costing system with our own

Superintendent Engineer and Clerk of Works, who gives us estimates of work to be performed and from time to time —we have not always done so—we have gone to tender to find out the level at which we were operating. But, in any case, I always consider it the duty of my Committee to examine the cost of the work being done by the craftsmen, and if it is unusually high from time to time with the Physician Superintendent we have held meetings and told them that if the job is not done within such and such a cost we ought to do something about it, and as a rule they have tightened up in that way.

1342. You employ a pretty big staff? ——Yes.

1343. Thirty-five*?——Yes.

1344. Are they on the job the whole time?——Yes, Sir, for general maintenance and for wards. If I may say this, wards are being decorated for the first time in 35 years. The Clerk of Works is leaving the hospital this month, and we have been going into this, and he cannot remember after working there for 35 years them ever having been decorated.

1345. You really mean to say—I am not contradicting you—that these bricklayers, carpenters, painters, plumbers, etc., to the tune of 35 are constantly occupied?——Constantly. So much so that we have been employing contractors to do some of the wards.

1346. The other 21, what are they? ——They consist of steam people; glazier, the tremendous work of windows involved, because, of course, they are built with very small panes of windows, Hampton Court style; there is a drain man——

Vice-Admiral *Hughes Hallett.*

1347. When you do your re-wiring will you do that with your own staff? ——Yes, entirely. As we do each ward we take the old wooden coping down and replace it with the ordinary tubular casing with the wire.

Sir *Henry D'Avigdor-Goldsmid.*

1348. Does your Clerk of Works appear in the list as building supervisor? ——Yes.

1349. Is he up to date in his ideas? Are you satisfied he is on to the new techniques because with large financial commitments I should have thought that was a major consideration?——In 1948 we abolished the division between the Clerk of Works as such and the Superintendent Engineer and we asked for and recruited an engineer with qualifications of building as well as engineering, and we were able to abolish the difference between the two with the result the young engineer with up-to-date methods has been able to impose them generally on the building department.

Captain *Waterhouse.*

1350. You have 14 people in the Stoking and Boiler Plant. Is that entirely on your heating?——Yes, heating and hot water.

1351. Have you got a series of plants, or one?——One main boiler house.

Vice-Admiral *Hughes Hallett.*

1352. Fifteen does sound enormous compared with most industrial plant? ——It must be remembered we also maintain a hospital some seven miles away with 300 people in it at Malden. That means there are stokers for Malden as well.

1353. Do you know how many stokers you have got in your main plant?—— Twelve.

1354. Have you automatic stoking? ——No.

1355. Would you like them?——Yes, we would indeed. We had boiler plant in the hospital which went two years ago which had been in 60 years, and they replaced it with one from a hospital where it had been for 50 years.

1356. You gained 10 years?——We gained ten years. In fact, it cost £2,500 to put the old boiler they had taken out of the other hospital into our boiler room to replace our boiler which had burst its seams and had given up the ghost. We are in some difficulty here. We are almost at breaking point on electricity because however much we try we cannot keep the nurses from putting on their electric fires because the heating of the hospital is totally inadequate. It is a thing we have been on to the Board for for a new boiler, because they

* Not reported.

are so old, the old Lancashire type of boilers.

Captain *Waterhouse.*

1357. If I may pursue that. You have had a quotation for a new plant, have you not?——The new plant is tied up with the developments of the Regional Hospital Board and it is anticipated we shall not get a new plant there until they have decided where they are going to put the Fountain Hospital which is a mental deficiency hospital. Whether they are going to put it on the Springfield site and give a plant to serve all the hospitals I do not know.

1358. How big is your site?——We have had 26 acres taken away for a new L.C.C. school. We have now 120 acres.

1359. It is enough for your new big scheme?——If they can get the Fountain Hospital in a corner of a field on our agricultural land, they would build us a new boiler house to serve both hospitals. The cost of a new mental deficiency hospital must run into millions. I feel that is far away, so is the heating of the hospitals. It is really frightful on a cold day.

Vice-Admiral *Hughes Hallett.*

1360. If you wanted to have a careful costing calculated out as to how long it would take a high pressure system to pay for itself, whom would you get to do that?——We have our own Engineer who is qualified to that extent, and, secondly, we would go to our Regional Hospital Board in consultation with our own Superintendent Engineer to tell us the cost and the saving we would make by having an efficient boiler plant.

1361. I am very surprised about this. I have had experience of this, and would you agree in general if you changed over from an old type heating system to a modern one, one usually reckons on paying capital cost in somewhere between three and five years, and, therefore, I would have thought that very considerable economy would result from a modernisation measure of this sort?——We would find it in the fires, the gas fires and electric heaters which are used by everybody to warm the hospital. I believe we would save the cost of those boilers at least in seven years if we were to have efficient plant put into the hospital.

*Chairman.*

1362. In staff?——Yes. We have adopted it in one instance where the water used to run away. It cost us £1,500 to put in a new water cock, thereby governing the flow of water, and in two years it paid for itself in our water bill.

Mrs. *Hill.*

1363. Parsimonious capital expenditure is false economy, you feel?——All the way through, that is so.

Vice-Admiral *Hughes Hallett.*

1364. Whose job is it to put forward a scheme of this nature?——The Regional Hospital Board's.

Captain *Waterhouse.*

1365. What is the size of your plant? Could you give us your consumption of coke or coal?——3,500 tons.

1366. A mixture of the two?——Very small of coal, mostly coke which we draw with our own lorries from the Wandsworth Gas Company.

1367. How many boilers have you? ——Five, four in the main building and one at Malden.

Mrs. *Hill.*

1368. Do you require them to give you a lot of steam? You have not operating theatres, but you have kitchens and a laundry?——Yes.

1369. How does it provide steam for those?——Very poorly.

1370. How about steam ovens and jacket pans?——We do not use the steam. We have got boiling pans. We cut down the use of steam as much as we possibly can. We have to look in other directions to boost it. We are trying to put a booster plant on the nurses' home, as there are no radiators in the nurses' home. It was built in 1934.

*Chairman.*

1371. How much staff would you save, do you think, with the modern heating plant?——I would say we would save at least a third of the staff.

Vice-Admiral *Hughes Hallett.*] More than that, would you not?

Captain *Waterhouse.*

1372. With a modern plant you would do it with one man per shift?——With mechanical stoking, probably two-thirds of total staff.

1373. I am still not quite clear about the machinery for initiating proposals of this nature. Where would the initiative start?——The initiative would start with my Committee. We would receive a report from our engineer that our plant is inadequate and in danger of breaking down. We call for a report from him which is submitted to the Regional Hospital Board.

*Chairman.*

1374. Your initiative will spring from the fact that your plant is inadequate. Whose inspiration will it be that there can be overall savings; who will recommend it from the savings point of view rather than the inadequacy point of view?——It would be the Regional Hospital Board. We would make out a case on reports received from our officers that if we had certain machinery installed we would be able to save a certain amount, and that would be sent on to the Regional Hospital Board who investigate it.

1375. I am wondering this: are there people whose life work is to think out how you can save money by modern installations?——Can I put it this way? I did instance how we went to the British Launderers' Research Association and asked them to look at the laundry and tell us how we could improve the efficiency of the laundry. They sent a report to us for about thirty guineas.

1376. Could you do that with heating? ——We could do it with heating. We have already done it, I think. (Mr. *Connor.*) There was a report from an efficiency firm which made suggestions. (Mr. *Parker.*) We did call for a report from an efficiency firm on our boilers and I would be very happy to send you a copy.*

*Chairman.*] We would be grateful if you would.

* Not reported.

*Chairman.*

1377. Have you an adequate costing system? Is it essential in a mental hospital?——It is very essential in a mental hospital, and you are able to arrive at cost reasonably well.

1378. Have you a good one?——Yes, we think we have.

1379. Do you ever set ceilings through various departments, say drugs?——The ceiling is set by the allocation of our budget.

1380. Dr. Beccle was saying that when he noticed costs were going up in drugs he put the brake on. Has he ever set a ceiling?——(Dr. *Beccle.*) No, I have not, because that is not easy to do.

1381. What does the 4s. stand for with regard to your catering costs?——(Mr. *Parker.*) That is the Catering Officer.

1382. It is considerably above the national and regional averages?——Are you referring to catering costs per person?

1383. Table —*, Catering £21,000, 4s. weekly cost?——(Mr. *Connor.*) Our catering cost is 4s. It is true it is above the national average——

1384. What does it stand for?——It stands for the Catering Officer and all her staff. That includes cooks, kitchen porters, waitresses, and others we employ. The next item, I think, is lower than the national average. I assume that other hospitals may well have many of those working under the control of the Matron and not under the control of the Catering Officer. I should say we are about equal to the national average. (Mr. *Parker.*) The difficulty is as to the allocation of the various types of people who work in a hospital. On one scale we may be higher, and on another lower. We may assume that one staff from another hospital is allocated a different type of person.

1385. You have already spoken about efficiency experts. Would you welcome visits by O. & M. teams?——We would welcome them.

1386. Is there any likelihood of that happening?——Well, we call them in from time to time of our own volition,

* Not reported.

We feel it is necessary to get an assessment——

1387. As a member of the Regional Board you do not instigate that?——We do, from Management Committee level.

1388. Do you get suggestions from your staff for economies?——Yes. I, with the chief officers of every department, meet quarterly to discuss the efficiency of each of the departments, and they put forward suggestions for improvements that may be made.

1389. Do you welcome the idea of financial reward for that? We have a Memorandum here from the Association of Hospital Management Committees, and it says that it understands that schemes offering financial rewards for suggestions have resulted in efficiency and economy and are being operated successfully in the Post Office and in industry?——No, I do not think so. My present opinion is that I do not think it would amount to very much.

1390. It would make the staff cost-conscious?——I claim, Sir, that if the officers are doing their job they should be on their toes with their staff to find all methods of saving money. I feel that financial rewards is not the answer if you want to find an incentive for people to put forward ideas and suggestions for improving the efficiency of a hospital.

1391. You make no suggestions in your Memorandum as to what might be done to improve efficiency or economy. Have you many suggestions in your mind now? I wonder what they are? ——If I deal solely with mental hospitals, I cannot see at the present moment in any way that we can save money on our existing budgets. If we were to stop the progress which is so evident in Springfield of redecoration, remodernisation, increased facilities for the patients, better clothing for the patients, we could save, but we cannot in any way make any further economy, only at the expense of cutting those particular items I have just outlined.

Vice-Admiral *Hughes Hallett.*

1392. I take that point, but in the answers to some of the earlier questions from Dr. Beccle surely there is one scope for saving, and that is so to improve the treatment that you reduce the population of the hospitals?——I was not referring to the question of the reduction of the population of hospitals. That is a matter in an answer from the Medical Superintendent. It is right and proper that he should answer that question. (Dr. *Beccle.*) Yes, it is inevitable that a lesser load on the hospital must result in an economy, apart from the undefined and nebulous effects when the patient returns to his home, saving in National Assistance, National Insurance benefit, and so on, which a cut in the stay in hospital must inevitably give rise to.

1393. You did say earlier that you did feel there is a real hope of the trend being in this direction?——Very much so. Those of us pioneering in this field feel that.

*Chairman.*

1394. Do you feel that the day can be envisaged when you will have fewer and fewer admissions and be able to close beds?——Yes, particularly if we can effect a liaison with the big general hospitals and deal with a great deal of early psychiatric order of that level without the formality.

1395. Do you feel that people are sent to you when it is not necessary?——I am on treacherous ground here and must guard my statements very carefully. We are perhaps a little biased, but we do feel that sometimes.

1396. Whose fault is that?——It is very easy to say that it is the absence of judgment of peripheral hospitals and so on, but there it is. One must be careful in making statements of that kind.

1397. Do you think people are too open——?——To certify?

1398. I was thinking of getting rid of aged relatives?——Undoubtedly, unquestionably.

1399. Decent people would look after them?——The ceaseless spate of old people in various states of moribundity and senescence rather than psychosis who flood into the place I report each month regularly in detail.

1400. Who authorises that?——This is a combination of the duly authorised officers upon whom family pressure is brought to bear, plus the Section 20

accommodation of the peripheral hospitals.

1401. Section 20? —— Observation wards, I should say.

1402. Then some group or groups of people are rather exploiting you?—— Yes, I think it is fair to make a categorical statement of that kind.

1403. What steps do you think this Committee could recommend that would lead to the stopping of that?——Well, it involves ethical and physical matters. First of all, I think we must raise the social conscience of the populace to look after their own, and not get rid of them in this perfunctory way to hospitals.

1404. That is a very long-term business?——Yes.

1405. Is there a short-term way, that it should be made less easy for them to do so?——Yes, that it should be made less easy for them to do so, and perhaps that there could be some extension to the chronic sick accommodation in the large general hospitals.

1406. That would not bring about economy to the Exchequer?——(Mr. *Parker.*) It would cost more.

Captain *Waterhouse.*

1407. Have you any paid beds at all? ——(Dr. *Beccle.*) No.

*Chairman.*

1408. Why need the hospitals, Springfield or any other hospital, admit the old people to——?——One has to look at it from the point of view of a young married couple who have an aged and rather cantankerous relative to deal with; they find they cannot cope, and that is part of the problem, I imagine.

1409. There has to be some measure of certification before you take them?—— Yes, indeed; they are certified. That is the whole point. They come under the generic term senile dementia.

1410. Do you think that the general provisions are rather too lax in certification like that?——Yes, indeed. We need a complete reform of the methods of certification dealing with the aged. Of course, a Commission is dealing with it at the moment.

Mrs. *Hill.*

1411. Probably we shall get something from the Royal Commission on that? ——Precisely.

1412. Would you think that geriatric units would be of help?——Unquestionably. We are doing precisely what a geriatric unit purports to do.

*Chairman.*

1413. You are not suggesting that would lead to a saving of money?—— (Mr. *Parker.*) No. The geriatric units would cost more than to send them into Springfield. (Dr. *Beccle.*) The only thing is—and this is politically explosive material—to impose a fee, to impose a charge on relatives for the treatment of old folk.

1414. They not only get rid of cantankerous people but save money?—— Yes.

Captain *Waterhouse.*

1415. Do you know if hospitals have paid beds?——No, other than Holloway Sanatorium. No other hospitals other than private and registered hospitals. That is a national thing now.

1416. You would welcome paid beds? ——That is a rather——

1417. That is what your answer was to the Chairman?——In that case, yes.

Vice-Admiral *Hughes Hallett.*

1418. One very important thing seems to come out of your observations about the improved treatment, which is that the overcrowding about which we hear so much is a thing——?——Which is diminishing.

1419. It may solve itself?——It may solve itself.

*Chairman.*

1420. Due mainly to improved methods of treatment and partly to the fact that the "bulge" is getting worked away?——And, of course, a lot of the old patients, let us look at it rather crudely, are dying off, and we do not expect in the future to have such chronically dependent and disturbed patients to look after, because of the better treatment. Even the older people can now in a good number of cases be sent out

to live in their own homes, perhaps on a lower level of cerebration, but they can live outside the hospital.

Captain *Waterhouse.*

1421. The average cost per case is £560 17s. 7d. per case for all cases that come to your hospital?——(Mr. *Connor.*) The South-Western Board have made us work that out in an artificial manner. We have to divide the amount of money we have spent during the year at the hospital by the number of discharges and deaths during that year, and they think that it gives them some guide. It is not the actual cost of the case.

1422. It is a quite artificial sort of figure?——It is an artificial cost. They think it gives them some guide as to how costs are going per case.

1423. It would take in some of the cases which have been there for some twenty or thirty years?——Yes.

Sir *Henry D'Avigdor-Goldsmid.*

1424. Do your patients draw retirement pension?——We claim for them.

1425. They receive that?——Indeed, in extra comforts.

1426. In fact, you do charge them if you claim their pension and do not pay it to them. They are in fact paying something?——(Mr. *Parker.*) Some is returned to them in the way of cigarettes or sweets, chocolates, whatever the case may be, as an extra comfort.

1427. The full amount of the pension you draw on their behalf is returned to them in cigarettes and sweets?——In some.

1428. Not in some rather abstract form of extra bedding or things like that?——In short, every patient, whether receiving a pension or not, receives that extra comfort in whatever form it may be, sweets or chocolates.

*Chairman.*

1429. The value of the pension is not entered as a contra in your account?——(Mr. *Tarlton.*) Any extra money received on a patient's behalf is credited to that patient, and whatever the patient draws in cash or in kind is debited to that account.

1430. An old age pensioner does not get the full value of the pension?——A pension is modified by the Ministry. It is usually 7s. 6d. after a year. That is credited to that patient.

1431. I am talking of the difference between 7s. 6d. and the full pension?——Anyway, when the patient comes into hospital he is credited with the full amount of sickness benefit. After eight weeks in a hospital that is reduced, and finally it is reduced again after a much longer period. We do not get the credit.

1432. The credit, if any, is taken in the Treasury?——Yes, at Ministry of Pensions level or National Insurance, as the case may be. An amount is kept back from the sickness benefit at Ministry level. We do not get credit for it ourselves.

1433. What amount is it?——The reduction finally comes to 7s. 6d. It may start at 40s.

1434. That is pocket money?——That is credited to the patient's account. The difference between the 7s. 6d. and the 40s. stays in the Treasury. We do not have it at all.

Sir *Henry D'Avigdor-Goldsmid.*

1435. Supposing you get one of these typical old people sent to you, as we have been discussing, who would be drawing their retirement pension of 40s.? Do they start being credited with the 40s. for the first three months?——Yes.

1436. And then it is subsequently reduced?——That is right.

*Chairman.*

1437. Are those only voluntary patients?——(Mr. *Parker.*) Certified patients.

1438. Why should a certified patient receive three months at 40s.?——Eight weeks. (Mr. *Connor.*) This applies to all status of patients, certified temporary or voluntary.

1439. One final question. Do you think that in a Mental Hospital Management Committee you have sufficient autonomy, control over the spending of money? I suppose you are always struggling for the greater power?——(Mr. *Parker.*) Strange to say, no. I have just been appointed to Regional Hospital Board, to which I then get the sack as the Chairman of the Management Committee. It is a strange process,

but there it is. I think we have all the powers we want. I mentioned earlier that we would like the power of appointing senior medical officers. We think it is a waste of time to go to Regional Hospital Board where the views of the Superintendent and Chairman of the Committee are taken and the person is appointed, provided he is suitable. It seems a waste of time, really, to go to the Regional Board.

1440. Perhaps all the Hospital Management Committee Chairmen may not reach your high standard?——It is all very nice of you to say that. The fact remains, I think, that we have sufficient power in our Management Committee to do all we are competent to do.

1441. If you are a good Management Committee?——Well, Sir, they are hand-picked. We have had no additions to the Committee, only the people recommended by other members, and secondly, we have had no retirements from the Committee.

1442. I should like you to give me a really candid answer to this question. Do you think your Committee is an average, or above average, or below average standard, of mental hospitals? ——I think that ours is far above average. We are very fortunate indeed to have obtained the number of people on to this Committee. I feel that the Regional Board and the Health Service have been very fortunate in the members chosen.

1443. You think there are some mental hospitals nowhere near so fortunate? ——I feel I would like to sack many of them, even our own Region. May I say this: it may surprise the Committee, but in 1948 the patients were drinking out of jam jars at Springfield Hospital. That was a state in which you could gauge the general dilapidation of Springfield Hospital; and in eight years, from 1948 to the present day, the place is completely transformed. The patients now take regard of their clothes, because we installed a Hoffman press, employed a presser, and the saving overall on the number of suits worn by the patients was sufficient to pay for the capital of the Hoffman press, and secondly to pay the wages of the presser. They are the sort of improvements that have to come from Hospital Management Committee level and could not be imposed by a Regional Board or by the Ministry of Health. I think it is the initiative of the people on the spot. Only if you can get the right type of people will you get that efficiency within the existing service.

1444. So you think that the same high standard can be maintained?——Yes.

*Chairman.*] Thank you.

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## TUESDAY, 19TH MARCH, 1957.

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Members present:

Mr. Nicholson, in the Chair.

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| Mrs. Hill. | Mr. Robinson. |
| Mr. Holt. | Captain Waterhouse. |
| Vice-Admiral Hughes Hallett. | Mr. Willis. |

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Mr. NORRIS M. AGNEW, C.B.E., Chairman, Dr. F. N. MARSHALL, M.D., B.Sc., D.P.H., Senior Administrative Medical Officer, Mr. J. GIBBON, F.H.A., Secretary, and Mr. J. EMLYN JONES, A.A.C.C.A., Treasurer, Manchester Regional Hospital Board, called in and further examined.

*Chairman.*

1445. Do you consider the system of basing allocations to H.M.C.s on historical expenditure, to use your own words*, as unduly restricting your ability

* Evidence p. 59.

to encourage economies in the more extravagant Hospital Management Committees?——(Mr. *Agnew.*) I think the answer to that question is really that up to now that is the only method that the Regional Board has had of doing it, and I would not say in the latter years at any rate that it is encouraging extravagance, not at all.

1446. You can modify the pattern enough to prevent it becoming something fixed or prescriptive?——Yes; as time goes on a Regional Board is learning more and more about Hospital Management Committees, as to what they want, and I think the time has come now when what was rather rough and ready in the early days I do not think you can call rough and ready now. I should say that the method which is adopted now does ensure, as far as possible, a fair and reasonable distribution of the global sums to the various Hospital Management Committees.

1447. Referring to the global sum allocated to the Regions, starting from that end first, you said that it is invariably less than the total sum estimated as necessary. Your words were: "This sum is invariably less than the total sum indicated in the estimates supplied to the Ministry".* If the original estimate was based on the level of service currently provided, is not this bound to result in a reduction of standards?——No, Sir, because the estimate which is sent in is not only for running the services as they exist. We also include what the H.M.C.s estimate they will want for consequential maintenance on developments and improvements, and when one says "We do not get what we ask for from the Ministry", it does not necessarily follow that the money required to maintain the service as at 31st March is not available.

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Mr. *Robinson.*

1449. Could you for the information of the Committee express in rough percentage terms the amount asked for developments in any whole year as against total maintenance, and the amount received on an average?——Might I ask if the Treasurer could give you actual proportions of what we have done for this coming year? I believe the amounts are just available. (Mr. *Jones.*) In rough figures, the request of the Board for the maintenance of the service and developments contemplated in the Region comes to approximately £26 million. We have received an allocation of £25¼ million. Included in the original estimates of £26 million was a sum of between £800,000 and £900,000 for developments. We have been able, out of the allocation we have received, to allocate in round figures £300,000 for developments, so, in effect, we have had to cut our contemplated developments by something over £½ million.

1450. And you have managed to save about £¼ million on the existing level basis?——In effect, yes. Could I make it clear that Management Committees and Boards, when they submit their estimate for the maintenance of the existing level of service, do include in that some sums for the maintenance of buildings, for purchase of equipment, all of which is regarded as the maintenance of the service, although it might represent some slight measure of improvement.

*Chairman.*

1451. Another Board has told us that their way of encouraging Hospital Management Committees to achieve economies is virtually to promise them that the money they save will go towards improvements and developments*.——(Mr. *Agnew.*) That is not so with the Manchester Board.

1452. It disturbs this Committee a little. I was told that there is very little other incentive that you can use with regard to Hospital Management Committees, and this Committee is a little worried lest the money so saved might be spent on projects that will incur a recurrent liability to maintain afterwards. I hope I have made myself clear. ——That could not happen. That is what might happen, am I right, in this other Board?

*Chairman.*] What does happen in this other Board?

Mr. *Robinson.*

1453. Could I put it in another way? Do you never tell a Management Committee who put forward to you a certain

* Evidence p. 59.

* Evidence p. 88.

small development project "You may do that provided you can find the money out of your existing allocation"?——No, I will tell you what we do do. I think I can put it this way, that we do not give any bait to a Hospital Management Committee that if they can save on an item they could do some small job, but what we do do is this—which I personally feel, and the Board feel is an encouragement to Hospital Management Committees—to let them do their own small jobs which they know a great deal more about than we do at Board level. But we do not give them that money out of anything they may save on provisions, drugs, dressings or anything else. We give them that money to be spent on specific small jobs which they put up to the Board and the Board approve of; they get these small sums of money to do these small jobs. The Board do know it is going to be spent for that purpose.

*Chairman.*

1454. Any economies they achieve would accrue pound for pound to the Board?——To meet the over-spending of another Hospital Management Committee. I mean to say that with thirty-three Hospital Management Committees you are bound to have some over-spending, you cannot avoid it, and under-spending on one meets the over-spending on another.

1455. Is that the way you create your development fund?——No. The development fund, this £175,000 for deferred maintenance which the Board takes out from the very start, never goes to Hospital Management Committees. That is one of the Regional reserves. Our policy, if I may put it this way, in handing out money to the Hospital Management Committees at the beginning of the year, is, to be quite blunt, to hand out as little as we feel they really require to maintain the service, and, having done that, we create reserves at Board level.

1456. I quite see that, but I do not understand what happens to any saving that a Hospital Management Committee may make?——It comes back. It is there in the Board's possession, and it goes to meet the over-spending of another Hospital Management Committee.

1457. You mean that there has never arisen an occasion when savings surrendered to the Board are surrendered to the Treasury?——Since I took over four years ago, the Board's result at the end of the year has been most extraordinarily close. I do not quite know how it is done, but it has in fact been extraordinarily close; I do not know if we have ever had a case where we have been under-spent. (Mr. *Jones.*) Yes, we have, and it is the policy of the Board that should savings arise then they may be returned to the Treasury. I say "may" because the Board normally would not utilise savings or under expenditure on any scheme just for the purpose of using up that appropriate money. They might utilise the savings to meet urgent and necessary demands that they have had to postpone, but would certainly not use them for the purpose of just spending money rather than returning it to the Treasury.

Mr. *Robinson.*

1458. When you talk about savings from Hospital Management Committees coming back to the Board, you are referring to overall savings, not savings under a particular head or sub-head?——(Mr. *Agnew.*) Overall, yes. (Mr. *Gibbon.*) By and large, we do take the view that under a proper system of estimating there really should not be savings, and that it is perhaps dangerous to offer, to use Mr. Agnew's word, too strong a bait to Hospital Management Committees to effect savings, as thereby they might be encouraged to decrease the service below what it ought to be in order to arm themselves with funds to implement some very cherished object.

*Chairman.*

1459. Alternatively I suppose it might tend to overestimate consistently?——Precisely, that is another danger.

1460. You do not think you can have the urge to economise without the danger of overestimating?——That is what we feel.

Mr. *Robinson.*

1461. Do you feel your powers at Board level are sufficient to control over-estimating?——(Mr. *Agnew.*) Yes, I do. With the consultations we have, the consultations our officers have with the

officers of the Hospital Management Committees, and the information we have, the answer to the question I should say is definitely yes.

1462. Do you have a revised estimate stage when they have consultations with all the Management Committees?—— Yes.

*Chairman.*

1463. Do you think the new costing system will strengthen your hand?—— Yes, I think it will. If you want a purely personal opinion—it was my Board's opinion too—I think that it has been attempted on rather too large a scale at first. I think that it would have been better if we had felt our way a bit, but it has been decided that that should not be, and I think that although it is going to cost some money, it is going to pay dividends.

1464. Will it depart from what the Guillebaud Committee call the subjective approach? Will it be departmental rather than subjective?——Yes. Departmental, outpatient department, pharmacy, laundries, etc. (Mr. *Jones.*) Laboratories, X-ray, physiotherapy, medical and service departments particularly in those hospitals participating in the main scheme. There are two schemes. The main scheme is to apply to hospitals with expenditure in excess of the £150,000 per annum, and the simplified scheme is to apply to all other hospitals.

1465. The criterion of comparison will not be primarily subjective?——No. It is primarily objective, departmental.

1466. You issue comparative cost statements to Hospital Management Committees?——(Mr. *Agnew.*) Yes.

1467. Are they effective in stimulating criticism?——Undoubtedly. We can put it to a Hospital Management Committee, we can ask them to compare with one another, saying "Why is this so and so?" and I think they are an enormous help.

1468. What steps are taken following upon that?——(Mr. *Jones.*) They vary according to the approach of the Management Committee. In the first instance a Management Committee will compare one hospital with another. We will have drawn their attention to the fact that their hospital is in excess of the regional average and we will suggest comparison with another hospital which is on the regional average or below. They look into it; they may find that they are high on provisions; they may find better methods at the comparative hospital; they may find that the comparative Management Committee could bring about economies in use of staff; they may find laundry methods are not as efficient as they could be. By bringing these matters to their notice we encourage them to enquire into these items and encourage them to take what action they can to reduce their costs commensurate with the efficiency obtaining in those Committees which have what we call the regional average standard.

Mr. *Willis.*

1469. Do they report back?—Yes, they report back to the Board.

*Chairman.*

1470. Do you ever pare down their estimate in the light of that?——We adjust their estimate in the ensuing year in the light of consultations.

1471. With regard to your deferred maintenance reserve, your £175,000* might that not mean Hospital Management Committees tend to incur excesses? Another Regional Hospital Board make the initial allocation complete with nothing extra coming at the beginning of the financial year. They say they have got to keep within it. You do not think your system allows Hospital Management Committees to have the feeling that there is a rich uncle round the corner who may see them through?——(Mr. *Agnew.*) No. In the Manchester Region it must be remembered that we have a lot of hospitals, old mental hospitals, 150 years old, and that kind of thing. We get this £175,000, we decide where that money is going to be spent, and we decide on what job it is going to be spent. The Hospital Management Committees do not. It is completely under the control of the Board, so that the Board can spend this money on deferred maintenance on those buildings which in the Board's opinion are in most need.

* Evidence p. 59.

1472. That fund never goes to make up over-expenditure on budgetary outlays?——No, Sir, but the deferred maintenance reserve of £175,000 is a reserve for that purpose, for no other.

1473. In effect, Hospital Management Committees know they have got to keep within their estimate, barring another fund you say you create made out of the savings of other Hospital Management Committees?——Not made quite out of savings. Each Hospital Management Committee is given an allocation at the beginning of the year. That allocation at the beginning of the year is what the Board feels is a reasonable minimum required for that Hospital Management Committee to maintain its day to day services as at that date. When we have satisfied ourselves that that minimum requirement has been satisfied, if there is any balance over, as there always is, we create reserves at Regional level to be expended as we think best. There are two reserves of £175,000, one is for deferred maintenance, and the other is to meet the consequential maintenance of developments, appointments of additional staff. Hospital Management Committees come along and want to appoint additional staff ; if they have not the funds, application has to be made to us. We keep a reserve for appointment of additional consultants during the year. Dr. Marshall will come along and say that the service is lacking in such and such a thing in such and such an area, and we want another consultant. We keep a reserve to meet those appointments.

1474. I thought you implied that if a Hospital Management Committee could save in a given year that might be applied to over-expenditure by another Hospital Management Committee?——It is rather more. You see, we look at all this money from the Board's global figure. We hand cut to thirty-three Hospital Management Committees £20 million, whatever it might be. What I am saying is that if one Hospital Management Committee has underspent by £5,000, that £5,000 is not given to that Hospital Management Committee for it to spend on something it thinks it wants. It is retained by the Board in case there is another Hospital Management Committee £5,000 overspent.

1475. Another little fund is made, or a big fund?——It is not handed out. (Mr. *Jones.*) I think there is a little confusion here, Sir. What Mr. Agnew has in mind is that normally as the year progresses there might be relatively small underspending or relatively small over-spending by Hospital Management Committees through no fault of their own. The Board impresses on all Management Committees that they must exercise every economy, that they must not over-spend and must only deal with essential things. Consequently, at the end of the year we have found that in fact these small over-spendings by one or two Management Committees are met by the accumulative small under-spendings on others.

1476. Can you say what total sums are involved in that process of adjustment?—Yes. In total something of the region of £25,000 to £30,000.

1477. Over all the Regions?——There is one further point which may have given rise to misunderstanding, and that is that when the Board make their allocations to Management Committees they do retain in reserve a contingency sum of £100,000 which is retained until revised estimate stage, and possibly, thereafter, depending on the circumstances which may be existing in the Region and the movement of prices generally and all the other matters which may affect the financing of the service in the Region.

1478. I think you have made it quite clear. Thank you very much. Now about bed occupancy figures, or poor turnover figures, what particular pressure can you exert?——(Mr. *Agnew.*) As to our bed occupancy figure, as you will see from table —*, the overall for 1955-56 was 91 per cent., and going back to the year 1950-51, even at that time it was 89·3 per cent. That is the overall figure including long-stay and acute.

1479. So you do not feel there is much pressure called for?——No.

Vice-Admiral *Hughes Hallett.*

1480. Bed occupancy is one thing, but it has been suggested to us that the proper yardstick for economy or otherwise of a hospital is the cost per case, which raises the question of the turnover. What are your views on that?——(Mr. *Jones.*) We

* Not reported.

extract the cost per case for all the fourteen Regions, as we agree that bed occupancy itself indicates nothing, although, in association with the throughput of patients, that is the number of patients dealt with, it can indicate a lot. So far as the cost per case is concerned, Manchester shows up favourably in comparison with other Regions, and out of the acute hospitals, which are divided into four categories, the 300-900 bed the 100-300, the 51-100, and the 1-50, we are fourteenth, fourteenth, twelfth, and fourteenth respectively.

Mr. *Holt.*

1481. In what?—In cost per case, out of fourteen Regions.

Vice-Admiral *Hughes Hallett.*

1482. I was really asking whether you have any views from the financial point of view as to which is the best yardstick, that is to say the cost per in-patient a week, which appears to be favoured by the Ministry of Health because their tables are made out on that basis, or the cost per case, or, indeed, the view has also been expressed it should be expressed as the cost per unit of population?——(Dr. *Marshall.*) It is rather difficult to say. The thing is I think to take the percentage bed occupancy not alone, but in association with the turnover, that is the important thing, because you can have, for instance, a hospital, of a 100 beds shall we say, where there is an 80 per cent. bed occupancy, where the average length of stay of each patient is sixteen days, and that would have a turnover of 1,825 patients a year, but you can have a similar hospital with a 75 per cent. bed occupancy where the patient stays one day less with the same turnover, and I would think that was a more efficient hospital, with a less bed occupancy, but with as big a turnover, provided, of course, that the patients were not being discharged too soon, and provided they were getting the appropriate treatment. We have no means of measuring that, but the average length of stay of patients has considerably declined as a result of the development of medical science, blood transfusion, anti-biotics, better anaesthetics, and that sort of thing, all contributing to a reduction in the length of stay of patients in hospital.

Mr. *Robinson.*

1483. Would you not agree that another factor, certainly in surgical cases, is whether the surgeon in charge of the case is in favour of early ambulation or not, and it makes a difference to the bed turnover?——Yes.

1484. There are two distinct fields of thought with regard to early ambulation, and both sides feel they are absolutely right?——That is so.

1485. Is that not another example with regard to the validity of comparisons between one hospital and another?——I think that it is extremely difficult. I have always said that it cannot be done. These figures, in my view, are only useful in comparing one particular unit in a hospital from year to year and are hardly applicable to the comparison of hospitals in different parts of the country, because, of course, practice varies so immensely.

Mr. *Holt.*

1486. Would you agree that it is a good thing to have reference as suggested to the size of the population?——The turnover of a hospital depends to a large extent on the pressure exerted by a waiting list, and the pressure of the emergency casualty cases. For instance, you have a busy hospital in the centre of London with a big waiting list, a popular hospital, they probably have a very high turnover as compared with a country hospital where there is not a big waiting list, where the pace is slower, where it is not in an industrial area, and where the number of casualties is small.

*Chairman.*

1487. Does it necessarily follow that the big turnover hospital is the most efficient?——It does not necessarily follow, no.

Mr. *Robinson.*

1488. Reverting to the question as to the desirability of measuring on a cost per population served basis, would that even be possible in a Region like yours? Are the hospitals designed to serve a specific catchment area with a fixed population, or do their so-called catchment areas—I am not talking of mental hospitals, the general hospitals—merge into one another?——They do merge into one another, but it would not be

practical to compare the needs say of 4½ million people in the Manchester Region with the needs of say 4½ million people in the South of England, because the needs of the population are different. We have a very high casualty rate from industry, congested roads, bad traffic, and all sorts of illnesses from which people suffer, different to some extent from other parts of the country.

1489. And there is a variation within the Region?——There is a variation within the Region. Within the Manchester conurbation we require a large number of accident beds, orthopaedic beds, surgical beds.

Mr. *Holt.*

1490. If that is so, why use these costing statistics, if there are so many factors outside of them as important as the figures themselves?——(Mr. *Jones.*) One benefit of the cost, as Dr. Marshall has said, is the comparison, for each hospital, of its progress year by year and its change of cost, whether it is rising or not. Equally, although one cannot compare one hospital with another altogether, one can ask why the difference exists, and oftentimes in the investigation, in an inquiry into this difference one finds certain action can be taken with a view to economy and better efficiency.

Vice-Admiral *Hughes Hallett.*

1491. If I could go back to the question of population, would you agree that taking the hospital service as a whole the true criterion will eventually be found by relating the costs to the population served rather than to the total beds provided?——(Dr. *Marshall.*) I think that is the true criterion, but it is difficult to estimate, and there is no information at present to relate the cost of the hospital service to the needs of the population which, of course, vary in different parts of the country. For instance, in Lancashire the average age of the people is higher. We have a higher proportion of old people because of emigration from Lancashire. In a town like Blackburn, I understand that one in five of all the female population is over sixty-five years of age. The average in the rest of the country is about 11 per cent. of the population; in Blackburn it is 20 per cent. of the population. The consequence is that in the Manchester Region we require a higher proportion of chronic sick beds. We have actually got a higher proportion, but we have still not got enough beds to meet our needs for the relatively high age group in our population.

Mr. *Robinson.*

1492. Could you ever say what the population served by individual hospitals in your Region was?——Not now. We have only one group which is pretty well circumscribed, and that is the Barrow group, which serves Barrow-in-Furness, and there is very little interchange, except for cancer cases which come to Manchester, and highly specialised cases like that. Otherwise we are more or less like London; we are so densely populated, it is very difficult to separate.

*Chairman.*

1493. May I go back to the question about which I was asking before, referring to the £175,000 for maintenance and development fund. Is that the precise amount allocated to you for that purpose by the Ministry?——(Mr. *Agnew.*) No, the Board creates that out of the global allocation received from the Ministry and the amount of the Board reserves, including that one, depends, of course, on (*a*) how much we get from the Ministry and (*b*) how much the H.M.C.'s require to maintain their essential services.

1494. The Ministry do make a special allocation to you for that purpose?——Yes; the Ministry do, and in our case last year it was something over £2 million.

1495. A private fund of the region?——That is a fund which the Minister insists should be spent by H.M.C.'s for the specific purpose of maintenance of buildings and for nothing else. To make sure that money is spent for that purpose we add this £175,000 to it.

1496. The £175,000 which is given by the Ministry for a different purpose?——Not necessarily.

1497. What was it given for?——(Mr. *Gibbon.*) I think there is perhaps some confusion here too. The Ministry in making their global allocation to the Board do specify a minimum prescription in relation to what must be spent

on maintenance of building, plant and grounds. That is unconnected with developments and improvements as such, unconnected with an expansion of the services. We ourselves create this reserve of £175,000 in order to fund developments which we know are going to accrue in the following year.

1498. I am sure it is your way of doing it and that your motives are excellent. Is not the plain truth of it that that fund is deducted from moneys which are allocated to meet a budget which was supposed to have been drawn up on minimal lines?——Not quite, Sir. As the Treasurer explained, when the estimates are submitted by the Regional Hospital Board to the Ministry they do contain one element, and I think it was £800,000 on the last occasion, which is related to developments and improvements.

1499. You made that quite clear. The Ministry say in paragraph 17 of their Memorandum*: "The principles on which allocations are made to Boards have varied according to the circumstances of the time, but in recent years allocations have been based on estimates of the amount necessary to enable Boards to maintain during the coming year the level of services expected to be reached by the end of the current year"?——That is in relation to bare maintenance of the services, and does not take into account any items in relation to expansion of service.

1500. You are expanding the service?——Indeed.

1501. You are expanding the service out of moneys allocated for another purpose?——(Mr. *Agnew.*) When you say "expanding the service," with regard to this deferred maintenance money reserve, that is not expanding the service at all. This is rather complicated. We have got two reserves, each of £175,000.

Mr. *Robinson.*

1502. Is not it a fact that the Minister gives you a global sum to carry on the hospital service in your region; the Minister is not interested in how much you give to each Committee?——Precisely, excepting that he does insist that a certain sum is spent on maintenance of building, plant and grounds; he insists that a certain sum is spent on improving feeding standards in mental hospitals.

1503. In total, but not for individual Hospital Management Committees?——Exactly. Let me put it this way. If we felt that the moneys allocated to H.M.C.s was not sufficient for them to maintain their services there would be no £175,000 reserve fund available, because that must come first.

*Chairman.*

1504. You have said enough to clarify my mind; thank you very much. You will remember, Mr. Agnew, speaking about reaching economies in the use of expensive drugs?——Yes.

1505. In the last resort would you ever insist that drug expenditure by a H.M.C. or H.M.C.s in general could be kept below a definite ceiling?——No.

1506. You would not?——We could not.

1507. From the point of view of doctors making the best use of the sum allocated to them?——We would do what we have done. We saw a very alarming increase in the cost of drugs, and we have asked our Medical Advisory Panel, which is the highest medical body we have got, to advise the Board; we have asked them to go into it.

1508. That is what you said before?——That is what they are doing. I might say that at the last meeting of the Finance Committee we still had not heard from our Medical Advisory Panel, so we sent another memorandum to them to ask them to let us hear.

1509. You have no weapon up your sleeve to coerce them if they still go on over-spending?——No. I do not honestly see how any Board—may I say "dare"?—dare do it. I think that unless the medical people are prepared to play ball with us, so to speak, on this question of drugs I personally do not see what a Regional Board, or any other Board, can do about it.

1510. You think it would be definitely immoral to fix a ceiling?——I should say so, Sir. I have got my doctor here. If he would say it is all right for the

* Evidence p. 5.

Board to do it——. (Dr. *Marshall.*) I would agree it would be immoral; I think it would be impracticable.

Mr. *Holt.*

1511. May I ask a question which I did ask the other Hospital Board? What happened in the voluntary system when they were severely curtailed financially? Perhaps Mr. Agnew may have some experience of that. Sometimes it must have happened that they were very short of money and that the doctors had only so much to spend on drugs during the year?——As you know, no voluntary hospital ever shied from the idea of going into debt. It liked running into debts! The bigger debts they ran into the more they were able to claim from the public in their appeals. But in those days the cost of drugs was nothing like it is today. Compared with the cost of these rare drugs, penicillin, cortisone, and drugs of that sort, and the discoveries being made almost daily now, in the old voluntary hospital days it was just a case of aspirin, morphine, and there was not anything really expensive.

*Chairman.*

1512. In your latest Memorandum, paragraph 3*, you mention that controls over non-medical staffing establishments should be relaxed?——(Mr. *Agnew.*) Yes.

1513. How effective is the financial control over numbers of staff now?—— I think all the information is available to Boards and to H.M.C.s to make it completely effective.

1514. So really what control there is now is nominal?——(Dr. *Marshall.*) By the Ministry of Health?

Mr. *Robinson.*

1515. Is it not a Guillebaud Committee recommendation talking about the Ministry of Health?——Are you speaking of medical or non-medical staff?

1516. Non-medical?——(Mr. *Gibbon.*) The machinery is precise and exact. A Hospital Management Committee cannot engage an additional pantry maid without specific approval of the Board if by so doing they would exceed their fixed establishment.

1517. Would the establishment be fixed by you?——No, it was not fixed by anybody. It was frozen under a Ministry of Health circular in 1951.

*Chairman.*

1518. You are suggesting H.M.C.'s should have more control?——We are.

1519. How effective would the financial control be in that case?——That is speculative, Sir, but we feel that our knowledge of the Hospital Management Committee's financial needs is now so much greater than it used to be that we can effectively control by means of the budget alone what previously we needed to control in detail.

Vice-Admiral *Hughes Hallett.*

1520. A question on staff: is there the same distinction when staff is taken on between established and non-established staff as one finds in the Civil Service? ——No, I was not using the word establishment in that context.

1521. Is there any distinction, as a matter of interest?——There is. Some people are taken on in a temporary capacity, others are taken on in an established capacity, and it is probably already within your knowledge that in regard to the manual classes they have to serve a term of two years before they become eligible for superannuation.

1522. In this recommendation in paragraph 3 were you proposing control should be relaxed over established staff as apart from temporary staff?——No, Sir; we were talking of staff as staff, irrespective of status.—(Mr. *Agnew.*) As I see this paragraph it is meant to imply that the Guillebaud Committee recommend the relaxation of the controls and we, or I, support it, because I now feel we have got sufficient control by the budgetary control. In other words, we have the knowledge now and H.M.C.s have the knowledge to make budgetary control effective.

*Chairman.*

1523. In paragraph 5* you imply there that more responsibility should be placed

* Not reported.

* Not reported.

on House Committees in order to maintain their interest?——I do not think I am saying that more responsibility should be placed on them. What I am saying is, as I said last time, that I view the House Committees as very important Committees, but I think I have said here I agree they should not have any spending powers; I do not think they should have executive powers. What I am saying here is that they should be given sufficient powers to enable them to feel they really have a job of work to do.

1524. What sort of powers would they be?——Power to engage or dismiss their junior people; power to raise Leagues of Friends for their hospital; the right to put up to their H.M.C.s any scheme which they feel might benefit their hospital, however small it may be. Of course, they would know that it is their job to keep in touch with the staff of the hospital, the chief cook, the laundry people, for example, and that is why I think the House Committee is so important.

1525. Some people say that the medical superintendent system works better. Have you any views on that?——I personally have not, Sir, because I have never worked in a hospital or had anything to do with a hospital which has had one. Before I took over the Chairmanship of this Board all my experience had been with voluntary hospitals. I have never, as I say, had experience of them, so I am afraid I cannot answer that question.

1526. We have had at least one memorandum sent in which urges it very strongly. We rather want your views in order to balance that?——I do not know what Dr. Marshall's views are. I should say I doubt whether it would be popular with the senior medical staff employed.

1527. As I see it, it means in effect the appointment of a general manager to the hospital?——A medical general manager. (Mr. *Gibbon.*) May I say that the Board, as distinct from Mr. Agnew, as a body when considering what kind of evidence they should put to the Guillebaud Committee did think about this particular thing, and expressed no view whatever in favour of the medical superintendent in its usually accepted sense. What they did recommend was the appointment—and this was the Board's phrase—of senior clinicians in hospitals with the duty of co-ordinating the work of the various medical departments, but not, to use your term, comprehending having a general manager of the hospital, but somebody whose job it would be to co-ordinate the clinical work of the hospital, perhaps regulating the admissions, adjusting the number of beds available to a particular specialty at a particular time to meet varying and changing needs, a kind of medical factotum.

1528. You think there is room for an increase of that?——That was the Board's view, and I personally would not dissent from it.

Mr. *Robinson.*

1529. Did you give any evidence to the Guillebaud Committee?——We did not give verbal evidence.

1530. Not to the Bradbeer Committee?——Our Board were very much in favour of the Bradbeer recommendations, and Guillebaud seems to endorse them.

*Chairman.*

1531. That would not detract from the power of the Committees too much?——I do not think so; I see no reason why it should at all.

1532. It is a matter of internal reorganisation rather than a change of function?——Yes. One has the situation these days under which quite a number of medical men, consultants of various kinds, are visiting hospitals, none of them owing allegiance to any person or making obeisance to any particular person, not under anybody's direction, and the feeling is that the activities of these numerous consultants visiting the same hospital should be co-ordinated by somebody—that somebody would have to be a medical man.

Mrs. *Hill.*

1533. You are not suggesting that that medical man should do nothing other than co-ordinate. He would be an active person doing a job of work in that hospital?——Yes, as the Bradbeer Committee recommended.

1534. Rather in the way you have one or two instances where you have a

Clinician Superintendent in one or two of your hospitals now?——Yes. (Dr. *Marshall.*) In special hospitals. We also have directors of special departments of general hospitals. (Mr. *Gibbon.*) They have a man looked on as a kind of *doyen.* (Mr. *Agnew.*) I know that sounds all very nice, but I do not know whether it would work.

*Chairman.*

1535. You are differing from Mr. Gibbon?——I have not had experience of it. It sounds all right, but if you want my personal view about it, I think there might be some difficulties in getting it to work satisfactorily.

1536. We have a note from the Association of Municipal Corporations, and they say that they invite us to consider whether the present system of divided responsibility between Secretary, Matron and Committee makes for economy. Do you feel there is anything in that?——I should have thought the control of the hospital was in the Hospital Management Committee, not in the matron or consultant staff.

1537. They go on to say should not the Hospital Management Committee rather be able to turn to one officer for advice on such matters as staffing and equipment, an officer whose duty it would be to accept administrative responsibility for running the hospital economically and administratively as a whole. It is rather revolutionary, is it not?——I should have thought that if the Hospital Management Committee wanted advice on nursing it would go to matron, and the matron is probably the best person to go to.

Mr. *Holt.*] I think the reference was to an overall superintendent, which is rather different.

*Chairman.*

1538. I have got Mr. Gibbon to go so far as to speak of a *doyen* clinician? ——(Mr. *Gibbon.*) Yes.

1539. It is the same principle?—— (Dr. *Marshall.*) I do not think there is any doubt in the old days in the early 'thirties when the local authorities took over the old Public Assistance Institutions and made municipal hospitals out of many of them that the key factor in developing those ex-workhouses into hospitals was very often the medical superintendent. If you had a good medical superintendent you were well on the way to having a good hospital, but I do not think that system would work today. I do not think it is practicable. As for finding someone, a *doyen,* to work on a medical staff of a hospital, I think that is supremely difficult today because the biggest proportion of the medical staff in the hospitals in Manchester, at any rate, have been appointed since 1948 and are all perhaps in their early forties, and many of the older men do not command the respect of these younger men. I think it would be extremely difficult to find anyone willing and able to take on the responsibilities of acting as medical administrator and doing his own job satisfactorily. I think that has been proved to some extent by the difficulties that have been experienced in carrying on the Middlesex County Hospitals under that system, a very good system inaugurated by the Middlesex County Council before the Act, but it has been difficult to carry it on, and there is no financial incentive to a man to give up clinical work and take on the additional responsibility of medical administration—and there *are* additional responsibilities.

1540. You do not think there is much point in it, if it can be worked on a team basis without it?——That is my feeling. I used to think we could save a lot of money, in fact, I did say earlier on that if I could spend £50,000 a year on medical administration I would save the Board £100,000. I was young in those days. I do not think I could do it today.

1541. Do you think you have gained wisdom or lost in enthusiasm?——I think the pattern of development is completely different from what it was originally, more and more consultants, all experts in their own field and no outstanding able administrator amongst them to hold the reins.

1542. Thank you. That was rather an interposition of a subject. I want to go back to tidying up a few points on your original Memorandum about the extent to which group services have been centralised*. Have you anything to say about that?——(Mr. *Agnew.*) Yes. I should say group centralisation of services has been in the Board's mind and

* Evidence p. 60.

has been pursued by the Board for a quite considerable time.

1543. Is it bearing fruit?——Undoubtedly it is bearing fruit. When I say centralisation, I mean such things as laundries—whether I should be too bold to say that centralisation of laundry service is now complete, I do not know (perhaps it would be a little bold), but it is well on the way.

1544. Even as far north as Westmorland?——We cannot in Lancaster and Kendal—Lancaster is the most scattered Hospital Management Committee we have got.

1545. But in the more central areas?——Yes, West Manchester, South Manchester and North Manchester groups. We could in Lancaster, but I do not see that it would stretch from Lancaster to Kendal.

1546. Can you give a rough figure of the saving you think would be brought about?——I am sorry I cannot. Can we work it out and let you know?

1547. Do you think it has been a saving in pounds, shillings and pence, or inefficiency?——I should say in both.

1548. We would like to have a figure?——(Mr. *Jones.*) I doubt very much whether we could on this. It is a policy which the Board initiated in its early days and has been gradually progressing since 1948. It is difficult to assess into pounds, shillings and pence today what it would have been had we not in fact centralised our laundries.

1549. You spoke of transport and maintenance departments. Has there been some centralisation there?——There has been centralisation generally of transport, that is making it into group transport rather than each hospital on its own: you also have group maintenance departments being set up rather than for each hospital doing it as an individual unit; you have group stores performing group functions, maybe even sub-group stores, rather than having individual stores at hospitals; you have your laundries.

1550. Roughly how many group laundry schemes are there?——I should say there has been a tendency in every one of our groups to centralise one or more hospitals.

1551. But within groups?——Within groups.

1552. Not two groups together?——No. There has been only one instance of inter-group laundry arrangements.

1553. Do you think you could let us have a note on general group services?——(Mr. *Agnew.*) Certainly.

Mrs. *Hill.*

1554. On group stores would you say it has meant you need smaller stocks, that it saves widely scattered stocks, and you have less money standing idle?——Standing idle, yes, undoubtedly.

*Chairman.*

1555. Turning to section 3 in your original memorandum*, under Management Committee Estimates, you give the standard form provided by the Ministry of Health. Do they often require modification in the estimates prescribed under these subheads? Are there requests for virement between subheads? Do you feel the subheads are a reality, or not?——(Mr. *Jones.*) The subheads are a reality, and the applications which the Board receives for operation of virement, to transfer from one head to another, are very small.

1556. You do not think there are too many subheads?——No.

1557. If you reduced the subheads you would give H.M.C.'s more responsibility, would you not?——Yes, but equally it would perhaps destroy the regional pattern to which the Board does attach some importance.

Vice-Admiral *Hughes Hallett.*

1558. Can you amplify what you said about the extent to which virement was allowed, because I thought it was rather extensive, or am I wrong?——As far as we operate in Manchester, and I can only deal with that, application for virement is made only in isolated instances, and then only approved by the Board, provided that the under-spending is the actual result of economy or circumstances over which the Committees have no control, that is, movement in prices, or something of that nature; secondly, that the item on which they wish to expend their saving is urgent and important,

* Evidence p. 60.

and such as is necessary to the proper maintenance of the hospital service.

1559. I would like to link this to the earlier recommendation which you support concerning the right to take on additional staff and establish staff if necessary. Is it quite certain that by a process of virement the staff could not be expanded as a result, shall we say, of a saving one year on drugs, thus landing oneself into recurring expenditure on higher staff?——(Mr. *Agnew.*) You can rest assured that a saving by a Hospital Management Committee on drugs would have nothing to do with the appointment of additional staff.

1560. It would never be permitted to that extent?——Nothing to do with it in any shape or form. (Mr. *Jones.*) Nor would we allow virement to be used to incur expenditure which would have an effect on the following year or on future Estimates.

*Chairman.*

1561. With regard to major developments and improvements, you show remarkable figures as to the number of sessions for consultants and specialists, and also remarkable figures as to increased turnover of 44,000 a year in beds in acute hospitals*. How have you achieved both those remarkable results? ——(Mr. *Agnew.*) The increased turnover of beds has been brought about by the additional medical staff, by early ambulation, and that kind of thing.

1562. You tend to early ambulation up there, do you?——Yes, certainly, improved turnover. With regard to the number of sessions, of course, that is all arranged by Doctor Marshall.

1563. How has Dr. Marshall done that?——(Dr. *Marshall.*) The measure of the consultant sessions in 1948 is merely a measure of the parlous state the hospital service was in at that date, and 307 consultants giving only 1,846 sessions indicates that parlous state, and purely by hard work——

1564. By efficient direction by you? ——We have built up the service to 426 consultants.

1565. In fact, there is no answer except efficiency, really. In section 4 (*j*)† you refer to the decline in the number of beds in mental hospitals, which I think is reflected in most mental hospitals in the country now. Waiting lists are lessening and there is a tendency towards a decline. What is being done with the additional beds—are wards being jumped up?——Nothing yet has been done because there is a considerable degree of overcrowding, and the patients are more spread out in the hospitals themselves.

Mr. *Robinson.*

1566. Have you any figures with regard to the degree of overcrowding in your mental hospitals?——Yes. It is not as high in the Manchester Region as in some others—something, I think, about 10 per cent.

*Chairman.*

1567. You still have 98 per cent. occupancy; you will meet the situation by reducing the number of beds in a ward rather than by closing wards?——Yes. (Mr. *Agnew.*) May I make one point. I am not sure we are quite right here. This paragraph I thought meant to show that we were reducing beds at the big mental hospitals because we were opening mental beds in the general hospitals. I do not know whether you have got the impression from Dr. Marshall that we have not got the same mental patients wanting to get in.

1568. I should imagine you have a number, which is beginning to decline, of long-stay mental patients?——(Dr. *Marshall.*) That is so. (Mr. *Agnew.*) But also we are being able to lessen the beds in the big mental hospitals because these other units are coming into existence.

1569. Psychiatric units in acute hospitals?——Yes.

Mr. *Robinson.*

1570. Last year for the first time since the war the total number of mental patients in mental hospitals showed a decline. Could you say whether that decline was reflected in the Manchester region?——(Dr. *Marshall.*) The number of beds occupied in the Manchester region on 31st December, 1955 was 12,857, and in 1954 it was 12,991. I do not know the figures for last year yet.

* Evidence p. 61. † Evidence p. 62.

19 *March*, 1957.] Mr. NORRIS M. AGNEW, C.B.E., [*Continued.*
Dr. F. N. MARSHALL, M.D., B.Sc., D.P.H., Mr. J. GIBBON, F.H.A.,
and Mr. J. EMLYN JONES, A.A.C.C.A.

*Chairman.*

1571. You refer to the improvement in the figures of chronic sick*. How have you done that?——(Mr. *Agnew.*) The improvement to chronic sick premises has been a matter of pounds, shillings and pence.

1572. With regard to the turnover? ——The turnover, I think, to a very large extent has been accounted for by the fact that we have appointed these geriatrician specialists who are interested in this work and have done invaluable work, I think.

1573. There is a certain Borough in London which has started a sort of workshop, two hours a day for old people in order to give them a feeling of being wanted, and they get pocket money, and it is claimed that in this way it has kept people out of mental hospitals and kept them from becoming chronically sick. Have you any experience of that sort of work in Manchester?——We have got these occupational industrial centres for the mental deficient cases.

1574. I do not mean that. I mean people up and about, but who are liable to deteriorate mentally and physically. It is really a question of how you think you can keep people out of hospital? ——(Mr. *Gibbon.*) We have not got such a thing in our region. We have not even heard of it.

1575. Have you any ideas how to keep both the aged and the people who are mentally deteriorating out of hospitals?——We certainly have ideas on how to get them out of hospital, which is our job.

1576. No, to keep them out?——(Mr. *Agnew.*) I do not see why the scheme we have got running at Oldham, which is an industrial occupational scheme for the mental deficients, should not be extended—not in the same place, but the same idea to cover the chronic sick as well. I think it would be an excellent idea.

Mr. *Holt.*

1577. Am I not right in thinking that under the local health authorities centres are being run in the Manchester region? If I remember rightly, such a centre was opened in Bolton?——(Mr. *Gibbon.*) For the aged?

1578. Yes——(Dr. *Marshall.*) We would not have much knowledge of it if it was being run by the local authority. We have a day hospital in Bolton for old people, where they are occupied during the day and sleep at home at night. At the Bolton General District Hospital we have such a centre.

*Chairman.*

1579. Have you any idea how you can induce general practitioners to make less use of hospitalization?——(Mr. *Agnew.*) To make less use of hospital beds?

1580. Yes?——I think by giving the general practitioner the opportunity of getting equipment in the hospitals, X-ray, pathological laboratories, and those things. I think those all help the G.P. to keep his patients out of hospital.

1581. Do you notice a tendency towards that?——Oh, yes.

Vice-Admiral *Hughes Hallett.*

1582. In your region do the G.P.s have access to the radiological and pathological equipments?——I believe I am right in thinking—Dr. Marshall will tell me if I am wrong—that in Manchester region every G.P. has now available to him X-ray services in one of our hospitals, and a laboratory as well.

1583. That is without reference to the consultant?——(Dr. *Marshall.*) Yes, direct access to X-ray departments and pathology laboratories.

*Chairman.*

1584. Going back to the chronic patients, the Association of Hospital Management Committees urges the consideration of the possibility of boarding out suitable chronic patients and mental patients*. Have you anything to say on that?——(Mr. *Agnew.*) Where are they going to be boarded out?

1585. Those are their words?——(Mr. *Gibbon.*) It is not an easy job, Sir, the boarding out. Most people will agree, particularly those who have experience, such as local authorities, that boarding out is a very difficult job.

* Evidence pp. 62–3.

* Evidence p. 222.

Mr. *Robinson.*

1586. Except in Scotland?——It may be easier in Scotland. In England it is a matter of considerable difficulty to get a decent family to take in a mental defective under guardianship. It is even difficult to get a decent family to take a normal child, a deprived child.

Vice-Admiral *Hughes Hallett.*

1587. Do you consider that sufficient or maximum possible use is made of the Home Nursing Service in trying to keep down the load on the hospital service at present?——(Mr. *Agnew.*) I should say—I have not any evidence of it—the answer is no.

1588. In other words, it might be spending more on Home Nursing Services than possibly one might save on balance by keeping people out of hospital?——(Dr. *Marshall.*) I would think so quite definitely.

1589. Would that apply also to the Midwife Service?——I think we are possibly going to be driven more and more to that in the Manchester Region because we cannot get midwives in the hospitals. The public demand is largely to have their babies in hospital if possible, but we have many beds closed for lack of midwives and the only thing to do in those circumstances is to urge the local authorities to make more provision for domiciliary confinement.

1590. One final question: do you think that the present tendency to relate salaries to the number of beds in commission is desirable in principle from the point of view of trying to deduce the hospital population of patients?——(Mr. *Agnew.*) Do you mean the relation of salaries paid to officers based on number of beds?

1591. Beds in use, yes?——Well, we have been talking for an hour and a half this morning on that very point. My own conclusions are that there will be much to gain from not basing officers' salaries on the number of beds which happen to be in their particular groups.

Mr. *Robinson.*

1592. Could you put forward any alternative basis that might be used?——What I feel is that the number of beds must have some criterion to it, but we do feel it ought to be left to the Regional Board in conjunction with the Hospital Management Committee concerned to decide whether there should be a " plusage " in certain circumstances. We do not like the idea of it being fixed because there are so many beds in a particular group and that the salaries of the chief officers must be so and so. (Mr. *Gibbon.*) It is too refined at the moment.

Mrs. *Hill.*

1593. Would you say it tends not for economy because the officers are not going to urge that beds should be reduced because their salaries would in the event be downpointed?——(Mr. *Agnew.*) That is one of the main reasons for it, and it is not only the officers themselves who might feel that it is so, but Hospital Management Committees too.

Mr. *Robinson.*

1594. Does it apply to senior nursing salaries also?——Yes.

*Chairman.*

1595. You have a very good record of medical and administrative staff per inpatient. It is lower than the national average. Can you account for that?——(Dr. *Marshall.*) You mean the number of consultants?

1596. No, the total medical and administrative staff. You have a greater number of inpatients per unit of medical staff or administrative staff than the national average. I wondered if you had any comment on that?——(Mr. *Agnew.*) I should say one of the reasons possibly is that we have tried to amalgamate the services into one or two hospitals of the same kind, instead of it being scattered over an area, thereby saving time, and possibly Manchester is fortunate in this respect that our hospitals on the whole are near together or reasonably near together, and I think that the consultants probably in our Region spend less time travelling about from hospital to hospital than they might spend in a very much more scattered Region, which means of course that they are spending more time with the patients, therefore it needs less consultants.

1597. I suppose there are inevitably different patterns in different Regions?——I should say so.

1598. You would resist and reject any suggestion of a lower standard?——I would. I am not saying that with more medical staff and nursing staff we could not do a bigger service than we are doing now, but what I do say is that the patients who have passed through our hospitals have received as good a treatment as they would have received in other hospitals.

Mr. *Robinson.*

1599. Do you find any difficulty in discontinuing a consultant session which you are certain has become redundant? ——(Dr. *Marshall.*) I do not think we have had that experience as yet with consultants. We have had it with other grades. I am thinking of part-time officers in the hospital service and also in general practice. I do not think we have had the necessity to reduce consultant sessions, but then perhaps we are rather different from other Regions, in that instead of appointing a consultant for maximum part-time, that is nine sessions, we invariably begin at the bottom and appoint them for possibly eight, and then if it proved that the work is more then we will consider increasing the sessions.

*Chairman.*

1600. You spoke of a special department for keeping under continuous review all medical establishments?—— That is a section of my department and we keep the consultant and senior hospital medical officers and all these people under continuous review, and occasionally we have to bring to the Board suggestions for increasing or reducing sessions, but, so far as consultants are concerned, I do not think we have had occasion as yet to reduce their sessions. One of the things is that we are still understaffed; we are still gradually building up the staff, and in the speciality in which there is a certain amount of redundancy up and down the country, namely T.B. chest physicians, we appointed chest physicians in the Manchester Region who are not merely chest physicians, but really general physicians at the same time, so they are taking on the work of general physicians as the demand on their services for chest diseases gradually dies down. We have occasionally reduced sessions by agreement, but never forcibly.

1601. How do you co-ordinate the provision of services with the United Manchester Board of Governors?—— (Mr. *Agnew.*) I think, of course, it does help to some extent having the same Chairman of both. We did before I took over have a liaison committee of the two boards which met, but they both thought that there was no need for that with the same Chairman. On our Medical Advisory Committee of the Regional Board we have a number of Board of Governors medical people; on the Board of Governors we have representatives from the Regional Board; on the Regional Board we have representatives from the Board of Governors, and I honestly feel that the co-operation between the two Boards is complete. If the Secretary of either Board wants to discuss things with the other, they know each other perfectly well, and all the officers do, and if they want to call me in I am there as well. There is no difficulty at all.

1602. I will ask a question to which I think I know your answer: do you think there is false economy over lack of minor capital expenditure on small projects? Could you achieve an annual economy by comparatively minor capital investment?——(Dr. *Marshall.*) Yes. (Mr. *Agnew.*) Could we achieve more economy?

1603. Economy in your annual expenditure by relatively minor capital expenditure?——(Mr. *Gibbon.*) We do quite a lot of capital expansion, Sir. We allow the H.M.C.s to carry out quite a number of minor capital schemes, and quite frequently those schemes produce revenue savings, or hold out the prospect of doing so.

Mrs. *Hill.*

1604. Could the service save more if there were more capital expenditure? ——(Dr. *Marshall.*) Yes, definitely.

*Chairman.*

1605. A very comprehensive question: what is done, and what could be done to make all ranks of the service more cost-conscious?——(Mr. *Agnew.*) I think the experiment which is going to start on 1st April will help.

1606. Do you feel the medical profession is cost-conscious? Do you feel that young medical students and doctors

are taught enough to consider questions of cost?——That is a very difficult question to answer.

1607. Can something be done in that direction?——(Dr. *Marshall.*) Something is being done already by circulating to all hospital staffs the information put out by the Ministry of Health on cost of drugs, and the same material goes to general practitioners.

1608. That goes to every doctor?——That goes to all hospitals, junior staff and even to consultants. We have got them interested in bed occupancy figures, and things like that, by circulating memoranda from time to time and at the present time we are trying to get the senior consultants interested in the question of drugs. Each Group Advisory Committee has this matter under consideration at the moment, the question of drugs, and I think that by and large they are becoming more and more cost-conscious.

1609. If a particular hospital finds a way to make a saving on something are steps taken to circulate that information?——(Mr. *Agnew.*) Yes, I should say so definitely. That would be reported to me. Every second month I have meetings with every H.M.C. chairman and that would go down on the agenda of the meeting automatically.

1610. We were told the other day that at a small hospital with 90 beds they took to buying their swabs ready-made, and they found it saves in the small hospital £3 a week. Are little minor things like that investigated, and if they work is the information passed round?——(Mr. *Gibbon.*) Well, Sir, we did about two or three years ago specially invite Hospital Management Committee Chairmen at one of the periodical meetings at the Board's offices to let the Board know of any private ideas they had which might secure efficiency and particularly if they secured improved economy. One or two Management Committees did respond to that, but I am afraid it has fallen into disuse, and we have got to "winkle" these things out these days. There seems to be something of a fear in some Management Committees—and I am not criticising them for this—that if they let the Regional Board know too much as to how they are able to save here and there that might be used by the board as a financial penalty in the following year, although we have given them every kind of assurance we would not do that.

1611. There is a certain sales resistance to economy?——No, I would not say that. My own personal view is that throughout the whole hospital administration at every level, with the possible exception of pockets, there is a very lively cost-consciousness.

1612. You would never think of giving awards, for instance?——That is done in some hospitals.

1613. The Association of Hospital Management Committees think that that should receive consideration at least?——Yes, it is even practised. (Mr. *Agnew.*) We have all grades of officers' meetings at the Regional Board, Treasurers, Finance Officers, and if there is a hospital which finds a method of saving money it seems inconceivable to me that that would not be reported by the appropriate officer to his opposite numbers when they next meet.

1614. Relatively tiny things?——Yes, I am certain it would, and if it was important I would not even be asked—it would go on the agenda for my meeting with H.M.C. Chairmen.

1615. Have you anything to say to us on how to make the hospital service more economical without lowering standards?——No, I cannot think of any method which is going to make any substantial reduction in the running costs of the hospital service. I feel that there is so much we have still got to do. We have done a great deal, but there is still a lot to do, and I feel Parliament grants the money to the Ministry, the Ministry grants us, the Regional Board, a certain amount of money, and we grant it to the H.M.C.s, and I feel that the policy for a long time to come is going to be for us to spend that money whatever it might be, not to look upon it as income, but it is a grant for the year, for us to spend that money in the best way we can in the hospital service, knowing perfectly well that it is not enough.

1616. Would I be right in saying your feeling is that the greatest safeguard for the taxpayer is the highest possible quality of administrator?——Yes.

*Chairman.*] Thank you for your evidence today.

TUESDAY, 26TH MARCH, 1957.

Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Vice-Admiral Hughes Hallett. |
| Mrs. Hill. | Mr. Robinson. |
| Mr. Holt. | Mr. Willis. |

**Memorandum submitted by the South-East Metropolitan Regional Hospital Board.**

(1) *Description of the Board and Region*

If you draw a line from London Bridge to Brighton and back round the coast and along the south bank of the Thames to London Bridge, you will enclose the area of this Board, including approximately eight metropolitan boroughs of London, the County of Kent and the administrative County of East Sussex. The number of hospitals administered is 170. The local health authorities concerned with this area are the County Councils of London, Kent and East Sussex and the County Borough Councils of Eastbourne, Hastings, Brighton and Canterbury. Coterminous with these local health authorities are the Executive Councils, except that Kent County and Canterbury County Borough combine to form a single Executive Council. Within this area there are three teaching hospitals, Guy's, King's College and the combined Bethlem Royal and Maudsley. Details of the area and population are:—

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|---|---|
| London. The metropolitan boroughs of Bermondsey, Camberwell, Deptford, Greenwich, Lewisham, Woolwich and parts of the boroughs of Southwark and Lambeth ... ... ... ... | 977,500 |
| Kent ... ... ... ... ... ... ... ... ... | 1,614,000 |
| East Sussex ... ... ... ... ... ... ... ... | 623,500 |
| | 3,215,000 |

The Board consists of twenty-four members including its Chairman, all of whom are appointed by the Minister of Health for periods of three years at a time. One-third of its members vacate office every year, but are eligible for reappointment. The Board's membership was drawn originally from the governing bodies of voluntary hospitals (this has been its most enduring element), from local health authorities, from the University of London, from Executive Councils and from various consumer interests. Of the 24 appointed in 1947, no fewer than eleven are still members. Voluntary hospitals have been replaced as a source of recruitment by hospital management committees. 14 members of the Board are members of Boards of Governors of teaching hospitals and the two management committees most concerned with Guy's and King's College Hospitals draw a substantial portion of their membership from them. Executive Councils are chiefly represented on management committees rather than on the Board itself. Changes in the membership of local health authorities, resulting from elections, have outpaced their representation on the Board and on its management committees.

The present membership comprises 19 men, of whom eight have medical or dental qualifications. Of these eight, two are general practitioners, one a dentist, one a retired Psychiatrist Medical Superintendent, two retired surgeons and two Deans of Medical Schools. The five ladies include a retired Matron and two barristers who are not practising. It is worth remarking that none of the twelve laymen has retired from his profession. They include three company directors and managers, an Accountant, a farmer and men holding executive posts in various walks of life. Eleven members of the Board are Chairmen of hospital management committees, and the Board expect all members to serve as members of a management committee or Board of Governors. Most do, but they do not necessarily owe their appointments on the Board to their hospital experience.

There are 28 management committees whose Chairmen and members are appointed by this Board. They are:—

*General*

Camberwell.
Bermondsey and Southwark.
Greenwich and Deptford.
Lewisham.
Woolwich.
Sidcup and Swanley.
Dartford.
Medway and Gravesend.
Canterbury.
Isle of Thanet.
South-East Kent.
Mid-Kent.
Tunbridge Wells.
Orpington and Sevenoaks.
Bromley.
Hastings.
Eastbourne.
Brighton and Lewes.
Mid-Sussex.

*Mental*

Bexley.
Darenth and Stone.
St. Augustines.
Oakwood.
Leybourne Grange.
Hailsham.
St. Francis and the Lady Chichester.

*Special*

Seamen's.
Preston Hall.

In appointing management committees the Board formally consult local health authorities, Executive Councils and senior medical and dental staff (all of whom are in fact represented on every management committee) together with various other organisations from which the Board select members though by no means finding a place on every committee for each organisation. The organisations from which the most members are drawn are the County Trades Councils, the Royal College of Nursing and local medical committees. Another important source of recruitment is the management committee itself which is expected to find suitable members from minor local authorities, leagues of friends, House Committees, etc., with a view not to give representation to local sectional interests, but so as to make up the best balanced team for the work.

Local General Practitioners and Medical Officers of Health are well represented on management committees or, in appropriate cases, on their Group Medical Committees.

2. *A brief description of the methods by which we implement our financial responsibilities with special reference to steps taken to ensure maximum economy by the hospital management committees in using their current account allocations.*

The allocation by Board to hospital management committees is made on an historical basis. The system of relating the allocation to the estimated actual expenditure of a preceding year has been replaced for the past two years by building the allocation for the year which is about to commence upon the basis of the revised approved estimate of the current year with additions for (i) salary awards (ii) price increases (iii) cost of incremental progression (iv) special purposes, e.g. cost of new

functions decentralised by Ministry of Health (v) cost of maintaining developments and improvements of the service already effective in the current financial year.

Future developments, which are selected for priority for finance by the Board from a list of all proposals submitted, are dealt with by separate allocations to each group from a reserve set up by the Board for the purpose.

Costings have not been used by the Board in their assessment of the initial allocation made each year to hospital management committees. They have been used in limiting at the revision stage the applications received from hospital management committees for additional budgetary provision. The Board's aim has been, within the limits of available finance, to add to the approved budgets of those groups whose costs are relatively low so as to enable them to improve their standards whilst those already high " mark time ".

Apart from these generalisations the following are illustrations of the principal ways in which the Board has exercised some centralised financial control of the budgets of hospital management committees: the allocation to each hospital management committee is made in three parts (1) Nursing Staff Salaries (2) Maintenance of Buildings, Plant and Grounds, including the wages of direct works staffs (3) other sub-heads of expenditure:

(a) *Nursing Staff Salaries.* (27 per cent. (about) of hospital expenditure).

In the early years of the service much difficulty was experienced over the economic provision, within the approved allocation, for nursing staff salaries. It was found that when hospital management committees were given freedom to divide their global budget over all sub-heads they made either—

(i) excessive provision under the Nursing Staff Salaries sub-head in accordance with over optimistic forecasts of the prospects of recruitment, or

(ii) inadequate provision under this sub-head in order to facilitate more generous provision under others.

The effect of (i) was a large end of year surplus under the sub-head resulting in numerous requests for transfers of budgetary provision to other sub-heads which, if granted, in turn produced hurried and ill planned spending, and of (ii) the plea that nursing staff were of necessity being " turned away " or, in extreme cases, discharged for lack of finance.

These difficulties were overcome by a system of dealing with the estimates under this sub-head on a regional basis. The Board approve for each hospital management committee a total for the Nursing Salaries sub-head, based on current expenditure. The Board guarantees to meet from their central reserves the amount by which any hospital management committee overspends the amount allocated for this sub-head.

Transfers to or from the sub-head are not allowed. During the last month of the financial year a very close estimate of the expenditure of each group on Nursing Staff salaries (based on 11 months' salary payments) is obtained and an addition or reduction made to the sum approved for each to accord therewith. In this way recruitment may be carried on without central administrative or financial consents and no question of surpluses for transfer to other sub-heads arises. There is no doubt that this system has worked well and has facilitated the planning of expenditure within a closer margin of the regional budget than would otherwise have been possible. The system will require examination again if and when the stage is reached when nursing staff establishments at some groups have reached a fully satisfactory level.

It is of interest that the amounts which the Board has been required to meet from reserves under the guarantee given to hospital management committees has been for the past two years—

| | |
|---|---|
| Year ended 31.3.1955 ... ... ... ... ... | £8,000 |
| Year ended 31.3.1956 ... ... ... ... ... | £23,000 |

For the current year recruitment has shown some real improvement and the amount likely to be required under the guarantee is £80,000.

(b) *Maintenance of Buildings, Plant and Grounds (including wages).* (8 per cent. (about) of hospital expenditure)

The Board has always been alive to the needs of the Region in this respect. From early days a part of their allocation to hospital management committees has been earmarked for Maintenance of Buildings, and not freed for transfer to other sub-heads. In common with other Regions, and perhaps more than some as a result of the inclusion in the area covered of the heavily bomb damaged areas of East London and Kent, there were considerable arrears of essential maintenance work existing in 1948. Some progress has been made in coping with these arrears but much yet remains to be done.

The present allocation to groups is made as follows:—

(i) the sum earmarked as a minimum figure in the Minister's allocation is accepted as the initial sum for distribution. The Board's Architect and Engineer are asked to advise on the distribution to groups.

(ii) about 90 per cent. of this sum is distributed initially to hospital management committees for "basic" maintenance. The basis used on the recommendation of the Architect and Engineer is £17 per mental or mental deficiency bed and £33 for other types of bed, subject to adjustment in the light of technical considerations such as age and state of buildings and equipment, climatic conditions, etc.

(iii) the remainder is considered to be available for "special works" a complete list of proposals having been obtained from hospital management committees and scrutinised by the technical staff of the Board. Their recommendations are considered by the Board and priority for finance awarded. Part of the balance is then approved for allocation and the remainder held for reconsideration and issue at the revised stage of estimates.

(iv) at revision any balance of the Board's reserves which can safely be regarded as free for issue is added to the regional total for maintenance of buildings and allocated to hospital management committees for special works selected from the uncompleted list.

(v) transfers sought by hospital management committees to Maintenance of Buildings from other sub-heads, mainly the one for "Other staff salaries" are approved only after consideration of the projects involved.

By this means the expenditure of the region under the combined sub-heads for Maintenance of Buildings, Plant and Grounds is subject to a degree of central control sufficient to ensure that proper priorities are observed. Planned expenditure under these sub-heads exceeded the Minister's minimum allocation for the purpose for 1955–56 by £50,000 and for the year 1956–57 is likely to exceed it by £75,000. These excesses are calculated after excluding the effect upon total expenditure of wages and price increases.

(c) *Other sub-heads*

*Provisions.* (13 per cent. (about) of hospital expenditure.)

The Board has arranged for hospital management committees to prepare on a uniform basis and to submit for consideration monthly figures of the cost per person fed at every hospital in the region. These unit costs are examined monthly by the Board in the light of a report made by the Board's Catering Officer.

This close examination of costs at each hospital has been proceeding for several years. Variations persist but are no longer extreme. It has never been the purpose of the Board to lay down fixed financial standards for feeding. Their objective has always been to secure, with expert advice, as high as possible a standard within the limits of available finance and to ensure that full value is derived from the money spent. In fact the Board's work has tended to increase the expenditure under the sub-head; for example, in Mental and Mental Deficiency Hospitals when the policy of improving the dietary was adopted by the Board some time before the Minister commenced to issue a special allocation for this purpose.

(d) *Other staff salaries.* (28 per cent. of hospital expenditure.)

Control of this sub-head is more administrative (by man-power) than financial.

Each separate increase of Administrative or Clerical staff proposed by a Hospital Management Committee must receive the prior approval of the Board.

For all other types of staff included under this combined heading each group has a single ceiling figure. The number employed cannot exceed this ceiling without the approval of the Board; but it is the custom to seek the Board's approval to all new posts, even though their addition will not affect the total approved.

With the difficulties of recruitment to the Hospital Service which have so far persisted the tendency has been for some savings to be shown against the financial provision made under this sub-head by hospital management committees. This is in the main where the requests for transfer of budgetary provision to other sub-heads arise towards the close of the year. Such transfers are considered by the Board and for the most part approved for use in the purchase of Medical and Surgical Equipment, Domestic renewals and approved projects of Building and Engineering Maintenance.

*General*

These notes have been directed towards those matters in which the Board has introduced an element of central financial control on broad lines which may not be common to all Regions. They do not pretend to deal in any way with the routine checks on expenditure and the actions arising therefrom which are themselves an important factor in financial control.

(3) *A description of any central purchasing arrangements in this region.*

This Board have not made any arrangements for regional purchasing.

Apart from central purchasing by the Ministry of Health, there are arrangements for group purchasing within the region.

*Discount.*

Certain suppliers of the following items have agreed to aggregate in their books the purchases made by individual management committees, so that each committee obtains the discount which would have been allowed to a single purchaser placing the same aggregate order.

Ice cream.
Methylated spirits.
Detergents.
Cable.
Conduit.

In the case of cable and conduit, and of the detergent sodium metasilicate, purchases from all four metropolitan regions are aggregated to obtain the discount.

*Joint Purchasing.*

Each management committee has its own supplies officer. Besides meeting every month to compare prices, they have divided themselves territorially into six groups. These groups investigate the possibilities of jointly purchasing items other than those mentioned above. If they see an advantage in joint purchase, a single contract is placed by one of their number. Textiles are commonly purchased by this method direct from manufacturers, but the evidence that it is cheaper than individual purchase is inconclusive. Drugs and pharmaceutical sundries are commonly purchased by joint order, and it is generally agreed that a substantial saving results from increasing the quantity of the order when purchasing these articles.

(4) *A list of the heads under which Hospital Management Committees prepare their estimates for approval*

Hospital Management Committees are requested to prepare their estimates in the form prescribed by HM (56) 67 Statement 2. Thus:

A. Hospital Maintenance ... ... ... ... ... ...
(I) Salaries & wages ... ... ... ... ... ... ...
(*a*) Medical (Category B) ... ... ... ... ...
(*b*) Nursing (Category C) ... ... ... ... ... ...
(*c*) Administrative & clerical ... ... ... ... ...
(*d*) Works & maintenance ... ... ... ... ...
(*a*) gardeners & stokers ... ... ... ... ...
(*b*) others ... ... ... ... ... ... ...
(*e*) Other staff (Category D except works & maintenance) ...
(*f*) Total ... ... ... ... ... ... ... ...
(II) Provisions ... ... ... ... ... ... ...
(III) Uniform & clothing ... ... ... ... ... ...
(IV) Drugs, dressings, medical & surgical appliances and equipment ... ... ... ... ... ... ... ...
(V) Fuel, light, power, water & laundry ... ... ... ...
(VI) Maintenance of buildings, plant and grounds ... ... ...
(VII) Domestic repairs, renewals and replacements ... ...
(VIII) Other hospital expenditure ... ... ... ... ...
(*a*) rates ... ... ... ... ... ... ...
(*b*) all other expenses ... ... ... ... ...
(IX) Totals ... ... ... ... ... ... ... ...
(X) Less direct credits ... ... ... ... ... ...
B. Central administration expenses of the Committee ... ...
C. Other expenditure (Table C) ... ... ... ... ...
D. Totals ... ... ... ... ... ... ... ... ...

The allocation made to each Hospital Management Committee by the Board is in three parts:

1. Nursing staff salaries (A. (I) (*b*)).
2. Maintenance of buildings, plant and grounds (including wages) (A. (I) (*d*) *a* and *b*, A (VI)).
3. All other expenditure.

Hospital Management Committees are then asked to divide (3) in accordance with their requirements over the appropriate subheads and submit the result to the Board for consideration and issue of approval.

At the revised estimate stage each group is required to prepare and present a statement reconciling in some considerable detail, with an explanation of differences, the sums requested on revision with the sums in their existing approved budgets. This is done in order that their requests for additions may be fully understood and examined by the Board.

(5) *A description of any major developments or improvements approved in recent years, with an indication of the extra expenditure incurred*

It is appreciated that to be of value in this context a description of developments and improvements should explain the extent to which increases in the Board's running costs are related to capital outlay and to development of the services provided. It is unfortunately impossible to present the two sides in this relationship. Much of the Board's capital outlay (for instance, the plant redeployment programme) has been accompanied by a reduction of running costs; while certain developments which have had a significant effect, directly and indirectly, on the

services provided, had no significance in either capital or maintenance expenditure. An example of the latter was the change of function and reservation of beds in three hospitals for early cases of tuberculosis which, by giving cases of shorter duration a measure of priority over more serious cases, resulted eventually in reducing the waiting-list.

However, the individual items which follow have been selected as interesting examples of development out of a large number of major works completed. The total capital expenditure of the Board since the appointed day amounts to £5,125,000.

The trend of development in this Region has followed a pattern which has mainly involved, not a very great overall increase in the number of beds, but rather an upgrading of facilities and the provision of ancillary medical services which were sadly lacking in many of the hospitals taken over. In this way the Board has attempted to avoid an excessive increase in revenue expenditure and to ensure a better use of the hospitals and the beds in them.

The main changes of interest which have taken place otherwise concern the closure of redundant establishments, the change of function in certain hospitals, the co-ordination of specialities within the area of Hospital Management Committees, the planning of a Regional service for certain of the rarer specialities and for tuberculosis, and the provision of teaching facilities and extra beds for the Teaching Hospitals within the Region. The Radiotherapy Service has been established on a Regional basis and two new units completed.

(a) *General Hospitals*

(i) *The Brook General Hospital* situated in the Woolwich area was formerly a London County Council hospital for infectious diseases. Some £78,000 has been spent to develop this as an acute general hospital and to organise here two main Regional Centres for neurology and neurosurgery and major thoracic surgery of all types. There remains in the hospital a modern unit for infectious diseases which now contains one of the chief centres for the severe type of anterior poliomyelitis.

(ii) *New Cross General Hospital,* formerly the South Eastern Fever Hospital suffered considerable war damage and for several years after the appointed day was used as group offices, stores accommodation and a nurses' home annexe for Guy's nurses. Though there were no hospital beds in use, it cost the Board some £50,000 a year to maintain. It has been possible to open wards gradually and after providing twin operating theatres, out-patients and X-ray departments at a cost of £85,000 there are now 325 occupied beds which include an allocation to Guy's Hospital for teaching purposes. The annual cost of maintaining this hospital is now £275,000.

(iii) *Cuckfield Hospital,* a war time E.M.S. hospital attached to a local authority institution and situated in the rural area of Sussex, has been substantially developed and improved to serve the local community as the main district hospital of the Mid-Sussex H.M.C. area. A new out-patient department, operating theatres and a pathological laboratory have been developed and 205 beds reopened since the appointed day, at a cost of £100,000.

(iv) *Farnborough Hospital*—an interesting scheme for the erection of two operating theatres on the flat roof of a three storey building at a cost of £49,000.

(v) *Lewisham Hospital*—this hospital suffered considerable war damage. A master plan covering its restoration and development has been prepared and the first phase of a new large out-patients department at a cost of £212,000 is in hand.

(vi) *Miscellaneous*—

In all 12 new out-patients departments have been completed and others are in course of construction.

14 Single and twin theatre suites have been built.

12 Major X-ray units have been built or developed.

King's College Hospital has been provided with over 200 beds at Dulwich Hospital, nursing staff being provided by the Regional Hospital Board.

(b) *Mental and Mental Deficiency Hospitals*

The Board were faced with problems of severe overcrowding and long waiting lists for entry to mental and mental deficiency hospitals. They have concentrated on bringing into use as many new beds as could be staffed and maintained :—

(i) *St. Martin's Hospital, Canterbury*—this hospital suffered extensive war damage and had to be evacuated during the war. Parts of it have been restored at a cost of £34,000 and there are now 130 occupied beds devoted to the care of aged patients mostly suffering from confusional states who normally need not be admitted to wards of an active mental hospital.

(ii) *St. Francis Hospital, Haywards Heath*—a new admission villa accommodating 60 beds and ancillary departments is in course of erection at a cost of £140,000.

(iii) *Leybourne Grange Mental Defective Colony*—this is a new colony which was practically completed by the Kent County Council in 1939. Approximately £75,000 has been spent on further improvements and furnishings since the appointed day with the result that eight more villas have been brought into use enabling 400 beds to be staffed and opened.

(iv) *Hill House, Rye*—this was a former public assistance institution which was acquired at a cost of £20,000 from the East Sussex County Council in 1950. £60,000 has been spent on adaptation, and it now provides accommodation for 140 mentally defective children.

(6) *A description of any significant reductions in current expenditure in recent years.*

On "the appointed day" the Board inherited 86 voluntary and 89 municipal hospitals. The voluntary hospitals were of course nearly all under different management. The total number of local authorities maintaining the 89 municipal hospitals was 21. The concentration of all available beds under one management has enabled the Board to close a number of units whose occupancy was low and whose patients could be diverted to other hospitals with a consequent rise in the occupancy of the latter. The units were:

| | beds |
|---|---|
| St. Anne's Convalescent Home ... ... ... ... ... ... | 112 |
| Kettlewell Hospital ... ... ... ... ... ... ... ... | 96 |
| Rusthall Grange ... ... ... ... ... ... ... ... | 17 |
| Seaside Convalescent Home ... ... ... ... ... ... | 52 |
| Riseley Maternity Home ... ... ... ... ... ... ... | 8 |
| White Oak ... ... ... ... ... ... ... ... ... | 169 |
| Children's branch of the Diabetic Convalescent Home at Birchington | 18 |
| | 472 |

The cost of these hospitals in the last full year before each was closed aggregated £154,000. The exact savings cannot be computed.

The dwindling demand for T.B. beds also contributed to enable the Board to determine their contract with the Grosvenor Sanatorium Co. Ltd. which in 1954-5 cost the Board £116,000.

On "the appointed day" a number of infectious diseases hospitals which were maintained in reserve by scattered joint hospital boards and other minor local authorities were transferred to the Board and were kept in the hope that nurse recruitment would improve and they could be staffed and used for tuberculosis. These hospitals were not in the end required, and have been closed and disposed of. It has now been possible to make a plan for the order in which T.B. hospitals, which are now in operation, will be closed in different areas if, as appears likely, the demand continues to fall.

(7) *A description of any major increases in staff establishments of Hospital Management Committees authorised in recent years.*

The increases in nursing establishments and in the miscellaneous category (i.e. all except medical, nursing and administrative and clerical) are due to better recruitment rather than to newly authorised additions to establishment.

The administrative and clerical establishments, which in the first two years since establishments were "frozen" at the end of 1952, had shown a decrease from 2,027 to 2,004, had risen by the end of 1956 to 2,100 including 54 posts which were added to the Finance Departments of Hospital Management Committees for internal audit, hospital departmental costings and other forms of financial control.

(8) *An explanation of any significant rises or falls in hospital running costs indicated by the costing returns for the Region in recent years.*

It is true to say that there has been no fall in the running costs of hospitals over the past few years. There are a number of examples throughout the Region of the success of revenue saving projects such as (i) replacement of antiquated boilers with more modern ones or in some cases with oil fired or mechanical stoking installations (ii) introduction of engineering equipment for fuel economy purposes (iii) setting up of group laundries to centralise existing hospital laundries or to take over laundry work previously put out to contract. Though the savings resulting from these and similar measures are of some significance they disappear against the background of mounting prices and the incidence of awards of increased wages and salaries to staff employed. In the year 1956/57 the effect of these two factors is increased expenditure of £1,100,000 of which £860,000 is attributable to awards.

The present costing statements need to be used for comparison purposes with very great care. High and low cost at two hospitals placed in the same category for purposes of the National Costing Return does not necessarily provide evidence of extravagance at the one and efficiency at the other. The figures may point to the need for inquiry into the causes of the difference and when this has been made it may be found to be in great measure attributable to the number and calibre of specialised departments and to the design and age of buildings. Subject to these limitations the returns for the financial year 1955/56 show that the hospitals of the Region under the various types are running below or close to the average costs of hospitals of the same types of the four Metropolitan Regions.

1955–56

*Average net weekly cost per in-patient (adjusted by notional out-patient Expenditure)*

| *Type of Hospital* | *South East Metropolitan Board* | *Metropolitan Regions* |
|---|---|---|
| Acute: | £ s. d. | £ s. d. |
| 301 to 900 beds | 18 6 4 | 18 9 5 |
| 101 to 300 beds | 18 12 10 | 19 1 6 |
| 51 to 100 beds | 18 10 0 | 18 7 10 |
| 1 to 50 beds | 15 8 10 | 16 10 11 |
| Mainly Acute | 17 19 6 | 17 8 6 |
| Partly Acute | 14 1 5 | 15 7 1 |
| Mainly Long Stay | *15 7 3 | 12 8 11 |
| Long Stay | 9 10 9 | 9 7 7 |
| Chronic | 8 5 0 | 8 12 3 |
| Pre-convalescent | 10 9 0 | 10 14 11 |
| Convalescent | 7 2 3 | 7 15 1 |
| Rehabilitation | 7 10 11 | 8 4 10 |
| Isolation | †24 8 9 | 23 6 10 |
| Maternity | 19 13 5 | 20 15 3 |
| Mental Illness | 5 3 11 | 5 11 6 |
| Mental Deficiency | 4 14 11 | 5 7 0 |
| Orthopaedic | 15 15 3 | 15 12 4 |
| Tuberculosis and Chest | 13 16 4 | 14 3 0 |
| T.B. Chest and Isolation | 15 14 2 | 18 18 2 |
| Childrens | 20 18 2 | 20 13 6 |

* Average is made up from costs of only three hospitals of which one, Bermondsey Medical Mission is of very special character and another, New Cross General is in the midst of developments which will completely change its character. These two account for high average cost for type.

† High average cost due to low occupation of isolation hospitals at Denton (Port of London) and the port town of Newhaven, which have to be maintained although uneconomic.

9. *An explanation of any significant variations in the Board's central expenses in recent years.*

The growth of the Board's expenditure on their own services may be shown financially as follows:—

*Central Administration.*

| | £ |
|---|---|
| For the first complete year ended 31st March, 1950 ... ... ... | 98,000 |
| For 1955-56 ... ... ... ... ... ... ... ... ... | 135,000 |
| Increase ... | 37,000 |

*Other Expenditure.*

| | £ |
|---|---|
| For the first complete year ended 31st March, 1950 ... ... ... | 1,442,000 |
| For 1955-56 ... ... ... ... ... ... ... ... ... | 2,334,000 |
| Increase ... | 892,000 |

(1) *Central Administration.*

Most of the expenditure, and most of the increase, comes under the head of Salaries and Wages of the Board's own staff which rose from £75,000 in 1949-50 to £105,000 in 1955-56. Part of this increased expenditure is due to higher rates of pay and the cost of incremental progression. The remainder is attributable to an expansion of the Architectural and Engineering department for which the Ministry of Health authorised an additional 10 posts in 1954, 7 of whom have been recruited. The number of Professional and Technical staff of the Board now in post is 27.

It will be observed from Table —* that the administrative and clerical staff has risen by one only during the last three years. The Board's full-time medical administrative staff numbers only three, or one less than were employed immediately after "the appointed day" and before civil defence became a serious commitment.

(2) *Other Expenditure.*

(a) *Contractual Arrangements*

Annual expenditure over the period has risen from £237,000 to £301,000. About 130 additional beds have been secured for Chronic Sick patients through the co-operation of the King Edward Fund, the B.R.C.S. and the W.V.S. A general increase in the rates payable has taken place over the period.

(b) *Mass Radiography*

Expenditure has risen from £7,000 in 1949-50 (arrangements for taking over the existing Mass Radiography Units operating in the area were not completed until late in that year) to £50,000 in 1955-56.

At the end of 1950 four units were in operation, two in the London area, one in Kent and one in East Sussex. During 1953-54 a third London Unit was commenced and in 1954-55 a second Kent Unit was brought into operation. The three London Units are centred on Bermondsey, the two Kent Units operate from Maidstone and the East Sussex one from Brighton.

During the year ended 31st March, 1956, the six units examined a total of 280,396 persons at an average cost of £17 12s. 8d. per 100 persons examined.

(c) *Salaries and Travelling Expenses, Senior Medical Staff*

Payments under these combined sub-heads account for nearly 80 per cent. of the Board's total expenditure.

The statement below shows the variation in terms of expenditure. Fair comparison is most difficult owing to the changes which have taken place, e.g. the transfer from Hospital Management Committees to the Board of the

* Not reported.

payments to Registrars for salaries and travelling expenses during 1951-52, the announcement with retrospective effect during 1950-51 of the merit awards for consultants. However the statement reflects:

(i) *Salaries of Consultants, S.H.M.O.s and S.H.D.O.s*

The growth of the service in terms of notional half days from 4,860 at 31st March, 1950, to 5,766 at 31st March, 1956. Expenditure is also profoundly influenced by increased scales of remuneration and incremental progression.

(ii) *Locums*

The strict control exercised by the Board on the engagement of Locums which has produced a reduction in the cost since 1953-54.

(iii) *Domiciliary Visits*

The substantial increase in the calls made upon this service over the years.

The pronounced rise in the cost of the Domiciliary Visiting service has taken place during the years 1952-53 onwards. Though the number of specialists authorised to undertake Domiciliary Visits has only slightly increased since 1951 the number of visits rose in round figures from 14,000 in 1951-52 to 21,000 in 1955-56 and on present indications is likely to reach 27,000 for the current financial year. The specialties mainly responsible for the greatly increased number of visits are Psychological Medicine, Radiology, Orthopaedic Surgery and General Medicine.

REGIONAL BOARD ACCOUNTS

*Expenditure on Salaries and Travelling Expenses of Senior Medical and Dental Staff*, 1949–50 *to* 1955–56

| | 1949–50 | 1950–51 | 1951–52 | 1952–53 | 1953–54 | 1954–55 | 1955–56 |
|---|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ | £ | £ |
| SALARIES: | | | | | | | |
| Consultants, S.H.M.O.s, S.H.D.O.s | 1,021,027 | 1,373,323 | 1,309,658 | 1,356,221 | 1,405,054 | 1,595,318 | 1,611,425 |
| Domiciliary Visits | 54,781 | 59,408 | 56,378 | 67,987 | 72,802 | 79,314 | 95,403 |
| Locums ... ... | 29,726 | 36,857 | 28,273 | 28,483 | 32,953 | 27,733 | 23,909 |
| Registrars ... | *— | *— | 155,456 | 141,602 | 143,216 | 153,830 | 151,150 |
| TOTAL SALARIES | 1,105,534 | 1,469,588 | 1,549,765 | 1,594,293 | 1,654,025 | 1,856,195 | 1,881,887 |
| TRAVELLING: | | | | | | | |
| Consultants, S.H.M.O.s, S.H.D.O.s | 41,467 | 44,694 | 47,908 | 65,560 | 73,133 | 73,777 | 79,372 |
| Registrars ... | *— | *— | 5,138 | 5,606 | 7,939 | 8,458 | 9,679 |
| TOTAL SALARIES AND TRAVELLING EXPENSES ... ...£ | 1,147,001 | 1,514,282 | 1,602,811 | 1,665,459 | 1,735,097 | 1,938,430 | 1,970,938 |

* Paid by Hospital Management Committees these years.

(10) *Any comments on the current operation of the hospital service together with recommendations for greater efficiency or economy in the future.*

(a) *Area Nurse-Training Committee.*

Section 4 of the Nurses Act, 1949, reads:—

"4. (1) Expenditure by a Hospital Management Committee appointed by the Regional Hospital Board for a hospital area and expenditure by the Board of Governors of a teaching hospital situated in a hospital area, being in each case expenditure—

(*a*) wholly or mainly for the purpose of, or in connection with, the training of nurses; and

(*b*) of such description as the Minister may specify for the purposes of this subsection ;

shall, *so far as it is incurred in accordance with estimates appoved by the area nurse-training committee* for the area, instead of being defrayed in accordance with section fifty-four of the National Health Service Act, 1946, be defrayed by that committee."

The intention of the legislature was to ensure that expenditure on the training of nurses received exclusive priority without having to compete with other calls on the purses of management committees. If full emphasis is given to the words " as far as it is incurred in accordance with estimates approved by the area nurse-training committee " this intention seems to be carried out. But the construction put on section 4 by the Ministry of Health is that management committees cannot use the funds supplied to them in the ordinary way (that is, under section 54) on those objects for which provision is to be made via the Area Nurse-Training Committee. The total sum made available for headquarters expenditure, the 3 teaching hospitals and 28 management committees in the region is only £124,000 or about half a per cent. of the main budget. When the allocation of this sum is made, it has to be carved up into 75 tiny budgets for the 75 training schools which it finances. This operation demands an unbelievable degree of delicacy and foresight. Items of equipment costing under £10 have to be foreseen and budgeted for. The allocation of this small sum involves more detailed clerical work than the distribution of the main budget. It is appreciated that the Committee of Estimates are not concerned with recommendations which involve amending legislation. But if the true construction is placed on section 4 and management committees were permitted to use ordinary funds to supplement those received via the Area Nurse-Training Committee,

(i) many items of expenditure, whose priority is recognised and which cannot be met merely because they were not budgeted for, would be met ; and

(ii) the total expenditure on the purposes of nurse-training would not be exceeded.

However, it is the segregation of budgets which is at the root of the trouble, and it is presumed that amendment of the Nurses Act would be necessary to effect a merger of the two budgets, without derogation from the Committee's administrative control (assuming that one is inevitably committed to the exercise by that Committee of planning functions which overlap the Board's).

(b) *Senior Medical Staff : Travelling expenses claims.*

The increasing complexity and precise detail of the rules governing entitlement to travelling expenses of doctors employed in the Hospital and Specialist Services is causing grave administrative difficulty. There are grounds for thinking that in addition to the work which they create, not only for administrative and clerical staff at Board and Hospital Management Committee level, but also for the doctor himself, the rules are of themselves a source of friction between the profession and the administrative personnel of the Hospital Service.

Every effort should be made to find a way out of these difficulties without increasing the charge to the Exchequer. With co-operation at all levels it should be possible to devise a system of fixed allowances, based on an estimate of the annual mileage of each specialist by reference to the terms of his contract, which would obviate the necessity for the preparation and submission by the doctor, and subsequent checking by the Hospital Authorities concerned, of detailed claims for all travelling expenses incurred in the course of his duties.

(c) *Geriatrics.*

The hospital service would be substantially relieved if sociological arrangements were such as to provide for those aged and infirm persons who are now admitted to hospital because there is a good temporary reason for getting them in somewhere, and once in a hospital bed stay there until death, although they do not require the varied and costly facilities which a hospital can provide to patients in need of curative treatment.

26 *March*, 1957.] Mr. K. I. JULIAN, C.B.E., Dr. H. L. GLYN HUGHES, C.B.E., D.S.O., M.C., Q.H.P., Mr. C. M. KER, O.B.E., and Mr. G. A. COLE, F.C.A. [*Continued.*

**Examination of Witnesses.**

Mr. K. I. JULIAN, C.B.E., Chairman, Dr. H. L. GLYN HUGHES, C.B.E., D.S.O., M.C., Q.H.P., Senior Administrative Medical Officer, Mr. C. M. KER, O.B.E., Secretary, and Mr. G. A. COLE, F.C.A., Treasurer, South-East Metropolitan Regional Hospital Board, called in and examined.

*Chairman.*

1617. Mr. Julian, what Counties do you cover?——(Mr. *Julian.*) We cover the whole of Kent, East Sussex and part of the London County Council, the Metropolitan Boroughs of Bermondsey, Camberwell, Deptford, Woolwich, Greenwich and parts of Southwark and Lambeth.

1618. It has got a great voluntary hospital tradition, has it not?——Yes, probably not as much as some of the other Metropolitan Boards. We have one very old teaching hospital, Guys, and one not so old, King's, and we have the very old Bethlem.

1619. Do you find it difficult to get suitable Chairmen for H.M.C.'s?——Not generally speaking. We have got 28 Committees, and one occasionally has difficulty perhaps every few years, but, by and large, I would say no particular difficulty. We have a rather unusually large number of members of the Board who are Chairmen of H.M.C.s—11 of our members are themselves Chairmen of H.M.C.'s.

1620. You think that is a good arrangement?——We have found it admirable.

1621. On the whole, you are satisfied with the quality of your Chairmen of the Committees, are you?——I would say so of the Chairmen ; I do not think I would generalise as far as the Committees are concerned, as I think the membership of Committees could be improved a good deal.

1622. As far as Chairmen are concerned, it has been suggested that they might be partly paid, perhaps. Do you think that would detract from their position, or would be a good thing?——I think it might result in your getting a slightly different type of Chairman. It is an angle I have not given any thought to. I should not like to answer that without giving it further thought.

1623. With regard to the membership of the Boards and Committees, do you agree with the Guillebaud Committee's recommendation that by and large there should not be more than 25 per cent. medical representation?——Yes, I would agree.

1624. Do you think 25 per cent. is too much?——I think it depends upon the way you designate a medical man. I think we have got a number of medical men, not only on the Board but on the Committees throughout the region, who are retired and who are excellent. I think that as far as some of those are included in the 25 per cent. it definitely is not too many.

Mr. *Robinson.*

1625. I see from your memorandum you have something over 40 per cent. who have medical or dental qualifications. Do you consider that is excessive? ——I would, yes. But only 8 of our 24 members have medical or dental qualifications. I do not know whether one would describe a whole-time dental surgeon as a medical man. That is a thing to which I have not given much thought. We have Sir William Fry, President of the Royal College of Dental Surgeons, and whether he would come into the medical category, I do not know.

*Chairman.*

1626. He is a very great man whatever category he comes into?——Yes, indeed.

1627. Are you satisfied there are enough people with administrative, managerial or business experience in your region altogether, not only on the Board?——On the Board, yes ; in the Region, no.

1628. Could you enlarge upon that? ——I think when one started appointing these Committees one had more or less to follow a pattern, because one was taking over voluntary hospitals and public authority hospitals and hospitals which had already got governing bodies established, and one willy-nilly had to take over, perhaps, and appoint people from sources rather than for their particular ability. As I say, one had to form a sort of pattern. I think we would be

wiser—this is a criticism of myself, not of the system—if we put people straight on to H.M.C.s who had not had any experience whatsoever of hospital work or local authority work. I think one could put on to a Committee one or possibly two young able commercial or professional men without their having had any previous hospital experience at all.

Mr. *Robinson.*

1629. Do your Board ever do that? ——Occasionally, but not enough.

1630. Do you get that type of person coming forward for nomination?——I think we could find them. You see, as you know we consult with the various authorities and various organisations every year when considering the appointment of members to H.M.C.s, as in fact does the Minister when he is getting Board members together, and I do not think the authorities one consults are necessarily the best avenue for getting the sort of nominations I have in mind because these people may not have done any public work at all hitherto. I think there are a lot of able young men who have not had a lot of opportunity perhaps of making their mark in public authority work, or in the other organisations which one consults, whom one could with great advantage put on to the various Committees in small numbers, possibly one or two on each Committee.

1631. What additional organisations would you recommend consulting?—— I do not think I have in mind consulting any organisations. I think it would be a good idea if Chairmen of H.M.C.s and members of the Board could come along and say " We have a good fellow who is a young solicitor, or we have a young chap who is a bank manager, or a manager of an insurance company, and he would be an excellent person to go on to a Committee " to put a completely new slant on to the problems Committees have to face.

*Chairman.*

1632. You have contact with the other Chairmen of Board. You are the senior member of your Association? ——I act as Chairman of the other Chairmen.

1633. Would you say your practice is the general practice. I personally gained the impression that other Regions did not make it a *sine qua non* that you had to have previous experience?—— We do not make it a *sine qua non,* but I do not think we depart sufficiently from it.

1634. What I was trying to get at is: would you say your practice is typical, or does it vary?——I would have thought it was typical—that is only a surmise. I would not know how the other Chairmen would proceed about this. I would say that I thought we did more or less what the others do.

1635. You are telling us it is unusual for people to be appointed straight on to a H.M.C. unless they have had some experience of public work or in the Hospital Service?——I would say so.

1636. What are your comments, Dr. Hughes?——(Dr. *Hughes.*) We had hoped that House Committees would be the stepping-stone to the H.M.C. I think that was one of the main policies we thought of in the early days. You did ask about the medical representation. I would agree with the 25 per cent.; I do not think one ought to go lower than that, because you do want some width of experience. We have tried on every H.M.C. to have a representative of general practice and, wherever possible, local authorities too, and I think if you went lower than 25 per cent. you would be running into the realms of too little experience.

Mr. *Robinson.*

1637. You would regard as a minimum what Guillebaud recommends as a maximum?——I would. I would make it flexible, and I would say that is a minimum.

1638. Do you find it is possible to get general practitioners to sit on Committees and attend?——Yes, indeed. We have some very good ones who are hand-picked.

1639. They do turn up?——They do turn up, yes.

*Chairman.*

1640. Would it be your opinion from the technical, professional side that the business, management, financial supervision side is inadequately represented or adequately represented throughout the region—I am regarding you as representing the professional approach,

I may be wrong: would you say that the business, financial approach, is generally adequately or inadequately represented? ——I would agree with the Chairman that it is quite adequate on the Board.

1641. I do not think he is agreeing it is so on the Committee?——I would say with him that it is in some cases difficult to find the people in that sphere for Committees.

1642. To turn to something else to which the Guillebaud Committee referred. They said that there was no need in the ideal hospitals for House Committees to have executive powers. Do you agree there?——(Mr. *Julian.*) It is a difficult question. The first trouble you run up against in connection with House Committees is what their function shall be. We have had impressed upon us time and time again by a succession of Ministers that we must not create more tiers of administration. We have got as it is the Minister, the Regional Hospital Board, the Hospital Management Committee, and it has been felt, and I agree, that you cannot have yet a fourth tier of administration at House Committee level. On the other hand, I am a very great believer in House Committees. I think they are not only desirable, but essential, and although they are not compulsory in any way within the framework of the Act, the setting up of Committees is a matter of discretion for H.M.Cs. I think it is, by and large, a most excellent thing to have them, because they maintain the individuality of the hospital and do create a human contact between the people working in the particular hospital and the authority, which is not there otherwise. I am not in favour of their being given any administrative——

1643. You agree with the Guillebaud Committee?——Yes.

1644. It has been suggested to us that there is something to be said for a return of executive power to the Hospital Medical Superintendent. How would that strike you?——You mean that it would be a good thing to have a Medical Superintendent?

1645. Yes, rather as a sort of general manager?——I should think again it is extremely difficult to generalise. It might be a good thing in certain hospitals. It might be a very bad thing as a general policy.

1646. Would you accept that it might be better in a certain type of hospital like a mental hospital rather than in a general hospital?——You have it in mental hospitals now.

1647. Do you think that is why it is better there, because it must be a homogenous organisation?——Yes, I think so. I think a mental hospital is very much more self-contained in every way than a big general hospital or an acute hospital. It is a world within its own area really.

Mr. *Robinson.*

1648. Would you say if your Board has come to a conclusion about the recommendations of the Bradbeer Committee on this subject of medical versus lay administration?——I do not think so as a Board. (Dr. *Hughes.*) Up to a point we have. We feel there is a place for medical administration and we have tried to perpetuate it, to take away from executive medical officers, if you like to call them, anything that is really a lay problem and a business matter. It is so frightfully difficult to differentiate between what is clinical and what is administrative, but I think you have got to have somebody there to be able to give advice at a moment's notice to the administrative staff, it is essential. We have laid down terms of reference. You may have seen in the Bradbeer Report these terms of reference which were put in as an appendix, suggested terms of reference for the administrative side of a clinician's work, and we feel in large hospitals it is a good thing. In fact we would like it to be flexible. At the inception of the Hospital Service, we did have one H.M.C. whose secretary was a doctor, and it made a great difference at that stage. To come into the mental field, there are certain reasons for which Medical Superintendents are in that position in hospitals.

1649. You mean statutory reasons for it?——There are certain executive duties they have which are not in the medical duties of an ordinary hospital.

Sir *Henry D'Avigdor-Goldsmid.*

1650. Do you feel with regard to the manning of H.M.C.s that it is possible to get a satisfactory standard of administration? Do you not feel that with the

man-power available and the number of Committees you have to fill with members the whole matter is rather a strain? ——(Mr. *Julian.*) We deal with getting on for 3½ million people, and the number of Committees we have to fill, I suppose, is relatively small compared with the number of Committees of various sorts of organisations which would have to cover an equally big area. It is in population quite a large number of people and it means finding about 550 to 600 people throughout the Region, quite a lot of whom were almost self-selected. When we started this over ten years ago—it was in April, 1947, when we started—we had 170 hospitals of which quite a number were voluntary. There were a lot of ready-made candidates for Committees there, and to some extent there has been an obvious succession to some of the members, and the number of new people we have had to find perhaps has not been as large as it may sound at first. I think, of course, that the fewer people you have on a Committee the better it is going to do its work—large Committees are difficult to manage, and it makes it difficult for them to function, and I think there are certain places on Committees where you are more or less bound to fill from certain offices in order to get the integration of the services with the other ancillary services and other sociological factors connected with an area, so I think the number which you are free to fill is not perhaps more than 20 to 25 per cent. on each Committee. I do not think the number of people perhaps is a very serious matter. As I was saying just now—this is a self-criticism—I think it would be better if we were a little more bold and put somebody straight on to a Committee without any previous experience.

*Chairman.*

1651. You were in the beginning under an obligation that you would consult various bodies and organisations were you not?——We still are, Sir.

1652. Is there a local obligation?——(Mr. *Ker.*) Yes, when we fill any vacancy at all. (Mr. *Julian.*) I think we have to consult under the Act.

1653. That does not mean to say you have to take their advice?——No.

1654. I am not attempting to acquit you or convict you of your self-criticism, but there is nothing to prevent you getting these people if you want them, is there?——There is nothing to prevent one sallying forth to find them oneself. It is not very easy, perhaps, and it requires co-operation from local Committees to get them put up to the Committee itself. I think one would have to do a little bit of canvassing amongst one's own Committees to convert them to the process of getting somebody who is not quite the usual type of candidate. I sense from your question, rightly or wrongly, that you may think there is room on Committees for people who have a somewhat wider experience than a lot of members on Committees have, and I would agree entirely, and say that it will be a good thing if the odd one or two in each Committee did come from the big outside world who had not been too involved in either local authority work, or indeed in hospital work before.

Sir *Henry D'Avigdor-Goldsmid.*

1655. The point I had in mind was of your 28 Committees, leaving out 8 or so which are mental or special, that is leaving 20 Committees for which you have got to find Chairmen, each of which has an expenditure of £400,000 and upwards, I would think that on *a priori* grounds if you have someone capable of being a Chairman handling a total of £400,000, he could also be capable of dealing with expenditure of about £1 million, and if in fact your problem was that instead of having to find 20 Chairmen you had only to find a dozen Chairmen, the chances are, are they not, that it would be easier? Would it not appeal to you to amalgamate some of these Committees if the possibility arose? ——It would appeal to me, but actually Guillebaud went the other way. He rather talked about making H.M.C.s control less rather than control more, which would aggravate the personnel problem more than it is aggravated now. Guillebaud, if he made any comment, commented on the largeness of the number of beds which the H.M.C.s controlled.

1656. We are dealing with a fairly populous region where difficulties of geography do not come in at all. The areas themselves are entirely manageable?——It is geographically very nearly the easiest of the lot.

*Chairman.*

1657. Do the H.M.C.s accept your supervision and direction?——I think so, by and large. I think we live on good terms with all of them. Periodically, of course, we have disagreements, it is inevitable. I should say that by and large we live fairly happily together.

1658. You do not feel the need of any sanctions?——No.

1659. Do you feel as the Guillebaud Report does with regard to the danger of the administrative side getting bogged down in too many Committees?——I do not know what he means by that.

1660. In paragraph 249, it says that there is a real danger of the administrative side of the Health Service getting bogged down in a morass of paper work. This paragraph talks about the Committee structure and the mass of paper work which it entails?——Yes, I do agree. I feel also to some extent the same thing with regard to statistics. I feel that the Boards call for statistics which come in from all sides, and when they come in sometimes I very much doubt whether they are of any use.

1661. The Report goes on in paragraph 250 to say that it urges lower delegation, and that this delegation " would be facilitated if the Hospital Secretary were given a higher status in hospital administration, and if the post of Hospital Secretary were to become a normal starting point to a hospital administrative career at group or regional level "?——I would agree definitely. I think that is another fault. As you know, the whole set-up of the non-medical side of the Service is being looked into at the moment on behalf of the Minister, and that is a point which I am sure is going to be very strongly raised. I do not think there is anything like sufficient fluidity within the Region and also throughout the whole country. There is not enough movement from hospital to H.M.C., H.M.C. to another H.M.C., Regional Boards to other Regional Boards, I think. It has got too static.

1662. You can do a lot to loosen it, can you not?——I do not think we can. The H.M.C. has a very definite life of its own, a very definite entity of its own, and the power of the Regional Board to influence the movement of the H.M.C. staff is nil.

1663. You cannot stop them appointing an assistant in a post to succeed the man in the post because he happens to be the man on the spot and is not highly qualified?——We have no jurisdiction.

1664. You can exercise moral suasion? ——Yes. We have nothing but moral suasion.

1665. Do you ever use moral suasion, or do you leave them alone?——I suppose the answer, really, would be that by the time we realise successful moral suasion would be a valuable thing it is probably too late. One would not realise difficulties that might arise in any particular case until it was too late to act.

1666. Would you say that by and large you were satisfied with the quality of administrative staff employed by the Committees?——I would say we were satisfied with the administrative staff employed by the Regional Boards, but I would say we were not very happy at the intake at the lower level. I should like my officers to corroborate, or otherwise, what I am saying to you. I would say that we are not satisfied with the intake at the lower level. I would say the present set-up of the Service is not attracting the right type of recruit. So far as the H.M.C. is concerned, I think I would say the same thing, by and large, that the officers who are holding the senior posts at the moment are satisfactory, but again I would imagine that their intake is not good.

1667. Is your Treasurer in touch with the other Treasurers?——Oh, yes, indeed.

1668. Are many of them qualified men like you are, Mr. Cole?——(Mr. *Cole.*) The other Regional Board Treasurers, do you mean?

1669. The H.M.C.s' Treasurers?—— They are nearly all qualified, nearly all have a recognised accounting qualification. I think the majority are Members of the Institute of Municipal Treasurers. There are, I think, two unqualified Finance Officers.

1670. Would you say that there is a tendency to demand higher qualifications, or more qualifications than there used to be, or is there a tendency to slip back and have people of no qualifications? ——I do not think the position has changed as regards demanding qualifications, but I think it is growing a little more difficult to get them.

1671. Because they are not paid enough?——I think that is the reason.

Vice-Admiral *Hughes Hallett.*

1672. When you spoke of the greater fluidity, would you be in favour of a regional or national service for hospital administrative officers?——(Mr. *Julian.*) I would not be in favour of a national one because I think that if you had a national one you would begin to remove the necessity for Regional Boards at all. I do not say that it might be a good thing to remove Regional Boards; I am not dealing with that question now. I think if you had it at national level, it would be doing away with almost the major functions, or one of them, of the Regional Boards.

*Chairman.*

1673. The point would be not that the Secretary or Treasurer should be appointed by the Ministry of Health, but that they should produce a list of available people of the required qualifications, which the Regional Board should have before them to choose from?——You mean from other departments?

1674. No. The picture I have is that various people in the Hospital Service would reach such proficiency and eminence that they would be suitable for Secretaries or Treasurers of Regional Boards. When your Regional Boards are short of a Secretary or a Treasurer you would ask for a list of suitable people, interview them, pick from them and appoint one?——Would it give you any easier access to them than you have at the moment? At the moment presumably, anybody interested would apply, would they not? They would get to know about it.

1675. I think you would have to be prevented from picking people who did not go through this national sieve?——I would go on to say this, but I think it would be quite a good thing—and this also deals with the question which was mentioned just now—if Regional Hospital Boards had a hand in the appointment of Senior Officers of the H.M.C.s in this sense: that if a Senior Officer of an H.M.C. were going to be appointed I think it might be a good thing if the Regional Hospital Board were asked to send a "sitter-in" in the same way as the Regional Board invites H.M.C.s to send a representative to make an appointment to the consultant grade. We have an *ad hoc* Committee on this, and part of the *ad hoc* Committee consists of two people from the H.M.C. involved. I think it would be a good thing if that were extended to the Regional Hospital Board, and they could sit in at appointments in the senior categories of H.M.C. Secretaries, Finance Officers, Matrons, and I would not mind if we were going to make a senior appointment to our Board, if a representative of a H.M.C. sat in. I cannot think you can have too much integration, and it seems to me that the assistance of a Regional Board in a co-operative way might be an advantage at times at H.M.C. level here.

Mrs. *Hill.*

1676. Do you not do anything of that now?——We are not allowed to.

1677. Do not your H.M.C.s ask your Senior Officers to give advice?——(Dr. *Hughes.*) Sometimes the matron does, and the Regional Nursing Officer does go down and sit in. (Mr. *Julian.*) May I correct what I said? On occasions we are asked, but not as a matter of course by any means.

*Chairman.*

1678. Do you think it would detract from the independence and initiative of H.M.C.s if the Regional Hospital Boards sometimes appointed after consultation?——I think they would not like it at all. They would resent it very strongly.

Vice-Admiral *Hughes Hallett.*

1679. Let us take an extreme case at the moment and imagine that they were all appointed from Whitehall. I do not quite see how you say that would remove the need for a Regional Board. After all, in most of the government services the man in charge of a local area has no say whatever in the appointment of the officials who serve under him. A Minister of the Crown cannot choose his own Permanent Secretary, but it does not prevent his being in effective control?——You are contemplating a reconstruction of the Act. At the present moment it is the Minister who is the link between the House and the Regional Board, not the Ministry, therefore, as the thing stands at the moment it will have to be the Minister

himself who makes the appointment, not the Ministry.

*Chairman.*

1680. Is that a real distinction?——I think it was supposed to be a real distinction. I thought it was a way in which this particular Service is unique almost.

Mr. *Robinson.*

1681. To go back to your suggestions about how you might improve the choice of senior staff for H.M.C.s. If all your suggestions were adopted it would merely mean that all the H.M.C.s in your Region would get slightly better staff. It would not help the Service as a whole. Is not the limiting factor the quality of available staff for these posts?——The present available staff. I think my suggestions will not bear fruit till long after I am dead and buried. You would have to have a better intake to start with. I think the intake is poor. We have not a chance against the big commercial houses or, in fact, other public authorities and big nationalised industries. I think that that has first of all got to be remedied, if in fact that is remedied. Then, as you know, there is in a minor and little way a training scheme afoot, part of which has been done by the King Edward Fund and part in the north of England, which is really a drop in the ocean dealing with 16 picked students. But I think that the main difficulty at the moment is these watertight compartments of H.M.C.s *vis-à-vis* other H.M.C.s and other outside Boards. I know there is nothing to stop Manchester Regional Board appointing a secretary who comes from the Kent Regional Committee. I have a feeling however that the movement is not enough.

*Chairman.*

1682. In other words, you would say that the absence of a co-ordinated career structure is seriously affecting the efficiency of the Service?——Yes.

Mrs. *Hill.*

1683. If you put in an advertisement for a Hospital Secretary, do you receive many applications from all over the country?——Yes, I think you do.

1684. Would not you say that there is some movement between hospitals?——There is some. This may be nothing more than a feeling, but I do have a feeling that there is not a movement, let us say, between H.M.C.s and teaching hospitals. There is no reason why there should not be. They both do the same work. Also, between teaching hospitals and Regional Boards there is not a flow of people moving in and out of the Service.

Mrs. *Hill.*] Is there not a desire by many officers of hospitals under H.M.C.s to get into teaching hospitals, but they do not get the chance?

Mr. *Robinson.*

1685. But no desire in the reverse direction?——We are doing a bit of movement. (Mr. *Ker.*) Instead of picking out posts for training officers, which we thought would rather limit possibilities, what we do is to pool all the names in groups and then arrange for direct interchange one with another.

*Chairman.*

1686. What positions are you talking about?——Any posts.

Mr. *Robinson.*

1687. Is it an interchange within the Board, or within the Region?——The parties to the exchange are the Board, the Management Committees and the teaching hospitals.

*Chairman.*

1688. What sort of posts?——We are not selecting posts for the interchange because we want to make this an unlimited exchange. We are picking officers whom we think would benefit from the exchange.

1689. Do you mean temporary exchange?——Yes, temporary exchange.

1690. For how long?——We have not managed to do more than three months yet.

*Chairman.*] That does not answer this old problem of the career structure, does it, which seems to me to be the key to the whole hospital service, possibly?

Mrs. *Hill.*

1691. You literally second a promising officer to some other post?——Yes, an exchange.

1692. Either an exchange, or you give him a dual duty?——No, we make him do the work. It may be a triangular

exchange, or there may be four officers in the movement, but they do one another's work instead of just observing one another's work.

Mr. *Robinson.*

1693. Does this happen at fairly senior level?——So far we have arranged it up to Grade E, which is the third highest grade.

Mrs. *Hill.*

1694. You have never seconded, for instance, a Deputy Secretary of a H.M.C. and let him go and take charge of a hospital so that he has got both angles of the work, or do the same with a Deputy Finance Officer and let him take charge?——The Board are sending the Administrative Assistant to be Hospital Secretary to the Evelina Hospital, under Guy's, which is as big an exchange as you can have—there is a difference in the work.

*Chairman.*

1695. Have you anything more you would like to say about the improvement of the quality of administrative staff of Boards and H.M.C.s, which we feel is a good point as to career structure, or the method of appointment or qualifications or anything else, or with regard to rewards?——(Mr. *Julian.*) I think when we get Sir Noel Hall's appreciation of the position and if we can get an improvement of the conditions of service and remuneration as a result of that I think we should then try and tackle it quite seriously and vigorously, and I think we should try and extend the number of vacancies in these two training establishments at the King's Fund Administration Staff College and at Manchester. I think that the Regional Board Chairmen as a body feel very strongly on this, and when that time arrives I think we shall try and produce some practical results as far as we can.

1696. Do the Regional Board Chairmen act very much as a body? How often do they meet?——Every two months, or more if necessary.

1697. You have a little secretariat? ——Yes. We have no association. We meet more as a forum; we really meet to exchange views, and it is very, very helpful indeed, of course.

Mr. *Robinson.*

1698. Do you find it really achieves very much beyond an exchange of troubles and that sort of thing?——It probably achieves more from the looseness of the set-up than it would if we were an association. I would like to make clear that I am Chairman of the Regional Board Meetings because I happen to live in London, possibly. There is nothing official about it. We meet the Senior Officers of the Ministry afterwards. I think it is a very good thing. We do not discuss anything much in detail at all. It is rather the sort of matters we are discussing as we sit round with you today.

*Chairman.*

1699. Coming on to rather a different subject, do you think it is possible that Regional Boards have too much detailed establishment control over H.M.C.s' administrative staff? You have got budgetary control; do you think you have got too much control?——I do not know any other control we have got.

1700. You have to authorise increases? ——It is a negative control. It is a control within a sort of ceiling. We have an arrangement with most of our H.M.C.s—it is a benign control as far as we are concerned. I do not think we have any real authority to press the matter. Having laid down their budget and ceiling, I would have thought that is where our legal control ended. As a matter of fact, we do live on terms of pretty good friendship with them, and they nearly always consult us about appointments.

1701. To turn to questions of financial control, it is all based on these inherited patterns with regard to the financing of the Hospital Service?——Yes.

1702. Do you think this means it is inflexible?——Which tier, the Treasury control, the Minister's control, or our control?

1703. The whole control, down to the individual hospital?——I think I would like to ask the Treasurer that. I am not technical enough to answer that. (Mr. *Cole.*) May I have the question again?

1704. Assuming it is correct to say that the finances of the hospital services are really based on an inherited pattern, do

you feel that is too inflexible?——No; I think the last nine years have shown some flexibility. It certainly was an inherited pattern, but I think the pattern is changing a little. It is bound to change a great deal with development. As a hospital develops it changes its character; it requires more money when it gets it. I do not think it could really be described as inflexible.

1705. The urge for economy is really limited to an urge to keep within the previous pattern. Does it not imply some inflexibility?——It is not a rigid pattern. Money is allocated on the basis of a preceding year's expenditure, or a preceding year's Estimate, but it is subject to an addition for quite a number of things, and also is subject to reduction for any particular saving such as the closure of hospitals and the change of functions of hospitals which results in savings.

1706. Do you in your initial allocations give as far as possible the full year's requirement, or do you keep something up your sleeve?——We keep a small regional reserve, but I think the principle is to distribute the majority of our available resources. We find a small reserve more satisfactory.

1707. When improvements are made, are they made very often out of savings? ——The part of the budget which relates to improvements is segregated before the commencement of the financial year and that is dealt with separately.

1708. Do you not ever tell a Committee that if they want such and such improvements they must save it out of other heads?——That has been done, yes.

1709. Is that a practice?——You could not do it on a big scale if it was a major improvement. There is not the margin in a Committee's budget to enable them to do that.

1710. Are savings ever made in your region which are handed back, or is it applied to other useful purposes?——It does not happen very often but we do get savings handed back at the revised stage of Estimates.

1711. Savings handed back by H.M.C.s?——Yes.

1712. You hand those savings back to the Treasury?——No; we then take them into reserve and can use them.

1713. On major improvements?—— Yes, or for any Management Committee which is in actual need at that stage, which does happen.

1714. Do you feel these savings are evidence of bad estimating?——No, Sir. They may be due to a variety of causes, but my feeling is that the budgeting throughout the region now is reaching a very good state.

1715. Are you aware of the danger that some improvement or development may be financed quite legitimately out of savings and may involve the Hospital Service in recurrent annual expenditure in subsequent years?——It may do, Sir, but, in any case, with regard to that I think the Management Committee would come to the Board and point it out and get our authority.

Vice-Admiral *Hughes Hallett.*

1716. What precautions are taken to make sure through the practice of virement that recurring expenditure is not in fact incurred?——I think it would be automatically noticed in the request for virement that came up. Even if we were not told about it we should notice it. I think Management Committees are careful about that.

Mr. *Robinson.*

1716.* Does it happen that a Management Committee will embark on a development which involves additional maintenance henceforward without informing, or getting the approval of, the Regional Board?——I do not know of any case.

Sir *Henry D'Avigdor-Goldsmid.*

1717. Is it not your experience in the last three months of the financial year that H.M.C.s are in fact busily engaged in looking for means of spending funds at their disposal?——I have no doubt that was true eight or nine years ago. I have seen very little evidence of it in the last two years. The budgeting is much closer and expenditure is very much closer. The only way it does arise towards the end of the financial year is when we have to pass out a certain amount of money to cover, for example, increased prices, and some of that money may not be fully required for those prices, and that would be used in such a way, but I would say that that has diminished enormously over the last seven or eight years.

1718. In a situation where prices have risen would you make a point of not passing out increases if bed occupancy had fallen below the level at which such additional funds would be justified: do I make myself clear?——Yes, I think it is quite clear. It is only in very few cases where you get that fluctuation in bed occupancy that it could produce that result. In those cases I do not think we should withhold our normal distribution of increased prices. It is not a very large amount in any case. This small amount spent in the closing months of the year, which does go on now, is of considerable benefit because there are still arrears of domestic equipment, that type of thing, which I think it is a good thing to put Management Committees in the position of being able to buy.

*Chairman.*

1719. What is the size of your regional improvements and development reserve?——For the coming year it is £150,000.

1720. Where does it come from?——It comes from the Ministry of Health. It represents the surplus that the Board manages to keep back, together with a small general reserve from the whole of the budget.

1721. Is it a revolving thing—are you always paying out of it and replenishing it?——No. It usually goes out as the improvements come into effect. We make an addition to the Management Committees' current budget.

1722. That is in addition to what the Minister earmarks for development. It is a private fund?——We never manage to keep the whole of the amount which the Minister gives for development for development.

1723. You never manage to keep your development expenditure within what the Minister gives?——Not the whole of it.

1724. You exceed it by about £150,000?——The Minister gives us for development £200,000; we set aside about £150,000 of that and probably the difference is used in our allocation to Management Committees for current expenditure.

1725. Let us get that quite clear. The Minister gives you how much?——Rather more than £200,000.

1726. You set aside another £200,000?——No, Sir. We set aside £150,000 of that £200,000 for development.

1727. What do you do with the balance of £50,000?——As to the balance of £50,000, in a sense you can say that balance, plus a little bit more, is used as the Board's general reserve.

1728. So, in effect, you spend less than the Ministry authorised you to?——That is true.

1729. Which is quite the opposite of what other Boards do, is that your experience?——(Mr. *Julian.*) I think this figure in relation to the budget is a very tiny figure, it is three-quarters of one per cent. of the budget, and when you get a budget like ours, which is getting on for £22 or £23 million, however desirable it may be it is quite impossible to allocate the budget down to the last pound in the way it has been put up because it has come back cut. We put in a budget for £23½ million and it comes back twenty-two and something millions, and part of that figure, the end bit, is £200,000 odd for an unnamed development, and of that, by the time the budget has been sorted out, we find ourselves with £150,000 of the £200,000 for that last call of the budget. If other Boards are able to set aside more than the Ministry have given for their development programme, that means they have been able to make do on less than they have asked for for the rest of the budget.

1730. Would you accept a smaller maintenance allocation if you got a larger development allocation—I am referring to capital?——I would not have thought so. This question of maintenance allocation is a matter for technical experts of which I am not one, but I imagine the amount you can spend on maintenance is the sky with the hospitals we have got. I do not know whether we are particularly unlucky in having such a lot of old ones. We find it is all we can do to get along on the maintenance allocation we have got.

Mrs. *Hill.*

1731. Would you consider that if you were allowed a greater sum for capital expenditure you might economise in other ways? The lack of expenditure is

a bar to progress, is it?——I agree. Ultimately a high capital expenditure would make for economy provided you were able to deal with it as you wanted to. If you had to spend it on new structures and additional beds it would involve you in additional expenditure.

Vice-Admiral *Hughes Hallett.*

1732. What would you regard as the main factor in the great increase in costs which there has been in the nine years the Health Service has been operating, rising prices, rising salaries and wages, or what?——Salaries and wages represent just over 60 per cent. of the total expenditure.

1733. You spoke a little earlier about extra allocation in respect of rising prices each year. What is your yardstick? Do you judge by the Cost of Living Index, or do you accept what has been paid? ——(Mr. *Cole.*) It is calculated by the Ministry of Health on the Index.

1734. You accept the Ministry of Health's figure?——Yes.

*Chairman.*

1735. It is a notional forecast?——I think not. It is calculated and handed out in arrear.

Vice-Admiral *Hughes Hallett.*

1736. You get a figure from the Ministry of Health. Have you ever experienced a decrease since the service began during the year?——There has been an actual decrease in the calculation of their figures, a detailed decrease but it has always been more than offset by an increase—the result is always a net increase.

1737. I want to come to that figure you got from the Ministry of Health. Have you ever experienced a year when they say the figure has fallen and therefore there should be a saving?——There has never been a net saving.

*Chairman.*

1738. At what stage in the year is the figure issued?——It is always issued twice a year.

1739. To help the coming Estimate? ——Yes. There is always an initial Estimate to cover price increases when you get your original allocation from the Minister. There is always a second estimate to cover price increases which you get after the revision stage of Estimates. I think in certain years there have been three issues.

1740. Is that to cover expenditure you have already made?——Yes, to cover expenditure already made, and to bear the burden of that expenditure up to the end of the curernt year.

Vice-Admiral *Hughes Hallett.*

1741. This happens to be a year, I think I am right in saying, in which the Index as far as food is concerned has fallen. What will happen about the food prices as far as the Hospital Service is concerned?——It will be more than offset by the increased price, for example, of fuel oil and, therefore, we always get a sum in addition. That was why I mentioned the word "net" increase.

1742. Is that not divided up between categories of stores?——No, Sir.

Mr. *Robinson.*

1743. Could I follow up your answer about it being in respect of additional payments in arrear? Surely the amount of money you get from the Ministry is an amount to enable you to continue the service at its level at the end of what is then the current financial year. Surely any surplus over that must be against future increases——?——It is not only in respect of the future. The amount we get issued to us in either December, 1956 or January, 1957 has to cover the price increases that have taken place since the previous September and up to 31st March, 1957, so it is partly an arrear and partly in the future.

Vice-Admiral *Hughes Hallett.*

1744. I am not happy about this at all. Why do you say that the higher cost of fuel, or petrol chiefly, will more than offset the fall in the cost of food in the Hospital Service? What is the relationship between your fuel bill and your food bill?——I do not think I can answer that straight off. I could give the percentages.

*Chairman.*

1745. You mean it is just fortuitous that so far it has happened like that? ——Yes.

1746. That is all you mean, is it not? ——Yes.

Sir *Henry D'Avigdor-Goldsmid.*

1747. Would you not recognise that individual Committees, finding they had an over-allocation on provisions in the coming three months would busy themselves with ways of spending that over-allocation under the heading of "provisions"?——In a case like that, Sir, I think they would come to the Board for approval to transfer that money to another subhead.

1748. The question I am putting to you is this: if they had an over-allocation on provisions due to under-occupancy of beds, or some other reasons, with a few months to go, would you not think it possible in fact they would endeavour to spend that before the end of the financial year by increasing, as it were, the "ration scale" for the last two or three months of the year, and, if so, would that come to your attention? ——Yes, it certainly would come to our attention because we have provision costs from every hospital for every month of the year.

*Chairman.*

1749. I think we have thrashed that out, and I think these questions are partly for the Ministry. There are fairly wide variations between hospital and hospital?——Yes.

1750. Have you been successful in reducing variations in costs and standards in your region?——No.

1751. Why not?——You are talking about the whole of hospital costs?

1752. Yes?——I think this is an extraordinarily difficult matter. The costs which we have are the best that we have so far been able to manage. They are extremely difficult to interpret and very dangerous to use in comparison unless you have all the facts as well as all the figures.

1753. I think it has been our experience with other Hospital Boards that they have claimed that the pattern of variations is getting narrower. In other words, they are getting more homogeneity into the regions. That is not your experience?——I think there is a tendency that way, Sir, but it has got a long way to go yet. (Mr. *Julian.*) I was going to say that I was looking up the other night the occasion when I appeared before a Select Committee in 1948-49 and this question which I thought you would probably raise was raised then, and I remember the point being made from our side of the table that the most imponderable thing of all in the Service is to devise a yardstick whereby you can measure the cost as between a patient in one hospital and a patient in another, and we have tried various means over the succeeding nine years to achieve this result. As you know, it has been the subject of investigation by the King Edward Fund, the subject of investigation by the Nuffield Organisation, and has been the subject of investigation by various professional bodies to try to discover this. Nobody has yet discovered it, and the reason is that you cannot get the common factor prevailing in hospitals. You may get the 300-bedded hospital in Brighton costing 50 per cent. more than what appears to be a precisely similar hospital in Lancashire. It is one of the greatest problems one has to face in the Service. We have tried to do it. One way has been by a most elaborate system of the cost of food. We are one of the few Regional Boards who have a Catering Officer attached to the Board. He has produced over some years now statistics of the most intricate and accurate kind of every hospital in the region. I believe it is done weekly. (Mr. *Cole.*) I think they are done at hospital level weekly, and monthly for us. (Mr. *Julian.*) To that extent we have found it has been possible to get a narrowing of the extremes without any deterioration in the service. If one could do that under every head of the expenditure one would get somewhere.

1754. Do you feel that the new costing system will help when it comes along? ——I think it is a matter of trial and error. I think we shall have to wait and see.

1755. There are various ways of costing, of course. You might take cost per case, or cost per patient week, or compare one department with a similar department in another hospital. Do you feel there is room for progress there? ——(Dr. *Hughes.*) I think by and large there is some improvement in the variation rate, just as in the provisions. One of our Committees we found were spending too little and were really parsimonious in that respect, and by our close supervision we were able to act. I think myself that there is an improvement in this variation.

1756. Have you the feeling that the costing and comparison is really done on the wrong basis. If so, what do you think the right basis is?——That, Sir, is what I say is the trouble. I do not know how you can get the common factor which you must have if you want to make comparison.

1757. On the other hand, I suppose it is quite clear to you that some hospitals are better run, some extravagantly, and and some economically run?——Yes, definitely.

1758. You must apply some yardstick for your own mental satisfaction?——I I think you can see it when the difference is very great. It is quite obvious if you compare the cost of keeping a patient in a teaching hospital and compare keeping a patient in an acute general hospital outside of London you will see a difference of as much as £10 a week in the cost. You will see the cost of keeping a patient in an acute hospital is £18, or something like that in our region, £17 9s. 6d., and you will see that in a teaching hospital it may be £28 a week.

1759. The teaching hospital is outside your orbit?——Yes, but whether it is outside the orbit or not, I think your comparison has got to be made not only with hospitals within your own man-made region but throughout the country. I think the aim is to discover why it is so that it costs £28 a week in one hospital and £14 in Aberdeen, for example.

1760. I was looking at it from the point of view of bringing down the costs? ——Within our own region?

1761. Yes?——I instanced to you just now the statistical return we get with regard to provisions which have been very illuminating indeed. They have shown us that we can reduce the costs sometimes without reducing the quality of food. They have shown us that other hospitals have been spending too little.

1762. How do you enforce your views?——You can only enforce them budgetarily. There is no other sanction you have got as far as the H.M.C.s are concerned.

1763. All you can do is to cut down next year and say you will have to do with so much?——Yes. At this stage one has to bear in mind the uncontrollable wage factor. We all keep forgetting the fact that two-thirds of the whole of our expenditure is uncontrollable, except numerically. You cannot control it as far as what you are going to pay is concerned, and, as I say, it represents two-thirds of the whole of our expenditure.

1764. Do you feel there is any future in more central buying, more central services?——There again the question of central buying has been one we have debated now for ten years, and we always seem to come to the same conclusions ultimately, that most people who are discussing it are satisfied it is their particular level which is the best level at which to buy, and I do not think they say that with an idea of being humorous. People at ministerial level think you ought to do it at ministerial level, Regional Board people think you ought to do it at Regional Board level, and H.M.C. people think it should be done at H.M.C. level. I think there are certain things you can buy with advantage at each level.

1765. Do you buy anything at Board level?——We have a sort of sub-regional level at which things are bought between six sets of Hospital Management Committees.

1766. Those five headings?——They are nothing very much. I was going to say that when the Ministry decided to purchase X-ray equipment at ministerial level that was quite a good thing.

1767. Manchester Board purchases textiles at regional level and get savings in that way; other Boards try and get common purchasing of individual items like tumblers and crockery, and things like that, and get substantial savings? ——There are other things that are purchased at central level where great losses are incurred. It has just been described recently in the papers. I am not converted to the idea of mass buying.

1768. If not mass buying, are you in favour of constant contact between different committees as to the prices they are paying for articles of common use? ——Definitely.

1769. I think it was Oxford who told us in regard to tumblers that there was a variation in price which was almost astronomical, and they made arrangements to purchase through the same source in the end. Is much of that done in your region?——Each Committee has

its own Supplies Officer and besides meeting every month to compare prices they divide themselves into six groups and investigate in these groups the possibility of buying jointly, and if they see any advantage in joint purchase they do so.

1770. There is no stimulus, then, from you?——Other than the general stimulus we thoroughly approve of what they are doing. We do no central buying ourselves.

1771. There is no central laundry service, is there?——Yes, we do quite a lot of laundry centralisation. There is an example here in the current years, 1956-58, we shall be spending £75,000 on group laundries and modernisation including dry cleaning plant, etc. We are spending and shall spend £75,000 which will show us a saving of £18,000 a year in the running costs.

1772. That is on your initiative as a Board?——Indeed yes ; it is part of our plant redeployment programme.

1773. What about drugs?——They do this group buying of drugs.

1774. I was not thinking about the buying of drugs. I was thinking, and perhaps Mr. Hughes can tell us, what control is exercised over the prescribing of drugs?——(Dr. *Hughes.*) We watch the expenditure of the H.M.C.s, and several H.M.C.s in the Region do have an actual Committee which watches the amount that is being used, and they have H.M.C. meetings monthly as a sort of means of bringing home to the doctors on the staff what is being spent on drugs.

1775. The question which really lies at the basis of the Health Service is this, I think: to what extent do you think the medical profession is cost-conscious? ——Not nearly as much as it ought to be, and, frankly, I think it stems really from this. Taking drugs alone, and if you like pathological investigation, that sort of thing, a young doctor comes out of a teaching hospital with preconceived ideas of the importance of these things, and does tend, unless controlled by the consultant staff, to overdo not only the use of drugs, but pathological investigations and all that sort of thing. The Ministry of Health are conscious of this and we do send to H.M.C.s and to Group Medical Committees advice on these things and advice on the alternative use of drugs which are cheaper, and that sort of thing.

1776. You did not say every H.M.C. had this Committee to do that?——No.

1777. Why not?——I do not know why not. They are all drug-conscious, I think, the H.M.C.s themselves, but some do have a Committee which sits on this. I think most of them produce evidence given to them by the pharmacists rather than having a Committee.

1778. The Regional Board takes a direct interest in that?——Yes, definitely. One thing we do know and take interest in is this, that I think there is an awful lot of unnecessary prescribing in out-patient clinics rather than sending back to the general practitioner. We are for ever going round keeping an eye on what is being prescribed in out-patient clinics, because they should be consultant clinics and are becoming more and more treatment clinics, that is my view. In other words, it means the patients coming back. We watch that very carefully, with regard to the number of total attendances in relation to new patients at out-patient clinics.

1779. Is there any connection or link between the use of out-patient departments and hospitalisation? Would it be possible to say that the more the out-patient clinics are used for treatment the less occupancy of hospital beds?—— Yes, I imagine one could say that really, but you cannot generalise on that. It would depend on the particular type of case. It is difficult to make a specific instance of that. What I think, and I am sure I am right, is that there is much too much treatment being done by and large and the patients are coming back too often to out-patient clinics.

1780. Coming back to drugs, it has been suggested by some people that an overall ceiling should be set for drug expenditure, leaving the doctors to work out how they do it themselves. Would you think that was immoral?——I do not know how you fix your ceiling. When you are thinking of a patient it is a human problem. You cannot be absolutely rigid in this impersonal way.

1781. Is there a danger when expensive drugs are prescribed that they are not reviewed at frequent enough intervals and the cost goes on?——That depends on the drug so much. There are certain

drugs which should not be prescribed to out-patients lightly.

1782. I was thinking about in-patients. ——I would not say that. I would say from my knowledge of the handling of patients by consultants that would not occur.

1783. Every treatment is reviewed every four or five days?——Yes. Every time a consultant does a ward round he will review the treatment which his patient is having. It is not left to the House Officer to go on as he will. I think in the first instance the House Officer is probably extravagant.

Vice-Admiral *Hughes Hallett.*

1784. I would like to link the question of the drugs to the whole question of the financial control. I still do not understand the mechanism for getting a reduction if the price Index falls. In the case of drugs, I see that between 1953 and 1955 the price index for drugs fell by 13 per cent., but the cost of the drugs expended by the Hospital Service as a whole rose. How is that possible? ——The Treasurer will probably know more about that than I. I think that the answer is that there is so much more attendance that is necessary, recurring attendance. They probably get a fresh prescription every time they come.*

1785. I understand your explanation. What I am unhappy about is what assurance is there that exactly the same process would not go on with every single item, including for instance, food.

Mrs. *Hill.*

1785.* Would it be correct to say that while some of the drugs have fallen, you will be using more of the newer drugs which are expensive? Have you had a big uplift in the rarer drugs?—— The Treasurer can probably answer that. I think of one in particular where there was an uplift and that was in the mental field with regard to "Largactil". That is one where I would criticise the use of it in out-patient clinics and by general practitioners, but in mental hospitals it has made a very great difference and it has improved the conditions in mental hospitals out of all knowledge. (Mr. *Julian.*) Can I answer the question, or rather ask one: when you say the cost had gone up despite the increase of 13 per cent., where was that?

1786. In the Hospital Service?——I think that is a very interesting point. We should not know about that until we got the final increase at the end of the year. I would like to know whether that happened to us. If it did, I should like to know why it happened to us. I think personally that it is a lot of over-prescription, and I think perhaps it is a question which is also for Dr. Hughes to touch on, but I would say that I think there is far too much prescribing done. (Dr. *Hughes.*) I did say so. (Mr. *Julian.*) I said it perhaps with more force than you did. It does seem remarkable——

Sir *Henry D'Avigdor-Goldsmid.*

1787. On the use of tranquillisers of one form and another, each one of these seems to have the effect of making the previous one used out of date. Has Dr. Hughes any comment on that?——(Dr. *Hughes.*) You have referred to the one which I did mention. I am afraid we shall always be subject to that. These young doctors are always out to try something new. On the other hand, I think the pharmaceutic people are really out to help in this way by producing these new things.

*Chairman.*

1788. You mean manufacturers, do you?——Yes, the manufacturers. I am sure the manufacturers are doing their best.

1789. What is "Largactil"?—— "Largactil" is one of these tranquillisers which has produced these better conditions in mental hospitals.

1790. It was suggested to us the other day—mental hospitals were being talked about—that research was done as they went along, new discoveries were made and so on, and perhaps they did not get into general circulation quickly enough. Do you feel that there is any need not only with regard to drugs, but with regard to all forms of administrative economy for a pooling of all sorts of experience, or does each H.M.C. live in a watertight compartment?——(Mr. *Julian.*) All the Finance Officers of the H.M.C.s, who are the equivalent of the Treasurers of the Regional Boards, all meet periodically like the Chairmen of the Regional Boards. Each month they meet, as do the secretaries, as do the

supply officers—they have a very constant meeting ground.

1791. Supply officers are not going to recommend anything which will do away with their job, are they?——I do not think you would do away with their jobs. We have not all that number of supply officers, and we are spending between £20 million to £25 million a year.

1792. The more central purchasing you have, the less supply officers you would have?——You could not do 100 per cent. central purchasing; you probably could not do 50 per cent. central purchasing. There would always be a job for the supply officers. There are not many of them.

1793. How many are there?——(Mr. *Ker.*) There must be under twenty.

1794. I see that your turnover of patients appears to be below the national average. Have you any comment on that?——(Dr. *Hughes.*) Are you referring to Table —?

1795. Table —*. There may be some simple explanation for it. It is mainly in the acute, you see?——You mean the actual turnover in the acute hospital per available bed?

1796. Yes. I think it is below the national average?——(Mr. *Julian.*) Where is the national average? Have we got the national average?

1797. Do you do anything to get the turnover moving?——(Dr. *Hughes.*) That is one thing we most definitely do. I did not quite agree with the Chairman when he was speaking derogatorily about statistics. One knows that they are not always absolutely correct, but we do use them very largely in such things for example as duration of stay. With regard to the average duration of stay, it is evident perhaps that doctors are not being quite as busy when you get a long average duration of stay. In general medicine if the average duration of stay is over 24 days, I look into it.

1798. How do you get these facts brought to your notice?——Monthly reports from the H.M.C.s from hospitals.

1799. They are averages, are they?——They are factual statements of each speciality. If a general surgical one is over 17 days I want to know the reason why. If it is a long duration of stay, either doctors are keeping them in too long, or the type of patient is more aged and staying longer. There are various factors and we do watch those very carefully. The other thing we watch is the turnover interval, which is the number of days a bed is empty in between the admission of patients. You will find if it is 3 or 4 that is a complete waste of beds. It should not be more than about 1·5. We watch all that.

1800. What steps do you take to ginger up hospitals that fall down in this respect?——By personal contact.

1801. Do you mean by ringing them up on the telephone?——By dropping a line to the Group Medical Committee, or the secretary of the H.M.C. If I am writing to one, I write to the other for information as well.

1802. And you express your disapproval and anxiety, do you?——I just want to know why; I just ask. If you make them realise that you are watching these things, they will discuss it amongst themselves to see what they can do about it.

1803. Do you see results always?——Not always, no, but I think by and large one does. (Mr. *Julian.*) Do we know what this difference is? Is it a serious difference?

1804. In all acute non-teaching hospitals the national average is about a turnover of 20?——(Dr. *Hughes.*) If you take childrens' beds, there is not a demand on children's beds. You have a large number of children's beds and they have a very low occupancy, and that brings it down. You have got to know the hospital to get the right picture.

1805. With regard to the first four figures on Table —, it averages out at 18 or 19?——Yes.

1806. I think you will find that is below the national average. You do get the national statistics circulated to you, do you?——Yes.

1807. You can make comparisons?——Yes.

1808. I know there are various explanations, but your percentage occupancy seems to be falling in

* Not reported.

Table —*?——I do not think it is falling very much.

Sir *Henry D'Avigdor-Goldsmid.*

1809. Would those figures take into account the situation that arises when you get some infectious disease?——Closing wards and that sort of thing, yes. When we get these low figures one does search about and you suddenly find a ward has been closed for decoration, or something like that. If you take Sidcup for example, which seems very low, that has a large unit there for pleura-effusion and we have taken over beds there for other things, that is to show how it would affect for a time the occupancy.

*Chairman.*

1810. The total number of beds has fallen by over a third at Sidcup?——That was because the L.C.C. had a large hospital for children there. When they were running it they were able to fill it by sending there from all over London. It is closed now, and we have got rid of it.

Vice-Admiral *Hughes Hallett.*

1811. The thing is to reduce the number of people in hospital and in beds?——Yes.

1812. Do you think there is sufficient incentive at present for the Service to reduce itself as the health of the population improves, or whether you think the tying of the salaries to the number of beds is a disincentive?——It is a disincentive to the people on the spot, but not to the Regional Hospital Board. The Regional Hospital Board would look at it completely impartially, and we have closed two hospitals in that particular group for economy sake.

1813. Do you hope to be able to continue that process?——Yes. I think in the same way the policy with regard to capital expenditure has been not to increase the beds throughout the regions, but rather to increase the ancillary developments which would not put the revenue expenditure up so much.

Sir *Henry D'Avigdor-Goldsmid.*

1814. When these statistics look unsatisfactory you have mentioned that you approached them through the Group Medical Committee?——Yes.

1815. Is there no other way in which they are brought to the attention of the H.M.C.?——I always write to the Secretary and the Group Medical Committee as well, I never write to one without writing to the other, but I may only write to the Group Medical Committee when it is a particular professional problem.

*Chairman.*

1816. Do you write in an admonishing fashion?——No. I ask for information.

1817. And you get it and you persist?——Oh, yes, rather. They will always give you a reason.

Sir *Henry D'Avigdor Goldsmid.*

1818. I see that percentage occupancy with regard to Lewisham has fallen considerably from 84 per cent. in 1955 to 79 per cent. in 1956. No doubt there is some reason for it, decoration, or something of that sort. It does seem a striking reduction?——That group is one of our largest T.B. hospitals and one of our largest infectious disease hospitals—the incidence of that has dropped and you can put your finger on the reason for it.

1819. The number of available beds has gone up. Is it not for consideration that it is not necessarily worth staffing quite so many beds in those circumstances?——That I can explain again. We are cutting down on the T.B. policy throughout the region. We are reviewing our establishments elsewhere and keeping certain hospitals as regional hospitals. Secondly, with regard to infectious disease hospitals, where a lot of the accommodation is good and it is not wanted for infectious diseases, we are developing those for the chronic sick, for instance. That is the reason for the increase in beds. (Mr. *Julian.*) Is our occupancy level about average?

*Chairman.*

1820. The national turnover rate for acute beds is 20?——I meant the percentage occupancy.

1821. The bed occupancy is higher, I think?——(Dr. *Hughes.*) I get worried if it drops into the mid-eighties. (Mr. *Julian.*) What is the bed occupancy average?

* Not reported.

1822. In acute the average is 82?——It requires quite a measure of efficiency to achieve high occupancy.

1823. You make an interesting suggestion about annual travelling allowances, in section 10 (*b*) of your Memorandum. Do you think doctors would accept it?——It would save an enormous lot of work.

Mr. *Robinson.*

1824. Are you thinking of giving evidence to the Royal Commission on these lines?——Under a *nom de plume*!

Vice-Admiral *Hughes Hallett.*

1825. Do you really think doctors, or anybody for that matter, would object strongly to that proposal?——You will be surprised how difficult they are sometimes on these matters if you want to make alterations.

Mr. *Robinson.*

1826. Could you give some idea how much clerical work is involved in working out these travelling expenses over a year?——(Mr. *Cole.*) In a Regional Board office on the Treasurer's side it is a man and a half full time. That is with regard to the checking of travelling expenses. That is of a pay roll of about 1,350, but of course there is other work on those travelling expense claims on the administrative side of the Board.

1827. Disputes and things of that kind, do you mean, disagreements?——(Dr. *Hughes.*) Domiciliary consultants. It has been an increasing cost recently, and you will be surprised as to the specialties in which it is increasing. (Mr. *Cole.*) In addition, the claims are examined at Management Committee level where they are submitted, and the doctor has an enormous amount of work in preparing his claim

*Chairman.*

1828. Another very fundamental question: can more be done to deter G.P.s from filling hospital beds with people with simple complaints?——(Dr. *Hughes.*) I would not say G.P.s do that. I am fortunate in being a Senior Administrative Medical Officer who was in general practice and I would not say that G.P.s do that. I think they do tend to send more patients to out-patient departments than they did before.

1829. The Association of Municipal Corporations refer to it, and the implication is that G.P.s are a little wild in their use of hospital beds?——They cannot be wild in the use of hospital beds because they have not the "say-so".

1830. And as to out-patients?——I quite agree that, but I think we are still going through a state of flux that will right itself in due course. I think it is essential to have G.P. beds available to G.P.s and I have throughout the time I have been at the Board tried to put them aside in hospitals for General practitioners in our own general hospitals.

Vice-Admiral *Hughes Hallett.*

1831. Is it the practice in your region for the G.P.s to have free access to X-ray services, and so forth?——Yes.

1832. Do you think we make as much use as we ought of the Home Nursing Service, or whether it would pay to expand it?——I think, there again, it is hard for us as a hospital service to say what would be the answer to that. (Mr. *Julian.*) You mean to prevent people going into hospitals? (Dr. *Hughes.*) I was assuming you meant to prevent them coming in where the G.P. would be involved and to let them go out earlier?

1833. Yes?——Yes, I do.

1834. You think it would pay?——Yes.

*Chairman.*

1835. Do you think it is right that salaries should be paid on a bed complement basis? Is there another way you could do it?——(Mr. *Julian.*) I think it is quite wrong.

1836. How would you do it?——I think you would have to have a graded salary basis for the Senior Officers of H.M.C.s, which I hope we shall have suggested to us by Sir Noel Hall. I certainly should not base it on beds.

1837. Have you anything which you particularly think we should know?——I think the thing we did not mention, as we did not want to introduce too controversial things, was that we feel strongly on the enormous increase in the number of domiciliary visits being paid, and we think it ought to be a matter for consideration. We are worried about

that. (Dr. *Hughes.*) It is a good thing that the domiciliary consultative service has been made available to the poorer class, but we as a Board from the inception have kept a rigid look-out on the whole thing, and even with that it grows out of all knowledge. When they included whole-timers in the service the number of domiciliary consultations in psychiatry went up from 267 to 861, that is just in psychiatry alone.

1838. Paying visits to patients in their homes?——Yes. The same thing was apparent in most specialities. I will not worry you with the figures, but we do watch domiciliary consultations very carefully.

1839. Do they come back on your expenses?——Yes, very much so. They are at four guineas a visit, but what is worrying me is the fact that in a very large number of cases indeed they are not consultations because the G.Ps. are not attending. They are visits by the consultant to the patient of a G.P., but the G.Ps. are not taking advantage of that consultation to improve——

1840. I thought the G.P. had to be there all the time?——That is what is expected of them. Again, we are in a state of flux, and I do not like to criticise my colleagues. I think it will right itself.

1841. Would you let us have a note on it?——Yes, on the consultative service as a whole, and I can give you chapter and verse of the number of consultations G.P.s have asked for.*

1842. Thank you. Are some G.Ps. lax about it?——(Mr. *Julian.*) Yes. (Dr. *Hughes.*) The point is we have G.Ps. who have asked for as many as 150 domiciliary consulations a year. I as a G.P. would know from my own practice I would never have exceeded a dozen in the whole year. (Mr. *Julian.*) Did not we also have it with regard to dermatology? (Dr. *Hughes.*) Yes. As you would expect, after general medicine and general surgery, the main ones, generally speaking, are orthopaedics and gynaecology, and, coming next, ophthalmology and dermatology—ophthalmology you can understand, old people in bed wanting spectacles.

1843. Would you be relieved by any efforts being made to cope with old people other than in hospitals for chronic sick?——No. I think we have produced a procedure which I have found quite good. We do try to get four types of beds and have a well-organised service, but where we are suffering is from the fact that local authorities are not providing the accommodation to remove the patients from our beds who have been rehabilitated.

1844. How much does the chronic sick cost you per week?——About £9 I should have thought—£8 to £9. I did a survey myself. I saw every patient at the end of last year, somewhere about August or September, in Kent, and we have got 200 to 300 patients in our beds who should not be in hospital accommodation but who should be in Part 3—that is 300 whom I could take off my waiting lists.

1845. Is that number decreasing do you think. We had evidence from a mental hospital the other day and they had about 2,100 beds, and I asked how many were chronic permanent inhabitants, and they replied about a third, 700. They said it will get less and is beginning to get less because earlier psychiatric treatment is preventing the people becoming chronically mentally sick. Does that apply to your side as well as to the mental side?——Up to a point. The tragedy of cases is that a number of those patients are confused old people who should not be in hospitals. To take our chronic sick, I think that by the organisation which we have set up where we do have an active rehabilitation unit for these people it does mean we can put them into circulation more and more and get them out of hospital if they have a home to go to. If they have not a home, the local authority cannot take them and we get stuck with them.

1846. Do they not board them out a good deal?——I do not know if they do that. (Mr. *Julian.*) It is a sociological thing really. (Dr. *Hughes.*) I am sure that if relatives had to pay for the old people in hospitals they would take more of them out.

Vice-Admiral *Hughes Hallett.*

1847. As to this domiciliary service, what is the procedure for authorising a visit?——A G.P. merely has to ask for the services of the consultant he chooses.

1848. Why is there any cost?——A consultant is allowed four guineas for

* App. 10, p 394.

each domiciliary consultation, plus in addition two guineas if he has to use his own equipment, such as X-ray or electro-cardiograms, and four guineas extra again if he has to do some form of obstetric operation. It becomes quite expensive.

*Chairman.*

1849. It is quite apart from salary. It is his fee?——He is only allowed to do 200 a year.

1850. 200 domiciliary?——Yes.

1851. He is only too delighted?——Certainly, but I have one chap who did 363, and did 163 for nothing.

*Chairman.*] I would like to thank the witnesses for their evidence.

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TUESDAY, 2ND APRIL, 1957.

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Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | Captain Waterhouse. |
| Vice-Admiral Hughes Hallett. | |

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**Memorandum submitted by the Association of Hospital Management Committees.**

RUNNING COSTS OF HOSPITALS

**Introductory**

1. The Association desires to express its appreciation of the invitation extended by Sub-Committee D to submit comments on this important subject, and although the time limit imposed has presented difficulties every effort has been made by the Association to obtain the observations of its 357 constituent members.

2. The content of this memorandum is influenced, and to some extent qualified by the following factors, viz.:—

(*a*) The report of the Guillebaud Committee covered most of the subject quite recently.

(*b*) A new Costing System commences on 1st April next and a more informed opinion on variations will be possible when the resultant figures are available.

(*c*) The small percentage of the total cost which is within the control of Hospital Management Committees.

3. The following table shows the breakdown of gross maintenance costs for 1954-55 (Table 23—Report of the Ministry of Health 1955) viz.:—

| | *Per cent.* |
|---|---|
| Salaries and Wages | 61·4 |
| Provisions | 12·2 |
| Fuel, light, power, water and laundry | 7·3 |
| Drugs and dressings etc. | 3·4 |
| Maintenance of buildings, plant and grounds | 3·4 |
| Medical and surgical appliances and equipment | 2·8 |
| Domestic repairs, renewals and replacements | 2·6 |
| Staff uniforms and patients' clothing | 1·1 |
| Other expenditure | 5·8 |
| | 100·0 |

4. There is no " standard " hospital, and useful indices of comparison can only be ascertained by close investigation of the complete content of each hospital comprising the services provided, the character of the facilities available and the overall efficiency of the equipment and staff. Assuming equality in all other things there remains the difference in performance of individuals which accounts in some degree, albeit small, for variations in total costs. These considerations are equally applicable when seeking the reasons for variations in groups and regions.

**Variations—Main Considerations affecting Running Costs**

5. (a) *Regions*

(i) Geographical situation.

(ii) Density of population.

(iii) Proportion of specialist hospitals.

(b) *Groups*

Chiefly as for (a) above and the variety of the hospitals within the group as affected by the factors detailed in (c) below.

(c) *Hospitals*

(i) Age, size, design and lay-out.

(ii) Adequacy of existing services.

(iii) Size of units and distances between departments.

(iv) Standards of staffing and catering.

(v) Proportion of specialist staffs.

(vi) Function (an acute hospital may be 100 per cent. Medical, Surgical, Orthopaedic, Gynaecological etc., or any variation of these).

(vii) Bed turn-over.

(viii) Ancillary departments—Out-patients, X-ray, Physiotherapy etc.

(ix) Services provided for other hospitals in Group.

(x) Services provided for other Groups or for Region.

(xi) Training schools for Nursing, Radiography etc.

In addition the present costing returns are fallacious because in respect of certain items (laundry and general maintenance etc ) the allocations under sub-headings are made according to the methods employed in providing the service (within the hospital or by outside contracts). Comparisons are also affected by the fact that under the present system expenditure for acquisitions or replacements of expensive equipment (medical and surgical appliances etc.) is charged in full when purchased and inflates costs during that particular year.

Another important factor is that present figures are based on the assumption that *five* out-patient attendances equal *one* in-patient day, and the reliability of this calculation is much questioned. One Committee has established by factual information in respect of one hospital that the ratio is nearer *eight* to one. This percentage of error becomes increasingly greater as out-patient " attendances " become higher.

**Factors directly affecting Running Costs**

6. The main criterion is the content and standard of the services provided and the variations are innumerable according to the size and function of each particular hospital.

Standards of staffing, standards of catering, proportion of out-patients to in-patients, techniques and procedures of medical and nursing staffs, methods of purchasing, methods of carrying out maintenance works, extent of use of modern appliances for cooking and cleaning, number of patients requiring clothing (as in Mental and M.D. hospitals), system of laundering etc., all have an important bearing on running costs.

7. The procedure for the preparation and approval of estimates of current expenditure is described in detail in paragraphs 266-278 and comments on the " method of allocation etc." are given in paragraphs 281-298 of the Guillebaud Report.

It appears that the methods employed by the Regional Hospital Boards in exercising " general oversight and supervision " vary and the opinion expressed by some Management Committees is that although in theory they are *responsible* for " management " their functions become more and more " custodial " rather than " managerial " owing to the detailed control exercised by a Regional Board. It is submitted that if in these regions, Management Committees (who are appointed by the Board) were given more freedom of action within the limits of the finances allocated to them the overall effects, financially and administratively, would be to the benefit of the service.

In some regions too much reliance is placed on the previous year's expenditure in framing estimates and this tends to perpetuate inequalities as between Management Committees.

8. Most Committees point out that it is present practice, at local and regional levels, to carry out investigations of wide variations when costing returns are issued, and that as a result the margin for further economies, short of change of policy, is extremely small.

It is a general view that substantial economies are not possible without lowering standards of service and in the case of some hospitals (particularly Mental) public opinion and official approval indicate the necessity for improved standards with consequential increases in cost.

**Suggestions for Economies**

9. It is thought that economies of any magnitude can only be obtained by a change of policy, but the following suggestions are considered worthy of further investigation for effecting ultimate savings within the existing structure of the service.

(a) *Standardisation* of all items of common use including staff uniforms, patients' and staff records which would be conducive to further development of large-scale *purchasing*.

(b) *Standards*—It is considered that there is much scope for O. & M. or " Cost of Service " teams to provide data for the fixing of standards in connection with staff, provisions costs, etc. The establishment of such standards would also facilitate fair comparisons of costs between hospitals.

(c) *Laundries*—Further development of centralised services to eliminate uneconomic units.

(d) *Boarding-out*—The possibility of boarding-out suitable chronic patients and mental patients should be fully explored.

(e) *Sickness Payments*—The present regulations regarding medical examination of staff upon entry to the service and subsequently should be overhauled.

(f) *Rewards for Suggestions*—It is understood that schemes for offering financial rewards to staff for suggestions which result in efficiency and economy operate successfully in the Post Office and Industry—these should be examined with a view to introducing a scheme for the hospital service. It is considered that it would be a useful means of encouraging staff to be " cost conscious ".

**Factors affecting the Total Load**

10. Probably the two most important factors affecting the total load borne by the hospitals today as compared with the services given prior to nationalisation are:—

(*a*) the number of patients remaining in hospitals because alternative accommodation is not available, and

(*b*) the gravitation of patients to hospitals for advice and treatment previously provided elsewhere.

With regard to (*a*):—

it is well known that relatives are unwilling to accept responsibility since the legal obligation for maintenance was removed and local authorities have insufficient accommodation for the non-sick.

In connection with (*b*):—

it has been suggested that the overall organisation of the service encourages too frequent reference of patients to the hospital and it would be more efficient and cheaper to encourage more extensive treatment and control of patients at the general practitioner level. Whatever may be the merits of this suggestion it is certain that present practice adds considerably to hospital costs particularly in hospitals having large out-patient and treatment departments and their own dispensaries.

Other examples of the inflation of costs by services provided which are strictly outside hospital functions are spectacles for school children, medical and surgical appliances and requisites, hearing aids etc.

**Suggestions for reducing Total Load**

The Association is of opinion that the present total load can be substantially reduced by measures designed to ensure that hospitals are used only for strict hospital functions, or that costs incurred in undertaking extraneous services, as indicated above, should be shown separately in the accounts.

**Comments on Current Operation**

11. The Association is firmly convinced that Management Committees are handicapped in their efforts to secure economies by the present distinction between "capital" and "maintenance". Most Committees are cognisant of economies in "maintenance" expenditure which would be possible if funds were available for minor new works or new equipment which under existing regulations are classified as "capital". It is recommended that capital monies should be allocated under two headings, i.e. "major" and "minor", and that a sum under the latter heading should be given to each hospital and full discretion in the spending be granted to Management Committees.

12. It is regretted that in the short time allowed it has not been possible to do more than present the main points contributed by member committees, but the Association would be pleased to arrange for a small deputation to amplify this memorandum by verbal evidence if Sub-Committee D so desire.

**Examination of Witnesses.**

Sir STEPHEN LYCETT GREEN, Bt., J.P., Chairman of the Council, Mr. D. CLEAVE CROSS, a Member of the Council, and Mr. A. G. TILL, Secretary, Association of Hospital Management Committees, called in and examined.

*Chairman.*

1852. Sir Stephen, will you say something about your Association and what it does?——(Sir *Stephen Lycett Green.*) Our Association is an association of the Hospital Management Committees of England and Wales constituted under the National Health Service Act and at the present time we have as members 357 Management Committees out of the total of, I think it is, 375 Management Committees in the country.

1853. You are a statutory body?——I think we are statutory in the sense that under the Amendment Act provision was made for Hospital Management Committees to subscribe to our Association, but we were not constituted as such under the National Health Service Act itself.

1854. I should describe it as a voluntary body?——We are a voluntary body.

Mr. *Robinson.*

1855. When did you come into being?——November, 1949.

*Chairman.*

1856. How often do you meet?——Our Association only meets as an Association once a year at its annual general meeting, which can be attended by all the representatives of all the constituent members. We have a National Council which consists of two members and their alternates appointed by the regional branches, one for each of the 14 hospital regions in the country. That meets once a month.

1857. Do you produce reports or journals for your members?——We produce an annual report which is presented to our annual general meeting, and we also circulate to our members the minutes of our Council meetings in which we set out at some length the various letters or other memoranda which have been submitted to us by our regional branches or our members and the decisions of the Council thereon.

1858. Do you discuss all the current difficulties of H.M.C.'s?——Apart from such matters we may discuss ourselves which may be of interest to us, any of our members or our regional branches may refer to us matters troubling them, and we discuss them at our Council meetings. If we can help them of course we take a decision, but, generally speaking, we have to make representations to the Ministry or any other body. A very considerable number of problems are concerned with questions raised about the application of salary scales and awards, which we pass on to our representatives on the various Whitley Councils.

1859. Have you considered the question of what the proportion of medical members on H.M.C.s should be and the ideal composition of a H.M.C.?——Yes. We were asked by the Ministry to consider that question when it was mentioned in the report of the Guillebaud Committee. If my memory serves me aright, we referred in our turn that question to all of our regional branches and on their replies we informed the Ministry what our opinion was.

1860. What was it?——I think as far as I remember we agreed with the recommendation of the Guillebaud Committee.

1861. That it should not be more than 25 per cent.?——Yes.

1862. Do you think there should be more outside people with business experience put directly on to H.M.C.s who have not worked up, so to speak: do you feel there is a shortage of people with general knowledge of the world serving on H.M.C.s?——I think our view is that the H.M.C. representation does represent the ordinary average lay individual, but we are a little concerned about the way in which the medical profession infiltrate on to our bodies. There should be taken into consideration not only the direct representation of medical staff through their various staff associations, but very often they come on in other ways, for instance, through the executive councils or sometimes, even, say, from a local authority.

1863. Do you take the view that it is desirable a Committee should be representative of as many interests as possible, or do you take the view, which rather conflicts with the first view, that a Committee should try and get as many highly efficient people as possible—in other words, do you take the representative or the functional point of view?——It is not an easy question to answer. I think if I may answer that question in a very broad way, we think that the H.M.C. should be representative of the patient or the potential patient, which roughly means it should be representative of the community as a whole. How you are to get that representation is, of course, a very difficult matter.

1864. You do not feel a H.M.C.'s job is to run the hospital efficiently, with due attention to getting full value for every penny spent?——I would say we do think that, because, of course, we think it is to the advantage of the patient that should occur, but what we feel is that the membership of the H.M.C. should be representative of the lay community as a whole—perhaps I should not say "lay", of the community as a whole, and that those who are on it should be there because they are efficient or members of the community, even potential patients, but they should not be there because they happen to be representing the Loamshire County Council or the Borough of Mudtown, or even the doctors in the particular hospital. That is

the feeling we have always had in our Association, and we have always tried to the best of our ability to maintain the principle of the voluntary control of the hospital.

1865. What I wanted from you was whether you thought enough attention was paid to getting really effective and efficient people to see the hospitals are run efficiently, and I rather gathered from you that that is not your prime object but rather a secondary object, though one to which you attach importance?——No, Sir. I would say that we are concerned in the efficient running of our hospitals as representative of our membership.

1866. When you say "efficient", I am thinking of getting value for money: do you think enough attention is paid to getting really good value for money? ——I would say that was a part of efficient administration.

Vice-Admiral *Hughes Hallett.*

1867. When you said you felt that the Management Committees should represent the public as potential patients, which would you regard as most important, the public as potential patients or the public as actual taxpayers? The two things on occasion may tend to clash?——It is very difficult to divorce their ultimate interests, however easy it may be at any one particular moment for one aspect to be clearer to the individual than the other. When a person is in hospital he no doubt feels everything should be done to cure him as rapidly and, if necessary, as expensively as possible. If he is not in that position, he is more concerned in seeing that the expenses of the hospitals are cut down so that he as a taxpayer has not got to find the money. I do not wish it to be thought that we as an Association or as members of H.M.C.s try to divorce the patient from the taxpayer. All I am saying is that we consider that the membership of H.M.C.s should as far as possible reflect the general community.

*Chairman.*

1868. I still feel a little unhappy, I must confess. Do you think they *should* reflect the general community? ——I would say, Sir, primarily, because it is a service which is owned by the community, if I may say that without introducing questions of political principle.

1869. I may be misunderstanding you, but I feel the prime object of a H.M.C. ought to be getting people who can best run that hospital, with of course, the necessity in the background of keeping in touch with the public in general, but a prime consideration, surely, should be that they are really good people at running a hospital?——I would not say that necessarily conflicted with the principle I suggested. When I say it should be run by members of the community, I think it is implicit that those who are selected from the community should be those who are selected for their interest and experience of hospital administration.

Mr. *Robinson.*

1870. If the witness took the view that the main concern in running a hospital is solely regard for the taxpayer's money, would he consider there was a place for the H.M.C. as envisaged by the Act and as appointed in the way it is today?——It is a difficult question to answer straight off. I would say yes.

1871. May I put it another way? Do you not think that the reason a Management Committee has been set up in the form it has is to take into account other considerations besides those of pure economy?——Far be it from me or my Association to try to read into an Act of Parliament what was in the mind of Parliament when they passed it, but what I would have thought—and here perhaps I express an entirely personal view —was behind the whole organisation of the administration of the Health Services was the idea that if the country was to make a national service out of the hospitals of the country which were taken over in 1948 they could be run by some form of Civil Service. It is possible to envisage them being run by a civil service on the normal lines controlled by the Minister of Health. In setting up the rather complicated system of Regional Boards and Boards of Governors and H.M.C.s Parliament, in my view, was trying to devise a system of running the Hospital Service by an unpaid civil service and have the advantage of the great fund of voluntary goodwill which has always been at the call of the hospitals and probably always will be .

Sir *Henry D'Avigdor-Goldsmid.*

1872. It would be a travesty to say that the view you have expressed is that the Hospital Management Committee's

object is to be a consumers co-operative. You did say to us you thought it was your object to represent the patient: would you on consideration really maintain that view?——I would not like to have it thought that by saying we represent the patient that that was to be meant too literally. Perhaps it would be better if I said to represent the public, all of whom are potential patients.

*Chairman.*] I think we quite understand your point of view, and we will not pursue that any further.

Captain *Waterhouse.*

1873. Would you consider the presence of your Committee, the fact your Committee is all part of the machine, did or did not tend for an economic running of the hospital?——That, I think, is a very difficult question to which to give a straight answer. I think that all our Committees find themselves subject to a dual allegiance, or perhaps I should say they are pulled in two different ways. On the one hand, they are proud of their hospitals and they want their hospitals to give the best possible service, and to that extent, of course, they are pulled away from the idea of economy. On the other hand, all of them are ultimately taxpayers, and I think all of them have the sense of responsibility of those who are appointed or elected to administer public money.

1874. You have been connected with hospitals over a long time, have you not?——I have not been connected with hospitals for as long as perhaps I ought to have been. The first time I came into hospital administration was when I was appointed a Chairman of my H.M.C. about a week before the appointed day, and I had not the advantage of a great many of my colleagues on my Council of having been in hospital administration on either the voluntary or local government side for a great many years.

1875. Could one of your colleagues better answer this question: do you think the hospitals now are as cash-conscious in their management as they were in the pre-Act days?——(Mr. *Cleave Cross.*) I should say they are not. I was connected with a voluntary hospital for twenty years before the appointed day and there we were very cash-conscious, and we were always very careful to see that whatever we spent was as economical as possible. At the present time we have members on the H.M.C. who have come from outside organisations who are not so much cash-conscious and they cannot understand why the standard of hospitals cannot be increased and they are not worrying too much about where the money is coming from.

1876. Apart from the tremendous advance there has been in medical science in the last 10 or 15 years, would you say you gave a better service to your patients than you did in your earlier days in the voluntary hospitals?——As a whole we do, not individual hospitals, because many of the hospitals had specialised departments before and others were just simply run without them. Now there is an aim throughout the service to raise the standard of all hospitals, bringing in more medical clinics to these hospitals than they have ever had before and appointing additional consultants and additional clinical assistants. There is a general raising of standards. Some of the old local government hospitals did not have the advantage of the same standard of consultants as the voluntary hospitals and now, of course, there is a levelling up of those hospitals.

Mr. *Robinson.*

1877. Would it be true to say that in the days when in your view they were more cost-conscious the standard was lower than it is today?——They are more conscious of the standard of service today. The medical side are the people who are not cost-conscious. All the time they are trying to raise the medical standard of the hospitals and are always requesting for new clinics and new departments.

Mrs. *Hill.*

1878. And additional staff?——Automatically, yes.

1879. And secretaries, and so on?——Yes.

*Chairman.*

1880. Do you find difficulty in finding suitable people willing to take on the job of chairman of a H.M.C.: is it increasingly difficult or less difficult to find suitable people—are you aware of difficulties?——(Sir *Stephen Lycett Green.*) I personally am not aware of them. There are usually enough good members of H.M.C.s to make no difficulty

in finding them. That is what I would say.

1881. Do you think the time has come, or will come, when the part-time payment should be made, or do you think that would wreck the whole atmosphere? ——I think it would probably wreck the whole atmosphere. (Mr. *Cleave Cross.*) I do not think there is any necessity for part-time payment.

1882. There are still plenty of good people coming along?——Yes. I go to the meetings at Regional Boards headquarters and I should say the standard of chairmen is being fully maintained, although there are changes and they are getting in business-men now, whereas before they often had, especially in the local council hospitals, members because of their political interest rather than their hospital interest.

1883. That rather links on to what I was asking Sir Stephen. You are a member of the Regional Board?——No, only of a H.M.C.

1884. You would say, would you, that there are enough people with outside business experience?——My experience is that we are trying to get them in, but it is somewhat difficult to get really good men to spare the time when they find they are so controlled from the top and where there is not sufficient flexibility—as I say, so much of it is controlled from above.

1885. We will get on to that aspect later. I wanted to ask you about House Committees. Do you believe in House Committees in individual hospital?——(Sir *Stephen Lycett Green.*) I am in a little difficulty here because I personally do not, but I think that as a whole the Association does. I should perhaps say that my experience of Hospital Management Committee administration has come from a small group where we are able to run without House Committees.

1886. What do your colleagues who differ from you believe the functions of a House Committee should be?——I think they consider they should be to bring a more intimate knowledge of particular hospitals in a large group to bear on its day to day running and administration. (Mr. *Cleave Cross.*) House Committees should not have executive control; they are mainly for the welfare of the hospital.

1887. And liaison?——And liaison and to advise, but under no circumstances executive control.

1888. How do you think medical administration is best done?——(Sir *Stephen Lycett Green.*) You are not referring now to medical representation?

1889. No, administration within the hospital? My next question is: do you believe in the appointment of medical administrators in the larger general hospitals?——This is a question on which I think it would be fair to say that our Association would be very much divided in its opinion, and I think the opinions would be very much influenced by the experience of the particular person who was replying to the question. I know that most representatives of voluntary hospitals are opposed to the system of a medical superintendent in a hospital. On the other hand those who have had experience of the administration of local authority hospitals favour it. If it had been our previous Chairman of our Association who was giving evidence before you he would, I am sure, have told you he agreed with that system of medical superintendents, because I heard him say that to the Guillebaud Committee.

1890. A medical administrator is not quite the same thing, is it. I am quoting from the Bradbeer Report, where it talks about a medical administrator. I take it he would really administer the medical side only, whereas a medical superintendent would be the general manager of the whole hospital?——Yes. Perhaps I am wrong in referring directly to medical superintendents, but I think the idea that there should be one man responsible for medical administration of the hospital is not generally accepted in the Association. (Mr. *Till.*) I would say so, yes. (Sir *Stephen Lycett Green.*) Although there would be individuals who would be prepared to support that. (Mr. *Till.*) I would say there has been a very definite change of opinion on this matter since 1948 because in many hospitals the consultant staff has been increased, particularly in ex-local authority hospitals, and the concept of the medical superintendent has faded because it really does not work where you have a large staff of consultants.

1891. So it is going out of fashion? ——That is my impression because of the

differences of opinion between consultants and the medical superintendent regarding status.

1892. Do you think there is a danger of H.M.C.s operating too much through sub-committees and committees as Guillebaud says?——(Sir *Stephen Lycett Green.*) I think there is a very definite danger of it. I do not know how universal it is. It varies from committee to committee. My own Committee has no sub-committees, but there are others I know which proliferate to an amazing degree. (Mr. *Cleave Cross.*) You have got to have a certain amount of subdivision, such as establishment and supplies, I would suggest.

1893. I must honestly say that I am not very clear how you remedy it. It is equally clear, as the Report says, there is a danger of the thing getting bogged down by committees. How do you think that might be remedied?——(Sir *Stephen Lycett Green.*) I think the way it could be remedied would be much more delegation.

1894. To individuals?——To individuals or to officers. I think that here perhaps I may be expressing a personal point of view, but I think there has been inherited from the local authority field a tremendous belief in committees. I first had some slight experience of local government before I became hospital chairman, and when we started I was under the impression we ought to operate through a lot of committees. I found in practice we could reduce to nothing as far as standing committees were concerned, and only operate when necessary through *ad hoc* committees. I represent a small group and we can do that. In larger groups I can see that some standing committees may be necessary. I think there could be a lot more done in the way of delegation to chief officers which would reduce the need for sub-committees.

1895. Does your Association urge that on H.M.C.s?——Our Association has, I think, supported the recommendation of the Guillebaud Committee.

1896. And all your member committees are aware of the view held generally by the Association?——We have circulated that view, and what effect it has had I do not know.

Mrs. *Hill.*

1897. You say you are in favour of the whole service being more officer-run than run in close touch with the public as it is today?——No, I would be against that, but I think committees, having decided their policy, should be prepared to leave the carrying out a great deal more to officers than they do. I am not saying they should leave the whole thing to them, but I think there are a number of committees which like to form a sub-committee for no other purpose than to see that the chief officer is doing his work and then referring a report to the main committee for ratification, which produces an enormous quantity of paper to be hastily passed through the meeting of the full Committee.

Sir *Henry D'Avigdor-Goldsmid.*

1898. In your experience is the officer standard of H.M.C.s sufficiently high to enable such delegation of authority to be safely done?——That is perhaps one matter I would have to consider very carefully. On the whole, I should say in the higher posts yes, but it is a grave weakness of the administrative staff of the hospital service which is causing my Association a certain amount of concern at the moment that there is too big a gap between the higher grades and the intermediate grades.

*Chairman.*

1899. Does the degree of autonomy and independence given to H.M.C.s vary from region to region?——Speaking only from knowledge of one region, but from the general impression I derive from my colleagues on the Council, I would say yes.

1900. You refer to that in your paragraph 7: "In some regions too much reliance is placed on the previous year's expenditure in framing estimates and this tends to perpetuate inequalities as between Management Committees". That is an important statement. Is that backed up by evidence?——It is very difficult in this field to be able to speak properly about any region other than one's own. In my own region I have never felt particularly conscious of that difficulty. I believe Mr. Cleave Cross feels differently about it. (Mr. *Cleave Cross.*) We have got the opinions of so many different H.M.C.s throughout the country, and it appears the control of

Regional Boards varies very considerably and the liaison between the Regional Board and Committees varies considerably. Some Committees feel that they have very little managerial duties left, and that they are there just as custodians, whereas with others the Regional Board have very close liaison, meetings with the chairman and the officers, and there is better liaison and H.M.C.s are left with more discretion. But there are certain areas and regions where the Regional Boards are just simply tying them down, giving the H.M.C.s little scope.

1901. Which region would take that line?——That I would not like to say.

* * * *

1905. No. In any case the H.M.C.s have a responsibility of deciding how to spend the money allocated, have they not—you cannot take that away from them ; you cannot say they are just custodians if they can decide how to spend the money?——Speaking for myself, I have not suffered from this, so it is difficult to be able to say how the control is exercised, but, of course, the degree of control, I imagine, is bound up with the amount of trust the Regional Board is prepared to put into the H.M.C.s and the extent to which they allow them to spend money without reference to the Regional Board.

1906. Mr. Cross said that sometimes Hospital Management Committees were put into the position of being custodians. Surely that is an exaggeration, is it not? Have they not always got considerable scope in deciding how money should be spent?——(Mr. *Cleave Cross.*) No ; some hospitals are very badly staffed, mainly because they are in an industrial area, and they are not allowed sufficient money perhaps to bring their staff up to establishment ; the Regional Boards at the beginning of the year give them a certain amount of money for staff purposes irrespective of whether they are up to establishment or what the conditions of the standard of the staffing are. They say " You have got to contain yourself within that allotted amount ", and there is no question of what the conditions in the hospitals are like. We had a case last year where at the beginning of the year we had only got one cook out of five in one hospital, and the Regional Board said " There is the money. You have got to contain yourself within that allotted amount, and no increase in staff at all." How on earth are you to carry on when you are controlled without their knowing the conditions?

1907. That still leaves the H.M.C.s considerable power. It may be very disagreeable to have to exercise it, but are you not exaggerating when you say they are custodians?——We are not allowed in some regions to engage certain extra staff beyond the number you started at the beginning of the year without permission, and so far as salaries are concerned, we have no control on upgrading clerical staff. We have got to get permission. The Board, without knowing the conditions happening at the hospital, will often refuse that application, with the result that we get a number of appeals to the Whitley Council, and invariably the Whitley Council upholds the Management Committee's opinions.

1908. H.M.C.s prepare the estimate, do they not?——They have to prepare it on the basis of last year's spending, and that is the root trouble of the complaint. If any hospital started with a very low basis, that has continued year after year.

1909. And vice versa, if it is a high basis?——Yes, and that is where you could save money. Some of the hospitals which are well off and whose standards are high, make certain there is no reduction of standard by the end of the year.

Captain *Waterhouse.*

1910. Are you talking of establishment, or of the actual people in the hospitals?——Establishment and maintenance.

1911. You said one hospital had one cook, and they ought to have had five? ——That was establishment. I am only pointing out that Regional Boards have given us very little discretion in the appointment of extra persons if it is necessary.

*Chairman.*

1912. Surely, the H.M.Cs. decide how much of their allocation they will devote to staff?——The amount given to you by the Board has a great bearing on what was spent in the previous year.

1913. I accept that. They are more or less given a lump sum to run the

hospital on?——But that has to be subdivided into different headings and that has to be approved by the Regional Board.

1914. In the first place, the subdivision is made by the H.M.C.?——I believe so.

1915. I should have thought that if the Regional Board co-operated the H.M.C. still had an important and significant role to play?——Yes, but that is pruned down dependent on the amount given to each of the Regions by the Exchequer.

1916. Which Region are you in?——In the North-East Metropolitan, which is one of the happiest Regions in the country. I have got to say that from what I have heard from the others.

Vice-Admiral *Hughes Hallett.*

1917. Would you favour a more precise delineation of the respective functions of the Regional Boards and Management Committeees?——(Sir *Stephen Lycett Green.*) Personally, I think there is no need to define it very much further. I think it is a matter not of defining always but a matter of relations between personalities.

1918. But surely an organisation which depends on relations between personalities is basically unsound? The one thing it must be is that it should be independent of any pecularities which the people holding the key positions have? ——I think you can lay down your functions, but unless you define the boundaries it would be extremely rigid, and I think you are bound to come to the point where it involves an interpretation of the functions as between two parties. I think that one finds in the Hospital Service in some cases that the organisation runs very smoothly—as Mr. Cross says, his Region is one of the happiest in the country. I know that the East Anglian region has always been happy; in others they may be unhappy.

1919. All that may be so, but in paragraph 7, one of the key paragraphs, you say the complaint is that there is a substantial variation from one Region to another?——Yes.

1920. And the *prima facie* solution to that is to define with greater precision what the relative duties should be. I am not certain why you oppose that. It would appear to follow?——I think it is a sphere in which the definition of the responsibility is terribly difficult. Attempts have been made to define it since the beginning of the service, and they always seem to work rather differently in one Region as opposed to another. The broad distinction made at the beginning was that the region would be responsible for general policy, planning policy, and that the Committees would be responsible for administration, but the point at which policy shades into administration is really capable of being drawn at a different point rather dependent on who is drawing it.

*Chairman.*

1921. Do you think that if the number of subheads in the estimates were reduced it would give H.M.Cs. the requisite scope?——On the whole, I think we would be in favour of that. (Mr. *Till.*) Might I intervene on the last point, Sir. An illustration of what we mean is that although the regulations governing capital expenditure are standard there are variations in interpretation. A literal interpretation means that if you want an extra wash basis in a ward room, or an extra tap, that is capital expenditure and therefore you must obtain the approval of the Regional Board. Prior to 1948 such items were generally treated as maintenance and the present procedure, if strictly enforced, is regarded as irritating and frustrating. Some Boards have established a scheme whereby a certain sum of money is allocated to each Management Committee for "minor" capital works to cover such items as those mentioned and the arrangement works well. But all the Boards do not do this.

1922. Is there an antipathy or strained relations between Regional Boards and Hospital Management Committees—is it inherent in the system?——(Sir *Stephen Lycett Green.*) No, I do not think it is necessarily inherent in the system.

1923. You think there is a strain?——In certain cases there is. I think there is always a tendency in any form of administration to consider that the people in the hierarchy immediately above you are lunatics. There is always I think that sort of feeling in any organisation. I think the H.M.C. members probably came into the scheme in 1948 more disposed to think that. But I think that in the progress of time it has ironed itself

out, except possibly in one or two regions, and there I cannot speak with first hand authority.

1924. I think the weakness—it may be the strength—is that it depends so much on personalities?——Yes.

1925. I am inclined to think that it is more of a weakness than a strength, but where things go wrong, would you say it is due to personalities?——I think it probably must be, because my own experience has been of a Region where on the whole things have gone right, and there I think it has been again due to personalities. We have had an excellent Chairman, Lord Cranbrook, who has built up from the start excellent relations with his H.M.C. Chairmen. We have had a very co-operative S.A.M.O. and the Regional Board staff are on the whole friendly, and get on well with their opposite numbers at H.M.C.s, and the thing works on the whole well.

1926. Do you say that there is one Region, or more, where it does not work well?——I feel in the great difficulty that I only know of one Region, and can only judge of other Regions by the way colleagues on our National Council talk about their Regions, and in one or two cases I have formed the opinion that the relations are not happy.

1927. Only in the minority?——Yes. (Mr. *Till.*) For example, with regard to the maternity service, in some areas all the authorities are working hand in glove, and have got a scheme going. In others, there is no scheme at all. (Sir *Stephen Lycett Green.*) That is in the field of hospital service, local government service and executive council, and we have found it comes down there on personality. If the local officer and the medical officer are prepared to make things work they work, and if they are not they do not.

1928. Would you say that the Chairman of a Regional Board is the main key? Would you say that a good Chairman will in a year or two get a good Region?——I think he sets the tone, and if he is out to be friendly and understanding with his H.M.C. Chairmen, in turn his officers become friendly with the H.M.C. officers.

Vice-Admiral *Hughes Hallett.*

1929. I am more interested in financial control than I am in personalities. It seems to me from what you have said that the basis of complaint in paragraph 7 of your Memorandum concerns a decrease of financial autonomy granted to the Management Committees. Surely the remedy both from the point of view of satisfying Management Committees, and from the point of view of having proper financial control of the system as a whole, is for the extent to which spending power may be delegated from one level to another to be laid down with great precision, as indeed one would find in any other branch of spending of public money? ——I should say probably on the whole, yes. (Mr. *Cleave Cross.*) We are given a certain allocation of money. We have to divide that into separate headings, and if we can make a saving in one of the headings we are not automatically allowed to transfer that on to another where perhaps there have been extra heavy expenses without special permission of the Board. You have got to go to the Board and ask for special permission. On provisions, for instance, we want to raise the standard of feeding. If we make a saving in drugs, we cannot automatically transfer any savings on drugs to a higher standard of provisions without special permission.

1930. You are referring to *virement.* Would you not agree that to extend *virement* would be in practice a matter of whether it should be uniform throughout all the Regions and Committees? ——There is no standard, that is the difficulty, and until you have got some form of standard the feeding standards of different hospitals are totally different, and you have got a service which is different. You have some hospitals giving group service, others giving a regional service, you have the hospital that is giving, shall we say, the laundry service for the whole region, and others doing no laundry work. There is no standard between any two hospitals, and until you have got a standard there is no rigid rule that can be laid down.

Sir *Henry D'Avigdor-Goldsmid.*

1931. Do you attach any importance whatsoever to the presence of the local health officers of Hospital Management Committees? I think it is one of the points made in the Guillebaud Committee Report. Does your Association attach any importance to that?——It is

never a point we have considered. I think it depends again very much on personalities. If the Medical Officer of Health is prepared to come on as a member of the Committee, he can be most useful, but if he is purely there to represent the interest of his authority he may very well turn out to be just a nuisance. I say that having had a Committee. I have had two Medical Officers of Health, one from the local authority and one from the county council, and both have been extremely useful, but have not acted primarily as representatives of their authority. (Mr. *Till.*) One of the difficulties of putting this into practice is that in some groups a number of medical officers or area medical officers are employed by different local authorities and adequate representation of each authority is not always possible because of the numbers involved.

*Chairman.*

1932. I want to get on to the quality of the senior administrative staff. I suppose you would agree that the efficiency of the service hangs very largely on that?——Yes.

1933. And that it is a constant source of anxiety to all connected with the service. What in your view is the remedy? Have you any definite views. For instance, taking the Treasurer and Secretary, how can you be sure of getting a higher sort of person? Do you think there should be a form of regional or national training; do you think, for instance, that the senior administrative staff of committees should be appointed from a list provided by the Regional Board?——(Sir *Stephen Lycett Green.*) I think our Association would like its members to be free to appoint with a complete discretion, and I do not think they would like—in fact, I am sure they would not like—it to be a question of simply a Regional Board list. I think at the present moment the system is working fairly well. I think the wastage among senior members of group staff is not very high at the moment, and when it does occur there is a pretty good field from which you can choose, but I think we are rather worried about the future.

1934. Is there not a temptation to just appoint the number two in the office?——I would say no.

1935. Are you satisfied with the amount of cross-promotion as between different committees and regions and so on. There is nothing like a general pool of available talent, is there?——If you take the general pool, all the hospital administrative staff in the country, I think there is a fairly large size pool at the moment. What the overall quality is I would not like to say. My impression is—this is my impression, and I am sure Mr. Till will be able to tell you more about this—that any H.M.C. which wishes to appoint a Group Secretary has only to advertise for one and it will have an enormous list of applicants from which it can produce a pretty good short list. (Mr. *Cleave Cross.*) At the present moment we are living on the good quality of men who came into the hospital service at the beginning. There has been a certain amount of apprehension nationally and in regions as to the quality of persons coming in, and there are national training schemes being set up both nationally and in each region for training young men for these higher positions.

1936. They are rather small in extent, are they not?——Yes, but it has been considered there are about 2,000 senior positions available in the Health Service and a wastage of fifty a year; that is all we have got to cater for. In regions and nationally they are trying to train for at least that number to be available as the wastage arises.

1937. There will be more than that, I take it—that looks as if the average position is held for forty years by the same person?——Yes.

*Chairman.*] It is not very likely really.

Vice-Admiral *Hughes Hallett.*

1938. Surely the training by itself is no solution to this problem. To get an efficient and satisfactory service is it not necessary to support the training scheme by a career scheme which will ensure the able man gets to the top?——That is what they are doing.

1939. How are you doing it?——At the present moment—I am talking of one region—they are selecting suitable young men for training, and the Board have seconded them away for two years and are sending them round to all the different hospitals for experience.

1940. I appreciate that. What is the guarantee that the brilliant young men

get the plum appointments?——(Sir *Stephen Lycett Green.*) If I may say so, I think this is an extremely difficult question and one which causes anybody who is thinking about the future interests of the Hospital Service a great deal of concern, and it has been bothering my Association. I think the fundamental difficulty which cannot be disregarded is the fact that to run a hospital group, particularly a large size hospital group, properly you have got to have an administrative officer of considerable ability. Down below him you only need persons of not so considerable experience, and I think the weakness of the Hospital Service at the moment is that if you get the young man who is of the status and promise to fill the job you have nothing to do with him when he is in the intermediate stages. That is, I think, a weakness of the Hospital Service at the moment.

1941. Mr. Gladstone solved this problem one hundred years ago by establishing the Civil Service. Why is the Hospital Service different? Why is it not possible to have a unified service of administration with central appointing? Why is it necessary for individual Boards to make their own appointments? ——Touching that question for a moment, it seems to me that even if you had central appointment you would still not have the work for the man to do in the intermediate stages which would enable him to keep in the Hospital Service till the plums become available.

1942. Might you not have two classes like you do in the Civil Service?——I know nothing about the Civil Service, but my impression of the hospital administrative service at the moment is that you have in any group a chief administrative officer, the secretary and his deputy, and possibly in the larger hospitals a hospital secretary, who are men who require a good deal of experience and ability, and below them you need only perhaps to have "stooges".

1943. The clerical officer type?——Yes, who are not the sort of people who are going to train on into being the top class. Of course they intend to, and it may come to the time when they are the only people available.

*Chairman.*

1944. Does that in your view make it unlikely there would be a proper career structure?——At the moment, as no doubt you are aware, there is an enquiry being carried on by the Ministry of Health and they have appointed an investigator to go into the whole question.

1945. We want your views now on that, if you would be kind enough to give them?——We are trying to give our views to the investigator and it has been one of the questions we have brought up again. It is a rather fundamental one and I am not sure myself—and here I do not know to what extent I am representing the views of the Association—but I am not at all sure the solution is not to have a career structure in the Hospital Service which will be interchangeable with the local government service.

1946. Surely it is a special sort of life, the Hospital Service?——Yes, I think it is.

1947. Would it not be the greatest possible mistake to marry it to local government service?——(Mr. *Cleave Cross.*) I am against it. (Sir *Stephen Lycett Green.*) I am not saying that it should be married to it, but I say that a good man in the local government service would be able to go into the Hospital Service. Let me say that I am not prepared to elaborate this without a great deal more thought, but at the present moment it does seem to me that there is a great weakness in the Hospital Service that on its present structure it is not going to be able to stand on its own feet.

1948. It has two aspects: the training and qualification aspect and the career aspect?——You have got to bring the bright young man in who is eventually to become a capable group secretary, and that you can do by selecting him and training him. You are then going to be faced with the problem of how you are going to deal with him whilst he is going up the ladder.

Vice-Admiral *Hughes Hallett.*

1949. Any career structure must involve some system of central appointing; the two are inseparable, I think. What is the great antipathy to any form of central appointment?——First of all, may I say this is a matter which has not been considered by the Council of the Association in connection with this particular matter, so I am very much

answering the question on my own responsibility. With that proviso, I think I would say that the antipathy would be that the Management Committees would wish to feel that the man they appoint as their chief officer is a man who enjoys their confidence and who they have had a hand in appointing themselves.

*Chairman.*

1950. That seldom happens in life. The Minister does not appoint the permanent head of a department he has to work with. I should like to go into the compromises. You could have a regional advisory appointments committee for senior administrative staff on the lines of the advisory appointments committee which deals with the appointment of medical specialists—you know of that?——Yes.

1951. Why not have a Committee which sifts and selects the possibles on a regional basis?——I think I am bound to say I do not think it is a proposal which would be acceptable to the Association of H.M.C.s if it was directly put to them now, but, giving my own view, I think that that is possibly a solution which they might eventually accept provided that the appointment was one they themselves made.

1952. You would not claim, would you, that every appointment was a good one?——By no means.

1953. Surely it is desirable that there should be a certain minimum standard? ——I might put it this way, I think that the illustration you have given of a regional appointments board for consultants differs from this particular one in that there it is an appointment the region is making of its own staff because the consultants are employed by the regions and the consultant they appoint may not necessarily be employed whole-time by one group, they may share his services. I think that if there were an appointments committee possibly on which the Regional Board was represented, but which was an appointments committee of the Management Committee to select from a list, that would be a proposal which might well be more acceptable.

1954. Is it not a fact that in certain regions where relations are good the regional representative is invited to sit in when these appointments are being made to give the benefit of his advice? ——That is so. It has certainly happened in my own Committee, not in connection with chief officers but in connection with the appointment of matrons.

1955. Your Association would welcome that as an extension into every field, possibly, would they not? They are anxious for good relations with regions?——They are and are anxious also to preserve their independence.

1956. You do not preserve independence by being "touchy", but by being co-operative?——This is probably one of the matters I will have to consider when the publication of this evidence is considered. I personally would have nothing against your suggestion which, with respect, I consider is an admirable one, but, going from discussions which have taken place in our Association, I doubt whether it is acceptable with them. (Mr. *Cleave Cross.*) That is only to do with the senior posts?

1957. Yes?——There is a difference between the hospital or group secretary and a consultant, because the consultant is mainly concerned with the patients and the medical side, whereas it is very important, as far as the senior administrator is concerned, that he maintains personal contact with all staff. They are quite different from the consultants.

1958. I am aware of that, but a senior administrative staff has a very heavy financial responsibility, for example a Treasurer or a Secretary, and I am sure you agree it is essential he should have qualifications and character?——(Mr. *Till.*) That is the difference today between the two grades of staff. Your medical staff have their qualifications universally recognised, and that is not so with the other group, the secretaries and the finance officers.

1959. When you said you were in favour of my suggestion, that was a suggestion that there should be a regional appointments committee, was it?——(Sir *Stephen Lycett Green.*) No. Perhaps I should say that there should be an extension of the practice of sitting-in. I should prefer to see an Appointments Committee of the H.M.C. possibly with a very considerable representation of outside interests in order to weigh up the qualifications of the persons coming forward.

Captain *Waterhouse.*

1960. What do you mean by "outside interests"?——Mainly Regional Boards.

1961. Anything else beside the Regional Boards?——I would not like to say off-hand. It might well be there might be some ground for having in the local representative of the Institute of Hospital Administrators to give advice. That was what I had in mind. I am not saying I would necessarily on consideration press that.

Sir *Henry D'Avigdor-Goldsmid.*

1962. Would you like to follow up your suggestion there that there might be some interchange between local government officers and hospital officers? I can see your point about finance officers and presumably supply officers. Would you think that was practical with hospital secretaries as well?——As to hospital secretaries, I should say no, because I think the running of a hospital is a specialised subject. Whether it would be possible with group secretaries again, I am a bit doubtful. On the one hand, I think that a capable administrator can probably administer anything with a bit of time to grasp the problem, but I think it is better that the group secretary should know a good deal about the working of the hospital.

1963. You would be recruiting your finance officers differently from your group and hospital secretaries?——Following up my view, I think you probably should, and that is probably a weakness in my answer. (Mr. *Cleave Cross.*) You can get a finance officer from a local government whose training is equally good, but with regard to a group secretary, he must have had hospital experience. (Sir *Stephen Lycett Green.*) I think that if one were to maintain the present system in hospitals, whereby there is a compartmentalisation, if I may coin a horrible word, between the secretary side and the finance side, I think you could probably have an interchange between local government and hospital finance officers, but we are very much opposed to that system, because we feel that the whole Hospital Service should be one, and that there would be a greater change over from general finance and administration and back again than there is at the moment.

*Chairman.*

1964. Do you think that the Regional Boards should make the maximum allocation at the beginning of the financial year, as Oxford do,* or should they retain a maintenance reserve, as Manchester do.† Manchester retain a sort of pool reserve, a quite substantial one?——I only know one Region where a reserve is maintained, and, on the whole, I think that seems to work well. (Mr. *Cleave Cross.*) We have had an experience where a Region has not maintained an ample reserve, and they have got into difficulties because there are unforeseen expenses which come up during the year. (Sir *Stephen Lycett Green.*) I can endorse that.

1965. Now, coming on to the rising cost of drugs, how do you propose to deal with that, because, of course, it must be dealt with? Do you think an expenditure ceiling for drugs would be one way?——I would personally say no. I think it is the sort of form of expenditure in which it would be rather difficult or dangerous to fetter the doctors, but at the same time my view is that the way to keep it down is by constant war on the medical profession.

1966. Con you make the doctors cost-conscious by constant effort?——I find, from my own limited experience in the hospital, that every time you say that the cost of drugs has been going up in the last three months and it must come down, and you turn on your consultants, they immediately agree they turn on their house men, who are mainly the culprits. I think it is the man who is just qualified who perhaps causes difficulties.

1967. Splashes it about a bit, you mean?——Yes.

1968. Does your Association deal with things like that? Does it make recommendations to its members?——Not specifically, except in so far as this, that from time to time we pass the experiences of specific hospitals or Management Committees around.

1969. You are speaking as an individual rather than as the Chairman of the Association?——Yes. That has been my experience as a Chairman of an H.M.C., and I think it is probably the

* Evidence p. 89.
† Evidence p. 59.

experience of most of the members of the Association.

Captain *Waterhouse.*

1970. Has your Hospital Management Committee in fact any right to give instructions to the doctors that they must cut down their drugs?——(Mr. *Cleave Cross.*) No. We have no right and no authority over the doctors at all.

*Chairman.*

1971. But you are obliged to pay close attention when the estimate looks like being exceeded?——That is a problem for the individual H.M.C., nor for an Association.

Captain *Waterhouse.*

1972. I am asking you whether your Management Committee have power over doctors——(Sir *Stephen Lycett Green.*) I think we have power to say to the doctors: "We have so much money in our estimate for drugs, and we look like exceeding it, and you must cut it down". (Mr. *Cleave Cross.*) We have the power over all medical equipment. (Mr. *Till.*) I think more could be done than is done to keep doctors informed as to the amount spent month by month, to keep them cost conscious all the way through.

*Chairman.*

1973. Does your Association as a whole believe in regional purchasing schemes or joint purchasing schemes? ——On the whole, we are in favour of joint purchasing schemes.

1974. In paragraph 10 of your Memorandum headed "Suggestions for reducing total load" you say ". . . the present total load can be substantially reduced by measures designed to ensure that hospitals are used only for strict hospital functions, or that costs incurred in undertaking extraneous services, as indicated above, should be shown separately in the accounts." How are you going to ensure hospitals are used for only strict hospital functions? What had your Association got in the back of its mind there?——(Sir *Stephen Lycett Green.*) I think it is that we find that on to our costs are loaded things like attendances for private spectacles for school children, and so on, which are not really things you have to go to hospital for.

1975. Were you not meaning that steps should be taken to see individuals were not hospitalised unnecessarily?——Yes. It is very strongly our view that a lot of people come to hospital for outpatient attendances, for instance, who could be dealt with very much better in the general practitioner's surgery.

1976. How would you bring that about?——I am afraid we are in very great difficulties in providing a solution to that in view of the present trend. For instance, there is always this fear now throughout the medical profession of law suits, and I think the general practitioners very often pass on to hospitals a patient about whom they feel they ought to be on the safe side, and that they ought to have a second opinion. (Mr. *Cleave Cross.*) We have a large number of patients sent up for X-ray purely as a precautionary measure against litigation, and there are thousands of beds in the Hospital Service now utilised for old "chronic" and senile patients, and as the chairman has said we are providing spectacles and hearing aids which really is not a hospital service. (Mr. *Till.*) We have heard from a number of Committees —what can be done about it I do not know—that the practice of consultants today is not just to consult but to treat their patients, and that results in a terriffic overloading of out-patients departments and also the pharmacy department because they treat and prescribe. Instead of giving their opinion as they used to do, and send the patient off to the general practitioner to carry out the treatment, they do it in the hospitals.

1977. My final question is this. I know it is impossible to have a yardstick of the efficiency of a hospital, but, such as they are, do you favour the cost per in-patient per week as a yardstick, or the cost per case?——(Mr. *Cleave Cross.*) It is quite impossible because of the different services given by each hospital. How are you going to assess this if each hospital is giving a different service, and there is no standard of service?

1978. The Ministry of Health statistics are mainly on a weekly basis. Cost per case is sounder. Have you any views on that, comparing hospital with hospital?——There again, it is the standard of service. Can I give you one

example of what has happened in one instance. There are two hospitals giving exactly the same service, the same size, the same in every way. They have compared costs between those two hospitals to find out why there is a difference between the cost per patient, and it was found that the difference in the amount of money is as much as £150,000, the whole of that difference is because of the difficulty in one hospital of getting up to establishment with hospital staff because they are "out in the wilds". They are short-staffed, and therefore it is difficult to compare. Then some hospitals are doing the laundry for the whole of the group.

1979. Yes, but they are paid back, are they not?——No. It is all charged to that hospital per patient, and is not shared with the other hospitals in the group.

1980. Are you sure that common services undertaken by a particular hospital are all charged to that particular hospital?——Many of these group and regional services are not shared. That is a difficulty in comparing, Sir.

1981. Have you anything you would like to say to us, something you would like to bring to our notice?——(Mr. *Till.*) The point I would like to emphasise is the question about rewards for suggestions. My own view is that it is a very important thing indeed because that in itself does make the staff cost-conscious. I have proved it in hospitals where I have administered that schemes of this nature do help in reducing the cost and make for an economic running.

1982. We have had that put up. It has always been in rather vague terms. Could you give us a precise example of the scheme?——Details of something that has happened?

1983. Yes?——One case was a suggestion with regard to the question of using floor polish, and as a result of a suggestion it was reduced by over 50 per cent. in twelve months. Somebody put forward that idea.

1984. What reward did they get?——£10.

*Chairman.*] Little things like that are most interesting.

Sir *Henry D'Avigdor-Goldsmid.*

1985. Perhaps we could have a note on that?——Yes, what we have in mind?* I have not the details of it, but the Post Office have a scheme.

*Chairman.*

1986. I should like the details of a scheme installed in any hospital?——There are no schemes at the moment.

1987. Was not the floor polish scheme in a hospital?——Yes, many years ago, about 1931 I think.

1988. Is there anything else you would like to say to the Committee?——(Sir *Stephen Lycett Green.*) I think we would like to emphasise what we said in our memorandum, that we think the principal ways economies could be achieved would be by a greater standardisation of such things as uniforms and so on. We think that in individual hospitals the variation of standards does produce unnecessary expenditure. (Mr. *Till.*) It is amazing how opinion has changed in the few years of the National Health Service with regard to the question of standard uniform for nurses. It was opposed at the beginning. Now many Committees feel it is a good thing to do.

1989. Whose responsibility is that? ——As to the standardising of the uniform?

1990. Yes?——(Mr. *Cleave Cross.*) You would have to get round the General Nursing Council. They are dead against that. One thing that has not been mentioned, and that is the fuel question. There is a tremendous amount of fuel lost through inefficient boilers. It is impossible with the small allocation given to maintenance to make effective changes, but if some of the old very inefficient boilers could be replaced many hundreds of tons of fuel could be saved. There is a great deal of waste of fuel and we do feel that it would be better if capital could be ear-marked to save revenue than for starting new hospitals, or if a fair percentage of capital could be ear-marked for saving revenue, a great deal could be done.

*Chairman.*] I am sure you are right. Thank you very much.

* Not reported.

**Memorandum submitted by Dr. David Lawson, M.D., M.R.C.P., Physician Superintendent and Consultant Paediatrician, Queen Mary's Hospital for Children, Carshalton, Surrey.**

VARIATIONS IN COST BETWEEN ONE HOSPITAL AND ANOTHER, USES AND LIMITATIONS OF HOSPITAL COSTING, AND MEDICAL AND LAY ADMINISTRATION

**Variations in Cost between one Hospital and another**

1. Wide variations in cost between one hospital and another may be due to the interaction of any of the following general factors:—

(a) *Variations in the nature of the clinical work*

These may lead to justifiable variations in cost, which should be capable of analysis by or with the assistance of experienced clinicians.

(b) *Variations in the efficiency with which available funds are used*

This is, of course, well recognised, and should be under continuous study at all levels.

(c) *Variations in the intrinsic cost of maintaining at a given standard, buildings and equipment which may be anything up to* 100 *years old*

Within broad limits these differences can be analysed and should be taken into account in comparing costs. If capital were available for the hospital service in useful quantities, this would presumably be one of the major factors to be taken into account in deciding whether to rebuild, rather than to maintain an obsolete unit.

It is, however, open to question, whether sufficient attention is given to the desirability of low future maintenance costs in the design of new buildings. In particular, new buildings are almost always maintained at unnecessarily high temperatures.

(d) *Variation in the levels achieved in Staffing, Maintenance, Equipment, and in the resulting quality of the service given*

Historical factors have resulted in the monies allocated to each hospital or group leading to extremely wide variations in the standards of staffing, maintenance and equipment which the different authorities can hope to achieve. I think that it would be found on investigation that the proportion of the total hospital service estimate allocated by the Ministry to each Board and by the Boards to each hospital or group are still, nearly ten years after the inception of the Health Service, more closely related to the estimates made by each authority for the first year of the Service, than to what is required to maintain more or less equivalent standards throughout.

For the first year of the Service, some Groups made conservative estimates, some made liberal estimates, and some included large additions to the expenditure of previous authorities for the express purpose of overcoming arrears of maintenance accumulated during the war years. These differentials have been very largely carried over year to year, so that while some Groups are, for instance, able to repaint all buildings at three or five year intervals, others (for example, Queen Mary's Hospital for Children, Carshalton), are still using for clinical purposes some buildings which have not been redecorated since before 1938. Annual forecasts may be prepared by each Committee which make provision for the overcoming of accumulated arrears of maintenance over, say, a five year period, but the resulting Board allocations continue to follow very closely the allocation for the previous year, allowing for changes in the value of money. Boards and Groups which inflated their estimates in 1948-49, continue to benefit year by year at the expense of authorities which did not so do. At Queen Mary's we prepared in 1954, an estimate of arrears of maintenance dating since before the Appointed Day, which amounted to about £250,000. (Total net expenditure 1954-5 = £403,778.) (Total expenditure on works and maintenance 1954-55 = £49,872.)

The following year we presented our estimate in two parts:—

(1) Normal expenditure.

(2) One fifth of the estimated arrears (£50,000).

Any additional monies granted under (2), however, have the effect of increasing the cost per patient week as returned to the Minister, and the Board, with an eye on these returns, find it difficult to allocate useful sums. While this situation continues, each year's works budget has to be spent in such a way as to overcome the most serious arrears, while new arrears continue to accrue.

In my view, no useful comparison can be made between the costs of various hospitals until arrears of maintenance have been made up to agreed standards, or at least until new financial yardsticks have been devised which have the effect of distinguishing in costing returns between the cost of overcoming arrears, and the cost of normal maintenance. This proposal, of course, bristles with difficulties, but until it has been implemented in some way, the costing returns available to the Minister of Health will continue to be almost useless for comparative purposes.

One way of dealing with this problem would be to lay down standards of maintenance, to set a day, say 10 years ahead, by which all arrears were to be overcome, and to allocate the necessary funds year by year for this purpose to each authority outside the normal budget in respect of which annual costing returns are made.

**Uses and Limitations of Hospital Costing**

2. In attempting to analyse variations in cost within a service, it is natural to turn to normal costing procedures: these can be valuable, but there are certain reservations as to their use to which we draw attention as follows in a recent Memorandum to the South West Metropolitan Regional Hospital Board:—

> "Hospital Costing, properly applied after the considerable field research which is necessary before this can be done, has an essential part to play in the economical and efficient running of the hospital service. We have been greatly assisted in recent years at Queen Mary's by the extremely efficient subjective costing system worked out and applied by the Finance Department here."
>
> "One essential difference between hospital costing and industrial costing must, however, be borne constantly in mind. Industrial processes have as their object the production of an article, which can be defined, and even seen. The costing of many individual processes in production can therefore be drawn together in a final comprehensive costing of the article produced, which can be related to its market value, or price."
>
> "This final, and essential part of costing must, unfortunately, always be absent from hospital costing systems. For the end product is the treatment and rehabilitation of a sick person with as little disturbance of his life and personality, with as great an improvement in physical and mental health as possible, and in as little time as possible. No cash value can ever be set upon this complex, nor can comparison between good, indifferent, and bad treatment be translated into financial terms."
>
> "The costing of hospital services, therefore, must always be limited to the costing of those particular processes, or departments which are costable. Difference in cost between different hospitals or departments may prove valuable pointers to the possibility of increased efficiency. But the actual judgment of the relative value of different clinical "end products" must remain largely subjective, and in this field no financial yardstick can take the place of the subjective judgment of those who are fit to judge."
>
> While hospital costing techniques have an essential part to play there is a danger that they will be brought into disrepute with those capable of making subjective judgements, if they purport to measure the immeasurable.

**Medical and Lay Administration**

3. Current thought and discussion about Health Service administration, and in particular, the reports of the Bradbeer and Guillebaud Committee, tend to overlook the increased efficiency and therefore the greater economy of expenditure which

could be achieved by a wider use of Medical Superintendence under modern conditions. Thought on this subject is to some extent governed by prejudice which stems from experience under local authority administration before the inception of the Health Service. The somewhat authoritarian practice of Superintendents in the past in hospitals which were not provided with a full range of consultant services tends to blind people to the possibilities of achieving by this means a greater continuity of medical and other administration than is usually observed in hospitals where a lay administration is dependent upon the advice of a medical committee and its temporary chairman, none of whom have any contractual obligation in respect of administrative matters.

Putting it in another way—the fear which consultants have of being arbitrarily ruled by one of their colleagues has led the profession to acquiesce in putting an undue amount of the administrative control of the hospital into lay hands without effective day to day medical supervision or advice.

The Health Service opened up various new possibilities in this field. One was to put administrative responsibility, and with it the guidance of policy, almost exclusively into lay hands. This is the course which was generally followed. There was, however, and still is in hospitals where a Physician Superintendent is in office, another possibility. One of the factors in the past which brought Medical Superintendence into disrepute among the profession, was the concentration in the Superintendent's hands of all officer control of both medical and lay matters. This had two effects: firstly, it concentrated into one doctor's hands the possibility of excessive authoritarian control over his colleagues without adequate democratic checks or opportunities for the formal receipt of advice. Secondly, it gave the Superintendent so much detailed administrative work of a kind for which his training had not fitted him, and for which medical training was not indeed required, that he had little time and energy left for his primary job as a doctor.

With the coming of the Health Service and the appointment of lay secretaries, supplies and finance officers and more effective local committee control, it became possible for the Physician Superintendent, while retaining direction of those aspects of hospital administration which required a doctor for their efficient prosecution, and while providing a continuity of medical advice to all levels, to spend a minimum of his time on those aspects of administration which are better dealt with by lay officers.

At the same time, the development of medical advisory committees with direct access to the management committee, has both provided a formal method of consultation for the Superintendent with his colleagues and ensured that he will use it.

The job of Physician Superintendent has thus been potentially transformed. It used to carry so much detailed administrative work as to leave little time or energy for clinical medicine and was thus unattractive to doctors who wished to remain doctors. It can now be a post in which a consultant spending over three quarters of his time on clinical work, can also carry a contractual responsibility for administration which can be effectively discharged without either jeopardising his clinical career or bringing him into conflict with his colleagues.

It is along these lines that the administration of this hospital has been developed in the three and a half years that I have been here: and there is no doubt that this has enabled efficient administration to be achieved with the minimum loss of clinical working time. An administrative structure which relies too much on work *in committee* and too little *outside it*, can and does result in unnecessary and costly expenditure of time by many of the most highly-paid employees of the hospital service. Used in this way, I believe that Physician Superintendentship has yet much to offer in the economical and efficient administration of the hospital service.

**Summary**

1. The variations in cost between one hospital and another reflect the differences in the nature of the clinical work, the efficiency with which money is spent, and the cost of maintaining buildings of a widely varying nature. There are also wide variations in the standards of staffing, maintenance and equipment. Those boards

and hospitals which were generously treated in the first year of the Health Service have continued to benefit at the expense of those which made conservative estimates. These differentials should be closely studied throughout the Health Service. The overcoming of arrears of maintenance should be completed by a given date, say 10 years ahead, and the money allocated for this purpose should be regarded as outside the normal budget, and should not enter into comparative annual cost figures.

2. In designing and interpreting hospital costing procedures, it should be remembered that in the hospital service only separate processes and departments can be costed. The end product—the efficient and humane treatment of disease —cannot even be clearly defined, let alone accurately costed.

3. A reformed system of Physician Superintendentship has a valuable part to play in the efficient running of the hospital service, but there is a serious danger that for historical reasons the possibilities will be ignored.

**Examination of Witness.**

Dr. DAVID LAWSON, M.D., M.R.C.P., Physician Superintendent, Queen Mary's Hospital for Children, Carshalton, called in and examined.

*Chairman.*

1991. Dr. Lawson, thank you very much for your memorandum. What is your job?——I am Physician Superintendent of Queen Mary's Hospital for Children, Carshalton, which is a big children's hospital, of 700 beds. It is a full time job, nine-elevenths clinical and two-elevenths administrative.

1992. Have you had long experience in the Hospital Service?——I have been in the hospitals since before the appointed day. From the appointed day until 1953 I was at Great Ormond Street, since then at Queen Mary's.

1993. As to variations, you refer to variations in efficiency, which you mention as affecting costs. To what extent do they contribute towards variations in costs?——Do you mean variations in efficiency?

1994. Yes. You quote variations in the nature of clinical work. That is understandable and self-evident. Then you refer to variations in efficiency with which available funds are used?——I think that the whole structure of the administration affects its efficiency. I have not a particular point to make there. I was really leading up to the last one which I was picking out for further discussion.

1995. Which do you mean, paragraph 1 (*d*)?——Yes, the variations in staffing, maintenance and equipment, particularly works and buildings maintenance.

1996. What would you like to tell us about that?——You will appreciate, Sir, that my experience with regard to this is limited to one hospital over three and a half years, but I think that the experience I have had there has a bearing on the rest of the service. Queen Mary's had very substantial arrears of maintenance when it was taken over. We estimated them in 1954 to be about £¼ million with a maintenance budget of under £50,000. All the time, with our £50,000 or so a year on maintenance, we are struggling to catch up on arrears which go back to before the war. The result is we pick out the things which we feel are most important. The problem is that if we were given that additional £50,000 over five years to get up to date on maintenance, it would have the effect of putting up our cost per patient by £2 per week.

1997. It would result in ultimate economy, would it?——Once you have got down to a certain state of internal redecoration and all the paint is peeling off, it does not get very much worse as the years go by, and it does not cost very much more, unless you are going to paint it. I do feel that at the appointed day there was wide variation as to the sort of standards on which initial budgets were made.

1998. What we are complaining about is the inherited pattern based on the state of affairs at the appointed day?——Yes. I am clearly not here, Sir, to talk about this particular hospital, except as an example, but I do know, for instance, that whereas we have wards in clinical use which have not been repainted since before 1938, there are groups which can repaint on a five year schedule, as they

should. I think that this is something which can be looked into. The suggestion I make, and, of course, it is not a rigid solution as it stands, is that this business of arrears of maintenance should be looked at separately, and money set aside for overcoming it. The Guillebaud Committee did recommend that the Board should work out means for getting certain standards of maintenance.

1999. Where would you suggest the money should come from, from an additional grant?——I would not have any suggestion to make about that.

2000. I was wondering whether you would suggest the Regional Board kept back some of its allocation for maintenance as a special reserve for this purpose?——I would say so, yes, within the whole Health Service estimates. They should be levelled out, for purely physical maintenance, for things which would probably result in the allocating of less to those who were well up on maintenance and more to those a long way behind. One of the difficulties is the business of maintaining old buildings. If we were in Sweden, this hospital would have been pulled down a long time ago and rebuilt for economic reasons. I do not think it is sufficiently appreciated that if there is a shortage of capital to replace old buildings their maintenance costs are going to be higher, and you must accept that as long as you intend to run those old buildings.

Vice-Admiral *Hughes Hallett.*

2001. If I may ask a question on maintenance? As you are doubtless aware, in all the public services the whole question of maintenance and renewal of buildings is invariably, I think I am right in saying, run by a department quite independent of the users of the buildings at that time. You have two different financial standards and two different sets of people. In your judgment, might there be a case in the Hospital Service for spreading responsibility for maintenance and renewal of buildings from the actual Board who are adminstering the hospitals and the medical and patient side?——It had not occurred to me, Sir. I would not have thought there was a lot to be said for it, because, in fact, the question of how the money is allocated is already under the control of the Regional Board. Board approval has to be obtained for switching from one subhead to another. It is a new idea to me, Sir. I would not have thought there was a lot to be said for it.

2002. The reason I have for pursuing it is this: for example, the Foreign Secretary and the Diplomatic Service are not responsible for the maintenance of the Foreign Office, and the reason why is that it is thought that they would know nothing about it, whereas the Ministry of Works does. Surely, up to a point, the same thing applies to a Management Committee of a hospital. How do they expect to be experts in this highly technical problem?——Is it so highly technical as all that? We are considering mainly repainting of buildings and maintenance of services which are in the normal course of experience of an engineer who is on the staff. I do not think the parallel which you put is really very close to this one, because the use of the hospital is bound up more perhaps with the user. Over the last few years, I think, we have achieved a high local efficiency in the use of money through a collaboration between myself, the engineer, and the secretary, and, for example, we make sure we do not put a piece of paint anywhere where we do not want it. I presume the question means to separate it outside Group level. I would be opposed in general terms to splitting responsibility any further, I think.

*Chairman.*

2002*. We wanted to see you because of your interesting remarks about medical superintendents. We have put that to various other witnesses, and they have not exactly gulped it down. They say that the consultants would not like to be bossed about. Do you still adhere to the view that you think it has great possibilities?——I think it has.

2003. I have always thought of a medical superintendent as a general manager of a hospital?——Yes, but the position has changed rather. If I may say so, much of the opinion given to the Bradbeer and Guillebaud Committees was put by organised lay administration which has certain vested interests in what is said, and from the medical side I think there has been very little experience of how personal medical administration can run since the appointed day. There are, in fact, comparatively few medical superintendents who have been appointed since the appointed day.

2004. They were mostly local authority hospitals?——Yes. My predecessor, for instance. I had a lot of trouble in the first year—I have been there three and a half years, and now it is settling down—because my predecessor expected to control the actual clinical activities of his colleagues. There is no necessity to do that. You have a full range of consultants in full control. There is no need, either, for the superintendent any longer to be responsible for any purely lay business administration of employing non-medical staff, and with regard to finance and so forth. It is all dealt with by lay officers. That has made it possible to have a superintendent to do the job, and to combine it with clinical work without being overloaded. I am working in a single hospital group. Many of the problems the Bradbeer Committee tried themselves to solve are problems of multiple units in a single group, which very largely disappear when one is considering a single hospital.

2005. It would be up to the Hospital Management Committee to appoint a medical superintendent if it wanted to?——No. All consultants are appointed by Regional Boards direct. I am a consultant. I do not think there is any future in the medical superintendent who is not a consultant.

2006. Why not?——All the remarks made in the Bradbeer Report which discuss the difficulties of recruiting good people into those jobs I think apply, but a doctor's job, to my mind, is to be a doctor, and if he takes on a job purely administrative, he ceases to be that.

2007. You mean to keep him as a consultant?——I mean a consultant physician.

2008. You mean as a rank or as a job?——All the specialists in charge of beds in hospitals are called consultants.

2009. You are referring to it as a rank?——Yes.

2010. Rather than distinguishing it from his work?——Yes. I would say this. Many of the reasons against medical superintendents were negative, for instance, that a doctor should not waste his time on work which is not medical, and that if you put a doctor in charge of other doctors they will not like it. To my mind, they are all negative reasons. If you accept them you get into a position that, because of the fear doctors have of being arbitrarily ruled by one of themselves, they push the responsible control of hospitals into lay hands. Many lay secretaries are excellent people, but there is not any one of them who can really understand all the details of a hospital and how they work out in the way that a doctor can. Over that field, a lay secretary cannot act as a fully responsible officer. He has got to have advice. If he has someone appointed, and that man has a contractual responsibility to give that advice on an administrative level, the Committee and the hospital are going to be better served than if the secretary is either subject to the chap who pushes hardest on the medical staff (and he is not in a position to judge the clinical issues) or his medical advice is in the hands of a Chairman of a Medical Advisory Committee, the Committees which have very useful functions to perform, but the Chairman of an Advisory Committee is acting as such rather than acting as a responsible individual for the functions I have outlined.

2011. Would your medical superintendent be able to give orders to the secretary?——This is the sort of a question which always arises when you try and put the structure down on paper, but we have a very smoothly working organisation which has been built up in the last three years, and where the superintendent, the matron, the secretary and the engineer are all directly responsible to the Committee.

2012. I agree that is ideal, but it depends on personality, does it not—it depends on the people having enough sense and judgment and temperament to work together?——Yes.

2013. Surely, you have got to lay down some order of seniority and some order of precedence, have you not? I again ask you whether the medical superintendent is in a position to give orders to the secretary?——I think that is a structural difficulty which one would run up against in trying to put this down on paper.

2014. But you have got to put it down on paper. What is your answer to my question?——I would be very sad to have to put it on paper. I would not like in my present set-up for it to be put on paper. As far as the various sections of

the hospital are concerned, the secretary, who happens to be finance officer and supply officer, is responsible for all his departments, the matron is responsible for nursing domestic staff, linen and so forth, the engineer is responsible for all works, and I am responsible to the Committee for all medical and ancillary staff.

2015. There must be someone who has the senior rank?——I take the Chair at the officers' conferences which we have at regular intervals, and that position is accepted rather better perhaps than it would be if put on paper.

2016. Would it be true to say that the medical superintendent is primarily answerable to the Hospital Management Committee, but that the secretary is more or less expected to fall in with his wishes? Is that how it is?——They do not conflict. We are covering different fields.

2017. If you want to get the hospital service to accept that theory, you would, of course, have to make the powers and functions of medical superintendents absolutely crystal clear?——It is almost impossible to do. I think perhaps it could best be done in a single hospital group. I think the medical superintendents should be in charge as far as anybody is. I do not think the question of his giving orders to lay secretaries would arise. I think the position has been achieved that I am regarded as in charge really. Of course, I took over from a predecessor who was.

2018. I am delighted to hear that there is somewhere where personal relations are happy, but if you want to sell the idea, it has got to be watertight, has it not?——Yes.

Vice-Admiral *Hughes Hallett.*] I cannot understand what this fear is of somebody administering, that somebody is in charge. After all, there is always a top man in every organisation.

*Chairman.*

2019. To put it rather crudely, if there are twins, one of them is senior, is it not?——Yes. I do not think it matters very much. Do you mean as between a lay and a medical person, or as between medical people?

Vice-Admiral *Hughes Hallett.*

2020. In any organisation, I should have thought it essential to have an absolutely clear chain of command, and for everyone to be aware who the Chairman is, for example. I cannot see what the objection to that is from your point of view?——You mean as to accepting the medical superintendent?

2021. Yes?——It is a historical one. It may be difficult unless you have been in this to realise the strength of this feeling. It is the history of hospitals in which the superintendent was top dog, and did things without asking anybody. To come down to personalities, my predecessor did not even believe in having a medical advisory committee at all, and said that he could run the hospital. I think that I have gradually achieved the confidence of my colleagues.

Sir *Henry D'Avigdor-Goldsmid.*

2022. The secretary does the work of the finance and supply officers as well, so is it not right to say that the medical superintendent does the work the secretary would probably be doing——?——I do not do any of the detailed work of communication with the Board with regard to minutes and carrying out instructions of minutes, and so forth, but, in fact, I have a fairly effective hand on the tiller over all the departments, and it works.

Vice-Admiral *Hughes Hallett.*

2023. What I would like to ask, if I may, is this, which perhaps is rather a leading question. How many doctors are there who like you have the necessary flair for the administrative side to run things efficiently?——It is not a question perhaps which I can be expected to answer, Sir, but I do not think there will be many, until some such function is an accepted function. To some extent I am taking over something from the past, but in other ways it is a bit of a pioneer job. I think that so long as medical administration is under the cloud, it is at the moment, young men are going to have no incentive to acquire experience in, or to develop a flair for, administration. That is one of the main reasons against Bradbeer's suggestion that administration should be in the hands of changing Chairmen of Committees, which means that he must take it in turn, and all the members of a hospital staff will not be good at it.

2024. You are saying that the lack of cost-consciousness is a direct result of

the divorce between administrative responsibility and professional advice at the present?——I would say so. I was listening to the previous evidence on drugs. It is difficult for a lay Committee to make a decision, and tell doctors to do something about a professional matter. To take a specific instance, when I came in, £600 was being spent on vitamin preparations, and I had a look at those, and I thought that it was a hangover from the days of the war when they were being given at that time to make up for the possible dietary inadequacies. I went into it, and it was being given by ward sisters without prescriptions. This never went to the Committee. With my colleagues I said "If nobody has any objection, I am going to issue a circular to the junior medical staff saying that no vitamins are to be issued without prescription". As a result of that, we cut that bill from £600 to £150. If you were to bring that up to a lay Committee and start talking about it, you have annoyed people before you have started.

*Chairman.*

2025. Why "annoy" them?——Because doctors do not like to be told to do things by laymen.

2026. What do you think about Bradbeer's suggestion that a medical administrator should be responsible to a Medical Staff Committee? I do not think much of it myself?——May I put it this way, Sir? If I were offered the Chairmanship of our Medical Advisory Committee, I would refuse it, because I have a personal contractual responsibility to the Board for medical administration. I discuss everything with the Committee. I do not try to run the place without them, but if there has been a conflict I may have had to say "You go on, but I am bound to say it is not my view when it comes up." If I were Chairman of an Advisory Committee as well as holding a contractual job, I could not do both things.

2027. May I sum up your views so far? Do you think there is a case that can be made for a medical superintendent on the grounds that it will produce greater efficiency and hence economy, because a doctor is more easily dealt with by doctors than by a secretary?——Partly on the personal level, partly because he is someone who is at the centre who understands every process that is going on in the hospital.

2028. Does he have certain lay non-medical responsibility?——No.

2029. The secretary will do the "donkey work," with regard to the supply side?——Yes. In fact, if we take a concrete example, when I first came, there were these arrears of maintenance, and we went round in three months, the secretary, the maintenance engineer and myself, and we assessed the state of maintenance, and we arrived at the rough figure I said of £¼ million.

2030. How many beds did you say you have?——700. That figure for maintenance was about five times our normal maintenance budget. I organised that, and the working out of the information was done by all of us together in the officers conference, with myself in the chair. We presented a joint report.

2031. You have put some very interesting ideas into our heads. I would ask you, before you can sell the idea, must it not be put forward with the tiers of responsibility clearly defined, even though you are a nice happy organisation?——We are not entirely nice and happy. We do have our problems.

Captain *Waterhouse.*

2032. Do you say this change would lead to direct economies, or a general increase in efficiency?——I think increase in efficiency rather than actual economy. I will give you an example where it leads to economy. With regard to drugs, I keep an eye on the drugs with the pharmacist.

*Chairman.*

2033. Do you know of the passage in Guillebaud where they say there is a danger of the Health Service being bogged down in Committees?——I think there is a lot which can be done out of Committees, in other ways. They say that the doctors should not waste time on administration. In one session which I do—I work in another hospital where there is a superintendent, but he does not function according to my views—the doctors, the consultant staff waste far more time in so-called administration than we do. There is far more consultant time wasted on something which is called administration than there is in our hospital.

*Chairman.*] Thank you very much.

TUESDAY, 16TH APRIL, 1957.

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Members present:

Mr. Nicholson, in the Chair.

Mrs. Hill. | Mr. Robinson.

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**Extracts from a Memorandum submitted by the Board of Governors of Guy's Hospital.**

(1) A BRIEF DESCRIPTION OF GUY'S BOARD

**Board of Governors—Constitution.**

29 Members plus the Chairman.

Chairman. The Right Hon. Lord Cunliffe.

Company Director.

Lord Cunliffe has been a Governor of Guy's Hospital since 1932, was Chairman of the old Court of Governors before the introduction of the National Health Service Act and has been Chairman of the Board of Governors since the inception of the National Health Service.

Vice-Chairman: Mr. E. G. Slesinger, O.B.E., M.S., F.R.C.S., B.Sc.

Consulting Surgeon.

Mr. Slesinger was, up to a short time ago, an active member of the consultant surgical staff. He retired from the active staff owing to the age limit.

The remaining 28 members of the Board consist of:—

9 members who have been or still are members of the clinical staff of the Hospital or the teaching staff of the Medical and Dental Schools.

1 general medical practitioner and consultant.

1 housewife, who is also S.R.N. and S.C.M.

1 member of the teaching staff of another hospital.

2 chartered accountants (one is also Chairman of an H.M.C.)

2 solicitors.

1 actuary and general manager of an insurance company.

1 member of a prominent insurance broking firm and member of Lloyds.

1 manager and director of a brewery.

1 trade union secretary.

1 general dental practitioner.

1 retired general manager of a gas company.

1 partner in a prominent firm of surveyors and estate agents.

2 retired regular army officers (one is a member of the Kent County Council; one is a landowner in Hereford).

1 barrister

1 member—a director of a publishing firm issuing technical journals.

1 member with mixed business interests. Company Director and he is also Chairman of the South-East Metropolitan Regional Hospital Board.

2. DUTIES AND QUALIFICATIONS OF ADMINISTRATIVE STAFF—GRADE "E" AND UPWARDS

| | | |
|---|---|---|
| **Counting House:** | | |
| 1. Secretary and Finance Officer. | Clerk to the Governors | Chartered Accountant. Fellow of the Institute of Hospital Administrators. |
| 1. Deputy Secretary ... | Assistant Clerk to the Governors. | B.A. Fellow of the Institute of Hospital Administrators. |
| 1. Deputy Finance Officer | Accountant ... ... | Associate of the Association of Certified and Corporate Accountants. Associate of Institute of Hospital Administrators. |
| 1. Grade "G" ... ... | Senior Accountancy Assistant. | Associate of Institute of Hospital Administrators. |
| 1. ,, "F" ... ... | Accountancy Assistant | No qualifications. |
| 1. ,, "F" ... ... | Administrative Assistant. | No qualifications. |
| 1. ,, "E" ... ... | Administrative Assistant. | B.A. (Lond.). |
| 1. ,, "E" ... ... | Accounting Machine Supervisor. | — |
| 1. ,, "E" ... ... | Accounts Clerk ... | (Endowment). |
| 1. ,, "E" ... ... | Senior Secretary ... | — |
| 1. ,, "E" ... ... | Accountancy Assistant | — |
| **Central Stores:** | | |
| 1. Grade "G" ... ... | Administrative Assistant (Supplies). | Fellow of Institute of Bookkeepers. Member of Purchasing Officers' Association. |
| 1. ,, "E" ... ... | Storekeeper and Deputy Administrative Assistant (Supplies). | — |
| **Superintendent's Office:** | | |
| 1. Assistant to the Superintendent. | — | — |
| 1. Grade "F" ... ... | Secretary to Superintendent. | — |
| **Evelina Hospital:** | | |
| 1. Hospital Secretary—0–5. | — | Associate of the Institute of Hospital Administrators. |

(3) A BRIEF DESCRIPTION OF GUY'S HOSPITAL AND OF THE TYPES OF PATIENTS ADMITTED

Guy's Hospital, founded in the early part of the 18th Century, is a general hospital with an under-graduate teaching school. In addition, it has an exceptionally large dental hospital within the curtilage which is used for dental under-graduate teaching. It is a general hospital covering all types of work and has, in addition, 45 beds for psychological cases. It consists of four main blocks of buildings containing beds as follows:—

Guy's House—Built in 1722 containing surgical beds and theatres, surgical X-ray, administration, etc.

Hunt's House—Built in the 1850's containing medical beds.

Nuffield House—Private patient block. Built in 1935. Accommodation—70 beds in single rooms and four-bed cubicles.

York Clinic—The psychological unit built in 1940. Accommodation—45 beds in single rooms and three-bed cubicles.

Connection between these blocks, which are some distance apart and occupy a site of approximately nine acres, is by underground subway, or at ground level by going into the open.

In addition there are separate blocks for out-patients connected physically with the medical block; psychological medicine (approximately 100 yards outside the general curtilage); physiotherapy, laundry and boiler house; works department, stores, maids' home; two main nurses' homes and nursing accommodation in three other separate buildings on the site, with a large nurses' home at a distance in Earl's Court. With the attached Children's Hospital, the total bed complement is 815 (this includes half of the bed complement of the joint Guy's/Maudsley Neurosurgical Unit, which is situated at the Maudsley Hospital and contains 30 beds). The buildings of the Medical School occupy the same site and in most instances are physically attached to the hospital buildings. With regard to the dental department, the accommodation occupied solely for teaching purposes by the Dental School is in the same building as the hospital department.

In brief, the hospital has grown piecemeal from its foundation in 1725, the original building still constituting a major part of the accommodation and the layout is without any planned basis.

(4) A DESCRIPTION OF THE METHODS BY WHICH GUY'S HOSPITAL IMPLEMENT THEIR FINANCIAL RESPONSIBILITIES, WITH SPECIAL REFERENCE TO STEPS TAKEN TO ENSURE MAXIMUM ECONOMY IN SPENDING THE MONEY ALLOCATED TO THEM. IN PARTICULAR, THE CONTROL OF EXPENDITURE ON DRUGS, DRESSINGS AND APPLIANCES, AND STEPS TAKEN TO MAKE ALL LEVELS OF STAFF "COST CONSCIOUS".

Control over expenditure is exercised as follows:—

(i) By monthly returns to the Finance Committee comparing actual expenditure with loaded proportions of the year's budget.

(ii) A Building and Plant Maintenance Committee has monthly returns of expenditure under this head, controls the amount of work put out to contract and the work carried out by the permanent maintenance staff. Monthly returns of staff employed compared with an approved establishment are also submitted.

(iii) The Diet and Catering Committee has regular returns on the cost of feeding, including the cost per head of raw materials, cost of kitchen and dining room staff and comparison of total expenditure with the budget allocation.

(iv) A detailed record of the authorised establishment of the hospital staff is kept and the clerk responsible maintains running comparisons with the pay roll.

(v) The House Committee is the body primarily responsible for approving proposed additional expenditure. Items involving recurring annual expenditure or single items of expenditure of a non-recurring nature of over £100 are all referred to the Finance Committee and, subsequently, to the Board, the Finance Committee only to report on whether or not finance is available. All orders for goods or services costing more than £100 must be signed by the Clerk to the Governors or his Deputy.

(vi) With regard to medical staff salaries there are, periodically, meetings of a sub-committee to consider the number of appointments and the number of sessions for which contracts have been granted.

(vii) With regard to expenditure on drugs, dressings and appliances the Medical Advisory Committee states which expensive drugs such as antibiotics should only be supplied when the prescription is authorised by a consultant. Proprietary medicines are, in the main, not issued. The Medical Advisory Committee have prepared a list of proprietary medicines which can be substituted in the dispensary by the dispenser's own compounded substitute. This

is done even if the proprietary medicine is ordered by name. Detailed records of the costs of drugs purchased are kept in ledger form, i.e. an account for each drug. These record quantity purchased and cost: substantial variations are reported by the Pharmacist. Requests for the purchase of Surgical Instruments have to be approved by the Director of Surgery and the Superintendent.

Other steps taken to control expenditure and make the staff "cost conscious" are:—

(*a*) Matron calls Sisters' attention to any marked increase of expenditure with which they are concerned at her regular meetings with all Sisters.

(*b*) The Staff Side of the Joint Consultative Staffs Committee are told of the budget position and asked for suggestions for economies.

(*c*) The Medical Advisory Committee are informed of increased costs of individual items and on occasion asked to place their requests in order of priority or asked to say what is essential as distinct from desirable.

(*d*) Spot checks and comparisons and analyses of items of expenditure are made if trends are for increased cost or increased consumption.

(*e*) A cross analysis of expenditure under departmental heads has been maintained for many years.

(5) A Statement of the Total Amounts of Improvement and Development Money made available to Guy's Board and a description of Major Improvements authorised for Guy's Hospital in recent years, with an indication of the extra expenditure incurred.

During the years 1953-54, 1954-55 and 1955-56 the Ministry of Health's maintenance allocation to the Board has, on each occasion, been less than the Board's estimate of maintaining the service at approximately the same level as the preceding year so that any estimate for major developments and improvements has been severely restricted (see attached schedule). The Board's main pre-occupation during this period has been the erection of the new building which is the first instalment of the complete rebuilding of the hospital and which will accommodate the surgical wards, theatres, casualty department and departmental floor. In view of this imminent major scheme no plans have been made for any other large scale developments at Guy's and, in fact, the only development of any magnitude during the last four years has been the setting up of the joint Neurosurgical Unit in conjunction with the Bethlem Royal and Maudsley Board of Governors. The full cost of the Guy's-Maudsley Neurosurgical Unit was first felt in 1953-54, the cost being approximately £20,000 a year, which is half of the total cost of running the unit, the balance being borne by the Bethlem and Maudsley Board. The current cost of this unit to Guy's is approximately £27,000.

There are, of course, continuous minor changes and developments in a hospital of this size and these have been included in the normal maintenance expenditure in the years in question. Among their number are the following items:—

| | *Annual Expenditure* £ s. d. |
|---|---|
| *1953-54:* | |
| Operation of a non-resident staff canteen (a credit to this sum is received by way of payments for meals) ... | 2,560 0 0 |
| Appointment of a consultant in Encephalography ... | 622 0 0 |
| Appointment of a second consultant Radiologist ... ... | 1,922 0 0 |
| Appointment of a second senior registrar in the Dental Department (this was intended to be a training post for a consultant in Orthodontics) ... ... ... ... | 550 0 0 |
| Appointment of a second middle grade registrar in the X-Ray Department ... ... ... ... ... ... | 775 0 0 |

| | *Annual Expenditure* £ s. d. |
|---|---|
| *1954-55 :* | |
| Introduction of new system of medical records (unit system) and attendant improvements in out-patient reception arrangements ... ... ... ... ... ... ... | 1,400 0 0 |
| Appointment of a second consultant Neurosurgeon for the Neurosurgical Unit ... ... ... ... ... ... | 907 0 0 |
| Appointment of Psychologist and Psychiatric Social Worker | 1,200 0 0 |
| Appointment of additional radiographer and part-time secretary in Radiotherapy Department ... ... ... | 475 0 0 |
| Appointment of additional clerk in Radiotherapy Department to meet Minister's demand for increased statistical information and also the cost of additional work done by the department ... ... ... ... ... ... ... | 350 0 0 |
| Appointment of Grade F clerk in Accounts Office to meet Ministry demands for increased financial details and statistical information ... ... ... ... ... | 750 0 0 |
| Appointment of additional nursing staff in maternity ward to meet criticisms of Central Midwives Board ... | 440 0 0 |
| *1955-56 .* | |
| Appointment of additional clerical staff to meet demands of Ministry for inventory keeping, establishment control, further financial statistical data for budget purposes and returns to Ministry of Labour *re* disabled persons ... | 2,500 0 0 |
| Conversion of part-time to whole-time registrarship in anaesthetics ... ... ... ... ... ... ... | 600 0 0 |
| £ s. d. | |
| Appointment of consultant dental radiologist 975 0 0<br>and dental radiological registrar ... ... 550 0 0 | 1,525 0 0 |
| Appointment of additional clerical help in medical records | 350 0 0 |
| Appointment of additional nursing staff ... ... ... | 3,080 0 0 |
| Appointment of Metabolic Dietitian ... ... ... | 465 0 0 |

It will be noted that despite increases in staff mentioned above, the total staff numbers as shown in the summary have decreased largely due to reductions under the heading of maintenance staff.

With regard to capital works the cost of these involved no major recurring maintenance expenditure during the three years in question, apart from the acquisition of additional nurses' accommodation which was opened early in 1955-56, the annual running cost being in the region of £8,500.

| Year | Board's Forecast Estimate (net) i.e. Expenditure less Direct Credits | Ministry Allocation | Revised Estimate | Actual Expenditure | Specific Amount asked for Developments and Improvements | Amount specifically allocated for Developments and Improvements |
|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ | £ |
| 1953/54 ... | 1,311,940 | 1,169,400 | 1,245,000 | 1,247,672 | 16,050 | Nil |
| 1954/55 ... | 1,294,265 | 1,246,000 | 1,270,463 | 1,272,836 | Nil | Nil |
| 1955/56 ... | 1,317,510 | 1,296,000 | 1,357,000 | 1,365,487 | Nil | Nil |

(6) An Explanation of the Significant Reductions in Expenditure by Guy's Board in Recent Years.

The only significant reduction in expenditure made by the Board during the past three years has been under the heading of " Maintenance of Buildings and Plant ". For practical purposes this expenditure covers both the cost of Works Department salaries and expenditure on work carried out by contract labour as well as the cost of maintenance materials. Total expenditure in 1953-54 was £116,000, in 1954-55 it was reduced to £114,000 and in 1955-56 it was further reduced to £106,000. Taking into account the general rise in wages and in cost of materials over these years this represents a considerable reduction.

This reduction made at the request of the Ministry is arbitrary and is against the long term interest of the hospital. The hospital is in an area in which there is considerable industrial activity and on one side is London Bridge Station. The fall-out of soot and dirt is heavy and the state of decoration of the hospital, both internal and external, leaves much to be desired. By deferring work of this nature which has no immediate adverse effect upon the service rendered by the hospital, the more important maintenance work has been continued, but the long term effect of economies of this type can only result in a state of affairs deplorable in a hospital.

A minor reduction in expenditure was achieved on bedding and linen following the introduction of a central linen exchange service, since surplus stocks withdrawn from individual wards have helped to reduce the size of replacement orders for these items on the centralized system.

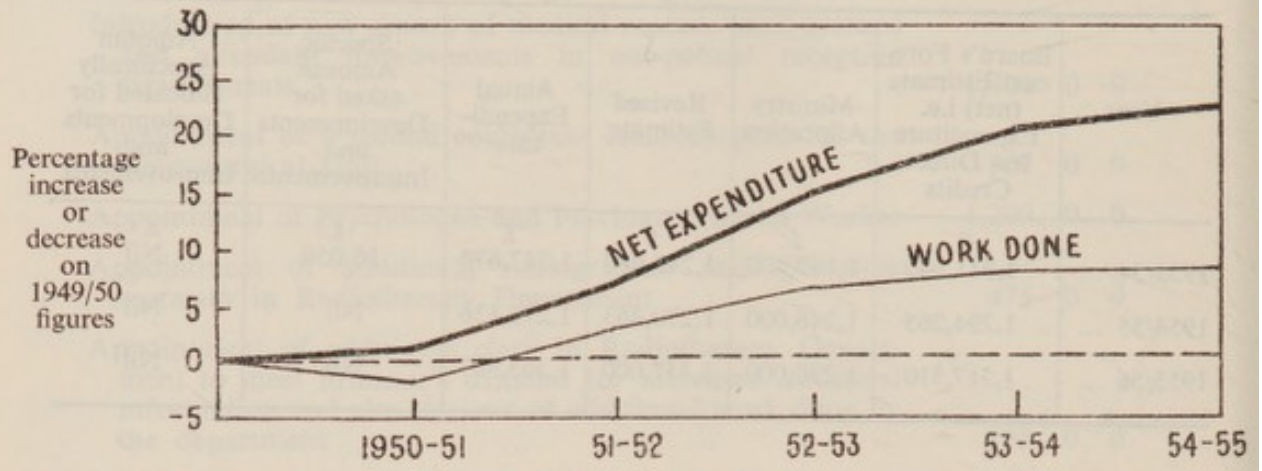
Although not strictly a reduction in expenditure, it should be noted that the amount of work carried out by the hospital is, in general, increasing, while there has been little, if any, increase in cost in terms of real value since 1949. The attached graphs which appeared in the Hospital's Financial Report for 1954-55, and anticipated somewhat similar general conclusions in the report by Professor Titmuss and Mr. Brian Abel Smith prepared for Mr. Guillebaud's Committee, give an indication of the real cost of the hospital in relation to the amount of work which it performs and the falling purchasing power of the pound from 1949 to 1955.

In brief, although expenditure in terms of pounds sterling has not shown a reduction over the years in question, a greater amount of work is being performed in terms of number of in-patients treated, number of out-patient attendances and the number of examinations and investigations performed for approximately the same cost in terms of real value.

## WORK DONE, COST and INFLATION

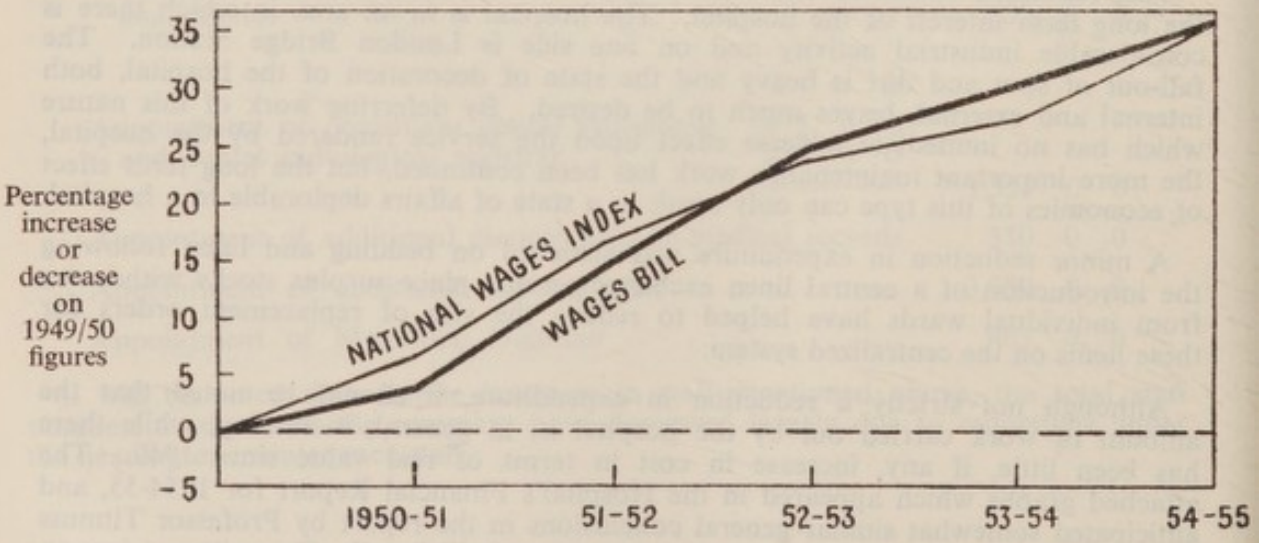
1949–1955

Diagram I




This diagram compares the NET EXPENDITURE of the Hospital since 1949 with the amount of WORK DONE for the same period.

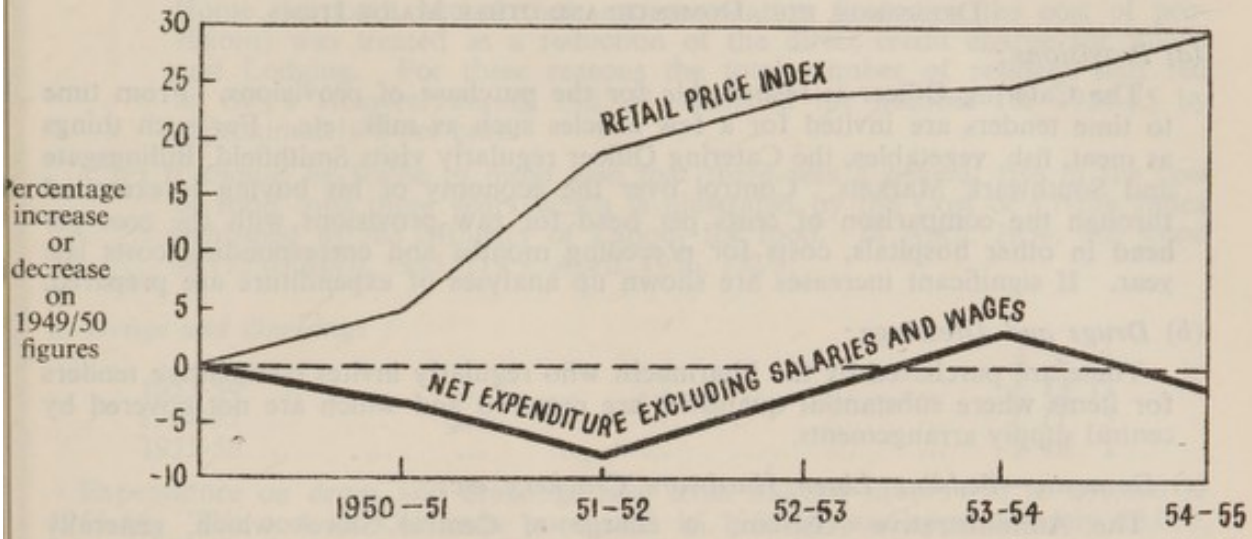
Diagram II




Since salaries and wages account for so large a proportion of the Hospital's expenditure this diagram shows how the Hospital's WAGES BILL has increased since 1949, and against it is traced the rise in the National wages rates as shown by the Ministry of Labour WAGES INDEX.

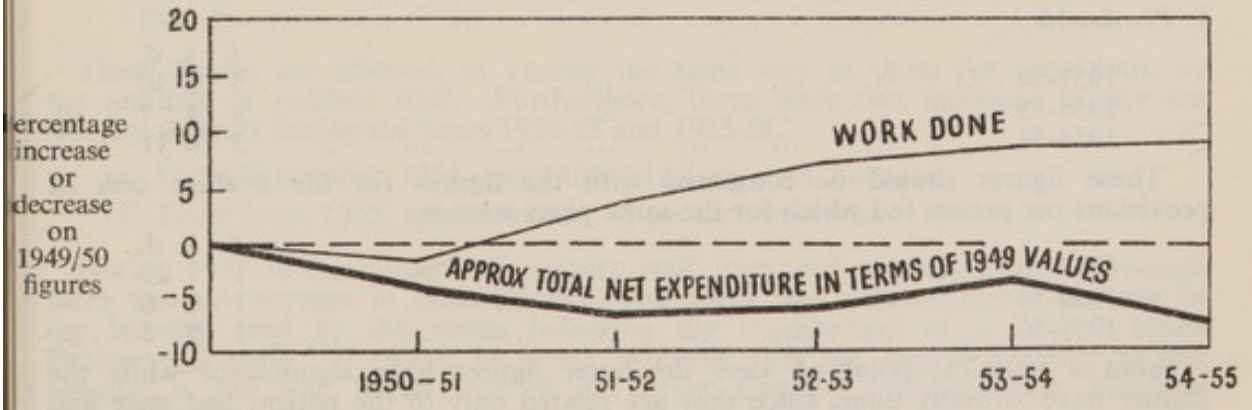
(It should be remembered that the increase in the Hospital's salaries and wages bill covers increased numbers of staff as well as increased rates of pay. The Ministry of Labour wages index relates of course, only to increased rates of pay.)

iagram III




AFTER EXCLUDING EXPENDITURE ON SALARIES AND WAGES the remaining cost is less in 1954/55 than in 1949/50. This figure includes expenditure on provisions, coal, electricity, stores, etc., and is in marked contrast to the rise in the price of these items as shown by the RETAIL PRICES INDEX.

agram IV




The three preceding diagrams have shown expenditure which has been progressively increased by inflation. This diagram avoids the distorting effect of inflation and shows the approximate NET COST IN TERMS OF 1949 VALUES of running the Hospital from 1949 to 1955 compared with the WORK DONE.

(8) A Description of Guy's Purchasing Arrangements for Provisions, Drugs, Dressings, etc., Domestic and other Major Items.

(*a*) *Provisions:*

The Catering Officer is responsible for the purchase of provisions. From time to time tenders are invited for a few articles such as milk, etc. For such things as meat, fish, vegetables, the Catering Officer regularly visits Smithfield, Billingsgate and Southwark Markets. Control over the economy of his buying is exercised through the comparison of costs per head for raw provisions with the cost per head in other hospitals, costs for preceding months and corresponding costs last year. If significant increases are shown up analyses of expenditure are prepared.

(*b*) *Drugs and Dressings:*

These are purchased by the Pharmacist who regularly invites competitive tenders for items where substantial quantities are required and which are not covered by central supply arrangements.

(*c*) *Domestic—Bedding, Linen, Hardware, Crockery, etc.:*

The Administrative Assistant in charge of Central Stores which, generally speaking, includes all stores except drugs, dressings and food, is responsible for obtaining tenders or competitive quotations. So far as possible the unit of purchase is that at which it is thought the most economical price will be obtained.

(*d*) *Maintenance—Buildings and Plant:*

Normally, for any work that has to be carried out by an outside contractor, the Building and Plant Maintenance Committee call on the Chief Engineer and Clerk of Works to obtain three or four competitive tenders, and these are submitted to the Committee.

(9) An Explanation of the Significant Rises or Falls in Hospital Running Costs indicated by the Costing Returns for Guy's Hospital in Recent Years.

The following variations in the figures of the Ministry of Health costing returns for Guy's Hospital call for comment:—

1. *Provisions:*

| | £ | s. | d. |
|---|---|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | 3 | 2 | 10 |
| 1954-55 ... ... ... ... ... ... ... ... | 3 | 4 | 7 |
| 1955-56 ... ... ... ... ... ... ... ... | 3 | 10 | 11 |

These figures should be compared with the figures for the average cost of provisions per person fed which for the same years were—

| | £ | s. | d. |
|---|---|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | 1 | 7 | 10 |
| 1954-55 ... ... ... ... ... ... ... ... | 1 | 8 | 6 |
| 1955-56 ... ... ... ... ... ... ... ... | 1 | 9 | 5 |

From a practical point of view the latter figures have significance while the former have virtually none, since they are related only to the patient bed state and take no account of the relative numbers of resident or non-resident staff and the total number of meals taken or persons fed. The reason why the cost for provisions per patient week has risen disproportionately to the cost of provisions per person fed are

(*a*) Between 1954 and 1956 the number of nursing staff increased so that increased numbers of resident staff were fed.

(*b*) A new Nurses' Home was opened in 1955, to which a number of nurses, formerly resident in a Nurses' Home belonging to the Bermondsey and Southwark Group Management Committee, were transferred. Under the approved accounting procedure the cost of food consumed at the new Nurses' Home is now included in the cost of provisions per patient week,

whereas when the nurses were accommodated at the New Cross Nurses' Home the total cost of their accommodation (including the cost of provisions) was treated as a reduction of the direct credit charge for Board and Lodging. For these reasons the total number of resident staff fed at Guy's Hospital during 1955-56 exceeded the number for 1954-55 by approximately 8 per cent.

(*c*) It should be borne in mind also that there was a general rise in the cost of food over these years which is illustrated by the Cost of Living Index published by the Ministry of Labour for food. In April, 1954, this stood at 112·6, April, 1955, 119·9, April, 1956, 132·9.

2. *Drugs and Dressings :*

| | £ | s. | d. |
|---|---|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | 1 | 13 | 11 |
| 1954-55 ... ... ... ... ... ... ... ... | 1 | 11 | 3 |
| 1955-56 ... ... ... ... ... ... ... ... | 1 | 16 | 1 |

Expenditure on drugs and dressings rose from £51,000 in 1954-55 to £58,000 in 1955-56. The cost of Cortisone purchased in 1955-56 was approximately £8,000. In 1954-55 Cortisone was not fully available and such supplies as there were were received free under Ministry of Health Supply. There was no apparent compensatory reduction in the prescribing of other drugs.

3. *Laundry :*

| | s. | d. |
|---|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | | 10 |
| 1954-55 ... ... ... ... ... ... ... ... | | 11 |
| 1955-56 ... ... ... ... ... ... ... ... | 11 | 4 |

Owing to an accounting procedural change the cost of laundry wages was removed in 1955-56 from the heading of "Wages" and transferred to the heading of "Laundry". These figures should, therefore, be considered in conjunction with the figures for Laundry under "Standing Charges". Combined they read as follows:—

| | s. | d. |
|---|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | 8 | 2 |
| 1954-55 ... ... ... ... ... ... ... ... | 8 | 6 |
| 1955-56 ... ... ... ... ... ... ... ... | 11 | 4 |

These figures are affected, in exactly the same way as those for provisions, by the number of resident staff. Furthermore, there were two increases in pay for laundry workers during the years 1954-55 and 1955-56.

(*a*) From September, 1954, approximately 4 per cent. increase.

(*b*) From June, 1955, approximately 7½ per cent. increase.

During 1955-56 recruitment of laundry staff improved to some extent (although there was no increase in establishment) and there was a considerable increase in the laundry used by the wards following the introduction of a Central Linen Exchange Scheme. It should be noted, however, that the cost of Laundry at this hospital is still well below that of any other London Undergraduate Teaching Hospital, i.e., for 1955-56—

| | s. | d. | | £ | s. | d. |
|---|---|---|---|---|---|---|
| Guys ... ... ... | 11 | 4 | St. Thomas's ... ... | 1 | 7 | 1 |
| | | | St. George's ... ... | 1 | 3 | 8 |
| | | | King's ... ... ... | 1 | 2 | 5 |
| | | | Westminster ... ... | | 19 | 10 |
| | | | St. Mary's ... ... | | 19 | 0 |
| | | | Charing Cross ... ... | | 16 | 0 |
| | | | Middlesex ... ... | | 15 | 4 |
| | | | St. Bartholomew's ... | | 15 | 2 |
| | | | London ... ... | | 14 | 9 |
| | | | Royal Free ... ... | | 13 | 9 |

4. *Nursing Staff :*

| | £ s. d. |
|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | 6 9 10 |
| 1954-55 ... ... ... ... ... ... ... ... | 6 12 9 |
| 1955-56 ... ... ... ... ... ... ... ... | 7 10 7 |

A part of this increase in cost of nursing staff is due to salary increases including the award of "equal pay" increases to female nursing staff from the 1st July, 1955, and to the general increase in pay which had effect from the 1st December, 1954. In addition the actual number of nursing staff on the pay roll of the hospital was much closer to the approved establishment than it had been in previous years, so that the "saving" arising from a "below establishment" nursing staff was eliminated, and a small number of additional appointments were authorised by the Ministry of Health.

5. *Fuel, Light, Power and Water :*

| | £ s. d. |
|---|---|
| 1953-54 ... ... ... ... ... ... ... ... | 2 3 11 |
| 1954-55 ... ... ... ... ... ... ... ... | 2 8 4 |
| 1955-56 ... ... ... ... ... ... ... ... | 2 14 8 |

The bulk of the expenditure on Fuel, Light, Power and Water is accounted for by the purchase of coal, the cost of which amounted to approximately £55,000 in 1955-56, out of a total expenditure on Fuel, Light and Power of £93,000. The cost of coal has risen consistently although consumption has varied. In 1953-54 the average price per ton was 95s. 6d., in 1954-55 this increased to 98s. 6d., and in 1955-56 it rose to £5 12s. 10d. per ton. Total consumption of coal in 1953-54 was approximately 9,350 tons, 1954-55 10,350 tons and in 1955-56 9,850 tons.

New water tube boilers were installed some years ago and difficulty with these has been experienced so that at times Lancashire Boilers have also had to be kept under steam thus increasing coal consumption disproportionately.

Although not contributing to so great an extent to the total cost of Fuel, Light, Power and Water, it should be noted that gas has risen from 1s. 2d. per therm in April, 1953, to 1s. 5¼d. per therm in 1956. The cost of electricity rose very slightly between April, 1953 and April, 1955, but following a new agreement with the London Electricity Board a more advantageous rate was subsequently obtained.

6. *Maintenance of Building Plant and Grounds :*

| | £ s. d. |
|---|---|
| 1953-1954 ... ... ... ... ... ... ... | 1 13 5 |
| 1954-1955 ... ... ... ... ... ... ... | 1 8 3 |
| 1955-1956 ... ... ... ... ... ... ... | 1 4 11 |

The steady reduction in expenditure under this heading must be considered in conjunction with expenditure on salaries under the heading of "Works Maintenance" giving the following comparison :—

| | £ s. d. |
|---|---|
| 1953-1954 ... ... ... ... ... ... ... | 3 10 11 |
| 1954-1955 ... ... ... ... ... ... ... | 3 9 4 |
| 1955-1956 ... ... ... ... ... ... ... | 3 5 6 |

This reduction as mentioned earlier has not been achieved because there is less maintenance work to be done, but because work has been left undone in order to meet Ministry of Health budget requirements. This reduction in terms of £ s. d. is emphasised when note is taken of the increase in building costs between April, 1953 and March, 1956. According to the trade index there has been a rise in costs of approximately 11 per cent. over this period.

(10) COMMENTS ON THE CURRENT OPERATION OF THE HOSPITAL SERVICE, TOGETHER WITH SUGGESTIONS FOR ACHIEVING GREATER EFFICIENCY OR ECONOMY CONSIDERED POSSIBLE.

One major difficulty is the inability to carry forward grants for capital expenditure or building maintenance. The Hospital needs far more work doing to it than can be done with the grants available. There is a natural and understandable desire not to lose any part of a grant available with the result that, on occasions, work is carried out that would normally not be given first priority. The reasons for this may be that the work to which priority would be given would cost more than the amount still available or unearmarked in the year or, in the case of equipment, owing to uncertainties of delivery the risk is not taken of committing the following year's budget allocation and at the same time leaving un-used part of the current year's grant.

The auditors and the Ministry are inclined to press the checking of stocks, inventories etc., and the institution of additional cross checks to the point where the administrative cost far exceeds any possible saving from avoided losses. In fact, few losses are avoided: all the checking does is confirm in some detail that losses have been incurred.

The rigidity of the scales of wages and the classification of the job, and so the rate of payment, prevent the granting of reward to the exceptionally good employee, be he cook or engineer. The good employee leaves the service and two are needed to replace him or, in some cases, the loss of a good employee leads to less efficient handling of stores and so more waste.

It may be that too many hospitals are being upgraded to provide for the acutely sick. A two or three tier classification would reduce costs, e.g., in Guy's Hospital at present there are approximately 40 cases for whom we can do nothing more. They are now occupying beds that could more usefully be used for the treatment of the acutely ill, so utilising to the full the expensive diagnostic facilities available at Guy's.

There is no limit to the advances that might be made in medical science, to the trend for increasing but narrowing specialisation, or to the development of more and more complex aids to diagnosis. In our opinion there is little that can be done to save expenditure without curtailing the service and only a decision at the highest level restricting the development of the service will prevent continual expansion.

**Examination of Witnesses.**

The Rt. Hon. the Lord CUNLIFFE, Chairman of the Board (attending by permission of the House of Lords), Mr. E. G. SLESINGER, O.B.E., M.S., F.R.C.S., B.Sc., Vice-Chairman of the Board and Chairman of the Finance Committee, and Mr. B. LEES READ, O.B.E., A.C.A., F.H.A., Clerk to the Governors, Board of Governors of Guy's Hospital, called in and examined.

*Chairman.*

2044. Lord Cunliffe, you are aware no doubt that this is the first teaching hospital that has given evidence to us; I hope you will be patient with our ignorance. As far as I am concerned, I want, first of all, to ask a question as to the main difference between the way a teaching hospital runs a hospital and the way a non-teaching hospital runs a hospital. My curiosity is based, of course upon the fact that the costs of teaching hospitals are markedly above the cost of non-teaching hospitals. I was wondering whether you would explain the main reason why the fact you are a teaching hospital meant your cost was so much higher?——(Lord *Cunliffe.*) May I ask you a question back? You had evidence from the Teaching Hospitals Association, I believe——

2035. Yes?—— —which does set out a good many reasons for that. I do not know whether I have a copy here, because I helped compile that, and that does set out a good many of the reasons.

2036. What do you yourself feel is the main reason?——You have got a very much higher standard, and a very much higher staffing.

2037. None of the cost of the teaching is directly charged to the cost of the hospital, is it?——Registrars' salaries are, or part of them, if not the whole—in many cases the whole, and some part, and registrars do a good deal of the teaching.

2038. It is not apportioned at all?——It has been, but I do not think there is any legal liability to apportion it.

Mr. *Robinson.*

2039. In the case of part-time consultants are teaching sessions always carefully distinguished from the clinical sessions?——No, there is no distinction at all.

2040. In fact, as to the part-time consultants the Health Service is bearing the cost of teaching?——In a teaching hospital, yes. If a part-time consultant is also working for a Regional Hospital Board his sessions are paid by the Regional Hospital Board when he is not working in the teaching hospital.

2041. If I may just repeat the question: in so far as your consultants engage in both teaching and clinical work within Guy's Hospital there is no distinction as between the types of session, and the whole cost of the consultant is borne by the Health Service? ——Yes, but it would be very difficult—I think Mr. Slesinger can answer this better than I—to define what part of his session was purely clinical and what part teaching.

2042. I would think it is impossible? ——(Mr. *Slesinger.*) A session in a teaching hospital usually goes on a good deal longer than the statutory period of the session. If you are seeing out-patients, for instance, very often it will go on longer, but in the very nature of things in everything a consultant is doing in the hospital he will have students round him, every time he operates, every time he sees a patient.

2043. The length of the session will largely depend on the consultant?——In a teaching hospital it is difficult for him to do anything else but go on, because he has students.

*Chairman.*

2044. You are completely autonomous financially, save that you are under the Ministry of Health?——(Lord *Cunliffe.*) We are responsible to the Minister in the same way as a regional hospital board is.

2045. Is a comparison made by you, or by the Ministry, between your costs and the costs of other teaching hospitals? ——Yes, we have the annual statistics which we examine, and if we have any marked discrepancies we probably ring up the other teaching hospitals and try to sort out what really has happened.

2046. That is up to you. Does the Ministry of Health enquire of you, for example, why your costs were greater than another teaching hospital?——We had an enquiry initiated by the Ministry of Health last year on a question of fuel and power. They compared us with the Newcastle hospital, and I think —I have not the exact figure here—the difference started at over £1 16s. 1d. and it finished, by the time they had made all the adjustments, at about four or five shillings. That, I think, could have been adjusted still further.

2047. Have you any idea why the costs of London teaching hospitals so greatly exceed those of provincial teaching hospitals?——I think again it is a question of standard, and very often, if you take the Newcastle comparison, the cost of fuel and that sort of thing is very much higher.

2048. The difference is considerable: the cost per in-patient per week in the year ended 31st March, 1956, in the London teaching hospitals is £27 3s. 8d., and for the provinces it is £21 11s. 2d. That is a very big difference, is it not? ——(Mr. *Read.*) I think throughout the whole scale of expenditure London costs are greater. All rates of wages and salaries are subject to London weighting, that is one item, wages covering all manual workers, building trades, clerical, administrative, and so forth. We undoubtedly pay higher prices in London for such things as electricity and coal than we would in most provincial centres. Our rating and other assessments are usually higher. I think every one of the London teaching hospitals has its school within its own curtilage, so there is a combination of activities. Birmingham, with which I am familiar, Manchester, with which I am familiar, have medical school buildings in the grounds

of the university, and students only go to the hospital for their clinical instruction. We have a combination of things.

2049. So London teaching hospitals have a much greater housing and lodging expense thrown on them?——They get those as well, yes.

2050. Why does that fall on hospital accounts and not on teaching accounts? ——There is no distinguishing the two functions. I think the question was as to lodging, I am not quite clear?

2051. Accommodation?——Accommodation of staff?

2052. I meant of the students?——I am sorry, I did not say we accommodated the students, but the school departments, laboratories and so forth, are all in the grounds of the hospital. We share a great many common services. To take the grounds of the hospital, we pay for the entire cost of the upkeep of grounds.

Mr. *Robinson.*

2053. The point you are trying to make is that because all the teaching services are carried on within the immediate curtilage of the hospital in London that does involve the London teaching hospitals in additional cost, which is not relevant to the provincial teaching hospitals which you mentioned? ——Yes.

*Chairman.*

2054. Would you say in your opinion that the standard of a London teaching hospital is higher than the standard of a provincial one?——I am not commenting on the professional standard, but on the standard of staffing, and standard of service provided to the patient; my answer would be yes, very definitely.

2055. What costs of Guy's are not included in these figures?——Are you referring to what we might spend under our endowment funds?

2056. No, I was not. What I am trying to find out is this: does the hospital bear the full cost of all the teaching? ——No.

2057. What is left out?——It bears some part of the cost, but not the full cost.

2058. How is the full cost accounted for?——The remainder of the cost comes in a grant to the medical school through the University Medical Grants Committee.

2059. Do you use that grant up to the full and charge the balance on the hospital?——(Lord *Cunliffe.*) No, the school is a separate legal entity and the grant is made by the University Grants Committee to the school. They pay for their professors and whole-time people, part-time professors too, and the staff actually in the school, but the point is that if you have a teaching hospital your actual work in the wards and in the hospital itself is more expensive. For example, take one fairly simple case. If somebody comes in with a twisted ankle or something like that, the consultant who sees him will say, "I do not think there is anything much wrong with this man, but we will take an X-ray just to prove I am right". That means perhaps an X-ray which need not otherwise have been made. You get the same thing with pathological examinations. They will say "My diagnosis is so and so. To prove or disprove that we will take these tests". He can then show it to his students and say, "My reason for giving that diagnosis was so and so. I take these tests to show you that by examining these other things they are probably unnecessary". All that, of course, puts the cost up.

2060. Getting back to what you said before, that if you had a strictly theoretically perfect allocation of costs there would be something charged to the teaching part, which is at present borne by the hospital, I am not suggesting it should be done, if you were doing it theoretically the hospital do bear some of the consultants' salaries?——There is no doubt about that.

2061. I meant the teaching part should be responsible for some?——(Mr. *Slesinger.*) It is laid down in the Act that part of the duty of a teaching hospital is to provide facilities for education of medical students, and part of the facilities are the bedside teaching. All the teaching done in the way of lectures and demonstrations, that type of work, is done in the school and is paid for by the school in the form of lecture fees, and so on. It is merely the clinical side where the patient has to be seen and treated which is the hospital side, and

it is part of the duty of the Board under the Act to provide—I am not quite sure of the wording—but I think it is to provide facilities for clinical teaching. It is laid down in the Act.

Mr. *Robinson.*

2062. A question on the nursing side which has always rather puzzled me. Why is the ratio of nurses per patient so much higher in the case of the teaching hospital, and why is the establishment proportionately higher? I understand you can get your establishment filled very much more easily than a non-teaching hospital: why is the establishment so markedly more generous in the case of a teaching hospital as compared with a non-teaching but nurse-training hospital?——(Lord *Cunliffe*). There, I think, the answer is that if you are going to teach the young doctor you want to show him the very best that can be done with nursing. The unfortunate non-teaching hospital, which cannot always get the staff, cannot give the same standard of nursing that the teaching hospital is able to give.

2063. But the ordinary non-nurse-training non-teaching hospital does not have even the same establishment, even if it is fortunate enough to be able to recruit up to establishment—the ratio of nursing is below that of a teaching hospital?——That is another point. If I may put it this way. In a non-teaching hospital nurses are not worried by the doctors so much. (Mr. *Slesinger.*) Every time students examine a patient always a nurse has to be present, obviously, especially with female patients, which means a lot of work. If I might say one other thing, all qualified medical men originally come from a teaching hospital. You must, if you are training people, set the very highest possible standard, because you know quite well when they leave the tendency is for the standard slightly to decline even with the best people, and, unless you teach them the very acme of what ought to be done, you are never going to get a good profession by and large. Therefore, you must set everything in a teaching hospital at the highest possible standard.

2064. I can see that, but would you not agree it may not be a good thing to teach students, the majority of whom may be going to a non-teaching hospital, to expect a ratio of nursing far higher than they would ever get in their future career?——You want to show them the ideal, surely. To take a simple example, the surgeon in the teaching hospital will religiously wash his hands for a very long time before operating in order to impress his students. He knows quite well he is overdoing it, but unless he does they are going to cut it and it will gradually slip. Do you see my point?

2065. I see yours; I hope you see mine, that is all?——(Mr. *Read.*) Another point which we might not have made clear. We may have as many as two or even three teaching rounds in a ward at one time, rounds where the consultant is examining patients and commenting on them, teaching his students as he goes round, and he must have a nurse in attendance in every one of the rounds—that is in addition to the nurses attending to the needs of the patient in the ordinary way. That is the main factor in the heavy ratio of nurses, the constant flow of nurses needed to attend on the medical man.

2066. Would you not say that in any hospital when the consultant does his rounds he is always attended by nurses? ——But the time taken is infinitely longer when he is teaching, of course.

*Chairman.*

2067. Do you select your patients to some extent? If it is an uninteresting casualty would you pass it on to a cheaper hospital?——(Lord *Cunliffe.*) It is not so easy with a casualty. They just arrive and it is not easy to pass them on, but, by and large, the difference between a teaching hospital and a non-teaching hospital is that the non-teaching has to allocate its beds in accordance with the incidence of disease, whereas the teaching hospital has to do it in accordance with the needs of teaching. You may get a thing like tonsils and adenoids, of which there are literally thousands but they are not of very much value for teaching. (Mr. *Read.*) We have to maintain a balance of a variety of cases to ensure we have suitable material for undergraduate teaching. It is more a process of selection from the waiting lists, that is where we do the selection.

Mr. *Robinson.*

2068. Are you finding it difficult to get the quantity of the type of material you need for teaching purposes?——(Lord *Cunliffe.*) It is not as good as it was.

2069. Have you any arrangements with a regional board hospital for the supply of the type of material you want?——We have an arrangement with a regional hospital board, but not for supply of material. (Mr. *Slesinger.*) It is really our out-patient material that is affected, not in-patients. The other point is that like most other teaching hospitals every big teaching hospital tends to get the bad cases. For instance, we have, I suppose, the finest cardiac clinic in the world and we get an enormous number of heart cases, and so in other departments. That again means large nursing staff.

*Chairman.*

2070. Changing the subject, when you are teaching are efforts made to make your students cost-conscious? If so, how do you do that?——(Lord *Cunliffe.*) Mr. Slesinger tells me we have notices as to costs of the various things, X-ray and X-ray departments, and that sort of thing, and, of course, with regard to the consultants themselves I think that probably it was easier in the old voluntary hospitals because they had not the money before and there was nowhere for it to come from unless they begged for it, and if the begging was not successful they did not get it. I do not think we have the same difficulty in getting our consultants cost-conscious, and they pass it on to students. I was talking to one consultant a year or two ago, and he told me he was experimenting with a new drug and had given it up fairly quickly because it was very expensive as he did not want his students to get into the way of using it because of its cost. That is an example.

2071. Is it more or less haphazard, or is it definitely part of your syllabus that students should be made cost-conscious and that the economic side of the Health Service must always be present in their minds?——It is the sort of thing which I think it is no good putting in a syllabus; you must have a periodical drive. If you put it in a syllabus it tends to get rather forgotten. What we do on the question of drugs, for instance, is that if any particular drugs go up in price and the quantity consumed is getting greater the pharmacist brings that to the attention of the superintendent and we then find that the best way of dealing with that particular drug, or whatever it may be, is to say it may only be ordered or prescribed on the signature of a consultant. You get sometimes quite simple things. I remember one case we had in connection with liquid paraffin, and we found it was rather a fashionable thing and house officers said, "Use liquid paraffin, it won't do any harm anyhow". That was one case where we were able to cut down consumption very considerably.

2072. Are you under pressure from the Ministry of Health to make students cost-conscious?——I do not think so. (Mr. *Slesinger.*) No, I do not really think it is possible to make a student cost-conscious. They are much too busy learning medicine to get through their examinations.

2073. You are bringing them up in an atmosphere that "The best is good enough for us"?——The best is good enough for the patient is the attitude we take.

2074. Surely it would be appropriate if students were told that the whole Health Service will break down unless it is administered with the greatest reasonable economy? I am only suggesting that teaching hospitals have a very heavy responsibility for the whole future of the Health Service, and I wonder if they are aware of it?——I think they are. You asked about the attitude of the Ministry. The attitude of the Ministry to us is illustrated by a rather curious attitude. They are always telling us that we must cut down costs but we must not curtail any service to the patient, which is always a very difficult feat to accomplish because everything in a hospital is a service to the patient. I do not know if you are thinking particularly about prescribing?

2075. I am not only thinking of prescribing, that is very important I know. I was thinking of what you said, that if you put it in the syllabus it tends to be forgotten, which is rather an alarming statement to make I thought

for anybody administering a syllabus, as the future cost depends almost entirely on the people you are turning out now. If they do not see the bearing the economics of the Health Service has on its future, I think you are missing a chance? ——With great respect, I do not think it is quite true to say it depends only on the doctor. The costs of a hospital are very largely due to various salaries and wages which are fixed irrespective of us by Whitley Councils and national agreements, and so on, and we have no say in it.

2076. The variables very largely depend on the doctors?——(Mr. *Read.*) Salaries and wages are about 60 per cent.; the remaining one third includes all standing charges, heating, lighting, Gas Board, telephone, contribution in lieu of rates, etc. You have about 10 per cent. of total expenditure which can be regarded as controlled. (Mr. *Slesinger.*) About 10 per cent. of the total cost of the hospital is really under our control.

2077. It is substantial, even that?—— It is substantial. One would think one would be able to control it all; it is only a small part.

2078. It does go further than that, because with regard to staffing although the rates of wages are not comparable the number of staff is partly influenced by the medical profession?——(Mr. *Read.*) But again the numbers of staff are controlled by the returns of the Ministry of Health.

Mr. *Robinson.*

2079. On the question of drugs, which is the one field in which the doctor can exercise either reasonable economy or gross extravagance, probably without very much difference to the service to the patient in the end, I was really wondering at what point in a doctor's career is it brought home to him that he cannot just prescribe the first drug that comes into his mind quite regardless of cost, and that there is a responsibility on him and on his colleagues collectively to see that the drug bill under his control (of course it is under nobody else's control) is kept within reasonable bounds?——(Mr. *Slesinger.*) I think that is pressed all the time. We at Guy's have gone even further than that. We have a committee which went into various drugs being prescribed by various people, mostly proprietary drugs which were being prescribed, and we arranged with our dispenser—and the students know of this—that if so-and-so is ordered the equivalent which is quite cheap is produced by the dispenser.

2080. That is automatic, is it?—— That is automatic, and at the same time the Medical Committee gets a report every two months of new and expensive preparations, the amounts ordered, the costs, and if anything comes up suddenly high every one draws their house officer's and registrar's attention to this and says, "Look, this cannot go on."

*Chairman.*

2081. You would agree, would you not, although it is outside the scope of this enquiry, that the attitude of the medical profession not in the Hospital Service contributes a great deal to the economy or wastefulness of the Health Service as a whole?——Yes, I think it does. I think, if I may digress, it would be much easier if there were not so many advertisements for patent medicines and if the public were not so patent medicine conscious so that they almost browbeat the doctor to prescribe something. It is the most difficult thing in the world to see a patient and refuse to give him anything nowadays.

2082. You cannot expect a doctor to do so unless it is drilled into him when he is training that he should economise? ——I think it is drilled into them daily that it is very seldom necessary to give them a so-called "bottle of medicine".

2083. You have come some way since your first answers?——No, I have not. I said it was not in the syllabus in the teaching of students, but the principle is part of the teaching in that treatment is largely a matter, apart from surgery, of the type of life the person leads, the environment and general surroundings, rather than actual drugs.

2084. You would say every man who qualifies from Guys is fully seized of the importance of the greatest economy in prescription and in other ways?——Yes. I would not have said it was stressed because of the economy. It is stressed because of the needlessness of most prescribing, which is rather different.

2085. I was hoping you were going to say that the need for saving the nation's money is certainly not forgotten, but is very important?——I think the doctor's primary duty is to do the best possible thing he can for his patient. If he thinks it essential to give a patient any particular drug I do not think he ought to consider what it costs. I think what he ought to do is to avoid giving anything which is both useless and unnecessary, but, if it is necessary, I do not think he should be asked to consider what it costs.

Mr. *Robinson.*

2086. You would agree, would you, that in the days before the National Health Service precisely that freedom to prescribe anything in the patient's interest did exist?—Where?

2087. In the teaching hospitals or other hospitals?——In a teaching hospital certainly.

2088. That the doctors before the Health Service had the same freedom to prescribe any drug however expensive to any number of patients——?——Yes. (Mr. *Read.*) Subject to what Mr. Slesinger has always said, that an expensive item will go back to the Medical Committee, and we then have the control from the dispenser. That was applicable before the days of the Health Service ; we are continuing something we did before.

*Chairman*

2089. You do not think there is a danger of the young medical practitioners thinking that the resources at their disposal are more or less limitless, and that they miss the point that they must make the best use of limited resources?——(Mr. *Slesinger.*) Financial resources?

2090. Yes?——No, I do not think they feel that. They are mostly taxpayers, and I think they are just as anxious to see economy as anybody else.

Mrs. *Hill.*

2091. I think it has been suggested to us—certainly I have heard it said—that young doctors are not as conscious of the cost of drugs as they might be, and that it would be a good thing if they became so conscious. One does not mind them prescribing an expensive drug provided they do not over-prescribe, and that, is it not, is one of the factors?——That is true, and that is why, as I said myself, in many cases we only allow certain things to be prescribed over the signature of the consultant, which means a young doctor has to go and get that signed for by his consultant, who will probably say to him, as I have often done in the past, "There is not the slightest reason to do that. Why on earth are you doing it?", and one gives him a dressing down and he is not likely to do it again.

Mr. *Robinson.*

2092. On the question of nurses, Guy's, almost alone of all the hospitals in Great Britain, appears to have slightly more nurses than patients.* I would like to know how you have reached that ratio. What controls are exercised over the nursing establishment? Is it merely that if the matron decides she wants more nurses the Board of Governors says "All right"? To what extent do you control the matron, and to what extent does the Ministry of Health control you over the nursing establishment? ——(Mr. *Read.*) Is this a reference to the statistics we sent you?

2093. Yes?——I think in the covering letter I pointed out that the figure is counted to a certain date, and that date was after fifty intake had come in.

2094. Shall we say, then, you have roughly the same number of patients and nurses, which I think is a higher ratio than in most hospitals in the country?——I did not know it was higher. (Lord *Cunliffe.*) There are one or two reasons for that. The question of the establishment is gone into very thoroughly probably three or four times a year. The Nursing Committee has only recently just had one. We have a schedule showing the exact number of nurses, sisters, staff nurses, nursing in training in each ward and department of the hospital, and that goes to the Nursing Committee. If we want an additional nurse above our establishment we have to make our case to the Minister, and he will either agree or not. I think that answers part of your question. As regards the staffing, the department which has the highest ratio actually per patient is the maternity ward, and I do

* Not reported.

not feel that is quite fair because, in fact, we only count the mother and child as one patient.

2095. The same statistical anomaly applies to all other hospitals in maternity departments?——The other one is that we have the York Clinic, a psychiatric clinic, and there the staff is frightfully high.

2096. Nursing staff?——Yes. There you may have one patient who has to be "specialled", in other words he has to have a nurse attending to him every hour, which means three nurses for one patient.

*Chairman.*

2097. How many nurses are there at the York clinic?——There are 44 beds, I think—it is 43, and one part-time.

2098. I make it that you have 634 patients and 791 nurses, less the 50. I do not think we need argue about details. I think you will accept you are highly staffed with nurses?——(Mr. *Read.*) Yes.

2099. We might have a note on it perhaps; we do not want to pursue it too far?——There are also, I think a number of other factors affecting our total number of nursing staff in relation to number of patients. We have trained nurses in radiography and physiotherapy; we have a big dental hospital with nurses in attendance, purely out-patients; we have the ordinary out-patient department, which also has nurses; we have also co-operated with Regional Hospital Board to supply nurses to T.B. sanatoria.

Mr. *Robinson.*

2100. How many have you got at the sanatoria at any one time?——At any one time about 30; we are staffing 50 beds in T.B. sanatoria. We have a number of nurses out on attachment in mental hospitals. The ratio of nurses to beds is a very bloated figure, unless one takes into account the number required in out-patient and dental departments, and the fact you are making a speciality of training people in radiography—the superintendent radiographer, for example, is a trained nurse and radiographer, and she counts as a nurse.

2101. I was making a comparison with the other teaching hospitals where, I think you will agree, the same sort of considerations would apply, and even at teaching hospital level I think you are well staffed?——I do not think so. Taking the dental, there is not a dental hospital in the country as big as the one we have.

Mrs. *Hill.*

2102. With regard to your physiotherapy, have you any counted besides those who are nurses as well?——There are physiotherapists without nursing qualifications, but we have physiotherapists with qualifications of nursing in charge.

2103. Are you a physiotherapy training school?——We are a physiotherapy training school as well as a radiography training school.

*Chairman.*

2104. On the question of financial control, do you think the system of basing allocations to Boards on an inherited financial pattern is too rigid? I was wondering if you did not rather perpetuate variations in standard and costs; I thought it might facilitate expansion but not contraction. Would you rather tend to say, "What I have I hold"?——(Lord *Cunliffe*: I think perhaps by now after ten years probably the historical side is tending rather to disappear.

2105. Do you feel you would be greatly helped by the new costing system?——When it is going properly I think we may be, but it is going to be several years before they are truly comparable. We have actually been carrying out a very similar costing system for five or six years I think. (Mr. *Read.*) We started it during the war, and it was abandoned through lack of staff and it has been running since the war ended. Our departmental costing is similar to that advocated by the Minister. We have been doing it.

2106. What opportunity do you have of comparing costs department by department with other teaching hospitals?——We have done major comparisons. My deputy spent some time at Glasgow Infirmary and we compared the two hospitals side by side,. I took two teaching hospitals in another instance and we got down to analysing administrative and clerical staff compared with our own.

2107. London teaching hospitals?——Yes. It takes weeks to compare one item of administrative and clerical staff because two different names are given to officers, and there are different subdivisions of different officers duties with different names.

2108. This was done off your own bat?——Yes, off our own bat.

2109. You are not inspired by the Ministry of Health?——No, we did it for our own satisfaction to check where we were going.

2110. The efficient running of the Hospital Service depends on the zeal and initiative and imagination of the people involved?——I think so. Any activity is dependent on that.

2111. You do not feel it would be beneficial if the Ministry of Health took a larger part in it?——(Lord *Cunliffe.*) Do you think the Ministry are going to show any more initiative than the individuals involved in the actual management of the hospitals.

2112. I do not know. I have the impression—you may correct me if I am wrong—that you are really almost completely autonomous, that you happen now to have able people on your Board and that you get the right sort of people, that it is rather a tenuous line of support for efficiency that you should be so autonomous?——I am afraid I would not agree with you there. I think you have got more chance of initiative provided you are not tied down too much centrally.

2113. I am not saying you should be tied down centrally. I should like to see more friendly intervention and not interference by the Ministry of Health? ——(Mr. *Read.*) There is nothing to prevent them doing that. We would welcome any suggestions they may put forward, provided they are sensible.

2114. Do you find it difficult to get the right people to join your Board? ——(Lord *Cunliffe.*) It is getting increasingly difficult. Of course, the appointments are made by the Minister and we do not always know who is coming on or what their reasons are for coming on, or what reasons the Minister has for appointing them. It is, as I say, getting increasingly difficult. I think through high taxation people cannot afford to give so much time, particularly the younger people.

2115. You are consulted when people are appointed to the Board, are you? ——Officially the only people not consulted about appointments are the teaching hospitals.

2116. Unofficially you personally are? ——I have been, and I have not always been.

Mr. *Robinson.*

2117. Is it different from the procedure with the Regional Board whereby a Regional Board is entitled to nominate people as suggestions to the Minister—we know the Minister is not obliged to accept them, and frequently does not do so?——In the Act we do not have to be consulted. The Regional Board and many Committees do, but not teaching hospitals.

*Chairman.*

2118. They may be wished on you? ——(Mr. *Slesinger.*) And have been in the past without any apparent qualifications.

Mr. *Robinson.*

2119. I was going to say what do you think the qualifications are?——I think it is very important that a Board of Governors of a teaching hospital should have on it people of the various types of experience needed in the various activities. I mean you need legal experience, you need purchasing experience, you need labour experience, you need various types of individual, and although we have got a fairly good cross-section we have got one or two people who do not seem to have anything to contribute.

2120. You are suggesting that the members of the Boards of Governors should, so to speak, duplicate the activities of the paid officers, surely, which is rather implicit in the first half of your reply? You have, in fact, a finance officer, a supply officer, or officers responsible for these things. You are not suggesting that you want the members of the Boards to duplicate those departments?——No, but I do not think that members of the Board with particular experience can check that particular side of the hospital.

2121. Do you not think it is desirable you should have members of the Board who represent the patient?——Yes, I do. (Lord *Cunliffe.*) I am not quite sure who does represent the patient. We are all human and are all subject to illnesses.

2122. I was thinking of the person Mr. Slesinger was indicating who did not appear to have any qualification. I should have thought the claim of such a person might be that he was representative of a typical patient and might have a contribution to make. (Mr. *Slesinger.*) That was not the type of person I had in mind. I know what you had in mind.

2123. Consumer interest?——We had one representative on our Board who I think represented what you have in mind and who was not reappointed by the Minister, and, in spite of the fact we put him up again with a great deal of pressure behind it, he still was not reappointed, and we have co-opted him on to one of our Committees and he is a very valuable member.

*Chairman.*

2124. A man of common sense and experience?——He is a man of common sense and experience. I think, if I may say so, at that time, his political outlook upset somebody and he was put off the Board, but, as I say, he was a most valuable member. We still find him so, and have co-opted him on to our House Committee.

2125. What do you feel about the proportion of medical representation on the Board?——I think it is a bit high. (Lord *Cunliffe.*) Before the war we had no active consultant on the Board of Guy's and we found we got our liaison in other ways, which was just as satisfactory.

2126. You have ten now?——(Mr. *Slesinger.*) I am not there as a medical. I am appointed on the principle that a retired poacher makes a good gamekeeper!

Mr. *Robinson.*

2127. You would count amongst Guillebaud's 25 per cent?——I originally was on the nomination of the Medical Committee, and then when I retired I was reappointed on the nomination of the Minister. I happen to have medical qualifications.

Mrs. *Hill.*

2128. Is there any age limit which the Minister exercises on reappointments?——(Lord *Cunliffe.*) Officially—no; actually, I think there is.

*Chairman.*

2129. It would be true to sum up this part of your evidence by saying you are apprehensive that it may not be possible to maintatin your high standard?——I am very apprehensive about it.

2130. Do you think there should be more interlocking with membership of other Boards or Regional Boards?——No, I think we have quite enough liaison with Regional Board.

2131. You would not interlock with members of other teaching Boards, would you?——No; we have the Teaching Hospitals Association and they consult together and you get your general liaison. I do not think you would get any particular value by having them on your Board.

Mr. *Robinson.*

2132. I believe you, Lord Cunliffe, are on Regional Board are you?——Yes, the South Eastern.

2133. Perhaps this is rather an invidious question to put to you, but I was going to ask you whether you thought that in general the existing liaison between Regional Board and teaching hospital was of any value at all?——Oh, yes, I think it is quite definitely.

2134. I was wondering what other nominees there are from the Regional Board on your Board of Governors—you have got three or four, have you?——Five.

2135. As Regional Board nominees they are themselves members of Regional Board?——They are all, but need not be.

2136. You think it does work?——Mr. Julian is very useful liaison, Colonel Newey is very good, too, and if you get the right people you do not want very many—two or three will do it. One of the troubles, I think, with this very big nominated representation is that it is very difficult to get the right sort

of general experience on the Board. If we have to take not more than one-fifth from university, not more than one-fifth from Regional Board, not more than one-fifth from medical staff it does not leave a great deal to play about with for the general management of the hospital. We have got not more than three-fifths who are wished on us.

*Chairman.*

2137. You have been extended now as Chairman?——Yes.

2138. For three years?——Yes.

2139. Were you nominated by the Minister or elected by the Board?——Nominated.

2140. Nominated as Chairman?——Yes.

2141. You were on the Board before?——Yes.

2142. Are many of the members of the Board nominated out of the people who have had no previous experience of hospitals?——We have had it, yes. There are only two-fifths, and we have had one or two people nominated who do not seem to know very much about hospitals.

2143. If they are good men of business it does not matter, does it?——They have not always been always that. I do not mind a person who knows nothing about hospitals. It is when they appear to have no particular qualifications of any sort. In the old days when we appointed our own Board we naturally put on people who had not previous experience of hospitals because if we could get them young we hoped to train them up.

Mr. *Robinson.*

2144. There is a point in all our lives when we have had no experience of hospitals?——In the old days when people went on to the board of a teaching hospital they probably had not got any experience. We had a very much larger Board then of between 60 and 70, of which 30 did the work, which is what does it now. You could choose one or two and discard the rest if you found they were not very good. Now you cannot.

*Chairman.*

2145. I want to go back to the question of financial control. Do you undertake new expenditure more or less on your own, or out of savings that may involve recurrent additional expenditure in subsequent years?——Yes. When we have any new expenditure that is divided up into two bits, the capital and running.

2146. Do you not often find yourself developing a service although the Minister has not allocated money for it, a service which will entail future commitments?——I think we find that more often on Regional Board than we do at Guy's.

2147. Why?——Because there is so much more development to be done.

2148. In fact development is not one of your major problems?——We have got a major problem now as it happens over development, and we do get problems, but the main costs of the development, as we have explained, are in wages, and if it is a development which does not increase your staff, it may only increase the facilities the staff have got to operate, the additional running costs are not as high as they would be in a Regional Board.

Mr. *Robinson.*

2149. A question about free moneys. Are you particularly well-endowed with free moneys?——Yes.

2150. To what extent do you use it, for example, to supplement staff salaries and wages?——We are not allowed to.

Mrs. *Hill.*

2151. Do you use the extra money for extra buildings?——We are offering £½ million for a new surgical block because the old one is two hundred years old, and its foundations have been condemned by no less than three different lots of architects, and as a gesture to persuade the Minister we felt it was of vital importance to the hospital and we offered £½ million to the new block.

*Chairman.*

2152. Out of capital?——Out of capital.

2153. What control can you exercise over the consultant domiciliary service?

——(Mr. *Read.*) I do not think we can exercise any control. We do not handle the domiciliary visiting service. Some of our consultants are on the panel for the region, but we have nothing to do with the organisation of it. (Lord *Cunliffe.*) It comes under the Regional Board.

Mrs. *Hill.*

2154. Do any of your consultants visit a case before it comes into hospital? ——In a patient's home, yes. A number are on the domiciliary panel.

*Chairman.*

2155. Do you feel that service is abused to some extent?——(Lord *Clunliffe.*) To some extent, I think there is no doubt about it. (Mr. *Slesinger.*) I think in some cases it is a very big extent. Personally, I think it is one of the worst features of the Health Service. It is obviously very necessary and desirable and it is a frightfully difficult thing to control. I had experience of it, not personally because I have never done a domiciliary visit in my life, but when I was at a regional hospital before I retired I used sometimes to be asked by the then superintendent to have a look at various requests and a large number of them seemed to me to be quite fantastic.

2156. Would you say Guy's men are warned against that sort of thing?—— We have nothing to do with it.

2157. Your product may have something to do with it later on?——I hope we inculcate a proper moral outlook, which is really what is required.

Mr. *Robinson.*

2158. This kind of teaching might come rather more within the professorial field rather than the clinical field of teaching, and, if it is done at all, you hope it is done mainly in the medical school and in lecture rooms?——If you are talking about domiciliary consultations, a thing that used to worry me was that I used to get an impression so many of them are arranged for the convenience of the doctor rather than the need of the patient.

2159. You do not think some of them are occasionally arranged for the benefit of the consultant?——(Lord *Cunliffe.*) Much more likely for the benefit of the G.P.

2160. He does not get anything out of it?——He does not have to go, and sometimes they do not even go to the consultation. I am hoping this Royal Commission on doctors' pay may consider that.

2161. Do you think it would be a good thing if we gave it a favourable wind? ——I do not think you would do any harm. (Mr. *Read.*) Could you examine, may I suggest, at what date in the financial year do people undertaking domiciliary consultations reach the allotted maximum and see how much they do afterwards.

*Chairman.*] That is very interesting.

Mr. *Robinson.*

2162. What is the maximum?——The maximum is £800 per annum.

*Chairman.*

2163. That is a very valuable thing; thank you very much. Do you have any joint purchasing scheme with other hospitals, or with the Regional Board?—— (Lord *Cunliffe.*) We are starting a joint purchasing scheme for drugs. We have had various schemes. For instance, the Regional Board found the mental hospital produced pigs and we buy pigs from Regional Board. I do not know whether you call that joint.

2164. It depends on the "joints"? ——It is very good, I am told! (Mr. *Read.*) May I contribute something to that. I think there is more consultation between our buyers than joint purchasing schemes. I know our catering officer consults with one or two of his opposite numbers whom he thinks are capable (he has I know a low opinion of some of his colleagues) and they find it a benefit to bring to one another's notice any particular line or price or market they have come across.

2165. May I digress for one moment? I see you have accountancy qualifications?——Yes, I am a chartered accountant.

2166. That is merely the good luck of the hospital, is it not? Do you think it should be laid down that people in your position should have accountancy qualifications?——(Mr. *Slesinger.*) We would not be able to get them.

2167. I hold the view—perhaps it does not apply to teaching hospitals—that throughout the hospital system very often it may happen somebody takes a job as secretary or finance officer with no qualification whatever, and it worries me. What view have you on that?——(Mr. *Read.*) I think if anyone in my position has had a really broad training as I have had, having served five years' articles, I feel you are bound to get a broad knowledge of business, financial control and methods generally.

2168. I could not agree more?——I think a person in a similar position to myself is very much better off with financial knowledge.

2169. Do you think that should be obligatory?——I think your difficulty in making it obligatory arises from the fact that there is already in existence a conflict between the so-called administrative officer and the so-called finance officer. A good many finance officers who have accounting qualifications regard the whole thing as a tactical exercise in bookkeeping and accountancy, and there is a constant clash between the man who is absolutely rigid in his financial approach and the man who is approaching the problem in the hospital from the administrative or human angle without any regard to accountancy.

2170. I do not mean that letters after a man's name necessary means he is wise; it means a man has scope for acquiring wisdom, that is all. I see, for instance, that your deputy secretary has no accountancy qualifications?——If he were here I am pretty sure he would admit it is a handicap to him.

2171. You do think it is a handicap?——I think it will be.

2172. Do you think there is any increased scope for joint purchasing schemes so far as teaching hospitals are concerned?——(Lord *Cunliffe.*) Yes, I think there probably is. I think you have got to go very carefully with it because you may get certain people who are good buyers in certain articles, but, once you start making the thing compulsory, then I think everybody will find fault with the articles purchased.

2173. One Regional Board, Manchester, has done a lot of standardisation for instance in textiles, and others have done standardisation of crockery, things like that. What are your views on that sort of thing?——I think if you are going to standardise textiles you have got to standardise matrons probably, and that would be very difficult.

2174. You do not think there is scope for considerable economy?——Of course, they have done some of it. Leeds have done it with regard to woollen things, I think. In Manchester I think there is a Government testing organisation, and I think they use that to quite a large extent.

2175. Why are your medical salaries above the average? Is it that you employ more?——(Mr. *Read.*) Largely, I think, from what I can find out, it is due to the fact our staff is rather more distinguished than most and we have a large proportion of merit awards.

2176. The average for London Teaching Hospitals is £6 12s. 10d. per patient; your average is £7 12s. 8d., a very big difference, is it not?——I think you will also notice we are just on the average cost with regard to the London Teaching Hospitals—although up on some items, we are down on others.

Mrs. *Hill.*

2177. One question on one of these sheets given us* as to the actual expenditure figure of 1955-56, £365,487—does that apply to Guy's only, or does it take in the Evelina Hospital and the other Home—is it the whole included in the sum?——I think that is the Guy's figure. I believe I said so in a letter to the Committee.

2178. Does it cover your 727 beds or your 823 which you have here?——(Lord *Cunliffe.*) In the letter to Mr. Ryle* you will see in paragraph 5, "As the Ministry of Health Costing Returns for Guy's Hospital relate only to Guy's Hospital itself and do not include its associated Children's Hospital and Convalescent Home, the table showing the expenditure at Guy's Hospital under each approval head also has been confined to Guy's Hospital itself and excludes the associated Children's Hospital and Convalescent Home."

2179. So that £360,000 odd is purely for Guy's?——Yes.

* Not reported.

*Chairman.*

2180. You did make some suggestion with regard to carry-over power when allocating money. Would not that only benefit hospitals that over-estimate?——Under-estimate.

2181. Over-estimated and save money?——Yes.

2182. The Guillebaud Committee did not like that idea at all?——When we started off with the Health Service we were accustomed to carrying over from one year to another, and we had to learn the Government method of financing, but my own view was that if people like the Admiralty and Air Force and Army could manage it I did not see why we should not be able to do as well. I think we are managing now to adapt ourselves to this method of financing, without being extravagant over it. There was a tendency in the early years to try and save up and at the end of the year and when you found you had got a balance, you "blued" it on something without seeing whether it was first priority or not. What we are doing is that we are going into the matter very carefully, and we are spending rather more than the right proportion in the early part of the year, then drawing in our horns towards the end, so we feel we are only spending on the right things instead of possibly on some of the wrong ones.

Mr. *Robinson.*

2183. Have you been over-spending or under-spending in the last two or three years?——(Mr. *Read.*) We have been very close. (Mr. *Slesinger.*) Two are almost dead level, and this one (*indicating*) is slightly over-spent.

*Chairman.*

2184. You talk about long-stay patients. Could not they be sent to chronic hospitals, which cost less?——(Mr. *Read.*) We have no power to.

2185. You are just landed with them?——(Mr. *Slesinger.*) It is a very difficult thing to do.

2186. Cannot you arrange for their transfer?——Nearly all the long-stay hospitals are full up. There is an awful shortage of geriatric beds.

2187. You have achieved a considerable reduction in cost per patient, taking into consideration the changing value of money in these very interesting graphs which you have given us.* How have you brought it about?——(Mr. *Read.*) We have not expanded the service to the same extent as the level of national income has risen. I presume you are referring to graph number iv?

2188. Yes, number iv particularly?——If you take the fourth one, the work done is arrived at by the Ministry formula of five out-patients equals one in-patient day. So we take the actual figure of out-patients attendances and in-patient days, and take approximate total expenditure in terms of 1939 values—you see we use Ministry of Labour wage indices and we take price indices——

2189. We are not so much interested in how you have arrived at it, but in how you have arrived at such satisfactory results?——It is not a question, I think, of our having done anything in the sense of achieving economy or to get economies; it is done because the expansion of the hospital service has not gone ahead.

2190. To the detriment of the patient, or what?——Only to the extent you have not added amenities to what you already had.

2191. You are doing more work more cheaply, and I wondered why?——We are doing more work more cheaply. (Mr. *Slesinger.*) We are doing more work not more expensively.

Mr. *Robinson.*

2192. Not so much more expensively?——(Mr. *Read.*) Not so much more expensively, that is what it amounts to (Mr. *Slesinger.*) When you talk of amenities, we have an instance at the moment. We are anxious at the moment to develop a radioisotope unit, and we cannot do it because we have not the money.

*Chairman.*

2193. I see you have a tremendous lot of administrative and clerical staff. The figures are one to every 3·7 beds occupied Is that because of the teaching?—I thought we had a very low one compared to most other teaching hospitals.

2194. According to the figures we have been given, the national average of teaching hospitals is one to 4·6; you

* Evidence pp. 251–3.

are one to 3·7?——((Lord *Cunliffe.*) I think a very large number of those clerical staff are engaged on the medical side and not on the administrative side. We have always rather taken the view it was a more economical use of time for a consultant to have a typist to type out his notes than to have to do it himself in long-hand. That is one example. Then you have got your clerical staff who make appointments for patients and try to prevent too much waiting time. That, of course, all takes up staff. We rather have taken the view it is more economical to employ the rather cheaper labour in larger quantities. (Mr. *Read.*) I would not accept it differs in proportion unless I saw what was included in the other figures. We did a detailed comparison with St. Thomas's, King's College and St. George's, and without exception they were all more heavily staffed than we were, whereas they had a lot of their clerical work done by people who came under the heading of "other officers" because they gave them another name.

2195. Is there anything you would like to say to us?——(Mr. *Slesinger.*) If you are looking for economy, one of our grumbles against the Ministry is that they are always pressing us to do inventories and checks on minor articles, and I feel you do not do any good by doing it. All you do is to discover you have already lost six spoons and you will not stop losing them, but it costs you a lot of time and people.

2196. I think you made that point in your Memorandum?——We would like to stress that.

2197. You are being messed about a little on non-esentials?——Yes. (Lord *Cunliffe.*) We take the view we gain more by employing a security officer than we do by taking an inventory. We have an ex-Scotland Yard police officer, who is extraordinarily valuable. He saves an enormous amount of time. If a nurse gets anything stolen she is turned on to him instead of the matron and it saves her having to waste time. He deals with it and does it very efficiently.

Mr. *Robinson.*

2198. Does he even stop the theft of bed linen?——No; we have caught people going out with sheets all round them!

*Chairman.*] Thank you very much.

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TUESDAY, 14TH MAY, 1957.

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Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | Captain Waterhouse. |
| Vice-Admiral Hughes Hallett. | |

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**Memorandum submitted by the Royal College of Physicians.**

*Comparisons of Cost*

Year by year the Ministry of Health have published their Hospital Costing Returns in which the cost of each hospital in the National Health Service is analysed under some forty headings. This analysis has shown big differences—not only between different regions but also between apparently comparable hospitals—in the weekly cost of maintaining a bed. But as a basis of comparison

the net cost of a hospital per bed per week has proved deceptive. In an industry, nobody would think of comparing two factories, in terms of their cost per week, without taking into account the quantity and quality of their products: if, for example, the two factories made chairs, a glance at the finished article might suffice to explain why workshop costs were higher in one than in the other. In a hospital service, as in an industry, there may be great variation in the kind, amount and standard of work done; but unfortunately such differences will be less apparent and they will often be difficult to express in figures.

Thus a high weekly cost per bed, though it may be evidence of extravagance, may equally be evidence of efficiency. To make the best use of its beds, a hospital must develop a rapid tempo: it must lose no time in giving the patient the full benefit of its diagnostic and therapeutic resources; it must retain the patient no longer than is necessary; and it must fill his bed as soon as he leaves. A hospital doing this will probably spend more on drugs, dressings, and methods of investigation, and its ratio of staff to beds may have to be relatively high. All this looks expensive. Again, more staff will be needed, and costs will be raised in other ways, if a hospital undertakes teaching; and, quite apart from the teaching hospitals, a great many now have teaching commitments of one kind or another —e.g., training for medical postgraduates and students, schools for nurses, radiographers or physiotherapists, and ward rounds, lectures, or discussions for general practitioners. A further reason for high costs may be the need to use inconvenient old buildings or obsolete equipment (such as extravagant heating systems) which no industry could afford to tolerate. Good work can be done in bad buildings but seldom without excessive expense.

Conversely, a low weekly cost per bed, though it may be evidence of good housekeeping, may equally be evidence of failure to do the job. Whether through lack of proper staff or for other reasons, patients may not get all the investigation and treatment the hospital could be expected to give them; standards of food, amenities, and medical or nursing attention may be low; the turnover may be too small; and little or nothing may be made of the hospital's opportunities for teaching.

*Medical Aims*

In every hospital active steps have been taken to "achieve economies", but to the medical profession it seems that economies which prevent efficiency—e.g. inadequate maintenance and the use of goods of poor quality—are fundamentally a disservice to the hospitals and to the public. Moreover, in seeking economies which can be made "without lowering the general standard" too little attention is paid to the fact that, because more and more can now be done to cure and relieve patients, standards of care which were good yesterday may be inadequate today and unacceptable tomorrow. What was extravagant in 1939 may be a normal requirement in 1957—for example, the degree of privacy to which an increasing proportion of people now attach importance but which is often denied them because many hospitals cannot yet find the relatively small sums required for providing cubicles or even for putting curtains round the beds.

In a good hospital the chances of recovery and restoration to health are better than in an inferior hospital receiving similar patients. Even in the narrowly economic sense of the word (the Guillebaud Committee said), money spent on the National Health Service may properly be regarded as "productive" in so far as it improves the health and efficiency of the working population. Clearly it is more expensive to arrange that patients needing operation, even at night, shall be anaesthetised by trained specialists in anaesthesia instead of by junior house staff as was formerly usual; but a considerable number of people now alive would be dead if money had not been found for this unspectacular change of practice.

Naturally, doctors have not concerned themselves primarily with the reduction of costs: indeed, their efforts have often worked in the other direction. They have given full encouragement to sensible economy campaigns, for which there is still some scope; but their main interest has been to ensure that the best use

is made of whatever facilities they possess, to see that wherever possible each advance in knowledge is applied to the benefit of patients by improvement of methods, and at the same time to make the hospital a pleasanter (or less unpleasant) place both for patients and for those who have to look after them. They have been, and are, highly conscious of the defects of many hospitals and the reasons why these cannot attract and keep the staffs necessary for efficiency. The co-operation in achieving "economy" will not be fully secured until they know that the Ministry of Health, the regional board, and the management committee are all working with them to the same end, and are as anxious to increase medical efficiency as they are to reduce budgets.

*Methods of Comparison*

In pursuing true economy, comparisons can be useful; but, for the reasons indicated, the weekly cost per bed is a highly fallible guide. The 1956 Hospital Costing Returns include for the first time a rather more significant figure—the cost of the hospital per patient treated. Even this, however, does not become a satisfactory basis for comparing two hospitals unless one knows that they differ little in the kind of cases they treat, in the results they get, and in the feelings they inspire.

A method of comparison which might prove really useful, at any rate within a region, would be to select comparable hospitals and assess their merits on a points system which takes account not only of costs but of the efficiency of medical care and the degree of satisfaction given to patients and others. Thus the length of stay, mortality, and subsequent morbidity of selected groups of patients (not known in advance) could be examined, and points awarded accordingly; and further points could be scored for such items as the quality of the food and its service, the standard of hygiene prevailing, the promptness of correspondence with local practitioners, the consideration paid to patients' visitors, appointments for out-patients, and whether the lighting enables patients to read comfortably in bed. For many years King Edward's Hospital Fund for London has sent visitors to hospitals who (though they do not use a points system) take note of important details of this kind; and the Fund's experience might be valuable in developing such surveys, which could be made to promote a healthy competition between similar hospitals. This could do nothing but good to their patients.[1]

Meanwhile it can be said that the differences between the costs of hospitals of similar type have been diminishing in recent years as the less expensive ones have been made more efficient and therefore more costly. The gap is likely to narrow further, though there will always be differences so long as some hospitals, for geographical or other reasons, cannot secure the staff they need—whether because their establishment is insufficient (e.g., with one consultant physician looking after 80 beds) or because lay staff prefer employment in local industry.

Actually, detailed examination of hospitals in relation to some approved standard would probably demonstrate deficiencies more often than waste. Even the existing figures have served to draw attention to the traditional but indefensible defects in the feeding of patients in the majority of mental hospitals.

*Economical Use of Resources*

Perfection being unattainable, the College readily accepts the Guillebaud Committee's conclusion that the aim must be "to provide the best service possible within the limits of the available resources." But, if every pound is to be made to do its work, one has to consider not only waste through expenditure but also

[1] For more than thirty years the American College of Surgeons used an elaborate points system in assessing the suitability of hospitals as training centres, and the procedure has since been taken over, with modifications, by the Joint Commission on Accreditation of Hospitals which decides what standards a hospital must reach before approval. The commission (660, Rush Street, Chicago, Ill.) is formed by the American College of Physicians, the American College of Surgeons, the American Hospital Association, the American Medical Association, and the Canadian Medical Association.

waste through failure to spend. Hospital administration is by no means free from this error.

*Finance and Administration*

A cause of waste which demands further study is the divorce, under the National Health Service, of financial control from administrative responsibility. For bringing finance and administration back into closer relationship the new system of departmental costing—introduced experimentally in a few hospitals—should be helpful; for it should give the heads of medical and other departments a stronger sense of personal responsibility for the use of money. (As things stand, the people in charge seldom know how much their department costs and how its expenditure alters from year to year.) What is particularly required, however, is that the administrator and the finance officer should work together instead of separately: it is obviously wrong that (as sometimes happens) estimates should be prepared without proper consultation between them. In practice, one individual, living right outside the hospital's atmosphere of clinical responsibility, can depress the level of a hospital's work, and the morale of its staff, by pursuing economy in inappropriate ways.

*False Economies*

A common example of false economy is the tendency to save on maintenance.

One of the more important causes of waste in hospital—increasingly recognised by doctors but not yet apparent to most laymen—is "cross-infection" (the infection of one patient by germs from another): far too often people have to stay in hospital for weeks, instead of days, because their wounds have become infected in the wards or even in the operating-theatre. The use of antibiotics, valuable though it is, has unfortunately led to the development of resistant strains of bacteria, such as "the hospital staphylococcus", which may cause serious complications; and the only way to safeguard patients against these unnecessary additional illnesses is to achieve a very high standard of hospital hygiene. This need, however, is seldom reflected in the maintenance programme. Despite the dangers of dust in any place where wounds are dressed, the walls and ceilings of wards are washed only infrequently—partly because this is the kind of thing on which every householder is accustomed to economise but also because the trade unions insist that only skilled painters shall wash paintwork.

Hospital infection is seen in its most tragic form when one or more patients—perhaps young and healthy—are fatally infected with tetanus or gas-gangrene while undergoing some simple operation. One recognised cause of this is that the operating-theatre has an antiquated ventilating system by which dust is drawn in under the doors: but the comparatively small expenditure needed to put such faults right may be postponed until there is an actual disaster. Similarly the sterilisers and autoclaves of hundreds of hospitals—often obsolete—are a standing menace and quite probably the source of much illness which is wrongly regarded as inevitable.

The risk of infants acquiring gastro-enteritis in hospital is another serious one which cannot be eliminated without very close attention to detail: indeed, hospitals ought not to admit children at all unless they are well enough staffed and well enough equipped to ensure safety. Even in adults, outbreaks of food-poisoning in hospital are not unusual; and the cause will often be found in failure to provide the kind of kitchen that would be considered essential for outside catering establishments with comparable tasks.

A different kind of false economy is the failure to enlarge a department which has become a bottle-neck. Patients often spend useless days in hospital waiting for their turn to go to an overworked radiological department.

*Quality of Administrative and Technical Staff*

To make the best use of money, the users must be people of judgment; but the existing inflexible salary scales discourage able administrators and technicians from entering the hospital service. In the old days of voluntary and municipal hospitals it was possible to reward special merit but today, with rigid scales,

increments are related to length of service and not to quality of work. The output of individuals varies greatly, and, as Professor Kennedy has lately pointed out, those working at high pressure for good pay are usually more profitable to their employers than those working at low pressure for moderate pay.(2) Unhappily, for too many people in hospitals there is no financial inducement to additional effort: indeed it may pay better to work slowly, as in the case of the medical secretary, whose only means of getting a rise of salary is to acquire an assistant.

A big London teaching hospital, which spends more than £2 million a year and has a staff of over 2,500, has only three officers with a salary exceeding £1,500: the catering officer, who spends £150,000 and looks after a staff of about 200, gets £1,000. In any large hospital, the key members of the staff, such as the secretary, the chief pharmacist, the catering officer, and the engineer, are each in a position to save possibly thousands of pounds a year by skilful husbandry; yet, though their efficiency in doing this may gain the approval of their boards or committees, there is no way of recognising it practically and of preventing capable men—perhaps with families to consider—from leaving to take more remunerative posts in industry. Many of them do in fact stay in the hospitals, but their loyalty costs them dear.

The long-term effect of this rigidity of salaries must be loss of the best brains from the hospital service and a lowering of the quality of entrants. Until the elements of a good employer-employee relationship are taken into account, the service as a whole seems likely to grow less rather than more efficient. The simple remedy is to delegate more authority to the periphery, where alone local conditions can be fully appreciated.

*Expansion and Contraction*

As has been said already, unceasing advance of medical knowledge means that every year more can be done to save life and health. Sometimes this means a new and elaborate organisation to treat even a single patient, and this tendency towards elaboration is bound to continue as science progresses. On the other hand, some medical advances simplify treatment, so that this can now be given outside hospital and likewise preventive medicine, coupled with improvement in living conditions, is abolishing diseases which formerly needed hospital care. Even a single scientific discovery may within a few years greatly reduce the demand made on the hospitals by a particular disease and, though some general hospitals still have long waiting-lists and most mental hospitals remain so overcrowded that many of their patients do not get proper care, there is reason to look forward to a time not far distant when the total of hospital beds in the country, so far from needing to be increased, can be actually reduced.

This favourable trend is already seen in the decrease of admissions to children's hospitals and to tuberculosis sanatoria, many of which have empty beds and even empty wards.

But it is far from easy to arrange for even a sanatorium to change its function and anybody who has tried to close a children's hospital, or even a children's ward, will soon have learnt how difficult it is to make the hospital service contract at any point. The whole thing "is geared to move only one way—towards expansion",[3] because most of the people in it have very good reason to want their section to get larger not smaller. Not only do the medical secretary's hopes of a higher salary depend on her acquiring an assistant, but the matron and the administrator may actually have their income reduced if their own efficiency, or a change of circumstances, enables a ward to shut. Even the medical staff cannot always look with equanimity on such consequences of the success of medicine, which may affect their livelihood.

[2] "One of the trends in business organisation is the increase in the proportion of administrative to operational staff. If twenty men, drawing only moderate salaries and working at half pressure, could be as effective as ten men working at full pressure, this might not matter so much, but it is not so. If they can be obtained, a smaller number of men earning more pay and doing much more work in the same time will produce far better results." Kennedy, A. (*Lancet*, Feb. 2, 1957, p. 261).

[3] See *Lancet*, Feb. 4, 1956, p. 238.

This state of affairs surely calls for further thought. On the administrative side at least, it seems not only undesirable but also unnecessary that financial incentives in the service should work towards continuous and general expansion rather than towards economical use of hospital resources and eventual contraction of the service. The system of remuneration should certainly not be such as to generate opposition—conscious or unconscious—to all changes except those that are expensive.

### *Supplementing Hospital Resources*

*Free monies*

The desire of the public to help their hospitals still exists, as is admirably demonstrated by the great increase in Leagues of Friends. Further official encouragement of fiscal free monies is much needed. An important practical deterrent is the lack of remission of surtax on deeds of convenant.

One way in which even small sums of money contributed by the public can make a big difference to a hospital is the provision of amenities for staff. In finding local labour to do their work, hospitals are everywhere in competition with local industry, and often they fail to get enough workers of the right kind because their amenities of service, canteens, and sports facilities, and so on, bear little relation to those of their competitors. As things stand, however, they depend on non-Exchequer funds for providing such amenities. At the present time many hospitals can barely meet the cost of Christmas extras, or prizes for their student nurses.

*Pay-beds*

Another possible source of additional income is the greater use of pay-beds, in which the patient pays the full cost of his hospital care.

Patients who want privacy are often able to get it by paying £4 a week for an amenity bed and in an ideal service they ought always to be able to get it, on medical grounds, without any payment at all. Pay-beds, however, will remain necessary for a quite different reason—namely, to enable a patient to choose his own medical attendant. In a public service, whatever improvements are made, it will never be possible to guarantee that a patient shall be looked after by a given person, though when a practitioner specifies a particular consultant every effort is made to arrange this. Many people are prepared to pay for the certainty of care by the doctors of their choice. They are in fact being treated privately on hospital premises, and this saves the service the cost of their treatment in a public ward.

Pay-beds at present represent about 1 per cent. of the total beds, and the demand for them is steadily rising with the big increase in new subscribers to provident funds. Unfortunately, in some hospitals such patients are regarded more as miscreants than benefactors to the public. If pay-beds were regarded from an economic point of view and their cost placed on a more realistic basis, income from this source could probably be doubled or trebled without any fundamental change in the character of the hospital service.

### *Reducing the Load on Hospitals*

In an ideal medical service, the family doctor will want to look after his patient himself whenever he can do so successfully. He may need help with special investigations (radiological, pathological, etc.) but he will prefer to retain responsibility for diagnosis and treatment if these are within his compass, and he will therefore wish to keep the patient at home if there is no strong reason to the contrary.

In an ideal service, the patient referred to a consultant at hospital for advice and investigation will be investigated as an out-patient. Even if his examination demands that he should stay overnight, he need not necessarily be admitted to a hospital bed, but can stay at a simple hostel attached to the hospital or be boarded out in lodgings for the night as is sometimes done for people who live a long way from the centres to which they have to go for radiotherapy. Again, in case of acute illness the hospital can sometimes send its team of specialists to the home, where they bring hospital facilities to the aid of the family doctor.[4]

[4] R. Lightwood, and others. *Lancet*, Feb. 9th, 1957, p. 313.

In an ideal service the patient does not occupy an expensive (and often rather uncomfortable) hospital bed any longer than he need. Some hospitals discharge their patients as soon as possible to annexes which are more homely and less elaborately staffed. Others send them home soon after their operations, arranging for doctors and nurses to visit them frequently till they are well again.

These features of an ideal system are good because they lighten the load on the hospitals, which ought to be used only by people who really require hospital care.

Much has in fact been done to lighten the load in such ways, and in many places something near the ideal has been realised. But this has been done in spite of, rather than because of, the financial incentives of the present system. For instance, most hospitals will agree that they still have to diagnose and treat (as outpatients or inpatients) many patients who could have remained under the care of their own doctor at home. And an obvious reason for this is that the financial incentive acting on the doctor (if he allows it to act) is in favour of his disclaiming responsibility for anything at all difficult and sending the patient straight to a specialist. What pays the doctor is to have the biggest allowable list of patients, the least allowable equipment, and no conscience about shedding his own load. Happily few practitioners think in these terms; but the fact remains that, so far as money goes, their incentive is negative—to give themselves the benefit of any doubt as to who should do the work.

More fundamentally, what should be the common task of providing the best service possible within the limits of the available resources is hindered because the three sections of the National Health Service—general practice, the hospitals, and the care of patients by local authorities—are separately financed and each is in a position to save at the expense of the other. At one end the family doctor could reduce the burden on hospitals, but he can do this only by doing more work which brings no financial reward. At the other end local authorities could help hospitals to discharge patients quickly, and especially by providing more residential homes to which old people could go; but it pays the ratepayer much better to let these people remain in their hospital beds.[5] The third party, the hospitals, are less well situated for refusing to do what is asked of them; and their reaction has rather been to use the pressure on their beds as a justification for their expansionist predilections.

Of course, the above paragraphs overstate the case. Since the National Health Service is largely run by people who are doing their best for the public, faults which loom large in theory may be small in practice. Thus, despite potential objections from their ratepayers, many local authorities have gone a long way not only in arranging aftercare for discharged hospital patients but also in supplying home helps and nurses whose daily or nightly attentions enable many patients to remain in their own beds under the care of their own doctors. Indeed there is some reason to think that, judged merely as a means of saving money, the care of old people at home is sometimes being carried too far, since in awkward circumstances it can be more expensive than care in hospital.[6] Nevertheless it remains true to say that a tripartite system, each of whose parts is interested in its own task and its own solvency, will not necessarily keep the good of the whole service, and of the public, in view. If system is tripartite, the parts should be made to work to a plan in which the function of each is defined, and in which the financial incentives favour efficient performance of that function. Such a plan does not yet seem to be in action.

[5] The Guillebaud Committee recommended that, to encourage local authorities to provide residential accommodation for the aged, this should attract a 50 per cent. Exchequer grant. (Cmd. 9663, p. 262.)

[6] National Corporation for Care of Old People (Nuffield Lodge, N.W.1.): annual report for year ended Sept. 30th, 1956.

**Examination of Witnesses.**

Sir RUSSELL BRAIN, Bt., D.M., F.R.C.P., and Dr. F. AVERY JONES, M.D., F.R.C.P., Royal College of Physicians, called in and examined.

*Chairman.*

2199. Thank you very much for your Memorandum, which we have all read with great interest. We do not want to waste your time, so I shall skip a lot of the usual formalities. The College represents all physicians, does it, including junior medical staff?——(Sir *Russell Brain.*) To a large extent it does. The members of the College number 3,000, comprising a good many of the general hospital staffs who are represented in the College.

2200. With regard to what you said in your Memorandum about comparing costs, you do not like the cost per patient per week per basis very much, do you, as a yardstick?——I think it is a helpful figure, but it has to be accepted with discrimination, because it is the resultant of a number of factors which do not always appear.

2201. Do you not feel cost per case may be a better measurement?——I am not sure how it would prove more valuable.

2202. I should have thought myself it would have some relevance when you are considering turnover and efficiency of the service, or would you not agree? ——(Dr. *Jones.*) I would agree it is a better figure than the crude cost per bed per week. It was published for the first time in the last year's annual report on costs of the hospitals.

2203. Do you think that there is anything in estimating cost per head of the population in the Region; do you think that is a comparable figure, or would that be pointless?——No, I think it would be a reasonable index.

2204. Have you any suggestions to make to us as to what system of measurement of cost you would prefer?——No. I think the cost per patient treated, provided you are comparing comparable hospitals, is a reasonable yardstick, but is only an incomplete picture of the state of affairs, and in assessing efficiency, value for money spent, I think one has got to take into account not only cost of the patient but also the service provided to the public.

2205. Will the new costing system be a help, do you think?——I do not know the new costing system, I am afraid.

*Chairman.*] One is being introduced.

Vice-Admiral *Hughes Hallett.*

2206. If one wants to watch the trend of cost in any given hospital, comparing it one year with another, which of these various indices would you say is the best?——I should have thought that cost per patient treated is the best. (Sir *Russell Brain.*) And the new costing system will help us with regard to specific cases of individual departments compared one year with another.

2207. Perhaps one ought to break down all hospitals into departments and consider the departmental costs as distinct from the total costs of hospitals? ——I think both are helpful. (Dr. *Jones.*) I think that has been one of the difficulties in the past that we have had no idea of, say, the out-patient, which has been an arbitrary figure, 5 out-patients equal 1 in-patient, and I suspect that is very far from the truth and varies considerably in different hospitals, and, until one has got costing of major departments, the out-patient department, X-rays, etc., I think one would be very much in the dark in comparing different hospitals. I think there is a case for comparing costs of departments between comparable hospitals.

Captain *Waterhouse.*

2208. Is it possible to get a completely accurate "split" of out-patients?——I would have thought so, yes. It does need, of course, a fair amount of organising within X-ray departments and pathology departments. You have got to have some proper means of assessing the various investigations, but that is not insuperable.

2209. In the ordinary way, when a patient goes to an X-ray department, do people in the X-ray section know whether they come as out-patients or not?—— (Sir *Russell Brain.*) Yes, they do.

*Chairman.*

2210. I want to turn now to what you said in your Memorandum. "Naturally doctors have not concerned themselves

primarily with the reduction of cost "*. Do you not think they should? That is an implied criticism, is it not? ——The emphasis is on the word "primarily". They have concerned themselves with reduction of cost. For example, in most hospitals the drug bill has been up for consideration by medical committees, and recommendations have been made to the residents as to how economies can be applied, but I think they are primarily concerned, obviously, with the welfare of the patient, and they may often have to say that the welfare of the patient demands some treatment which will in fact add to the cost. I think that is all it means.

2211. You would not go so far as to say that every medical student and every doctor is imbued with the idea that the more money he can save the better in the long run it will be for the Hospital Service, henceforth the patients; you would not say the optimum state of affairs has been reached?——I do not think the optimum has been reached, but efforts have been made increasingly to bring that home to residents and students.

2212. Are students taught to consider costs during training?——It is becoming an increasing factor in their education, but I would agree there is still room for improvement in that respect.

2213. Then you go on to say, "They have given full encouragement to sensible economy campaigns, for which there is still some scope". What do you mean by that; what sort of ideas have the College in mind?——(Dr. *Jones.*) The prevention of waste in wards by use of unnecessary amounts of dressings, for instance, the cutting down of over-prescribing by junior staff, adequate supervision of prescribing by their seniors, and getting the staff to appreciate the costs of certain more expensive methods of treatment. Only a few years ago, I think, many junior staff had no idea at all of the cost of their giving a pint of blood or a pint of plasma.

2214. How is it brought home to them now?——I think the facts have been broadcast on a number of occasions, and they come out in the prescribers' notes, and in various supplementary reports which have been organised in various hospitals under the Medical Committee setting out costs of drugs and treatments. I think it is fair to say that hospital medical staffs have been aware of the increasing drug bill and have taken such steps to keep it under reasonable control.

2215. Would you say that in every hospital in the country prescribed courses of treatment are regularly reviewed to see it is still necessary to go on with expensive drugs? Would you say that every doctor in a hospital is well aware of the need to increase bed turnover, for example—I am not saying it is not, I am asking your view?——I thought that idea had got over pretty well in the last five years. There has been a lot of publicity about the increase in costs.

2216. Done at the initiative of individual Hospital Management Committees?——Not entirely. Some of the initiative has come from the Regional Boards.

2217. Does your College take any steps in that direction?——(Sir *Russell Brain.*) Through the members of the medical staffs of hospitals a great deal has been done.

2218. But not as a College?——I do not think that as a College any specific steps have been taken.

2219. In your Memorandum you say this: "The co-operation in achieving 'economy' will not be fully secured until they know"—they being, of course, the doctors—"that the Minister of Health, the Regional Board, and the Management Committee are all working with them to the same end, and are as anxious to increase medical efficiency as they are to reduce budgets"*. So the implication intended there is that the Ministry and the hospital authorities are not as anxious to increase medical efficiency as they are to reduce budgets?——I think the feeling is that they may often be handicapped. For example, it frequently happens that a capital expenditure on a new building for a hospital, or on modernisation of equipment, would indirectly effect an enormous economy, but if the capital is not available it cannot be done.

2220. You say more than that, you say ". . . are as anxious to increase medical efficiency". The word

* Evidence p. 272.

* Evidence p. 273.

"anxious" rather perturbed me; it seemed to imply that they did not give due consideration to medical efficiency, but if all you meant to say was that you did not get as much capital as you needed to increase medical efficiency, there is nothing more to be said?——(Dr. *Jones.*) I think it represents a feeling of frustration in hospitals, frustration, because it is often so difficult to get small items of capital expenditure which would make a tremendous difference to the efficiency of the hospital.

2221. You do imply there that the lack of that is due to a rather obstructive attitude on the part of the Ministry of Health, the Regional Boards and Management Committees?——I think that is true in a sense that there are such rigid lines drawn between capital and maintenance. For example, to add one extra lavatory in a kitchen is costing, perhaps, £70, and that just cannot be done out of maintenance, because it is a capital expenditure, and that may have to wait in a long queue two or three years. Out of minor capital works, perhaps £3,500 is the allocation for my Group, where the total expenditure is £1½ million. It is an immense frustration to hospitals that they are not able to get on with minor capital works in this way, and I think that that was the feeling behind that phrase. If one had not that rigid definition of capital and maintenance, if one had a little more ability at the periphery to do these small works, I think it would be much less of a frustration. Again, it comes back to this over-centralisation of control, and I think the periphery does need latitude in these matters. Speaking personally, I should have thought £100 margin for capital works ought to be allowed out of maintenance. That would do away with a tremendous amount of frustration.

2222. That is the responsibility of the Regional Board, whether the Regional Board keep up their sleeve a floating sum, and so on?——Yes. I think it has to be approved by the Ministry, but I am not too certain about that.

2223. Some Regions keep a certain sum in reserve; they keep back some of their allocation?——I agree there is some in reserve, yes.

2224. Talking about economy in general, you have referred to voluntary efforts to bring about economy. Do you think hospital authorities have any pressure they could exert and do not exert to supplement the voluntary efforts?——(Sir *Russell Brain.*) Does this refer to some particular passage in our Memorandum?

2225. No?——(Dr. *Jones.*) It is essentially an attitude of mind which one has to inculcate in all staff working in hospitals and that, of course, has got to permeate from the top down. That comes back to the need for getting your best possible administrators, your best possible catering officers, and your best possible engineers.

2226. I think I should like to interpose here one or two questions on what seems to me a most important aspect of the Hospital Service, and that is the securing of the highest type of administrator throughout the service. I suppose you would say, would you not, that you felt although there were many admirable people in the Hospital Service of the highest type they are doing it largely from a sense of vocation, and that so far as the inducements offered them are concerned there is no chance of getting a continuance of such a high type, would you agree?——(Sir *Russell Brain.*) Yes, indeed.

2227. I am not trying to put words into your mouth, but would you think it feasible to create a pool of very highly qualified people, out of which the major appointments had to be made—I mean lay appointments?——I think we come back partly to the inducements. Unless men and women in these high appointments can look forward to the sort of salaries comparable with those they could obtain elsewhere, they will not be attracted into the Service. I would think anything that could raise the standard directly or indirectly would be valuable. I am not quite sure about the implications of a system which would make it compulsory to draw people from a particular pool or source. I am not really sure what that would imply.

2228. You might say, for example, that a finance officer should have certain institutional qualifications, I am not suggesting necessarily which institutions, or that a catering officer should have a particular training, be trained by some body in that line of work. I think it is two-fold really: the salaries and inducements and the chance of promotion, and there are the qualifications taken in

return for that. Do you think that sort of arrangement would be resented in the Hospital Service?——It is difficult to say. I do not think that a proposal that certain qualifications are required need apply any more on the lay side than on the medical side.

2229. There would be objection if definite individuals were appointed to a definite hospital or to a definite Regional Board, but you would not mind appointments from outside?——No.

2230. The idea would be that there would be a list of qualified people and the Regional Board or the Hospital Management Committees should be urged to appoint from that list?——(Dr. *Jones.*) I am not very happy about the idea of a closed list like that. My own feeling is that the thing that is lacking at present is a sufficient ladder of promotion.

2231. Yes, but you cannot expect promotion to be so easy from a relatively minor post to another hospital or Regional Board unless there is some guarantee the man is qualified?——I would have thought that most key officers were very well qualified in their particular sphere.

2232. In spite of the lack of salary inducement?——In spite of the lack of salary inducement, and they have qualified certainly some of them by experience, but most of them have had some sort of academic background or training. That is certainly true of the catering officer, but we finish up, you see, with the position of a large hospital spending over £2 million a year, and its catering officer, with a staff of some 200, getting £1,000 a year.

2233. Yes, but in a way, if I may say so, you are contradicting yourself. You are saying that although the inducements are insufficient you are getting the right type of person?——We have still got the right type of person, but whether we shall still get that type of person in ten years' time I do not know.

2234. You agree there is an inadequate ladder?——Yes.

2235. You cannot get a ladder unless you have some form of service, whether on a regional or a national basis, a service in the sense of an organised structure. You cannot develop an organised structure unless there are qualifications, can you, with promotion from one body to another; that implies a service with qualifications and a salary scale, does it not?——I think the qualifications are there. I think there are the various diplomas and special training which they have for example, in catering.

2236. There is no reason why I should not be a catering officer, or a finance officer, or a secretary of a Regional Board, with no qualifications whatever, if I were appointed, is there?——(Sir *Russell Brain.*) I think previous experience is a factor and there are courses. The King's Fund runs courses for hospital administrative officers; there is an organisation of hospital administrators, all of which are concerned to maintain standards. I think that if the ladder consisted of the possibility of financial promotion in relation to responsibility and not necessarily in relation to expansion of hospitals, that would be a good thing, and at a lower scale we are constantly hearing from hospital administrators that they have no way of rewarding the more efficient and more hard-working workers in various departments. They all have to be paid at the standard rate.

2237. That is a different point. Taking senior medical staff, they are appointed after being recommended by the Medical Appointments Advisory Committee, are they not?——Yes.

2238. The administrative staff of a hospital plays just as important a rôle, a different rôle, of course, in the good maintenance of a hospital. Would you not accept some analogous method?——Do you mean appointment by an advisory committee?

2239. I mean that they should go through the sieve of an advisory committee?——I would not see any objection to that. It is now done by a sub-committee of the Board or the Management Committee concerned.

2240. I think I am right in saying that the Board or Management Committee concerned has a perfectly free hand as to whom they appoint?——I should think so.

2241. That is not the case as to senior medical staff; they have got to pass through the sieve first?——(Dr. *Jones.*)

I do not think there would be any reason against having a broadly based appointments committee for catering officers or for other trained staff, engineers for example.

2242. Would you think that should be on a regional basis, a group basis, or on a national basis, or what?——I think you have got to have it broadly based with regional representation and management committee representation, and perhaps some outside body, the King's Fund for example.

2243. Should it be a national board or a regional appointments board?——I should have thought it should be on a regional basis. A national basis I think would be too cumbersome.

*Chairman.*] I rather thought you would say that.

Mr. *Robinson.*

2244. Would you not think it might lead to difficulties if the employing authority were not the authority to make the appointment; in other words, if it were a Group secretary, might it not lead to difficulty if the Regional Board decided to appoint?——I think that would be very strongly resisted if the Regional Board took over appointments, but I think the suggestion under discussion was as to a broadly based committee, with representations from various sources.

*Chairman.*

2245. My feeling at the moment is this. You can say " Here is a list of five names. Either appoint from them or give us a very good reason why you appoint somebody else ". I cannot see how else you can arrange for promotion with regard to having what you call a ladder, can you?——I do not see how your names get on to that list in the first place.

2246. If there was a very good hospital secretary in a small hospital, might he not be put on a list for a bigger hospital or Regional Board, and he might have qualifications. Otherwise he might spend all his life in that small hospital, would he not?——(Sir *Russell Brain.*) That is the normal practice now, is it not? The ladder consists of broadly promoting the men from small hospitals to a bigger one, with more responsibility and better pay.

*Chairman.*] That is all done *ad hoc* at present, is it not? There is no organisation for that, is there?

Mr. *Robinson.*] It is done by advertisement.

Captain *Waterhouse.*

2247. Is there in fact a ladder?——I think there is a ladder, yes.

2248. Do you think it is a ladder which does operate fairly satisfactorily? ——I think it does broadly, but we feel the ladder does not go high enough.

2249. You say that a catering officer gets £1,000 a year. What sort of figure would you say is comparable to keep a man in the hospital rather than going to industry?——(Dr. *Jones.*) I should have thought £1,800 to £2,000.

2250. Is that within your knowledge of what is paid by industry for the running of a canteen for example, would you know that?——(Sir *Russell Brain.*) I would not personally.

2251 and 2252. It seems to me to be an awful lot?——(Dr. *Jones.*) It is running catering for perhaps 3,000 people with a budget of perhaps £150,000 a year, which is a very large amount to be responsible for. And I am quite certain that if one went to industry or to one of the well-known catering establishments you would find their key caterers were paid more than that.

2253. Do you find within your knowledge of the working of the national scheme in the last years that these officers have got better, more efficient or less efficient?——I think there has been a steady upgrading, because there have been so many organisations on this, and I can quote again the King's Fund—I happen to be associated with that body as Chairman of their Catering Committee —and much work has been done to build up the catering.

2254. While you feel some people are going into industry you do not feel there is enough going into industry to be very bad for the Service?——I am very worried about the next generation, frankly. I think the present generation has very much a sort of esprit-de-corps.

*Chairman.*

2255. Vocational feeling?——Yes, there is a vocational feeling about it that we shall not lose. We shall lose a certain number, I am sure, but not a tremendous proportion. The real anxiety is I think as to the next generation, and I am quite certain that the best people will not dream of coming into the Hospital Service, and I think that goes not only for caterers but for engineers and pharmacists under present scales, and not only with regard to the size of the maximum salary, but also the fact that there is just no possibility of recognising any special merit in the individual.

*Chairman.*] I think we are a little at cross purposes. Are you not saying the answer is more freedom in the salary scales and in recognising the merits of the particular individual? I am saying just as with the pharmacists he has to qualify as a pharmacist, so it is desirable a caterer should qualify as a caterer, so an accountant should qualify as an accountant, a secretary should qualify as a secretary and the same with regard to other senior posts as well, because if you are demanding a higher salary scale you must get something in return which will guarantee an individual in return reaches a certain standard.

Mrs. *Hill.*

2256 and 2257. Would you say all Management Committees and Boards of Governors are indeed asking or looking for people with more qualifications than they did some years ago? There is an urge, would you say, to have people with better qualifications—I am speaking of the catering field in particular?——I think that works out automatically, because you get, say 10 people applying for a post and some will be better qualified than others and you can choose those with the best qualifications.

2258. It is on the upward, so to speak, in that particular sphere?——Yes, indeed, and I would have thought that in most key posts the basic qualification was certainly adequate.

*Chairman.*

2259. In fact, you do not accept the opinion I expressed that you need higher qualifications? Are you satisfied, for instance, that the courses run by the King's Fund are extensive enough? Are they adequate in themselves; Are they widely enough supported? Are you satisfied most catering officers really do know their job and do their jobs properly?——I would have said yes. It was not true five or so years ago, but it is much truer today. The King's Fund has done much for the metropolitan regions, but not for the rest of the country. I cannot express an opinion as to outside the metropolitan region.

Mr. *Robinson.*

2260. Is that strictly true when it comes to training? Is it not a fact the King's Fund does take candidates for training from all over the country?——That is true. (Sir *Russell Brain.*) Could I say that the complaints that reach me about this come from hospital administrative officers, house governors, secretaries of Boards of Governors, and so on. They are the people who say they find this difficulty of retaining the people who are doing the work well because they are not free to pay them the kind of salary they would command in industry or in the big hotels, and that kind of thing.

*Chairman.*

2261. They are lured away?——Yes.

Mr. *Robinson.*

2262. Is there not some danger the remedy suggested in the memorandum may not lead to the same situation in the Hospital Service? In other words, if hospitals were free to reward merit to outbid each other for the best man, whilst the results for the individual might be advantageous it would not be very satisfactory for the Hospital Service knowing that at any moment somebody may come along and outbid them for their group secretary or their regional board secretary or their catering officer? Would you not say a raising of the scales all round is probably a better way of encouraging a better quality of entrant in the Service?——(Dr. *Jones.*) I think it is possible to have a fixed scale and, say, a one per cent. float of the salary your regional board or management committee have control of, and on a budget of £1½ million that is quite a lot, and such a one per cent. float would enable one to distribute extra salary here or there where there is special merit, and the difference in output of individuals is tremendous; the difference it makes to

a hospital having an efficient pharmacist, for example, may save that hospital perhaps £20,000 a year.

2263. You have not faced the dilemma I have put to you, with respect. Does not it also enable you to offer more to the man already in a job which he is performing well in order to bribe him away?——(Sir *Russell Brain.*) Only to a limited extent because the inducement would be limited, but, in principle, it is accepted surely that there are higher salaries for posts where there is higher responsibility in relation to the number of beds, the size of the hospital area concerned? I do not think it introduces a new principle but allows more flexibility.

*Chairman.*

2264. Everyone would get the maximum in the end, would not they? It is a temptation to get the best man by offering a maximum; would not that be the case?——Not necessarily, I think.

Vice-Admiral *Hughes Hallett.*

2265. May I ask a question about caterers? Take the time before the National Health Service came into being, were they always paid at a fixed salary or was it sometimes done by contract? ——(Dr. *Jones.*) Before the National Health Service came into being there were relatively few catering officers. The catering was often the responsibility of the matron, and it is only in the last ten or fifteen years that the post really has developed in hospitals.

2266. Was it ever done by contract? ——Very seldom. It has never been a popular method in hospitals.

Mr. *Robinson.*

2267. Is it not becoming more popular at this moment? Is it not a practice now beginning to extent, certainly in mental hospitals?——Not to my knowledge, no. I know it is so occasionally. I have not had much experience of it, or heard much of it.

Vice-Admiral *Hughes Hallett.*

2268. Might I ask one general question? Supposing you went the whole hog and had a completely centralised National Health Service and—I am not talking about the medical people but the lay people—appointments were controlled by the Ministry of Health, what is the real objection to that, bearing in mind that, after all, the regional boards are not really the employers, it is all public money, of course. Why is the Hospital Service different from, shall we say, a great government department?——I would say the answer is that the periphery differs so much. If you take your Post Office, for example, it is standardised throughout the whole country. Your hospitals vary so tremendously in character, in the work they do, their potentialities, and I think most of us are most fearful of anything that might reduce the individuality of the hospital at the periphery.

2269. I do not quite follow this point. If you take colonial conditions, for example, they vary, but the appointment of the people there is done centrally?—— (Sir *Russell Brain.*) Is there not a tendency to increased independence in the colonial sphere? Surely, decentralisation is one of the very important principles in the Health Service, to give as much local autonomy to regional boards and to the management committees as possible, and it seems to work very well. I think they would all feel it interfered with their autonomy if they had no choice in selection of staff.

*Chairman.*

2270. Is there not a "halfway house"? Is it not possible to give people limited choice but insist they should keep within certain standards?——I think that would be preferable, but even in medicine the standards are not imposed by the Ministry of Health, but by the Colleges and universities, but if standards are imposed by autonomous bodies—

2271. I do not mind who imposes standards, as long as they are imposed. Would you not agree with that?——I do not see any objection to that. It seems as sound in principle as requiring standards for doctors.

Vice-Admiral *Hughes Hallett.*

2272. On the question of standards, can you think of any way in which one can produce an effective career structure unless you have a centralised service? Surely the two things must go hand in hand?——I do not myself see it follows. I think the career structure depends on what you might call the hierarchy of appointment, giving better remuneration

for increased responsibility, and giving appropriate qualifications for different branches of work. I do not see you need a central structure any more than you need it in industry or in law or other spheres in which a man can move from one part of the country to another and hold more responsible posts. (Dr. *Jones.*) One can take the analogy of the consultant. Their appointments are made by regional board and they hold their contract not with the hospital where they work but with regional board. Their qualifications as physicians are ensured by the College we represent.

Captain *Waterhouse.*

2273. Would you say your general structure is rather in line with the one followed by local authorities with regard to appointments of surveyors, officers of health, and architects? There is a certain general level of competence which they expect, but any local authority can go to anybody else's employee and take them away. Would you say your system is similar to that? ——(Sir *Russell Brain.*) I believe it is, and they have qualifications as architects and surveyors independently.

2274. General qualifications, but no precise structure?——Yes; and posts of different responsibility are rewarded.

*Chairman.*

2275. I think we have pursued that interesting line perhaps far enough. May I turn to another page of your Memorandum? You speak of "the divorce under the National Health Service of financial control from administrative responsibility"*. What do you mean by that?——(Dr. *Jones.*) I think it was meant to indicate that those in charge of departments have had very little knowledge of the cost of the department.

2276. That those in charge of a department have little knowledge of the cost?——Little knowledge of the cost of their own department, and that, of course, would be overcome by the new system of departmental costing which is being introduced. The budget of a hospital, the estimates, have been made up by the finance officer, and I think it has sometimes been felt that there has not been enough contact between finance officers and those in charge of separate units of the hospital.

* Evidence p. 274.

2277. In other words, you think that although the doctors are very anxious to be cost-conscious, they do not get enough assistance from the finance officers?——I agree with that, yes.

Mrs. *Hill.*

2278. Would you not agree that in some hospitals where the administrator compiles the budget as well he must have some contact with heads of the different departments so that he knows exactly what is wanted in those different departments and for which he must put in an estimate to the finance officer of the group? After all, there are several hospitals in a group. It is different where you have one hospital with its whole range of officers. At the lower level of the hospital surely the administrator must have some contact with his departmental heads otherwise he is not going to know what is required for that department?——I think that is true. I think he has had that contact, but you have two pathways. You have your administrative pathway and then you have your finance department. Before the National Health Service your administrator was responsible for finance as well as the administrative side. Now finance has been divorced completely as a department from the administration, and the feeling behind this paragraph is that the divorce has been too complete.

*Chairman.*

2279 to 2287. What is your remedy, apart from departmental costing?—— That, I think, is a very big contribution to remedying it. It is really an administrative problem for Regional Boards to make certain there is adequate and proper liaison between finance department and administration.

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Captain *Waterhouse.*

2288. Does your paragraph mean that there is too definite a distinction between administration and finance, that you would rather have one officer who was in charge of both, or that the two officers ought to be much more closely connected?——(Sir *Russell Brain.*) I think there is a double meaning to administration here, the administration of the hospital and the administration of the department which would usually be by a medical officer. The implication

here is that the medical officer of the department should be in close relationship with the financial administration in estimating the cost of his department in asking for further expenditure, and that kind of thing, and that in turn has to be related to the collective mind of the hospital as a whole.

2289. In this connection, the word administrator did not mean the secretary or the governor of a hospital?——No. It meant the head of the department, X-ray department and so on.

Vice-Admiral *Hughes Hallett.*

2290. Would you think in practice it is possible to exercise effective financial control so long as value of money is changing?——(Dr. *Jones.*) I think that is just a technical point of administration.

2291. Do you think the knowledge required to do so with the changing value of money is more expert than in fact will be available?——I think that is quite likely.

Sir *Henry D'Avigdor-Goldsmid.*

2292. Is not that covered by the fact a supplementary estimate can be put in owing to changed costs of salaries wages and services, and those are always accepted?——There is one other major aspect here, and that is that there is a rivalry, I am sure, between finance officer and administrator.

*Chairman.*

2293. Again using "administrator" in the technical sense?——Administrator in the sense of senior administrator.

2294. Meaning a doctor?——No. I meant the group secretary. I think with regard to the group secretary and finance officer there is probably quite a lot of rivalry which is professional and which does not make perhaps for the best co-ordination.

2295. Is that the considered view of the College, or is that your personal experience?——(Sir *Russell Brain.*) I do not think the College has really considered that particular point.

2296. Elsewhere in your Memorandum, you speak of the ideal Medical Service.* You imply that the present hospital service is operating at variance with the ideal service?——I think we would agree it has not yet attained the ideal.

2297. To what extent can that ideal service be more nearly approached by action by the Ministry of Health or by Regional Boards?——I would have thought to a larger extent it is a question very largely of co-operation and co-ordination between different branches of the hospital service which hitherto have been organised as different entities, co-ordination between the hospital service, the general practitioners, the Ministry, Regional Boards, better medical advisory committees—those all come into it; all those new expenditures to provide facilities of X-ray equipment for general practitioners, to have general practitioner beds, and so on. It is a complex problem with a number of factors which have to be related together.

2298. Do you feel that the remedy should be sought through Regional Boards or the Ministry of Health?——I would have thought both working together. I do not think that one can succeed without the other.

Mrs. *Hill.*

2299. Would you consider that general practitioners today are more prone to send patients to outpatient clinics of hospitals much sooner than they would have done in former days?——(Dr. *Jones.*) I think that arises as much from the patients themselves, for instance, that they, having read "Readers Digest" about the latest medical discoveries, ask their doctors to send them up for an X-ray, and there is no doubt that the demand on hospitals for investigations has gone up tremendously since the National Health Service was introduced.

Vice-Admiral *Hughes Hallett.*

2300. Can I go back? I notice that you quote from the statement in the "Lancet" that the system tends to be geared only to expansion*, which is a point the Committee has considered before. I would like to ask you whether you have any practical remedies to prevent it being geared to expansion only?——I think the possibility is to have a less definite margin of salary scales in relation to size of hospitals. At the present time, I cannot quote the figure but if your hospital is up to 300 beds your administrator gets so much, and above 300 beds he gets a substantial increase, so if you have a hospital of

* Evidence pp. 276-7.

* Evidence p. 275.

about that number there is a very considerable desire on behalf of all concerned to get the hospital above 300 beds. If they get to 299 I think it is not true to say their salaries are reduced, but their expectation of salary is reduced; in other words, they come to a lower maximum than they would have done otherwise. I think there is an error here in saying that their income was reduced, but it is true their expectation was reduced.

*Chairman.*

2301. What other way would you have of basing administrative and matron's salaries?——By leaving considerable discretion with the Regional Board in relating the salary of an individual to his responsibility. (Sir *Russell Brain.*) And perhaps to his seniority. (Dr. *Jones.*) Yes. (Sir *Russell Brain.*) I think that is one of the factors which are rather intangible. I think we will agree that there is, and has been for some years, an over-emphasis on the hospital side of the hospital service, and part of the answer is to make it more possible for the general practitioners to do more and to give them more facilities to do more than they do at present for their patients, which would reduce the strain on hospitals and costs as well probably.

2302. Do more where?——Do more investigations of various kinds, with bed facilities in less expensive units.

2303. Using the hospital just the same?——Not necessarily. Health centres if established would provide a good deal of investigation.

Mrs. *Hill.*

2304. Would doctors welcome health centres?——By and large, I think they would. The few that have been set up seem to be working satisfactorily. I think it is generally agreed that not all doctors would work for them, or would be suited to work for them, nevertheless, they have a very important part to play.

Vice-Admiral *Hughes Hallett.*

2305. To what extent would you say the tendency towards constant expansion is the fault of the health service on the one hand as opposed to the public becoming more hypochondriacal on the other?——(Dr. *Jones.*) I do not think I would accept the public are more hypochondriacal. I think it is a reasonable interest on their part; I think they have become better aware of the progress of medicine and I am all in favour of their having special investigations if it seems proper to their doctors. There is no doubt that there is a much greater scope these days for scientific investigations of cases than there was fifteen years ago, and I would not discourage that, except on medical grounds, and I think the proper judge of the case is the general practitioner. I would like to see much more facility for the general practitioner independent of the hospital, and at the present time if he wants an X-ray—I am talking of the London area—he has to send his patient to the consultant at the hospital. The consultant sees the outpatient, arranges an X-ray, and writes a letter in due course. It will be very much preferable I would suggest if the practitioner could request his X-ray direct from the hospital department or from some department outside the hospital.

*Chairman.*

2306. You mean not go through the consultant?——Yes. At the moment the consultant working in hospitals is cluttered up with patients who come up for X-ray rather than a consultant's opinion, and that is certainly very true of my own outpatient department.

Captain *Waterhouse.*

2307. Have most practitioners got sufficient knowledge to specify what they want from the X-ray department?——I would have thought the practitioner is trained for that, yes.

Mr. *Robinson.*

2308. One or two questions on pay-beds, referred to in your Memorandum*. Is it the policy of the College to advocate an increased number of pay-beds, and how do they get their estimate that income could probably be doubled or trebled by an increase in the number of pay-beds—I am now talking of Section 5 beds?——(Sir *Russell Brain.*) As you know, the cost of pay-beds at present is extremely high. When the patient has paid the estimated cost plus 25 per cent. they are costing in the region of 20 to 30 guineas a week in many places. Since the health service came in there has been a great demand to join provident schemes which enable people to subscribe and to draw money which would meet their expenses, but of course the subscription

* Evidence p. 276.

on a scale which requires to meet 20 or 30 guineas a week is fairly heavy, you can imagine, and it is reasonable to think that if the cost were reduced, the number of people who would be prepared to avail themselves of it would be much larger than at present, and they would then in fact be paying for beds over and above their contributions to the National Health Service to a larger extent than they do now.

2309. When you talk about the cost being based on a more realistic basis, what you are asking for is subsidised Section 5 beds, because they are assessed on actual cost and as you know the basis has been reduced within the last three or four years?——Their present cost is, as I understand it, the estimated cost of the hospital bed, plus 25 per cent., which is additional to the contribution which the individual makes to insurance and tax to pay for a bed in that hospital if he needs it, so I would not accept the view that to charge less than that is subsidising.

2310. You admit he is receiving private treatment in a public hospital?——Yes.

2311. Is it unreasonable he should pay the full cost if he is receiving private treatment—would not anything less than that be a concealed subsidy?——That would not be my personal view. He has already paid ; he can go into a bed for nothing because he has paid for it in taxation and insurance, and I do not think to ask him to pay less than 125 per cent., the cost of that bed over and above what he has already paid indirectly, is to subsidise him. That is my personal view.

2312. 25 per cent. is overheads, 100 per cent. plus something for overheads, is it not?——(Dr. *Jones.*) That included the outpatient department which he has not used. There are often expensive sections of the hospital which he has not used. The present scale is probably substantially above the actual cost for that particular patient.

2313. I am right in saying it was reduced by amended legislation three years ago?——Yes, it was reduced, but it is still above the actual cost, I would suspect. The idea behind this if you look at it from a business point of view, if you want to reduce the cost of the service it could be done to a small extent without any fundamental change in the character of the service by, as I say, looking at it as a business man would and saying if we charge £15 a week for these beds instead of £30 a week we shall get more customers, three times as many, and therefore can cut our total cost for that hospital by £40,000 a year.

2314. In fact, it is not. It would be four or six times as many. If you are going to reduce the cost by half, and the income would be trebled, you are estimating there would be four to six times the people using Section 5 beds at the reduced rate?——I do not think that that would alter the character of the hospital service. Only between 1 and 2 per cent. are private beds. If you put it up to 5 per cent. you still have the character of the service unchanged, unlike the American hospitals, where you have 50 or 60 per cent. private.

*Chairman.*

2315. Have you a lot to learn from the Americans in his respect, do you think? ——(Sir *Russell Brain.*) I think the Americans have a lot to learn from us as regards the health service, in providing facilities for people who cannot afford to pay very large sums.

Mr. *Robinson.*

2316. One final question. There is not evidence that the present number of pay-beds on the present basis of pay is in any way inadequate, is there?——No. It must be a guess as to what the effect would be of reducing your charges, but based on some provident fund experience one estimates it would in the long run pay.

2317. At the moment, the number available, 1 per cent., is adequate to meet the demand?——To meet the demand at the high existing rates.

*Chairman.*

2318. Are amenity beds taken up or not?——It is hard to generalise, but in most hospitals I know it is much less so, because the amenity bed does not enable the patient to have his own doctor.

2319. But it is very much more comfortable is it not?——It is more comfortable than general ward, yes, but on the other hand as the facilities in general ward increase there is less and less to choose between the general ward and amenity beds. (Dr. *Jones.*) And usually there is no telephone, which is one reason why people come into pay-beds,

because they can keep in contact with their business, particularly so with regard to the one man show and where they have just got to keep in touch.

Mr. *Robinson.*

2320. Is it not true to say that the existence of Section 4 beds is not so extensively publicised by the medical profession as the existence of Section 5 beds?——We publicise them appreciably at our hospital.

2321. I meant generally?——The response has been negligible, and my own feeling is that people in general find it is a little un-English; they feel they are jumping the queue with amenity beds. With a private bed they are asking for something specific.

*Chairman.*

2322. Can you say anything about this points system mentioned in your Memorandum*?——(Sir *Russell Brain.*) It was a suggestion really based on what is done elsewhere in various ways, that if one had to form an estimate of the good and bad points of hospitals in relation to their costing some system of this kind might possibly be devised.

2323. And could be made sufficiently objective?——I think it could. There is here the example of the King's fund, and although they do not have numerical points they do investigate a number of features and form an opinion based on the results of looking into these particular features.

2324. It would get away from a lot of difficulties, would it not?——Yes.

2325. We are always told there is an inherited pattern in the Service, and it might get away from that, might it not?——Yes.

2326. There are various other questions I wish to ask you. Certain regions are below the average in cost, are they not? Do you think that implies greater efficiency or a lower standard of service, or both?——I think it is very hard to generalise, because it is so difficult to compare one region, for example, with a large number of mental hospital beds in it, which would show, presumably, a different level of costs, with another region that has not got that factor in it. A region with a highly specialised centre in it will have a higher level of cost. There are so many factors to take into consideration, it is hard to generalise.

2327. Would the medical profession, as represented by yourself, very much disapprove of going slow on raising the standard of the better regions and going a little quicker on raising the standard of the lower standard regions?——I think they have done that for ten years. I think the best hospitals have been marking time while the less efficient ones have been building up. I think the better hospitals are getting tired and frustrated at being held back.

2328. Viewing the service as a whole, I suppose that is inevitable?——It has been inevitable, and I think that it has been recognised so.

2329. Coming on to general matters, you have given two rather different answers when I asked whether you thought doctors were sufficiently cost-conscious. You said you thought they were, but at the same time they were out of touch with the finance officers. Turning to one particular line, drugs, do you think the expenditure can be better controlled?——I think so. (Sir *Russell Brain.*) Yes, I think it can. A good deal has been done already, but I think if all hospitals achieved the level of the best the result would obviously be better.

2330. Do you think there is enough pooling of experience in the Hospital Service? One hospital, for example, might find some method of economy, and do you think that it gets round quickly enough to the other hospitals?——I should rather doubt whether it does. (Dr. *Jones.*) There are publications, of course. Hospital administration does receive publicity, and I should have thought where any significant advance was made in administrative technique that it did get round.

2331. I was told that at a little hospital they saved £3 a week on swabs by buying them rather than making them themselves, and I do not suppose for one moment that sort of information will spread round very rapidly—you may think it is trivial, but it is something. Do you not think there is scope for pooling of information?——I am sure there is more scope for it, particularly if some incentive were placed in the way. At some American hospitals I remember seeing notices of rewards offered for any ideas which would lead to saving of

* Evidence p. 273.

money. I think some incentive is always helpful in these matters.

2332. How can higher occupancy and turnover of beds be best achieved, do you think?——(Sir *Russell Brain.*) One very important factor is provision of more convalescent beds or beds to which patients recovering from acute illnesses can be moved, where they can be effectively nursed, thus freeing the expensive bed in the more expensive hospital for other cases.

2333. Do you think teaching hospitals have too high a standard?——Of turnover?

2334. No, in general. We have only examined one teaching hospital, which has a very high standard indeed. I was wondering if some teaching hospitals always said "Only the best is good enough for us; we wish to show the perfect hospital", and they have an unduly high expenditure?——It is difficult not to sympathise with it.

2335. One sympathises with it very much indeed. We are here to protect the taxpayer's interest?——I wonder whether in the long run it is not desirable that some hospitals should be devoted to the highest possible standard, because very often, again in the long run, that leads to economies because of better treatment.

*Chairman.*] I would accept that.

Vice-Admiral *Hughes Hallett.*

2336. You would definitely agree those should be the teaching hospitals? ——In general, yes. There may be exceptions.

*Chairman.*

2337. Have you any opinions about the domiciliary consultant service? It seems to me that it may be rather abused?——I have no evidence personally that it has been abused. It seems it serves a useful purpose and may lead to economies by in some cases avoiding admission to hospital.

2338. You would say it was not being abused?——I have no evidence it has been abused.

2339. You have no reasons for thinking that the regional board should have fuller control over that service?——I am not certain what form that should take. I think in general it would work perfectly well by trusting the general practitioner to decide when he needs a consultant.

2340. Why should a consultant not be paid on a salary basis instead of on a fee basis?——For domiciliary visits?

2341. Yes?——I think that raises a very big question. I am not quite sure how it would be done. If you mean he would be paid a fixed salary to be available for any number of calls, how that would work I am not quite sure.

*Chairman.*] I do not say the abuse is widespread, but clearly there is scope for abuse, is there not?

Mr. *Robinson.*

2342. Is it not a fact that the number of domiciliary visits done by a doctor after he reaches the maximum for which he can be paid in the course of a year falls off, to say the least, as a general rule? It does seem that if the domiciliary visit is done only when absolutely necessary in the interests of the patient one would expect the number of visits to be roughly equal throughout the year?——(Dr. *Jones.*) The general practitioner, I suspect, is the cause of that, because if he knows the consultant has reached the maximum he is much more likely to call out someone else. That operated with the whole-time service; the general practitioner very seldom called out a whole-time consultant.

2343. How does he know the consultant has reached his maximum? Does the consultant circularise them and say, "Do not bother with any more, I have reached my maximum"?——It might well be it is an item of information which might easily escape socially. In fact, I have seen no abuse personally of the domiciliary consultant service; I think it is one of the most important features of the National Health Service and of very real benefit to the public. Even if it were abused to a certain extent, I would say it really has served a vital purpose.

*Chairman.*

2344. I think we had a memorandum saying that general practitioners are not always present at the consultations, only 38 per cent. of the time*; is that the case in your experience?——Yes, I think that is true, that in a proportion of cases the practitioner is not present.

* App 10, p. 395.

2345. Ought not he to be?——I think it is preferable for him to be.

2346. Surely it is more than that; it is essential, is it not?——I would not use the word essential, because often by a telephone conversation afterwards one can achieve as much as one could at the time, but I think it would be infinitely preferable for the two to meet.

Mr. *Robinson.*

2347. Does not the Act require it?——I am not aware of that. (Sir *Russell Brain.*) I think it is obviously desirable, but I do not think it is any more essential than that a practitioner should attend every consultation in a consulting room, for example. There are instances where it is obviously important, but quite frequently the essential information can be given by telephone or in some other way.

*Chairman.*

2348. My final question is this: in the opinion of the College do the Ministry, and after the Ministry the regional boards, effectively exercise their financial control so as to provide the best service possible within the limits of the available resources—I am quoting from the Guillebaud Report. Have you any strong feeling about financial control?——We have, I think, made the point, which I think the Guillebaud Committee made also, that the present system is perhaps not the most conducive to economy.

2349. You mean the tripartite nature of it?——Partly that and partly if the board or management is not able to use any money it can save for its own purposes because it is so rigidly tied to the budget there is a tendency to spend it unnecessarily perhaps as it knows it cannot make any other use of it. I think that is a general accepted weakness of the present system.

2350. You see the difficulty is that if money saved is spent on a capital project it may result in an annual commitment indefinitely in the future?——Yes, I think it is difficult either way.

Vice-Admiral *Hughes Hallett.*

2351. Arising from that last question, to what extent, if at all, would it be possible, and if possible would it be advantageous, to change over to block grants as a method of payment?——I thought it would be possible and, in some respects, advantageous. (Dr. *Jones.*) It has worked well enough at universities, and I do not see why it should not work in relation to a capital programme. I think that in maintenance a yearly budget is much more workable but for capital expenditure I feel a block grant over five years is really a much better, sounder way of approaching it.

Captain *Waterhouse.*

2352. A block grant by region or by hospital?——Well, throughout the region—it would come down to the hospital. The region would be responsible, obviously, for its capital programme within the region as it is at present.

Vice-Admiral *Hughes Hallett.*

2353. On the question of the information given to doctors about the finance and general cost of the service, it does seem to me that the time that should be done is when they are being taught as students. Would you be against the student courses including some brief instruction on the general financial set up of the whole National Health Service, bearing in mind the great majority of them are going to work for it?——(Sir *Russell Brain.*) Not at all; I think it would be excellent.

2354. Who would have to initiate any such change?——That would rest with the schools, of course, and presumably that would come into the work of the department concerned with social medicine, that sort of subject.

2355. It would be within their competence to do that?——Yes.

2356. I am not sure how much they are tied about their syllabus?——Some are already dealing with such matters as cost of prescribing, I think.

2357. On a different matter, I notice there has been a certain amount of criticism in America that an undue amount of money is spent on the hopeless type of case really not to the benefit of the patient or his relatives who in America have to pay. Would you say there is any danger of that whatsoever in our system, or not?——I do not think there is. I think at the moment our problem is to provide enough facilities for the hopeless type of case, but in fact if we had more facilities we could take some of the burden off the more expensive hospitals where these people have to stay, because there is not at present enough accommodation or

nursing facilities available for them elsewhere.

2358. My final question is a rather wider one. There is a constant trend towards rising costs as a result of the urge to improve the Hospital Service; there should be a constant trend towards falling cost as the health of the nation improves thanks to the National Health Service: which trend is likely to prevail as things are at present?——I think it is a very complex question. As medicine becomes more effective because it is more complicated the methods of treatment become much more expensive, and as we keep people alive longer we then have to deal with the ills of old age, and therefore fresh problems arise; and nature has a way of producing unsuspected new disorders which have to be dealt with. So that I think it would be over-optimistic to think that the counterbalancing tendency which theoretically should occur will to any large extent in the foreseeable future diminish the expanding costs.

*Chairman.*

2359. You do not fear unemployment?——No, not as doctors.

2360. When a hospital shows a constantly rising drug bill would you object to a ceiling being fixed; would you think that would be wrong?——I think it should be the subject of some investigation. I would not be happy to fix a ceiling without knowing exactly what the reason was.

Mrs. *Hill.*

2361. What have you in mind with regard to the relationship of the local authority service with the Hospital Service? You do mention on page 15 that it is quite possible that to save the rates going very much higher probably some service might not be given—that is how I read it. What other way of dealing with the matter do you suggest, by greater grant from the Minister to the local authority for dealing with cases for care and after care, is that what you have in mind?——Yes, broadly, I think. If local authorities had the facilities and money they should very often in some instances take over responsibilities at less cost; but, of course, if the cost falls upon the ratepayer the local authority perhaps does not feel that is perhaps to its advantage. Whether it could be met by increased central grant, I do not feel competent to say—(Dr. *Jones.*) In my own ward I had four people out of 25 who were there on social grounds.

*Chairman.*

2362. What do you mean?——They had recovered from acute episodes but their social conditions were such that we could not send them back because they had no one to look after them and needed some simple care and they were blocking expensive beds.

2363. They were left alone?——Yes, they had no one at home; they were left by themselves, and the responsibility was not really with the Hospital Service but with the local authority, and there is not sufficient co-ordination between the local authority and the Hospital Service for that type of case, and that adds to the cost of the Hospital Service and its inefficiency—(Sir *Russell Brain.*) That is a growing problem. It is chiefly the elderly man or woman who has been left alone and they are all right until they become ill and then after the illness, although they could be well looked after at home if someone could look after them, they cannot look after themselves. (Dr. *Jones.*) The rising age of the population is a very real thing in hospital practice, taking as an example the admissions for bleeding from ulcers about 20 years ago 10 per cent. of the admissions were over 60, and at the present time it is about 40 per cent. of admissions due to the increased age of the population.

*Chairman.*] Thank you very much for coming and for what you have told us.

TUESDAY, 21ST MAY, 1957

Members present:

Mr. Nicholson, in the Chair.

Sir Henry D'Avigdor-Goldsmid.
Mrs. Hill.
Mr. Holt.
Mr. Robinson.
Captain Waterhouse.

**Memorandum submitted by King Edward's Hospital Fund for London.**

The Fund would, of course, wish to do anything in its power to help the Sub-committee. They feel sure, however, that the Sub-committee will appreciate that the Fund stands in a special relationship with the hospitals. In so far as there must always be some degree of tension between the hospitals and the guardians of the public purse, the Fund is by virtue of its constitution on the side of the hospitals!

1. It has, from the early days of the Fund as a grant-giving body, been a maxim that it must take "efficiency" into account. Hence the Fund has always been much interested in hospital administration and was in the early years of the century instrumental in securing the general adoption among the London voluntary hospitals of a uniform system of accounts, and undertook the publication of an annual statistical summary of the work and expediture of the London voluntary hospitals. Its interest has culminated in recent years in the establishment of a Division of Hospital Facilities and of the Hospital Administrative Staff College.

2. Interest in the comparative costs of hospitals has a long history, and attempts to compare data between St. Batholomew's and St. Thomas' hospitals go back to the seventeenth century. Miss Nightingale and Sir Henry Burdett were among those interested in the subject in the latter half of the nineteenth century. Scathing comments were made by Miss Nightingale on the lack of statistics to show "the relative mortality in different hospitals", and other allied medical data which would "enable the value of different methods of treatment and special operations to be brought to statistical proof". Her efforts in this direction proved abortive, but Sir Henry Burdett persistently collected and published data on the comparative costs, out of which eventually grew the King's Fund statistical summary and now the series of Hospital Costing Returns and Hospital and Specialist Services Statistics prepared and published by the Ministry of Health. All these returns have been based on the assumption that it is possible and useful to compare a bed in one hospital with a bed in another. It is important to appreciate that this basis of comparison—"cost per bed"—which has such a long history behind it was from the start so crude a measuring stick as to be almost as misleading as it was useful. When used in conjunction with the old subjective analysis of expenditure—in all essentials an amateur effort of the mid-nineteenth century—it is not surprising that the resultant statistics contain many anomalies. For comparative purposes hospitals are inevitably grouped according to the number of beds, which may bear but little relationship to the range of services provided and no relationship to their efficiency or standards of service. Over the years when it used to distribute grants for maintenance among the voluntary hospitals, the Fund acquired considerable experience of the pitfalls likely to be encountered in the use of this type of statistical table. Its value lies in drawing attention to sub-heads which may need explanation or investigation. The Fund has noted with interest the inquiries made by the Ministry of Health into certain departments of hospital expenditure (see e.g. Anual Report of the Ministry of Health 1955, Part I, pages 42/3). No doubt similar studies are undertaken from time to time by the Regional Boards, but the results do not appear to be published. It is, in the view of the Fund, much to be desired that such information should be made generally available.

3. It thus still remains the case that no real solution has yet been found to the fundamental problem which Miss Nightingale saw so clearly, viz., the need to marry medical and financial statistics in such a way as to afford a real guide for arriving at an assessment of efficiency.

4. It may be noted that the "per-bed" formula tends in many ways to perpetuate an obsolete approach to hospital affairs. For centuries past founders of hospitals set themselves the limited task of providing as large a number of beds as they could afford, which number might bear little relation to the need of the population served. It was taken for granted that there existed an unlimited reserve of potential patients so large that the hospital could always be kept full. But with the coming of local authority responsibility and finally with the creation of the National Health Service a radically different goal was set, viz., the provision of beds adequate for the needs of the community.

5. Seen from this angle the provision of a fixed number of beds is anachronistic. It seems clear that a truer criterion of the efficiency of the hospital service will eventually be found by relating costs to population served rather than to beds provided. (Cf., however, paragraphs 282–3 of the Guillebaud Report.)

6. As the Sub-committee is no doubt aware, the Fund has long stressed the need for a system of departmental costing and believes that the lack of such a system is a radical defect in the machinery for the control of hospital expenditure. Evidence on the subject was given on behalf of the Fund by a member of the staff, Captain J. E. Stone, to the Select Committee on Estimates for the Session 1950–51 (see Eleventh Report of the Select Committee on Estimates). It therefore welcomes the recent decision of the Ministry of Health to introduce a modified system of departmental costing, as recommended by the recent Working Party. It believes that, when comparative statistics of the costs of hospitals can be prepared on the new basis, important light will be thrown upon the disparity in costs between the different hospitals which are now the subject matter of the Sub-committee's deliberations.

7. In the absence of such data the allocation of the funds as between different hospitals has perforce been based largely on historical factors, and the Ministry of Health and Regional Hospital Boards have been forced at each stage to determine their allocations primarily with reference to previous expenditure, making additions from time to time to allow for increases in prices and in salaries and wages. It would be an advantage if the criteria used by the Boards and the Ministry in determining the allocations were fully disclosed in regularly published reports. As matters stand today it is difficult for a body such as the King's Fund, or even the hospitals themselves, to appreciate upon what basis these allocations are made.

8. The availability of data based on departmental costing will provide for the first time a means of spotlighting the variable factors which influence costs, and the excessive costs of hospitals which have inherited obsolete buildings and equipment will become much more easily recognisable.

9. In all the circumstances it is not, in the opinion of the Fund, surprising that disparities should continue to exist. It is surprising rather that, relying to such an extent on commonsense and goodwill, the system should work as well as it does, and that the increase in cost of the hospital service should be but little more than can be attributed to inflation of prices and increases in salaries and wages.

10. Most hospital authorities would recognise that there are still economies to be effected, but there is a need for appreciation of what ought to be minimum standards of hospital service and efficiency. Many hospitals still fall far short of proper standards, and caution is therefore needed in the approach by the Government to hospital authorities. Since 1948 there has been constant pressure to achieve "economies without lowering the general standards of the service provided." There have been review teams and more or less arbitrary financial cuts. Continued pressure of this kind, unless backed by exact knowledge of inefficiencies or extravagance, too often results in resistance or in a lowering of minimum standards.

11. The Fund has always advocated the maximum independence for the Hospital Management Committees and would be sorry to see control over expenditure exercised by a network of regulations from the centre. It believes that in the long run the best and most truly economical hospital service will be evolved by persistent attention to fundamental problems of administration, such as those mentioned below. Whatever is done from the centre, the long term solution of marrying financial and other statistics with efficient appraisal of hospital services will only come from the development and training of board and committee members and administrators, medical, nursing and lay, and by a development of a competitive spirit between employing authorities. A noticeable feature of the work of the Hospital Administrative Staff College has been the very keen desire of a large majority of committee members and officers to be efficient in their work, and to produce a hospital service a little in advance of others.

12. Some of the matters which materially affect the running costs of hospitals were covered in the Report of the Committee on the Internal Administration of Hospitals set up by the Central Health Services Council in 1951, and in the comprehensive Report of the Guillebaud Committee, published last year. Evidence was submitted on behalf of the Fund to both these Committees. Among these matters the Fund laid stress on the following:—

(*a*) The need for a clear grasp of the traditional principles of hospital administration if excess of Committee work is to be avoided.

(*b*) The need for more effective integration of administration and finance.

(*c*) The importance of training of hospital personnel and progress in the art of hospital administration in its widest sense.

(a) *The need for a clear grasp of the traditional principles of hospital administration as understood in this country.*

13. In its evidence to the Committee on the Internal Administration of Hospitals the Fund expressed the view that it was important that the traditional principles of hospital administration as affecting the relationship between the governing body, the medical staff and the matron should not be obscured by the new set-up established by the Act of 1946:

"The main principles traditional in this country took definite shape during the Nightingale era, when the new conception of the place of the nurse in the hospital was grafted on to the already well defined partnership between the governing body and the medical staff. These principles may be summarised as follows:—

(i) the medical care of the patients was entrusted to the visiting physicians and surgeons and their assistants;

(ii) these visiting physicians and surgeons jointly comprised the medical staff, which acted in an advisory capacity to the governing body of the hospital;

(iii) the governing body of the hospital was primarily concerned with the enlightened pursuit of economy 'so far as it is consistent with the requirements of the sick';

(iv) its function was largely delegated by the governing body to a chairman, house governor or other officers acting in conjunction with a weekly or fortnightly Executive or House Committee;

(v) the matron has, since Miss Nightingale's day, been admitted as a third party to the partnership between the governing body and the medical staff. The nursing care of the patients as well as the control of the training school is entrusted to her care;

(vi) the hospital is therefore to be regarded as a tripartite organisation, the governing body exercising a wise economy in consultation with the Medical Committee and with the matron as representing the nursing staff.

The King's Fund sees no reason to doubt that the principles are fundamentally sound and that they have contributed very largely to the advances which have taken place in our hospitals since the eighties of the last century."

14. This conception of the hospital as essentially a tripartite organisation was discussed in some detail by the Committee on the Internal Administration of Hospitals and broadly endorsed by them. In such a view of hospital affairs much depends, of course, upon a true interpretation of economy. It must be understood in its old and wide sense and include a positive provision of all facilities required for the treatment and comfort of the patients.

15. Experience at the Hospital Administrative Staff College, however, suggests that there is frequently a failure to use this traditional pattern to full effect. Thus there is too often found among the members of the committee and its staff a tendency to misinterpret the duty of the governing body, and to substitute cheese-paring methods for a sense of responsibility for expenditure as a whole. When this happens the committee is apt itself to undertake the threefold function, and acts, as it were, as the managing director of the hospital. The result is a cumber-some superstructure of committee work. Paper work is multiplied, and there is a general loss of efficiency which is eventually reflected in costs of working and in the standard of service provided. Much attention is being given to this subject at the Staff College, but it will be apparent that progress can only be gradual.

(b) *The need for more effective integration of finance and administration.*

16. This subject also was discussed by the Committee on the Internal Administra-tion of Hospitals, and an extract from their Report is set out as Appendix B to this memorandum. This is admittedly a complicated matter, and no doubt to some extent outside the scope of the Sub-committee. But weakness at this point in the hospital set-up is still widespread, and until it is removed the service will continue to cost more than is necessary.

(c) *The importance of the training of hospital personnel in the art of hospital adminis-tration in its widest sense.*

17. It will be appreciated from the foregoing paragraphs to what a great extent control of hospital costs is dependent on the ability of the chief executive officer and his staff. The Fund believes that the work that is now being done in the training of hospital administrators requires to be supplemented by a thorough overhaul of the career structure, with the object of making hospital administration as a career attrac-tive in competition with other careers. The Fund has therefore noted with satisfaction the recent reference by the Ministry of Health of this subject to Sir Noel Hall, and it is hoped that his inquiry will point the way to the changes which the Fund believes to be necessary. It may be noted that the Fund is fully in accord with the observations made in the Report of the Guillebaud Committee on the subject of the status accorded to the hospital secretary.

18. The Fund believes also that there is need for an overhaul of the system of incentives. Salaries of administrators and of many other grades of staff in hospitals are too closely governed by the number of beds in commission, at a time when the closest attention should be given to reducing rather than expanding the number of beds.*

19. There are, of course, many other aspects of hospital affairs to which attention might be drawn and in which the Fund is in one way or another concerned. The

* Cf. leader in the " Lancet ", February 4, 1956:

" Hospitals are a necessity, and we must not rest until a very much higher standard is achieved in many of those we have today. But this does not mean that the hospital services as a whole ought to go on expanding, bit by bit and year by year. At present, even hospitals that know that they could contract find it hard if not impossible to get into reverse. Demand may fall off with diminishing population, or because of preventive or therapeutic advances: the lightening of the load on children's beds in many populous areas is an obvious example. But from within the hospital the process of cutting down beds and services looks far too much like defeat and far too little like the victory it should be acclaimed to be. Even the distant signs of its happening are a matter for concern: the consultant does not like it to be known that he has difficulty in filling his beds; the matron, the administrator, and the caterer have all been taught to look forward to the day when their hospital will be increasing rather than reducing its complement (their very remuneration is related to the number of beds), and any suggestion of contraction is discouraging and disconcerting. The whole service, in fact, is geared to move only one way—towards expansion.

problem, for example, of hospital supplies is at present being considered by a Working Party established by the Ministry of Health, on which the Fund is represented by Captain Stone; and the problem of hospital catering in all its aspects continues to engage the attention of the Fund. Needless to say, the Fund would be very glad to discuss with the Sub-committee these or any other aspects of the matter if desired.

20. The coincidence in time of vast administrative reorganisation with a period of dramatic change in the user of hospital facilities has rendered doubly difficult the task of disentangling the financial picture. It is to be hoped that before long statistics may be collected and published which will show much more graphically:

(i) the cost attributable to medical advances such as those in the fields of tuberculosis and children's diseases; and

(ii) the way in which the money saved is utilised for the extension of existing and the provision of new services.

*Appendix A*

THE RISING COST OF THE HOSPITAL SERVICE

i. The financial and statistical information contained in the government publications does not permit precise comparisons to be made between the year-by-year figures, but the broad conclusions to be drawn from the available evidence are clear.

ii. There has been a persistent rise in the cost of the National Health Service. Between 1949–50 (the first complete year of the National Health Service) and 1954–55 (the last year for which official figures have been published) the gross cost of the service in England and Wales rose by 12% from £388 m. to £454 m. and the net cost by 27% from £305 m. to £389 m.(*a*).

iii. The greater part of this expenditure and the greater part of the increase are in regard to the hospital service. The portion of hospital expenditure described in the Ministry of Health Annual Reports as "running costs" advanced from £202,094,306 (1949–50) to £265,933,457 (1954–55), an increase of 31·5%.

iv. During the six years in question there was a limited general increase in the volume of work as measured in terms of bed and patient statistics.(*b*) This indicates a more economical use of hospital resources but would not of itself cause a proportionate increase in total expenditure. A substantial part of the increase would appear to be due to higher prices,(*c*) but it is the greater expenditure on salaries and wages which is responsible for most of the increase in running costs.

v. Throughout this time the proportion of the gross maintenance costs absorbed by salaries and wages was never less than 60·1 per cent.; in 1954–55 it was 61·4 per cent. and amounted to £172,686,603.(*d*) This large sum, which represents an increase of 42·4 per cent. on the corresponding figure for 1949–50, was spent on

(*a*) The estimated gross cost for 1956–57 is £541 m. and the estimated net cost £471 m.

(*b*) Comparing 1954–55 with 1949–50, the numbers of available and occupied beds increased by 6·3 per cent. and 7·1 per cent. respectively and the numbers of new out-patients and out-patient attendances by 11·3 per cent. and 6·7 per cent. respectively, but there was a significant fall in the numbers of casualty patients and attendances during 1955.

(*c*) For example, the proportion of the yearly total gross maintenance costs expended on Provisions steadily increased from 11·1 per cent. to 12·2 per cent., and on Fuel, Light and Power from 6·4 per cent. to 7·3 per cent.; in both cases the amount spent in 1954–55 was 57 per cent. higher than that spent in 1949–50. It may be noted that during the period under review the official Index of Retail Prices advanced approximately 50 per cent.

(*d*) This figure is not the total sum spent on salaries and wages; nearly £5 m. is contained in other sections of the hospitals' accounts excluded from "gross maintenance costs".

the salaries and wages of some 444,700 staff, an increase of approximately 18 per cent. on the corresponding number for 1949–50.(*e*)

The breakdown of these figures can be summarised as follows, viz.:

| Item | Cost in £000 | | | Number of staff and appointments(i) | | |
|---|---|---|---|---|---|---|
| | 1949–50 | 1954–5 | Percent. increase | 1949 | 1955 | Percent. increase |
| Medical ... ... | 22,027 | 30,787 | 32·0(ii) | 29,234 | 36,700 | 25·5 |
| Nursing ... ... | 45,182 | 62,603 | 38·5 | 148,812 | 176,300 | 18·5 |
| Other ... ... ... | 52,082 | 79,296 | 52·0 | 198,154 | 231,700 | 17·0 |
| Total ... ... | 119,291 | 172,686 | 42·4(ii) | 376,200 | 444,700 | 18·2 |

*All Industries and Services*

(i.e. those included in " Index of Rates of Wages ") 32·0 per cent.(*f*)

(i) Both whole-time and part-time appointments are included.

(ii) This percentage has been calculated on an amended cost for medical salaries for 1949–50 so as to include retrospective salary increases paid in 1950–51.

vi. To what extent this higher expenditure on salaries and wages is due partly to the employment of more persons, partly to higher rates of remuneration or party to improvements in working conditions, e.g., hours of duty, has not been determined. But there appears every reason to believe that the trend of rising cost will continue.

vii. There was a yearly increase in the number of whole-time medical and dental staff, from 8,954 in 1949 to 11,400 in 1955 (27 per cent.); part-time appointments rose from 20,280 to 25,300 (25 per cent.) but this does not necessarily mean that there was a corresponding increase in total sessional time for these appointments. The numbers of nursing staff also show a continual rise—whole-time staff from 125,752 to 143,500 (14 per cent.) and part-time staff from 23,060 to 32,800 (42 per cent.).

viii. A detailed examination of the figures relating to " Other Staff " is confused by changes of analysis, but it may be noted:

(1) that administrative and clerical staff numbers altered but little—from 27,368 in 1950 to 27,500 in 1955, and were below this level in the intervening years; and

(2) that in regard to all other staff included in this category the number with whole-time appointments increased from 142,037 in 1950 to 151,200 in 1955, and the number of part-time staff rose steadily from 32,481 in 1949 to 53,000 in 1955 (63 per cent.).

ix. In some degree the additional staff now employed are due to the progress of medicine; improved techniques and methods of treatment, more extensive investigations, increased specialisation, etc., cost more in materials, space and manpower, although this may be partly offset by a " reduced length of stay " and a more economical use of hospital resources. Whether or not this trend of increasing employment continues to the present day it is not possible to say, but it is understood that hospitals still find it difficult to recruit domestic staff, junior clerical staff and student nurses. It is also stated that there is a growing shortage of physiotherapists, radiographers and other technicians. Part of this rise in employment may

(*e*) Staff figures relate to the position as at 31st December each year, include both whole-time and part-time appointments and ignore the fact that in many instances several medical part-time appointments are held by one specialist; also, they exclude honorary appointments. Comparison of these figures with those of expenditure must therefore be treated with reserve.

(*f*) The official " Index of Rates of Wages " was stabilised at 100 on the 30th June, 1947; for all industries and services covered by the Index, the average for 1949–50 was 109 and for 1954–55 it was 144, an increase of 32 per cent.

therefore amount to no more than an alleviation of the shortage, and this may well be so in the case of nursing staff. On the other hand there are grounds for believing that the extra numbers of "other staff" arises, partly at least, from a substitution of quantity for quality. The circumstances suggest that higher rates of remuneration would lead to improved standards. Fewer but more highly trained staff might lower the overall cost of salaries and wages, and at the same time by greater efficiency lead to economies in other directions.

x. In the face of the rising cost of employing each and every worker, all attention must be given to working methods and procedures so as to obtain the maximum benefit from the services of those employed and to ensure that the number of staff is kept to the minimum, but without any detriment to the nature and standards of the treatment services.

xi. In most hospitals, no doubt, a constant review of the establishment and the existence of financial pressure have meant that the number of staff is not greatly in excess of that considered necessary for the work as at present defined, and in some instances may be below the level desired. The general situation, however, requires something more than a superficial assessment of numbers of staff in relation to present work. A much deeper form of inquiry, involving the character and methods of work, policy, capital expenditure, and the quality and training of staff is essential if real savings of manpower are to be found. The hospital group is closely acquainted with all the facts necessary for an objective inquiry of this kind, but to be fully effective there must be a clear understanding of regional policy, e.g., whether or not the services are to be maintained at the same level.

xii. The present high rate of employment emphasises the competition for both skilled and unskilled staff, and the present terms of hospital appointments must be measured against the rates and conditions of employment offered by industry and commerce. In this respect hospitals can be regarded as fighting a perpetual rear-guard battle, and it is the very nature of their services that makes this so. Industry's great advantage is that it is able to obtain a constantly increasing gain from mechanisation, and in consequence each year sees a further advance of between 2½ per cent. and 3 per cent. in the rate of productivity. The industrial employee receives his share of the benefit of higher productivity in the form of higher wage rates; hospitals, lagging behind, must likewise improve their rates of remuneration if they are to obtain and retain staff.

xiii. The treatment of the sick is a very personal service, and does not offer the same opportunities to make use of mechanisation or automation as a means of increasing productivity so as to reduce costs. Not only will hospitals be obliged to follow the remuneration pattern set by industry and commerce but, inasmuch as salaries and wages constitute by far their largest item of expenditure, the result of doing so may well have a considerable effect on the rate of the running costs.

*Appendix B*

COMMITTEE ON THE INTERNAL ADMINISTRATION OF HOSPITALS

*Extract from Report, August*, 1954

*Para.* 186

We have received from the King's Fund a valuable memorandum of evidence on the financial administration of hospitals, which we think of sufficient interest to quote at some length. The Fund suggests that the finance officer's

"responsibility may be divided into three sections:

(1) routine control;

(2) financial information; and

(3) financial advice.

The first has as its aim to secure purity of administration. There must be machinery for ensuring that expenditure is properly sanctioned, that the collection of monies is conducted with diligence and honesty and that no precautions for the protection of financial interests are overlooked. The second section is equally important but it is less developed. Broadly, the objective is to keep the Board or Committee informed on the financial aspect of its work. . . .

> The third and perhaps most important aspect of financial control is the giving of advice. . . . Financial control thus conceived exhibits nothing of the coercive element sometimes associated with this term. It will be seen that we have here differentiation of function—finance and administration—and the relationship between the administrative department and the finance department depends for its smooth and efficient working upon a mutual understanding of the functions and responsibilities of each. It is the function of the finance department to supply the administrative department—and, indeed all other departments—with information and financial advice: it is the duty of the administrative department to absorb the information and to consider the advice. . . . This conception of the relationship which should exist between the administrative and the financial functions is not a new one; it has been expressed in different ways many times before. There are two totally different conceptions of financial control. The first and more or less traditionary one, based on constitutional analogies, is that administrative departments are to be distrusted, watched and checked. The practical tendency of such a theory when put in force is towards the creation of twin rival antagonistic powers; administrative departments seeking to spend; the finance department to criticise and check. Efficiency and economy are thus at war, or rather the expenditure which should be directed solely to secure efficiency tends to exaggerate into extravagance and an economy which should check waste to result in incomplete efficiency. The second and more modern notion of financial control means the union of finance and administration so that financial considerations may attend and determine administrative policy from its inception as well as control it during its progress and review it in anticipation of each financial year. Unfortunately . . . too often the finance department is looked upon as necessary and useful only so long as it keeps to the performance of the functions of cashier and paymaster. . . . On the other hand, there is a tendency on the part of the finance departments to imagine that no one can be genuinely interested in economy but themselves."

*Para.* 187

Dealing more specifically with the relation between the officers concerned, the King's Fund say:

> "Finance is definitely an integral part of hospital administration and it cannot be divorced therefrom without impairing the efficiency of the administration. At the same time finance officers must have the necessary authority to carry out their statutory responsibilities. They must not be regarded as assistants in the secretary's department; they are executive officers in charge of an essential function of management and any attempt on the part of secretaries to belittle their standing in this connection will sooner or later react unfavourably on the administration."

*Para.* 188

The observations we have quoted from the King's Fund seem to us wholly sound and practical.

**Examination of Witnesses.**

The Rt. Hon. the Lord McCORQUODALE, P.C., Chairman of the Management Committee (attending by permission of the House of Lords), Mr. A. G. L. IVES, C.V.O., Secretary, Captain J. E. STONE, Consultant on Hospital Finance, and Mr. W. E. HALL, of the Division of Hospital Facilities, King Edward's Hospital Fund for London, called in and examined.

*Chairman.*

2364. Lord McCorquodale, it is very good of you and your colleagues to come today, and it is a particular pleasure to your old friends to see you once again in your old haunts?——(Lord *McCorquodale.*) Thank you.

2365. Would you, in a very few words, for the sake of the record say what the function of the King's Fund is and how it operates?——The King Edward's Fund was started by King Edward, as the name denotes, very many years ago to collect a capital sum the income of

which should by statute be used for the London hospitals. While the hospitals were all voluntary bodies, of course, the funds were largely dispersed in grants for the maintenance of hospitals. Since the hospitals have been taken over by the National Health Service, we have more freedom of action in regard to our funds, as we do not make general grants to hospitals that are now under the National Health. We make some grants to disclaimed hospitals where we think it is desirable and we make grants for particular purposes to the National Health hospitals, mental hospitals and the like, and we also run a Division of Hospital Facilities which gives advice on requirements of hospitals and the like; we run certain schools or colleges, one to help and improve the knowledge of administrators, one for matrons and assistant matrons, one for ward sisters, and one for the catering world, in the hope of improving services of hospitals to their patients, and that about disposes of our available income (we jealously guard our capital) which last year was about £380,000.

2366. I want to concentrate on one main line of thought. You speak particularly in paragraph 17 of your Memorandum of the need for the Hospital Service to be made more attractive. Would you agree with the general statement that the efficiency and repute of the Hospital Service depends mainly on the calibre and type of personnel attracted to it?——Undoubtedly.

2367. And that the best of schemes based on systems under the most minute financial control are of little avail unless you have the very highest type of person to administer the Service?——Yes.

2368. I know that the Fund have carefully studied this question, and the Committee would be most grateful if they knew what the results of your thoughts have been. How can the Service be made attractive; do you think there should be a National Hospital Administrative Service with senior appointments being made by the Ministry, for example—it is those sorts of questions I mean, and we would be grateful if you could make an objective statement as to the way in which you think the best possible person can be attracted to the Hospital Service?——I think the most we could say on the subject is that we have been pressing for a long time for a flow of what you might call the best quality students and others to come into the Hospital Service. Just after the war, the King's Fund ran a bursary system, by which selected candidates from the armed forces were given one, two and I think three year bursaries, so that they could learn hospital administration. People who had done well in administration in the armed forces could take advantage of that, and by and large those bursaries have been successful and a great number of the top posts in the London area hospitals, and outside too are occupied by some of our bursars. The Hospital Administrative Staff College grew out of this. We run training courses and refresher courses for hospital administration in the widest sense, right from the top, Hospital Management Committee secretaries and Regional Board secretaries, down to officers carrying on the day to day administration of the hospitals. We have been entrusted now by the Ministry of Health, we and the University of Manchester, jointly to train some eight each of university graduate type of persons, young persons who want to come into the Hospital Services. They come under the jurisdiction of ourselves or Manchester University for three years, part of which time they will have spent at our College, and part of the time in selected posts in hospitals under instruction from ourselves, to give them a proper training, something comparable with what industry offers in the hopes of attracting the right people. Actually, the Ministry had a very large number of applications for these jobs and the first eight are now in session at Palace Court at our College, and the University of Manchester has got another eight. I understand there is one lady on each course.

2369. That only touches the fringes of the problem. What I really want to know is: do you think that the present system, or lack of system, is likely to go on providing people of the right standard, or indeed to raise that standard?——No, we think there should be a thorough overhaul of the whole career system in the hospital administration world really, and I understand the Minister has appointed a Committee under Sir Noel Hall, who runs the staff college at Henley on the Thames, to make inquiries to that end. As to the method of promotion, the lack of any opportunity for any incentives for

rewarding good service as against indifferent service, must militate against efficient and good administration in general. We think, as we say in paragraph 18, that a certain overhaul of the system of incentives is needed. We think that at the present moment the salaries are dependent upon the size of the hospitals rather than on the efficiency and the quality of the job done, so that a catering officer with "*x*" number of patients to look after gets one salary, but another catering officer with 10 patients more is in a different grade and he or she may get a higher salary. This means that the emphasis is on expansion, expanding your hospital beds, expanding this, that and the other, whether they are wanted or not, in order to get a more reasonable salary. From the point of view of the administrator there is no incentive to cut down ; there is no incentive to diminish the work of a hospital if it is not required ; there is no incentive to have as economically small a unit as is desirable for the area. The whole pressure of salary increases under the present Whitley system is for expansion only.

2370. I am sure we could agree on the diagnosis and on the nature of the ills to be cured, but it is on the nature of the cure we want your opinion. For instance I am asking the question I originally asked: should there be a national hospital administrative service, with appointments made by the Minister ; do you think there should be a separate branch of what I must call, to use that much maligned phrase, the Civil Service, devoted to the Hospital Service—either with appointments made direct by the Minister, or with appointments only made from a selection of people selected by the Minister?——The only thing I can say is that I do not think as the King's Fund we have ever considered that. Speaking personally, I regard it with horror. I think we have got too much Civil Service in hospitals generally, without adding to it more, but that is only a quick answer. It is a question I must say I have never heard posed.

2371. If I may make myself a little clearer, for the senior posts, Regional Boards and so on, should there be definite qualifications demanded of candidates for those posts?——I suppose it would be very useful if we could get some form of syllabus worked out, and all the rest of it. I do not see it as a practical proposition just at the moment. The Regional Hospitals Board should by now know what they require of a secretary, and, although we think that some of the methods of selecting candidates adopted by Regional Boards leave much to be desired—indeed, we have published a paper to that effect—we would not like to take away from Regional Boards and Hospital Management Committees the responsibility placed on their own staff and to place it in the hands of the Ministry.

2372. I was not suggesting that. What I am suggesting is this, that a finance officer, for example, should have accountancy qualifications, and that a minimum standard should be required for people in senior appointments?——I would merely say all our evidence goes to show the finance officers do not come sufficiently into the general line of administration in hospitals. Rather they stick severely to finance and not get into the general run of the hospital, which we think is retrograde. We have had a great deal of evidence given us in our Administrative Staff College which makes us feel that the financial department should be the hand-maiden of the administrative officer and not a little department by itself.

Mr. *Robinson.*

2373. Do you think that if one insisted on an accountancy qualification for finance officers one would be able to supply the Hospital Service with finance officers on the present basis of salaries?——I should not think so, in England at any rate ; in Scotland, I should think probably.

*Chairman.*

2374. I should like a definite answer from you on this: is it your view that minimum qualifications for senior positions should be compulsory ; in other words, you should not be able to appoint somebody without these minimum qualifications, leaving on one side what the qualifications should be?——Before you got to that position, however desirable it might be, you would have to alter the salary scales.

2375. Yes, I accept that fully. I think it all ties in with the ladder of promotion and with the creation of a service, not necessarily a Civil Service, a service with proper promotion and proper prospects and proper pay, and so on?——I think

it is very difficult to lay down hard and fast rules though. Administrators are either administrators or not administrators. You can teach them things to aid them in their province, but some people would never make administrators however many courses they went on and however many qualifications they had. I do not think in the Hospital Service on the administration side you can lay down hard and fast rules—there are exceptions to every single thing.

2376. How is one to prevent the appointing of a local boy because they all know him, who has no qualifications—he may be an admirable chap but is not necessarily the best person for the job?——I think you can improve the technique of selection. A great deal of work has been done on it in professional circles, so that when they are selecting candidates for a post, the selectors should know what they are looking for.

Mr. *Robinson.*

2377. Arising out of what you have said so far, could you say briefly what proposals you have in mind for improving the method of selection by Regional Boards for senior administrative staff?——We did do a pamphlet, but I do not think we published it ; we issued it to our own friends.

*Chairman.*

2378. Could we have a copy?——Yes, certainly.* I do remember one phrase in it that selection committees were apt so often to select candidates whom they thought most like what they hoped they themselves were at that age, if I may put it that way. I think that is probably true. PEP and other people have done a lot of work on this matter, and I think there is a big room for improvement there, but I think it would be a mistake to take it away from the judgment of the selection board and to lay down hard and fast rules, an 11-plus examination for adults, so to speak.

2379. With regard to the senior appointments, do you think that senior Hospital Management Committee staff in designated posts should be appointed by Regional Boards in consultation with the Hospital Management Committee?——I am afraid I would not be able to answer that question. (Mr. *Ives.*) I should have thought that one of the things outside our ambit. We have never participated in any way in the machinery of such appointments. We really have not any data on which to answer it.

2380. Do you think there should be a regional appointments advisory committee for senior administrative staff? After all, you have something like that for senior medical staff?——(Lord *McCorquodale.*) This is a purely general remark, but we think there is too much proliferation of committees in general in the hospital world at the present time. The emphasis so far as possible in hospitals, which we are considering rather more than the hierarchy of the Regional Board, should be on leaving the tripartite set up, the medical, administrative, and the matron, to get on with their jobs as much as possible and not endeavour to use these Management Committees and the rest for executive actions, which happens so often. I should hate to suggest to the medical world another committee beyond any that they have got already.

2381. This matter of appointments is of crucial importance. How else are you to ensure Hospital Management Committees really appoint the best people unless they have the advice at the very least from, for example, the region?——I do not say that they do not now. Applications have to be advertised, previous experience and the records of the candidate are laid in front of the selectors, and in many cases I am afraid it is a fact that there is not a very large field for the selectors to choose from, with the salaries as they are at the present time.

2382. Surely you want something in the nature of a Service adequately paid, with a ladder of promotion from which senior appointments should be made?——Yes, I think that senior appointments must come from inside the Service by and large, and not from outwith the service. You cannot equate the Hospital Service quite with industry, and one of the things administrators have got to learn is how to get on with the doctors and the consultants.

2383. How do you get the best people in the Service unless you have some form of integrated structure ; what is your answer to that?——It is an interesting train of thought, and one which I should like to put to my Administrative College to study. I am not an authority on it,

* Not reported.

I am afraid. (Captain *Stone.*) You only get the right man if you pay the right salary. We have difficulty in staffing the Service because salaries are not sufficient and people can get better jobs in industry and commerce.

2384. One is bound to require certain qualifications if one pays the right salary?——I would like to have certain qualifications, but would combine experience with it. It does not follow that because a man has qualifications on paper he is the right man; experience should count at the same time. In the Hospital Service, you may have a man with the qualifications of an accountant, but you may also have another man up for the same appointment with much better experience, and I think that on balance the man with the experience would be preferred to the man who has the paper qualifications.

2385. When you are starting anything fresh you have to give honorary qualifications to people with experience to start with, but in the course of time surely it would be better if everybody who started in the Service had to have certain qualifications?——I think sooner or later that would be the case. For instance, nobody would think of appointing a matron unless she were qualified. I do not think they would be prepared to appoint a finance officer unless he has qualifications.

2386. Many finance officers have no qualifications, have they?——The great majority have; there are some without, but the great majority have. They are either Chartered Accountants, Incorporated Accountants, or Members of the Institute of Treasurers and Accountants, the great majority.

2387. I will take it from you; I am surprised you say the great majority have?——(Lord *McCorquodale.*) I was talking about incentives. Now in the University grants world, I believe I am right in saying that the University Grants Committee permit what they call supplementary grants of a permisible amount. They say if you are spending £x thousands on salaries you may be allowed one-hundredth of £x or two-hundredths, whatever it might be, for incentive payments or payments for good work or rewards, what have you, apart from the scale of salaries under their control, if that is passed by the Treasury so far as University grants are concerned, and it might be an enormous boon to a Hospital Management Committee to have a little permissive money with which it can reward good service either of a stoker or someone in the kitchen, or from the administration point of view.

2388. That is only tinkering with the problem. Surely the real problem is if you want to get the higher man and pay the sort of salary to attract the higher type of man it means the formation of something in the nature of an integrated service from which alone the senior posts would be available. Would you agree with that?——We would hate to see the H.M.C. level in any way weakened in responsibility and task. We think that is the key position, that the H.M.C. must be responsible for carrying out the hospital services of their Group and we would not like them to be dictated to in that work either by a Regional Board, and very much not by the Ministry, is that right, Mr. Ives?——(Mr. *Ives.*) Yes.

2389. It is surely evolution run riot to give H.M.C.s power to pay high salaries and give them a free hand to appoint anybody into senior posts without their having qualifications? Is it not possible to say, "Here is a list of names of people with qualifications and experience, and you must appoint from that list", and not appoint an individual over their heads, and in other words to say your field is limited to that extent?——(Lord *McCorquodale.*) I do not think we have any grounds, so far as Greater London area is concerned, to criticise the Management Committees on the choice of appointments out of the field that is offered to them. It is a field which may not be as large as one would like, or as qualified as one would like. We think that the hospital world is so big over the country, and so enormous that whatever we are spending on hospitals at the moment you must break down and decentralise it, and you must give people a responsibility at the point where they are looking after the patients, and I would not like to think we are going to go away from having the power in the H.M.C., as I am quite sure that is our key place.

2390. I think you are placing yourself in a dilemma. You say salaries are not high enough to compete with other

industries and occupations?——Certainly, in many cases.

2391. What you now appear to be suggesting is that Hospital Management Committees, for example, should be empowered to pay these high salaries?——I do not think I said high salaries—adequate salaries.

2392. I accept the correction—to pay adequate salaries, with no corresponding obligation to appoint people with qualifications and experience, and they might appoint me or somebody with no experience whatever?——Heaven forbid! I do not think that is a real danger. The Hospital Management Committee cannot spend more money in these matters than what is provided for it. We would like to see more freedom in the H.M.C. as to how they would spend the money allocated.

2393. Your previous point was that more adequate salaries should be paid?——We think, and in fact it is in this paper, that if more adequate salaries were paid it would almost certainly lead to an economy, because less bodies would be needed.

2394. I am in entire agreement with that. If you are demanding the higher salaries, about which personally I am entirely with you, would you not say the Treasury are entitled to have people holding those appointments at those high salaries with qualifications? How do you think that could be achieved?——(Captain *Stone.*) Do they raise the same query in connection with Local Government there? For the appointment of treasurer they do insist on qualifications, and I think in the appointment of a town clerk the appointment states that he must be a barrister or a solicitor, and I am wondering would that apply in the same way to the Hospital Service.

2395. You have taken the words out of my mouth. I tried to get Lord McCorquodale to agree with me, but he hesitates?——(Lord *McCorquodale.*) I hesitate because I should hate to see you having to take a lawyer as secretary.

2396. *Mutatis mutandis*, of course?——There is the Institute of Hospital Administrators which provides courses and diplomas, and those seeking the higher posts should get the necessary qualifications such as are laid down by these bodies.

2397. Are those qualifications high enough and good enough, and are there enough of them?——That would not be a question for me to answer.

2398. Do you think these qualifications are adequate for Fellowship of F.H.A.?——I never think these things are perfect, but they are growing. There is a lot of work to be done. We have a new Service.

2399. I am afraid the standard will gradually deteriorate because salaries are inadequate and because no qualifications are insisted on in senior posts?——I think the Ministry is making an effort that way. These new university graduates are coming in on a scale which is comparable, for a university graduate not trained in any sphere, with what most industries offer, yours or mine, or Marks and Spencers.

2400. How many of them are there?——There are 16 coming in every year.

2401. That is not very many, considering the field to be covered?——This is an experiment, you know.

2402. Can you say that there are prospects in front of them of rising to the same level as they would in industry, that there is a ladder of promotion?——Only up to certain appointments.

2403. Also with regard to cross appointments from one part of the Service to another?——One part of the Hospital Service to the other.

*Chairman.*] But it is all haphazard.

Mrs. *Hill.*

2404. Would you say exactly "haphazard"; it is not my view that it is haphazard in the literal sense. Is it your view that other Management Committees do, in fact, seek people with qualifications for these higher posts?——Personally I have not had any experience of this matter. I have never heard serious criticism of the Management Committees' actions over this matter. We think their methods of selection, along with everybody else's, could probably be improved. It is a point which has been brought out at our College. I do not think that is a major difficulty.

Mr. *Holt.*

2405. If the government did insist on some qualifications, for instance solicitor or barrister or member of some administrative institute, with increased salary,

would you say this would unduly restrict the choice of people for the higher administrative posts, and that some people who might well be suitable would thereby be excluded?——I should have thought if you stuck rigidly to outside qualifications, barrister or whatever it might be, you certainly would exclude; if you have internal qualifications, such as the Institute of Hospital Administrators, I do not think you would exclude. I think all good hospital administrators above a certain level ought to have, and ought to have secured, something of that sort.

Mr. *Robinson.*

2406. In fact, they do?——In fact, they do.

*Chairman.*

2407. Do you agree that all new entrants to the Service at those higher levels should be required to have some good training qualification so that in course of time all Hospital Service senior posts would be staffed by people with the requisite qualifications?——No, I do not think there is a general recruitment from outside into the higher posts at all. The higher posts in hospitals are filled by the better people coming up from below.

2408. You have missed my point?——You said the higher officer coming in from outside—there are not such things.

2409. You have missed my point. What I was suggesting was that all people who mean to make their career in higher posts in the Hospital Service—like your university graduates—should in future have to be qualified in some form before they enter that career structure, so that in the course of time, thirty years if you like, all the senior posts would be filled by people with a certain qualification? ——Yes, I think that is happening now. These young people who are coming to us will, as part of their training with us, do some of the examinations of the Institute, and I think all ambitious young administrators now, practically all of them—I am not suggesting some of the very old ones—are going in for these examinations, and I should not have thought you would have found a Management Committee making a senior appointment today of anybody who has not some diploma or qualification from the Institute or an outside service qualification. Would you agree with that, Mr. Ives? (Mr. *Ives.*) Yes, certainly.

2410. My feeling is you are a little exaggerating there. Surely, there is always a danger that management committees would appoint inferior people unless they are assisted by the Regional Appointments Advisory Committee, or unless their field is limited to people with a certain measure of either qualification or experience?——(Lord *McCorquodale.*) I do not want to go as far as that; I do not want to limit within the field the discretion of hospital management committees. We feel that much more needs to be done. What we are trying to do at the Hospital Staff College is to get a real study not as to the qualifications of the administrator but what he should learn. The administration of a hospital is unlike any form of business to start off with—it is a tripartite one. You have got to weigh up the effects of high cost, high expense, quick return as against lower cost but perhaps longer stay, all sorts of problems which never come into the administrative field in industry. Therefore, I do not think you can go outside for these people; the more they learn inside the better. What we want to see is concentration, perhaps by ourselves and perhaps the Ministry as well, on making sure what they are taught is correct, not that having a diploma or a qualification to write after their names is the be all and end all of everything, but to make sure what they have learnt for that qualification is right.

Mr. *Robinson.*

2411. Do you think hospital management committees are any more prone than any other appointing body to appoint the second-in-command because he is known to them, and do you think they would be any more prone to do so at the regional boards if power were in their hands?——I do not think so. We have no evidence of that.

*Chairman.*

2412. Am I right in summing up your remarks by saying that you feel there is not an adequate career structure, and there are not adequate salaries?——I think a great deal more work has got to be done on career structure, and indeed it *is* being done at present. Certain salaries are certainly not adequate.

2413. But you have no suggestions to put forward to us. You are saying proceed as we do now and pay higher

salaries?——We would rather see more discretion given to H.M.C.s. We think that would help very largely, but I would not go further than that. It is not our job to fix Whitley scales and we would not plunge into that maelstrom if we could help it!

2414. I think you are in a dilemma in that you are demanding a standard of pay broadly equivalent to what men of comparable ability might get in industry or other careers, but you are not willing to lay down the qualifications or the standard of the calibre which would alone justify that. I think Captain Stone agrees with me; I do not think you do? ——I think that is right. Personally, I would not be willing to tie the thing tight; I do not think we know enough about it yet. This Service is relatively in its infancy. It is remarkable what has been done considering the speed with which it was set up. The number of administrators as against beds is coming down; there is improvement going on. We think there is a great deal still to be learnt in the art of administration of hospitals, but I think it would be disastrous to go and take the responsibility away from the Regional Hospital Boards and put it anywhere else.

2416. What does Captain Stone think? ——(Captain *Stone.*) It does imply if you take it away from Management Committees and give it to Regional Boards that the Management Committees are not doing their job.

2417. I suggested that there should be a regional advisory committee, not that Regional Boards should appoint. They would select six suitable candidates for a post and give H.M.C. the chance of those candidates?——I think H.M.C.s could do that work themselves. I would be sorry to see that go to Regional Board.

2418. You do agree with me as to the desirability of qualifications?——I think in the long run we have got to have them.

2419. Have you any idea what that qualification should be?——I have not; that is a difficult thing at the present time. Many advertisements for administrators state that preference will be given to candidates holding diplomas of the Hospital Administrators Institute. That is looked upon as the qualification for administrators today. Whether or not that is sufficient I do not know. Certainly it will not be so for the future, I do not think there is any doubt about that.

2420. Do you fear, Captain Stone, that the level of administration in the Hospital Service will fall, not rise, owing to the relative inadequacy of the salaries? ——Yes, I do. We are already losing some good men.

2421. What is your remedy?——Well, I agree with Lord McCorquodale, I think the whole career structure has to be worked out anew; I think it is too rigid and it wants to be made more flexible and there should be discretion whether by Regional Board or Management Committees. I would prefer Management Committees to adjust salaries according to merits—that there may be a minimum and maximum salary and discretion should be left to the Hospital Management Committees to adjust salaries according to work done by the individual. At present he is appointed at the present salary and, providing he does not do anything wrong, he will get an increment; there is no incentive to a man to work hard and to be outstanding. I think given an opportunity we can get a better Service. (Lord *McCorquodale.*) There is one point I would like to make as to the questions you have asked me today which I have endeavoured to answer, and that is that they are not questions to which the King's Fund normally turns its attention. There are other bodies, of course, notably Whitley more than any other, and I would not like what I have said to be anything else but a personal view. We have given you here in the paper our views collectively. I do not want to go down as saying that the King's Fund think everybody is not getting enough money or anything of that sort. It is not really our job at all.

2422. I think it is quite clear that I was asking you these questions as a man of experience, and, if I may say so, a very old friend whose judgment I value, and I was not attempting to pin your personal views on the Fund. If I may say so, this memorandum we have received is quite the best and clearest we have of all the many we have received, and we are most grateful for it?——Thank you.

Mr. *Holt.*

2423. From what Lord McCorquodale has said about the importance of Hospital Management Committees and their retaining of responsibility, they have at the moment to deal with things like the wages of a particular group of people or persons getting out of line with the wages paid to comparable people perhaps in that particular area in industry. Would he think it would be a good thing if the Government found some more flexible way of conducting their finances so that for argument's sake there was always a 5 per cent. block of money for the running of the hospital, and that this 5 per cent. could be used by a Hospital Management Committee for either increasing the salary of their own administrator, or at the moment for instance with regard to radiographers, where I understand there is great difficulty at the moment. My own hospital at Bolton is understaffed by 50 per cent. with regard to radiographers. There is a problem with which the Management Committee could perhaps deal, but they have little flexibility. Do you think it is a good thing if the Government found a way of giving a sum of money which the Hospital Management Committee should have complete freedom to use in whatever way they wanted, including increased salaries?——I agree. I think perhaps 5 per cent. is rather on the large side—I do not tie myself to that, certainly a sum of 1 or 2 per cent. they could do wonders with, I am sure. There is another point which I might emphasise. If you could look at Sub-section 7 of our memorandum on page 4, arising from that I would like to say that nobody seems to know how the allocation is made up, whether it is a percentage of what it was before or anything of that sort.

*Chairman.*

2424. It is done on what they call an inherited pattern, is it not?——We want to know what criteria they take into account.

2425. May I put to you an idea of my own, that the Hospital Service should be formed into some sort of board or corporation, given a lump sum and to be able to spend it exactly how they liked. You might divide the lump sum into current and capital, certainly, but apart from that there should be no strings attached whatever, and that it should be done on the lines of the B.B.C. or something like that, to be formed into a *quasi*-independent corporation which would be given what money the State would allow for a year or for a certain period of years, perhaps five years at a time, and be told to get along with it and make the best Service they could with that money?——I do not believe that that attractive idea in fact could work. The B.B.C., if they run out of money, can cancel one of their services or can cut down on the Third Programme (and everybody would be relieved, or not, as their predilections are), but you cannot do that with the Hospital Service, you cannot cut down on the maternity service because they are short of money; it is the patient who has got to be attended to, and although we want to do it with economy, we cannot say, "This is all the money there is, and therefore a lot of you will not get any attention at all". We have, of course, to attend to everybody.

2426. That is what happens now. In effect, the Estimates are passed by Parliament and that is all there is for the year?——But the Estimates are based on what the hospitals are asking for, and it comes up through the Regional Boards who have checked those Estimates which have come up from below. I would hate it to be plonked down from above, and for the others just to get on with it.

2427. My idea of what you call it, being "plonked down from above" would be that it would not be a matter of sixpence chucked into a beggar's hat, but it would be reached by agreement with the allowance of a much greater freedom. You have something analogous now in the Regional Board—I do not think in fact the Regional Board have enough freedom and independence. Is it not possible to envisage a national corporation or organisation on the lines of the Regional Board with complete independence as to how they spend their money?——I should not have thought politically that would be possible.

Mrs. *Hill.*] You would be subject to audit, would you not?

*Chairman.*

2428. A grant-in-aid is not subject to audit?——It would be difficult for the Minister to say "Bolton have got no radiographer; I have no responsibility for that—that is the responsibility of the

outside body". It is the Minister's responsibility, and I do not think you could do that in fact.

*Chairman.*] It is a responsibility which some people think the Ministry of Health is not fully qualified to have. Are we not in danger of falling between many different stools, with no clear definition of responsibility?

Sir *Henry D'Avigdor-Goldsmid.*

2429. Can I come back from the stratosphere to the Hospital Management Committees. I was interested in paragraph 15 of Lord McCorquodale's report, where in referring to Hospital Management Committees he uses the phrase in the third sentence that the Committee is apt itself to act as the managing director of the hospital, and he uses that phrase as suggesting that that is a great mistake on the part of the Committee. Does he mean that the Hospital Management Committee should have a greater freedom to spend their money—perhaps he could develop that; does he mean that the Committee should spend it, or that somebody else should spend it and the Committee be responsible for it?——If you could take the parallel of industry, for example, a board of directors appoint a managing director. In the tripartite system of this set-up, in which you have got medical and nursing and lay administration, the joint managing directors are those three really, and they should be responsible to the Management Committee, and indeed they are. What we are trying to say here is that there is a tendency unless it is watched for well-meaning persons, who are on the Hospital Management Committee, to over-interest themselves in the position and to endeavour through Committes to run what should be the responsibility of either the matron or administrator, or what have you, through the Board. What we are driving at is this. Let us have the trained chap running the hospital under the supervision of your Management Committee, which has considered the best possible people.

2430. Yes, I take that point. That is why I am interested to hear you say you thought greater power should be given to Committees to spend money in a fashion which certainly a Board of directors would not do. When you say the Committee, do you really mean some element of this tripartite entity?——I mean the tripartite set-up under the aegis of the Hospital Committee. You are quite right, I think it would be more correct that the people spending the money are the people running the hospitals, the professionals; they come under the aegis of the voluntary body.

Mrs. *Hill.*

2431. What would be the Committee's tasks if you say the various bodies, the matron, the medicals, and the lay administrator, are doing the actual work, where do the Committees come in, because if you take away all the responsibility from the Committees, are you not going to be in the position that the responsible people will not be able to attend meetings to say "Yes" and "No"—or mainly "Yes"?——I should not have thought so. So often we hear the criticism that the administrator really cannot get on with his work because he has got to attend so many committees all the time, and committee work can proliferate. That is what we want to say here. Surely the duty of a governing body is to govern, which means to appoint the whole time chap to carry out the work and to make sure he is doing it properly rather than to do it themselves.

Mr. *Robinson.*

2432. Is it a fair analogy to take the local authority, and, generally speaking, have not local authorities developed over the years a sort of dividing line as to what becomes the responsibility of the committee to decide and what is the responsibility of the officers, and what proportion of the latter has to have the subsequent endorsement of the committee; do you not think the same sort of pattern is in process of evolving in the Hospital Service?——I think so— I hope so. I feel that all major policy decisions must be taken by the committee, but management decisions should be more and more entrusted to the manager.

Sir *Henry D'Avigdor-Goldsmid.*

2433. Would you not say that now in a lot of cases the weakness of the administrative staff is made up for by certain exceptional ability on the part of the unpaid staff?——That is quite true.

2434. You do agree that there are cases—we see them in front of this Committee—where the chairman is doing far

more work and then taking more decisions than I imagine a local authority would in certain circumstances?——I think that is true when you get a strong chairman. Whether it is right he should or not is another matter, which, I think, it is not for me to go into now. I would not want to criticise chairmen. In one case the chairman may be more strong-minded than his officers, and he may be embarking too much on the professioning sphere.

*Chairman.*

2435. You said it is difficult to maintain the calibre of the senior administrative staff owing to inadequate salaries? ——I do not think we have gone so far as that, if I may say so. I think it is being improved at the present time—I think statistics would prove that. If you look at our analysis at the end you will find that the proportion of beds to administration is improving. It would improve faster and easier if there were more reward. I do not think we must run away from the fact there is an enormous amount of good work being done by administrators ; the alacrity with which they come to our courses, often in their own time, is remarkable—they think rather of serving their fellow men rather than what they can get out of a thing.

2436. You think more power to pay salaries comparable with industry is desirable?——I think we would get an even more efficient service if we had opportunities to pick up even abler people from time to time. Mr. Hall has been doing a lot of work on this matter. and he has been advancing a theory that a possible solution, rather than a very general staging-up of salaries which is not possible at the present time, would be if there were more rungs on the ladder and therefore more opportunities, especially in the management committee world to slightly promote a chap by putting him in a different category. (Mr. *Hall.*) The point I had in mind was that if there were more rungs on the ladder, in the way in which Lord McCorquodale has mentioned. you would get greater encouragement of migration from one hospital to another for officers and in this way they would add considerably to their experience and it would assist greatly when a management committee had to choose between candidates. There is a tendency at the moment for people to stay where they are and thus not gain experience which they would otherwise have gained if encouraged to move by the advantage of having more rungs on the ladder.

2437. You mean more grades?—— Yes, possibly in that way.

Mr. *Robinson.*

2438. Do you mean more rungs on the ladder in each hospital management committee?——No.

2439. You are suggesting that you want to devise a system to encourage somebody to leave the job he is doing at hospital A and do the same job at hospital B at a higher grade and salary? ——Yes, if it was made attractive enough for him to move he would gain in experience and it would be better for the Hospital Service as a whole, and in that way all your administrative officers would gain additional experience.

Mrs. *Hill.*

2440. Do you think the seconding of hospital officials within a group is a good thing?——Indeed. (Captain *Stone.*) Yes, I agree ; there should be more of it. (Lord *McCorquodale.*) For the efficiency of the Health Service obviously, but at times you are putting a strain on the hospital administration.

2441. For instance, that a finance officer should look after a hospital, that sort of thing?——At the present moment the finance officer is kept in a hierarchy of his own. We would like to see it broken down a bit, but I would not like to go on record as saying we would break it down to that extent.

Mr. *Robinson.*

2442. Granted that the present system of assessing salary levels based on bed complement is generally regarded as unsatisfactory, have you any suggestion to make as to an alternative yardstick which would take other things into account? You talk about rewarding increased efficiency as an alternative to rewarding the "empire builder"; how would you measure efficiency?——In America they have a points system. Guillebaud for a certain time toyed with the idea that, for instance, hospital beds should be related to population rather than to how big the hospital could grow. If one

could improve the hospital costing to the point in which it did give one a true guide to the efficiency of the hospital it would be easier to reward that group of hospitals for their efficiency in their service, apart from the number of beds. We have not got very far yet in the costing world.

2443. When you get there can you envisage a system so subtle it will also take into account the level of service it provides to the community —that is also a factor which ought to be taken into account?——It is indeed. It comes back to the point of a little discretion being used, by and large, and I would like to see a major proportion of that discretion used down the scale a little, for instance in respect of the head stoker who economises on fuel and provides the same amount of heat, who should be included in the rewards. You cannot compare the problem with industry from the point of increased productivity ; we are not producing anything here.

*Chairman.*

2444. You have certain criteria, have you not?——The American points system is one.

2445. Would you go for that?——I do not know enough about it. We are hoping to send people over to study it.

2446. You have high costs per bed as one criterion ; you have costs per head of regional population ; also you have got low occupancy or turnover to go by?——And you have got inadequate premises, which is one of the highest causes.

2447. I am sure that nothing can be done without careful and first-hand knowledge of inspection of hospitals, but it is possible to say hospital A is better than hospital B and that hospital B should come up to the better standard of A and that hospital A should not go ahead until hospital B has been brought up to it?——(Captain *Stone.*) It is difficult to say. We do not know you see what hospitals are costing. We have costing returns worked out on a bed occupied basis, but it is impossible to make a comparison on the basis that the hospitals do differ so much.

2448. What is your suggestion?—— The suggestion is that worked out by the working party and they worked out a system of departmental accounting which was introduced on the 1st April last.

2449. You pin your faith to that, do you?——I pin my faith to that quite a lot.

2450. That is largely a horizontal comparison?——Yes. It is impossible to compare hospitals from the all-in cost per head, but in future with costs for each department of the hospital before them one hospital could compare its kitchen with another hospital.

2451. That is why I call it horizontal? ——Yes, kitchen by kitchen or laundry by laundry. I think then we should get some real comparison made and it would give rise to inquiries. It is difficult to know where to start if hospital A is much more expensive than hospital B, or appears to be expensive on the figures. When a survey is carried out it is found often that the result is the other way round because in the departmental system we are relating cost to the volume of work performed ; on the cost per bed basis we are not doing that, of course.

2452. How would you get things straight ; what sanctions would you apply?——That is up to the Ministry.

2453. Would the Ministry apply sanctions, or the Regional Board, or what? ——Possibly the Ministry in making its grants, I do not know.

2454. Do you think their system of financial control is flexible enough for that?——Do you mean the new system?

2455. Do you think the Ministerial system is flexible enough to enable them to spur on the laggards and keep the others in check?——At present we have not the information. I think with the new system we are hoping the hospital will prepare budgets in a different way. In future, we hope they will be prepared on a departmental basis, each department will prepare its own budgets, then a departmental budget will be done at the Hospital Management Committee level, sent to the Regional Board and then to the Ministry ; then I think we have some basis to see where we are on that figure. We do not know, but I think that in time that will be the basis for grants. At the present time we do not know how the grants are allocated ; we have not sufficient information—I do not think the hospitals themselves have.

2456. So far as Regional variations are concerned, there are some startling variations; what more can be done to reduce the variations?——By comparing the new figures. At the present time I do not think much can be done; we do not know what these variations mean. Are they variations in administrative costs of Regions, are they variations in the costs of Regions including costs of Hospital Management Committees within Regions, which will also include costs of hospitals? Costs are contained in the annual budget to the Ministry; they are grouped together for a Region, but Regions vary according to population, according to composition, number of hospitals, type of hospitals, etc.

2457. And the geographical position? ——Yes, there are so many factors. You must bring it down to much lower units before you can get a cost to be used for comparison purposes.

2458. You mean laundry departments or radiology departments?——Yes, we hope to take each of those departments in turn.

2459. What do you mean, you hope to take them in turn?——Because the present scheme is a modified one. The working party did not want to burden hospitals with a complete departmental system of accounting at one fell swoop, so it is modified to 20 departments.

2460. Whom did you mean by "we"? ——I mean the working party.

2461. Which working party?——A committee set up by the Ministry of Health.

2462. Of which you are a member? ——Yes. That committee decided not to put in a complete system of departmental accounting but to start it on a modified basis with about 20 departments, and it is hoped as a result of that not only the Ministry but the Regional Board and the hospitals themselves will see the comparison of costs, and will be able to include all the departments of the hospitals.

2463. How many departments?——It could go up to 100.

Mr. *Robinson.*

2464. Is the departmental costing system being applied to mental hospitals to any great extent?——Only where the Hospital Management Committee wishes to do so. If a hospital spend more than £150,000 net it can be applied.

2465. It is permissive?——Yes. I think they are included, two or three of them.

*Chairman.*

2466. Do you think the Ministry have enough power to control the expenditure of revenue money on improvements and developments?——That I do not know. It is outside my province. (Lord *McCorquodale.*) Ultimately the Ministry have complete power to allocate the funds to Regional Boards.

2467. As far as I know they have no power to say that money saved on revenue account will not be spent on development?——I see what you mean. (Captain *Stone.*) There will be a saving on the total Health Service costs if by putting up a new building or by making substantial alterations to an existing old building the cost of maintenance was reduced. I think that could happen in many cases, for instance old boilers could be renewed.

Mr. *Robinson.*

2468. You will agree that the present financial arrangements make it difficult if not impossible to apply money saved on maintenance to capital development projects?——I do not think it could be done.

*Chairman.*

2469. Do you think the word "capital" is too tightly defined?——I do not think it is defined at all. I would like to know what is the Ministry definition of capital. It is a very difficult question to decide.

2470. Capital expenditure is defined in certain regulations, and in fact we have got the definition here.* However, we will leave that. Have you anything you would like to say to us about financial control?——(Captain *Stone.*) I do not know that there is much more to say except what is contained in appendix B of the King's Fund statement, to which I would like to draw your attention; it is on page 298, and I would like to stress that which is very important from the point of view of the practical working of the finance system.

2471. In other words, finance officers must have an improved status?——They must have the status given to them under statutory instrument 1414, and secretaries or administrators of hospitals must realise that they have got that status.

* Not reported.

2472. How does one get them to do that?——They have got the status under the instrument, but unfortunately many of them do not recognise it and we are not getting the service we should get. In many cases we are getting it mainly because finance officers say, "I know my responsibility, but I want to see this thing work", and they co-operate with the administration. I mention that because we are now considering finance to be part of the administration. In the past it has been considered as an entity of its own, quite separate. There is the finance department and the administration department, and never the twain will meet! The finance department is not just a bookkeeping department just to keep records.

2473. How are you going to bring that about?——It is a question of education and training.

2474. Does it not tie in rather with the attitude that there should be certain qualifications for finance officers?——To some extent, yes. But I think it is more a matter of education and training. (Lord *McCorquodale.*) We are endeavouring to do that at our staff college in our courses which have been very successful. I wish we could run more, but we cannot.

2475. I propose leaving financial control and going on to administrative control. Have you anything to say about controlling rising drug bills?——I do not think that has come without our purview at all.

2475*. You would not express an opinion about whether it is desirable that in certain cases a ceiling should be enforced?——I think that is more a medical matter. We do not interest ourselves in medical affairs, and drugs really come under the medical side of the tripartite. That is not an administrative problem so much as it is a policy decision as to whether an expensive drug should be used or not.

Mr. *Robinson.*

2476. This is really one of the fundamental questions about the Hospital Service. If you acknowledge an administration between lay administration, doctor and committee, surely the medical side then have unlimited power to spend within their own field without any financial responsibility whatever to define whether it is desirable and conducive to administration and can you define any way of curbing this complete freedom without interfering with a doctor's right of what is best for his patients?——I would hate to see the administrator coming into the field as to whether this drug is or is not necessary. I feel he could not do that. On the other hand there is the overall amount of money available for that hospital. If the doctor is going to spend it all on drugs, then they will not have such good food. He has got to keep his side of the expenditure within bounds just as the matron has got to keep the nursing, housekeeping and general administration and running of the hospital within bounds.

2477. Would you not agree that in the last analysis the doctor says "I need this", and he gets it?——Yes.

2478. That does not apply to any other aspect of administration—they are always subject to some check and control, or shall we say they are subject to a much greater degree of external check and control?——I think that fundamentally is true. The essential function of doctors is to save life or to cure a patient. If a doctor says this has got to be done, it is difficult for anybody except another doctor to say no.

*Chairman.*

2479. What pressure can be brought to bear on H.M.C.s with poor occupancy or turnover figures?——We published a book on hospital bed occupancy which had a very wide circulation, and the hospitals took it up with great *eclat* and I think it went well everywhere. It was one of our best circulated books, and I have a copy here for the Committee. (*Handed in.*)

2480. Thank you?——We also run for the regional Boards the Emergency Bed Service, and that at times comes in conflict with bed occupancy.

2481. What I wanted to know was this: what pressure can boards bring on hospitals, or should they be able to bring; do you think there should be any new machinery for that?——On H.M.C.s.

2482. Yes?——I think there should be in a clear case. The Board has financial control in the end.

2483. You think it would be by financial sanction?——I do not think the Board has any other sanction.

2484. I was thinking particularly of turnover: you think nothing can be done except moral suasion?——I do not understand what you mean by turnover as against bed occupancy. Do you mean pushing out people before they are cured?

2485. As soon as you can safely push them out?——I think that has got to be left largely to enlightened management.

Mr. *Robinson.*

2486. Is it not partly management and administration and partly medical again? ——Yes.

2487. With regard to bed occupancy, after all if you have one doctor in favour of early ambulation you will probably get a quicker bed turnover in that ward than in a ward where the consultant does not agree with it, and it is very difficult, would you not agree, for regional board to have any influence on that side. On the other hand, sometimes is not low bed occupancy due to administrative failings where regional board could exercise moral suasion?——I think that is a very fair statement. Then I think regional board could exercise itself in some things, such as homes for recovery where you could move a patient to, from an acute expensive hospital or to a cheaper convalescent home. There is a successful one at Chichester, where they have done a lot of work. The nurses find the work hard because the acute sick needed attention all the time and they needed rest. You get all sorts of by-products.

2489. Do you think the use of Section 4 and 5 beds can be increased?—— People think the whole question of amenity beds could be re-cast with profit to the Exchequer and to the community.

2490. By "re-cast" do you mean abolished?——No, I mean stabilised. It varies perhaps between one pay bed costing £30 a week and an amenity bed £2, whatever it may be. There must be grades between the two.

2491. Can we have this frankly? Is the suggestion that amenity beds are, in the opinion of the Fund, too cheap and do not bear a sufficiently high proportion of the hospital costs?——(Captain *Stone.*) They have to bear it now, Sir— the pay beds have to pay the full cost.

2492. I am talking of amenity beds, Section 4 beds?——I think it is only part. (Lord *McCorquodale.*) I would say that the Fund would not like to express a final opinion, but we think it is a thing which should be enquired into more than it is at the present time. There is a lot of criticism about the amenity bed system as to who goes in and who goes out.

2493. And about the pay bed system? ——Yes, but with pay beds the policy is more or less laid down.

Mr. *Robinson.*] Yes.

*Chairman.*

2494. Coming on now to the question of central purchasing and central organisation of laundries, transport, advertising, etc., do you think more can be done on central purchasing?—— (Captain *Stone.*) There is a Committee in the Ministry under Sir Frederick Messer which published a report three weeks ago recommending joint contracting. We think that this is going to be a good start. One difficulty which the committee has had is to find out all the methods adopted by hospitals in making their purchases, as there is such a variety of methods. Some hospitals have supplies officers to do it, some have an assistant secretary or a member of the secretary's staff, but after making enquiries into various methods, splitting the committee into three sub-committees each visiting a number of hospitals and organisations purchasing on a big scale and taking evidence from quite a lot of big hospitals as to how they carried out their purchasing, the committee came down very strongly in favour of central contracting.

2495. On a regional or a group basis? ——On a group basis, not regional. When I say on a group basis it may be two or three H.M.C.s, or even hospitals, can join in purchasing. It may be that hospitals on the periphery of a H.M.C. could join.

2496. Reducing the number of supplies officers very largely?——I do not think it has had any effect on them.

2497. It would, would it not?——It may do so, yes.

2498. The Fund's view is that the trend towards centralisation of purchasing should be encouraged?——I think that would be the Fund's view. (Lord *McCorquodale.*) I think that by and large we would agree.

Mrs. *Hill.*

2499. Centralisation on what level—from the top, or what?——(Captain *Stone.*) No, it is having what we call joint contracting, having two or three groups. The committee did not like it at regional board level, although there was nothing to stop that.

*Chairman.*

2500. We were told by Manchester that they had a regional linen purchasing system*?——Yes, and that works very well, too.

2501. Would you extend that?——Yes, we had a certain sub-committee examining the whole of that scheme, which works very well indeed. There is no objection to a region doing that. That is central contracting as against central purchasing, which is a very big difference. The committee was not in favour of setting up huge depots. The point is that a central contract will be made and individual hospitals will order direct from contractors and receive direct in order to avoid these huge depots.

2502. I am sure the depot idea is a mistake. A point which has been brought to our attention is the extravagant and unnecessary use of the domiciliary consultant service; have you any views on that?——(Lord *McCorquodale.*) No, we do not impinge on the medico.

2503. It has been put to us that the service is being abused. You have no comment?——No; we would hate to rush in on that one. We are not suggesting we are angels, but——

2504. I am sure you are not suggesting the corollary! In certain hospitals there is a tremendously large ratio of administrative staff to available beds. For instance, Guy's with 720 beds employ 170 administrative and clerical staff—admittedly it is a teaching hospital. Have you any evidence of that sort of state of affairs being widespread?——Of course the specialised teaching hospitals are rather a law unto themselves and they have problems and services which no other hospital has. Guy's spent a good deal of time recently in bringing out plans for modernising the hospital, and they were so expensive they were shelved. I would not criticise them, but they have to be rebuilt at some time and I have no doubt their buildings are inadequate. There is a quotation in the appendix saying, in actual fact, that by and large the administrative staff in the hospital world has tended to contract if you compare it against number of beds in occupation.

2505. You were talking about teaching hospitals having a different expenditure. Do you think they must be kept so very much above the standards of regional hospitals of comparable type; it does mean an enormous cost?——That is a very very big question which a lot of people are asking. They perform a unique function.

2506. We accept that it is desirable that doctors and nurses should see things done perfectly at some stage in their career to have a standard to work to, but still the cost is terrific, is it not?——Again you are not analysing like with like. I think we ought to be able to say more when the departmental costing comes out as to whether in the comparable sections of the teaching hospitals they are more extravagant than in the comparable sections of the others. Their functions are so different. Of course, a lot of them do an enormous amount of out-patient work as well, largely in training their people.

2507. We shall get the answer when Captain Stone's scheme is in operation?——Yes, you will.

Mr. *Robinson.*

2508. Would you think there is any administrative saving to the Hospital Service as a whole to be made by possibly integrating the teaching hospitals into the regions; do you think that that could be done without any lowering of standards?——I should think it would have about the same effect as if we had exploded an atomic bomb—I cannot

* App. 8, p. 391.

think of anything which would create more disturbance. I am only speaking of so far as the London teaching hospitals are concerned, as the Fund does not go outside there. I think their problems are so different that it would only complicate the management committee's work if they were integrated with them. They are management committees, they run groups of their own, but their financing is done on a different scale.

*Chairman.*

2509. Have you any ideas about teaching medical students about costs and the need for the greatest possible measure of economy if the Hospital Service is to flourish. Another analogous question is as to a suggestion scheme. Do you think enough use is made of that; do you think there is enough opportunity for an exchange of information about methods of economy that certain hospitals have discovered?——With regard to medical students the Fund does not interest itself as a Fund in what is taught to them, but I should have thought that should be a normal part of their curriculum.

2510. Do you think it is?——Fairly well, I think. I visited a fever hospital the other day where the doctor was acutely conscious of the cost of curing whooping cough by means of a new drug as against keeping the boy in hospital another week. With regard to the question may I expatiate a little. It is something which interests us very much and something on which I personally am rather keen owing to other affiliations. We think there may well be considerable scope for modern industrial techniques, such as method study and the like in the arrangement of the work in the hospital, and also organisation and methods studies as regards their administration, accounts and the like. Certain of the groups are at the moment considering taking steps in this direction. Discussions are going on as to whether the North West Regional Board should not carry out an experiment at Paddington Hospital. In the King's Fund we are due to decide at our next meeting as to whether to subscribe to a scheme which the Westminster Hospital would like to try for sending two or three of their most intelligent young administrators to take a study course at one of these industrial schools, Cranford or the like, and to see whether application of these techniques could not be applied with advantage in the hospital world. Those closest to the application of work study, such as Commander Currie at I.C.I., are convinced there is quite a big field here in the hospital world and it would create a new interest as well. I think there is little doubt that at our next meeting the Fund will agree to finance this experiment at Westminster Hospital and that should give us within the next year or so an idea as to whether these techniques should not be introduced more widely.

Mr. *Robinson.*

2511. They have not, in fact, been introduced at all?——No, not yet. It is still under discussion.

2512. This would be a pioneer effort?——Yes, a pioneer effort. You mentioned the suggestion box idea. That is a corporate portion of method study, as you know.

*Chairman.*

2513. Yes. It seems to me many hospitals must discover little ways of economising, perhaps only a matter of a few pounds or a few hundred pounds. Do you think there is opportunity for that discovery to be quickly circulated—after all, I suppose with regard to medical discoveries it is spread round?——I think our experience at the Administrative Staff College is that hospitals tend to keep themselves to themselves far too much on these occasions, is that not right? (Mr. *Ives.*) That is true. There is also done through the Division of Hospital Facilities.

2514. That only applies to London?——(Lord *McCorquodale.*) That only applies to ourselves. (Captain *Stone.*) It applies all over the country. (Lord *McCorquodale.*) We are the only organisation that really tries to do this.

2515. I have heard of a hospital that saved £3 a week on a new method whereby they purchased commercially manufactured swabs instead of making their own, and that was a saving of £150 a year?——That one has come to our notice and we will spread it round our own group hospitals.

2516. Do you think there should be some machinery set up for all the Hospital Service?——(Mr. *Hall.*) We did

have one application as to whether a cheaper form of thread could be introduced into the swab which would reveal it under x-ray. We have conducted experiments and have managed to persuade a manufacturer to undertake it, and as a result that hospital has saved about £300 a year. That is the sort of inquiry we do get.

2517. Do you not think there should be some central economy exchange set up?——That information we do impart to all those who are visited by the Division.

2518. Are not steps taken to circulate it round the country? —— (Lord *McCorquodale.*) I think there is scope to do more than is done now.

Sir *Henry D'Avigdor-Goldsmid.*

2519. In the first paragraph of your memorandum you say your Fund must take efficiency into account, that is what we have been talking about all afternoon. Could you tell us what your Fund applies as a criterion of efficiency?—— In the first place they would not give a grant unless accounts were kept in the prescribed manner—that was in the old days. Now, by and large, we depend on visiting lay and medical, and we visit all the hospitals once every three or four years and ask certain questions. We do get their accounts and study them ourselves, but now we do not give grants so much like we used to in the old "free" days—we do not give maintenance grants. Now, if a hospital needs to have a kitchen renewed and cannot get money out of regional board for it because they have spent all their money, we may well advise on how the kitchen should be re-laid out, as we have an advisory service specially for that, and, if our visitors think so, we would give them a grant towards that to enable them to do it.

2520. I do not think I have made my point. I was trying to direct myself to the word "efficiency" which you use in the first sentence of your memorandum, because the inspections which you mention were not in the army a substitute for certain detailed information on which probably a general would base the information as to the efficiency of a unit—he has the personal inspection and figures about delinquency and absenteeism and such things to help him. With your great experience of these things, can you tell the Committee how does one look for efficiency in the statistics of the Hospital Service?——I do not know that we can get efficiency entirely out of statistics.

2521. No, I said how does one look for efficiency in the statistics of the Hospital Service?——The visitors will make sure the fire precautions are right, the kitchens are right, etc., but until we get our departmental costing we cannot get the right comparison. Bed occupancy we consider.

Sir *Henry D'Avigdor-Goldsmid.*] Perhaps I am not making myself clear to you. How do you consider that? So many witnesses have told us there is no particular co-efficient of efficiency and that no statistic will give it to you.

*Chairman.*

2522. Would you say that you have your own home-made points system? ——No. I do not think we go into this as we did before. It does not arise so much because we do not make maintenance grants. Our visiting system and seeing hospital accounts, and so on, are all the guides we get, and we hope to get more.

Sir *Henry D'Avigdor-Goldsmid.*

2523. You cannot help this Committee, which does not have the benefit of person inspection, as to how it can get any information as to efficiency?——No.

*Chairman.*

2524. You agree there are co-efficients such as cost per bed occupancy, and so on?——They are all guides.

2525. Do you think the Ministry uses those co-efficients enough in the allocation of funds?——We do not know what the Ministry do. The Ministry are so secretive they will not say what they use in their allocation; I do not think anybody knows exactly how the Ministry work out their allocation of funds. Perhaps they think discretion is the better part of valour, I do not know.

2526. I am going to ask you a difficult question, which you may not wish to answer. Do you think the Ministry do all they can with regard to these various things, organisation and methods, exchange of bright ideas, creation of cen-

tral services, and so on; do you feel that the Ministry have a grip on this Hospital Service?——I think all we can say on that is that the Ministry have shown the greatest interest in anything we have tried to do and have co-operated with us to the full, and if we have had a number of good ideas they have published them in their annual reports and they have seldom referred to the King's Fund—but that is by the way and we do not mind that. They are receptive to ideas. With regard to the Staff College, they send all their young people to take courses, etc. We think there is a big field, and that is why we think we have an important role to act as a pioneer, or an energiser. It does not matter if we spend £20,000 very much. If the thing is a failure we have spent £20,000 and have made a mistake; of course, the thing may be a success, and we have tried it out. The Ministry find it difficult to do that, of course.

2527. The impression you give me is that the Ministry are terribly anxious and pathetically eager, but are not really willing to take the lead as they should?——I would not go so far as that. It is easy for us to experiment.

2528. Is the Ministry taking the lead?——The Ministry are taking a certain amount of lead in organisation and methods. I do not know whether anything has come out of it. The Treasury are pushing it.

2529. You feel, do you, that the Ministry standards of criteria, their selection of co-efficients, is shrouded in mystery?——I would say that the Ministry are receptive to ideas.

2530. They will not tell you on what basis they work?——That is as to allocation of funds.

Mr. *Holt.*

2531. There seems to be some slight contradiction about the validity of these bed occupancy and other figures with regard to efficiency. Lord McCorquodale's answer a moment ago indicated that they did pay some attention to these figures for assessing efficiency, but, if I remember rightly, in answer to a previous question Captain Stone—please correct me if I am wrong—when discussing the new costing system that is being tried out departmentally said that with hospitals which showed themselves the most efficient on some of the present costing systems when examined in detail the most efficient ones are actually often the least efficient?——(Captain *Stone.*) It might be found to be exactly the opposite, it is quite true. (Lord *McCorquodale.*) I do not think I said that the Ministry pay attention in the grants they give to the efficiency of the hospital, because we do not know what they do do.

2532. But do you?——We do not; we do not give any grants to hospitals now. We would have done in the old days.

2533. With regard to efficiency, you do consider efficiency of hospitals?——We do endeavour to ensure efficiency in hospitals by our visits.

2534. You now consider that the present costing figures can give no reliable guide to the efficiency of the hospitals?——(Captain *Stone.*) That would be my view, yes. (Lord *McCorquodale.*) I would qualify what I said. We do not give grants to hospitals, but have been giving certain grants to convalescent homes, and where convalescent homes do not give us details we would not give them much help.

2535. This document, then, is not worth printing?——As a printer I would not say that.

Mr. *Holt.*] No doubt it is beautifully printed, but it is useless.

*Chairman.*

2536. You refer to the desire to achieve savings in manpower. I suppose you imply that is the Ministry's job where it is not done before?——It is a job for the Service whether it is done at Regional Board level or Ministry level, or even at H.M.C. level.

2537. In paragraph 283 of the Guillebaud Report they refer to the method of allocation of revenue funds, and say there that although it has certain weaknesses it is probably the best that has been devised in present circumstances—that is as to the whole system of financial allocation; would you agree with that?——I would not like to criticise Guillebaud; they did an enormous amount of work and produced a lot of statistics of great interest. I would not

say they were remarkable for the originality of their ideas.

2538. I think you have said enough; it is a very good answer?——Perhaps not one that officially should be put before you.

2539. Would it not be possible to abolish the detailed establishment control exercised by boards over H.M.C.s' administrative and clerical staff; is that not rather unnecessary interference?——Guillebaud went into that in great detail.

2540. What do you think?——I have no views. I think we agree with what Guillebaud states.

2541. Do you not think the financial control is really more effective in control over nursing and other staff rather than the ceiling establishment?——Personally I hate ceilings and establishments and things of that sort, but you have to have them to a certain extent. I think financial control is ultimately the most efficient.

Mrs. *Hill.*

2542. I was wondering when we talk of financial control if a hospital has been very much under-staffed and it is suddenly able to recruit, then it is a great pity if finance is a "stopper" to that recruiting?——That is one of the very serious questions. A criterion must be made by somebody as to what the suitable bed complement in the hospital is, and if they can recruit more up to that then the funds should be made available. The criterion is whether it should expand because they can get more staff, or expand because the needs of the time require it. We were down at a mental hospital last week where if they could get more staff they could open some more wards, but, in actual fact, that would mean they could space the beds out a bit better and stop overcrowding. That would cost more money but would be an amenity. It is difficult to judge whether that expenditure could not better be made somewhere where the need was even greater than to stop this temporary overcrowding.

*Chairman.*

2543. Is there anything you would like to say?——No, I do not think so, except that a good many questions are, to use a Scotchism, outwith our general consideration. We do not set up to be complete critics or what-have-you's of the Health Service. We consider ourselves as an aid to the looking after of the needs of the sick in London. If we can do it by amenity, by helping Leagues of Friends or improving gardens of hospitals, where we do a very great deal of work, anything of that sort which makes the hospital a more human place to live in, we think that is our ultimate criterion, and we would emphasise it is the human problem that really counts in hospital administration, nursing, etc., because the end product of the hospital is a human being and nothing else.

*Chairman.*] I hope you do not think we have been unfair in asking you questions of a somewhat general nature. We were taking advantage of your general experience? Thank you very much for coming.

TUESDAY, 28TH MAY, 1957.

Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Mr. Robinson. |
| Mrs. Hill. | |

Mr. F. F. TURNBULL, C.B., C.I.E., an Under-Secretary, H.M. Treasury, called in and further examined and Mr. G. R. ASHFORD, a Principal, H.M. Treasury, called in and examined.

*Chairman.*

2544. There are various detailed questions we want to ask you, and then some more general questions. I think we will start with detailed questions in connection with staff. Do you think that establishment control over administrative and clerical staff is the right way to proceed now and has that, in fact, any reality?——(Mr. *Turnbull.*) We recognise that a good many of these authorities are now below the establishments which were fixed some time ago. We did consider, a year ago, whether these ceilings ought to be removed. The Treasury were reluctant to have them removed then because we wanted to have a rather longer period to see how financial control stood up in a period in which staff was available more freely than it had been. There was such a period in the last financial year, and I think we are certainly willing to reconsider this now if the Sub-Committee feel that this is something which ought to be altered.

2545. It seemed to me that this method of control, whether it is ceilings or establishment control, is based first of all on the assumption that the 1952 establishments are the permanent ideals and that it lacks reality in the sense that budgetary control would be more effective, rather than this theoretical establishment control. Do you agree? ——We are not quite sure whether the reason why staff is being held down now is because the budgetary control is biting on the staffing situation, or whether it is just the inability of boards to obtain the staff that they want. There has been a period when it has been very difficult for them to recruit particularly nurses, though in the last year it has been easier, and we did want to see whether budgetary control would stand up and continue to control the position when staff was available. On the whole, we think it has in the past year.

2546. So that you are inclined to abolish the more theoretical form of control?——Yes.

Mr. *Robinson.*

2547. One of your motives in doing so would be presumably to give more responsibility to the regional boards? ——Yes; I think we would feel that a single financial control is the best, provided we were satisfied it would effectively control the situation. We have wanted to wait and see whether events showed that that was the case.

2548. Rigid control was put on as an emergency economy measure in circumstances which really no longer exist in that form. Is not that so?——It was put on in 1952 after a period when the cost of the Health Service had risen very rapidly, and we were really looking for all the weapons we could find to control it at that time. I think we are more satisfied now that budgetary control by itself would be adequate.

*Chairman.*

2549. May I just get it quite clear? Is it you in consultation with the Ministry of Health that exercise establishment control, or the Ministry of Health in consultation with you?—— The Ministry of Health exercise control, but they would not remove it without the agreement of the Treasury.

Mr. *Robinson.*

2550. Did they impose it, so to speak, at the Treasury's direction?—— Originally the Treasury pressed for this control, yes.

*Chairman.*

2551. I was looking at what Guillebaud said in paragraph 219, that control from above of staffing establishments in the hospital service in England and Wales should be relaxed as soon as possible. Would you agree with that?——Yes; that is a recommendation we considered a year ago. A decision was deferred upon it at that time for the reason I have given, and also because certain things were happening in other services, and therefore it would not have been very harmonious to withdraw this control at that time.

2552. At the beginning of the next paragraph he refers to consultants and junior hospital medical staff, and suggests there should still be establishment control for that?——We think that is necessary.

2553. Why?——Because the number of consultants and junior hospital doctors does, we think, influence the size of the whole establishment in a hospital, and that if this were without any control it would not merely give discretion to the regional board to increase the number of doctors, but it would inevitably raise a demand for extra staff to back them up.

Mr. *Robinson.*

2554. In some ways it is rather a curious kind of control, in that there is no control anywhere of the number of doctors who, so to speak, get filtered off into specialisation, in other words, into the registrar-consultant pipeline: you merely control the number of consultants' appointments?——Yes. We do feel that it is desirable to keep this control over the medical grades at any rate for the present.

*Chairman.*

2555. I am sure it is my own ignorance, but I am at a loss to understand the precise allocation of responsibility as between the Ministry of Health and the Treasury. What is the Treasury's *locus standi* in insisting on these controls, and do you enforce it while you are considering the estimates, or not?——These are controls which were introduced in order to reinforce budgetary control over the hospital service.

2556. The Treasury has a right——? ——We have the right to press for administrative controls which will prevent expenditure increasing.

Mrs. *Hill.*

2557. May I ask what happens if you have evidence of an extension being needed? How do you deal with a situation like that as between the Ministry of Health and yourselves?—— A regional board has to apply to the Ministry for any increase. The existence of this control does not mean that there never can be additional appointments; it merely means that there is no discretion to the regional board, even if it has the money, to employ some more medical staff.

*Chairman.*

2558. You only go down to regional board level in your investigations?—— Yes; the Ministry's control is at regional board level.

Mr. *Robinson.*

2559. Why do you think that budgetary control is not likely to be as effective in this field as in the other field of staff and establishments?——We think that a regional board might in a given year find it had enough money, by making savings or otherwise, to take on additional doctors and that might produce, almost of necessity, a demand for further staff in order to supply the doctors with what they needed, and therefore this is a controlling element in the situation.

Mrs. *Hill.*

2560. What action do you take with boards of governors? We know they have teaching hospitals and that their staffs are always so much larger in proportion to the staffs under regional board control?——There is similar control of boards of governors.

Mr. *Robinson.*

2561. As effective as regional board control?——I could not say whether applications from teaching hospitals would be more readily considered. I would not have thought they would be.

*Chairman.*

2562. Have your efforts ever resulted in the great London teaching hospitals

refraining from appointing anybody they wanted to appoint?——I think they have resulted in restricting numbers. I do not think that the number of consultants has increased very greatly.

2563. Does the Treasury definitely lay down actual numbers and say what number of consultants should be appointed to a given teaching hospital?——(Mr. *Ashford.*) I think that there is some slight misunderstanding here. Detailed control is exercised by the Ministry over regional boards and over teaching hospitals in that proposals for additional appointments are put up to the Ministry. They do not come to the Treasury. The Treasury is concerned with there being control by the Ministry ; we do not come in on the details.

2564. Where do you come in?——On the general issue of there being control over staff complements and, in this particular case, medical staff complements.

2565. Yes, but when you say that what does that mean? Do you deal with figures at all?——No.

2566. Then what do you deal with? Do you just say to the Ministry: "We think there ought to be a limit"?——No ; the Treasury view has been that there should be a control, in certain details, by the Ministry as part of the general financial control of the Service ; and the Ministry administer that control.

Mr. *Robinson.*

2567. You give the Ministry a certain amount of discretion to increase expenditure within fixed boundaries—for example, senior medical staff—and if, as you say, regional boards and boards of governors come to the Ministry with an application, and it is not invariably turned down, therefore one must assume, must one not, that there is some discretion given by the Treasury to the Ministry?——Entire discretion.

2568. If the Ministry chose to accede to every request that was made, the Treasury could not object, even though it meant coming back to the Treasury? ——(Mr. *Turnbull.*) I think if it were used in a way which allowed the service to grow far more rapidly than the money could be allowed to be spent, we should certainly object.

Mrs. *Hill.*

2569. That is the point I am most interested in. How does the Treasury decide where to stop, because if the Ministry puts up a perfectly good case, having had it put up to them by either a regional board or a board of governors for, say, some particular extension of the Service, how and where does the Treasury say, "Well, you have spent enough money ; you cannot have it"? What, in short, is the yardstick?——We fix the annual estimate by the process which I described when I was here before, and which is set out in the Treasury paper. In a given year the Ministry can allow an additional consultant's appointment at any teaching hospital if they think it right to do so, but they have to keep within the global figures agreed in the estimate. There is, however, an element of expansion allowed.

Mr. *Robinson.*

2570. Which the Ministry retain for distribution in the course of the year? ——They decide in the sort of way described in one of their papers how to divide this money between different parts of the service. It may be consistent with that that there should be some small addition to the consultant staff.

*Chairman.*

2571. You have given me the impression—and perhaps I have got it wrong, and if so, then it is entirely my own fault—that the Treasury exercise some control over the appointments of consultants, but that is not the case? ——No ; I am sorry if I gave that impression, because it is wrong. What we have insisted on so far is that there should be a control exercised by the Ministry over medical appointments.

2572. How would you define the word "control"?——Their approval must be obtained for any increase.

2573. All you have done really is to say to the Ministry: "You must keep in your own hands approval of the appointment of consultant and junior medical staff"?——Yes.

Mrs. *Hill.*

2574. Has it ever occurred that the Ministry have asked for certain sums of money knowing that there are certain

extensions, new techniques and so on, and you have said, "No, we are sorry, you cannot have it"?——It has happened that the Ministry of Health have asked for an amount for the development of the Service in a given year and that they did not get the whole of it; they got something less.

*Chairman.*

2575. Do you refuse that whole sum after examination of the Ministry's request on its merits or do you refuse it on grounds of financial stringency? ——Mainly the latter. They come and make a case, and we have to weigh that case against the case put forward for other things in the light of the general financial situation of the time.

2576. Is there a large department of the Treasury that deals with the Hospital Service?——No.

2577. What does it consist of?—— There is one Principal, an Assistant Secretary, and myself, and some subordinate staff. The Principal is very largely engaged—almost wholly whole-time—on Health Service work, of which hospitals form a big part.

2578. So that it is no good our asking you detailed questions as to the administration of the Health Service; we can only touch on the broad general principles and the general view that the Treasury hold?——Yes.

2579. Have you any views on the fact that the salaries of hospital administrators, using that term in its widest sense, are so closely tied to the bed complement, and do you think it is possible that there could be any alteration to it or any alternative salary basis, because it must lead to empire-building and a desire to expand rather than to contract?——We think there must be some objective principle to which those salaries are related, that you cannot leave it to the discretion of the authority, unless there is some central control over what they do, and that it is more harmonious with the present system to have some objective standard. Hitherto we have thought that this system of relating salaries to beds, and certain other things which are brought in for administrative grades, is the best that we can find, but we recognise its weakness, that it may encourage people to cling on to their empires, so to speak. But we think that any alternative really drives you in the direction of central control with grading of posts.

2580. Have you any views as to what coefficient of efficiency you could concoct, what criterion of efficiency there could be?——That is obviously the central difficulty in the whole of the financial control of the Health Service. We have thought that it ought to be possible, particularly with the aid of the new costing system, to devise fairly good yardsticks for assessing efficiency. I do not think they exist now. You have only two main ones now, the cost per in-patient week and the cost per case, and they both have to be looked at to arrive at a reasonable view of what a given hospital is doing. You also have to compare with other hospitals which are doing substantially the same thing. Therefore, I think that these comparisons between hospitals have got to take account, as things stand now, of both the cost per in-patient week and the standard of service which may be reflected in the cost per case.

2581. Yes, there are various factors. But in brief your answer is, is it not, that you are pinning your faith to the new costing system?——Yes; we think that ought to make it easier to establish statistical yardsticks which will point to those places where the Service is expensive.

Mr. *Robinson.*

2582. There is still the quality of the Service, which so far as I can see must always remain an immeasurable factor? ——Yes.

2583. For instance, if you had a hospital which was extremely cheaply run on the basis of the cost per in-patient and the cost per case, it might well be that the mortality rate was extremely high, and in circumstances like that would you not assume that the quality of the service given was probably the cause of the low cost?——Yes.

Sir *Henry D'Avigdor-Goldsmid.*

2584. As against that, I think the Chairman of the King Edward Hospital Fund did mention to us that in America a similar fund had what he called a points system. I must say I would have

liked to have heard more about it. I wonder if such a thing has occurred to you?——Yes. I read that part of the evidence with a good deal of interest. I would have thought, at any rate when we got this new costing system, it ought to be possible to compile a points system which would at any rate direct attention to the places where there was a *prima facie* case for thinking that the cost of the Service was high in relation to what was provided.

*Chairman.*

2585. Would you urge the Ministry of Health in that case to vary their allocations to regional hospital boards?——Yes. We would like to see the distribution of the money effected by performance rather more than I think it is now.

2586. Have you any power to enforce your views on the Ministry?——Not by ourselves, no; but the Treasury as part of the Government have a voice in this.

2587. Do you in any way intervene in the allocation of funds to regional hospital boards?——We have not done hitherto, apart from discussing with the Ministry how they do it.

2588. Are you empowered to? Could you, for example, suggest that cuts should be made in the allocations to those regions which appear less efficient or to those groups that appear less efficient, and have you considered whether that would result in increased efficiency or simply in lower standards? Does that fall within your purview?——These are matters which have to be discussed between the Ministry and the Treasury; but we are entitled to discuss them because they affect the way in which public money is spent and used. There may be disagreement of course between us, in which case the only remedy we have is to have the matter taken up to Ministers.

*Chairman.*] Or by withholding supplies.

Sir *Henry D'Avigdor-Goldsmid.*

2589. Are we to take it really that your position is that these are governmental decisions and that in cases of disagreement, where your views are not acceptable to the Ministry of Health, it requires a governmental decision to sanction it?——Yes, that is always the case.

2590. As between Departments which are equal?——Yes.

*Chairman.*

2591. Has this sort of case ever come up, the idea that less efficient regions should be cut because the Ministry say that would result in lower standards? Do you agree with that, or do you think it would ginger them up?——I do not think one can preclude the possibility, in the circumstances of this Service, with a pretty wide variation of standards from one end to the other. If there is a limited amount of money it might be right that the standard at the top should be somewhat abated.

2592. I was suggesting the other way round, rather: that you should punish the less efficient regions by a more stringent financial approach?——We would agree with that if we could find a satisfactory way of doing it. I think the Ministry's argument is that it is very difficult to distinguish between high cost due to lack of efficiency and high cost due to higher standards; and I think that it may be very difficult to be quite sure that you are distinguishing solely on grounds of efficiency. Perhaps you have to make a subjective judgment in each case in the end if you do this.

2593. Now to turn to development and improvement expenditure. Do you think the Ministry has adequate control?——The paper which the Ministry have put in* shows what they have been doing over recent years in dividing up the money, and it does bring out, I think, that they have done a fair amount in the distribution of development money, to put it where it is most needed, and to give less to the authorities with a high standard of service. But we would hope that more could be done—particularly if we could cut into the basic amount, which is needed to carry on the Service at the existing level, and——

2594. Would you explain your last phrase?——Yes. You have two stages in this, really. You assess what you think is needed to carry on the Service in a region or a hospital group or a hospital, at the standard reached at the end of the previous financial year. On top of that you give something for development, which may be received by most authorities, or, rather, all regional

* App. 4, p. 378.

authorities will receive something, but not all hospitals will receive something. So far, however, the re-distribution of the money is being achieved solely by distributing the development money in the direction of the low-cost authorities, with a bias in that way. If you could widen the field of this operation by reducing, after due notice, the amount which is given to authorities which appear to be high cost, you could bring about this equaliation more quickly.

2595. Some regional boards make savings on maintenance and finance developments and improvements to a greater extent than is normally permitted in the allocations. Do you think that is right or wrong?——I think it rather depends on circumstances. This is part of the exercise of virement which is permitted to regional boards. If a hospital makes a saving which is a recurrent saving, that is to say, they save it this year and they will go on saving it from year to year, then it does not seem to us that it is wrong for the Regional Boards to be able to use that money for development which will offset the saving in the first year and in subsequent years. But there can be savings which are once for all savings, savings which do not repeat themselves in year two.

2596. If the savings are recurrent, surely it looks as if the application for money for maintenance was exaggerated and cannot be justified, does it not?——They may find new ways of making savings, though I agree that is so really; but if you want an incentive to these people to look for economies, this seems to us the only way you can give it.

2597. Does it result in economy?——It results in some economies: they are diverted to improvements.

2598. Oxford, for example, said "We had to finance developments and improvements in that year"—I think that was 1956-57—"of something like £150,000 to £180,000. For that we only got £32,000 from the Ministry", and they went on to say that they got the other together by keeping back a certain amount, by reducing the allocations to management committees, and so on. You think that is all right, do you?——I do not think this can result in a larger burden on the Exchequer than we have agreed to bear for that year.

Sir *Henry D'Avigdor-Goldsmid.*

2599. Would you not agree that the only conceivable way in which the burden on the Exchequer can in any way be reduced is for this power of virement to be severely curtailed?——If there were no power of virement, we should have fixed a given sum for expenditure in a year. If anyone made a saving we should get the money back; but the great danger of that is that they have no incentive whatever to make any savings, and therefore you do not get it back, and it seemed to us better, in the prevailing circumstances at any rate, to say: that if a regional board can make a saving in one of its groups, that is at its disposal for development purposes, because that is an incentive.

2600. If I may take it one stage further, there are some savings which boards cannot avoid achieving. A situation arises when there is an infectious disease in a children's ward and that children's ward is closed to any further occupancy by children, perhaps for as long as three months; there are a large number of empty beds, and there is in fact a cash saving, but there is no inducement and the money is saved. I want to put that to you. What do you say?——I think most regional boards run their affairs on the basis that when that sort of thing occurs, the money is drawn into the region; there may be other cases elsewhere where there is additional and unforeseen expenditure of a different kind.

*Chairman.*

2601. Are not we in danger of giving tacit approval to the theory that expenditure can only increase and the expenditure authorised in previous years is sacrosanct and forms a sort of jumping off place for the future?——Yes, we may be, but we have thought hitherto that, on balance, it is far better to give these authorities an incentive to find ways and means of saving money and to apply it to improvements where it is needed than to withdraw any such incentive——

2602. But there is no saving?——There is no cash saving to the Exchequer if they spend it.

2603. What do you mean by "saving"?——Well, we have not saved on the amount that we have fixed for the year, but we have met a need for

development which would otherwise be pressed upon us in the following or subsequent years as a claim for an increase in the annual amount.

*Chairman.*] Yes ; I accept that.

Mr. *Robinson.*

2604. If the power of virement were eliminated it would also eliminate the incentive to improve the Service from regional boards to management committees, would it not?——Yes ; I think if the power of virement were removed the pressure on the Ministry and, through them, on us for larger allocations for development would be increased.

*Chairman.*

2605. But if you approved this practice it might result in extensions taking place in regions or groups where the Ministry have definitely said they should not take place. Do you think that is right?——The Ministry, I think, have taken the line that they allocate a sum for the year and that is the limit that a regional board may spend ; they must not spend more, but they can spend the whole of it on whatsoever they deem best in the interests of the Service.

Mrs. *Hill.*

2606. You have occasionally had sums returned to the Ministry representing unspent balances by regional boards? ——Yes, it has happened.

Sir *Henry D'Avigdor-Goldsmid.*

2607. That is proof of lack of administrative ability by that regional board, according to your thinking?——No, I think it is a good thing if they feel that they can do that.

2608. But in answer to the Chairman you have expressed I think the opinion that if they could spend the amount they had saved on one head on something else, then that was a satisfactory development because it relieved the Treasury of future calls upon them. You have expressed that opinion?——Yes.

2609. Surely it comes back to what I said before, that if they do not act in this satisfactory fashion, therefore they must be acting in an unsatisfactory fashion in returning funds?——They may not have any means of being able to use moneys which they save for some fortuitous and reasonable development in the year, in which case they have to return the moneys to the Exchequer. It is a normal operation of the annual system.

*Chairman.*

2610. This you might call extra-development expenditure?——Yes.

2611. Surely that tends to make the disparity between regions even greater, does it not?——It may have that effect.

2612. It may lead to extra current expenditure in subsequent years?——I think in most cases a saving made in a year will be made part of the way through the year and may produce a larger saving the following year. But I think that this process has to be watched. It is quite arguable that a regional board ought to be told by the Ministry that they should control this in a way which ensures that the savings are going to be enough to finance developments in the second year.

2613. But do you not think it would really be better if the thing went according to rule, if you worked according to rule, and that the Ministry had complete control over developments, as the Minister was meant to?——Yes, I think it would have great advantages.

2614. In fact, you would agree with that?——I think it would have advantages from the Treasury's point of view.

Mr. *Robinson.*

2615. Could you say how conceivably the Ministry of Health could decide as between priorities in widely differing fields of medicine and in widely differing parts of the Service?——They do now distribute a sum for development, new money, but what I understand the Chairman to be suggesting is that if there are savings on the estimates of regional boards during a year, those should be brought into the Ministry to use as new development money and distributed again.

*Chairman.*

2616. Do you think they are always savings due to efficiency Do not you think that very often they arise from a deliberate decision of a regional board not to do certain things in the course of a year and to transfer that money to

developments? If it were savings due to efficiency I could understand your argument; but are you sure they are savings due to efficiency?——There was one source of abuse, and that is that at one time savings were made on building maintenance—you did not redecorate, you put it off for a year, and thus you saved so much money, and you put that into development. That was one form of saving. It is not saving annually. We think we have dealt with that now because we earmark each year a minimum sum out of the allocated money which must be spent on building maintenance, and I think that does ensure that an essential minimum of maintenance is carried out.

Mr. *Robinson.*

2617. Would not it be true to say that the typical kind of virement that we have been discussing would be, for example, where a small tuberculosis hospital, or even ward, were closed down because of a fall in the incidence of the disease, and were then reopened as an old people's geriatric unit? That would in effect be saving in one department and developing another, probably with no cost to the Hospital Service. Would that be an exercise of the power of virement in the sense that you have in mind?——Yes.

*Chairman.*

2618. Oxford actually said that they finance this deficiency of about £120,000 or £130,000 by keeping back a certain amount, by reducing the allocation to management committees, and it looks as if there is something queer going on somewhere?——Yes; they have really been doing on a regional scale, I think, what I was suggesting might conceivably be done more on a national scale; that is to say, they have been cutting into the allocations to management committees for running costs and forcing them to make do with rather less and using the proceeds for development.

2619. I asked them whether that did not mean they over-estimated their requirements and they said that it did not. Will you now turn to a slightly different point? Do you approve of the Manchester Regional Hospital Board's practice of retaining at the beginning of the year a small maintenance reserve, very strictly limiting the initial allocations, or do you prefer the Oxford method of making a once for all allocation at the beginning of the year, or do you think that is a matter that should be left in their hands?——I should have thought it was a matter you could leave to the regional boards themselves.

2620. You do not think it is your business?——I have no strong views about it.

2621. I want to turn to rising expenditure on drugs. I imagine that you are disturbed by that, are you not?——Yes, but of course it is the reflection in part of a good thing: these more expensive drugs do I think enable people to be cured more quickly.

2622. Is not that rather a touchingly childlike expression of faith?——I said "in part". I think one must recognise that these very expensive drugs push up the drug bill, but they also have the advantage that they are accelerating the rate at which people can be put through hospitals, to use an unpleasant phrase. They are also preventing a certain number of people even going into hospital. But, having said that, I think one must recognise that this very large increase in the drug bill is alarming.

2623. Have you any ideas as to how it should be controlled?——I am afraid that we have not been able to think of anything much better than what the Ministry have put before you. There is to be the Hinchcliffe Committee on this which will I think explore the possibilities of improving the attitude of doctors to drugs, making them cost-conscious during their training. A certain amount of that is already being done in medical schools. The only other hopeful line seemed to us to be what one or two witnesses have I think suggested, that the system under which the use of expensive drugs by junior hospital staff and by consultants might be extended to meet a more universal——

2624. May I interrupt you there? Have you ever thought of the ceiling idea, or do you think it is impracticable?——We are naturally attracted by the ceiling idea; but the difficulty about it is an obvious one, that it may bring you up against the right of a doctor to prescribe what he thinks necessary in a given case, and if there is a ceiling on

expenditure in a given period in a hospital you may obviously come to the point at which the ceiling comes down on some particular case.

2625. One would apply the ceiling only where there was manifest extravagance and something had to be done. But there are great difficulties, I know. Now have you considered the domiciliary consultants service?——Yes; we saw the evidence which was given about this.* The system of paying whole-time consultants something extra for domiciliary visits has only been in operation since 1955.

2626. Why was it introduced?——The reason why it was introduced was that part-time consultants had had this all along as a result of a recommendation of the Spens Committee, and there was increasing feeling I think among whole-time consultants that this work did put an extra burden upon them in fact and that it was not equitable that part-time consultants should receive these payments and that whole-time consultants should not receive them at all. The present system is that they get payment for domiciliary visits in excess of eight in each quarter of the year. They do eight visits for nothing and if they are called upon to do more than eight they get payment.

2627. It does seem a little queer at first sight that a man should be paid for a domiciliary consultation during normal working hours, and you may recollect some of the evidence was most disturbing about this—I am thinking particularly of the evidence given by South-East Metropolitan Regional Hospital Board: in six years domiciliary visits increased from 14,000 to 23,500 and the expenditure went up from £56,000 to £100,000, and I think I recollect there was some disturbing evidence about the times when those visits occurred?——Yes. This is for both together, whole-time and part-time?

2628. Yes. Would you enlighten my ignorance about part-time consultants? On what basis is such a consultant paid and how is part-time apportioned?——(Mr. *Ashford.*) I cannot remember the precise details, I am afraid, but he is paid on a sessional basis, a session being a half-day. He gets a proportion of the full-time rate according to the number of sessions he does per week. There is a certain weighting: for example (I may not have got the figures quite accurate) a consultant doing four days a week, that is four half-days work, might get paid 4½ elevenths of the full-time consultant's salary, there being eleven half-days per working week.

Mr. *Robinson.*

2629. The extra half being theoretically to cover travelling time?——Yes, and I believe his continuing responsibility for patients out of duty hours. But this is all negotiated in the Whitley Council.

*Chairman.*

2630. Do you think there is abuse of the domiciliary consultants service and can you do anything to check up?——(Mr. *Turnbull.*) I think we have had no cases suggesting it was abused, but if the sub-Committee feel that the evidence given before them shows that there is abuse, we should certainly want to consider the position further. It is a matter which would have to be discussed, through the Whitley machinery, with the profession.

Sir *Henry D'Avigdor-Goldsmid.*

2631. Could I ask a slightly allied question? Do you think there is an excessive use of these out-patient department facilities due on the whole to the doctors' unsatisfactory position in law at the present time, including liability to be sued for damages in certain cases?——No, and I have no knowledge of this really; I have no basis on which to give an answer, but I think that is a point that could be put to the Ministry.

*Chairman.*

2632. Have you got the Memorandum from the South-East Metropolitan Regional Hospital Board on the domiciliary consultant service*?——No, I am afraid we have not got that with us.

2633. In the third paragraph it says that originally the intention was that all requests made by general practitioners for such a service should be passed through the hospital in question and they said that that would provide an important form of control. It was, however, abandoned with the agreement of the Minister in 1951 for the sake of convenience. They go on to say that that removed any control by regional boards;

* App. 5, p. 385; App. 10, p. 394.

* App. 10, p. 394.

it means that any control by regional boards of this Service can be exercised only after a visit has been made, that is to say, in the course of subsequent examination of a claim for fees and travelling expenses presented by the specialist who made the visit. It is a little worrying, is it not?——It is.

2634. Perhaps you would study that Memorandum, because I think it is interesting?——Yes.

2635. Now we have had some evidence from various people about how difficult it is to get small capital works done like replacing boilers and so on. Is it possible that "capital" is too rigidly defined?——We would think it was right to keep a clear distinction between capital expenditure and current expenditure. The system for controlling capital expenditure as between us, the Treasury, and the Ministry of Health is that an annual total amount is fixed, and we give agreement to the starting of big schemes that are going to involve expenditure over the years, so that we do not get faced by a small expenditure in year one and some big expenditure in the future without knowing that it is within a total sum that we can agree. It is not a matter of great importance to the Treasury how it is divided between big works and small. On the whole we prefer small works which are going to be quick revenue savers. The programme for this year does include £4 million for plant replacement schemes of a revenue saving type, which is a larger amount than in previous years.

2636. You did read the evidence of the Springfield Mental Hospital, did you? ——I am afraid I do not remember it on this point.

2637. I do not necessarily accept all they say or all the deductions they may have made from their experience, but it was interesting?——Yes.

Mrs. *Hill.*

2638. Has the point been put to you, that had there been more capital expenditure we might indeed have saved in other ways on the Service?——Yes, often, but it rather depends I think on what you mean by saving. Our feeling is that most of the big capital projects at any rate at the present are going to enlarge the cost of the Service because many of them are extensions. There are these other kinds of schemes which are replacement schemes which contain I think a considerable element of improvement, but which may make a saving both in the sense that you get the same thing, or something slightly better, for a lower annual cost.

2639. It would be true to say that some schemes, because they have been deferred owing to this limit on capital expenditure, are in fact going to cost very much more because of the delay? ——Because of rises in prices?

2640. Yes?——Yes, that is true.

*Chairman.*

2641. Now I turn to more general questions. Do you think it is right—I am not being tendentious in this—that the very high standards of the teaching hospitals and the very great cost of the teaching hospitals should be so much at variance with the regional hospitals? ——We are no more than laymen in viewing this; but our feeling has certainly been that the great disparity between the teaching hospitals, and particularly the London hospitals, and general hospitals is greater than we would have thought, on the face of it, was reasonable. There are obvious reasons why they should be more expensive—but whether they are more expensive because of higher standards and higher costs than they ought to be, I think must be a matter of opinion to some extent. We would have thought that in the existing situation, with limited availability of money for the Service, the disparity was rather too great.

2642. Is the Treasury doing anything about it?——We have not so far brought this to the point of challenging it, apart from discussions with the Ministry, who I think feel that they are already doing something through the distribution of development money to reduce the disparity.

2643. If you take the case of Guy's who gave us very interesting evidence, the ratio even of administrative staff, and if you include the nursing staff it is even more disproportionate to beds, is extraordinary when compared with ordinary regional hospitals?——Yes.

2644. The answer is, of course, that Guy's feel that they want in the course

of a doctor's career to show him how to do a thing and that it is done perfectly and to the highest standard, but the net result is that costs in teaching hospitals far exceed those in regional hospitals? ——Yes.

Mr. *Robinson.*

2645. Would you give as your opinion that the financial control exercised by the Treasury through the Ministry on boards of governors of teaching hospitals is less effective than on regional boards? ——I do not think it is less effective ; it has been exercised in such a way, I should say, that, by and large, the teaching hospitals are getting less advantage out of development moneys than hospitals under regional boards. I should have said, on what the Ministry say*, that they have to some extent favoured regions as against boards of governors.

2646. That would be a fairly recent change, would it?——Since 1954-5, anyway. In some years boards of governors have had nothing ; in others they have had an amount related to the number of occupied beds—that is to say not related to expenditure.

*Chairman.*

2647. The variations as between regions are being reduced, as we have seen. Is it your opinion that that reduction is proceeding fast enough? There was a 34 per cent. deviation in 1951-2 and it is only 20 per cent. now. That is in costs. Would you say that that is proceeding fast enough, and would you say that you expect a rapid improvement in that when you get a proper costing system?——I do not think that the costing system is likely to affect this very much, unless it is used in a way which will accelerate this process, and we would hope that it would be by the sort of techniques I was trying to indicate earlier: that you would use this costing system to try to detect the places where it would be right to reduce expenditure because expenditure is high in relation to the standard provided. But I am not sure that can be done automatically.

2648. Now I wanted to ask you two fundamental questions. The first is this. Do you think that there is any body or any group of people who have the time and the ability to sit down and think about the future of the hospital service and its longer-term objectives? Do you think that there is conscious control of the direction in which the hospital service is going?——I think the only place where this could exist is in the division of the Ministry of Health which deals with the hospital service, but whether they are sufficiently manned to give enough time to long-term thought on this, I do not know.

2649. Do you detect any evidence of long-term thought?——I think that in distributing the money they are trying to change the pattern of expenditure.

2650. Trying to change the pattern? ——They are trying to change the pattern of expenditure. They have achieved something, as has been shown in the example of 100 notional beds to which you have referred* ; but how far they give thought to changing the existing pattern, otherwise than by distributing development money, I do not know. I have no indication that any new plan is being worked out.

2651. Would you agree with what I certainly feel very strongly, that you will never get the ideal service from the point of view of efficiency unless you recognize that fundamentally it depends on getting the right men into the Service and keeping them there, and that the greatest help that anybody can give to the Hospital Service is to see to it that the right people are recruited and that a proper career structure is open to them?——We agree that is very important.

2652. It is fundamental?——Yes.

2653. And that efforts to achieve both economy and efficiency break down if you have not got men capable and qualified to run this elaborate and complicated work?——Yes.

2654. My final question is this. I rather wonder how much you can claim that there is Treasury control of the Hospital Service's expenditure. Are you satisfied with the degree of control you have got and do you think it is a reality, or is your function really limited to signing the cheque?——As I said, I think, when I appeared before, we are satisfied that we have got control of the total ; we do not think it can run away. In recent years at any rate the system within this Service has seemed to us to

* App. 4, p. 384.

* App. 3, p. 378.

work pretty well; that is to say, we have fixed a sum, it has never been exceeded by any big amount, and we think that the Ministry have power to ensure that it is observed. But on this question of the distribution of money within the Service, we frankly recognize that we have not very much control, no more than that we can try to influence it, unless a decision were taken to change the system by which the Ministry distribute the money.

2655. Is it the job of the Treasury to turn their mind to the possible fundamental recasting of the system? Do you think about that in the night watches? ——It is not one of our primary tasks. We do think about these things. However—we cannot devote enough time to this particular topic to re-think it from top to bottom; that would have to be done in the Ministry.

2656. Is your Treasury view that something like the block grant system should be instituted?——We have a view about the block grant system, yes.

2657. What is it?——That it is wrong to have a block grant system for a service which is 100 per cent. Exchequer-financed, and particularly so when it is on as big a scale as this—if you mean a block grant system over a period of years.

*Chairman.*] Yes.

Mr. *Robinson.*

2658. Would you have the same objection to an annual grant, non-returnable? I am talking now of maintenance expenditure?——The annual grant non-returnable is a fixed amount of money; it is really allowing a carry-over, which is contrary to all the doctrines for which the Treasury stand as to the control of government money.

*Chairman.*

2659. I have received the impression that there is both too little and too much central control; that the Ministry of Health are not really capable, not necessarily through their own fault, of running the Service; and that their efforts to do so have very often thrown a spanner in the works and resulted in making confusion worse confounded. I am wondering if the Treasury have something at the back of their minds that they would like to suggest for recasting the system. Perhaps that is an unfair question?——No, I do not think I can put anything forward on that.

*Chairman.*] That is getting rather a long way from our terms of reference, I think.

Mr. *Robinson.*

2660. Would you agree, from your experience, that the Ministry exercise a more detailed control over the expenditure of money with the Health Service than was envisaged in the Act?——I should not have thought so.

2661. You would have thought that control of establishments was envisaged in the Act?——I do not think it was precluded. If you mean control exercised through the distribution of money, I should have thought the answer was No.

2662. I really meant the approval of development schemes; and I was also thinking of approval of capital schemes, but that is rather outside our terms of reference. You do not think there is more control?——No, I do not think so.

Mrs. *Hill.*

2663. Would there be objection to looking, say, three or five years ahead and allocating a sum for capital expenditure with the release of so much annually, so that everyone could plan forward?——This is part of a very big issue. The Treasury view is that we have to have controls over all capital expenditure which is financed from Government funds, because this is a very big element in investment as a whole.

*Chairman.*

2664. Control means you authorise every allocation?——That there must be programmes for the work which is to be started in each year, which have been approved after being looked at as a whole in a sort of global way, so that we can see what sort of commitments the Government is accumulating to be met out of government funds or government-raised funds.

2665. Like the Road Service?——Yes. I think we should be very hesitant of entering into long-term commitments for a great many large government programmes of capital works which became unalterable for a period of time, and which you could do nothing about if the economic situation demanded that they

should be contracted. Capital works are controlled now, the big ones, in terms of starts: it is agreed that so much shall be spent on starting major schemes in a given year and how the cost will be spread, say, over five years. While there is no absolute assurance, there is a basis for planning ahead and, certainly on big schemes, it would be a very abnormal situation which would cause us to demand that they should be slowed down, once begun.

*Chairman.*

2666. Those are all the questions. Is there anything you would like to say to us?——No, I do not think so.

*Chairman.*] Thank you very much indeed for attending and for your help.

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## TUESDAY, 4TH JUNE, 1957.

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Members present:

Mr. Nicholson, in the Chair.

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| Sir Henry D'Avigdor-Goldsmid. | Vice-Admiral Hughes Hallett. |
| Mrs. Hill. | Captain Waterhouse. |
| Mr. Holt. | Mr. Willis. |

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Sir JOHN HAWTON, K.C.B., Permanent Secretary, Ministry of Health, called in and examined; Mr. J. E. PATER, C.B., Under-Secretary for Hospitals and Specialist Services, and Mr. A. S. MARRE, C.B., Under-Secretary for Finance and Accountant-General, Ministry of Health, called in and further examined.

*Chairman.*

2667. Sir John, I should like to ask you a very fundamental question to start with on which everything else hinges, and that is: to what extent does the Minister regard it as his duty to plan and guide development of the Hospital Service as a whole? Do you think that the Minister and the Ministry are really capable of being a fully effective instrument for that, do you feel that they are charged with more than they can perform, or do you think they can, and do, perform it?——(Sir *John Hawton.*) I do not think they are charged alone with it; it is a combination of the Minister with responsibility for the future policy of the Service working through experienced and mostly voluntary people both at regional and local level; it is a partnership of those three tiers, plus (side by side with that) the teaching hospitals, which I would rely on to secure proper development. I should not say that it rested entirely with one Minister or his Department; it rests on a combination.

2668. Would you say that the Minister is mainly concerned with planning or with having general supervision over administration?——He is concerned with much more; he is concerned statutorily with the duty of seeing that the public gets as good a Service as it is possible to give it with existing resources.

2669. That implies that the Ministry, or some people in the Ministry, should have time to sit down and think and should be capable of formulating a clear objective in their mind and that they should be working towards that objective. Would you say that takes place and who does the thinking? Is there any time for that?——The great majority of the Ministry does, with examples which I need not bore you with; the majority are concerned with nothing except the Health Service under the present arrangements, with the Minister, and a big section of that is concerned

with nothing but the Hospital Service, and that is assisted by a big section of medical and other advisers, some of them part-time, some of them full-time.

2670. Is that a clear objective? Is there enough opportunity for clear thinking about the future?——Perhaps I should not express a personal opinion here——

2671. I hope you will?——I do not think that pure thinking, in the abstract, detached from the administration of the Service, is what is wanted. I think that what is wanted is the administration of the Service under the Minister, coupled with a continuously developing concentration on seeing that it develops the right way.

2672. I will give you an example. Has the Minister—and obviously in that term I would include the whole Department—any clear idea as to how in future the administrative side of the Service shall be staffed, how to ensure there will be a career structure, or ladder of promotion, and how to make sure that the really best people are secured for the Service and a suitable career offered to them?——That is a very good example of what I have just said. It seems to me that all that is part of the administrative service. Securing that there is a proper career structure or securing that the administrative structure is the right one throughout the service, is exercising the Ministry a great deal and has, indeed, been referred for special investigation to Sir Noel Hall. That is only one example. That applies to all the different branches of the Service.

2673. Do you mean that all major questions of principle have to be referred to outside bodies?——I think you would agree that it is a very good idea to import outside opinion to weigh against one's own, and not to rely entirely on a desk bureaucrat.

2674. By saying that you imply that with which indeed I am in full agreement: that a Department headed by a Minister is not suited to formulate long-range policy for a service so complicated as this?——No, Sir; I think that one cannot differentiate between the Minister and his Department. A Minister with his Department behind him is perfectly competent to do all those things; he is merely aided in doing them if he refreshes himself with outside expert opinion, for which indeed the National Health Service legislation itself provides.

2675. That being so, can you tell us what the Minister's ideas are as to the creation of a satisfactory career structure in the administrative branches of the Health Service?——I really cannot, of course, describe what his personal ideas are, but I should think he would weigh other opinion.

2676. May I interrupt you by saying that you have already said you were not distinguishing between the Minister and the Department?——I am sorry. When I speak of the Minister all the time I mean the Minister entirely supported, and his policy entirely carried out, by his officers; there is no distinction between them; they are there to serve him. Apart from things like the Noel Hall inquiry, he institutes all kinds of other experiments. He encourages experiments for three-year training courses for hospital administrators to see if we can develop a new kind of opportunity for administrators. There is the beginning of such a scheme in Manchester and London.

2677. I must interrupt you again, and it will save time if I cut you short. I merely wanted to find out from you what the Department's ideas were and why they were getting Sir Noel Hall to check up, and what is the mind of the Department on the question of a suitable career structure?——If we knew in the Department precisely what career structure or precisely what administrative arrangements were ideal, there would be no need to take anybody else's opinion at all.

2678. But presumably you have some ideas of the subject?——We want to improve the career structure and we want to give more interchangeability to the higher administrative posts. We want people to feel that there is more movement for them from one kind of job to another in the higher fields of the Hospital Service. It is how to get the actual pattern of that that we seek other advice to reinforce us.

2679. Would it be unfair to deduce from that, that people are too busy in the Department to formulate even a tentative scheme for achieving those objectives, and that therefore they have to fall back on outside advice?——No, Sir, I do not think it would be fair to assume that.

2680. Then may we know what these tentative schemes are?——I tried to describe them a moment ago.

2681. I cut you short. In other words, you reject the suggestion that the Department has not quite enough time to think of formulating long-term schemes?—— It is always a problem for a Department to find time to divide between its daily preoccupations concerned with keeping the thing going, and its long-term planning. I believe that in the Department a blending of that is going on all the time.

2682. Thank you. Now, to turn to more detailed questions: does the Department follow up enough the distribution of the money they have allocated to regional boards?——I wonder if you would be good enough to amplify that, Sir?

2683. For instance, there are wide variations in regional costs, as you would agree?——Yes.

2684. What is the Minister's policy with regard to these variations?——He obtains costing figures to enable them to be compared and to see how far they are justifiable.

2685. You are putting your trust in the new system of costing?——Partly in the simple, slightly hit or miss system, which has gone on for many years, but particularly in the new departmental costing system.

2686. But there are still variations amounting I understand to as much as 20 per cent.*?——There will always be variation according to the conditions in the region, the type of buildings that they have to use, and the type of hospitals. We do, in making allocation of money for their expenses each year, take into account those regions which have been running at a lower rate than others, and give them some benefit for that, so that we are all the time trying to keep a fair balancing up.

2687. I understand that you do not give reasons for variations in allocations. Is that deliberate, so that you will not get involved in endless argument? I just put it to you, that it might give more guidance to regions if you told them the basis on which you worked?——It does not quite work like that, Sir. I am trying to keep my answer short. Each year each of the regions, mainly through its accounts officer, has out with our own Accountant-General on behalf of the Minister the needs of the year, pruned down to what is in fact available. In the course of that considerable discussion takes place involving all kinds of points of the type you have mentioned, so that he is under no illusions as to what is taken into account. When all that is finished we then say, "Now the result here is £*x* million. It is your job to make the best use of it." The difference I am trying to draw is between the finished announcement which gives them freedom to use it to the best advantage, and the process by which you arrive at a reasonable total figure, which involves a tremendous amount of analysis of figures and work.

2688. I asked the question because it has been stated to us in evidence that it was thought that the Department worked in rather a secret and mysterious way and that nobody fully grasped the basis on which they proceeded. But perhaps that is a misconception?——I think that is a misunderstanding.

2689. Now I come to teaching hospitals. What is the Departmental attitude towards the very much higher cost of the teaching hospitals, particularly undergraduate teaching hospitals, and the very high standard maintained there? This is not a tendentious question. Do you think it would be possible to reduce it and to spend more money on other hospitals?——I think there are many reasons why undergraduate teaching hospitals, on grounds with which we are all familiar, will cost more always proportionately than the ordinary non-teaching hospital.

2690. More than a provincial undergraduate teaching hospital?——It depends where it is situated. The teaching hospital because it is a teaching hospital is bound to cost more. To start with, it has far more activities through its teaching organisation in the hospital. It needs a higher degree of staffing for those reasons. It nearly always has more specialised Departments than others; it usually has very big out-patient work. One could go on with the reasons and I will not bore you with them all. Those are the kinds of reasons which differentiate a teaching hospital from the ordinary medium provincial hospital.

2691. And the Department is satisfied to continue with the present state of

* App. 3, p. 378.

affairs in which those costs are very much higher? Do you think that is desirable? ——We are never satisfied with the costs of any hospital without checking it. We do constantly watch the costs both of teaching and other hospitals.

Vice-Admiral *Hughes Hallett.*

2692. You would agree, then, that the cost per patient rate of a teaching hospital does in fact include an element in respect of those functions as a teaching hospital, notwithstanding the efforts made to keep the accounts of the hospital and the teaching school separate?——In respect of the results of its being a teaching hospital as distinct from the direct cost of teaching.

*Chairman.*

2693. Lord Cunliffe told us about this on behalf of Guy's. I asked him whether the standard of the London teaching hospitals was higher than that of provincial hospitals, and he said: "I am not commenting on the professional standard, but on the standard of the staffing and standard of service provided to the patient; my answer would be yes, very definitely*". That is not quite clear, but in other words, they have set up a very much higher standard in London hospitals than in the provincial ones. Do you think that is the answer?——I should say offhand (and I hope some of my colleagues will correct me if I am wrong) that one of the reasons for that is that generally I think the London undergraduate teaching hospital is spending far more of its time and concentrating its activities far more on its teaching side, although it does ordinary hospital work, than most, though not all, of the provincial teaching hospitals probably do, where what I would call ordinary hospital work bulks rather larger.

Mrs. *Hill.*

2694. Would you relate that to a very large medical school like Manchester University, where students go to the Royal Infirmary? Would you say that there their standard should be lower than London?——I think it obviously varies with the area, and I think you have chosen a very highly developed one.

*Chairman.*

2695. Lord Cunliffe did say that the standard of service provided to the patient is higher, which puts a slightly different complexion upon it, does it not? ——It is very difficult to measure the standard of service provided to the patient. One would assume that if, in fact, the hospital is staffed with a very high quality teaching staff, and attracts therefore on the whole better ancillaries, and has far more subsidiary departments, perhaps the standard one would expect would be a little better; but I should hate that to be taken as a reflection on a really good non-teaching hospital. I am talking in general terms over the country.

2696. Would you agree with paragraph 212 of the Guillebaud Report, which recommended that regional hospital boards should be told, and hospital management committees should accept, that regional boards were responsible for exercising a general oversight and supervision over the administration of the hospital service in their region?——Yes; I do not think there is very much there that is different from the existing situation.

2697. You do not think it needs——? ——I do not think there is any sort of revolutionary change envisaged there.

2698. If you turn back to paragraph 211, they say they are of opinion that "the primary need now is to give more emphasis to the regional boards' responsibility for the general oversight and supervision of the service." Has the Department done anything about that? ——The progress since the scheme began has been definitely in favour of increasing the powers of regional boards, particularly their financial control over management committees, and giving them more control of the service than was envisaged at the beginning.

2699. Yes, but that is rather a general statement. Have you done anything recently to give more emphasis—to use Guillebaud's words—to their responsibility? For instance, what steps have you taken to improve the quality of recruits entering the hospital administrative service?——All the things that we are doing about trying to improve the administrative structure of the whole service will have a bearing on this, but there is no specific thing, no overt act, since the Guillebaud Report which I can quote to you. But it has been expressed publicly by certainly the present Minister's predecessor, and I think by the present Minister, though I cannot recall that for the moment, that that kind of thing is his view.

* Q 2054

2700. I am rather disappointed with that reply. I hoped the Department regarded the quality of recruits as absolutely cardinal to the whole running of the service efficiently and economically, and I was hoping that you would be able to tell me that something had been done, rather than the maintenance of a benevolent frame of mind?——I think I have, in trying—very inadequately—to say some of the things that are being done: for instance, the institution of these special training courses, the provision of funds for people already in to take refresher training courses or to take classes outside with financial aid, the reference to Sir Noel Hall of the problem of saying what would be a better—or the best—administrative structure for the Service: all these are things springing from a benevolent state of mind, but perhaps a little practical in their application.

2701. Perhaps you are a little slow in their application, do you not think?——This thing evolves a little slowly; it has not been going, after all, for very long—such as things like the local government service—but I would like to see it develop quicker and so, I am sure, would my Minister.

2702. Would you agree that the whole thing turns—literally—on getting the right men to run the service?——I think it is very vital that the service should evolve an efficient and contented staff at all levels.

2703. With the very best people coming in—I am talking about the administrative, not the medical, side now—and making that their life's work and career?——If we can possibly attract them, yes.

Vice-Admiral *Hughes Hallett.*

2704. As a general statement, not necessarily applicable to the Hospital Service only, is it possible to reconcile complete devolution in appointing—in other words, a large number of separate appointing authorities—with any form of really satisfactory career structure?——I think so; it is done in local government.

*Chairman.*

2705. Yes, it is done in local government. But you do demand usually, do you not, certain qualifications for the posts?——For some posts.

Vice-Admiral *Hughes Hallett.*

2706. May I put a question which I have put to a number of witnesses before? We are all familiar with the arguments that led to the creation of the Civil Service about a hundred years ago, a centralized Civil Service, by Mr. Gladstone. Why do they not apply to a service the size of the Hospital Service?——Are you suggesting, Sir, that a better system would be to have throughout the National Health Service on the hospitals side a single corps of recruited people, all recruited in the way that one might be recruited and become a member of the Army or of the Civil Service, and all able to be posted wherever was most convenient?

2707. No, I am not suggesting that that would be the best system. I am trying to find out. What I am asking is: why is a system like that in its very nature not applicable to an organization such as the Hospital Service in the same way as it has been found to be applicable to the transaction of the public service in a Government Department?——The first reason is, surely, that the Hospital Service as it now exists by statute is administered by a very large number of people in two tiers, two separate authorities, and that if you were to say that employment in the Service shall be centralized you would have the extra predicament to face of having to say to any one of those authorities, "You cannot choose an officer you want; we shall post him to you. You cannot control him, and only we can dismiss him."

2708. That I appreciate. But are not you yourself, Sir John, in that position? To what extent can you in fact make an appointment within your own Department?——But I am not in the position of being part of an organization administered by an independent authority. I am administered more as the Army and the Fighting Services are, as part of a single entity, not operated by an independent authority.

2709. I have still found no satisfactory answer to this question. I quite understand the desire of regional boards or hospital management committees to make their own appointments, but I cannot understand why it is necessary for them to do so. After all, Ministers of the Crown do not make their own

appointments within their own Ministries?——On senior ones they are always consulted.

*Chairman.*

2710. Have not you given a clue in that word, have not you got a parallel in the senior medical appointments which are appointed after consultation with the regional advisory appointments council? You are saying there are only two possibilities, but surely there are many middle courses which would introduce some career structure into the Service and which would still leave hospital management committees or groups free to choose from a selected number of people?——But in the case of the relatively small number of consultant appointments that take place the advisory machinery is set up each time *ad hoc* to control appointments. To apply that and to generalize it to all senior appointments of all kinds, administrators, architects, engineers, and so forth, throughout the Service employing some 300,000 people, would I think be unworkable.

2711. I think you are being unfair. I was not suggesting that every one should be appointed like that; I was thinking that finance officers and hospital secretaries should be appointed after consultation with the regional advisory committee. You may say that for the senior consultant posts it is an *ad hoc* board set up separately on each occasion; that is merely a question of machinery. But that does not rule out the suggestion. After all, I am quite sure you would be the first to admit that many unsatisfactory appointments to senior administrative posts have been made, and are being made?——I am not aware of that.

2712. Well, it has been put to us in evidence. I am glad you are so satisfied with the Service?——I am not satisfied with the Service in the fullest sense, and I hope that I never will be, and I am perfectly sure that no Minister I have known has been. It would be the end of it if they were. But I would not, on the evidence that I have met, say that there have been any substantial numbers of obviously bad appointments of senior lay staff.

2713. Would you say, then, that you are pretty certain that in most cases the best men were appointed hospital secretaries and finance officers?——I think in most cases good people are appointed. I hope that by the ways and means which I described earlier, and will not repeat, we shall improve on that, and I hope always go on improving.

2714. What objection do you see to it being obligatory that a region should be consulted before the appointment of senior administrative officers?——I see a great deal of objection—at least, I would see a great deal of objection. I am sure that if I were a member of a hospital management committee, giving my services for nothing, and responsible for the success of the hospitals I was administering, I would not like to have to go to somebody else to say what person, or even which of two persons, I should appoint to a post, which, unlike a consultant's post, is one in direct employer-employee relationship day by day. It is very different. You do not tell a consultant how to conduct an operation, but you may, if you employ a secretary of a committee or a finance officer, want to tell him that you want something done in a particular way, so there is that difference.

2715. Yes, but do you think that the feelings of the person who gives his services free should be paramount, even above the efficiency of the service and the saving to the public purse? You think, do you, that it really would be monstrous to say, "Can we have a list of half-a-dozen names, and choose one of them?"——But I do not think that there is any question of that. The fact that the feelings of the voluntary governor of a hospital are considered means that you may get good or bad employees. I think the great solution to this is to have mobility by a practical process of advertising the better jobs, so that the man who is good will look round and apply for and be appointed to a better job, so that in other words he will move, and not just be thrust upon an employing authority.

Mr. *Holt.*

2716. Do I then understand that even if your ideas are not firm yet, your attitude or feelings towards the system, if you can call it such, are more akin to the flexible career structure for a town clerk or a borough treasurer, rather than some development of the Civil Service, even if it is somewhat adjusted? Would I be right in that?——Broadly, I would say, as a short answer, that would be

my view, rather than having a fully centralized and centrally posted Service.

2717. But developing the kind of requirements that are demanded of a town clerk or a borough treasurer—building up the qualifications?——And building up also, I should hope, the attractive jobs, which will lead one as he gets a little older to apply for another post under another authority in the Service.

2718. And also, I think I am right in saying, in the case of town clerks and borough treasurers, a good many of them have been brought in from outside. I mean that, although most people may have gone up a certain ladder to become eventually a town clerk or a borough treasurer, at the moment it is not exclusive and you could draft in some other legally qualified person who perhaps had never even been employed by a local authority to be the town clerk of a big borough. I think that is so, and I take it you would want to preserve that non-exclusivity?——I see no reason why there is anything bad in that, as long as one assumes, of course, that one does indeed draft in the right and competent man.

*Chairman.*

2719. I am afraid you have given an impression to me at any rate that you do not want to give, and that is that you think the present system by and large is satisfactory, in which case I do not see why you have appointed this other committee?——As I have tried to show, I am not satisfied—and when I say that, of course, I mean the Minister and the Ministry—and certainly no Minister that I know of and no Department would ever say, " We are now satisfied we have the best of all possible worlds."

2720. The appointment of this new committee implies that you are not satisfied, does it not?——No, I do not think it implies that any more than the fact that when the Health Service was initiated there was set up beside the Minister, with power to advise him whether he wanted it or not, an expert Central Health Services Council; that did not imply that even before the Service started it was going to be unsatisfactory; that only implied the importation of expert advice to assist those responsible for running it.

2721. May I finally read to you, though perhaps you may not have seen it, what the Manchester Regional Board Secretary said to us? (I am told his memorandum has been sent to the Ministry): " It is common knowledge that appointments which are seriously open to question have been, and continue to be, made to senior administrative posts in the Hospital Service* " That is the authority for what I have said.——I do not know the author of that statement. Is that a statement made by a particular regional hospital board?

2722. I said the Secretary of the Manchester Regional Hospital Board.——I beg your pardon.

2723. And we have had other evidence. I hope your loyalty to your Department will not lead you to tell the Sub-Committee that everything in the garden is lovely, because I am sure you do not think that?——I have just said so.

Mrs. *Hill.*

2724. Do you agree that there is at the present moment quite a desire for movement among senior staff in the Hospital Service, judging from the number of applications in response to advertisements for senior officers in various places, and that people are not anxious to remain static?——I should think there is every indication of that at the moment, that they do want to move around and I should think that is a very healthy thing.

*Chairman.*

2725. How do you see a better career structure being created for senior administrative staff unless there is some greater power given to regional boards to influence senior administrative appointments?——The two do not necessarily go together.

2726. I should have thought they did? ——The great thing, surely, is that there should be a structure or a ladder which provided sufficient incentive to people to move about. It does not imply that that has to be under the influence of the regional boards, the Minister or anyone else. The great thing is to arrive at a ladder that works.

2727. But you are torturing words, are you not, if you imply that there is a structure when everything is left to advertisement and chance appointment by committees?——No, the two go together. There is a structure now in the sense that there are gradings for administrative posts. A lot of those did not exist when the scheme started in 1948. A lot came in 1951, or about that time

* App. 7, p. 390.

and from then onwards. We feel that the time has now come when a much more intensive review, to see that all these gradings provide a much better and more balanced ladder—if one is needed, and I think it will be—should be undertaken, and that is being undertaken by Sir Noel Hall. But I do not think that carries with it, whatever his findings may be, an implication as to who should do the appointing. What we are concerned with for the moment there is this: is the structure one which offers opportunity, is it a good structure, does it suit the Hospital Service and does it work?

2728. But you cannot have a structure unless somebody or some body of people is in a position, at any rate, to influence movement up the ladder, surely?——The people who influence movement up any ladder are the people who offer the appointments and make the appointments.

2729. Then that must be some person or body of persons in a superior position to the appointing committee?——Forgive me, Sir, why?

2730. If you are in a region you cannot expect the management committee to have the same feeling of responsibility towards the success of the career structure as the regional board?——But you could expect another hospital management committee with a vacancy to want to get the best possible candidate by advertising the post, and in that way looking for the best possible candidate.

*Chairman.*] I am sorry, I cannot regard the use of advertising in this way as being very much of a career structure. I have here the evidence of the Chairman of another Hospital Board who said, "I do not think there is anything like sufficient fluidity within the Region and also throughout the whole country*" and he went on to say that there was not enough movement from one area to another, from one hospital management committee to another or from one regional board to another, that it was static. Is it not a misuse of words to maintain that there is a structure because appointments are being filled from advertisements?

Mrs. *Hill.*

2731. May I ask Sir John this? Would you agree there is a difference between having generally available a pool of people who might be expected to answer such advertisements, and having a structure or a ladder like you have in the Civil Service? The alternative is to have a pool in the sense that if you advertise widely you can expect a number of people to respond to the advertisement. There are two systems and the latter is largely followed by industry, I know?——I will try to avoid using the word "structure" if I can, because I think there is a certain ambiguity here. I am trying to think of an alternative. What we want in simple terms (and I think you have just expressed it better than I could) is this. We want a situation, first, where, throughout the Service, there are both opportunity and attraction; second, able to take advantage of those opportunities in the Service are people of good calibre; and, thirdly, if I might say this, no restriction always that only set qualifications will enable you to do a particular job, because it may very well occur every now and then that a person who may be qualified as an accountant would, in fact, be just the man for a different job, or, indeed, that a person not qualified as an accountant, might be an expert finance officer if he took it up. We do not want to draw rigid rules. I do not want to portmanteau all that into the word "structure," but that is what we want.

2732. I understand that. May I just ask this second question? You would agree that hospital management committees have, in fact, a great deal of responsibility under the present arrangements, and they feel that they are fit and proper people to choose their senior administrative officers, even though they may consult you? Would you say, if you think they are not fit and proper people to choose their senior administrative officers, how can they really be fit and proper people to carry out the responsibilities that they have already to carry out under the Act?——I should say that normally they are perfectly capable of choosing a proper officer, assuming that a supply of proper officers is available.

Vice-Admiral *Hughes Hallett.*

2733. You say that by advertising the candidates come forward and they choose the best, but how can they tell really who is the best? Do you visualize a system of reporting and recording which will be available to them, so that they will be able to get an independent view on the past records of individuals?

* Q. 1661.

——This, surely, is a problem common to every kind of selective appointment in every field of activity. If you have candidates before you, you have got to use all the resources you can, such as obtaining references from people for whom they have worked before. There is nothing peculiar to the Health Service in that.

2734. I still would like to know what system is visualized. After all, if you take the Fighting Services, with which I am familiar, there is a most elaborate system to ensure absolute fairness when it comes to promotions, and I cannot quite understand how you can ensure the same degree of fairness under the existing arrangements?——I am, unfortunately, unfamiliar with the Fighting Services, but would you say, Sir, that it is perfectly certain that in no circumstances is there any unfairness in the selections made?

2735. No, to a very large extent I should say they are fair?——I just do not know, of course.

Mr. *Holt.*

2736. Which do you place higher, fairness or getting the best person for the job?——I take them to mean the same thing.

Vice-Admiral *Hughes Hallett.*] Almost the same thing.

Mr. *Holt.*

2737. I would not have thought it was. Fairness to the person as far as the Army is concerned, apart from the top people, is a matter of degree affecting the people at the bottom, who just go up the ladder. Would you agree that that kind of promotion, which subject to correction I understand to be the normal way in the Services, is not necessarily appropriate to the Hospital Service, and that seniority does weigh rather heavily in the scales?——If I may be permitted, Sir, I really would rather not comment on a subject I know nothing about, and that is a comparison with what goes on in the Armed Forces.

*Chairman.*

2738. I am sure it is quite enough to ask you to comment on something you are familiar with?——Yes ; I just do not know.

*Chairman.*] Yes, I am sure the Sub-Committee understand that.

Mrs. *Hill.*

2739. May we have it put in the civilian context? Would Sir John consider that a sort of general stepping up is a better way of appointing your senior officers rather than by competition between different people? For instance, you advertise a post and you get thirty-six applicants—I think that is a fair number to take, though I have known as many as sixty—and to choose from those, would you think that was a better way of choosing your officers than just by having someone ready and waiting who seems eligible for the next step up the ladder?——By the second alternative, do you mean following seniority and nothing else?

2740. Yes?——This is a problem with which I am familiar in another field in the Departments of the Civil Service, and I should say that seniority, other things being equal, is always a factor ; but seniority must not govern the day, or else there will never be any incentive to the more brilliant but younger people.

Sir *Henry D'Avigdor-Goldsmid.*

2741. Do you consider that with the existing pay scales the proper type of person will be recruited to the administrative side of the Health Service?——I think the answer to that is that we must work it out, when we can get the best grading system (I avoid "structure") from Sir Noel Hall, and then go to the Whitley machinery, which is both the management and employee sides, and say to them, "Now here are the kind of posts which might be made in future years available throughout the Service. We now want a sufficiently negotiated and worked out pay structure which will produce"—as you say, "enough incentive."

2742. Would the short answer to my question be "No"?——I think the answer is that it must come after you have really satisfied yourself that you have got the number of grades of the kind that you want.

*Chairman.*

2743. I am sure you have better things to do than to read the reports of the proceedings of this Sub-Committee, but I think you ought to be told that we have examined three regional boards and that two of them have expressed grave

doubts as to whether the best people are appointed to the administrative staff of the Hospital Service. The Chairman of the Oxford Board, for instance, said: "We do suffer . . . from an insufficient number of good quality administrative officials, which means that what I feel is an unduly heavy weight of responsibility is put upon the voluntary members* ". The Treasurer said he had suggested the appointment of someone to a senior post and that someone else whom he named should be second, but that the "local boy" had been appointed because of pressure from the local group†. All through the evidence we have heard we have been told that regional boards feel that the right people are not being appointed, and that was behind my original statement which you criticised. Therefore, I do ask you whether you do not agree that something in the way of rather drastic reorganisation ought to be done, because I myself feel the key is to give regions rather greater influence in the appointments to senior posts?——I do not think the remedy lies in changing the appointing authority. I think that one would always want to see the proper quality of candidate available. But one has to remember, without making any reflection upon them at all, that still the great majority of the people engaged in administering the Health Service are people inherited from the former service, and our problem is——

2744. You are quite sure you mean the great majority?——Oh, yes, I think so. I am not of course talking of people like typists, but of the senior people—perhaps I should say that. I cannot give you figures, but I should think that it was undoubtedly true. Now, as I was saying, our problem is to attract, and I agree this, too, that they are not necessarily better—I am not reflecting in any way on present people—but we have to attract the better type of candidate, to attract the best we can get into this Service, and, for that purpose, to make the Service such that it has some incentive to offer which will attract them. I do not believe that that would be done by simply saying that authority A shall now appoint instead of authority B.

2745. I have been very careful to point out that that was not what I was suggesting. I am not suggesting that committees should not appoint, but that they should always be obliged to receive advice?——I still do not think that that would improve the quality of candidate available, which is the thing I think that we want to concentrate on.

2746. You are a little evading the point?——I do not think so, Sir.

2747. What I was suggesting was that of the candidates available, perhaps it might be easier to get the best if outside advice were taken?——I am not evading the question at all, because, as I understand the point, you are suggesting that regional boards for some reason or another would be in a better position to form a judgment of the quality of candidates than a management committee who were going to employ them.

2748. That, at any rate, is your opinion with regard to senior medical appointments. But I do think you must assume that regional boards are composed, on the whole, of people with wider experience and with greater ability than hospital management committees; they have access to a far wider field, they have more experience, and therefore surely it is not unreasonable to assume that their advice would at least be valuable to hospital management committees?——I cannot agree, Sir, that there is any general reason to assume that a regional board's judgment would be any better or any worse than that of a management committee. The matter of consultant appointments is in a different field because it is an appointment made by the regional board, and he is their employee. No one suggests that you should go and consult a management committee to make sure you have made a right choice.

Mr. *Holt.*] Have we had a comment from a regional hospital management committee to say that they in fact were satisfied with their choice, in spite of the fact they had disagreed with the recommendation of their management committee, because you said that in the case of Oxford they had made some recommendations but that the actual appointments had been made by the management committee? Have we checked up from that particular management committee who made the appointments, in spite of other recommendations, as to whether in fact they are satis-

* Q. 815. † Q. 826.

fied with the finance officer or whatever it is they have got?

*Chairman.*] It was a general statement by the Treasurer of the Oxford Regional Board—and I rather telescoped the reply when I quoted it earlier. I asked this question: "Could you say anything about the appointment of the Finance Officers on the Hospital Management Committees? (*A.*) Yes. As Sir George says, I have attended two or three meetings where Finance Officers have been appointed, but I have not been asked on every occasion—Sir George was referring to cases where I have been invited and I have suggested that 'All things in all I suggest that so and so be appointed, and that so and so be second', but the local boy has been appointed because of pressure of the local group*."

Mrs. *Hill.*] This is not against the advice of the regional board, but merely against the advice of one of their people attending by courtesy of the hospital management committee.

*Chairman.*] I cannot say, but I presume it was because the regional hospital board has not set up this advisory committee service which I am suggesting.

Mrs. *Hill.*

2749. Are you aware of management committees asking regional boards to send an officer along to advise them? ——It is perfectly open, of course, to an appointing authority such as a management committee, if it thinks it will be a benefit or an advantage, to invite someone from the regional board to come and sit in and to listen to any views they have got, and no one would wish to discourage it, but I do not think there is any benefit in imposing a regional board's judgment on a management committee.

*Chairman.*

2750. May I once again make it quite clear that I was not saying that, and I have never said that from the start? ——May I correct it, then, Sir, because I realise that was a loose phrase? I see no justification in imposing formal consultation with the regional board upon the employing authority.

* Q. 826.

Vice-Admiral *Hughes Hallett.*

2751. I would like to come back to the original question I asked on this, quite apart from any invidious comparisons between the judgment of one board and that of another. If you have, as at present, a very large number of independent appointing authorities, I think you would agree that you cannot guarantee that the bright young man who enters at the bottom of the administrative ladder in the Service will necessarily get to the top. That being so, would not you further agree that with this system one has got to offer substantially bigger salaries to get the same quality of men at the beginning?——I must not at the moment express an opinion on the level of salaries because that will be settled for the very reasons we both have in mind, incentive reasons, by the Whitley Council; and therefore it would be quite improper for me to express an opinion.

*Chairman.*

2752. I think you are bound to answer the questions of the Sub-Committee?—— Yes. I was just going on to say I cannot obviously express an opinion on the levels as they are, but I would answer your question by saying two things: first, that obviously the level of remuneration which you can offer to the bright young man is going to affect the recruiting of bright young men very much; and, second, that I know of no service and no organisation at all in which one can truthfully say that there is not some element of luck. One's job is to reduce that to a minimum.

Vice-Admiral *Hughes Hallett.*

2753. That is a question of degree. But would not you agree, if I can give you a parallel, that if it was decided that from tomorrow appointments in the Civil Service should be personal appointments made by Ministers and that a Minister would not be restricted to those already serving, one would have to offer Assistant Principals a higher salary if you wanted to attract men of the same quality, merely because there would be no assurance they would ever enjoy that appointment?——But appointments to the Civil Service are not made by one man.

2754. No, this is purely hypothetical. If it was made completely open to anybody, would not you then find that to

attract the same quality of entrant you would have to offer a very much higher initial salary because there would be no assurance of any permanent appointment?——I should think you would, but it is not analogous to the National Health Service.

*Chairman.*

2755. For the sake of accuracy, when regional appointment committees appoint senior hospital medical staff, consultants, etc., there is always a representative of the hospital management committee concerned on the advisory committee; so that it is quite untrue to say that they are appointed over the heads of the hospital management committee?——But they are directly employed by the regional board.

2756. Yes, I grant that?——And appointed.

2757. Yes. I think we have thrashed this out sufficiently, and we will change the subject. Do you think that detailed establishment control over boards, committees and administrative staff could be removed since budgetary control now appears to be tighter?——It has always been open to argument as to whether it is sufficient to have budgetary control, or whether you need the other. It is a question which probably is waiting on the views of this committee first.

2758. I really was asking you for your opinion?——I should think, at the present time, no matter what may have been true in the past, with the present budgetary control you probably could do without detailed approval of numbers.

2759. Thank you. Now another subject, rather incidental. The Royal College of Nursing recommended an increased use of nursing teams in view of the shortage of nurses. Do you think that there is anything in that?——I am not quite sure what a nursing team consists of.

2760. We received a memorandum from them, and it is too long for me to read. Perhaps you will give us a note of your views?——With pleasure*.

2761. I am told you have this memorandum, M.18?——I certainly have not seen it.

2762. It was a new phrase to me; I did not understand what it was all about?——And I do not at the moment, but perhaps I can examine it.

2763. I thought it was of sufficient interest to have the Ministry's views?——Yes.

2764. Now the salaries of hospital administrators, medical superintendents, matrons, and so on, are largely tied to bed complements, are they not? Do you think that is desirable, or do you think there is any alternative system?——We have not thought of any alternative system which would provide for variation in accordance with the load of work and responsibility which they carry at the moment.

2765. You do see disadvantages. Then there are other factors like out-patient responsibility, casualty departments, and so on?——Yes, it is a sort of general formula, but we have not been able to think of a better one. I would not say it was perfect.

Vice-Admiral *Hughes Hallett.*

2766. Would you not agree it is one of the greatest single factors in the tendency for the whole service to expand the whole time?——I would not agree with that.

*Chairman.*

2767. It has been suggested to us, for instance, by the Royal College of Physicians and the King's Fund, that small bonuses should be available for good work at almost all levels. Personally, I do not favour the idea. What do you think?——It seems, an the face of it, to knock the bottom out of the whole principle of Whitley negotiations on a national scale. I am assuming again in parenthesis that we are talking mainly of senior officers?

2768. No?——Anybody?

2769. Yes?——Yes, I believe it is done with typists. Summarizing, there are a few classes like shorthand typists and machine operators, where the work is clearly assessable, where it is done, but I would not think it would be a good thing to have it rest on the judgment or, if you like, the patronage of an employer.

2770. Would not you get a position where everybody received the maximum?——Yes, I am perfectly sure you would.

* Not reported.

Vice-Admiral *Hughes Hallett.*

2771. I was personally a little surprised at your answer about the bed complement question, because we have had quite authoritative evidence which links this slogan that the service is an expanding one to the fact that salaries also expand with the service as it is at present organized?——I can only give you my own view, that that is not a factor in its expansion or would be a very minute consideration compared with the other needs for expansion in giving a service to the public.

2772. Would you agree fundamentally with the people who say that the service is a necessarily expanding one?——I would say most emphatically that if you could look at the service in isolation, there is infinite room for expansion and improvement. I realize, as Ministers must realize, that that need has to be weighed against other needs of other services and other calls on the national economy.

Captain *Waterhouse.*

2773. May I ask the witness to reconsider that phrase "infinite room for expansion"?——That is perhaps rather loose. May I qualify it? I would say "very large room for expansion."

2774. For expansion as opposed to improvement?——I said "expansion and improvement", Sir.

2775. But room for expansion on its own?——In some fields. To take one, mental deficiency.

2776. In that particular field, is not the demand happily tending to go down? ——Yes, but that stage will not be satisfactorily reached until sufficient mental deficiency accommodation is there. It is better now than it was. In some fields it is a question of substituting newer and more up to date and even more economic buildings for the outworn ones sometimes inherited from the old Poor Law.

*Chairman.*

2777. We have had evidence from one mental hospital to the effect that they confidently expected that the number of permanent patients would decline fairly soon; in fact, it was already declining, and would go on declining steadily until there were hardly any, and that in fact, with modern psychiatric methods of treatment, these diseases would decline, so preventing chronic cases from developing. Would you agree with that?——First, what I said just now was concerning mental deficiency and not mental illness, but on the mental illness side I hope that is true. We shall consider that on a full study of what action can be taken on the new report of the Royal Commission.

Vice-Admiral *Hughes Hallett.*

2778. I am very worried about this expansion, because I would have thought, as a general proposition, that if the National Health Service is a success in this country, the number of people in hospital should steadily fall. If it does not fall, then it is a sign that the Service as a whole is not evolving correctly. Surely that is so?——I think a better sign as to whether the Health Service is evolving correctly is that, while the waiting lists over the years since the Health Service started have fallen considerably, the actual treatment completed and discharges made have in fact gone up, which means a more skilful and quicker turnover and, I should have thought, a more efficient service.

*Chairman.*

2779. And greater morbidity?——Not necessarily.

2780. Talking about bed complements leads one on to the question of whether there are co-efficients of efficiency which can be applied or taken into account when the Ministry is allocating money to boards. It has been put to us that you might consider, in addition to such things as bed occupancy, length of stay, bed interval, bed turnover, staff ratio, cost per in-patient week, and so on, the cost per head of population in a regional area. Do you think it is possible to work out any points system or a system by which they might be some criterion of efficiency?——I do not think it is possible to work out a foolproof system which can be applied to a formula, but I think that it is definitely possible to improve on your knowledge of the relative efficiency of hospitals by improved costing in the broadest sense.

2781. On a horizontal rather than a vertical basis?——Our opinion at the

moment, and we have already started it, is that the best costing we can try is full departmental costing, and that we have already started in something like 200 hospitals this year. The results will begin to come in next year.

2782. Will that enable us to get away from the inherited pattern in the allocation of money?——No, it is not quite that, but it will give us much more information about the relative efficiency in the use of money by these hospitals.

2783. Do you think that will conduce to economy and reduce expenditure?——Yes, or else I would prefer to hope the better use of money.

2784. Yes. Now do you think it is proper for the board to finance developments and improvements to a greater extent than was allowed for in the Minister's annual allocation, by reducing initial allocations to management committees and so reducing maintenance standards, because that is done in some cases? Do you think that proper, the saving on maintenance and so indulging in developments and improvements that were not originally envisaged or approved?——We do allow each board a block sum, and it is up to them how they allocate it between improvements and developments and maintenance. The more they save on one the more they have for the other. We believe that is a measure of independence which is a very good thing.

2785. Yes, but to some extent that may hamper the move towards less variation in standards between regions and may also lead to recurrent extra expenditure throughout subsequent years?——I am not talking now of capital expenditure.

2786. No, but it may involve recurrent expenditure?——Capital expenditure one must look at quite differently and bear in mind that it may lead to maintenance expenditure in future years. As you know better than I do, that is the custom of this House on capital expenditure. Other types of expenditure are separate. But, as I was saying, we arrive at what we find is the best block figure we can give to a regional board and they then distribute it to their management committees. Then it is up to them. We do not say, "This much is for development and improvement." We say, "It is up to you."

2787. But do you think that is sound? I should have thought you would have laid down that "If we give you so much for maintenance, it should be spent on maintenance"?——We do not believe, as a matter of policy, in that amount of interference with the discretion of boards.

Vice-Admiral *Hughes Hallett.*

2788. What I am not quite clear about is why virement is so smiled upon really in this service in contrast to its being so heavily frowned upon in most other walks of public expenditure?——Perhaps I could ask the Accountant-General to answer that.—(Mr. *Marre.*) I think the answer is that we believe—and all the Ministers we have had so far have also believed—that the kind of system we have now got, gives the bodies responsible for administering the hospital service a definite inducement to use the money, in the best possible way and that——

*Chairman.*

2789. Is this regional or hospital management level?——We are talking now of our dealings with regional hospital boards who in their turn deal with management committees. We think that without such a system there would be much less inducement to get priorities right and to save money. We think it ought to be saved in order to effect other improvements which are needed. It is for that reason that we think that this kind of budgetary system, almost amounting to a block grant for the particular year, is the only reasonable way of administering this kind of service.

Vice-Admiral *Hughes Hallett.*

2790. If you do not allow virement there would be no incentive to save under Item No. 22 if you cannot divert the money to Item 23—is that so?——Yes.

2791. May I therefore ask, arising from that, whether it has ever been suggested that one might have a halfway house and allow a percentage of the money, say, 50 per cent., to be transferred and the other 50 per cent. to come back to the Exchequer?——There is a second point on this. I ought to say, first of all, that the amount of money we allocate to any regional hospital board, either for the maintenance of its existing services or for improvements, is allocated as one total sum and

is very much less than they themselves think they need. So that we start with a figure which the regional board itself considers inadequate, and we would have very great difficulty with that paricular board if we attempted to suggest that a particular part of that—to them—inadequate sum should be returned to us later on if it was not spent in some pre-determined way. The second point is that in practice I do not think you could really administer such a system without an enormous machine providing for very detailed control. If I may I will just give you an illustration. If you fill a vacancy for a nurse, to us in our kind of jargon that is a development or improvement——

*Chairman.*

2792. You do not mean to say that the appointment of a nurse is a development or an improvement?——Let me explain. I am saying that if you fill a vacancy for a nurse, which in the previous year had not been filled, that to us is a development or improvement. The hospital might decide to find the money for filling that vacancy by some reorganisation of the clerical side or some other side, and that latter action may result in a saving in the running of the existing service. But, in order to keep track of all these manifold and different kinds of changes you would need a kind of control which in my view would be far greater than could be justified by any results you could expect to get from asking for some part of some limited amount of money to be returned to the Exchequer.

2793. I want to pursue this a great deal further about savings to be returned to boards by hospital management committees, so retaining control over development. Why does not the Minister do the same? That is the first thing. The second thing is: in allowing money saved on maintenance to be spent on improvements and developments, surely you are refraining from using what would be the most powerful weapon in an effort at levelling up the standards of the different regions. Do you agree with that?——On that first point which you mentioned, I am not aware that any regional board require hospital management committees to return savings to the board.

2794. This is Mr. Agnew, of Manchester, talking about the creation of reserves at board level, and I said: "I quite see that, but I do not understand what happens to any saving that a hospital management committee may make?" The answer was: "It comes back. It is there in the board's possession and it goes to meet the over-spending of another hospital management committee*."——I do not know what exactly he had in mind. It may simply mean that if you have got a hospital management committee which at the end of a year has succeeded in making do with less money than the board had allocated to it, the board regard that money as theirs and that they are free to reallocate what is left to one of the other management committees.

2795. That is exactly what I said, is it not? I did not know why you differed. I said boards do take savings back and so retain control of development?——I do not think that it is quite right to say that boards take savings back when money remains unspent. As far as the management committee is concerned, it has succeeded in providing a service at a lower cost to the board which then finds itself able to give other management committees a higher allocation.

Mrs. *Hill.*

2796. Would I be correct in thinking that the board, even though it makes an allocation to various groups, it does not in fact hand out that money in total, but it is earmarked for them?——It issues funds every month.

2797. So that at the end of the year there may be something left?——Yes.

2798. Then I would like to ask you this. We are all very familiar with the remark, "Well, if you can do it out of your existing allowance, you can do some other thing; but if you have a budgeted or finalized figure, then you will be in difficulty, so that you cannot undertake any expansion"?——Yes, and that we regard as an inducement to economy.

*Chairman.*

2799. If regional boards can do that, why cannot the Department?——The Department does do it.

2800. But you have just said that you give people a lump sum which includes

* Q. 1456.

maintenance and you have no control over development and improvements? ——If a particular regional hospital board towards the end of the year informed us that it expected to spend less than we had allocated to that board, then that underspending would be available for the Minister to allocate to some other board if he thought fit. That is not taking any money back; it is the board voluntarily saying they had been able to manage with less money than they had expected or than had been allocated to them. But I am bound to say that it is pretty unusual for that to happen.

Captain *Waterhouse.*

2801. It has happened?——Yes.

2802. Supposing a Board came to you for extra money, would you give them a lump sum or a million each month or every three months, or as they demanded it?——They submit demands to us every month and we issue funds on those demands.

2803. Up to an agreed amount?—— Up to an agreed amount.

2804. And no more?——At the end of the year—we do not issue an exact twelfth each month, if that is what you had in mind?

2805. Yes?——At the end of the year, we would not issue more funds without some justification.

2806. But there is always a way of getting more if they really need more? ——If they really need it they would make their case to us.

*Chairman.*

2807. At any rate, you are determined, Sir John, to adhere to your policy of not earmarking some things for maintenance and some for developments and improvements?——(Sir *John Hawton.*) Yes.

2808. You do not think that is throwing away what might be a very valuable weapon in bringing regional costs and standards of efficiency more closely together?——No; we think it is the fairest way of treating the bodies that are running the hospitals, bearing in mind that every single one of them gets in its lump sum total less than it is convinced it needs.

2809. Would you agree that boards do control improvements and developments within the regions to some extent?——They can do it in different ways.

2810. Yes; but they do do it, do they not?——Some of them do it by holding back some money and by issuing it later in the year.

2811. But they do regard themselves as in some way responsible for developments and improvements in the regions? ——Yes.

2812. Why cannot the Ministry do the same?——Because we think the regional board should be the body that should have that responsibility.

Mrs. *Hill.*

2813. In other words, regional boards have a programme of work that they intend to carry out and earmark——? ——This is not a programme of work; in the sense of capital work.

*Chairman.*

2814. I am not happy about your answer; I cannot pretend I am; but you have given it very clearly. How can the rising drug bill be controlled best, do you think?——I am not sure that I know the full answer to that one. There are lots of things that can be done and are being done, and I think you have already had a full catalogue of them in evidence*, but they do consist largely of the use of a mass of different methods of persuasion and explanation. The Chief Medical Officer of the Ministry informs these people by letter of the things where costs are unnecessary, and we issue——

2815. Yes, we have all that?——a catalogue of things which I think you have, and so I would sum it all up by saying this, that all these are methods of biting all round the edge of this problem, but there is no ultimate solution in sight.

2816. Do they also include some efforts to see that medical students are made to economize?——Yes, they do include now, as one of the most important things, the urging on all medical schools to impress upon students right from the beginning the necessity for that.

2817. Now I come to the other and equally thorny problem concerning the

* Not reported.

domiciliary consultant service. We have had evidence to the effect that it is in danger of being abused or, indeed, that it is being abused. Would you agree with that?——No, Sir. The thing that is often forgotten is this, that the more the domiciliary service is used by the general practitioner, the less likely it is that an expensive hospital bed will be occupied.

2818. That still does not prevent it being abused, does it?——I am not suggesting that in a service of this size there are no abuses or abuses which are not detected.

2819. You do not think it is an abuse of the service if the G.P. is not there when the consultant comes?——The G.P. certainly should be there, because this is consultation. In some areas that has not been done as much as it should, but our efforts are directed to making it done.

2820. The South-East Metropolitan Regional Board said that there is a significant and "increasing tendency on the part of G.P's to absent themselves from the actual consultation," and that "in the case of domiciliary visits made by whole-time specialists this tendency is particularly marked. In the period, 11th November, 1955, to the 31st December, 1956, whole-timers made 2,627 visits at which the G.P. was present on only 994 occasions; that is approximately 38 per cent.* Is that something that the Ministry see to?——I think personally that that is wrong and bad.

2821. Well, what steps are you taking to check it?——When we hear of that sort of thing we must take it up with the regional board to see whether they can improve it.

Vice-Admiral *Hughes Hallett.*

2822. Of course, if an increase in such visits were to result in a reduction in the number of beds in use, I can quite see the thing would be justified financially. In fact, though, the number of beds occupied in the country has not gone down appreciably—indeed, rather the reverse—in the last five years, and I notice that the total number of visits—I get this from the Ministry of Health's Appendix†—has risen by practically 100,000, from 175,000 to 270,000 in a period of five years, 1951-56. Would not you agree that it is a matter that requires a little probing?——You would not expect yet to have seen an actual reduction in the use of hospital beds, but what you are seeing is a reduction in the demand for hospital beds. It has to be remembered that there are two factors: one is phsyical occupancy, the other is the waiting list.

2823. Then may I ask a further question? What is the actual justification, in principle, for full-time consultants being paid for domiciliary visits—having a fee for it?——On the face of it, it does look strange, but we adopted it for this reason, that the full-time consultant may in any given case be the obviously appropriate man in the right speciality for that case. If the general practitioner is denied the use of him, he may have to go to somebody who is not in the same degree of the right speciality, and he will tend not to call in the full-time consultant because he knows it is for nothing, and he does not think that fair to the whole-time consultant. So that, in the interests of getting the right person and giving the right facilities to the G.P., we have adopted this system of allowing full-time consultants to go, but we have put some qualification upon it, in that they have to do a certain number of free visits first.

*Chairman.*

2824. It has been put to us that that arrangement has been considerably abused, or that aspect of it?——Which aspect?

2825. Towards the end of the financial year these things mount up tremendously, but still it is in evidence, and what I was going to ask you was: there used to be more control by regional boards over this service, but you took it away?——No, there was not. There may have been in theory, but in fact the only workable way for the general practitioner to do it is to get on to the consultant and fix it and you cannot do it through a filtering machine in an office, and so on, and it was found——

2826. It was done simply for convenience?——Yes, and speed.

2827. I do once again express my surprise that during working hours a man should be paid for doing what he is paid

* App. 10, p. 395.
† App. 5, p. 387.

for as part of his job?——Well, the reason is the one which I gave.

2828. It does sound odd on the face of it, does it not?——Yes, it does.

2829. Now I want to talk about regional contracting and group centralization of certain services, such as laundering, storage and so on. Is the Ministry doing anything to encourage regional contracting and group centralization of such services?——Let us be quite clear about those two things. Indeed, there are three possibilities. One is that the Department should do it on a national scale——

2830. I am not suggesting that?——Yes, that restricted at the moment.

2831. Except, perhaps, for exceptional things?——Yes; that is exactly the position. Then, below that, there are two possibilities. One is that the hospital management committee which has a group of hospitals under it should contract to purchase for all those hospitals in its own group, and that is a common practice. It is not universal, but it is a very common practice.

2832. I am not including questions like standardization?——That part is contracts, and I think what you are really on is the problem which we are all on, and that is to get hospital management committees, each having a number of hospitals, to combine into, say, three or four groups—not just hospitals—but for more management committees to combine in joint contracting——

2833. Not only that, but in widely scattered areas it would be very difficult to get groups to combine. But the broad question is: is the Department doing anything to bring about more common contracting on common services where it is feasible?——Yes.

2834. What?——We are trying all the time to get more of what I was describing, more group purchasing, contracting by more than one hospital management committee, a collection or agglomeration of them.

2835. But how are you doing it?——By every kind of means. First of all, there has recently been issued a report of a committee to say which of these alternative methods of group purchasing were most suitable, and they recommended this particular form of grouping. That has been brought to everyone's notice, and at the moment we have asked every hospital group in the country for a return by next September of exactly what they are doing about it.

2836. You would agree it would conduce to both efficiency and economy?——On the face of it, wherever it is suitable—I quite agree there may be scattered areas where it is not—it is the right thing to encourage, and it is the Minister's policy to encourage it.

2837. I had got the feeling that the savings to be brought about by this sort of procedure must have been obtained for a long time, and yet the Ministry has moved rather gently in the matter?——We have appreciated the value of this from the very beginning. We had as early as 1949 urged the extension of this kind of group purchasing, but at that time there was also the policy of national purchasing and national contracting, which in a sense was a conflicting interest. Since about 1953 (I think it was, though I may have to check up on these dates a little) that policy has been altered, and the central part is now, as you said, Sir, limited to a certain number of obviously suitable things, so that we are now pushing much harder on our groups.

2838. The savings to be brought about really are considerable, are they not?——Well, they vary, of course, with the article. They may not be very considerable, but they are obviously worth doing. As we have demanded a general answer from every hospital as to what they are doing by September, I think we are now getting——

2839. For how long will the hospital service have been going by September?——It started in 1948.

2840. It is a long time?——As I said up to 1949, for some years later, there was a policy which was partly for group purchasing, but harping quite a lot on central purchasing.

Vice-Admiral *Hughes Hallett.*

2841. I should like to ask a question about the laundry service in hospitals, about which I confess myself to be very unhappy. I recognize that you had a bad inheritance, but what exactly is being done about it? Has there been

any outside inquiry into laundries as such since this Service was set up?——(Mr. *Pater.*) I am not quite sure what you have in mind by an "outside inquiry." There have been no official inquiries that I am aware of.

2842. If I may come straight to the point, on whose advice does the Ministry rely? Where do you get your experts from?——(Sir *John Hawton.*) We have our own laundry advisers for this purpose.

2843. What experience do you require of them in actual laundry work? I ask this particularly because I noticed an advertisement the other day and I also noticed that they required certain academic qualifications, but there was nothing said about having had to manage a laundry, which I should have thought is rather unnecessary?——(Mr. *Pater.*) The advisers we have are laundry engineers, not laundry managers.

*Chairman.*

2844. For machinery?——Yes. (Sir *John Hawton.*) And for the best way of organizing the mechanics of a laundry.

2845. They would not be advised by people who were running a laundry? ——These are people advising on the best way of running the mechanics of a laundry, getting the best results presumably for the least money.

2846. Not businessmen?——No. I do not know what qualifications, if any, we have specified in advertisements, and with the permission of the Sub-Committee we will, if we can, provide the Clerk with that information, but I am afraid I cannot answer now.

Vice-Admiral *Hughes Hallett.*

2847. Could we have a little paper on this, because I think you will agree there is considerable scope for efficiency and saving?——Yes, we will put into the Sub-Committee a paper saying what we do centrally about this question*.

Mrs. *Hill.*

2848. Is not it possible to have the advice of someone from the launderers' association, because I have a feeling that there are many persons outside our own National Health Service on whose advice we could call, who would come round to the hospitals and advise them on laundering methods and layout, apart from the pure economics of it. I have a feeling that it is possible?——There are two elements. We were talking about what we do in the Ministry on this, but of course hospitals who run laundries do themselves get their own advice as well from outside and might well use the very sort of person you have in mind.

Vice-Admiral *Hughes Hallett.*

2849. To turn to another subject, Sir John, this question of paying for Section 5 beds, I think you agreed earlier that the cost in a teaching hospital per patient really contained an element of the expenses of the school?——Forgive me —of the expenses as a consequence of its being a teaching hospital, which are rather different.

2850. Yes. Do you consider it fair, and is it actually necessary, under the existing legislation, for that element of cost to be borne by the users of Section 5 beds?——It is not any element of the actual cost of the teaching operations; it is the cost of the hospital which may be affected by the fact that it is a teaching hospital. It is the cost of the hospital service, and under the Act it has to be the full cost. It would mean amending the Act to alter that.

2851. You have no discretion to authorise a correction to be made by teaching hospitals to try to get at the true cost of the hospital *qua* hospital? ——No; as far as a person in one of these places receives a hospital service, even if it is more expensive because it happens to be inside a teaching hospital, we have no discretion to alter it.

*Chairman.*

2852. In the Department's previous evidence they said there was perhaps lethargy about putting non-paying patients in Section 5 beds. Are you doing anything about that? And also you have been doing something, I hope, to encourage the use of Section 4 beds?——Yes, we are doing everything we can to encourage the making known to patients of this point about Section 4 beds, which is very valuable because it does provide privacy, and will at the same time retain all the benefits of the Health Service.

* Not reported.

Sir *Henry D'Avigdor-Goldsmid.*

2853. There is one point which has exercised me a bit, and I am not sure who is the person who can best answer it. That is this: do you consider that the legal position under which doctors find themselves, as would appear quite often, sued as a result of treatment they have or have not given to a patient, causes an excessive use of the out-patient side of the hospital service and also of X-ray examinations?——I have no evidence whatsoever of that. I have heard it claimed, but I have no evidence or proof of it at all.

2854. So that your reply is that, in fact, so far as you know it is not correct?——So far as we know, no.

2855. Then how can one establish if it is correct, because if one were to inquire into the results of X-ray examinations I think it would be a little unprofitable and G.Ps in conversation will say that about 75 per cent. of the X-ray examinations they order are of no consequence because they prove there is nothing there for a specialist to diagnose. But I suppose that that cannot be called a useless X-ray examination, though, of course, it does add to the cost of the Service?——I know of no way whatever of ascertaining how many of those examinations are quite unnecessary, and even for the purpose of establishing a negative result I can think of no way.

2856. I want to ask a question about the legal position of doctors, because it must come to your attention. Do you consider that has any influence on the working of the Health Service, the fact that doctors do seem rather frequently these days to be sued at law?——No, I should not have thought so. The position now is that the doctor can, perhaps, be more easily sued with Legal Aid, but that is only one factor. I know of no general factor due to the Health Service.

2857. You in the Ministry I take it would have in your possession all the statistics in this connection showing the expenses of such cases and law suits of this nature? Would those be available? ——We could give you particulars of such cases. I have not a lot of details about them. We could give you an estimate of the cost over different periods*.

* Not reported.

*Chairman.*

2858. Now a different subject. These O. and M. teams have been a success, have they not?——They are a bit experimental, but we think they have been a success.

2859. Are you thinking of employing them on a permanent basis?——If they go on being a success like this.

2860. The departmental Memorandum* spoke very highly of them: "Many hundreds of recommendations have been made and most have been accepted." I will not pursue that. I have your answer. Thank you very much. Now there has been criticism that the load borne by the Hospital Service could be reduced by more co-ordinated and improved collaboration between the three bodies concerned with the Health Service, the hospitals, the committees and the local authorities. I suppose that any answer you gave would only be general, but we would like to know?——It has been a criticism all along from a number of different sources that the thing is administered in three different ways by three different bodies: indeed, it has been summed up as "three incomprehensibles in one incomprehensible." But a lot has been done. We have had a committee of the Central Health Service Council—that being the statutory advisory body of the Ministry—and they threw up a committee on the very purpose of co-ordination and it made a number of recommendations. But my own view is that you can do a certain amount by joint committees meeting on three sides or by consultation, but everything in co-ordinating depends on the persons. If in fact a medical officer of health of a local authority doing Part III of the Act collaborates with a general practitioner under Part IV of the Act, he does it effectively as a person. He will not do it any more effectively if you set up elaborate machinery and require him every Tuesday evening to meet his opposite number. I think he will do it if he is going to do it because that is what he wants to do; and that is what we are trying to encourage. The less formally we can do this, the better.

2861. It all boils down to a question of personality?——I think so myself. I think you will not make people do it unless they wish to already.

* Not reported.

2862. There are various general questions I think, most of which I think we have covered. In paragraph 283 of the Guillebaud Report they speak about: "On balance, therefore, we have concluded that the present system, if it has certain weaknesses"—that is the system of financing the Service—" is probably the best that can be devised in present circumstances." Do you hold that view yourself?——Yes.

2863. I hate to go back, but in paragraph 282, when they refer to the "apparent lack of consistent long-term objectives," would you plead guilty? ——No, Sir.

2864. What is your long-term objective?——To try all the time, bearing in mind local differences and differences in hospitals and differences in standards, to improve standards and to make our Service attractive to the best personnel.

2865. And to make the best use of the money that is available?——Of course.

2866. Now I have a personal "fly" to put to you—and I do not know if other members of the Sub-Committee are even interested in it—but do you think it possible that the real solution for the Hospital Service is the creation of a quasi-independent corporation to administer the service with considerable freedom, being in receipt of a block grant from Parliament, and with less departmental and parliamentary control? Is that possible?——Of course, it is not possible under present legislation.

2867. No?——I do not think it would be an improvement on the present system. I do not think that it would, with respect, be very commendable to Parliament from the point of view of financial control of such a large amount of money.

2868. You do have an analogous organization in the B.B.C., for example? ——There are very few organizations that I can think of which spend this amount of money and have not got direct and full answerability to Parliament by Ministers and by the accounting officers to the Public Accounts Committee.

2869. Yes, I would agree there. But, at the same time, I am impressed by the comparative lack of Treasury control and the comparative lack of Departmental control over the Service. Is there a great deal to lose?——It is difficult for me, as a witness, because I cannot agree that there is lack of Departmental control.

2870. I said "comparative"?——I think it has vastly improved over the teething years of the Service.

*Chairman.*] Those are all our questions. Thank you very much indeed for your evidence.

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## APPENDIX 1

### HOSPITAL STATISTICS

*Tables submitted on behalf of the Minister of Health*

### TABLE 1

HOSPITAL IN-PATIENT STATISTICS
ALL TEACHING AND NON-TEACHING HOSPITALS
ANALYSIS BY TYPE OF HOSPITAL
QUARTER ENDED 30TH SEPTEMBER, 1956

| Type of hospital | Number of hospitals | Bed complement | Average daily number of available beds | Average daily bed occupation | Discharges and deaths |
|---|---|---|---|---|---|
| Total: all Hospitals ... | 2,656 | 509,274 | 474,705 | 417,796 | 912,790 |
| Acute ... ... ... | 731 | 102,389 | 94,193 | 76,316 | 479,700 |
| Mainly Acute ... ... | 117 | 44,269 | 38,533 | 31,667 | 138,491 |
| Partly Acute ... ... | 41 | 16,982 | 15,243 | 12,480 | 37,712 |
| Mainly Long Stay ... | 60 | 12,785 | 11,491 | 9,911 | 16,470 |
| Long Stay ... ... | 60 | 13,810 | 12,838 | 11,719 | 7,467 |
| Chronic ... ... ... | 278 | 26,813 | 24,625 | 23,275 | 9,807 |
| Pre-Convalescent ... | 69 | 3,195 | 2,907 | 2,178 | 11,918 |
| Convalescent ... ... | 67 | 3,242 | 2,724 | 2,109 | 10,314 |
| Rehabilitation ... ... | 14 | 985 | 917 | 782 | 2,122 |
| Isolation ... ... | 72 | 3,453 | 1,919 | 818 | 2,907 |
| Maternity ... ... | 255 | 7,969 | 7,647 | 6,207 | 48,260 |
| Mental Illness ... ... | 129 | 150,834 | 149,290 | 143,200 | 22,852 |
| Mental Deficiency ... | 194 | 56,347 | 54,505 | 52,087 | 1,819 |
| Orthopaedic ... ... | 39 | 5,660 | 5,253 | 4,240 | 8,458 |
| T.B. and Chest ... | 197 | 23,571 | 21,063 | 17,489 | 13,030 |
| T.B. Chest and Isolation | 64 | 7,327 | 6,025 | 4,016 | 8,997 |
| Children's (Acute) ... | 48 | 6,409 | 5,819 | 4,126 | 25,595 |
| Eye ... ... ... | 22 | 1,972 | 1,614 | 1,264 | 9,096 |
| Other Hospitals ... | 199 | 21,262 | 18,099 | 13,912 | 57,775 |

### TABLE 2

ALL TEACHING HOSPITALS
QUARTER ENDED 30TH SEPTEMBER, 1956

| Type of hospital | Number of hospitals | Bed complement | Average daily number of available beds | Average daily bed occupation | Discharges and deaths |
|---|---|---|---|---|---|
| Total: all Hospitals ... | 152 | 27,974 | 26,361 | 22,727 | 131,532 |
| Acute ... ... ... | 40 | 16,810 | 15,969 | 13,995 | 86,136 |
| Mainly Acute ... ... | 4 | 762 | 708 | 604 | 2,724 |
| Partly Acute ... ... | — | — | — | — | — |
| Mainly Long Stay ... | — | — | — | — | — |
| Long Stay ... ... | — | — | — | — | — |
| Chronic ... ... ... | 3 | 437 | 400 | 395 | 305 |
| Pre-Convalescent ... | 5 | 211 | 211 | 181 | 1,254 |
| Convalescent ... ... | 16 | 701 | 614 | 480 | 2,140 |
| Rehabilitation ... ... | 1 | 52 | 34 | 10 | 55 |
| Isolation ... ... | — | — | — | — | — |
| Maternity ... ... | 10 | 909 | 868 | 748 | 5,740 |
| Mental Illness ... ... | — | — | — | — | — |
| Mental Deficiency ... | — | — | — | — | — |
| Orthopaedic ... ... | 4 | 496 | 483 | 417 | 1,118 |
| T.B. and Chest ... | 5 | 924 | 849 | 686 | 1,299 |
| T.B. Chest and Isolation | 1 | 90 | 47 | 31 | 86 |
| Children's (Acute) ... | 13 | 1,780 | 1,651 | 1,330 | 9,286 |
| Eye ... ... ... | 8 | 940 | 916 | 761 | 5,471 |
| Other Hospitals ... | 42 | 3,862 | 3,611 | 3,089 | 15,918 |

## TABLE 3

### Hospital In-Patient Statistics

### All Teaching and Non-Teaching Hospitals

| | 1949 | | | 1950 | | | 1951 | | | 1952 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths |
| | (See Note 1) | | | | | | | | | | | |
| Total: all depts. ... ... | 475,418 | 397,570 | 2,936,980 | 504,321 | 402,601 | 3,085,491 | 507,005 | 406,844 | 3,259,214 | 507,368 | 416,123 | 3,414,373 |
| Gen. Medicine ... ... | 33,739 | — | 401,745 | 35,757 | — | 403,607 | 33,633 | — | 421,295 | 33,193 | — | 436,173 |
| Inf. Diseases ... ... | 21,848 | — | 100,030 | 20,577 | — | 98,640 | 18,143 | — | 90,548 | 16,235 | — | 92,825 |
| Dis. of the chest (See Note 9) ... ... ... | 28,307 | — | 48,189 | 32,108 | — | 51,913 | 33,774 | — | 59,595 | 34,047 | — | 62,794 |
| Other general medicine (See Note 3) ... ... | 12,900 | — | 122,651 | 14,093 | — | 139,071 | 16,850 | — | 155,265 | 15,452 | — | 162,105 |
| Chronic sick ... ... | 54,587 | — | 81,167 | 56,057 | — | 83,852 | 56,930 | — | 92,390 | 57,705 | — | 100,831 |
| Gen. surgery ... ... | 32,332 | — | 663,708 | 34,207 | — | 691,676 | 34,502 | — | 720,147 | 35,035 | — | 769,333 |
| Trau. and orthe. ... ... | 11,846 | — | 132,984 | 13,513 | — | 145,920 | 14,361 | — | 167,294 | 16,721 | — | 189,867 |
| Other general surgery (See Note 4) ... ... ... | 13,329 | — | 344,713 | 17,511 | — | 421,771 | 18,436 | — | 479,600 | 18,139 | — | 512,736 |
| Gynaecology ... ... | 7,320 | — | 178,471 | 8,217 | — | 202,485 | 8,745 | — | 216,088 | 8,878 | — | 232,629 |
| Obstetrics (See Note 5) ... | 17,385 | — | 392,925 | 18,893 | — | 412,696 | 19,369 | — | 440,407 | 19,635 | — | 458,098 |
| Mental defective (See Note 6) / Mental illness | 198,713 | — | 75,860 | 208,336 | — | 81,735 | 52,739 / 156,863 | — | 3,672 / 84,640 | 54,794 / 156,493 | — | 4,149 / 88,706 |
| Pre-con. and convalescent | 6,664 | — | 71,375 | 6,779 | — | 73,700 | 7,124 | — | 81,127 | 7,150 | — | 84,199 |
| G.P. Maternity ... ... | — | — | — | — | — | — | — | — | — | — | — | — |
| Other G.P. work (See Note 7) ... ... ... | 7,864 | — | 96,314 | 6,499 | — | 113,499 | 6,941 | — | 130,292 | 6,735 | — | 124,115 |
| Other Units (See Note 8)... | 21,937 | — | 140,784 | 25,372 | — | 86,652 | 22,635 | — | 43,426 | 20,801 | — | 25,422 |
| Section 5: private ... | 6,647 | — | 86,064 | 6,402 | — | 78,274 | 5,960 | — | 73,428 | 5,726 | — | 70,391 |

TABLE 3 (*continued*)

HOSPITAL IN-PATIENT STATISTICS

ALL TEACHING AND NON-TEACHING HOSPITALS

| | 1953 | | | 1954 | | | 1955 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths |
| | (See Note 1) | (See Note 2) | | | | | | | |
| Total: all depts. ... ... | 478,367 | 424,122 | 3,543,544 | 481,613 | 427,630 | 3,630,269 | 481,710 | 426,047 | 3,651,978 |
| Gen. Medicine ... ... | 32,096 | 28,647 | 458,223 | 32,640 | 29,042 | 465,691 | 33,204 | 29,257 | 481,058 |
| Inf. Diseases ... ... | 9,663 | 5,362 | 92,519 | 9,547 | 4,460 | 74,417 | 9,067 | 4,688 | 82,771 |
| Dis. of the Chest (See Note 9) | 30,656 | 27,986 | 64,584 | 30,379 | 27,810 | 66,902 | 29,598 | 26,086 | 68,106 |
| Other general Med. (See Note 3) ... ... ... | 12,182 | 9,247 | 159,776 | 11,557 | 8,428 | 143,894 | 11,242 | 8,250 | 144,747 |
| Chronic Sick ... ... | 53,871 | 50,179 | 101,081 | 54,121 | 50,851 | 104,370 | 54,478 | 50,814 | 107,536 |
| Gen. Surgery ... ... | 34,785 | 30,467 | 779,058 | 34,346 | 30,575 | 811,043 | 34,227 | 30,358 | 811,324 |
| Trau. and other surgery ... | 16,885 | 15,354 | 198,648 | 16,742 | 15,547 | 212,721 | 16,835 | 15,532 | 217,869 |
| Other general surgery (See Note 4) ... ... ... | 18,179 | 14,156 | 517,175 | 18,660 | 14,862 | 556,591 | 18,774 | 14,453 | 517,707 |
| Gynaecology ... ... | 8,923 | 7,797 | 243,045 | 9,130 | 7,980 | 252,937 | 9,140 | 7,995 | 261,098 |
| Obstetrics (See Note 5) ... | 18,803 | 15,196 | 441,729 | 18,431 | 14,915 | 433,951 | 18,371 | 14,869 | 437,915 |
| Mental deficiency ... ... | 53,588 | 51,256 | 4,032 | 54,561 | 52,379 | 4,322 | 55,040 | 52,923 | 4,685 |
| Mental illness (See Note 6) | 155,718 | 149,615 | 94,829 | 157,427 | 151,450 | 100,497 | 157,880 | 151,741 | 111,375 |
| Pre-con. and convalescent... | 7,134 | 5,225 | 102,145 | 7,314 | 5,487 | 113,845 | 7,116 | 5,264 | 113,506 |
| G.P. Maternity ... ... | 2,036 | 1,489 | 46,779 | 2,480 | 1,847 | 59,206 | 2,670 | 1,893 | 61,987 |
| Other G.P. Work (See Note 7) | 6,525 | 4,712 | 116,634 | 6,667 | 4,719 | 116,644 | 6,750 | 4,685 | 114,148 |
| Other units (See Note 8) ... | 11,530 | 4,694 | 52,360 | 11,824 | 4,473 | 41,728 | 11,662 | 4,438 | 45,184 |
| Section 5: private ... ... | 5,793 | 2,819 | 70,927 | 5,787 | 2,805 | 71,510 | 5,656 | 2,801 | 70,962 |

## TABLE 4

### HOSPITAL SERVICES: IN-PATIENT STATISTICS
### TEACHING HOSPITALS

| | 1949 | | | 1950 | | | 1951 | | | 1952 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths |
| | (See Note 1) | | | | | | | | | | | |
| Total: all Depts. ... | 26,463 | 21,450 | 441,354 | 26,921 | 21,870 | 453,629 | 27,244 | 21,736 | 471,596 | 27,502 | 22,828 | 491,924 |
| Gen. Medicine ... ... | 3,903 | — | 53,696 | 3,759 | — | 54,694 | 3,908 | — | 58,118 | 4,197 | — | 63,241 |
| Inf. Diseases ... ... | 314 | — | 2,244 | 193 | — | 1,802 | 198 | — | 1,922 | 195 | — | 2,165 |
| Dis. of the Chest (See Note 9) ... ... | 739 | — | 2,670 | 965 | — | 2,617 | 972 | — | 3,054 | 1,024 | — | 3,212 |
| Other general medicine (See Note 3) ... ... | 2,710 | — | 41,691 | 2,747 | — | 41,976 | 2,887 | — | 41,227 | 2,599 | — | 36,680 |
| Chronic sick ... ... | 600 | — | 852 | 608 | — | 973 | 594 | — | 1,283 | 534 | — | 1,586 |
| Gen. surgery ... ... | 4,578 | — | 95,331 | 4,664 | — | 100,461 | 4,903 | — | 104,005 | 4,807 | — | 108,522 |
| Trau. and ortho. surgery... | 1,610 | — | 22,671 | 1,112 | — | 17,710 | 1.646 | — | 23,157 | 1,731 | — | 25,122 |
| Other general surgery (See Note 4) ... ... | 3,377 | — | 75,489 | 4,578 | — | 97,034 | 4,188 | — | 104,336 | 4,127 | — | 111,007 |
| Gynaecology ... ... | 1,588 | — | 36,479 | 1,674 | — | 38,613 | 1,676 | — | 40,251 | 1,665 | — | 41,499 |
| Obstetrics (See Note 5) ... | 1,602 | — | 40,763 | 1,524 | — | 40,713 | 1,670 | — | 41,034 | 1,785 | — | 44,230 |
| Mental Illness (See Note 6) | 858 | — | 4,789 | 728 | — | 4,321 | 729 | — | 4,820 | 796 | — | 4,837 |
| Pre. con. and convalescent | 1,191 | — | 14,168 | 1,131 | — | 13,799 | 1,122 | — | 14,410 | 1,236 | — | 14,862 |
| Other Units (See Note 8) | 1,585 | — | 24,340 | 1,717 | — | 12,968 | 1,155 | — | 9,289 | 1,267 | — | 10,547 |
| Section 5: private ... | 1,808 | — | 26,171 | 1,521 | — | 25,948 | 1,596 | — | 24,690 | 1,539 | — | 24,414 |

TABLE 4 (*continued*) TEACHING HOSPITALS

| | 1953 | | | 1954 | | | 1955 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths | Allocated beds at 31st Dec. | Average daily occupation | Discharges and deaths |
| | | (See Note 2) | | | | | | | |
| Total: all Depts. ... ... | 26,825 | 23,073 | 506,899 | 27,125 | 23,257 | 520,467 | 27,110 | 23,116 | 516,369 |
| Gen. med. ... ... ... | 4,286 | 3,967 | 69,182 | 4,577 | 4,230 | 73,508 | 4,694 | 4,318 | 76,553 |
| Inf. diseases ... ... | 122 | 84 | 2,132 | 257 | 146 | 2,859 | 267 | 168 | 3,134 |
| Dis. of the Chest ... ... | 889 | 796 | 3,144 | 922 | 804 | 3,467 | 952 | 837 | 3,746 |
| Other general medicine (See Note 3) ... ... ... | 2,154 | 1,788 | 31,762 | 2,009 | 1,596 | 27,912 | 1,937 | 1,608 | 28,622 |
| Chronic sick ... ... | 215 | 201 | 232 | 472 | 460 | 1,361 | 448 | 455 | 1,417 |
| Gen. surgery ... ... | 4,685 | 4,236 | 109,958 | 4,689 | 4,299 | 113,207 | 4,668 | 4,216 | 111,452 |
| Trau. and Ortho. ... ... | 1,732 | 1,678 | 26,569 | 1,739 | 1,602 | 27,093 | 1,754 | 1,638 | 27,633 |
| Other general surgery (See Note 4) ... ... ... | 4,185 | 3,615 | 114,330 | 4,164 | 3,734 | 120,013 | 4,195 | 3,520 | 110,518 |
| Gynaecology ... ... | 1,630 | 1,469 | 42,007 | 1,623 | 1,476 | 43,360 | 1,565 | 1,428 | 43,383 |
| Obstetrics (See Note 5) ... | 1,846 | 1,592 | 46,427 | 1,865 | 1,621 | 47,537 | 1,965 | 1,697 | 49,409 |
| Mental Illness (See Note 6) | 732 | 669 | 4,747 | 770 | 693 | 5,051 | 728 | 650 | 4,857 |
| Pre-con. and convalescent... | 1,292 | 1,006 | 18,547 | 1,256 | 1,002 | 19,158 | 1,240 | 928 | 18,822 |
| Other units (See Note 8) ... | 1,576 | 1,000 | 14,039 | 1,288 | 639 | 11,531 | 1,266 | 710 | 12,829 |
| Section 5: private ... ... | 1,481 | 972 | 23,823 | 1,484 | 955 | 24,410 | 1,431 | 943 | 23,994 |

NOTES:

(1) The number of beds allocated to each department from 1953 onwards is the number of staffed beds (including available and temporarily unavailable staffed beds); in previous years it was the number of all beds both staffed and unstaffed.

(2) The total of individual items in this column does not agree with the " total " shown at the top of the column, since the individual items contain a number of cases where departments were not in operation for the whole year and whose occupations were based on part of the year: the " total " is based on the whole year.

(3) " Other general medicine " includes Paediatrics, Dermatology, Neurology, Cardiology, Physical medicine and Venereal Disease.

(4) " Other general surgery " includes E.N.T. Ophthalmology, Radiotherapy, Genito-Urinary, Plastic surgery, Thoracic surgery, Consultant Dentistry, Neurosurgery.

(5) " Obstetrics " includes Special Care Babies.

(6) " Mental Illness " includes Child Guidance, Mental Illness treated under the L.M.T. Acts and " Others " (outside the Acts). In 1949 and 1950 figures for Mental illness and deficiency were collected as Psychiatry.

(7) " Other G.P." work includes G.P. Medical and G.P. Dental.

(8) " Other Units " include unclassified and Staff Wards.

(9) Before 1953 the figures shown against Diseases of the Chest were collected as " Tuberculosis " and included some " non-respiratory " cases. From 1953 non-respiratory cases are included against the specialist department responsible for treatment.

## TABLE 5

### Section 4 and 5 Beds

### All Teaching and Non-Teaching Hospitals

Number of beds

| | Section 4 | | | Section 5 | | | |
|---|---|---|---|---|---|---|---|
| | Beds(2) designated | Beds occupied (1) | | Beds designated | Beds allocated | Beds occupied (1) | |
| | End of period | Paying patients | Others | | | Paying patients | Others |
| | | Daily averages | | End of period | | Daily averages | |
| 1949 ... | 5,901 | — | — | — | 6,647 | — | — |
| 1950 ... | 5,388 | — | — | — | 6,402 | — | — |
| 1951 ... | 6,030 | — | — | — | 5,960 | — | — |
| 1952 ... | 6,086 | — | — | — | 5,726 | — | — |
| 1953 ... | 6,257 | 2,890 | 2,158 | 5,863 | 5,793 | 2,819 | 1,285 |
| 1954 ... | 5,900 | 2,886 | 1,898 | 5,893 | 5,787 | 2,804 | 1,262 |
| 1955 ... | 5,997 | 2,752 | 1,968 | 5,821 | 5,656 | 2,795 | 1,091 |

(1) No figures for average daily occupation are available before 1953. For the years 1949 to 1952 the total number of patients treated in Section 4 beds was 9·2, 12·7, 17·9 and 22·1 (thousands) and in Section 5 beds, 86·1, 78·3, 73·4 and 70·4 (thousands).

(2) From 1949 to 1951 beds which could be made available.

## TABLE 6

### Teaching Hospitals

Number of beds

| | Section 4 | | | Section 5 | | | |
|---|---|---|---|---|---|---|---|
| | Beds(2) designated | Beds occupied (1) | | Beds designated | Beds allocated | Beds occupied (1) | |
| | End of period | Paying patients | Others | | | Paying patients | Others |
| | | Daily averages | | End of period | | Daily averages | |
| 1949 ... | 302 | — | — | — | 1,808 | — | — |
| 1950 ... | 364 | — | — | — | 1,521 | — | — |
| 1951 ... | 454 | — | — | — | 1,596 | — | — |
| 1952 ... | 483 | — | — | — | 1,539 | — | — |
| 1953 ... | 488 | 186 | 228 | 1,535 | 1,481 | 979 | 219 |
| 1954 ... | 488 | 183 | 209 | 1,553 | 1,484 | 956 | 181 |
| 1955 ... | 473 | 166 | 232 | 1,511 | 1,431 | 944 | 199 |

(1) See footnotes above.

TABLE 7

ALL TEACHING AND NON-TEACHING HOSPITALS

STAFF

| | 1949 (See Note 1) | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 |
|---|---|---|---|---|---|---|---|
| Regional Hospital Boards (2) | | | | | | | |
| Headquarters staff | 1,320 | 1,573 | 1,736 | 1,828 | 1,907 | 1,973 | 1,990 |
| Blood Transfusion Centre Staff | 1,107 | 1,286 | 1,401 | 1,531 | 1,541 | 1,573 | 1,644 |
| Mass Radiography Staff | — | 501 | 603 | 660 | 691 | 708 | 700 |
| Hospital Management Committees and Boards of Governors | | | | | | | |
| Administrative and clerical staff (see Note 2) | 23,797 | 27,368 | 27,285 | 27,273 | 26,664 | 26,963 | 27,506 |
| Medical and dental staff | | | | | | | |
| Consultants, S.H.M.O's. and Senior Registrars— | | | | | | | |
| Whole time: weekly hours | 127,204 | 136,983 | 144,914 | 143,374 | 148,694 | 150,073 | 151,228 |
| Part time: weekly hours | 110,059 | 113,570 | 122,598 | 129,356 | 128,130 | 131,205 | 134,593 |
| Whole and part time: whole time equivalents (see Note 3) | 6,163 | 6,508 | 6,948 | 7,084 | 7,198 | 7,306 | 7,424 |
| Honorary Consultants S.H.M.O's. and Senior Registrars | | | | | | | |
| Whole time appointments (see Note 4) | — | 60 | 62 | 102 | — | — | — |
| Part time appointments (see Note 4) | — | 481 | 554 | 546 | — | — | — |
| Whole and part time: weekly hours | — | — | — | — | 6,964 | 8,850 | 10,046 |
| Other medical staff (except general practitioners) | | | | | | | |
| Whole time: weekly hours | 217,525 | 234,542 | 249,211 | 263,995 | 264,880 | 278,509 | 287,980 |
| Part time: weekly hours | 6,327 | 7,977 | 8,426 | 7,548 | 4,265 | 3,238 | 3,571 |
| Whole and part time: whole time equivalents (see Note 3) | 5,814 | 6,299 | 6,692 | 7,053 | 6,991 | 7,318 | 7,573 |
| Other honourary medical staff (except general practitioners) | | | | | | | |
| Whole time appointments (see Note 4) | — | 7 | 3 | 35 | — | — | — |
| Part time appointments (see Note 4) | — | 58 | 106 | 262 | — | — | — |
| Whole and part time: weekly hours | — | — | — | — | 1,817 | 3,350 | 2,764 |
| General practitioners | | | | | | | |
| Part time appointments (see Note 4) | 4,296 | 5,060 | 5,202 | 5,672 | 6,608 | 6,798 | 6,958 |

TABLE 7 (*continued*)

ALL TEACHING AND NON-TEACHING HOSPITALS (*continued*)
STAFF (*continued*)

| | 1949 (See Note 1) | 1950 | 1951 | 1953 | 1953 | 1954 | 1955 |
|---|---|---|---|---|---|---|---|
| Professional and technical | | | | | | | |
| Whole time (see Note 5) ... ... ... ... ... ... | 11,733 | 12,876 | 14,212 | 14,892 | 15,053 | 15,513 | 16,375 |
| Part time appointments (see Note 4) ... ... ... ... | 5,281 | 7,044 | 7,374 | 7,721 | 7,953 | 8,197 | 8,499 |
| Students ... ... ... ... ... ... ... ... ... | 4,151 | 4,080 | 4,510 | 4,617 | 4,614 | 4,580 | 4,420 |
| Maintenance, transport and domestic | | | | | | | |
| Whole time (see Note 6) ... ... ... ... ... ... | 103,191 | 105,514 | 107,867 | 110,650 | 133,175 | 133,271 | 135,939 |
| Part time (see Note 6) ... ... ... ... ... ... ... | 27,185 | 29,965 | 33,674 | 35,713 | 39,921 | 41,730 | 44,752 |
| Whole and part time (see Note 7) ... ... ... ... ... | 26,210 | 23,648 | 22,125 | 24,714 | — | — | — |
| Nursing and midwifery | | | | | | | |
| Whole time (see Note 6) ... ... ... ... ... ... | 125,752 | 132,408 | 136,210 | 140,964 | 144,558 | 144,680 | 143,347 |
| Part time (see Note 6) ... ... ... ... ... ... ... | 23,060 | 24,977 | 25,756 | 26,642 | 28,804 | 30,542 | 32,873 |

TABLE 8

TEACHING HOSPITALS
STAFF

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Boards of Governors | | | | | | | |
| Administrative and clerical staff (see Note 2) ... ... ... | 5,111 | 4,884 | 4,951 | 5,013 | 4,842 | 4,891 | 5,010 |
| Medical and dental staff | | | | | | | |
| Consultants, S.H.M.O's and Senior Registrars | | | | | | | |
| Whole time: weekly hours ... ... ... ... ... ... | 28,067 | 27,720 | 29,068 | 28,067 | 26,565 | 26,450 | 26,180 |
| Part time: weekly hours ... ... ... ... ... ... ... | 31,037 | 26,831 | 29,946 | 30,382 | 29,827 | 29,924 | 29,333 |
| Whole and part time: whole time equivalents (see Note 3) ... | 1,535 | 1,417 | 1,533 | 1,518 | 1,465 | 1,464 | 1,442 |
| Honorary Consultants, S.H.M.O's and Senior Registrars | | | | | | | |
| Whole time appointments (see Note 4) ... ... ... ... | — | 60 | 58 | 102 | — | — | — |
| Part time appointments (see Note 4) ... ... ... ... ... | — | 466 | 429 | 380 | — | — | — |
| Whole and part time: weekly hours ... ... ... ... ... | — | — | — | — | 6,428 | 8,269 | 9,405 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Other medical staff (except general practitioners) | | | | | | | |
| Whole time: weekly hours | 63,334 | 64,684 | 68,145 | 72,226 | 71,803 | 71,302 | 73,728 |
| Part time: weekly hours | 1,743 | 2,503 | 2,454 | 2,153 | 1,987 | 1,552 | 1,702 |
| Whole and part time: whole time equivalents (see Note 3) | 1,690 | 1,745 | 1,834 | 1,932 | 1,917 | 1,892 | 1,535 |
| Other honorary medical staff (except general practitioners) | | | | | | | |
| Whole time appointments (see Note 4) | — | 7 | 2 | 32 | — | — | — |
| Part time appointments (see Note 4) | — | 58 | 75 | 217 | — | — | — |
| Whole and part time: weekly hours | — | — | — | — | 1,626 | 3,178 | 2,527 |
| General practitioners | | | | | | | |
| Part time appointments (see Note 4) | 266 | 240 | 153 | 169 | 242 | 264 | 312 |
| Professional and technical | | | | | | | |
| Whole time (see Note 5) | 2,975 | 3,144 | 3,410 | 3,487 | 3,411 | 3,510 | 3,586 |
| Part time appointments (see Note 4) | 449 | 551 | 600 | 674 | 634 | 645 | 641 |
| Students | 1,837 | 1,618 | 1,883 | 1,880 | 1,871 | 1,979 | 1,843 |
| Maintenance, transport and domestic | | | | | | | |
| Whole time (see Note 6) | 13,148 | 13,704 | 14,600 | 15,000 | 17,448 | 17,379 | 17,581 |
| Part time (see Note 6) | 3,989 | 4,260 | 4,516 | 5,139 | 5,773 | 5,869 | 6,010 |
| Whole and part time (see Note 7) | 3,375 | 2,619 | 2,403 | 2,955 | — | — | — |
| Nursing and Midwifery | | | | | | | |
| Whole time (see Note 6) | 16,698 | 17,807 | 18,293 | 19,007 | 19,816 | 19,793 | 20,032 |
| Part time (see Note 6) | 752 | 902 | 928 | 1,024 | 1,068 | 1,215 | 1,157 |

NOTES

(1) Hon. appointments were not separately distinguished in 1949.
(2) Whole and part time staff not separately distinguished.
(3) Total weekly hours worked divided by 38½.
(4) Appointments at individual hospitals and clinics : one officer may hold several such appointments.
(5) The weekly hours worked by staff holding full time appointments divided by 38½.
(6) Numbers of whole and part time officers.
(7) Whole and part time officers not separately distinguished from 1949–1952.

## TABLE 9

### Nursing and Midwifery Staff

### All Teaching and Non-Teaching Hospitals

| | 1949 | | 1950 | | 1951 | | 1952 | | 1953 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time |
| Totals, all types ... ... ... | 125,752 | 23,060 | 132,408 | 24,977 | 136,210 | 25,756 | 140,964 | 26,642 | 144,558 | 28,804 |
| General ... ... ... ... | 70,350 | 9,092 | 73,745 | 9,714 | 76,168 | 9,494 | 78,749 | 9,587 | 50,408 | 4,973 |
| General practice ... ... ... | — | — | — | — | — | — | — | — | 2,841 | 951 |
| Mainly general ... ... ... | — | — | — | — | — | — | — | — | 21,002 | 3,337 |
| Mainly chronic ... ... ... | — | — | — | — | — | — | — | — | 2,633 | 788 |
| Chronic ... ... ... ... | 8,703 | 3,146 | 9,415 | 3,237 | 9,930 | 3,626 | 10,621 | 3,801 | 4,965 | 2,348 |
| Children's general ... ... ... | 3,802 | 224 | 4,084 | 294 | 4,290 | 337 | 4,532 | 365 | 3,954 | 322 |
| Tuberculosis ... ... ... ... | 4,781 | 984 | 5,332 | 1,064 | 5,657 | 1,173 | 6,040 | 1,185 | 4,777 | 1,077 |
| T.B. and Isolation ... ... ... | — | — | — | — | — | — | — | — | 1,915 | 538 |
| Isolation ... ... ... ... | 4,308 | 884 | 4,540 | 1,112 | 4,481 | 1,117 | 4,395 | 1,131 | 630 | 208 |
| Maternity ... ... ... ... | 4,011 | 700 | 4,369 | 761 | 4,518 | 923 | 4,619 | 981 | 4,492 | 1,060 |
| Mental ... ... ... ... | 19,159 | 5,570 | 19,663 | 6,043 | 19,415 | 6,184 | 19,394 | 6,317 | 20,009 | 6,578 |
| Mental Deficiency ... ... ... | 5,548 | 1,772 | 5,754 | 1,855 | 5,882 | 1,935 | 6,156 | 2,105 | 6,653 | 2,196 |
| Convalescent ... ... ... ... | — | — | — | — | — | — | — | — | 1,227 | 232 |
| Orthopaedic ... ... ... ... | — | — | — | — | — | — | — | — | 2,142 | 201 |
| E.N.T.... ... ... ... ... | — | — | — | — | — | — | — | — | 282 | 60 |
| Eye ... ... ... ... ... | — | — | — | — | — | — | — | — | 793 | 82 |
| Eye and E.N.T. ... ... ... | — | — | — | — | — | — | — | — | 227 | 78 |
| Miscellaneous ... ... ... | 5,090 | 688 | 5,506 | 897 | 5,869 | 967 | 6,458 | 1,170 | 15,273 | 3,681 |
| Clinics ... ... ... ... | — | — | — | — | — | — | — | — | 335 | 94 |

TABLE 9 (*continued*)

NURSING AND MIDWIFERY STAFF

ALL TEACHING AND NON-TEACHING HOSPITALS

| | 1954 | | 1955 | | March, 1956 | |
|---|---|---|---|---|---|---|
| | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time |
| Total: all types ... | 144,680 | 30,542 | 143,347 | 32,873 | 145,085 | 33,864 |
| Acute ... ... ... | 55,382 | 6,960 | 55,344 | 7,730 | 56,329 | 8,007 |
| Mainly acute ... ... | 17,682 | 3,126 | 17,209 | 3,396 | 17,131 | 3,438 |
| Partly acute ... ... | 5,454 | 1,050 | 5,776 | 1,244 | 5,655 | 1,160 |
| Mainly long stay ... | 3,523 | 953 | 3,713 | 1,029 | 3,759 | 1,122 |
| Long stay ... ... | 3,152 | 923 | 2,870 | 1,004 | 2,944 | 1,081 |
| Chronic ... ... | 5,504 | 2,653 | 5,489 | 3,112 | 5,498 | 3,267 |
| Pre-con. ... ... | 675 | 207 | 650 | 220 | 679 | 233 |
| Con. ... ... ... | 530 | 87 | 418 | 87 | 421 | 91 |
| Rehab. ... ... ... | 34 | 8 | 48 | 17 | 33 | 11 |
| Isolation ... ... | 574 | 184 | 512 | 216 | 543 | 231 |
| Maternity ... ... | 4,696 | 1,072 | 4,590 | 1,223 | 4,717 | 1,282 |
| Mental illness ... ... | 19,517 | 6,624 | 19,649 | 6,720 | 19,864 | 6,689 |
| Mental det. ... ... | 6,572 | 2,204 | 6,638 | 2,252 | 6,783 | 2,363 |
| Ortho. ... ... ... | 2,456 | 241 | 2,313 | 284 | 2,165 | 304 |
| Tuber. and chest ... | 5,078 | 1,090 | 4,673 | 1,116 | 4,649 | 1,166 |
| Tb. chest and isolation | 2,113 | 657 | 1,945 | 617 | 2,175 | 690 |
| Children's (Acute) ... | 3,933 | 333 | 3,664 | 367 | 3,754 | 373 |
| Eye ... ... ... | 831 | 92 | 927 | 108 | 870 | 115 |
| Others ... ... ... | 6,699 | 1,846 | 6,694 | 1,989 | 6,664 | 2,104 |
| Clinics ... ... ... | 184 | 104 | 181 | 139 | 379 | 131 |
| Other estabs. ... ... | 37 | 128 | 44 | 3 | 73 | 6 |

*Note*—None of the figures given for any of the various types of hospitals in 1955 are strictly comparable with those given for the various types in 1949.

## TABLE 10

NURSING AND MIDWIFERY STAFF, 1949–1956

ALL TEACHING HOSPITALS

| Type of Hospital | 1949 | | 1950 | | 1951 | | 1952 | | 1953 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time |
| General ... ... ... ... | 12,219 | 349 | 13,218 | 386 | 13,470 | 417 | 13,859 | 467 | 13,794 | 459 |
| General practice ... ... ... | — | — | — | — | — | — | — | — | — | — |
| Mainly general ... ... ... | — | — | — | — | — | — | — | — | 133 | 15 |
| Mainly chronic ... ... ... | — | — | — | — | — | — | — | — | — | — |
| Chronic ... ... ... ... | 179 | 44 | 182 | 50 | 185 | 46 | 222 | 43 | 49 | 13 |
| Children's general ... ... ... | 1,324 | 50 | 1,391 | 58 | 1,430 | 68 | 1,453 | 61 | 1,642 | 74 |
| Tuberculosis ... ... ... | 259 | 14 | 319 | 17 | 343 | 20 | 370 | 20 | 54 | 10 |
| T.B. and Isolation ... ... ... | — | — | — | — | — | — | — | — | 19 | — |
| Isolation ... ... ... ... | 46 | 10 | 44 | 12 | 51 | 10 | 50 | 12 | — | — |
| Maternity ... ... ... ... | 679 | 30 | 670 | 53 | 668 | 50 | 716 | 57 | 674 | 53 |
| Mental ... ... ... ... | 182 | 49 | 191 | 82 | 186 | 83 | — | — | 271 | 85 |
| Mental Deficiency ... ... ... | — | — | — | — | — | — | — | — | — | — |
| Convalescent ... ... ... ... | — | — | — | — | — | — | — | — | 202 | 16 |
| Orthopaedic ... ... ... ... | — | — | — | — | — | — | — | — | 288 | 19 |
| E.N.T.... ... ... ... ... | — | — | — | — | — | — | — | — | 172 | 22 |
| Eye ... ... ... ... ... | — | — | — | — | — | — | — | — | 445 | 25 |
| Eye and E.N.T. ... ... ... | — | — | — | — | — | — | — | — | — | — |
| Miscellaneous ... ... ... | 1,810 | 206 | 1,792 | 244 | 1,960 | 234 | 2,337 | 364 | 2,068 | 276 |
| Clinics ... ... ... ... | — | — | — | — | — | — | — | — | 5 | 1 |
| Totals ... ... ... ... ... | 16,698 | 752 | 17,807 | 902 | 18,293 | 928 | 19,007 | 1,024 | 19,816 | 1,068 |

TABLE 10 (*continued*)

NURSING AND MIDWIFERY STAFF, 1949–1956

ALL TEACHING HOSPITALS

| Type of Hospital | 1954 | | 1955 | | 1956 (March) | |
|---|---|---|---|---|---|---|
| | Whole Time | Part Time | Whole Time | Part Time | Whole Time | Part Time |
| Acute ... ... ... | 13,579 | 435 | 13,859 | 457 | 14,050 | 443 |
| Mainly Acute ... ... | 270 | 28 | 283 | 28 | 294 | 26 |
| Partly Acute ... ... | | | | | | |
| Mainly Long Stay ... | | | | | | |
| Long Stay ... ... | | | | | | |
| Chronic ... ... | 111 | 65 | 95 | 80 | 100 | 86 |
| Pre Convalescent ... | 25 | 5 | 18 | 3 | 82 | 7 |
| Convalescent ... ... | 174 | 24 | 137 | 23 | 127 | 26 |
| Rehabilitation ... ... | 1 | 1 | 1 | 1 | 1 | 1 |
| Isolation ... ... | | | | | | |
| Maternity ... ... | 692 | 49 | 717 | 61 | 775 | 56 |
| Mental Illness ... ... | | | | | | |
| Mental Deficiency ... | | | | | | |
| Orthopaedic ... ... | 282 | 20 | 281 | 19 | 293 | 18 |
| T.B. and Chest ... | 327 | 10 | 302 | 9 | 305 | 9 |
| T.B., Chest and Isolation | 17 | — | 16 | 2 | 16 | — |
| Children's (Acute) ... | 1,736 | 78 | 1,607 | 78 | 1,716 | 88 |
| Eye ... ... ... | 507 | 35 | 559 | 26 | 494 | 28 |
| Others ... ... ... | 2,054 | 336 | 2,144 | 367 | 2,092 | 367 |
| Clinics ... ... ... | 3 | 3 | 3 | 3 | 55 | 3 |
| Other Establishments ... | 15 | 126 | 10 | — | 4 | — |
| Totals ... | 19,793 | 1,215 | 20,032 | 1,157 | 20,404 | 1158 |

## TABLE 11

## NATIONAL HEALTH SERVICE

## CLASSIFICATION OF HOSPITALS

### DEFINITIONS

In 1949 hospitals were classified as follows:—

| | |
|---|---|
| 1. Wholly General ... ... | Medical and surgical cases (including children), gynaecological and obstetrical cases, but with no specific allocation of beds for the chronic sick or less than 5 per cent. |
| 2. Mainly General ... ... | Mainly (more than 50 per cent.) general cases as in 1, but also having a specific allocation of beds for the chronic sick. |
| 3. Mainly Chronic ... ... | Mainly (more than 50 per cent.) chronic sick cases, but also having a specific allocation of beds for general cases as in 1. |
| 4. Chronic ... ... ... | Chronic sick cases, except for a negligible (less than 5 per cent.) number of beds for other types of patients. |
| 5. Convalescent ... ... | Recovery hospitals to which patients are sent after actual treatment has been either completed or temporarily suspended. |
| 6. Isolation ... ... ... | Infectious disease only (excluding hospitals with accommodation reserved for the treatment of T.B.). |
| 7. Maternity... ... ... | Admitting only maternity cases (any size of hospital). |
| 8. Mental ... ... ...<br>9. Mental Deficiency ... | As defined by statute. |
| 10. Orthopaedic ... ... | Non-acute orthopaedic surgery including short-term and long-term cases. |
| 11. Tuberculosis ... ... | T.B. patients only (excluding hospitals with accommodation reserved for the treatment of infectious disease). |
| 12. Other Specialist Hospitals | E.g., Children, Ear, Nose and Throat, Eye, Dental. |
| 13. Miscellaneous. | |

In 1950–51 hospitals were similarly classified but with some minor variation affecting items 10–13.

In 1952 hospitals were classified as follows:—

| | |
|---|---|
| 1. General ... ... ... | Hospitals (other than those in type 12, 13 or 16) with specific allocations of more than one type of medical or surgical beds (including general practitioner hospitals) but with no specific allocation of beds for the chronic sick or not more than 5 per cent. of the total bed complement. |
| 2. Mainly General ... ... | As in 1, but with a specific allocation of beds for the chronic sick of more than 5 per cent. but not more than 50 per cent. of the total bed complement. |
| 3. Mainly Chronic ... ... | As in 1, but with a specific allocation of beds for the chronic sick of more than 50 per cent. but not more than 95 per cent. of the total bed complement. |
| 4. Chronic ... ... ... | Wholly chronic sick beds except for an allocation of other types of patients of 5 per cent. or less of the total bed complement. |
| 5. Convalescent (including Pre-Convalescent annexes). | Recovery hospitals for patients irrespective of former classification. |
| 6. Isolation ... ... ... | Infectious disease beds only (excluding hospitals with accommodation reserved for the treatment of tuberculosis). |
| 7. Maternity... ... ... | Hospitals with obstetric beds only (any size of hospital). |
| 8. Mental ... ... ...<br>9. Mental Deficiency ... | Hospitals where more than 50 per cent. of the beds are allocated to Mental or Mental Deficiency cases. If a hospital has both mental and m.d. beds it is classified under one category or the other according to the greater number of beds. |

| | |
|---|---|
| 10. Orthopaedic ... ... | All beds allocated to orthopaedic and traumatic surgery only. |
| 11. Tuberculosis ... ... | Tuberculosis beds only (excluding hospitals with accommodation reserved for the treatment of infectious diseases). |
| 12. Tuberculosis and Isolation | Hospitals with beds allocated to both tuberculosis and infectious disease only. |
| 13. Children (general) ... | Hospitals with beds allocated only to the one function. |
| 14. Ear, Nose and Throat ... | |
| 15. Eye ... ... ... | |
| 16. Eye and Ear, Nose and Throat. | |
| 17. Miscellaneous Hospitals (including other Specialist Hospitals). | Hospitals which do not indisputably fall into one of the above categories. |

In 1953 hospitals the classification was substantially the same except that for items 1–3 of the 1952 classification there was substituted the following:—

| | |
|---|---|
| 1. General ... ... ... | Hospitals either:— |
| | (*a*) with specific allocations of beds for general medicine and general surgery (with or without general practice (medical)), only; or |
| | (*b*) as in (*a*) but also with specific allocations to one or more other branches of medicine or surgery (including obstetrics) provided that the average number of beds occupied by mental, mentally defective and chronic sick patients do not in aggregate exceed 10 per cent. of the total average daily occupancy of the whole hospital, and that the average number of beds occupied by those three categories and also by patients in the departments of diseases of the chest and infectious diseases and by convalescents do not in aggregate exceed 25 per cent. |
| 2. General Practice (excluding general practice maternity hospitals). | Hospitals in which the wards are staffed by general practitioners only (senior specialist staff being available only on call for particular occasions). |
| 3. Mainly General ... ... | As in (1) (*b*) but with the aggregate number of beds occupied by the types of patient mentioned exceeding the percentages there mentioned but not exceeding 50 per cent. |
| 4. Mainly Chronic ... ... | Hospitals with specific allocations of beds for general medicine or general surgery (or general practice (medical)) and with an average number of beds occupied by chronic sick patients of more than 50 per cent. but less than 95 per cent. |

The definitions adopted from 1954 onwards are as follows:—

| | |
|---|---|
| 1. Acute ... ... ... | Hospitals with not more than 15 per cent. of their beds allocated to the " excluded departments ". (" Excluded departments " are those for mental illness, mental deficiency, diseases of the chest, chronic sick and for convalescence—including rehabilitation but not pre-convalescence). |
| 2. Mainly acute ... ... | Hospitals with more than 15 per cent. and up to 40 per cent. of their beds allocated to the " excluded departments ". |
| 3. Partly acute ... ... | Hospitals with more than 40 per cent. and up to 60 per cent. of their beds allocated to the " excluded departments ". |
| 4. Mainly long-stay... ... | Hospitals with more than 60 per cent. and up to 85 per cent. of their beds allocated to the " excluded departments ". |
| 5. Long-stay... ... ... | Hospitals with more than 85 per cent. of their beds allocated to the " excluded departments ". |
| 6. Chronic ... ... ... | Hospitals with 90 per cent. or more of their beds allocated to the chronic sick. |

| | |
|---|---|
| 7. Pre-convalescent ... ... | Hospitals with 90 per cent. or more of their beds allocated to patients who have already received elsewhere the most intensive part of their treatment but who still require active nursing care and medical oversight. |
| 8. Convalescent ... ... | Hospitals with 90 per cent. or more of their beds allocated to patients recovering from a disability who no longer require active medical supervision or nursing care in bed though they may need such simple nursing procedures as renewal of dressings or the administration of medicines |
| 9. Rehabilitation ... ... | Hospitals with 90 per cent. or more of their beds allocated to patients who no longer require nursing care in bed and who, with or without the aid of appliances, can get about and attend to their own needs with occasional assistance but who require remedial and re-educative treatment with a view to their attaining the maximum degree of recovery of use of functions. |
| 10. Isolation ... ... ... | Hospitals with 90 per cent. or more of their beds allocated to infectious diseases. |
| 11. Maternity ... ... | Hospitals (including General Practice Maternity Hospitals) with 90 per cent. or more of their beds allocated to obstetrics. |
| 12. Mental Illness ... ... | Hospitals with 90 per cent. or more of their beds allocated to Mental Illness. |
| 13. Mental Deficiency ... | Hospitals with 90 per cent. or more of their beds allocated to Mental Deficiency. |
| 14. Orthopaedic ... ... | Hospitals with 90 per cent. or more of their beds allocated to traumatic and orthopaedic surgery, including bone and joint tuberculosis. |
| 15. Tuberculosis and Chest... | Hospitals with 90 per cent. or more of their beds allocated to tuberculosis (both respiratory and non-respiratory) or diseases of the chest (including thoracic surgery) or both. |
| 16. Tuberculosis and Chest and Isolation. | Hospitals with 90 per cent. or more of their beds allocated to tuberculosis (both respiratory and non-respiratory) or diseases of the chest (including thoracic surgery) or both, and infectious diseases. |
| 17. Children's (acute) ... | Hospitals with 90 per cent. or more of their beds allocated as in "Acute" but for children only. |
| 18. Eye ... ... ... | Hospitals with 90 per cent. or more of their beds allocated to that one function. |
| 19. Other Hospitals ... ... | "Other Hospitals" include Dental, E.N.T., and Neurosis hospitals and also:— |

(i) All hospitals with 90 per cent. or more of their beds allocated to a single department not specifically named above unless that department is "General Medicine", "General Surgery" or "General Practice (Medical)" in which event the hospital would be classified as "Acute" (Type 1).

(ii) All hospitals otherwise classifiable as "Acute", "Mainly Acute" or "Partly Acute" with 50 per cent. or more of their beds allocated to one department unless the department is "General Medicine", "General Surgery" or "General Practice (Medical)".

(iii) All hospitals not clearly falling into any of the foregoing Types (1–19 (ii)).

## TABLE 12

### Revenue Expenditure of Hospital Authorities

### England and Wales

| | Actual Expenditure 1949–50 | Actual Expenditure 1950–51 | Actual Expenditure 1951–52 | Actual Expenditure 1952–53 | Actual Expenditure 1953–54 | Actual Expenditure 1954–55 | Actual Expenditure 1955–56 |
|---|---|---|---|---|---|---|---|
| 1. Salaries and wages (including employer's and employee's contributions to National Insurance and superannuation) | £ | £ | £ | £ | £ | £ | £ |
| (i) Medical (including specialists and registrars) | 22,027,396 | 25,647,001† | 24,972,420 | 26,046,786 | 27,217,231 | 30,787,246 | 31,704,030 |
| (ii) Nursing | 45,181,873 | 49,111,273 | 51,131,513 | 56,242,019 | 59,152,069 | 62,603,192 | 68,725,857 |
| (iii) Other | 52,081,953 | 58,105,333 | 65,745,917 | 72,224,870 | 75,752,199 | 79,296,165 | 85,723,842 |
| 2. Provisions | 21,881,955 | 23,558,897 | 27,127,912 | 30,940,335 | 32,862,984 | 34,334,321 | 36,413,156 |
| 3. Staff and Patients' uniforms and clothing | 2,492,269 | 2,897,823 | 3,376,961 | 3,386,791 | 3,311,440 | 3,203,882 | 3,381,945 |
| 4. Drugs and dressings, Medical and surgical appliances and equipment | 13,574,083 | 15,057,315 | 16,641,239 | 17,115,291 | 17,079,731 | 17,398,124 | 19,006,887 |
| 5. Fuel, Light, Power, Water and Laundry | 12,686,470 | 14,301,130 | 16,059,546 | 17,714,311 | 18,946,221 | 20,411,550 | 22,656,585 |
| 6. Maintenance of buildings, plant and grounds | 6,617,816 | 8,151,758 | 7,833,956 | 8,961,115 | 10,682,376 | 9,555,107 | 12,316,587 |
| 7. Domestic repairs, renewals and replacements | 7,105,191 | 7,487,608 | 7,915,748 | 8,622,194 | 8,516,169 | 7,272,036 | 8,143,611 |
| 8. Other expenditure | 13,091,421 | 13,683,950 | 14,967,180 | 15,603,955 | 16,171,861 | 16,205,740 | 16,966,698 |
| 9. Total Hospital Maintenance (including specialists' and registrars' salaries) | 196,740,427 | 218,002,088 | 235,772,392 | 256,857,667 | 269,692,281 | 281,067,363 | 305,039,198 |
| 10. Central Administration | 5,014,742 | 5,572,231 | 6,471,178 | 6,838,715 | 7,056,989 | 7,216,414 | 7,731,453 |
| 11. Blood Transfusion Service | 632,726 | 710,130 | 808,398 | 914,155 | 973,651 | 990,032 | 1,096,119 |
| 12. Mass Radiography Service | — | 356,775 | 427,582 | 441,088 | 468,004 | 487,932 | 532,645 |
| 13. Payments under contractual arrangements to Institutions outside the service | 1,445,263 | 1,647,660 | 1,847,628 | 2,059,005 | 2,114,763 | 2,225,946 | 2,369,097 |
| 14. Other miscellaneous expenditure | 1,421,910* | 871,316 | 1,017,702 | 1,270,553 | 1,365,918 | 1,456,744 | 1,523,120 |
| 15. Total Hospital Revenue Expenditure | 205,255,068 | 227,160,200 | 246,344,880 | 268,381,183 | 281,671,606 | 293,444,431 | 318,291,632 |
| 16. Direct Credits | 15,979,870 | 19,720,550 | 21,517,808 | 23,667,359 | 24,276,022 | 24,738,465 | 25,233,433 |
| 17. Total Revenue Expenditure | 189,275,198 | 207,439,650 | 224,827,072 | 244,713,824 | 257,395,584 | 268,705,966 | 293,058,199 |
| 18. Net Revenue Expenditure in Teaching Hospitals (included above) | 27,536,784 | 30,851,243 | 31,787,940 | 34,282,794 | 35,436,034 | 36,922,877 | 39,800,470 |

* Expenditure on the Mass Radiography Service is included in this total. † Includes arrears of distinction awards to Specialists in respect of earlier years.

TABLE

REVENUE EXPENDITURE OF HOSPITAL

HOSPITAL MAINTENANCE

| Types of hospitals | 1949–50 | Types of hospitals | 1950–51 | 1951–52 |
|---|---|---|---|---|
| General ... ... ... | 101,444,779 | Wholly General ... | 69,546,865 | 71,506,643 |
| Isolation ... ... | 5,417,127 | Mainly General... ... | 28,463,772 | 32,242,247 |
| Maternity ... ... | 4,916,478 | Mainly Chronic ... | 5,331,202 | 5,887,237 |
| Tuberculosis ... ... | 7,980,169 | Chronic ... ... ... | 6,663,461 | 7,420,678 |
| Convalescent ... ... | 1,080,698 | Convalescent ... ... | 1,235,400 | 1,310,032 |
| Mental ... ... ... | 25,668,862 | Isolation ... ... ... | 2,073,061 | 1,854,295 |
| Mental Deficiency ... | 8,141,862 | Maternity ... ... | 5,304,074 | 5,522,791 |
| Other ... ... ... | 14,047,850 | Mental ... ... ... | 26,793,052 | 28,467,204 |
| | | Mental Deficiency ... | 8,470,682 | 9,296,597 |
| | | Orthopaedic ... ... | 2,212,842 | 2,504,726 |
| | | Tuberculosis ... ... | 8,169,308 | 8,902,003 |
| | | T.B. & Isolation ... | 3,846,460 | 4,236,768 |
| | | Other Specialist... ... | 11,784,420 | 13,574,283 |
| | | Other Establishments ... | 3,007,415 | 3,716,495 |
| | | Clinics ... ... ... | 1,539,459 | 1,568,742 |
| Totals ... ... | 168,697,825 | Totals ... ... | 184,441,473 | 198,010,741 |

*Note*:

1. Expenditure on Regional Hospital Board's own services and central administrative expenses of hospital authorities. Table 12 items 10–14 and part of item 1 (i) (salaries of specialists and registrars) is not included above.

13

AUTHORITIES—ENGLAND AND WALES
(LESS DIRECT CREDITS)

| Types of hospitals | 1952–53 | 1953–54 | Types of hospitals | 1954–55 | 1955–56 |
|---|---|---|---|---|---|
| General ... ... | 74,536,553 | 78,923,797 | Acute ... ... | 85,274,249 | 93,444,022 |
| Mainly General ... | 36,782,127 | 36,971,909 | Mainly Acute ... | 26,941,236 | 29,565,602 |
| Mainly Chronic ... | 7,093,961 | 6,600,023 | Partly Acute ... | 8,966,343 | 10,206,207 |
| Chronic ... ... | 7,161,526 | 7,793,950 | Mainly Long Stay... | 5,342,629 | 6,357,217 |
| Convalescent ... | 1,751,079 | 1,884,674 | Long Stay ... ... | 4,287,527 | 4,368,860 |
| Isolation ... ... | 1,340,453 | 1,054,299 | Chronic ... ... | 8,567,557 | 9,626,593 |
| Maternity ... ... | 5,765,959 | 5,901,396 | Pre-convalescent ... | 982,259 | 1,084,357 |
| Mental ... ... | 31,692,981 | 33,664,000 | Convalescent ... | 1,018,045 | 1,059,709 |
| Mental Deficiency... | 10,594,859 | 11,409,168 | Rehabilitation ... | 281,620 | 306,746 |
| Orthopaedic ... | 2,706,078 | 3,062,266 | Isolation ... ... | 957,382 | 962,321 |
| Tuberculosis ... | 9,371,467 | 9,774,142 | Maternity ... ... | 6,076,136 | 6,633,286 |
| T.B. and Isolation... | 3,715,853 | 3,894,176 | Mental Illness ... | 35,291,822 | 39,056,493 |
| Children (General) | 4,818,117 | 4,906,393 | Mental Deficiency... | 11,789,343 | 13,077,671 |
| Ear, Nose and Throat ... ... | 565,997 | 541,626 | Orthopaedic ... | 3,364,577 | 3,619,880 |
| Eye ... ... | 1,604,422 | 1,659,602 | T.B. and Chest ... | 11,020,839 | 11,877,011 |
| Eye and Ear, Nose and Throat ... | 340,962 | 353,686 | T.B. and Chest and Isolation ... | 3,501,419 | 3,718,252 |
| Miscellaneous ... | 14,235,707 | 16,774,770 | Children's Acute ... | 4,894,761 | 5,346,471 |
| Other Establishments ... ... | 313,013 | 339,692 | Eye ... ... | 1,806,958 | 1,900,779 |
| | | | Other Hospitals ... | 13,320,854 | 14,150,421 |
| Clinics ... ... | 1,725,787 | 1,956,631 | Other Establishments ... ... | 381,080 | 480,312 |
| | | | Clinics ... ... | 1,839,601 | 1,923,625 |
| Totals ... | 216,116,901 | 227,466,200 | Totals ... | 235,906,237 | 258,765,835 |

2. The classification of hospitals by type for statistical purposes is explained in Table 11. The same classification was adopted for accounting purposes except that in the year 1953–54 the change made in the statistical classification was not followed for accounting purposes.

TABLE 14

The following Table shows the average cost per week of maintaining an in-patient in each of the years 1950–51 to 1953–54 and also shows, in the final column, what the 1953–54 costs would have been on the basis of wages and prices in force during 1950–51.

| Classification of Hospital | Cost per in-patient per week year ended 31st March | | | | 1953–54 costs adjusted to 1950–51 wages and prices |
|---|---|---|---|---|---|
| | 1951 | 1952 | 1953 | 1954 | |
| | £ s. d. | £ s. d. | £ s. d. | £ s. d. | £ s. d. |
| NON-TEACHING HOSPITALS | | | | | |
| General ... ... ... | 13 10 3 | 14 5 11 | 15 4 9 | 15 15 5 | 13 6 7 |
| Mainly General ... ... | 11 12 3 | 12 10 10 | 13 4 7 | 13 16 1 | 11 12 2 |
| Mainly Chronic ... ... | 6 18 4 | 7 5 1 | 7 12 10 | 8 6 8 | 6 18 10 |
| Chronic ... ... ... | 5 15 5 | 6 0 0 | 6 11 6 | 7 0 2 | 5 16 2 |
| Convalescent ... ... | 6 15 9 | 6 12 11 | 7 11 4 | 8 3 0 | 6 14 10 |
| Isolation ... ... ... | 15 11 1 | 17 0 1 | 17 0 0 | 19 9 2 | 16 4 3 |
| Maternity ... ... ... | 16 9 5 | 16 19 2 | 17 13 1 | 18 0 5 | 15 1 5 |
| Mental ... ... ... | 3 15 11 | 4 1 1 | 4 8 6 | 4 12 6 | 3 17 4 |
| Mental Deficiency ... ... | 3 11 4 | 3 17 1 | 4 4 4 | 4 8 11 | 3 14 0 |
| Orthopaedic ... ... | 9 17 0 | 10 15 3 | 11 13 0 | 12 9 11 | 10 8 5 |
| Tuberculosis ... ... | 8 17 2 | 9 6 7 | 9 19 5 | 10 8 1 | 8 13 4 |
| Tuberculosis and Isolation | 12 11 8 | 13 3 8 | 13 5 7 | 14 1 5 | 11 14 3 |
| TEACHING HOSPITALS | | | | | |
| General | | | | | |
| London ... ... ... | 23 16 10 | 23 13 8 | 24 18 8 | 25 4 2 | 21 7 0 |
| Provinces... ... ... | 17 5 10 | 17 15 8 | 18 13 9 | 19 2 9 | 16 5 6 |

NOTES:

1. There were minor changes in the definitions of hospital types for classification purposes affecting 1952–53 and 1953–54, but the figures for the four years are reasonably comparable.

2. The conversion of the costs for 1953–54 in terms of 1950–51 wages and prices has been carried out by reducing the wages element of the 1953–54 figures by reference to indices of wage rates in the hospital service for the three main groups of staff (medical, nursing, and others) and to the estimated increases due to salary increments; and by reducing the non-wages element by reference to the changes in the Ministry of Labour's Retail Price Index for all commodities. The conversion of 1955–56 costs in terms of 1954–55 wages and prices in Table 15 has been carried out on a similar basis as regards the wage element and by reference to an index of hospital prices, which is maintained in the Department, for the non-wage element.

## TABLE 15

The following Table shows the average cost per week of maintaining an in-patient in each of the years 1954–55 and 1955–56 and also shows, in the final column, what the 1955–56 costs would have been on the basis of wages and prices in force during 1954–55:—

| Classification of Hospital | Cost per in-patient per week year ended 31 March | | 1955–56 costs adjusted to 1954–55 wages and prices |
|---|---|---|---|
| | 1955 | 1956 | |
| | £ s. d. | £ s. d. | £ s. d. |
| NON-TEACHING HOSPITALS | | | |
| Acute ... ... ... ... ... | 16 9 0 | 17 15 0 | 16 17 1 |
| Mainly Acute ... ... ... ... | 14 18 3 | 16 7 3 | 15 10 7 |
| Partly Acute ... ... ... ... | 12 2 9 | 13 4 4 | 12 10 4 |
| Mainly Long Stay ... ... ... | 10 6 7 | 11 8 6 | 10 16 4 |
| Long-Stay ... ... ... ... | 6 19 5 | 7 15 9 | 7 7 3 |
| Chronic ... ... ... ... ... | 7 4 5 | 7 18 7 | 7 9 11 |
| Preconvalescent ... ... ... ... | 9 13 0 | 10 12 9 | 10 1 2 |
| Convalescent ... ... ... ... | 7 7 8 | 8 7 2 | 7 18 0 |
| Rehabilitation ... ... ... ... | 7 16 0 | 8 10 6 | 8 1 0 |
| Isolation ... ... ... ... ... | 20 13 8 | 20 19 5 | 19 16 11 |
| Maternity ... ... ... ... | 18 7 3 | 19 7 11 | 18 7 1 |
| Mental Illness ... ... ... ... | 4 16 9 | 5 6 6 | 5 0 10 |
| Mental Deficiency ... ... ... | 4 12 1 | 5 0 6 | 4 15 2 |
| Orthopaedic ... ... ... ... | 13 0 6 | 14 9 9 | 13 14 3 |
| Tuberculosis and Chest ... ... | 10 19 1 | 12 11 3 | 11 18 1 |
| Tuberculosis and Chest and Isolation | 14 18 6 | 16 7 4 | 15 9 11 |
| Children's (Acute) ... ... ... | 16 19 3 | 18 7 0 | 17 7 8 |
| Eye ... ... ... ... ... | 13 6 5 | 14 11 6 | 13 17 3 |
| TEACHING HOSPITALS | | | |
| Acute: | | | |
| London ... ... ... ... | 25 6 0 | 27 3 8 | 25 16 6 |
| Provinces ... ... ... ... | 20 0 0 | 21 11 2 | 20 9 10 |

*Note*—See Note 2 to Table 14.

## APPENDIX 2

### Salary Basis of Administrative Staff

*Memorandum submitted on behalf of the Minister of Health*

1. The salaries of senior lay administrators in non-teaching hospital groups, of some lay administrators in teaching hospital groups and of senior nursing staff are related to the number of hospitals and of beds in their administrative units. The salaries of senior lay administrators of Regional Hospital Boards and Boards of Governors are determined by reference to formulae which have regard to the extent of their responsibilities. Particulars (including the various methods of counting beds for the purpose) are given below.

2. The officers whose salaries are determined in this way are :—

(*a*) Group Secretaries and Deputy Group Secretaries
(*b*) Finance Officers and Deputy Finance Officers
} Non-teaching hospitals.

(*c*) Supplies Officers and Deputy Supplies Officers (both teaching and non-teaching hospitals).

(*d*) Hospital Secretaries (both teaching and non-teaching hospitals).

(*e*) Matrons and Assistant Matrons (in Mental Hospitals, Deputy Matrons).

(*f*) Chief Male Nurses and Deputy Chief Male Nurses (mental and mental deficiency hospitals).

3. The salaries of Secretaries and Finance Officers (and their deputies) of Boards of Governors of Teaching Hospitals and the salaries of Secretaries and Treasurers (and their deputies) of Regional Hospital Boards—and certain other Senior Regional Officers—are determined individually or in groups by the Whitley Council having regard to the extent of their responsibilities. For example, there are four salary scales for Secretaries of Boards of Governors: one relates to the undergraduate teaching hospitals and three relate to the post-graduate groups.

**Points System for Senior Lay Administrative Staff**

4. The salaries of the officers referred to in paragraph 2 (*a*)-(*d*) above are determined by reference to a "points" system which in turn is based mainly upon the number and type of beds concerned. The method of calculation of the points has been agreed by the Whitley Council and is described in Appendix B to A.C. Circular No. 33. The effect on an officer's salary of changes in the number of points is described in part II of Appendix A to that circular (but see paragraph 6 of the circular as regards changes affecting hospital secretaries).

For all these officers, except hospital secretaries, salaries are based on 7 points groupings which are the same in all cases. These points groupings are set out below, the salaries of *Group Secretaries* being shown by way of example:—

| *Points* | *Salary Scale (Group Secretaries)* |
|---|---|
| Over 60 ... ... ... ... ... | £1,691 to £2,162 |
| 50½-60 ... ... ... ... ... | £1,579 to £1,993 |
| 40½-50 ... ... ... ... ... | £1,442 to £1,823 |
| 30½-40 ... ... ... ... ... | £1,320 to £1,664 |
| 20½-30 ... ... ... ... ... | £1,223 to £1,495 |
| 10½-20 ... ... ... ... ... | £1,054 to £1,325 |
| 4½-10 ... ... ... ... ... | £890 to £1,196 |

For Hospital Secretaries there are 7 salary scales for non-teaching hospitals and 7 salary scales for teaching hospitals each within 5 points groupings.

**Matrons and Chief Male Nurses**

5. The salary scales of matrons and assistant matrons in general hospitals, and of matrons, chief male nurses, deputy matrons and deputy chief male nurses in

mental and mental deficiency hospitals are related directly to the number of beds. By way of example there are shown below the scales for a matron of a general hospital which is approved by the General Nursing Council for the training of student nurses:

| | |
|---|---|
| 1,500 beds and over ... ... ... ... | £1,095 to £1,290 |
| 1,000-1,499 beds ... ... ... ... | £1,070 to £1,265 |
| 700-999 „ ... ... ... ... | £975 to £1,170 |
| 600-699 „ ... ... ... ... | £935 to £1,130 |
| 500-599 „ ... ... ... ... | £895 to £1,090 |
| 400-499 „ ... ... ... ... | £850 to £1,045 |
| 300-399 „ ... ... ... ... | £790 to £985 |
| 200-299 „ ... ... ... ... | £735 to £905 |
| Under 200 „ ... ... ... ... | £710 to £845 |

The beds counted are normally the number of available beds; in mental and mental deficiency hospitals the beds on the female side usually count to the Matron and those on the male side to the Chief Male Nurse. When there is a permanent change in the size or status of the hospital the Senior Nursing staff are regarded as having been promoted or transferred to the appropriate new scale as from the date of the change, but subject in the case of adverse change to a reasonable period of notice. In certain circumstances an adverse change in size and status of a hospital does not affect the salaries of the senior nursing staff in post at the date of change.

## APPENDIX 3

### Notional Cost of Maintaining 100 Occupied Beds per Week

*Memorandum submitted on behalf of the Minister of Health*

1. The distribution of beds between the main hospital types on a national basis in several years is shown in the Table I below.

2. The notional cost of maintaining 100 beds in each region is obtained by taking the actual regional cost of maintenance for each type (according to the Costing Returns) and calculating a total on the assumption that the distribution of beds—of the main types quoted below—in each region was the same as the national distribution. The result is shown in Table II.

3. In one or two cases there are no hospitals in a region under one or other of the types included in the review; in those cases the cost assumed for the region is the national average for the type adjusted upwards or downwards as the average for the region for all other types bears to the national average for those types.

TABLE I

| Year ended 31.3.52 and Year ended 31.3.54 | Beds 1951–2 | Beds 1953–4 | Year ended 31.3.55 and Year ended 31.3.56 | Beds 1954–5 | Beds 1955–6 |
|---|---|---|---|---|---|
| General (301–900 beds)... | 6·66 | 6·71 | Acute (301–900 beds) ... | 7·75 | 7·66 |
| General (101–300 beds)... | 7·74 | 7·55 | Acute (101–300 beds) ... | 7·45 | 7·32 |
| General (51–100 beds)... | 2·04 | 2·03 | Acute (51–100 beds) ... | 1·89 | 1·93 |
| General (1– 50 beds)... | 2·50 | 2·34 | Acute (1– 50 beds) ... | 2·23 | 2·19 |
| Mainly General ... ... | 14·45 | 14·60 | Mainly Acute ... ... | 9·41 | 9·43 |
| Mainly Chronic ... ... | 4·79 | 4·42 | Partly Acute ... ... | 4·06 | 4·41 |
| Chronic ... ... ... | 6·00 | 5·23 | Mainly Long Stay ... | 2·94 | 3·06 |
| Mental ... ... ... | 37·53 | 38·21 | Long Stay ... ... | 3·15 | 2·92 |
| M.D. ... ... ... | 12·97 | 13·65 | Chronic ... ... ... | 5·29 | 5·68 |
| T.B. ... ... ... | 5·32 | 5·26 | Mental ... ... ... | 37·31 | 37·07 |
| | | | M.D. ... ... ... | 13·31 | 13·29 |
| | | | T.B. and Chest ... ... | 5·21 | 5·04 |
| | 100·00 | 100·00 | | 100·00 | 100·00 |

TABLE II

| Region | 1951–52 | 1953–54 | 1954–55 | 1955–56 |
|---|---|---|---|---|
| | £ | £ | £ | £ |
| Newcastle ... ... ... ... | 727 | 831 | 865 | 954 |
| Leeds... ... ... ... ... | 729 | 807 | 848 | 933 |
| Sheffield ... ... ... ... | 719 | 813 | 863 | 953 |
| East Anglian ... ... ... | 735 | 828 | 904 | 992 |
| North West Metropolitan ... ... | (*a*) 944 | (*a*) 1,010 | (*a*) 1,012 | (*a*) 1,084 |
| North East Metropolitan ... ... | 836 | 932 | 987 | 1,081 |
| South East Metropolitan ... ... | 842 | 908 | 942 | 1,025 |
| South West Metropolitan ... ... | 798 | 875 | 908 | 1,014 |
| Oxford ... ... ... ... | 835 | 945 | 972 | 1,053 |
| South Western ... ... ... | 802 | 894 | 923 | 1,032 |
| Welsh ... ... ... ... | 743 | 868 | 927 | 986 |
| Birmingham... ... ... ... | 748 | 841 | 845 | 925 |
| Manchester ... ... ... ... | (*b*) 675 | (*b*) 766 | (*b*) 813 | (*b*) 886 |
| Liverpool ... ... ... ... | 712 | 770 | 826 | 904 |
| National Average ... ... ... | 775 | 863 | 903 | 987 |
| Maximum percentage (+)... ... | 21·8 | 17·0 | 12·0 | 9·8 |
| Variation from average (−) ... | 12·9 | 11·2 | 10·0 | 10·2 |

(*a*) Highest. (*b*) Lowest.

## APPENDIX 4

### Hospital Development Expenditure

*Memorandum submitted on behalf of the Minister of Health*

1. This memorandum elaborates paragraph 17 of the previous Memorandum[1], in accordance with the request contained in the Clerk's letter of 15th April, 1957.

2. As stated in paragraph 17 of that Memorandum, the principles on which allocations are made to Boards have varied from time to time. The practice of making special provision in the allocations to meet the cost of new developments and improvements dates from 1952-53, and Tables A, B and C attached show the amounts involved from 1952-53 to 1957-58. It should, however, be noted that the detailed figures given are not necessarily in all cases strictly comparable.

3. The allocations to Boards of Governors of teaching hospitals include no special provision for maintenance expenses arising from the completion of capital works during the coming year. Boards are told that additional provision will be made on this account as capital schemes are completed and an appropriate reserve is retained by the Minister for issue as and when required. The initial allocations to Regional Hospital Boards for this purpose are based upon the Board's estimates of the amounts required (Table A).

4. The principles upon which the provision for general developments and improvements is distributed between teaching and non-teaching hospitals and between Regional Boards (Table C) have varied from year to year as follows:—

(a) *1952-53*

(1) *Regional Hospital Boards*

The total sum available—rather less than £2 millions—was divided first between the Metropolitan and the Provincial Regional Hospital Boards in a manner somewhat favourable to the latter; these two sums were then divided between Boards on the basis of population served.

[1] Evidence, p. 5.

Moreover, there was for this year a substantial adjustment in favour of Boards with relatively low weekly costs per patient in the distribution of money available to meet the cost in a full year of price and wage increases and developments taking effect during the previous year.

(2) *Boards of Governors*

No specific allocation was made for general improvements and additional allocations were made to individual Boards as necessary.

(b) *1953-54*

(1) *Regional Hospital Boards*

A larger total sum—about £2¼m.—was divided on the same general principal as in the previous year but the Metropolitan Boards received a larger share of the total (more than one-fifth instead of one-sixth). There was no further special adjustment this year in favour of low cost areas.

(2) *Boards of Governors*

No specific allocation was made for general improvements and additional allocations were made to individual Boards as necessary.

(c) *1954-55*

(1) *Regional Hospital Boards*

Considerably less money was available for developments this year and the total—about £¾m.—was divided in proportion to population and then adjusted in favour of Boards with relatively low costs.

(2) *Boards of Governors*

No specific provision for developments was included in the total for Boards of Governors. A small central reserve was created, for distribution during the year to Boards of Governors with special developments, by a proportionate reduction of the estimates of all Boards.

(d) *1955-56*

The allocations for general developments were arrived at in two stages. In the first place, a total of roughly £1¼m. was divided between Boards of Governors and Regional Hospital Boards in proportion to expenditure. The Regional Hospital Boards' share (about £1¼m.) was divided between Regional Boards half in proportion to population and half in proportion to expenditure. The Boards of Governors' share—about £¼m.—was divided in proportion to expenditure. From the figures thus obtained, there were then deducted sums totalling about £850,000, which the Boards were asked to save through economies. This saving was achieved at the expense of all Boards but fell more heavily on the London teaching hospitals and on those Regional Boards with highest costs per bed.

Deductions were also made from individual Regional Boards and Boards of Governors in respect of savings expected from closure or sale of hospital property and from specific revenue saving projects.

(e) *1956-57*

The total amount available for general developments was about £1m. The amount allotted to Regional Hospital Boards (£850,000) was divided between Boards, half in proportion to population and half in proportion to expenditure.

The amount available for Boards of Governors was divided between them in proportion generally to the number of occupied beds.

As in 1955-56, deductions were also made from individual Boards in respect of estimated savings from closures and sales and in respect of revenue saving projects.

(f) *1957-58*

The total provision available—about £1¾m.—was first divided between Regional Hospital Boards and Boards of Governors.

As between Regional Boards, £600,000 was distributed in proportion to population, £600,000 in proportion to the number of occupied beds and £375,000 to the eight Regional Hospital Boards whose bed costs were lowest.

The amount available for Boards of Governors was distributed between them in proportion generally to the number of occupied beds. As in the two previous years deductions were also made from individual Boards in respect of their estimated savings from closures and sales and in respect of revenue savings projects.

5. **Allocations for Special Purposes** (Table B)

(a) *Building Maintenance*

Because relatively little money was available in 1954-55 for developments in the hospital service, and because insufficient provision was made for meeting price increases, hospital authorities found it necessary to finance developments and improvements of high priority in that year by reducing the level of expenditure on building maintenance, domestic repairs and renewals and medical and surgical appliances and equipment. Deferment of works of maintenance was clearly undesirable on a long term view and special funds were made available in 1955-56 to redress the situation as far as possible. The Minister was anxious to secure that the substantial additional funds made available for building maintenance were, in fact, used for this purpose, and accordingly when Boards were notified of their allocations for 1955-56, and asked to prepare their budget, they were told that of the total sum a specified amount was " earmarked " for building maintenance purposes, and that this earmarked sum was to be increased during the year to take account of wage awards affecting building maintenance staff and, if necessary, of further price increases.

The arrangements for earmarking a portion of the allocation for this purpose continued in operation for 1956-57 and 1957-58.

(b) *Domestic Repairs, etc.*

As mentioned above, additional provision was also included in the allocations for 1955-56 to remedy in part reductions in expenditure in 1954-55. Earmarking would have been very difficult in this case in view of the wide range of services concerned, and the Minister, in making the allocations, did not go beyond indicating the purposes for which the additional money was being provided. There was, in fact, a considerable increase in expenditure on these purposes in 1955-56.

(c) *Improvement in Mental Catering*

In making the allocations for 1956-57, the Minister stressed the importance of raising the standard of catering for patients at many mental and mental deficiency hospitals; special provision was made in the allocations to enable Boards to improve these standards. Suggestions were later made to Boards on ways in which improvements might be effected, such as better diets, improved kitchen facilities and additional catering staff. Central control over the additional funds provided would have been difficult because of the various ways in which improvements might be made, but the Minister believes that the funds made specially available for this purpose are being wisely used.

**Central Control**

6. It is the policy of the Minister to interfere as little as possible in the day to day management of the hospitals and, with the exception of funds provided

for building maintenance to which reference has been made above, the allocations made to hospitals are not earmarked to specific purposes; subject only to the Minister's general directions and to the control of estimates through approval headings (referred to in Paragraphs 18 to 22 of the previous Memorandum[1]), hospital authorities are authorised to use the funds at their disposal as they think fit.

The additional funds included in the allocation in respect of developments and improvements are not the maximum amounts which may be spent on developments and improvements; they may be supplemented by savings which hospital authorities are able to make in their existing services.

[1] Evidence pp. 5–6.

TABLE A

£ million

| Region | Amounts included in the initial allocation for the year to meet the additional expenditure arising from Capital works coming into operation in that year | | | | | |
|---|---|---|---|---|---|---|
| | 1952–53 | 1953–54 | 1954–55 | 1955–56 | 1956–57 | 1957–58 |
| 1. Newcastle-on-Tyne ... | 0·175 | 0·035 | 0·054 | 0·091 | 0·130 | 0·069 |
| 2. Leeds ... ... ... | 0·105 | 0·163 | 0·189 | 0·126 | 0·121 | 0·090 |
| 3. Sheffield ... ... | 0·143 | 0·176 | 0·064 | 0·120 | 0·164 | 0·121 |
| 4. East Anglian ... ... | 0·040 | 0·015 | 0·013 | 0·063 | 0·038 | 0·048 |
| 5. N.W. Metropolitan ... | 0·145 | 0·072 | 0·103 | 0·092 | 0·060 | 0·060 |
| 6. N.E. Metropolitan ... | 0·126 | 0·112 | 0·052 | 0·076 | 0·062 | 0·060 |
| 7. S.E. Metropolitan ... | 0·125 | 0·120 | 0·113 | 0·134 | 0·101 | 0·120 |
| 8. S.W. Metropolitan ... | 0·205 | 0·133 | 0·045 | 0·170 | 0·088 | 0·132 |
| 9. Oxford ... ... ... | 0·044 | 0·047 | 0·061 | 0·062 | 0·006 | 0·019 |
| 10. South Western ... | 0·109 | 0·117 | 0·047 | 0·060 | 0·050 | 0·057 |
| 11. Wales ... ... ... | 0·305 | 0·116 | 0·058 | 0·096 | 0·123 | 0·077 |
| 12. Birmingham ... ... | 0·127 | 0·100 | 0·111 | 0·052 | 0·058 | 0·100 |
| 13. Manchester ... ... | 0·074 | 0·083 | 0·052 | 0·124 | 0·032 | 0·069 |
| 14. Liverpool ... ... | 0·083 | 0·058 | 0·026 | 0·044 | 0·036 | 0·094 |
| Total ... ... ... | 1·806 | 1·347 | 0·988 | 1·310 | 1·069 | 1·116 |

## TABLE B

### 1. Building Maintenance

£ million

| Region | 1955–56 | | | 1956–57 | | 1957–58 | |
|---|---|---|---|---|---|---|---|
| | Additional sums included in allocations estimated to restore generally 1953–54 Standard of Expenditure | Special additional allocation | Ear-marked sums | Special additional allocation | Ear-marked sums | Special additional allocation | Ear-marked sums |
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| 1. Newcastle-on-Tyne | 0·191 | 0·009 | 1·008 | —0·016 | 1·050 | —0·016 | 0·926 |
| 2. Leeds ... ... | 0·029 | 0·102 | 1·319 | 0·068 | 1·397 | 0·068 | 1·240 |
| 3. Sheffield ... ... | 0·058 | 0·088 | 1·353 | 0·053 | 1·451 | 0·053 | 1·346 |
| 4. East Anglian ... | 0·032 | 0·057 | 0·527 | 0·042 | 0·604 | 0·042 | 0·528 |
| 5. N.W. Metropolitan | 0·064 | 0·049 | 1·772 | 0·004 | 1·838 | 0·004 | 1·596 |
| 6. N.E. Metropolitan... | 0·183 | 0·017 | 1·725 | —0·026 | 1·787 | —0·026 | 1·631 |
| 7. S.E. Metropolitan... | 0·085 | 0·120 | 1·510 | 0·082 | 1·553 | 0·082 | 1·304 |
| 8. S.W. Metropolitan... | 0·323 | 0·231 | 2·507 | 0·167 | 2·645 | 0·167 | 2·447 |
| 9. Oxford ... ... | 0·013 | 0·014 | 0·524 | —0·003 | 0·682 | —0·003 | 0·579 |
| 10. South Western ... | 0·211 | 0·053 | 1·354 | 0·016 | 1·510 | 0·016 | 1·307 |
| 11. Wales ... ... | 0·113 | 0·013 | 1·187 | —0·019 | 1·338 | —0·019 | 1·188 |
| 12. Birmingham ... | 0·059 | 0·109 | 1·712 | 0·064 | 1·838 | 0·064 | 1·520 |
| 13. Manchester... ... | 0·130 | 0·045 | 1·824 | —0·004 | 2·030 | —0·004 | 1·795 |
| 14. Liverpool ... ... | 0·054 | 0·093 | 0·865 | 0·072 | 0·889 | 0·072 | 0·710 |
| Total R.H.Bs. ... ... | 1·545 | 1·000 | 19·187 | 0·500 | 20·612 | 0·500 | 18·117 |
| Boards of Governors ... | 0·111 | — | 2·627 | — | 2·891 | — | 2·657 |
| Total ... ... ... | 1·656 | 1·000 | 21·814 | 0·500 | 23·503 | 0·500 | 20·774 |

*Notes*

1. The additional sums included in the 1955–56 allocations in order to restore generally, on an estimated basis, the 1953–54 standard of expenditure on building maintenance, were repeated in the 1956–57 and 1957–58 allocations. To make good in part the leeway lost in 1954–55 a special additional allocation of £1m. was included in the 1955–56 allocations and £0·5m. in both 1956–57 and 1957–58 allocations.

2. The amounts earmarked for building maintenance in the allocations take into account increases in prices and wage rates up to the time the allocations were made. The figures for 1957–58 were calculated on a different basis from those for earlier years in that they did not include the wages of gardeners and stokers employed by hospital authorities (estimated at £5,278,673 in 1956–57).

TABLE B—*contd.*

II. DOMESTIC REPAIRS AND RENEWALS AND MEDICAL AND SURGICAL APPLIANCES AND EQUIPMENT

The following additions to 1954–55 estimated expenditure were made in the 1955–56 allocations with a view to restoring partially the large reductions made in that year under this heading:—

£ million

| Region | Additional sum included in 1955–56 allocation |
|---|---|
| 1. Newcastle-on-Tyne ... | 0·102 |
| 2. Leeds ... ... ... | 0·027 |
| 3. Sheffield ... ... ... | 0·036 |
| 4. East Anglian ... ... | 0·027 |
| 5. N.W. Metropolitan ... | 0·079 |
| 6. N.E. Metropolitan ... | 0·038 |
| 7. S.E. Metropolitan ... | 0·036 |
| 8. S.W. Metropolitan ... | 0·101 |
| 9. Oxford ... ... ... | 0·016 |
| 10. South Western ... ... | 0·046 |
| 11. Wales ... ... ... | 0·047 |
| 12. Birmingham ... ... | 0·056 |
| 13. Manchester ... ... | 0·089 |
| 14. Liverpool ... ... ... | 0·049 |
| Total R.H.Bs. ... ... ... | 0·749 |
| Boards of Governors ... ... | 0·082 |
| Total ... ... ... | 0·831 |

In 1956–57 and 1957–58 no further special adjustment was considered necessary.

TABLE B—*contd.*

III. MENTAL CATERING

£ million

| Region (1) | 1956–57 Additional amount provided for improved mental catering (2) | 1957–58 Further addition provided for improved mental catering (3) |
|---|---|---|
| 1. Newcastle-on-Tyne ... | 0·028 | 0·022 |
| 2. Leeds ... ... ... | 0·022 | 0·018 |
| 3. Sheffield ... ... ... | 0·028 | 0·022 |
| 4. East Anglian ... ... | 0·019 | 0·015 |
| 5. N.W. Metropolitan ... | 0·038 | 0·030 |
| 6. N.E. Metropolitan ... | 0·011 | 0·009 |
| 7. S.E. Metropolitan ... | 0·031 | 0·025 |
| 8. S.W. Metropolitan ... | 0·111 | 0·089 |
| 9. Oxford ... ... ... | 0·008 | 0·006 |
| 10. South Western ... ... | 0·046 | 0·037 |
| 11. Wales ... ... ... | 0·012 | 0·010 |
| 12. Birmingham ... ... | 0·065 | 0·052 |
| 13. Manchester ... ... | 0·055 | 0·044 |
| 14. Liverpool ... ... ... | 0·026 | 0·021 |
| Total ... ... ... | 0·500 | 0·400 |

*Note*

The total sum included in the allocations for 1957–58 for the improvement of mental catering was £1·4m., the provision made in 1955–56—£0·5m.—was regarded as having been spent on improvements coming into effect during the course of the year and carrying with them a liability in a full year (1957–58) of a total of £1m. The additional £0·4m. referred to in Column 3 represents provision for yet a further improvement in catering standards during 1957–58.

TABLE C

£ million

| Region | Amounts included in the initial allocation for the year for general developments and improvements | | | | | |
|---|---|---|---|---|---|---|
| | 1952–53 | 1953–54 | 1954–55 | 1955–56 | 1956–57 | 1957–58 |
| 1. Newcastle-on-Tyne ... | 0·162 | 0·214 | 0·083 | 0·061 | 0·055 | 0·108 |
| 2. Leeds ... ... ... | 0·170 | 0·137 | 0·085 | 0·072 | 0·059 | 0·141 |
| 3. Sheffield ... ... | 0·230 | 0·224 | 0·113 | 0·094 | 0·074 | 0·144 |
| 4. East Anglian ... ... | 0·079 | 0·107 | 0·025 | 0·031 | 0·025 | 0·045 |
| 5. N.W. Metropolitan ... | 0·085 | 0·142 | 0·005 | 0·034 | 0·071 | 0·100 |
| 6. N.E. Metropolitan ... | 0·067 | 0·111 | 0·052 | 0·031 | 0·060 | 0·083 |
| 7. S.E. Metropolitan ... | 0·071 | 0·118 | −0·002 | 0·042 | 0·065 | 0·087 |
| 8. S.W. Metropolitan ... | 0·101 | 0·169 | 0·078 | 0·090 | 0·102 | 0·148 |
| 9. Oxford ... ... | 0·078 | 0·106 | 0·002 | 0·017 | 0·026 | 0·038 |
| 10. South Western ... | 0·151 | 0·204 | 0·001 | 0·046 | 0·054 | 0·083 |
| 11. Wales ... ... ... | 0·144 | 0·191 | 0·044 | 0·048 | 0·048 | 0·086 |
| 12. Birmingham ... ... | 0·245 | 0·329 | 0·076 | 0·093 | 0·082 | 0·189 |
| 13. Manchester ... ... | 0·244 | 0·323 | 0·122 | 0·131 | 0·084 | 0·213 |
| 14. Liverpool ... ... | 0·117 | 0·154 | 0·063 | 0·056 | 0·045 | 0·110 |
| Total R.H.Bs. ... | 1·944 | 2·529 | 0·747 | 0·846 | 0·850 | 1·575 |
| Boards of Governors ... | Issued separately as necessary | | — | 0·079 | 0·136 | 0·225 |

## APPENDIX 5

### Methods of Financing and Controlling The Domiciliary Consultative Service

*Memorandum submitted on behalf of the Minister of Health*

**Original arrangements**

1. In 1948 at the outset of the National Health Service Hospital Boards were asked to make arrangements for domiciliary specialist services on as wide a basis as possible. For this purpose they were advised to ascertain which specialists were prepared to take part in the domiciliary consultative service and within what area. The operation of the service was envisaged as being based on certain hospitals which would act as bureaux for dealing with requests for visits. General practitioners were provided with information about the names of specialists available, the areas in which each had agreed to work and the hospitals to which requests should be made.

It was for the individual general practitioner to decide whether specialist help was needed, always provided that he was satisfied that the basic condition of the service was satisfied, i.e. that the patient's condition was such as to make it essential for him to be seen at his home.

The day to day operation of the service was regarded as the responsibility of Management Committees. Each Committee was charged with maintaining records of all calls made upon specialists through hospitals under the Committee's control and sending those records periodically to the Regional Hospital Board in order that payment of fees might be made accordingly. Similarly travelling etc. claims in connection with domiciliary visits were to be collected and approved by the Hospital Management Committee before being sent to the Regional Hospital Board for payment.

**Present arrangements**

2. Experience of the operation of the service on this basis showed that it was unsatisfactory. Instead of making requests to hospital bureaux, general practitioners were in many cases getting into touch direct with the specialists—as was the normal practice in calling in a specialist before the National Health Service. This in turn led to confusion as to whether the consultations were consultations under the domiciliary service or private consultations. Moreover, it appeared that the operation of the service through the hospitals was serving little or no useful purpose, and that they were acting more as a "post office" than as a means of effective control. It was accordingly decided in 1951 that the convenience of all concerned would best be served if requests for domiciliary consultations from general practitioners were made direct to the specialists. It was also decided to provide the service through Regional Hospital Boards only, and not (as hitherto) through Boards of Governors of teaching hospitals also.

In view of these revised arrangements, claims for payment for this service were no longer made to and examined by the Hospital Management Committees, but the specialist was required to submit to the Regional Board in respect of each visit a statement of:—

(1) The name and address of patient and date of consultation together with a certificate signed by the general practitioner to the effect that the consultation took place at his request and that consultation at home was necessary on medical grounds.

(2) The reason for the consultation; the nature of any operation performed; whether any use was made of consultant's own apparatus; and distance travelled. These particulars are certified by the specialist.

The specialist was also required to submit periodically to the Regional Board a claim for fees and for travelling expenses for domiciliary visits.

Payment for domiciliary visits was extended from November, 1955, to whole-time specialists who hitherto had been expected to carry out domiciliary work as part of their ordinary duties. The current rates and conditions of payment are set out in Appendix A.

**Control of Service**

3. There is no question of limiting the total number of domiciliary consultations which may take place in any given period. It is the Minister's policy that the service should be available to general practitioners when in their professional judgment (and that of the specialist concerned) it is required. It should be born in mind that a domiciliary consultation may help to obviate admission to hospital. Detailed control is the responsibility of the Regional Hospital Boards and is exercised through the Department of the Senior Administration Medical Officer.

**Extent of use of service**

4. Appendix B sets out for the different specialties the number of domiciliary visits made in each of the calender years from 1951 to 1956.

There is no general information available about the number of visits made by specialists after they have qualified for the maximum fee but it is believed that comparatively few specialists reach the maximum number of paid domiciliary consultations in any quarter.

*Appendix A*

DOMICILIARY CONSULTATIONS

*Current rates of payment and conditions of service*

(*a*) A domiciliary consultation shall, for this purpose, be limited to a visit to the patient's home, at the request of the general practitioner and normally in his company, to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

Visits not falling within this definition include (i) a visit made at the instance of a hospital or specialist to review the urgency of a proposed admission to hospital or to continue or supervise treatment initiated or prescribed at a hospital or clinic ; (ii) a visit made by a chest physician to a patient on the tuberculosis register of any chest clinic ; and (iii) a visit undertaken as part of work done for a local health authority.

(*b*) Part-time officers, and (subject to sub-paragraph (*d*) below) whole-time officers, shall be paid for each consultation a fee of 4 guineas with an additional fee of

(1) 2 guineas where any operative procedure other than obstetric is undertaken or where the officer uses his own electrocardiograph or portable X-ray apparatus ;

(2) 4 guineas for an obstetric operation ;

provided however (i) that the additional fee of 2 guineas or 4 guineas shall be payable once only in respect of each patient for the current illness and (ii) that where an officer is called for a domiciliary consultation and sees on the same occasion in the same residence or institution more than one case, the consultation fees payable shall be 4 guineas for the first case seen and 2 guineas for each subsequent case seen, with an overall maximum for consultation fees of 10 guineas however many cases are seen.

(*c*) In the case of part-time officers only the Board shall make payments, additional to the fees set out above and to the normal travelling and subsistence expenses, of 1 guinea for a journey to a place over 20 and up to 40 road miles distant, 2 guineas for a journey to a place over 40 and up to 60 road miles distant, and so on, with an additional guinea for every 20 miles outward.

(*d*) In the case of whole-time officers only, no payment shall be made in respect of the first eight domiciliary consultations made in any quarter.

(*e*) The maximum remuneration under this paragraph (excluding travelling and subsistence allowances, additional mileage payment, and fees for the use of the officer's own apparatus) shall be 200 guineas in any quarter or 800 guineas in any year, whichever the officer prefers.

(*f*) Where an anaesthetist provides his own consumable drugs in the course of domiciliary visits, he shall be entitled on request to secure replacement of these drugs free of charge through the hospital service.

*Appendix B*

*Domiciliary Specialist Service*

| Specialty | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 |
|---|---|---|---|---|---|---|
| | Total number of visits | | | | | (Estimated) |
| General Medicine ... ... | 62,645 | 65,290 | 69,861 | 72,936 | 76,357 | 81,753 |
| Paediatrics ... ... ... | 8,269 | 10,314 | 12,500 | 12,898 | 14,574 | 15,194 |
| Infectious Diseases ... ... | 270 | 452 | 415 | 717 | 583 | 791 |
| Diseases of the Chest ... ... | 2,592 | 1,997 | 1,922 | 2,647 | 3,016 | 6,197 |
| Dermatology ... ... ... | 5,557 | 6,527 | 7,447 | 8,507 | 8,630 | 8,255 |
| Neurology ... ... ... | 1,472 | 1,237 | 1,430 | 1,355 | 1,454 | 1,559 |
| Cardiology ... ... ... | 1,706 | 1,639 | 1,272 | 1,631 | 1,142 | 1,547 |
| Physical medicine ... ... | 650 | 643 | 986 | 1,518 | 1,617 | 2,067 |
| V.D. ... ... ... ... | 292 | 138 | 72 | 102 | 63 | 38 |
| Pathology ... ... ... | 4,383 | 4,707 | 4,785 | 6,187 | 7,084 | 8,549 |
| Geriatrics (1) ... ... ... | — | — | — | — | 641 | 3,941(1) |
| General Surgery ... ... | 40,264 | 42,626 | 48,952 | 53,611 | 54,869 | 55,347 |
| E.N.T. ... ... ... ... | 7,491 | 8,086 | 9,474 | 8,952 | 9,303 | 9,254 |
| Traumatic and Ortho-Surgery | 7,874 | 9,235 | 10,424 | 11,859 | 13,709 | 16,234 |
| Ophthalmology ... ... | 6,124 | 6,273 | 6,899 | 7,759 | 8,347 | 8,562 |
| Radiotherapy ... ... ... | 547 | 536 | 566 | 735 | 841 | 1,007 |
| Genito-Urinary (1) ... ... | — | — | — | — | 359 | 552(1) |
| Plastic surgery ... ... ... | 26 | 29 | 45 | 118 | 130 | 116 |
| Thoracic Surgery ... ... | 223 | 278 | 416 | 453 | 390 | 377 |
| Dentistry ... ... ... | 180 | 112 | 144 | 153 | 149 | 189 |
| Neurosurgery ... ... ... | 257 | 465 | 592 | 714 | 804 | 934 |
| Anaesthetics ... ... ... | 496 | 485 | 586 | 617 | 569 | 582 |
| Radiology ... ... ... | 3,186 | 3,455 | 4,516 | 5,874 | 7,147 | 8,827 |
| Gynaecology and Obstetrics ... | 14,024 | 14,586 | 15,953 | 17,722 | 18,558 | 20,424 |
| Psychiatry ... ... ... | 6,544 | 7,005 | 8,426 | 9,408 | 11,229 | 18,294 |
| Other Specialties ... ... | 432 | 439 | 742 | 806 | 106 | 28 |
| Totals ... ... ... ... | 175,504 | 186,554 | 208,425 | 227,279 | 241,671 | 270,618 |

(1) Separate figures not available prior to 1955.

## APPENDIX 6

INCREASE IN EXPENDITURE ON DRUGS, DRESSINGS, ETC., FROM 1953–54 TO 1955–56

*Memorandum submitted on behalf of the Minister of Health*

1. The total expenditure shown at item 4 of Table 12 of Appendix 1 for the years 1953-54, 1954-55 and 1955-56 comprises:—

| | 1953-54 | 1954-55 | 1955-56 |
|---|---|---|---|
| | £m. | £m. | £m. |
| (i) Drugs and dressings ... ... | 9·421 | 9·677 | 10·573 |
| (ii) Medical and Surgical appliances and equipment ... ... ... | 7·658 | 7·721 | 8·433 |
| | 17·079 | 17·398 | 19·006 |

2. An estimated analysis was made in the Department of the expenditure on drugs, dressings, medical and surgical appliances and equipment in 1953-54 and 1955-56 based on information obtained from representative selections of hospital authorities; it is therefore convenient to consider the increase in expenditure between these two years.

3. **Drugs and dressings**

(a) *Dressings*

It is estimated that dressings accounted for £2·721m. in 1953-54 and £2·863m. in 1955-56. The increase between the two years can be attributed almost entirely to price increases.

(b) *Drugs*

The estimated expenditure in 1953-54 amounted to £6·700m. and in 1955-56 to £7·710m.

Prices of drugs fell between the two years by about 13 per cent., which on £6·700m. would amount to about £0·87m., so that the gross increase in expenditure appeared to be about £1·88m. In fact this would represent the real increase in expenditure only if the pattern of consumption was the same in each year. It is not possible to account precisely for the increase in cost but some of the reasons for the increase in expenditure, apart from the changing pattern of consumption and the increased turnover of the service—as evidenced by the 3 per cent. increase in the number of inpatients and outpatients treated—are as follows.

(i) *Mental hospitals*

There has been a large increase in expenditure on drugs and dressings in these hospitals between the two years which after allowing for price changes amounts to about £0·25m. New methods of treatment are thought to be responsible, particularly the use of the new tranquilising drugs which were introduced in 1955-56.

(ii) *Tuberculosis*

The increase in expenditure on drugs and dressings in T.B. hospitals between the two years after allowing for price changes amounts to about £0·195m. Not all T.B. patients are to be found in these hospitals and allowing for the proportion of cases in other hospitals the increase in drug expenditure on this account (the increase in dressings expenditure is not really significant) may amount to nearly £0·25m. reflecting the new methods of treatment of the disease.

(iii) *Cortisone*

Prior to 1955-56 cortisone and hydrocortisone was purchased centrally and supplied free to hospital authorities. During 1955-56, however, they were made responsible for payment and incurred expenditure of the order of £0·3m.

(iv) Other examples of developments during this period are the appearance of the antibiotic erythromycin (£0·05m.) and a range of new germicides which are thought to be responsible for an increase of about £0·08m. in expenditure on germicides.

**Medical and Surgical Appliances and Equipment**

4. It is estimated that about £0·34m. of the total increase of £0·77m. was due to price increases and that the steadily increasing use of radiography in the hospital service accounted for most of the remainder.

## APPENDIX 7

### Procedure for the Appointment of Senior Administrative Staff of Hospital Management Committees

*Memorandum submitted by the Secretary of the Manchester Regional Hospital Board*

1. The National Health Service (Appointment of Specialists) Regulations, 1950 (S.I. 1950, No. 1259) made by the Minister of Health under Section 14 of the National Health Service Act, 1946, prescribe a special form of procedure for the appointment by Regional Hospital Boards of senior hospital medical staff*—consultants, senior hospital medical officers, etc. Under this procedure a Regional Hospital Board is precluded from making an appointment to any senior medical post in a hospital, except from among candidates who have been selected as suitable for the post by an Advisory Appointments Committee. A Regional Hospital Board is required on the occasion of every appointment to a senior medical post in a hospital, to appoint an Advisory Appointments Committee consisting of seven members. At least five of the seven members must be medical practitioners, one of whom must be the nominee of the Hospital Management Committee concerned, another the nominee of the University with which the Board is associated, and another a practitioner in the specialty concerned, drawn from outside the Region and commonly referred to as the external assessor. In practice, Advisory Appointments Committees consist of two laymen, one from the Regional Hospital Board and one from the Hospital Management Committee concerned, and five medical practitioners. The Regional Board appoint the Chairman of the Committee, and frequently (invariably in the Manchester Region) the Committee is chaired by the lay representative of the Board.

2. In many ways the Advisory Appointments Committee procedure is cumbersome and the procedure is not free from defects in other directions. Criticism has been voiced on occasion that amongst the medical members of the Committee are senior consultants who are, or who have been in earlier years, the mentors of one or more of the applicants and who have in some cases actually given referee's letters in support of an applicant or applicants appearing before the Committee. It is difficult, even with maximum honesty and propriety, to guard completely against this contingency since testimonials are frequently given by eminent medical men before they are even aware that they are to be members of a Committee dealing with a particular appointment.

3. Despite their defects, however, it is generally conceded that Advisory Appointments Committees have achieved the object for which they were designed, namely, to secure the appointment to the senior clinical posts in the Hospital Service only of men who are worthy to hold those posts. The procedure has

* Also senior hospital dental staff.

certainly eliminated most of the abuses of the past in the making of senior hospital appointments and its success in this direction has prompted the notion, which has been discussed from time to time, that the same or a similar procedure should be operated in connection with the filling of senior administrative posts in the Hospital Service. The idea has much to commend it for two reasons—

(1) That if it is necessary to have clinicians of proved skill and experience in the senior medical posts in the Hospital Service—and this point is of course beyond dispute—it is equally necessary to have first-class men in the top administrative posts ; indeed it could be argued that in the administrative field, the need is even more important since a bad appointment to a senior administrative post can have a damaging effect not only on a section of the work but on the whole of the hospital services over a wide area.

(2) It is common knowledge that appointments which are seriously open to question, have been and continue to be made to senior administrative posts in the Hospital Service.

4. There would be no practical or administrative difficulty in applying the Advisory Appointments Committee procedure to the appointment of hospital senior administrative staff and it is unlikely that there would be any need for frequent meetings. The Committees would need to comprise, as do the Advisory Appointments Committees for medical appointments, representatives of the Regional Board, representatives of the Hospital Management Committee concerned, possibly a University representative (who could conveniently be the Professor in Administration or some senior member of his staff) and at least one senior Hospital Administrator from outside the Region. The duties of the Committee would, however, need to be precisely defined. In the medical field, the Advisory Appointments Committee, in theory, is expected to submit to the Regional Hospital Board the names of all the applicants for a given post who in the opinion of the Committee are worthy to be appointed to that post, leaving the actual final choice to be made by the Regional Board. In practice, the Committees submit one name only to the Regional Board with a recommendation that the applicant named should be appointed ; alternatively (and this happens not infrequently) the Committee will report that none of the applicants is worthy of the post and the Regional Board will then instruct that the position be re-advertised. If Advisory Appointments Committee procedure were to be introduced for senior administrative posts, it would be necessary to determine the following points :—

(1) By whom would the actual appointment be made—by the Regional Hospital Board or, as now, by the Hospital Management Committee concerned?

(2) In either case, but particularly if the appointment were to be made by the Hospital Management Committee, would the Advisory Appointments Committee be expected to recommend one named candidate or would they be expected to submit a list of candidates from whom, in their opinion, a final appointment could properly be made by the appointing authority?

5. It would also be necessary to determine which of the senior posts should come within the ambit of the new procedure. Should the procedure be confined, say, to Group Secretaries and Group Finance Officers (and possibly their Deputies) or should it be extended to include other senior posts such as Supplies Officer, Hospital Secretary, Matron, Superintendent Engineer, etc. It is suggested that new procedure of this kind, if introduced at all, would need to extend no further than Group Secretaries and Group Finance Officers, although there may be good grounds for including also the Deputies of these officers.

6. Whatever might be done in the way of introducing centralised selection machinery for senior non-medical posts in the Hospital Service, it is certain that it would arouse a storm of protest from the Hospital Management Committees

and possibly from some, but not all, senior administrators. It has been a consistent complaint of Hospital Management Committees over the years that the system under which senior medical appointments are made by the Regional Boards has been productive of many difficulties for the Hospital Management Committees. The Management Committees say that consultants and other senior medical staff can, and not infrequently do, remind Hospital Management Committees that they are not the servants of the Committee but of the Regional Hospital Board and this attitude, the Management Committees claim, is one which creates difficulties and embarrassments for them in the discharge of their managerial functions. It ought to be stated, however, on this point, that the Manchester Regional Hospital Board (and, it is believed, other Boards also) have made it abundantly clear to their consultants and other senior medical staff that in the performance of their hospital duties and in such matters as leave of absence for holidays, etc., they are subject entirely to the managerial authority of the Hospital Management Committee. As a result, complaints by Hospital Management Committees against the non-acceptance of their authority by the senior medical staff are nowadays only infrequently heard.

7. It is interesting to note that Management Committees, from time to time, on the occasion of making senior administrative appointments, invite senior officers of the Board to sit in with them and advise.

## APPENDIX 8

### Bulk Purchasing

*Memorandum submitted by the Manchester Regional Hospital Board*

1. Following consultations over a period between officers of the Regional Board and the Supplies Officers of the various Management Groups in the Region, an experimental scheme of bulk purchase of commodities in common use at hospitals was embarked upon in 1954. Textiles were chosen for the initial experiment partly because standardisation in this field seemed to hold out prospects of major economies and partly because of the need for some foolproof method of identification to minimise pilferage. The experimental contracts were for a period of six months from the 1st April, 1954, and covered a number of textile items, e.g., woollen blankets, sheets, pillow cases, bath towels, bath towelling, Huckeback towels, and kitchen cloths. The total value of the contracts was £42,166 and it was estimated that this sum represented a saving of £4,000 against what would have had to be paid under the system of individual purchase by the separate Management Groups. The task of securing the agreement of all concerned to a common specification, and especially to the identification symbol, was by no means free from difficulty, but eventually, when deliveries commenced to be made, there was general acknowledgment that in no case were the new specifications inferior to the old and, in a number of cases, they were quite distinctly superior. Bulk purchase, therefore, on common specifications not only produced financial savings but enabled a foolproof and ineradicable identification symbol to be woven into the goods during manufacture.

2. One of the chief virtues of the Manchester Board's bulk purchase scheme is that it has been introduced and is operated without any central organisation having been set up and without a single addition to staffs, either at Board or Management Committee level. Neither has it involved any capital monies in the provision of enlarged or additional stores. The scheme is perfectly simple and works in this way. Common specifications having been agreed, a small number of Management Committees are selected to be " Contracting Committees " for different items. The Contracting Committees collate the needs of all the Management Committees for the particular item or items for which each Contracting Committee is responsible. The Contracting Committee then invites offers by public advertisement and a tender or tenders are accepted by the committee in the usual way. All tenders are based on a Form of Contract which specifies

delivery to various points, these points being those specified by the various Management Groups participating in the contract. This obviates the need for any special depots or central stores. When a Contracting Committee has accepted a tender and entered into a contract, such Contracting Committee advises all the other Management Committees participating in the contract, supplying them with details of prices, etc., and forwarding, where appropriate, standard samples against which deliveries can be checked. Each participating Committee is responsible for issuing its own orders under the contract and paying the contract price for its own deliveries.

3. The first experimental bulk purchase of textiles produced savings estimated at £4,000 on total contract values of £42,166. The savings on the second series of contracts were £5,600 on a total value of £61,033 and for the third set of contracts the respective figures were £6,967 and £73,340. It will be appreciated that as time goes on the estimates of savings become less and less precise.

4. Since the initial experiment with textiles, other commodities in common use have been brought within the ambit of the scheme, notably drugs. The first contracts for the bulk purchase of drugs were entered into on the 1st May, 1956, and covered only a very limited number of items totalling in value £19,677. The estimated savings on these contracts amounted to £5,717. The second series of contracts for drugs were enlarged to cover many more items, the total value on this occasion being £73,701, effecting an estimated saving of £18,136. Further items to be brought within the scope of the scheme are X-ray envelopes and Metasilicate on which small but nevertheless significant savings were secured. Other commodities now being considered for inclusion are X-ray developers, surgical and razor blades, electric lamps, and paint.

5. The development of the Bulk Purchase Scheme is in the hands of the Supplies Officers of the Hospital Management Committees acting in conjunction with other Management Committee officers in relation to particular commodities, e.g., the Hospital Pharmacists in regard to Drugs, the Group Engineers in regard to electric lamps, paint, etc. Liaison between the Supplies Officers and the officers of the Regional Board is continuous.

## APPENDIX 9

### Additional Comments in Answer to Certain Questions

*Memorandum submitted by the Oxford Regional Hospital Board*

**Question 823**

*The apparent inconsistency*

There is not really any inconsistency. It is the Oxford Board's policy to delegate the maximum responsibility to Management Committees, but that does not absolve the Board from the duty of watching whether the Committees exercise their responsibility properly. We have seen signs of danger in the case of appointments to Principal Officers posts. In this case we think that the intervention of Advisory Appointments Committees would be in the interests of the Service as a whole.

In order to be consistent we should have to accept the same procedure for appointments on the Board's own staff. We should not regard this as an improper interference with our own responsibility.

It should be noted that in the case of specialist appointments the function of an Advisory Appointments Committee is to interview the applicants and to advise which of them, if any, are properly qualified to do the job. The Committee place those whom they pass as qualified in what they consider to be a proper order of merit, but the Board is free to make its own choice from all the names. The

normal practice is to appoint the person put at the top of the list by the Appointments Committee, but there can be exceptions.

**Questions 879-881**

*Regional Reserves*

On reading the answers of our representatives we feel that these may have created a confusing impression. Our practice hitherto has been to retain a certain sum centrally :—

(*a*) to cover new developments planned for the coming year ;

(*b*) to meet demands for the salaries of additional nurses who may be recruited during the coming year, over and above those who are actually in post at the beginning of the year.

Beyond this we retain practically nothing. Some years ago the practice was to retain quite a substantial amount to cover possible inaccuracies in H.M.C. estimates as approved by the Board. It is in omitting any reserve of this last mentioned kind that we have changed our practice, and it is in this respect that we may possibly differ from the practice of other Boards. We found it necessary to retain provision for (*a*) because the amount available has always been less than the full amount required for all proposed developments and we have to decide as the year proceeds how to distribute the limited sum available.

As regards (*b*), we had found in practice that Management Committees tended to put in over-optimistic estimates of the number of nurses which they would be able to recruit in the coming year. It has proved to be a useful practice for us to say to them " We will only give you an actual allocation sufficient to cover the nurses which you already have, but we will hold you covered against the cost of any additional nurses that you may be able to recruit. (That is the one and only respect in which you may be able to exceed your budgetary allocation.) "

Until 1956-57 the reserve which we have held back for this purpose has always proved more than adequate. In 1956-57 we felt at times considerable anxieties that our reserve would not be enough. This put us in a dilemma. On the one hand we wanted at all costs to avoid overspending by the Board as a whole. On the other hand we felt it would be disastrous to have to tell our Management Committees to shut down on nurse recruitment. In the end it looks as if we shall get through 1956-57 without over-spending. The disquieting feature about our 1957-58 allocation is that we cannot retain anything like an adequate central reserve for nurse recruitment.

**Questions 954-960**

*Development expenditure*

The Chairman raised questions in connection with our statement that, " In effect this means that the bulk of improvements and developments are financed, not from additional funds advanced by the Ministry, but out of savings under other heads." The Chairman suggested (Question 958) that to some extent this might mean that we were getting money under false pretences. We should like to make it clear that the Board have kept the Ministry informed on all their developments and have understood that this course of action was on lines approved by them. In support of this we quote from the first paragraph of a Ministry letter of 14th February 1957 (which dealt with the 1957–58 revenue allocation).

> " The Minister is confident that he can rely on the continued co-operation of hospital authorities to use to the best advantage the funds made available to them *so as to maintain a steady improvement in the services provided, and in this connection he would again remind them of the contribution which*

*economies sought out and pursued by Boards and Committees may make towards financing improvements in the Service."*

The above makes it quite clear that the essence of the financial relationship between the Ministry and the Boards is, *without overspending the approved allocation,* to make the utmost use of what there is. Naturally the Ministry wish, throughout the year, to be kept informed of the position, and this is done by submitting

(*a*) at the commencement of the year a statement showing

(i) in total how much has been approved under each sub-head for Management Committees (as a whole, not separately),

(ii) how much is required for the Board's own services (actually this particular figure is subject to approval by the Minister—though we have never had difficulty),

(iii) the amount of any regional reserves ; and

(*b*) during the year monthly return of expenditure showing the comparison with the proportionate part of the approved estimates.

Within this framework the Minister leaves the Board free discretion in the distribution of funds, with the single exception that he prescribes a definite figure out of the total Regional sum as the minimum to be spent on the *maintenance of buildings.*

We trust that what has been said above clears up the point raised by the Chairman in Question 958. There was, however, another point made in this connection with which we should like to deal. It was suggested by Admiral Hughes Hallett that, if we could cut back money for improvements from our estimates for normal running requirements, the latter must have been over-estimated. We could not accept this as true in the sense that there had been any deliberate or careless over-estimating. It must be recognised that accurate estimation is not easy and that in certain cases there may be room for economies. For example, Management Committees may put in their estimates on the assumption that they will be able to fill all the posts authorised on their establishment. This, in fact, is hardly ever the case. Again, they may have put in estimates for maintenance and decoration of buildings which are perfectly justified but which the Board may feel it necessary to cut down for the sake of releasing money for urgent improvement purposes. It is also necessary to appreciate that sums which have been extracted from the normal estimates in this way represent a very small percentage. Looking back over the past years the amount which it has been necessary to extract from the normal estimates to finance what the Board regarded as necessary developments and improvements has not amounted to more than about 1 per cent. of the total available for normal running expenditure. One of the points which we made about the 1957-58 allocation is that this year the figure we have been allowed for normal running expenses is so restricted that we cannot regard it as possible to hold back even this small percentage to give us a margin from which to finance desirable improvements.

## APPENDIX 10

### The Operation of the Domiciliary Consultative Service

*Memorandum submitted by the South-East Metropolitan Regional Hospital Board*

Section 3 (1) of the National Health Service Act, 1946, lays upon the Minister of Health a duty "to provide . . . the services of specialists . . . if necessary on medical grounds at the home of the patient".

Regional Hospital Boards were asked (Ministry of Health circular RHB(51)11) to make arrangements for the provision of this service in their areas. It therefore became necessary to ascertain which of the part-time specialists employed in the region were prepared to take part in the domiciliary consultative service on the terms agreed. When this had been done, general practitioners were supplied with comprehensive lists, and changes are notified to them from time to time.

The original intention was that all requests made by a general practitioner for consultation with a specialist in the home of one of his patients should pass through a hospital. This method, which would have provided an important form of control in the service, was abandoned with the agreement of the Minister in 1951 for the sake of convenience. The general practitioner is, therefore, always able to make his request for a domiciliary visit direct to the consultant of his choice. This may operate to the benefit of both practitioner and patient but it means that any control by the regional board of this service can be exercised only after the visit has been made; that is to say, in the course of subsequent examination of the claim for fees and travelling expenses presented by the specialist who made the visit.

Payment for making domiciliary visits was from November, 1955, extended to whole time specialists who hitherto had been expected to do domiciliary work as part of their ordinary duties.

Most of the information sought by the Committee is set forth in the following appendices:—

*Appendix A.*—Analysis by specialties of domiciliary visits in this region in the years 1951-52 to 1956-57 inclusive. This shows the growth in the number of visits and in the cost of the service.

*Appendix B.*—Statement showing by specialties the increase in the visits made by whole time specialists since November, 1955, when they became entitled to remuneration for this service.

*Appendix C.*—Statement showing the result of action taken by the Board in a number of cases in which claims appeared to be excessive (the Board's action in these cases was to inform the Minister who sent a representative to discuss the matter with the general practitioner concerned).

In this region the number of specialists on the list for domiciliary visiting was 683 (all part-timers) in 1951. This has now increased to a total of 737 which includes 213 whole timers; but this increase is not the factor responsible for the increase in the number of visits made.

It is significant to note the increasing tendency on the part of general practitioners to absent themselves from the actual "consultation". In the case of domiciliary visits made by whole time specialists, this tendency is particularly marked. In the period 11th November, 1955, to 31st December, 1956, whole timers made 2,627 visits at which the general practitioner was present on only 994 occasions; that is approximately 38 per cent. The comments of the Board's Senior Administrative Medical Officer, which include this point, are as follows:—

> "Although it is appreciated that great good has accrued from a wise use of the domiciliary consultative service in that now the services of highly skilled specialists are available to all members of the community, nevertheless there is a feeling that excessive use is being made of the service in many instances particularly because in such a high proportion of cases general practitioners are not meeting the consultants at the patient's bedside. It is impossible to equate the words visit and consultation and, although in some cases the visit of a consultant may save admission to hospital and thus produce economy both in beds and money, it is not in the best interests of the patient or the general practitioner that he should not be present. Indeed, the desirability of his presence is formally stated in the Terms and Conditions of Service. (Appendix 5, p. 386.)

Appendix A shows the extent to which the service has grown both in the number of consultations and cost. It has almost doubled in the 6 years under consideration. One would expect the largest volume to be in the major specialties of General Medicine, General Surgery, Gynaecology and Orthopaedics but there are certain others which do seem inordinately high, e.g. Dermatology, Ophthalmology and Radiology. It is difficult to explain the rise in Dermatology which is almost greater than in any other specialty except Radiology; it is more than double. The Ophthalmological cases are very largely eye testing in old people. Radiological cases are mainy fractures and chests; many of the latter would seem to be unnecessary. Domiciliary requirements in Psychiatry have grown out of all proportion since whole time specialists have been paid; this is shown particularly in Appendix B.

This Board was careful to lay down a procedure for Geriatricians from the inception of the service and domiciliary visits have normally been regarded as part of their duties; for this reason the number of domiciliary consultations has not grown to quite the same extent as elsewhere. Pathology, in the same way, has not shown any increase as pathologists are not entitled to payment if the visit is solely for the object of collecting specimens."

*Appendix A*

ANALYSIS BY SPECIALTIES OF DOMICILIARY VISITS IN THE YEARS 1951–52 TO 1956–57 INCLUSIVE

| Financial years | 1.4.51 to 31.3.52 | 1.4.52 to 31.3.53 | 1.4.53 to 31.3.54 | 1.4.54 to 31.3.55 | 1.4.55 to 31.3.56 | 1.4.56 to 31.3.57 |
|---|---|---|---|---|---|---|
| General Medicine ... ... | 4,327 | 5,203 | 5,520 | 5,087 | 6,397 | 7,126 |
| General Surgery ... ... ... | 2,765 | 2,968 | 3,382 | 3,460 | 3,757 | 4,109 |
| Anaesthetics ... ... ... | 54 | 45 | 61 | 70 | 71 | 62 |
| Cardiology ... ... ... | 988 | 747 | 503 | 500 | 451 | 502 |
| Chest Diseases ... ... ... | 135 | 36 | 34 | 95 | 153 | 655 |
| Dental Surgery ... ... ... | 10 | 7 | 12 | 12 | 8 | 16 |
| Dermatology ... ... ... | 490 | 641 | 723 | 834 | 969 | 938 |
| E.N.T. ... ... ... ... | 760 | 766 | 702 | 666 | 707 | 741 |
| Geriatrics ... ... ... ... | 53 | 27 | 33 | 1 | 7 | 218 |
| Infectious Diseases ... ... | 5 | 6 | 4 | 17 | 1 | 6 |
| Neurology... ... ... ... | 309 | 216 | 332 | 353 | 305 | 360 |
| Neurosurgery ... ... ... | 7 | 9 | 5 | 6 | 41 | 4 |
| Obstetrics and Gynaecology ... | 714 | 724 | 939 | 884 | 978 | 1,335 |
| Ophthalmology ... ... ... | 650 | 617 | 655 | 714 | 700 | 796 |
| Orthopaedic Surgery ... ... | 522 | 667 | 926 | 899 | 1,105 | 1,463 |
| Paediatrics ... ... ... | 573 | 722 | 826 | 772 | 868 | 1,049 |
| Pathology ... ... ... ... | 668 | 528 | 547 | 714 | 761 | 576 |
| Physical Medicine ... ... | 111 | 134 | 197 | 291 | 217 | 297 |
| Plastic Surgery ... ... ... | 2 | 1 | 3 | 1 | 1 | — |
| Psychological Medicine ... ... | 409 | 444 | 531 | 643 | 841 | 1,743 |
| Radiology... ... ... ... | 391 | 614 | 760 | 1,120 | 1,334 | 1,295 |
| Radiotherapy ... ... ... | 51 | 22 | 55 | 30 | 121 | 88 |
| Thoracic Surgery... ... ... | — | 4 | 2 | 12 | 16 | 13 |
| Urology ... ... ... ... | 96 | 84 | 111 | 81 | 84 | 101 |
| V.D. ... ... ... ... | 1 | 1 | — | — | 8 | 7 |
| Totals ... ... ... ... | 14,091 | 15,233 | 16,863 | 17,262 | 19,901 | 23,500 |
| Cost ... ... ... ... | £56,379 | £67,987 | £72,802 | £79,314 | £95,403 | £100,000* |

* This figure is an estimate only.

*Appendix B*

STATEMENT SHOWING BY SPECIALTIES THE INCREASE IN THE VISITS MADE BY WHOLE-TIME SPECIALISTS SINCE NOVEMBER, 1955, WHEN THEY BECAME ENTITLED TO REMUNERATION FOR THIS SERVICE

| Specialty | 1.1.55 to 10.11.55 (Not paid) | 11.11.55 to 31.12.55 (Paid) | Total 1955 | Total 1956 |
|---|---|---|---|---|
| Psychological Medicine ... ... | 210 | 67 | 277 | 984 |
| Pathology ... ... ... ... | 276 | 50 | 326 | 312 |
| Chest Diseases ... ... ... | 42 | 22 | 64 | 455 |
| General Medicine ... ... ... | 68 | 22 | 90 | 247 |
| General Surgery ... ... ... | 10 | 6 | 16 | 63 |
| Paediatrics ... ... ... ... | 3 | 2 | 5 | 145 |
| Obstetrics and Gynaecology ... | 12 | — | 12 | 35 |
| Physical Medicine ... ... ... | — | 4 | 4 | 26 |
| Geriatrics ... ... ... ... | — | 5 | 5 | 175 |
| Infectious Diseases ... ... ... | 2 | — | 2 | 6 |
| Urology ... ... ... ... | 2 | — | 2 | 1 |
| Totals ... ... ... ... | 625 | 178 | 803 | 2,449 |

*Appendix C*

STATEMENT SHOWING THE RESULT OF ACTION TAKEN BY THE BOARD IN A NUMBER OF CASES IN WHICH CLAIMS APPEARED TO BE EXCESSIVE

| Case | Nature | Date of visit by Ministry | No. of requests in | | | | | | Remarks |
|---|---|---|---|---|---|---|---|---|---|
| | | | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | |
| 1 | Frequent calls on one Specialist. | 8. 8.52 | 77 | 54 | 25 | 22 | 23 | 18 | |
| 2 | Frequent calls on two Specialists. | 8. 2.55 | | | | 112 | 60 | 60 | |
| 3 | Frequent calls on two Specialists. | 21. 6.56 | | | | | | 73 | 65 before M/H visit. |
| 4 | Frequent calls on service. | 29. 6.54 | | | 118 | | 58 | 90 | |
| 5 | Frequent calls on brother. | 11. 6.53 | | | 41 (to May) | | 2 | | |
| 6 | Frequent calls on Radiologist. | 21.10.54 | | | 30 | 38 (to Aug.) | 19 | 9 | Radiologist on leave from Sept., 1956. |
| 7 | Frequent calls on service. | 24. 6.54 | | | 150 | | | 23 | |
| 8 | Frequent calls on service. | 1. 4.52 | 109 (Apl. to Dec.) | 27 (Apl. to Dec.) | 43 | 32 (to Sept.) | 55 | 29 | |
| 9 | Frequent calls on service. | 2.10.56 | | | | | 130 | 134 | 111 before M/H visit. |
| 10 | Frequent calls on one Specialist. | | | | | | 27 (July to Dec.) | 96 | M/H informed on three occasions. No action by them yet. |

## APPENDIX 11

### Running Costs of Hospitals

*Memorandum submitted by the Board of Governors of St. Bartholomew's Hospital*

We have given careful consideration to the points raised in the letter of the Clerk to the Sub-Committee dated 17th April, 1957. Some of the points raised are not points on which we feel we can express a useful opinion, but we shall endeavour to deal with those matters which seem to us to have the most bearing on the primary purpose of the Sub-Committee. We would also point out that such comments as we make are made from the point of view of a Teaching Hospital, which of necessity has peculiar problems of its own.

Bearing in mind the inherent difference between a Teaching and a non-Teaching Hospital, we have to say as follows:—

1. *Composition of Boards of Governors*

We believe it to be of the utmost importance that individuals appointed to be Governors of an Undergraduate Teaching Hospital should be persons who have a special interest in that Teaching Hospital by reason of local or other associations. We believe that this could be more readily secured if there were a greater measure of consultation between the Minister of Health for the time being and the Chairman of the Teaching Hospital concerned before the appointment of a Governor is made.

The number of Governors on a Teaching Hospital Board at the present time varies from 25 to 30. Such a large number of Governors does not necessarily make for the most efficient running of the Hospital's affairs. Few individuals who have accepted Governorships are satisfied to see their activities on behalf of the Hospital limited to attending a Board meeting, monthly or quarterly, as the practice of the individual Hospital may determine. In an endeavour to secure the feeling that they are playing a greater part in the running of the Hospital's affairs, there results the setting up of an often unwieldy number of sub-committees, which increase the administrative cost of the Hospital as well as increasing the time taken by salaried officials responsible for the business of those sub-committees. At most hospitals there will be found a number of sub-committees which have grown up since the institution of the National Health Service, considering and reporting on matters which were previously dealt with quite effectively by one central Executive Committee.

2. *The Relationship Between Regional Hospital Boards and Boards of Governors*

In the experience of this Hospital the relationship has been completely satisfactory. This has been achieved in a large measure by:—

(i) The inclusion in the membership of the Regional Board of one or more active representatives of the Board of Governors, and vice versa.

(ii) The establishment of a Liaison Committee consisting of members of the Regional Board and of the Teaching Hospitals in the Region.

3. *Variations in Standards and Costs Between Hospitals*

It must first be realised that cost figures at Hospitals do not accurately represent the standards existing, since the premises on which they are based vary widely between Hospitals. In a Service where the finished product cannot be evaluated nor the work involved standardised, comparative figures have obvious limitations, and too great a reliance should not be placed on their value. Thus just as a low cost does not necessarily imply a bad service, a high cost must not be assumed to indicate an extravagant one. To attempt to regiment all Hospitals down to a common cost pattern only would carry

with it the disastrous consequence of slowing up or even bringing to a standstill medical progress and advancement.

It is for these reasons that we have observed with some misgiving the imposition on the Hospitals of an expensive and untried costing system.

4. *The Degree to Which Greater Economies Could be Achieved in Running Costs by Minor Capital Expenditure*

Our answer to this question would depend very largely on what is meant by minor capital expenditure. There is hardly a Teaching Hospital in the London area, and it is particularly so in the case of St. Bartholomew's, at which it has not been found necessary to lease premises, often at some considerable distance from the Hospital, for the purpose of housing Nursing Staff. This involves not only the payment of high rentals but a considerable addition to overhead expenses which would be avoided if capital money could be made available to build Nurses' Homes in the immediate vicinity of the Hospital itself. At St. Bartholomew's we have vacant land adjacent to the Hospital on which the first stage of a Nurses' Home is about to be built out of the Hospital's endowment monies and not from public funds. There is ample space for extending this building to provide for all the Nursing Staff at present housed in two buildings in the West End. The capital cost of this work would amount in all to some £600,000, but once completed there would be a very substantial saving on the running costs of the Hospital. These distant buildings at present not only involve the duplication or triplication of staff, but by reason of their distance from the Hospital considerable expense is incurred in transporting the Nurses to and from their work, to say nothing of the waste of Nurses' time in an already busy day.

In matters of small capital expenditure in, say the Out-Patients Department, the Ministry have at all times been anxious to encourage schemes which could reasonably be expected to reduce running costs and many of these have been completed. In the main, however, such schemes are more often designed for the better services they will make available to the patient than to any reduction in running costs. The most fruitful field for the saving of running costs by small capital expenditure is undoubtedly to be found in the field of non-medical equipment i.e. modern and labour-saving equipment in laundries, kitchens, administrative and accounts offices, etc.

5. *The Possibility of Reducing the Total Load Borne by the Hospital Service*

In a large Teaching Hospital like St. Bartholomew's, the cost per patient per week is necessarily high. It is extremely desirable in the interests of economy that those patients occupying beds should be acutely ill persons who will utilise to the full the expensive diagnostic facilities available at a Teaching Hospital. Owing to the limitation of hospital accommodation for chronic sick patients, it is invariably the case that there are some 20 or so patients in the Hospital for whom nothing further can be done, but who are too ill to be sent home. The load on the Teaching Hospitals would be reduced if there were adequate accommodation for this type of case to which such patients could be transferred. We have in fact been fortunate at this Hospital in our relations with the Regional Board in this matter, who have always been most helpful in endeavouring to secure the hospitalisation elsewhere of such patients, but the available accommodation remains too small to meet all our demands.

One point not specifically referred to in the Clerk's letter, but which must clearly have a considerable bearing on the matters under discussion, cannot be omitted from these comments. By far the largest single item in any Hospital's expenditure is that which comes under the heading of Salaries and Wages. It is our view that the Hospital Service does not lend itself to the present rigid application of regimented salary scales and conditions of service, and regimented establishments and gradings. There is at present no latitude to Governing Bodies to reward good or efficient service, nor are there any incentives to the Staff

either to join the Service or to stay in it once there. This results in continual and damaging changes of staff. It has a frustrating effect on the Heads of Departments, whose competence and ability can frequently save the Hospital many thousands of pounds in any one year. As a result of this lack of incentive, and the inability of the Governing Body to reward an individual according to his merits, there is no doubt that the standard of entrants into the Hospital Service for such key positions as Hospital and Departmental Heads (Catering Officers, Superintendents of Works, Instrument Curators, Engineers, etc.), is deteriorating, and too often Hospitals find themselves with second-grade men incapable of conducting efficiently and economically the affairs of their Departments. The expenditure of an additional £500 a year on a Catering Officer's salary in order to secure the right man might well mean a subsequent saving of £10,000 a year in the cost of provisions.

In just the same way, cheap labour in the junior grades is almost invariably expensive. It acts as a strong deterrent to efficient working, and leads to constant changes in personnel, which in the administrative and clerical grades at this Hospital during 1956 was of the order of 52 per cent.

Further, the real secret of economy lies in the cost-consciousness of every employee. The greatest contribution to this cost-consciousness is that the individual shall have a pride and satisfaction in his work, and a sense of loyalty to his immediate employers. These all spring from the knowledge that he will have a fair deal from his employers and that good and outstanding service will be recognised. Under a system whereby his salary, his hours and his conditions are determined solely by some remote authority which does not know even of his existence, the qualities can never be fostered or achieved.

## APPENDIX 12

### Running Costs of Hospitals

*Memorandum submitted by the Council of the British Medical Association*

1. The Council agrees with Subcommittee "D" of the Select Committee on Estimates that the medical staffs of hospitals have a deep interest in the achievement of a fully efficient and economical hospital service and that they have had long experience of hospital administration and finance.

2. It must be emphasised that of recent years the interests of medical staff in these matters, and their qualifications to advise upon them have not always received their due recognition from other parties in the National Health Service.

**Participation of Hospital medical staff in administration**

3. The Council wishes first to express its basic opinion that a fully efficient and economical hospital service will never be achieved without the fullest and closest participation of hospital medical staffs in the internal administration of hospitals and of the whole hospital service from Ministry level downwards. In the past medical staff always have exercised great administrative responsibilities and have never asked for any reward for doing so. Such participation always characterised the voluntary hospital system and was one of the chief reasons for its high order of efficiency and economy in the past.

**Purpose and priorities in the Hospital Service**

4. We should consider next the purposes for which the hospital service exists. The primary purpose, under Assumption "B" of the Beveridge Report on Social Security, is to bring specialist treatment to bear upon all those members of the public who need it without a financial barrier in the form of fees or charges, except for those few that have since been introduced, such as prescription charges, charges for appliances and so forth.

5. It is quite clear, therefore, that the first priority in the hospital service must be the efficiency with which it discharges this function of medical treatment. If it is a question of rationing expenditure this should never take place at the expense of medical efficiency and there is plenty of evidence to-day that this does happen. It is possible for a hospital authority to spend large sums of money to please the local public, who do not appreciate that this is being done at the expense of medical efficiency. Sometimes certain hospital departments not of the first priority in need expand more rapidly and expensively than they should. Really efficient partnership between medicine and administration will help here and with such matters as extravagance in expenditure on, or use of, drugs and dressings. More thought should now be given to the placing of administrative responsibilities formally upon some members of hospital medical staffs as recommended by the Committee on the Internal Administration of Hospitals.

6. Another basic purpose of the hospital service is the medical education of both undergraduate and postgraduate students. This is systematically organised and need not be discussed in detail in this document but allied to this is the subject of medical research. Care should be taken under financial stress not to starve this aspect of the service which, in the end, will not be economic, and not to stint the service, for example, of financial assistance to carefully selected persons to whom study leave is granted. The expenditure of money on research should not be too tightly supervised from the centre.

7. It should be emphasised in priorities for expenditure in the hospital service that it is the detection of disease in its earlest stages, with the application of the necessary treatment to cure or restore to working capacity the patient, that is the first priority and if there is to be rationing of resources then care must be taken not to dissipate the expensive hospital facilities for diagnosis and active treatment of disease upon the compassionate care of the chronically disabled, of aged persons, and so forth. There is apt to be much pressure to do this. There is much evidence to-day that too many beds in acute wards are occupied by chronic cases. The provision for care and nursing of such cases in the community is inadequate and it would be an economical development if national funds were placed behind a great extension of the home nursing service, which is to be regarded as a mere skeleton service at the present time. A much expanded home nursing service could enable cases for which active hospital treatment is not required to be cared for under their own doctors' supervision in their homes. There are various other ways in which help can be brought to this type of case without wasting expensive hospital facilities.

**Inelastic and inefficient administration. Some of its causes**

8. Experience has shown since 1948 that economy and efficiency can suffer in a nationalised hospital service by inelastic administrative methods in which administration takes place on rigid lines, laid down centrally with little room for local initiative and elasticity.

9. It is most important that there should be the maximum of local elasticity and officers should be encouraged to exercise it. The basic requirement for maximum administrative efficiency and economy is to have the *highest possible quality of officers.*

10. The Council does not consider that this requirement has been met as far as administrative officers of responsibility in the hospital service are concerned. There are probably too many of them of second rate capacity employed at inadequate salaries. Probably greater efficiency could be achieved if a smaller number of officers of a high order of capacity were employed at a higher salary; for example, if a Hospital Group Management Committee had one secretary with a deputy, who were both much more highly paid than at present and were of a university honours level of professional qualification, then it should be possible to administer such a group much more efficiently, with

greater local initiative and adaptability, and possibly to dispense with some other posts. To obtain the right officers it appears that remuneration should be related to industrial and commercial conditions. It is also most important to efficiency and to economy that there should be maximum co-operation and consultation between officers in different departments, particularly between lay officers and medical officers.

**Co-operation and Partnership in Administration**

11. It should be underlined again that it should never be overlooked that a hospital service primarily exists for medical purposes, which are ultimately definable only by medical men. Experience since 1948 has shown that there is far too great a tendency for hospital organisation and administration to become fragmented. Lay administration will often have little consultation with medicine in the hospitals and with nursing. For this reason the Council strongly recommends to the Select Committee on Estimates the development in the hospital service of that spirit of co-operation and team work so well defined in the report of the Committee on the Internal Administration of Hospitals of the Central Health Services Council, 1954, and it is for this reason that the Council deplores subsequent policy such as reduction in the number of medical men sitting on hospital committees and boards. Developments of this kind can only, in the end, limit that spirit of consultation and co-operation that is essential to efficiency and economy. It should be realised that greater efficiency is not necessarily obtained by an increase of administrative staff, but by improving the spirit of partnership between the hospital authority and its staff—which has greatly declined since 1948. Efficiency is not served if the State crushes Medicine and tries to make use of it in the hospital service in some exploited way, like a subordinate technology. Efficiency and economy will only be fully attained if medical staff play a really responsible part in consultation and decision in administration and policy.

**Fragmentation**

12. Probably one of the reasons why there are differences in cost between one region and another and between one group and another, is the tendency to fragmentation which has sprung up since 1948 and grown more marked. Again constant close consultation is needed here. The Central Health Services Council some time ago published a circular recommending the setting up of liaison machinery at the periphery between hospitals, executive councils and public health departments. There has been little progress in this field and it would serve the cause of efficiency and economy a great deal if this liaison was developed with energy. Better liaison should also exist between Regional Hospital Boards, Boards of Governors, and Executive Councils. It is out of better liaison machinery of this character that greater unity of the whole health service may one day emerge.

**Spontaneous Evolution of the Service**

13. The Council considers it essential to the attainment of maximum efficiency and economy in the hospital service that it should be so organised that it contains within itself the power to spontaneous evolution and growth. This, again, underlines the importance of ensuring that all responsible officials are of a high order of efficiency; that they are given maximum power of discretion and action locally and that they work as a team in constant consultation together. Only in this way too can an adequate vocational drive, esprit de corps and sense of continuity of hospital tradition be preserved. It was the strength of these qualities in the past that so greatly assisted the attainment of hospital efficiency. There is a real danger to-day, especially in the non-teaching hospitals, under Regional Hospital Boards, of the hospital service gradually becoming more and more a mechanically moving bureaucratic machine, devoid of any such spirit.

14. The Council contemplates with anxiety the method of the appointment of members of Hospital Management Committees, Regional Hospitals Boards and Boards of Governors.

15. The Council feels that the same criterion of personal efficiency should predominate here and that it is necessary, for example, to do much more than just to try and choose a Hospital Management Committee to be a body merely representative of different sections of the local community. These committees are rightly small in number of members and have immensely important executive functions to perform, including the control of very large sums of public money. If they are to remain executive and management committees, as distinct from committees just expressing a local state of public feeling (and it is important that their executive functions should continue) the members should be more carefully selected purely on the basis of their personal qualifications to engage in hospital management. Evidence of successful experience in executive and administrative work should be required. There has been confusion of purpose here, many members of management committees having undoubtedly been selected just to represent various sections of the local community rather than because of their personal suitability for the difficult and complex task of hospital administration and management. It would be a bad thing to allow the realities of management and policy formation to pass into the hands of the Hospital Management Committees officials. In any case, these officials are appointed by their Hospital Management Committee and competent judgment in making the appointments is needed from each Hospital Management Committee.

16. The question asked about the total load borne by the hospital service has already been, in a large part, answered. A great extension of home nursing and the home help service far in excess of any of the present service would be far cheaper than using hospital facilities for the type of patient who can be looked after at home. It would enable the general practitioner to be more effective and many patients would be much happier.

**Central Planning**

17. The Council considers that the organisation for central planning in the hospital service is still defective and this adds greatly to inefficiency and unnecessary expense. As all hospitals now belong to the Minister, responsibility for adequate central administrative planning cannot be escaped by the Ministry of Health. In the opinion of the Council vastly better service would be obtained if the Ministry of Health's own planning machinery were greatly improved by constant collaboration with the medical profession. Something analogous to the general staff system that operates in the service departments needs setting up centrally. The peripheral hospital administrative bodies, the Boards and Committees, would be helped greatly not by dictatorship on matters of detail but by the provision from the centre of agreed general principles on which the hospital service should be run. The central planning machinery should include facilities for constant consultation between all groups of responsible workers in the hospital service. These should not be merely consulted separately at the centre. This practice has led to further fragmentation. One sometimes senses at the centre to-day a spirit at work which seems to be "divide and rule".

18. The Council is far from satisfied with the amount of consultation that the Ministry of Health has had within the medical profession in building up these principles, and in tackling hospital problems since 1948, and recommends that this should urgently be extended. The same type of partnership in consultation with the profession is badly needed at Regional Board level also, where at present it is stiff and rudimentary and failing to fulfil the many purposes which it could. Medical policy should essentially be formed as a result of partnership and consultation between the medical profession and Regional Hospital Boards. It should not be based primarily on the advice of non-clinical medical officials.

19. Such consultative machinery, of course, is well established and works well at Board of Governors level and this should be a model for the whole hospital service. It should frankly be recognised that there are strong sources of jealousy and hostility towards medicine outside the teaching hospital world and that these need firm administrative countering in the interests of the service. Medicine

has never asked for more than its proper position of partnership in the development and administration of hospitals in the interest of efficiency and economy but this position is far from existing today to the degree that it should.

20. The Council recognises that the Sub-committee cannot concern itself with matters of policy that might require legislation but feels that it must state that one day there probably will be great advantages in remodelling the statutory advisory machinery that exists by enactment at the centre, namely the Central Health Services Council. It is probable that this Council and its standing advisory committees could with advantage be reshaped to give this Council much more true democratic and representative force and to enable the voice of the profession really to be heard, and its wisest advice constantly to be given.

21. Properly constituted, the Central Health Services Council should be a dynamic vital influence within the Health Service (which it is not today).

**Possible Major Economies on the Health Services**

22. Much wasteful expense is incurred by admitting patients to hospital for investigation (Radiographic, biochemical, bacteriological) which could be done with equal efficiency if out-patient services were improved—so that, for example, a patient could have a place to rest, even to lie down, in the out-patient department where he could remain for testing most of the day—if necessary—returning home in the evening. This procedure would be inexpensive on running cost as compared with in-patient treatment, would involve some extension of out-patient premises, but much less costly than building new wards for in-patients, and some extension of laboratories and radio-diagnostic departments, but again sparing to some extent those in use for in-patient work. The result, too, would be a considerable reduction of waiting lists for medical cases.

23. Once a patient is admitted to hospital it often happens that little progress can be made in treating him until diagnostic procedures have been carried out. If there is one day of delay in getting these done there is a waste of patients' time, clinician's time, nurses' time and food and lodging—and this happens far too much—mainly owing to unavoidable delays in X-ray and pathological departments—mainly in turn due to shortage of staff—particularly radiographic staff. The Ministry seems to be unaware of the consequence of low rates of pay for radiographers—which must in fact cost five times as much as is saved in waste of the kind now mentioned. This is one of the bottlenecks in hospitals generally.

# INDEX

N.B. In this index, the figures following the name of the Witness refer to the Question number in the Evidence ; the figures following p. or pp refer to the page or pages of Memorandum; the figures following *Report* refer to the numbered paragraphs of the Report; Appendices are indicated by number followed by page reference.

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