Eleventh report from the Select Committee on Estimates : together with the minutes of evidence taken before sub-committee E and appendices, session 1950-1951: regional hospital boards and hospital management committees.

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ELEVENTH REPORT

FROM THE

SELECT COMMITTEE ON ESTIMATES

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

Session 1950—51

REGIONAL HOSPITAL BOARDS AND HOSPITAL MANAGEMENT COMMITTEES

Ordered by The House of Commons *to be Printed*
31st July 1951

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SELECT COMMITTEE ON ESTIMATES

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Session 1950—51

REGIONAL HOSPITAL BOARDS AND HOSPITAL MANAGEMENT COMMITTEES

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Friday, 10th November, 1950

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 suggest the form in which the Estimates shall be presented for examination, and to report what, if any, economies consistent with the policy implied in those Estimates may be effected therein:—

Ordered, That the Committee do consist of Thirty-six Members.

The Committee was accordingly nominated of Mr. Albu, Mr. Arthur Allen, Mr. Heathcoat Amory, Mr. Alexander Anderson, Mr. Awbery, Mr. Nigel Birch, Mr. Champion, Mr. Geoffrey Cooper, Viscountess Davidson, Mr. Diamond, Sir Ralph Glyn, Mr. Gunter, Viscount Hinchingbrooke, Mr. John Lewis, Mr. Selwyn Lloyd, Mr. Low, Sir Hugh Lucas-Tooth, Major Niall Macpherson, Mr. Manningham-Buller, Mr. Maudling, Mrs. Middleton, Mr. J. Enoch Powell, Mr. Thomas Reid, Mr. William Ross, Mr. Sydney Silverman, Mr. Norman Smith, Mr. Snow, Mr. Summers, Mr. Turton, Mr. Wade, Miss Ward, Captain Waterhouse, Mr. William Wells, Mr. West, Mr. Yates and Mr. York.

Ordered, That Seven be the Quorum of 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 record; 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 Minutes of Evidence taken before Sub-Committees.—(*Mr. Royle.*)

Wednesday, 15th November, 1950.

Ordered, That Mr. William Wells be discharged from the Select Committee on Estimates; and that Mr. Jenkins be added to the Committee.—(*Mr. Bowden.*)

Wednesday, 7th February, 1951.

Ordered, That Captain Waterhouse be discharged from the Select Committee on Estimates; and that Mr. Walter Fletcher be added to the Committee.—(*Mr. Popplewell.*)

Tuesday, 6th March, 1951

Ordered, That Mr. Selwyn Lloyd be discharged from the Select Committee on Estimates; and that Mr. G. P. Stevens be added to the Committee.—(*Mr. Royle.*)

Friday, 9th March, 1951

Ordered, That Mr. Sydney Silverman be discharged from the Select Committee on Estimates; and that Miss Burton be added to the Committee.—(*Mr. Kenneth Robinson.*)

Tuesday, 1st May 1951

Ordered, That Mr. Champion be discharged from the Select Committee on Estimates; and that Mr. Mulley be added to the Committee.—(*Mr. Popplewell.*)

Thursday, 10th May, 1951

Ordered, That Mr. Snow be discharged from the Select Committee on Estimates; and that Mr. Ian Winterbottom be added to the Committee.—(*Mr. Robert Taylor.*)

Tuesday, 29th May, 1951

Ordered, That Mr. John Lewis be discharged from the Select Committee on Estimates; and that Mr. James Johnson be added to the Committee.—(*Mr. Robert Taylor.*)

The cost of preparing the Shorthand Minutes of the Evidence taken before Sub-Committee E was £255 15*s.* 0*d.*

The cost of printing and publishing this Report is estimated by H.M. Stationery Office at £1,080 0*s.* 0*d.*

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ELEVENTH REPORT

The Select Committee appointed to examine such of the Estimates presented to this House as may seem fit to the Committee, and to suggest the form in which the Estimates shall be presented for examination, and to report what, if any, economies consistent with the policy implied in those Estimates may be effected therein, have made further progress in the matters to them referred, and have agreed to the following Eleventh Report:—

REGIONAL HOSPITAL BOARDS AND HOSPITAL MANAGEMENT COMMITTEES

1. Your Committee have examined those parts of the Estimates for the National Health Service, England and Wales, which cover expenditure on the Hospital Service. They heard evidence from the Ministry of Health; two Regional Hospital Boards; three Hospital Management Committees; the British Medical Association, the Royal College of Physicians, the Nuffield Provincial Hospitals Trust and King Edward's Hospital Fund for London. Memoranda were also received from the Royal College of Nursing, the Royal College of Surgeons, the Royal College of Obstetricians and Gynaecologists, the Association of Municipal Corporations and the Fellowship for Freedom in Medicine.

2. It was not possible in the time available to examine the whole of the Estimates for the Hospital Service. Your Committee have therefore refrained from examining the Estimates relating to the Hospital Service in Scotland. For the same reason they have not examined the Estimates relating to the Teaching Hospitals in England, except in so far as this was necessary for the rest of their inquiry.

THE SCOPE OF THE HOSPITAL SERVICE

3. The following table gives the total figures of out-patients, in-patients and staffed beds for all hospitals (including the Teaching Hospitals and Public Assistance Institutions) in England and Wales for each of the last three years.

	1948	1949	1950
Out-patients (total attendances)	Not comparable	Not comparable	35,893,001
In-patients (discharged or died during year)	2,871,978	2,936,980	3,085,491
Staffed beds (as at 31st December)	443,272	447,915	458,363

Though the comparable figures for out-patients in the two earlier years cannot be ascertained, the Royal College of Physicians stated that the number for 1950 showed a large increase over the previous year, and this is borne out by the evidence generally. Q. 2473 Qs. 248, 2488–9

THE STRUCTURE OF THE SERVICE

4. Under Section 3 of the National Health Service Act, 1946, the Minister of Health is required to provide hospital and specialist services to such extent as he considers necessary to meet all reasonable requirements, and he is to do so through the agency of the Boards of Governors of Teaching Hospitals, Regional Hospital Boards and Hospital Management Committees, whose respective constitutions are laid down in general terms in the Act. The 36 Boards of Governors of Teaching Hospitals are directly responsible to the Minister for all matters affecting their hospitals. The 14 Regional Hospital Boards are also directly responsible to the Minister; the Ministry of Health in defining their functions stated: "with the Minister and in collaboration with the Boards of Governors they plan and administer a co-ordinated hospital and specialist service for their respective regions". The function of Hospital Management Committees (of which there are 378 in England and Wales) is, according to the Ministry, to "undertake the day-to-day management of hospitals on behalf of the Regional Hospital Boards". It may be inferred from this and from Section 13 of the Act of 1946, which refers to the exercise of functions by Hospital Management Committees on behalf of the Regional Hospital Boards, that it was not the intention of Parliament at the time of the framing of the Act that Hospital Management Committees should have direct administrative responsibility to the Ministry.

Appendix 1

5. Whatever may have been the original intention regarding the respective functions of the Minister, the Regional Hospital Boards and the Hospital Management Committees, it became clear to Your Committee that there have been substantial changes in this connection, that a great deal of doubt and difficulty still exists, and that the satisfactory progress of the Service depends on a solution of the problems involved.

THE ESTIMATES

6. The estimated gross cost of the Hospital, Specialist and Ancillary Services in England and Wales in 1951-52 is £251,479,900 as against £237,980,100 in 1950-51. Of this, the figures for advances to Regional Hospital Boards for the running of hospitals were:

	1950–51		1951–52	
	England	*Wales*	*England*	*Wales*
	£	£	£	£
Capital Expenditure	7,000,000	350,000	8,220,000	483,000
Maintenance Expenditure	176,400,000	9,665,000	187,080,000	10,665,000

The system for compiling this Estimate, providing and controlling the consequent expenditure, and auditing the accounts, is described in a memorandum from the Ministry of Health which is printed as Appendix 1. The main features of the system are as follows. The Hospital Management Committees submit their estimates to their Regional Hospital Boards under twelve heads some six months before the beginning of the financial year. About six weeks later the Regional Hospital Boards submit to the Ministry of Health their estimates

for expenditure to be incurred directly by themselves, together with the estimates of the Hospital Management Committees, subject to any modifications agreed between the Boards and the Committees and to any comments made by the Boards. Finally, these estimates are approved by the Ministry of Health, subject to such modifications as may be imposed by the Department. The bulk of the expenditure incurred directly by Regional Hospital Boards consists of payment of specialists' salaries and capital expenditure, responsibility for these matters being the sole concern of the Boards. Q. 613 Appendix 1

FINANCIAL CONTROL

7. In the White Paper* of 1946, which outlined the form of organisation of the Hospital Service, it was stated that Regional Hospital Boards and Hospital Management Committees were to enjoy "as much financial freedom—by a system of block annual budgets or otherwise—for local initiative and variety of enterprise as general principles of exchequer responsibility make possible". The present position of Boards and Committees is very different from this. In practice, the powers of Regional Hospital Boards have been so much diminished that the Chairman of a Hospital Management Committee was able to say to Your Committee—"My own personal view is that the Regional Boards could be washed out entirely . . . The Regional Boards have to go to the Ministry afterwards for practically everything and why the dickens should we not deal direct with the Ministry?". Thus, though Regional Hospital Boards are still expected to scrutinise the estimates of Hospital Management Committees before passing them on to the Ministry, the time allowed for this, which should be among the most important of their tasks, is only about six weeks, and this is totally inadequate. As a result, the members of one Regional Hospital Board whom Your Committee examined stated that they had merely passed their Hospital Management Committees' estimates straight on to the Ministry without making comments or suggesting cuts; they proposed to do this later, when time permitted—perhaps after the Ministry had already examined the estimates themselves and made decisions thereon. Q. 2189 Q. 2192 Q. 1193

8. A second example of how the position of the Regional Hospital Boards has deteriorated, in the matter of financial control, dates from the 31st March, 1951. Until then, Regional Hospital Boards had the power to allow Hospital Management Committees to transfer their expenditure from one subhead to another. This power was withdrawn with effect from that date and reserved to the Ministry of Health. Regional Hospital Boards protested strongly when this was done, and, for the financial year 1951-52, the Ministry have proposed an uneasy compromise under which they and the Regional Hospital Boards are both to have power to authorise Hospital Management Committees to transfer expenditure from one subhead to another. Qs. 1262–7 Q. 3309

9. Difficulties are also experienced by Regional Hospital Boards in undertaking their duty of scrutinising the accounts of Hospital Management Committees and checking wasteful expenditure. These accounts are audited not by the Regional Hospital Board but by the Ministry of Health. The Ministry send copies of the annual report of the auditors to the Regional Hospital Boards, but this has sometimes taken place several months after the audit. Moreover, the auditors may make Qs. 916–20 Q. 960 Qs. 953–5

* Cmd. 6761. National Health Service Bill; Summary of the proposed New Service.

interim reports and these are not always forwarded to the Regional Q. 1341 Hospital Boards. One Regional Hospital Board claimed that it had to fight for the right to see the auditors' reports. This prevents Regional Hospital Boards from checking extravagance as it occurs and denies them an essential insight into the working of Hospital Management Committees.

10. Hospital Management Committees have their own difficulties Appendix 1 under the present system. They have to prepare their estimates in time to submit them to their Regional Hospital Boards each September for the year beginning the following 5th April, so that they have to cover a period of up to 18 months ahead, when, as the Ministry of Appendix 1 Health agree, conditions cannot be clearly visualised. Moreover, many of them have to wait until well after the beginning of the financial year before they know whether their estimates have been finally approved or by how much they have been cut. One witness claimed that approval was not given until nine months of the financial year had elapsed. In the current year, some Hospital Management Committees were not informed of their allocations until 2nd June. The Q. 3241 Ministry stated that though formal approval might not be given for quite a long time, every Hospital Management Committee knew how much had been allocated to it before the financial year began. Nevertheless, the delay in approval seems to Your Committee to be a genuine grievance of Hospital Management Committees. It was mentioned by Qs. 1580, 2312 representatives of two of the three committees examined, and one complained that his committee had once had to cut down the standard of feeding at a hospital after they had been notified of the estimate approved and found that it was not as high as they had allowed for.

11. In spite of the system of approval of estimates by Regional Hospital Boards and the Ministry of Health, the desired end of closeness of estimating does not seem to have been achieved. For example, it Q. 3230 was stated by the Ministry of Health that towards the end of the year 1950-51 it had become clear that the hospitals were not going to be able to spend up to their estimates by £5,000,000, and that it was obvious that, in preparing their estimates, some hospitals had made very large claims for money, asking for more than they really needed. Qs. 2312, 2316. Moreover, though Your Committee were told repeatedly of the difficulties that hospitals found in dealing with unforeseen and urgent items Qs. 1583–4, 1592, 2906–9 of expenditure, nevertheless Hospital Management Committees always seemed to have reserves to meet such crises, in spite of the fact that they were not allowed to budget for contingencies.

Tendency towards Centralisation

12. The Ministry of Health were asked whether it was their policy Q. 3409 that there should be increased centralisation of the hospital services. They replied that it was not. Their reasons for introducing stricter methods of control, and for interfering with the powers of Regional Hospital Boards in such matters as transfer between subheads were, Q. 3311 when analysed, twofold. In the first place, very large Supplementary Estimates were presented for the Hospital Services in both 1948-49 and 1949-50, and it was considered necessary to introduce stricter control in Q. 3416 order to prevent a recurrence of this in 1950-51. In the second place, the Ministry considered it to be their duty to ensure that different standards were not being applied to hospitals in different Regions.

13. While they recognise the difficulties of the Ministry of Health, Your Committee consider that the present position of Regional Hospital Boards is in some respects anomalous. If, either because of financial stringency or for other reasons, the Ministry cannot carry out the policy which was envisaged when the organisation of the National Health Service was designed, but have to maintain an increasingly direct control over Hospital Management Committees, many of the functions which were allotted to the Regional Hospital Boards and which those Boards have been trying to exercise become redundant. The interposition of a controlling authority between the individual Hospital Management Committee and the Ministry must of itself lead to considerable delays, some of which were mentioned to Your Committee in evidence, and it is for consideration whether these delays are justified in matters about which Regional Hospital Boards are to do little more than receive and transmit communications between the Ministry and Hospital Management Committees. Qs. 1575–82, 2312–17

14. The development of the Hospital Service appears to have reached the parting of the ways ; either the Ministry must decide to give greater scope to the Regional Hospital Boards than they at present enjoy, or alternatively they must move towards reorganising the service on the basis that the functions of the Regional Hospital Boards are purely of a planning and advisory nature. The choice between these alternative aims is a major question of policy on which Your Committee cannot make a recommendation. Nevertheless, they have formed the opinion that if the decision is not taken to enlarge the powers and to increase the independence of the Regional Hospital Boards, better results would be achieved and better relations established in the Service if the Ministry were to deal direct with Hospital Management Committees in financial matters through their Principal Regional Officers instead of through Regional Hospital Boards.

Block Grants : Transfer and Carry-over of Unspent Balances

15. One solution to the problems caused by the present system of estimating was proposed by nearly all the witnesses examined. It was usually described as a system of block grants. The witnesses appeared to have in mind, in fact, what are known in parliamentary language as " grants in aid ". By this, the supporters of the proposal meant that, as far as possible, the money allocated to hospitals should be in lump sums not tied to particular subheads or expendable in any specified period. It was generally agreed that the preparation of estimates would still be necessary, though these could be greatly simplified. It is to be observed in this connection that the Nuffield Provincial Hospitals Trust and the King Edward's Hospital Fund for London, who are investigating the preparation of cost accounts in hospitals, considered that statistics of costing would be of great assistance in deciding how much money should be allocated to each hospital if some block grant system were introduced. Qs. 210–20, 1348, 2526, 2939–42 Qs. 205, 1237–52, 2377, 2584 Q. 3181

16. It was suggested that the Ministry of Health, in giving their approval to these simplified estimates, should not approve each subhead individually, as at present, but should issue a lump sum to each Regional Hospital Board and leave it to the Board to distribute the sum among their Hospital Management Committees. The Hospital Management Committees would, in their turn, be free to use the money Q. 1244 Q. 199

Q. 2526 in the way they thought most appropriate ; any unspent balance at the end of the year would accrue to the hospital making the saving and would not be returnable to the Exchequer.

17. Much evidence was given to Your Committee by Regional Hospital Boards and Hospital Management Committees tending to show that the strict limitation of expenditure to the subheads of estimates approved by the Ministry was a deterrent to economy. A saving made under one subhead may not now be transferred to another subhead without the Ministry's consent (*see* paragraph 8), and since at the end of every financial year the authority to spend any unspent money lapses, the hospital authorities are tempted to make their estimates for every subhead as large as possible and then to spend all the money allocated to them on what they can within that subhead.

Qs. 1344, 1567–9, 2935–59

18. Coupled with the request to be allowed to transfer between subheads was the request to be allowed to carry over unexpended balances. It was urged that hospitals would be more economical if they knew that any saving they might make on their estimates would not be lost at the end of the year. The Ministry of Health have resisted this proposal on the ground that such a system is quite contrary to established principles regarding voted moneys other than grants in aid. In the event, however, of the introduction of a system of grants in aid or "block grants", as described in paragraph 15, the authorities receiving such grants would automatically possess powers of transfer and carry-over. Possession of these powers appeared to be one of the main objects of the advocates of block grants. For a block grant system to be effective, however, it is necessary for the grant to be made either of a fixed amount or at least in accordance with a definite formula for a series of years such as five or, at the least, three. Otherwise, annual detailed estimates would still be needed to fix the varying annual grant and hospital authorities would be in no better position with regard to their unspent balances at the end of each financial year than they are at present.

Q. 221

Q. 3293

19. The Ministry of Health were asked if they were, in fact, contemplating the introduction of a system of block grants. In reply to the question, "You are moving in the direction of allocating a total pre-determined sum to the hospitals and dividing that sum between the Regions in accordance, if not with a formula, at any rate with a pre-determined policy?" the witness replied "Yes." He stated, moreover, that the Ministry intended to leave the sub-allocation of each Region's share between Hospital Management Committees very largely to the Regional Hospital Board. Their further intention was, however, to retain the final decision over this sub-allocation, and Regional Hospital Boards would have to submit their proposals for sub-allocation to the Ministry.

Q. 3259

Q. 3260

20. The working out of a satisfactory system in this novel field of administration must be largely empirical. It must also be gradual, in that much essential spade-work, such as the preparation of a sound cost accounting system for hospitals, in England and Wales, still remains to be done. Moreover, the Service is not as yet sufficiently stabilised for hospital authorities to be able to estimate their needs several years in advance, so that a grant for three or five years might be practicable.

Qs. 3181–3

21. Nevertheless, Your Committee are of opinion that something more than a slight modification of the system hitherto in operation is necessary. The aim, in their view, should be the largest possible degree of decentralisation, to be effected as soon as it can be carried out. It may be noted in this connection that the Ministry of Health witness stated that he had no reason to believe that if Parliament were to give a grant in aid there would be any difficulty or wastefulness, and that he saw no difficulty in operating a system of grants in aid of the magnitude proposed. It should be added, though, that he had no confidence that Parliament would follow such a course. Qs. 3276–7

22. Whether or not a substantial modification is made on the lines of the suggestions outlined in paragraphs 15 to 18, there appears to Your Committee to be a strong case for an immediate return to the system which existed before 31st March, 1951, under which Regional Hospital Boards had the power to allow Hospital Management Committees to transfer their expenditure from one subhead to another of the estimates of those committees. There are no statutory or parliamentary rules which govern the power to make transfers in these estimates, as there are in relation to Estimates presented to Parliament. Your Committee therefore recommend that some clearly defined power of permitting transfer between subheads by Hospital Management Committees should be restored to Regional Hospital Boards.

23. There appeared to be misunderstanding amongst some of the witnesses about the nature of unexpended balances. They did not clearly understand that the amount of money included in a year's estimates of a hospital authority was not the year's income of that authority, but was merely the limit of permission to spend. When a saving has been made on an estimate it generally means that the authority has found itself able to provide the service in question at a lower cost than was allowed for in the estimate; it follows that the Ministry ought not, in the absence of some special reason, to approve an estimate in the following year for the same purpose and of the same size as before. If hospital authorities could carry forward unexpended balances it would in effect be requiring the Ministry to approve estimates for amounts exceeding the cost of the services in question by the amounts carried forward. On the other hand, while pointing out the fallacy, it is necessary to reiterate that the sense of injustice and the discouragement of economy are real. Your Committee recommend that where a hospital authority has been able by efficiency to effect a real saving on its estimates, recognition should be given to this in considering subsequent estimates of that authority. For example, the Ministry of Health might give approval to some other item of expenditure, required by the authority, in an earlier financial year than would otherwise be the case.

ESTABLISHMENTS

24. Rather more than 60 per cent. of expenditure on hospital and specialist services consists of salaries or wages. The total numbers employed on hospital staffs in England and Wales on 31st December, 1949, were 306,654 whole-time and 74,988 part-time; the details by Regions and types of employment are given in Appendix 2. The numbers have since increased under almost every heading. The Q. 3316 Appendix 2

totals for 1950 were 317,074 whole-time and 84,363 part-time employees.* Strictly comparable figures of administrative staffs before and since 5th July, 1948, are not readily available. For example, the former municipal hospitals were largely administered from the local government offices concerned, whereas they are now administered by the staffs of Hospital Management Committees.

25. Public criticisms of the hospital services have suggested that there have been considerable, and it is implied, unjustifiable increases in staffs, especially of those engaged on administrative duties. There
Q. 232 appear, in fact, to have been big increases. A British Medical Association witness, for example, gave his opinion that there had been astonishing and avoidable increases of administrative staffs. It was decided to
Appendix 3 take a sample, and the Sheffield Regional Hospital Board, at the request of Your Committee, submitted a series of returns and an analysis of their administrative and clerical staffs. From 5th July, 1948, to 31st December, 1949, the increase was from 1,017 to 1,515 ; from December 1949, to December 1950, there was a further increase up to 1,633 and by March 1951, the figure had risen further to 1,658. This means that there has been a 63 per cent. increase in numbers in the Sheffield Region between 1948 and March, 1951. Your Committee have no reason to doubt that this is a representative sample. The situation in all Regions therefore needs close investigation.

26. In their efforts to control the establishments of Hospital Management Committees, the Regional Hospital Boards are in an even worse
Qs. 766, 970, 1225, 1320–32 position than they are in their efforts to control estimates. The Ministry of Health send round their own visiting teams of experts in each field of hospital activity to find out where establishments of Hospital Management Committees are excessive or inadequate, and issue circulars and advice direct to those committees, both in general terms, about the sort of establishment which is considered desirable, and on specific appointments. There can be no doubt about the need for some supervision and advice in the matter of establishments, but Your Committee consider that the method employed is not satisfactory. It obviously makes the task of Regional Hospital Boards much more difficult—one of them described it as strengthening infinitely their Management Committees'
Q. 971 hands in negotiating for increases of staff. It must also leave the Management Committees in some doubt as to which of their two masters they are supposed to serve.

Qs. 766, 1297 27. At present the Regional Hospital Boards have power to control the establishments of the Hospital Management Committees only in so far as they can approve or disapprove estimates for any increase of an
Q. 788 existing establishment. The existing establishments themselves were determined historically, that is to say by the numbers employed in the hospitals at the start of the Service in July 1948, subject only to such
Q. 791 modifications as have since been made piecemeal ; they have not been subject to review, as a whole, either by the Regional Hospital Boards
Q. 1329 or by the Ministry, though the latter are now undertaking preliminary investigations to that end.

28. Your Committee believe that substantial economies can be achieved by a national review of the whole question of staffing. Even in those sections of the staff where an undoubted shortage exists, such

* Excluding honorary appointments.

as in nursing, a review should lead to considerable improvements in efficiency of employment. The question arises whether responsibility for supervision of the staffs of Hospital Management Committees should rest with the Ministry of Health or with Regional Hospital Boards. Attention has already been drawn to the urgent need to decide what are to be the functions of the Regional Hospital Boards, and this is one aspect of that problem, closely connected with, and second in importance only to, that of financial control. While financial control must of itself necessarily carry with it some general power to control staffs, which constitute so large a part of the cost of the Service, nevertheless Your Committee think that some direct responsibility in this connection should be vested in that part of the service responsible for planning, namely, the Regional Hospital Boards, whether or not they are given greater financial powers. They therefore recommend that the whole question of the staffing of the service should be reviewed on a national basis by the Ministry of Health and that the individual Regional Hospital Boards should be given more extensive powers of controlling the size of the staffs of their Hospital Management Committees than they possess at present.

WHITLEY COUNCILS

29. As wages and salaries constitute so large a proportion of the cost of the Hospital Service, the efficient working of the Whitley Councils, by which they are settled, is of the highest importance, not only to the Service but also to the national economy. Your Committee are not satisfied that the Councils work efficiently. It was alleged that there Q. 1352
was often considerable delay by Whitley Councils in reaching a decision ; in one case mentioned, this resulted in a " go slow " movement in the laundries of a Regional Hospital Board. Moreover, there were com- Q. 1365
plaints that Regional Hospital Boards and Hospital Management Committees, who are the actual employers of hospital staff, in that they have to engage them and to find the money to pay them out of their budgets, are inadequately represented on the Councils. Hospital Management Qs. 2912–30
Committees are not in fact represented at all, and do not even have any official information that wage claims are being considered by a Whitley Council. Regional Hospital Boards are represented, but the represen- Q. 1366
tatives of the Ministry of Health and Department of Health for Scotland outnumber them. As a result of these difficulties, it has been alleged that hospital authorities have not been accepting the decisions of Whitley Councils, and the Ministry agreed that they had had a number of cases brought to their attention where payments in excess of the scales agreed Q. 3317
by Whitley Councils had been made. They were proposing to lay a regulation before Parliament to deal with these cases. Your Committee recommend that the Departments concerned should give urgent consideration to the whole application of the Whitley Council system to the Hospital Service.

CAPITAL EXPENDITURE

30. Capital expenditure is a matter for Regional Hospital Boards and Boards of Governors of Teaching Hospitals, and not for Hospital Appendix 1
Management Committees. The situation is necessarily complicated by the dual basis of control which is imposed on the one hand by the need to determine priority under the Health Service, and on the other by the need to ensure compliance with the building control and the Government

Q. 3328 capital investment programmes generally. The Ministry of Health have divided the sum available into three parts; in round figures, the sums
Q. 3327 allocated are £7,500,000 to Regional Hospital Boards and Boards of Governors for their general capital expenditure; £2,000,000 for large schemes (i.e. those costing over £50,000); and £500,000 for emergencies.

Qs. 685–717, 1136–44 31. Your Committee received strong complaints from the two Regional Hospital Boards which gave evidence that owing to the inflexibility in operation of the controls they had been prevented from
Qs. 716–17 spending the full amount of their already restricted capital budgets,
Q. 3359 and it was suggested that something like 15 per cent. of the £7,500,000 allotted to the Boards might not be expended. The Ministry of Health did not deny either the irksomeness or the effect of the controls, though they said that the trouble would not have been so bad if some
Q. 3360 of the Boards had not been "so slow off the mark". While the
Q. 3332–4 Boards are permitted to start all schemes of less than £1,000 when such schemes have once been approved by the Ministry of Health, and may switch as they please from one to another within their authorised total of capital expenditure, all schemes over £1,000 require a special application to the Ministry of Health, who have to obtain the necessary sanction and a starting date from the Ministry of Works,
Q. 622, 640 and also, if the sum is over £10,000, a separate Treasury authorisation. The inevitable delay is such that a number of feasible schemes are pushed over the end of the financial year. The result is that less capital work is in fact carried out within the year than would have been physically and financially practicable, simply because of administrative delay. Your Committee appreciate that the Ministry of Health do their best to sponsor schemes as quickly as possible, and that some delay is inevitable in present circumstances; nevertheless, they consider that greater dispatch could be achieved by arrangements between the Ministry of Health and the Ministry of Works, and they recommend that the Ministry of Health should approach the Ministry of Works to this end.

ACCOUNTS

Q. 3206 32. Before the National Health Service Act, the British Hospitals Association published hospital statistics in a book every year, and the King Edward's Fund had an annual statistical survey. Since the Act came into force, hospitals have stopped sending their returns to the Fund and there has been no central organisation compiling these statistics. The only hospital accounts which are published are the summarised hospital accounts which are presented to Parliament with the report of the Comptroller and Auditor General thereon. These accounts are not only out of date by the time they are presented—the accounts for 1949-50 were not published until the end of April, 1951—but they are also useless as a means of studying and checking
H.C. 54 of 1950–51 expenditure. Your Committee note, however, that the summarised accounts of the Scottish Health Service for 1949-50 were published much earlier and that they contained a much more detailed analysis of hospital expenditure than that contained in the summarised accounts for England and Wales. They consider that the Ministry of Health should in future be able to prepare their accounts by the statutory date (30th November) and they recommend that they should present with them an analysis which would be of real value in examining unit costs in different types of hospital.

33. The Ministry of Health favour the local publication of hospital accounts, but the Treasury have suggested to the Ministry of Health that the accounts should be coupled with the auditors' reports. The Ministry think this would cause difficulties, as their auditors' reports have not hitherto been designed for public consumption; they fear that, if auditors know that their reports are to be published, they may be less frank in their comments and may even be influenced by fear of actions for libel. Qs. 3377–82

34. Your Committee share the view of the Ministry that early publication locally of the general financial position of hospitals is desirable. They hesitate, however, to accept any proposal which would limit in any way the full freedom of the Ministry's auditors to make any comments they think necessary on the accounts of the Hospital Management Committees, particularly as they are informed that the Comptroller and Auditor General relies very largely on the reports of these auditors in his examination of hospital expenditure. They therefore suggest that an alternative and better means of securing the object, which all concerned consider desirable, would be for each Hospital Management Committee to issue locally, as soon as the year's accounts are available, a statement in narrative form giving a general description of the committee's activities during the year and including the main operational statistics and the salient figures in the accounts. They believe that this would be more informative than mere publication of accounts, which are often difficult for laymen to understand, and that it would more effectively secure the object of maintaining or arousing local interest in the management of hospitals in the area. If in any area a demand were expressed for supplementing this statement by publication of the actual accounts, Your Committee would see no objection, provided that the auditor were given the opportunity of preparing for publication a separate report—a course which the Ministry said they were prepared to consider. Qs. 3387–89 Q. 3383

THE ORGANISATION OF THE SERVICE

35. Your Committee, in considering the suitability of the sizes of the areas of Regional Hospital Boards and Hospital Management Committees and of the sizes and composition of the Boards and Committees themselves, recognise that each Board and Committee has its own geographical and personal problems. Certain of these problems came to their attention and are considered below.

The Regions

36. Of the fourteen Regional Hospital Boards for England and Wales by far the largest is the South-West Metropolitan Regional Hospital Board, which stretches from the centre of London to Lyme Regis, serves a population of over 4,400,000 persons and deals with an annual expenditure of about £26,000,000. None of the witnesses appeared to be satisfied with the demarcation of this Region; it is too large for any Board to cover. The Board have themselves set up a Western Area Committee with delegated power over the south-western parts of the Region, but both the Board and the Ministry of Health agreed that this was not working well. Your Committee were told that the western area could not be made into a separate Region because there would be no Teaching Hospital within its boundaries. Yet Section 11 (1) of Qs. 989–998, 1023–27, 1040–41, 3564–65 Q. 3565

the National Health Service Act states that the Minister shall secure, so far as practicable, that each [Regional Hospital Board's] area is such that the provision of services in the area can conveniently be associated with a University having a school of medicine. It would not be a direct contravention of the Act, therefore, to split the South-West Metropolitan Region into two without associating each part with a University school of medicine, since the Act requires this to be done only so far as is practicable. No witness examined gave any strong reason why there should be a Teaching Hospital in each Regional Board's area, though it is true that a Teaching Hospital constitutes a natural focus for a large number of highly specialised services.

Qs. 1033, 2503–05

Q. 3539

37. Having considered the evidence, Your Committee do not consider that the lack of a Teaching Hospital in the western half of the South-West Metropolitan Region is a valid objection to splitting the Region into two. Although there is no Teaching Hospital in the western half of the Region, there are more than one in the London part of the Region, and there does not appear to be any reason why one of these should not be associated with a separate Region covering the western half. Your Committee recommend that consideration should be given to the possibility of splitting the South-West Metropolitan Region into two Regions.

Hospital Grouping

Qs. 260–1, 278

Q. 536

38. Your Committee received a number of criticisms of the grouping of hospitals, and suggestions for improvement. In particular, it was alleged that the Ministry had insisted upon too rigid an adherence to the principle that each group should provide roughly 1,000 beds. From such direct evidence as Your Committee were able to take on this question they gained the impression that the grouping is generally satisfactory, though there is probably room for revision here and there, particularly with a view to ensuring the preservation of natural local units. They were impressed by the fact that some of the Hospital Groups in the East End of London are very small and that, as they are over-shadowed by the London Hospital, there appear to be no appreciable waiting lists for beds at these hospitals, as there are elsewhere. The present position in the East End of London is somewhat peculiar, but Your Committee think that there is a case for reviewing the grouping in this area.

Qs. 2773–4

Q. 3581

39. The Ministry of Health said that there were three groups which they might like to revise, though they thought that the system had not really been in existence long enough to justify any attempt to break up or to redistribute groups. They assured Your Committee that the machinery existed for the revision of the hospital groups.

Membership of Boards and Committees

Qs. 281, 287, 294–7, 305, 1003, 1183–7

40. Some misgivings were expressed to Your Committee on the quality of members chosen to serve on Regional Hospital Boards and Hospital Management Committees. The British Medical Association criticised both the system of selection and the adequacy of medical representation. The Chairman of the South-West Metropolitan Regional Hospital Board also expressed the view that the quality of members appointed was deteriorating. Your Committee, in the time available, could test only a small part of the field, but they gained the impression that these views were not generally held in the Hospital

Service. The evidence of the South-West Metropolitan Regional Hospital Board appeared to express anxiety for the future rather than about any existing shortcoming. The medical witnesses were, as they readily admitted, more concerned with adequacy of consultation than with medical representation on the Boards. On the whole, Your Committee believe that medical representation on the Boards is ample. Q. 292

41. Your Committee also took evidence on whether the Boards and Committees were of the right size. The Chairman of the South West Metropolitan Regional Hospital Board thought that his Board was too small and that as a result the committees in the Region were thinly attended. The peculiar problems of this Region have already been considered in paragraphs 36 and 37 of this Report. Apart from this, Your Committee heard no complaints about the size either of Regional Hospitals Boards or of Hospital Management Committees, and have no reason to think that the present sizes are unsuitable. Q. 989

42. It became evident to Your Committee that decentralisation of the administration of the hospital services would lead to considerable economies and that the severance of the hospitals from other public health services caused considerable difficulties. On the other hand, under the present framework, Parliament is the only body available to effect detailed control of the expenditure on these services. To hand the control of expenditure over to local authorities would be outside the present statutory provisions and, so long as none of the hospital expenditure is raised from local revenues, the resulting control of expenditure would tend to be unsatisfactory. Nevertheless, until Parliament sees fit to alter the present framework, Your Committee desire to emphasise the great importance of encouraging local sentiment in the administration of the hospitals. Local sentiment is by far the most powerful agency preventing the Hospital Service from degenerating into an arid bureaucracy and it is vital that there should be adequate local consultation in both the administration and the development of the Service.

PARTICULAR ASPECTS OF THE SERVICES PROVIDED

Out-Patients

43. Nearly all the witnesses before Your Committee stated that there had been a greatly increased pressure on hospital services since the Appointed Day, and that this was true of most forms of treatment. Figures submitted by the Royal College of Physicians and taken from a general hospital are printed below. Qs. 1497, 2488

	1939	1948	1949
Beds (average daily number occupied)	707	733	789
Total number of admissions and births	9,168	12,726	14,701
Deaths	982	763	744
Operations, major and minor ...	7,869	11,513	11,195
Anaesthetics	4,464	7,670	8,937
Radiological investigations (patients)	6,653	21,640	22,621
Electro-therapeutic massage, etc. Number of treatments	36,094	52,249	53,760
Pathological investigations	20,494	93,517	106,718

44. It can be seen that the most substantial increases have taken place in the services rendered to out-patients, and the great increase
Q. 2473 everywhere in the number of out-patients was confirmed by the witnesses who gave evidence before Your Committee; the Royal College of Physicians added that there was no sign that the rate of increase was
Q. 2488 falling off. Last year showed the biggest single increase in the number of out-patients since the National Health Service began.

Qs. 392, 2473–79 45. This increase is, to a considerable extent, due to general practitioners sending to hospitals patients whom formerly they would themselves have treated in their own surgeries. Opinions differ as to
Qs. 379–95 whether or not this is a good thing. The British Medical Association
Qs. 392–4 claimed that it was not, and that if doctors were not over-burdened with clerical work, they could treat from 20 to 25 per cent. of the patients who are now, unnecessarily, sent to the out-patient departments of hospitals. The Royal College of Physicians, on the other hand, while
Qs. 2473–9 agreeing that the increased work of the general practitioner caused him to send for treatment patients whom he would not have thought of sending before the Service started, thought this development was a good one, as it tended towards earlier diagnosis and more efficient treatment.

Qs. 1891–1909 46. In some hospitals, the accommodation for out-patients has become very much overcrowded and patients have to wait a long time to be
Qs. 1912–13 examined. For example, Your Committee learnt that out-patients had to wait anything up to six hours in the orthopaedic department of one hospital before they were examined. Some hospitals operate
Q. 235 systems of appointments for out-patients with varying degrees of efficiency, but if the systems were made more elaborate and rigid the result would be that consultants would be kept waiting and could
Qs. 2062–5, 2074, 2465 therefore see fewer patients. Evidence was given that shortage of professional staff, especially medical, was the limiting factor in treatment.

Shortage of Beds

47. The shortage of staffed beds is also a serious feature of the present situation. Your Committee were told that at one hospital
Qs. 382–5 only one in five casualty or acute cases examined by the hospital doctor was admitted and that four were sent back home because the hospital had no beds available. It was added in evidence that many of these patients who came in as acute cases were in a condition in which they could safely be referred back to the general practitioner after examination. Hospitals are having great difficulty in coping with the long waiting lists for beds in certain categories of treatment.

Aged and Chronic Sick

Qs. 2787–8 48. The problem of dealing satisfactorily with the large numbers of
Qs. 376–89 aged and chronically sick patients is relevant to the shortage of beds. These patients, after initial treatment, often require little further treatment but have to remain in hospital, either because they are not fit enough to look after themselves and their relatives are unable or unwilling to take them when they have sufficiently recovered to leave hospital, or because there are not available institutions or public services which could provide the necessary accommodation or attention. As a result these patients are occupying beds which are not only urgently required for other patients, but which are also more costly either than those which could be provided in institutions or than the necessary attention would be if it were provided in their own homes.

49. Various remedies for this situation have been suggested. Your Committee consider that many of these suggestions are valuable; that they are not being implemented is due, they believe, to difficulty in co-ordinating arrangements between the various authorities responsible for different parts of the National Health Service. This problem is one aspect of the greater problem of the reform of local government generally. Qs. 454–7, 2542–63

THE HOSPITAL ENDOWMENTS FUND

50. Endowments of hospitals (other than those of the Teaching Hospitals) were transferred by the National Health Service Act to the Minister of Health, and income from the fund so constituted is distributed by him to Regional Hospital Boards and Hospital Management Committees according to a system outlined in Appendix 1. The Boards and Committees are empowered by the Act also to receive gifts and legacies.

51. The following table shows the approximate amounts available to hospital authorities in 1949-50 from these sources.

	Total	Boards of Governors	Hospital Management Committees	Regional Hospital Boards
	£	£	£	£
Receipts				
1. Cash on hand 1st April, 1949	2,178,611	1,521,278	645,726	11,607
2. From dividends, interest, property, etc.	1,689,881	1,647,009	42,790	82
3. From Hospital Endowments Fund	925,140*	—	465,446*	459,694*
4. From Regional Hospital Boards	148,157	—	148,157	—
5. Gifts, legacies, etc. under Sections 59 and 60 of the N.H.S. Act	1,175,048	497,989	676,107	952
6. Other receipts ...	505,649	358,095	137,758	9,796
Totals ...	6,622,486	4,024,371	2,115,984	482,131
Payments				
7. Invested	1,939,004	1,610,718	299,911	28,375
8. Payments to Hospital Management Committees	148,157	—	—	148,157
9. Hospital purposes and research (beyond provision made by the State)	1,267,651	909,543	345,995	12,113
10. Cash in hand 31st March, 1950	3,267,674	1,504,110	1,470,078	293,486
	6,622,486	4,024,371	2,115,984	482,131

* These figures include arrears for 1948–49. The distribution is at the rate of about £600,000 a year.

52. Hospital authorities find some difficulty in deciding on what to spend this money. The original intention was that it should be mainly available to provide amenities, but Hospital Management Committees hold divergent views on what constitutes an amenity. It is held Q. 850

Qs. 1932–44 by some hospital authorities, for example, that curtains, lamps, china of a more attractive design than the standard pattern and even wireless sets are not amenities but part of the normal equipment of a ward Qs. 855, 1945 which should be provided by the Exchequer. As a result, many authorities do not spend their yearly allocations. It will have been seen from the table in paragraph 51 that out of a total sum of £6,622,486 available to the hospital authorities in 1949-50, only £1,415,808 was spent. Your Committee consider that at a time of financial stringency like the present it is desirable that money from this Fund rather than from the Exchequer should be spent on those things which can properly be regarded as amenities. There should be no need for a chairman of a Hospital Management Committee to say in Q. 2363 evidence, "I go round and try to encourage them to spend it". Your Committee recommend that the Ministry of Health should draw up a list of items which should properly be provided by the hospital authorities from their share of the Hospital Endowments Fund, and for which Government money will not, normally, be available.

PAYING BEDS

53. Under the National Health Service Act, there are two kinds of hospital bed for which a charge can be made to the patient; the "amenity bed" controlled by Section 4 of the Act, and the "private bed" controlled by Section 5. Under Section 4 of the Act, a patient may be charged a small fixed sum in return for accommodation in a Q. 3785 single room or in a small ward. At present this is 6s. a day for a single room and 3s. a day for accommodation in a small ward. There may also be other minor amenities included for this charge, such as furniture of a standard higher than the average. Under the provisions of this Section, no other privilege is granted and the patient remains in every respect subject to the same conditions as to choice of surgeon, Q. 401 etc., as any other "public patient". The "private bed", under Section 5 of the Act, is charged for at a much higher rate. For "private" accommodation, the patient pays charges designed to cover the whole cost of the accommodation provided for him at the hospital, including an appropriate amount in respect of overhead expenses. In addition, the "private patient" has to pay the surgeons' and consultants' fees Q. 430 and other appropriate charges. He has, of course, a free choice of surgeon or consultant and it is this feature which makes the "private" bed more attractive to patients than the "amenity" bed, there being little to choose between them in the matter of privacy. In case of urgent need, either "amenity" or "private" beds may be taken for non-fee paying patients if no other accommodation is available.

54. Controversy exists on the working of Section 5 of the Act. "Private" beds are very expensive to the patient. Charges vary from £10 to £20 a week or even more.* The cost falls more heavily upon

* These figures are taken from a sample taken by the Ministry of Health in 1950. The Ministry stated that charges had probably risen since then. The sample gave details of charges in different types of hospital as below:

Non-teaching Hospitals	10 to 12 guineas a week.
Cottage Hospitals	15 to 17 guineas a week.
Teaching Hospitals	10 to 20 guineas a week.
Maternity Hospitals	£15 a week.
Mental Hospitals	£3 17s. to £13 13s. a week.

a patient who goes into hospital for some comparatively simple operation than it does upon the patient who requires more expensive and complicated treatment. The proportion of overhead expenses which the Act decrees he must pay means, in effect, that the patient may be subsidising departments of the hospital whose services he does not require. The converse is, of course, equally true. Because of the high cost, it was claimed that some "private" beds were unoccupied by "private" patients and that, if charges were reduced, these would be filled and economy would result. Q. 3801–02 Qs. 401–6

55. Another cause of controversy in this connection is the charge which consultants and surgeons may make to patients occupying "private" beds in hospitals. These charges are based on a complicated schedule drawn up by the Ministry of Health. The medical profession wish to abolish this schedule and leave the fees to private arrangement between patient and consultant. They claim that the schedule is inflexible and difficult to operate and that it does not protect the patient from overcharging. As this matter is the subject of discussion between the Ministry and the medical profession, Your Committee refrain from comment. Qs. 410, 414, 425, 2607–16

THE GENERAL PRACTITIONER AND THE HOSPITAL

56. Although figures are not available, it was generally agreed by witnesses that the number of hospital patients attended by general practitioners has diminished since the Appointed Day. This has been due to a deliberate change of policy under which whole hospitals or parts of hospitals hitherto available to general practitioners have been selected for special kinds of treatment. The British Medical Association stated that some of this so-called up-grading was unnecessary and extravagant. Apart from this, it was suggested that the general practitioner was being squeezed out of the Hospital Service and that he should be given more facilities to meet hospital staffs and to have X-ray and pathological examinations done at hospitals. The Ministry of Health stated that this had always been their policy but that at many hospitals it would lead to an increase in the number of such examinations and, consequently, to a further strain on hospital resources. The Royal College of Physicians considered that, on the contrary, if such facilities were granted, there would be less pressure on the time of consultants and on the outpatient departments of hospitals. Your Committee agree with this latter view and consider that such an arrangement would avoid the necessity for the further examination of a patient by a specialist after he had been examined by a general practitioner. They recommend that except where a hospital can advance cogent reasons against it, the facilities to general practitioners at hospitals should be extended, and that they should have the right to have X-ray and pathological examinations carried out. Qs. 353–59 2484–90, 3711 Qs. 353, 2481–91 Qs. 3727–8 Q. 2485

GENERAL CONCLUSION AND SUMMARY OF RECOMMENDATIONS

General Conclusion

53. The most important problem requiring solution in the Hospital Service is that of the anomalous position of the Regional Hospital Boards. The solution involves more than a slight modification of the system of financial control hitherto in operation. The Ministry

of Health must, in the opinion of Your Committee, either decide to give greater scope to the Regional Hospital Boards than they at present enjoy, or alternatively they must move towards reorganising the Service on the basis that the functions of the Regional Hospital Boards are purely of a planning and advisory nature. The choice between these alternative courses is a major question of policy (paragraphs 7 to 20).

Summary of Recommendations

54. Your Committee make the following recommendations:—

(1) Some clearly defined power of permitting transfer between subheads by Hospital Management Committees should be restored to Regional Hospital Boards (paragraph 22);

(2) Where a hospital authority has been able by efficiency to effect a real saving on its estimates, recognition should be given to this in considering subsequent estimates of that authority (paragraph 23);

(3) The whole question of the staffing of the Hospital Service should be reviewed on a national basis by the Ministry of Health (paragraph 28);

(4) The individual Regional Hospital Boards should be given more extensive powers of controlling the size of the staffs of their Hospital Management Committees than they possess at present (paragraph 28);

(5) The Departments concerned should give urgent consideration to the whole application of the Whitley Council system to the Hospital Service (paragraph 29);

(6) The Ministry of Health should approach the Ministry of Works with a view to making arrangements to secure greater dispatch in starting schemes of capital expenditure for hospitals (paragraph 31);

(7) The Ministry of Health should present with their annual accounts an analysis which would be of real value in examining unit costs in different types of hospital (paragraph 32);

(8) Each Hospital Management Committee should issue, as soon as the year's accounts are available, a statement in narrative form, giving a general description of the committee's activities during the year and including the main operational statistics and the salient figures in the accounts (paragraph 34);

(9) Consideration should be given to splitting the South-West Metropolitan Region into two Regions (paragraph 37);

(10) The Ministry of Health should draw up a list of items which should properly be provided by the hospital authorities from their share of the Hospital Endowments Fund, and for which Government money will not, normally, be available (paragraph 52);

(11) Except where a hospital can advance cogent reasons against it, the facilities to general practitioners at hospitals should be extended, and they should have the right to have X-ray and pathological examinations carried out (paragraph 56).

APPENDIX 1

THE HOSPITAL, SPECIALIST AND ANCILLARY SERVICES IN ENGLAND AND WALES UNDER THE NATIONAL HEALTH SERVICE

Memorandum by the Ministry of Health

The Administrative Arrangements

1. With minor exceptions mentioned in paragraph 21 below, the Minister's 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, is executed through the agency of Boards of Governors, Regional Hospital Boards and Hospital Management Committees. 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 original Boards (S.R. & O. 1946 No. 2158, S.R. & O. 1947 Nos. 1297 and 1298, S.I. 1948 Nos. 656 and 979, Orders Nos. 108,-020 and 108,-101 of 1948). The 36 Boards of Governors control the teaching hospitals of the country and are directly responsible to the Minister (Section 12 (3) of the Act of 1946). The control of the non-teaching hospitals is shared between the Regional Hospital Boards and 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 Board's services can be associated with a University having a medical school (Section 11 (1) of the Act of 1946 and S.R. & O. 1946 No. 2158). With the Minister, and in collaboration with the Boards of Governors, they plan and administer a co-ordinated hospital and specialist service for their respective regions. In accordance with a scheme approved by the Minister, each Board appoints local Hospital Management Committees, one for each large hospital or group of hospitals forming a reasonable unit for local administrative purposes. The Committees undertake the day-to-day management of the hospitals on behalf of the Regional Boards. The respective functions of the Minister, the Boards and the Committees are defined in more detail in S.I. 1948 No. 60 and S.I. 1950 No. 1260. Boards and Committees may appoint committees and sub-committees consisting wholly or partly of non-members in accordance with S.R. & O. 1947 No. 1298, except that the Finance Committee or Sub-Committee must consist wholly of members (S.I. 1948 No. 1414). There are in England and Wales 378 Hospital Management Committees. The service is responsible for about 3,200 hospitals, clinics, etc., and a staff of some 300,000 whole-time and 60,000 part-time. The Administrative arrangements are shown by way of diagram in Table A.

Service upon the Boards and Committees is voluntary and unpaid, except that provision is made under Regulations made by the Minister (S.I. 1949 No. 2340) to pay for loss of remunerative time and for travelling and subsistence expenses. The Boards and Committees appoint their own administrative staffs, who are not civil servants (Section 14 (1) of the Act of 1946). Regional Hospital Boards are responsible for appointing and dismissing certain grades of medical and dental staff in the non-teaching hospitals (S.I. 1950 No. 1260), Hospital Management Committees appointing and dismissing all other staff (S.I. 1948 No. 60). The Boards of Governors are responsible for all staff in the teaching hospitals (S.I. 1948 No. 60).

Finance

3. The net cost of the Service falls wholly upon the Exchequer subject to the following qualifications:—

(*a*) Boards and Committees have power to receive and hold property (including money) from any source, e.g., gifts, legacies, and to use it for purposes relating to hospital services or research (Section 59 of the Act of 1946). So far, the main source from which income of this kind has come has been the "endowments" transferred by the Act of 1946. "Endowments" are defined in S.7 (10) of the Act of 1946 as land (other than that transferred to the Minister as hospital premises), securities, cash in hand and at the bank and rights under existing covenants held by the governing body of the hospital. Under the provisions of that Section the endowments of any hospital designated under the Act as a teaching hospital held immediately before the appointed day now vest in the Board of Governors on trust for such purposes relating to the hospital services or with respect to research as the Board thinks fit. The endowments of all other hospitals held immediately before the appointed day have been vested in the Minister. A Hospital Endowments Fund has been established by the Minister and the income is rateably distributed in part to the Regional Hospital Boards (who in turn may either distribute sums to the Hospital Management Committees or retain them under their own control), and in part direct to the Hospital Management Committees. Various amenity provisions

and expenditure on research are at the discretion of the hospital authorities met from this source and from new monies or property received by them since the appointed day.

(*b*) Charges may be made in accordance with regulations of the Minister (S.I. 1948 No. 1505) for 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.

(*c*) Subject to the needs of the Service, accommodation in hospitals in single rooms or small wards may be made available for patients who undertake to pay for the cost of this accommodation as determined in the prescribed manner under Section 4 of the Act of 1946 (S.I. 1948 No. 1490). Under Section 5 of the same Act, accommodation may be set aside for patients who undertake to pay prescribed charges (S.I. 1948 No. 1490) designed to cover the whole cost of accommodation and services provided, including an appropriate amount in respect of overhead expenses.

(*d*) In accordance with the provisions of 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 estimated number of contributions payable by insured persons during the year.

Income of the various types described in paragraphs (*b*), (*c*) and (*d*) above appears 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 the provisions of Section 56 of the Act of 1946.

Accounting Arrangements

4. The service is financed by monthly advances of cash to the Boards of Governors and Regional Hospital Boards. The latter in turn advance money to the Hospital Management Committees. Departmental accounts are, of course, on the basis of receipts and payments; and the amounts included in the Vote (Sub-heads B.1, B.2, L.1, and L.2) are the cash advances to the Boards. The accounts of the hospital authorities are, under Financial Regulations made by the Minister with the consent of the Treasury (S.I. 1948 No. 1414) on the basis of income and expenditure. The expenditure of the year includes the amounts owing to creditors in respect of the year as well as the amounts paid, while the income of the year includes all the amounts recoverable in respect of the year whether or not collected.

5. Each hospital authority is thus a separate unit keeping its own accounts subject to the qualification that some of the Regional Hospital Boards have established mechanical accounting systems which are made available to their Hospital Management Committees, and in some cases also to neighbouring Boards of Governors. Under the provisions of Section 55 of the Act of 1946, the Minister annually summarises the audited accounts of the Boards and Committees and transmits them to the Comptroller and Auditor General, who examines and certifies them and lays them together with his report thereon before Parliament.

Measures of Central Control

6. It has from the outset been the policy of the Minister to allow a wide measure of independence in hospital administration to the hospital authorities, subject to necessary financial control from the centre. The main instruments of that control are:—

(*a*) Submission by each hospital authority of an annual estimate, with a revised estimate in the Autumn.

(*b*) Formulation of policy in its major features by the Department which is communicated to the hospital authorities in circulars and memoranda.

(*c*) Regular, periodical conferences with officers of the Ministry of the Chairmen of the Regional Hospital Boards and of the principal officers of Boards.

(*d*) National determination of salary and wage scales and conditions of employment etc.

(*e*) Monthly returns from the hospital authorities of their expenditure and income.

(*f*) Liaison through Regional Officers of the Ministry, who may attend the meetings of the hospital authorities and who receive their circulated papers.

(*g*) Central purchase by the Department of certain supplies.

(*h*) Current audit of the accounts of the hospital authorities by officers of the Ministry.

(*i*) Development of a system of hospital costing.

Such of the above features as need further elaboration are detailed in the paragraphs which follow.

Estimates of the Hospital Authorities

7. The system for the preparation, submission and approval of hospital estimates has been much developed since the service began. The description here given is that which operates in respect of the current estimates for the year 1951-52 and the revised estimates for 1950-51.

8. For maintenance expenditure of Hospital Management Committees the basic document is in the form in Table B and classifies income and expenditure under 35 numbered items. Of these, three require subdivision between normal annual outgoings and extraordinary items and six others require subdivision for other reasons. Thus, in all 54 headings of income and expenditure require to be completed separately in respect of every hospital establishment in the service. These returns are accompanied by statistical data of beds available, staff employed etc. It will be seen that the basic document serves to give both the revised estimate for the current year and the estimate for the forthcoming year, the actual expenditure for the previous year and the amount already approved for the current year being also shown for comparison purposes. The unit estimates are then aggregated for the hospital group as a whole, not under the detailed 35 headings but under the more limited number of headings used for approval purposes (see paragraph 12 below). The total for each heading is extended to show the figures according to the type of hospital e.g., general, maternity, mental, etc. Separate aggregations are prepared of the revised estimates for the current year and the forward estimates for the following year. The aggregation together with the detailed estimates and statistics for each unit are submitted by Hospital Management Committees to the Regional Boards who later transmit them together with their own estimates to the Ministry. Boards of Governors submit the forms direct to the Department. In both cases the forms include a separate and detailed estimate of the cost of central administration of the hospital authority.

9. The maintenance estimates of Regional Hospital Boards fall under six main headings (*a*) administration (*b*) Blood Transfusion Service (*c*) Mass Radiography (*d*) salaries and expenses of specialists, senior registrars and registrars—the appointment of these officers to non-teaching hospitals being reserved to Regional Boards (*e*) maintenance of patients under contractual arrangements with hospitals not vesting in the Minister (*f*) miscellaneous. Detailed estimates are provided for (*a*), (*b*) and (*c*).

10. The instructions on the preparation of the estimates require hospital authorities to observe the strictest economy and to exclude provision for any developments that are not essential and urgent or for contingencies. Explanations are to be given of all significant increases and decreases in the figures for each head of expenditure as compared with the estimates for the current year. In addition a statement is required of the amount included in the total net expenditure of the hospital authority:—

(*a*) maintenance of the service at the level at which it existed at the date of the estimate,

(*b*) developments to which the authority was, at the date of the estimate, already committed e.g., by building schemes already in progress,

(*c*) other necessary and urgent development, of which brief particulars are to be given.

11. Examination of the estimates of Hospital Management Committees usually starts at the officer level and is often preceded by informal discussion during the preparation of the estimates. They are then examined by the Finance Committee of the Regional Board and frequently more formal consultations take place with Management Committees at this stage. Finally they are submitted to the Board for approval before transmission to the Ministry together with the Board's own estimates which will also have been examined by the Finance Committee. The examination of the Management Committee estimates may extend over 2-3 months and in those cases provisional figures are submitted to the Ministry in order to comply with the Parliamentary timetable, schedules of adjustments being provided later.

12. When the estimates are agreed, approvals are issued by the Ministry to each Regional Hospital Board, Hospital Management Committee and Board of Governors. For this purpose the estimates of Regional Boards are approved under the six detailed headings under which they are submitted, as indicated earlier in paragraph 9.

The approval of the estimated expenditure of Management Committees and Boards of Governors is not related to the individual units comprised in each group controlled by the Committee or Board, nor to the detailed headings of expenditure set out in the estimates but is grouped under a limited number of "approval" headings, as follows:—

Administration	...	Central expenses of Board/Committee.
Hospital Maintenance	...	Salaries of medical staff. Salaries of nursing staff. Salaries or wages of other staff provisions. Uniforms and clothing. Drugs, dressings, medical and surgical appliances and equipment. Fuel, light, power, water and laundry. Maintenance of building, plant and grounds. Domestic repairs, renewals and replacements. All other expenses.
Other expenditure	...	All expenses other than on administration or hospital maintenance.

The object of grouping hospital maintenance under broad headings is to give the authority such reasonable measure of freedom in the daily administration of the hospitals as is consistent with adequate control of Exchequer funds. The grouping is indicated by the cross lines on the specimen form attached.

13. It is a condition of approval that the Board or Committee must limit its expenditure to the amount approved under each heading and that expenditure on services not covered by the approved estimates must not be incurred without the Minister's consent even though anticipated savings may be available to meet it.

14. The arrangements for the submission of capital estimates are broadly similar, save that capital expenditure is solely the responsibility of Regional Hospital Boards and Boards of Governors. The total amount which may be spent on capital works under the service in any year is fixed by the Government; and the Boards submit proposals in accordance with their allocations. Over and above the approval to the total of the annual estimate, individual jobs costing more than £10,000 require specific approval by the Minister, and in addition under the present building controls works costing more than £1,000 need the Minister's authorisation. The substitution of other schemes for those approved is not allowed without the Minister's consent.

15. This system can be fitted into the Parliamentary system of Estimates only with great difficulty. These difficulties arise because of the great number and type of budgeting authorities involved and the time required to co-ordinate them centrally; the fact that the accounts and estimates are on the basis of income and expenditure and these have, for the purposes of the Ministry's Vote, to be translated into cash requirements; the exigencies of the Parliamentary time-table which require the submission of the Department's figures to the Treasury in December which in turn involves completion of the estimates by Hospital Management Committees by the end of September and of Boards by the middle of November—months before the commencement of the year to which they relate; the fact that hospital requirements are by no means static but on the contrary fluctuate widely so that conditions fifteen to eighteen months ahead can but vaguely be visualised; the wide range of commodities used in the hospital service, causing special difficulties in estimating at times of rising prices. For these reasons it is the considered view that estimating within the narrow margins achieved with others of the Ministry's Votes and elsewhere will probably never be practicable.

National Determination of Major Items

16. The salaries, wages and conditions of service of all engaged in the service are fixed centrally through the agency of Whitley Councils or by central negotiation. The numbers and types of principal officers needed by Boards or Committees have been laid down administratively by the Minister from the outset. In addition, a review of establishments has now begun by local examination by expert teams dealing in the first instance with the following several fields—(*a*) Medical and dental (*b*) Nursing (*c*) Domestic (*d*) Administrative and clerical. The object of this review is to arrive at fixed establishments not to be exceeded without approval. The extent of central control which this provides will be evident from the fact that salaries and wages constitute about 60 per cent. of the total cost of the service.

Monthly Progress Reports on Expenditure

17. All hospital authorities are required throughout the year to make monthly returns of expenditure and income under the "approval" headings showing the amount expended to the end of the previous month compared with the proportionate amount of the approved estimates. One copy of the return from a Hospital Management Committee is transmitted direct to the Ministry and another goes to the Regional Hospital Board. Where overspending by a hospital authority is indicated, action is taken to secure that the overspending is eliminated or reduced so far as reasonably practicable.

Central Purchase of Supplies

18. Proposals to centralise in the Ministry the purchase of supplies need to be approached with care. It is not feasible at present to provide and staff new central stores at locations convenient for all the hospitals of the Country and to embark upon a policy of direct purchase. Nor is it practicable to transfer from the trade the ancillary services in the servicing and repair of medical articles. What is practicable in the first stages is to negotiate centrally running contracts with manufacturers for supply direct to hospitals of articles of common use, such as bedding, linen, crockery, furniture, etc. This is being done as rapidly as national standards of quality can be fixed in place of the wide diversity which has existed in the past. It is also being done with respect to expensive new drugs, such as cortisone, and expensive apparatus, such as X-rays, where it is important to secure improved design and where there should be some control over distribution to the hospitals. The estimated cost of central purchases in 1950-51 is £5,460,000, as indicated in Sub-head F.4 of the Vote.

Audit by officers of the Department

19. In accordance with S. 55 (2) of the Act of 1946 the accounts of all the hospital authorities (and of the Executive Councils) are audited by officers of the Department. A staff of 275, located at convenient centres throughout the country, is wholly engaged on this work. The audit is a current one, visits being made by the auditors three or four times a year or even more frequently according to the size and type of authority. At each visit the audit includes verification of cash balances and test checks of stores balances.

The audit is not restricted to accountancy and the auditor may question the reasonableness or propriety of expenditure.

On the completion of each interim or final audit a report is submitted to the Minister. Copies of all final reports and copies of, or extracts from, interim reports are sent to the bodies concerned. In the case of Hospital Management Committees these copies or extracts are also sent to the Regional Hospital Board concerned. The Act also provides for examination of the accounts of these bodies by the Comptroller and Auditor General and all reports by the Ministry's auditors are seen by his officers.

Hospital costing

20. Cost accounts are an important aid to financial control. Beginning with the year 1950-51 a uniform system of cost accounts has been introduced for all hospitals. This is a relatively simple system based on the financial accounts, adjusted to allow for the vacant bed factor and out-patient attendances. It is intended as a first measure. An investigation into unit costing at a small number of representative hospitals, at the request of the Minister, is being undertaken by the King Edward's Hospital Fund for London and the Nuffield Provincial Hospitals Trust.

Services other than those administered by the Hospital Authorities

21. As indicated in paragraph 1, certain functions are for various reasons outside the responsibility of the hospital authorities. The purchase of hospital land and property is reserved to the Minister, although the relevant hospital authority normally acts as the Minister's agent for the purpose. These expenses fall under Sub-heads B.3 and L.3. The bacteriological laboratories are administered on behalf of the Minister by the Medical Research Council. The cost is shown in Sub-head B.7 Broadmoor Institution (formerly known as Broadmoor Criminal Lunatic Asylum) (Sub-head F.7) and the Rampton and Moss Side State Hospitals for Mental Defectives of dangerous or violent propensities (Sub-head F.6) are administered directly for the Minister by the Board of Control. Under the Nurses Act, 1949, financial responsibility for nurse-training is shortly to be vested in Area nurse-training committees answerable to the General Nursing Council, whose expenses for this purpose will be defrayed by the

Minister. Payments to the Ministry of Works (Sub-head B.5) are in respect of the supply, renewal and repair of invalid tricycles and the conversion and extension of war-time hospitals prior to their handing over to Regional Hospital Boards. Payments to the Ministry of Pensions (Sub-head B.4) are in respect of the provision of artificial limbs, etc., treatment in Ministry of Pensions' hospitals for such purposes and repayment of travelling and other incidental expenses of persons attending limb-fitting centres.

Ministry of Health,
Whitehall, S.W.1.

December, 1950.

TABLE A

Diagram of the Administrative Arrangements

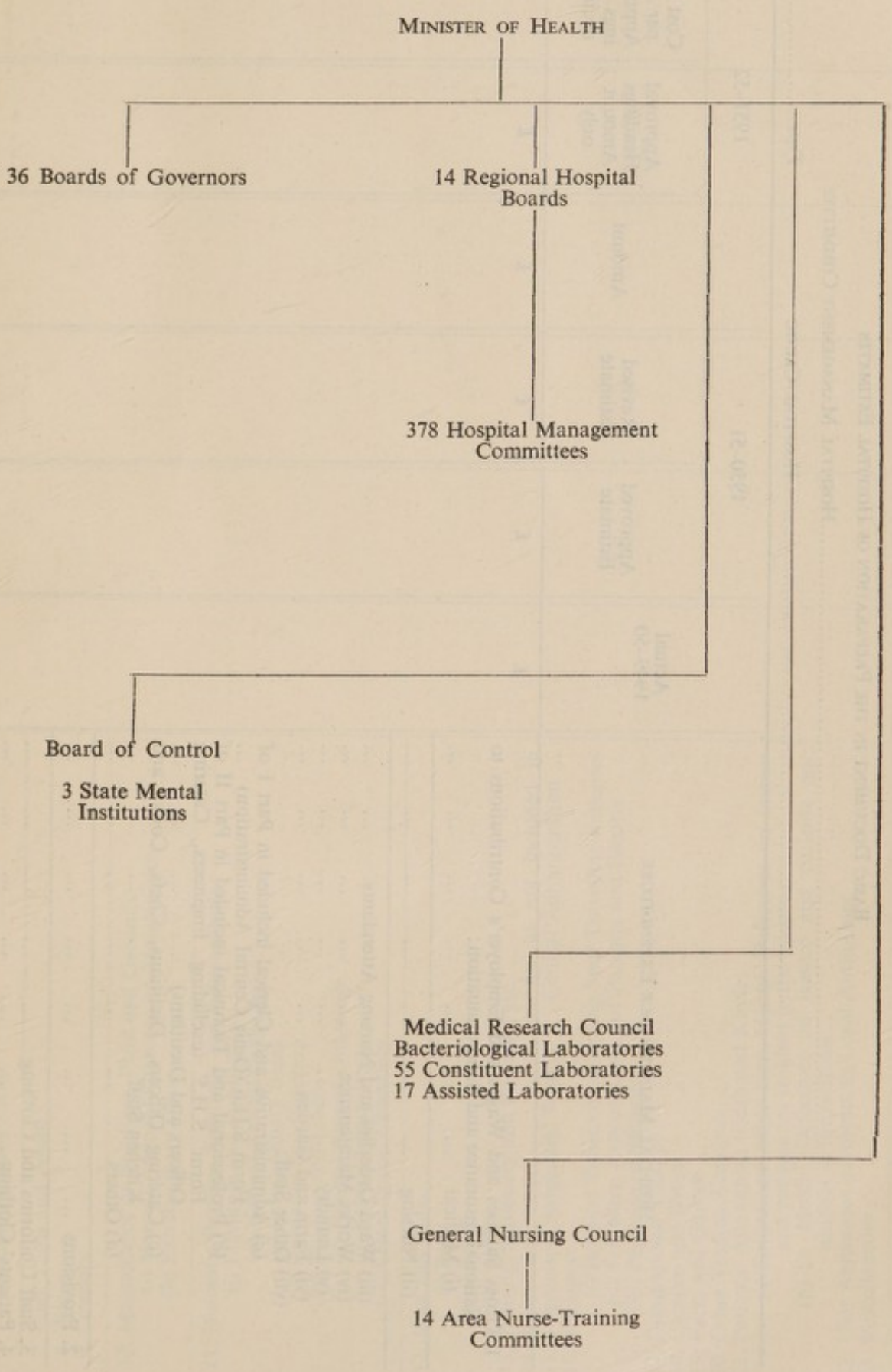

TABLE B

Basic Document in the Preparation of Hospital Estimates

.....Hospital Management Committee

.....Hospital/Clinic *Type*.....

Hospital Maintenance Expenditure	Actual 1949–50	1950–51		1951–52		
		Approved Estimate	Revised Estimate	Amount	Approval Headings Amount only	Cost per Patient per Annum on Approval Headings to nearest decimal point of £
	£	£	£	£	£	£
1. Gross Salaries and Wages and Employer's Contributions to National Insurance and Superannuation: (i) Medical						
(ii) Nursing						
(iii) Ward Orderlies and Nursing Attendants						
(iv) Works Maintenance						
(v) Laundry						
(vi) Farm and Garden						
(vii) Other Staff: (*a*) Administrative and Clerical included in Part I of Form S.H.6 (Omit Central Administration) ...						
(*b*) Professional and Technical included in Part II of Form S.H.5 (excluding Engineers, Catering Officers and Dietitians)						
(*c*) Catering Officers, Dietitians, Chefs, Cooks and Kitchen Staff						
(*d*) Others						
2. Provisions						
3. Staff Uniforms and Clothing						
4. Patients' Clothing						
5. Drugs and Dressings						

| | | |

.....HOSPITAL MANAGEMENT COMMITTEE

.....HOSPITAL/CLINIC *Type*.....

HOSPITAL MAINTENANCE EXPENDITURE	Actual 1949–50	1950–51		1951–52		
		Approved Estimate	Revised Estimate	Amount	Approval Headings Amount only	Cost per Patient per Annum on Approval Headings to nearest decimal point of £
	£	£	£	£	£	£
DIRECT CREDITS						
24. Receipts from Local Authorities under User Agreements and Receipts under Sections 18, 23 (2) and 62 of the N.H.S. Act ...						
25. Staff: Rent, Board, Lodging, Supplies and Services						
26. Occupational Therapy						
27. Canteens and Shops						
28. Farm and Gardens						
29. Other Trading Accounts						
30. Miscellaneous						
B. Total Direct Credits						
C. Hospital Expenditure *less* Direct Credits						
D. *COST*—(to nearest pound): (i) Average cost per patient per annum ... (ii) Average cost per patient per annum (excluding out-patient attendances on basis of 5 out-patient attendances = 1 in-patient day)						
E. Average number of beds occupied used in calculating "D"						

HOSPITAL INCOME								
31. From Patients—Appliances (Sect. 3 (2))								
32. From Patients—Single Rooms, etc. (Sect. 4)								
33. From Private Patients—(Sect. 5)								
(i) In-Patients								
(ii) Out-Patients								
34. Under Road Traffic Acts 1930 and 1934—(Tenth Schedule)...								
35. Miscellaneous:								
(i)								
(ii)								
(iii)								
E. Total Income								
F. Net Expenditure (Hospital Expenditure *less* Income)								

APPENDIX 2

ANALYSIS OF HOSPITAL SERVICE STAFF AT 31ST DECEMBER, 1949 AND 31ST DECEMBER, 1950

No.	Region	Medical		Dental		Professional and Technical		R.H.B. H.Q., Staff		H.M.Cs and B. of Gs. Admin. and Clerical	Maintenance and transport	Nursing and Midwifery		Domestic		Total	
		W/T	P/T	W/T	P/T	W/T	P/T	Admin. and Clerical	Others			W/T	P/T	W/T	P/T	W/T	P/T
1.	Newcastle ...	338	738	—	49	533	283	99	62	1,092	1,032	6,734	1,093	5,738	771	15,628	2,934
2.	Leeds ...	356	901	3	68	749	395	108	90	1,202	1,473	7,370	1,541	6,092	1,588	17,443	4,493
3.	Sheffield ...	475	1,006	—	48	884	414	93	114	1,630	1,703	8,173	1,866	6,729	1,687	19,801	5,021
4.	East Anglia ...	184	541	—	48	217	130	88	48	549	599	2,737	726	2,299	606	6,721	2,051
5.	N.W. Met. ...	806	1,546	5	65	1,431	384	205	84	2,013	2,465	9,351	1,322	7,393	2,381	23,753	5,698
6.	N.E. Met. ...	655	1,110	2	75	1,004	337	91	16	1,627	2,159	8,542	1,438	7,766	2,148	21,862	5,106
7.	S.E. Met. ...	558	1,367	10	88	1,094	393	104	3	1,813	1,974	9,065	1,759	8,527	2,169	23,148	5,776
8.	S.W. Met. ...	891	2,001	8	141	1,784	599	183	130	2,333	3,125	15,264	2,897	11,243	2,738	34,961	8,376
9.	Oxford ...	166	484	—	28	361	160	54	40	337	575	2,916	844	2,296	865	6,745	2,381
10.	South Western	354	1,550	2	115	840	521	92	92	760	1,542	7,529	2,193	5,188	1,663	16,399	6,042
11.	Wales ...	316	1,081	2	61	510	182	153	44	933	1,196	6,481	1,155	4,920	600	14,555	3,079
12.	Birmingham...	556	1,031	3	94	1,143	444	107	101	1,751	2,156	9,482	1,985	7,249	2,843	22,548	6,397
13.	Manchester ...	512	1,226	5	56	1,267	362	91	80	1,698	2,005	9,893	2,315	8,270	1,983	23,821	5,942
14.	Liverpool ...	366	775	2	46	636	256	112	77	948	831	5,517	1,174	5,198	1,134	13,687	3,385
	Boards of Governors	2,327	2,862	52	255	4,979	451	—	—	5,111	3,375	16,698	752	13,040	3,987	45,582	8,307
	GRAND TOTALS 31 Dec., 1949	8,860	18,219	94	1,237	17,432	5,311	1,580	981	23,797	26,210	125,752	23,058	101,948	27,163	306,654	74,988
								2,561*									
	31 Dec., 1950	9,539	21,621	133	1,299	19,046	7,063	1,445	1,414	27,505	23,648	132,408	24,977	104,064	29,465	319,202	84,925
								2,859*									

* A total figure is more reliable, as the returns are not in such a form that Administrative and Clerical staff can with any certainty be separately distinguished.

Note.—W/T = Whole time. P/T = Part time.

APPENDIX 3

CLERICAL AND ADMINISTRATIVE STAFF EMPLOYED BY THE SHEFFIELD REGIONAL HOSPITAL BOARD

Extract from Memorandum by the Sheffield Regional Hospital Board

Date	*No. of Staff*	*Cost of Staff* £	*Per cent. increase over earlier period*	
			No.	*Cost*
5th July, 1948	1,017¼	319,963		
31st December, 1949	1,515½	507,274	49	59
31st December, 1950	1,633½	554,526	8	9
31st March, 1951	1,658	563,653	2	2

The period of greatest expansion in clerical and administrative staff will be seen to be the eighteen months which followed the appointed day. Then, in terms of numbers, the staff increased from 1,017 to 1,515, representing an increase of 49 per cent., while over the same period the cost increased from £319,963 to £507,274 or 59 per cent. In the succeeding year, however, the rate of increase fell to eight per cent. in terms of numbers and nine per cent. in terms of cost: to provide a basis for comparison with the preceding eighteen months period these percentages need to be proportionately increased. During the first three months of the current year, the increases represent two per cent. in numbers and cost.

The foregoing details clearly suggest that, following a period of expansion after the appointed day, the position was reached at December, 1949, when major staff expansion had ceased and future staff increases might well be associated with the need to meet new development and additional duties imposed upon management committee staffs.

In considering the post-appointed day development, the Committee will need to have regard to the effect upon staffing occasioned by the transfer of responsibilities from hospital-owning local authorities to newly-formed management committees. In the case of hospitals previously owned by local authorities, many of the administrative and clerical services now the responsibility of the Management Committee were undertaken at the administrative headquarters of the owning authority, and that arrangement generally continued until 31st March, 1949. A less important point is related to smaller hospitals in scattered groups where posts such as telephonists, reception, etc., designated within clerical grades would, in larger hospitals, be undertaken by employees wholly engaged upon duties coming more correctly within non-clerical grades.

Upon the particular aspect of administrative and clerical establishment in its relation to mental hospitals, the Committee will have regard to the extreme paucity of nursing staff and the relative effect upon other types of staff. Certain management committees have a disproportionate number of clinics, where there is little staff other than the visiting medical officer and clerical assistants. An improvement in consultant services in hospitals has led to an increase in staff of the medical secretary type, but since the appointed day there has been a marked improvement in the information supplied by the specialist in the hospital to the general practitioner. Similarly there has been an appreciable expansion in medical records which has inevitably led to an increase in staff.

In summary, therefore, while there has undoubtedly been a marked growth in the administrative and clerical staffs of hospitals, there are directions in which the expansion is clearly attributable to an improvement in the service or to the transfer of duties which involve staffs being employed by management committees where, in the past, services were centralised in the administrative headquarters of the local authority.

MINUTES OF EVIDENCE TAKEN BEFORE SUB-COMMITTEE E

THURSDAY, 14TH DECEMBER, 1950.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. Alexander Anderson.
Mr. Diamond.
Mr. J. Enoch Powell.
Mr. Thomas Reid.
Mr. Turton.
Miss Ward.

Sir WILLIAM S. DOUGLAS, G.B.E., K.C.B., Permanent Secretary, Mr. J. M. K. HAWTON, C.B., Deputy Secretary, Mr. F. L. EDWARDS, O.B.E., Under Secretary for Finance and Accountant-General, Mr. A. J. F. DANIELLI, O.B.E., M.C., Deputy Accountant-General, and Mr. W. O. CHATTERTON, Deputy Accountant-General, Ministry of Health, called in and examined.

Chairman.

1. Gentlemen, we are very grateful to you for coming here this morning and also for letting us have this Memorandum* on the Hospital Service. I think it would be convenient, perhaps, if you would say anything you might wish to say in amplification of the Memorandum which you have sent to us, in the first place?—(Sir *William Douglas.*) I do not think I have anything to say in amplification.

2. Then may I first of all ask you this? The most important question which I think arises out of what you have told us here is how in fact you arrive at the figure which is shown in the Estimate as the total expenditure on this Service. Perhaps I should put it in this way. The total figure, I think, is somewhere of the order of £260 millions in the current Estimate. Is that a total figure which is decided by your Department and then divided between the hospitals, or is it a figure which is arrived at by ascertaining what the Hospitals need and adding it up?—Yes, Sir, it is worked out from below upwards. Perhaps I might ask Mr. Edwards to amplify that. (Mr. *Edwards.*) It is built up in detail from estimates submitted by each individual hospital authority in respect of every single hospital establishment, and so aggregated to a total which then, of course, has to be examined in its weight in relation to other budgetary expenditure.

Mr. *Thomas Reid.*

3. Do you place any ceiling on the total?—In this particular year there certainly was a ceiling imposed by Government decision.

Chairman.

4. Is that a hard and fast ceiling, because, if there be such a ceiling, in effect the total is arrived at by decision at the top and not by adding up the details?—(Sir *William Douglas.*) I should perhaps explain that the estimate was gathered in in the way that Mr. Edwards was explaining, and then, when the total was arrived at in the way that he has explained, it was at that stage that a ceiling was imposed.

Mr. *Thomas Reid.*

5. And then what happens? Supposing that the total of all the items coming in to you is £350 millions and you want to push it down to £260 millions, how do you wield the axe then?—There again it is a complicated matter of doing rough justice as far as we can. Each of the original estimates will have to suffer a proportionate cut in the first instance.

Mr. *Diamond.*

6. Proportionate?—Yes. But then, of course, that has to be weighted. As the Accountant-General's officers go through the detail they may come to the conclusion that one estimate has slightly more possibility of being cut than another estimate, so that in the final result it is not exactly necessarily a proportionate reduction all the way round.

Mr. *Turton.*

7. Your ceiling is a national ceiling and not a regional ceiling?—Yes, a national ceiling.

8. There is no attempt to make it a regional ceiling at first?—No. The first thing is a national ceiling.

Chairman.

9. Could you tell us the total of the first estimate you received in respect of the current year?—I do not know whether we have that.

Mr. *Thomas Reid.*

10. Is it in excess of the ceiling?—Yes.

* See Appendix I to the Report.

11. Greatly in excess?—The imposition of the ceiling had the effect of imposing a cut upon the estimate.

Chairman.

12. You could not give us the kind of figure, I suppose, without being precise?—It was not very great. It really worked out in this way, that it stabilised the estimate so that there would be no possibility of a suplementary estimate on the top of it. The effect of the ceiling, in other words, was to say, "Thus far and no further."

13. I fully accept the fact that you lay down a definite ceiling. I think what the Sub-Committe is anxious to know is how in fact this ceiling is imposed when you have already received estimates in excess of that ceiling?—I was explaining, in amplification, that the estimates received were not, on correction, in excess of the amount put down. If the figure that we received was £250 millions—I take that just as an example—that was the figure in regard to which the Government or the Treasury said to us, "That is your ceiling." It happened to be the same amount.

Miss Ward.

14. In other words, the actual ceiling was fixed, or agreement was arrived at with the Treasury, after the estimates had been received?—After the estimates were there and the figures were there.

Mr. *Diamond.*

15. And after the estimates had been carefully looked at in the first place?—Yes.

16. And would I be right in saying, therefore, that the estimates were walls which were built up carefully, brick by brick, and then the ceiling was placed on the top of those walls at that height?—Honesty compels me to say that the carefulness of the building up of the bricks, of course, is a relative term, in those early days; they were built as carefully as possible.

Mr. *Thomas Reid.*

17. Before the estimates are sent would it be right to say that your Ministry has sent instructions to all the people concerned to be as economical as possible and to try to keep the estimates within last year's, or something like that? Have circulars been sent out?—To be as economical as possible, certainly.

18. And nothing more definite?—We are dealing with the very early days, where we have no precedents to guide us, therefore it would have been rather unreal to go back to a previous year.

19. You have nothing in your circular more definite than to be as economic as possible? Or have you anything to indicate what services must wait till finances are better?—It is a general injunction to be economical. It is for the Regional Boards then to make up their minds how they will guide the Management Committees, and how the Management Committees will put up their figures, according to their demands, but there is no suggestion from the Ministry at the centre that certain services, for example, should be more strictly dealt with than others.

20. Supposing, then, one of these Management Committees or Boards put forward a scheme for clinics, a part of the scheme not yet implemented. Are they forbidden by you at the present time to put up estimates for clinics?—When we saw the estimates, if they had a lot of money down for new clinics which involved building, we should be able to say to them, "we are very sorry, but the general circumstances are such that it would not be a realistic figure to put in the estimates at all—not because we do not approve of them but because we see no probabilty that they will be able to be built in the year in which the estimate is made."

Chairman.

21. You are dealing exclusively, I think, with the Regional Boards in this connection?—Yes.

22. Disregarding the teaching hospitals in the meantime?—Regional Boards and Boards of Governors.

23. You are not considering the individual estimates of the Hospital Management Committees?—Yes, our dealings are with the Regional Hospital Boards or the Boards of Governors, but, in the case of the Regional Hospital Boards, we expect them to have obtained detailed estimates from each one of the Management Committees, and the Regional Board send to us all those estimates which they have received and vetted from the Management Committees, together with their own budget.

24. It is not a composite estimate?—No, Sir, it is the whole thing.

25. It is a series of estimates put together?—Yes, and then they become known as the estimate for that Region.

26. If you are going to impose a limit on the total which is submitted to you, do you tell the Regional Board that you limit their total either under one heading or over all, or do you tell them that you think particular items of that total should be looked at?—The way it happened this

14 *December*, 1950.] Sir WILLIAM S. DOUGLAS, G.B.E., K.C.B., Mr. J. M. K. HAWTON, C.B., Mr. F. L. EDWARDS, O.B.E., Mr. A. J. F. DANIELLI, O.B.E., M.C., and Mr. W. O. CHATTERTON. [*Continued.*

time was that the hospitals and the Regional Hospital Boards had freedom to put up what they thought the necessities of the case demanded, and those things came to a total. When they were summarised for each of the fourteen Regions they were brought then into a central account, and at that stage they were put to the Treasury, and the Treasury said, "Well, we will give a sort of provisional approval to that amount but there can be no more additions to those figures, so we did not have from the centre to impose in a preliminary way any restrictions either on the Boards or on the Management Committees. It might be different in the future when we had to do something else, but that is how it happened this last time.

27. By the last time you mean Autumn 1949?—Yes.

28. Since then, of course, you have had further estimates submitted?—Just coming in now.

29. Would it be premature to ask you how you are going to tackle that?—We are going to do the same thing exactly: we are going to assure ourselves, by a study of each of the Management Committee's estimates, and also of the Board's report on those estimates, that they have been carefully vetted—if I may use that expression—and then, having got them all, we shall summarise them (we are just in the middle of doing this) and the Accountant-General will prepare a global statement which he will submit, through me, to the Minister, and at that point they will then go across formally to the Treasury.

Mr. *Thomas Reid.*

30. And you have issued instructions that there are to be no supplementary demands? —We have issued instructions in connection with the current year that there are to be no supplementary estimates.

31. Might I ask, in that connection, if at the end of this financial year there is likely to be a supplementary demand for £100 million or anything like that?—I do not think we are in a position to say that yet.

Mr. *Turton.*

32. Going back to this current year, 1951-52, as yet you have devised no national ceiling for expenditure?—No, Sir.

33. Is it likely that the same system will be adopted this year as last year, that when the bricks have been built up by the Hospital Management Committees and Boards, you then put the ceiling on their structure? —I do not know, Sir; it is in the realms of prophecy.

34. That is the Minister's decision?—A Government decision, with the Treasury acting for the Government.

Chairman.

35. What you are saying is this: that the high policy decision taken by the Government on what the grand total shall be is only taken after you have submitted what you think is a proper estimate for all the hospitals?—Exactly. It might show that the estimate for next year was less than it had been.

Mr. *Turton*

36. And there might still be a necessity for a ceiling?—The whole thing is hypothetical, and therefore, as you say, the question of a ceiling or a restriction is not gone into until the facts are there, and the facts will be presented, as I said, before the end of the year, probably.

Chairman.

37. And last year, whether by coincidence or design, the Treasury ceiling was somewhere about the same as the total of your estimates?—That is so.

38. You were working to a ceiling when you prepared those estimates at all?—No.

39. And you do not intend to work to a ceiling in preparing this year's estimates, though you may have one imposed upon you?—Exactly.

Mr. *Thomas Reid.*

40. Is not it a fact that the Hospital Boards, naturally anxious to give a good service and finding endless needs for expenditure, are inclined to make big demands on you?—Yes, because of the services, I can see that, but did you mean excessive demands or big demands?

41. I do not know what is the difference? —Big in size. I will say, quite frankly, yes.

42. I have been around some of these hospitals in my constituency and they tell me that they want all sorts of things, but they are getting them gradually, and they would like you to give them more money, and so on. Have they grasped the idea that, in view of the enormous expenditure, they really must wait, and that they cannot get the millennium in ten minutes? What is their attitude? —It is most co-operative. I myself have written personally to every Chairman or every Regional Board and every Chairman of every Teaching Hospital, and I have had replies from every one, saying unanimously that they accepted the position; and, so far as we can see, they have, in the carrying out of their work since then, been animated by a desire to give service but to give it economically.

Chairman.

43. It might be convenient at this moment to ask you this question, which I think needs a little elaboration. There are certain matters which are within the control of the Ministry of Health, and there are certain matters which are outside direct control, at all events. The number of people employed in the Health Service is within the direct control of your Minister, is it not?—No, Sir. The hospitals would be able to take on nurses as they wanted to man the beds that they have got. Regional Boards—taking examples—would be and are able to appoint doctors, specialists, if you like, of particular hospitals as they think the service demands.

44. I have not made my question clear; I am so sorry. That is so under the present policy of the Minister, but it lies within his power to set a limit on the numbers employed?—Yes, certainly, we could do that.

45. If you chose to do so?—Certainly.

46. And he probably has given certain directions in that connection?—In connection with registrars, yes.

47. That is one which jumps to the mind. So that, if he chooses to use it, he has control of the numbers employed?—Yes.

48. But now, when it comes to rates of remuneration of those employed, he has not that same possibility of control—is that right?—Yes, Sir, those questions of remuneration are dealt with, as you know, by Whitley Councils, consisting of two sides, the staff side and the management side. The Ministry is fairly strongly represented on the management side, and therefore in that way the Ministry not only is aware of what is going on but is able to state its views, and may on occasion be able to carry its views. There is a control in that way.

49. But that is a matter of negotiation?—Yes.

50. And requires agreement on the part of those who are not directly controlled by the Ministry?—Yes.

51. To that extent it is outside his direct control?—Certainly.

52. Can you tell us in broad terms how far the total expenditure involved on the hospitals is within the direct control or outside the direct control of the Minister?—We reckon that, as a rough figure, 60 per cent. of the costs of the hospitals is in the form of remuneration to the staff, staff costs in one way or another.

Mr. *J. Enoch Powell.*

53. But that does not mean that there is 60 per cent. of costs that you do not control, since, in so far as you control the number of staff, you control that 60 per cent.?—To that extent.

Chairman.

54. That, I think, leads to the next general question About half-way down the first paragraph of your Memorandum you say this: "With the Minister, and in collaboration with the Board of Governors, they"—I think that is the Regional Hospital Boards—"plan and administer a co-ordinated hospital and specialist service for their respective regions". Now, that is saying that the three sets of bodies together plan how this control is to be exercised. Can you say what in fact happens to create this plan, what sort of meetings there are, who meets whom, and how often?—May I make the preliminary observation that this sentence is dealing largely with the actual services and not with the administration of the services, that is to say, the collaboration between the Boards of Governors and the Minister here. We are talking about the size, for example, of the consultants' team in a particular region. Of course, the teaching hospitals have to have a say with regard to teaching facilities offered. But, if you take your question more widely, then I could show that there are meetings at I think every possible level. I myself meet the Chairmen of the Regional Hospital Boards regularly; from time to time I meet the Chairmen of the Boards of Governors. The Medical Officers of the Boards and of the Teaching Hospitals meet with our Medical Officers. The Finance Officers meet with our Finance Officers. The Secretaries meet with our administrators. At every layer there is constant contact. In addition to that, we have Regional Officers who are out and about and who sit in at all important deliberations even of the Management Committees, especially where finance matters are being considered.

55. And it is at those meetings that the broadest questions of policy are considered—is that right?—Naturally at the Chairmen's meetings the broader questions of policy are considered, and then those filter down into the practical transactions in the other meetings.

Miss *Ward.*

56. And is it through those meetings that you keep each Region in step?—On general policy issues.

57. Because, looking at your previous remarks on expenditure and the way it comes up to the Ministry, one Region could in fact have a much more expensive and elaborate development of its scheme than another Region, because one Region might

take a different point of view with regard to economy from some other Region?—That is so.

58. And it is through those meetings that you keep the general picture moving in a common direction?—Yes.

Mr. *Turton.*

59. Is there any difference between those arrangements for dealing with your hospital specialist staff and the arrangements for considering expenditure on the administrative staff? I ask that because in paragraph 2 you say: "The Boards and Committees appoint their own administrative staffs, who are not civil servants." Does that sentence mean that there is less control over the administration and the administrative staff than there is over the hospital and specialist staff?—No, Sir, it was natural when the scheme was starting up—and it is very young yet—that these hospitals and Hospital Boards should be given a fair amount of freedom to build up their teams as they wanted to. Then the Whitehall machine gradually begins to accumulate facts and information about the build-up of administrative teams, and of medical teams, and then the ordinary processes, as we have been explaining, begin to apply, and we begin to look at differences between one place and another, and gradually exercise a control, but there is no difference in kind between the control of one type of staff and the other.

Chairman.

60. So that you are really saying that, to begin with, the ordinary form of Whitehall control was not possible because you had nothing to go on?—That is so. We had to take over a system which was already running, and it had to grow up.

Mr. *J. Enoch Powell.*

61. So that, referring to your paragraph 16, you would expect that as time goes on the administrative specification of numbers and types will extend downwards from the principal officers, to whom it is limited at present, to cover the four grades, (*a*), (*b*), (*c*) and (*d*), or part of them?—To an extent, Sir, except that I should hope it will never get so stereotyped that anyone can say the hospitals are being run from Whitehall.

62. But it is your aim to bring some regularity and some common form into the establishments right the way down?—So far as it can be achieved.

Chairman.

63. It might be convenient here to ask you this, parenthetically. At the bottom of paragraph 1 you have mentioned the totals of staff employed—a staff of some 300,000 whole-time and 60,000 part-time. In paragraph 16 you give in general terms the possibility of breaking that up, but I do not think that anywhere one can learn how those figures are broken up. Would it be possible for you to obtain those figures, to show how this staff is broken up as between the specialists, nurses, administrative staff and so on, sub-dividing, as far as you can, so as to give us a picture of what the health army consists of?—Yes, Sir, we shall be very happy to do that.

64. I do not think it is fair to ask you to do that here and now, because it must involve a lot of figures, but if you could let us have that I think it would be of great convenience to the Sub-Committee?—Yes.

Mr. *J. Enoch Powell.*

65. And could that be made to include the staff of the Boards, because I think the actual figures to which you referred are for the hospitals, etc., themselves, and exclude the staff of the Boards and Committees?—There will be no difficulty about that; the figures are there. It is just a question of putting them into the statement.

Chairman.

66. If we could have complete figures for the Hospital Service, the Boards and the Teaching Hospitals and the Hospital Committees, it would be very helpful, and we might want to ask you some questions perhaps in the light of the information just to clear up points?—Certainly.

Miss *Ward.*

67. I suppose it would not be possible to do it by Regions, and the number of beds available in each Region?—Yes, I think our statement would normally be submitted by Regions, because our service is so naturally carried out through Regions that it is better to do it that way.

Chairman.

68. Could you deal with it by Regions and at the same time give us, as a yardstick, possibly the total number or beds?—Yes.

69. I do not know that it is a very good yardstick, but if you could somehow try to indicate the relative sizes of hospitals it would help?—It is very difficult to get a yardstick—beds, population or what? We can give you beds, possibly outpatients' attendances, or some figure like that, if it would help you.

70. Could you put in perhaps more than one yardstick?—We will see what we can do.

Mr. *Thomas Reid.*

71. Talking about that yardstick, is not it a fact that you are short of a large number of nurses still?—Yes, Sir, we are. We should like more nurses.

72. Supposing they are able to find the nurses, it will mean that your estimates will go up very considerably, if all the hospitals are properly staffed, with a sufficient number of beds and nurses. Would you still keep a ceiling then, or what would you do? —The estimates are estimates in the sense that each Hospital Group, in preparing its estimates, has to make its case as to how far it thinks it will proceed in the period of its estimate in the way of staffing more beds, and therefore it makes the best possible guess it can of the numbers of extra nurses it is likely to get.

73. During the year?—Yes.

74. But if they go on increasing the number of nurses, your estimates are bound to go up?—Yes.

75. And therefore the ceiling is anything but fixed?—That is so.

Mr. *Diamond.*

76. With regard to paragraph 6, "Measures of Central Control", you mention, in (*a*), "Submission by each hospital authority of an annual estimate, with a revised estimate in the Autumn". Could we be told when that first estimate was submitted?—The first estimate is submitted by this time of the year; it was due on November 15th.

Chairman.

77. That is from the Regional Board?—Yes, and at the same time they give us their revised estimate for the year which is just on the point of elapsing, the current year, in fact.

Mr. *Diamond.*

78. Half way through the current year expenditure has been incurred——?—and they can see how they are going and what the estimate is likely to be.

Mr. *Thomas Reid.*

79. In drawing up these estimates I think you state somewhere that you have your own auditors or accountants and they have power not merely to check the accuracy of accounts but to question any extravagance or anything like that—is that so?—Yes, Sir, those are audits after the event. They are not concerned, as accountants, in the preparation of the estimates in any sense—I would like to make that clear—but once the expenditure is running the auditors are in and about the hospitals and looking at all items of the expenditure.

80. Who are these auditors?—They are an *ad hoc* body employed by the Ministry. Many of them have been recruited from the ranks of our district auditors, who go round examining the accounts of local authorities.

81. What sort of status have they? They are not chartered accountants or anything like that?—They are not chartered accountants. They have mostly, I think, got professional qualifications as auditors. Some of them have their own examinations.

Miss *Ward.*

82. What qualifications have they for commenting on hospital expenditure in so far as the efficiency of the hospital is concerned, both from the medical and administrative point of view?—I do not think that they are qualified to speak about the efficiency of the hospital. What they can do is to direct attention to certain items in the accounts which would seem to them to require some explanation. That is how they get at what they think is extravagant.

Mr. *Diamond.*

83. We are, of course, referring to the third sentence in paragraph 19, where it says, "The audit is a current one, visits being made by the auditors three or four times a year or even more frequently according to the size and type of authority. At each visit the audit includes verification of cash balances and test checks of stores balances. The audit is not restricted to accountancy and the auditor may question the reasonableness or propriety of expenditure". Do I gather that that sentence was intended to give us the view that it is not the normal restricted audit of a normal professional auditor but that the auditor is able to enquire beyond the normal professional limits?—(Mr. *Edwards.*) The auditor is not limited to vouching the expenditure; he is certainly empowered to examine the reasonableness of the expenditure.

Miss *Ward.*

84. Yes, but the reasonableness from the point of view of the hospitals or the reasonableness from the point of view of pure accountancy? The view of the nursing staff as to what is essential and helpful to good and proper nursing might differ very considerably from what the accountants might think is the proper expenditure on good and efficient nursing?—(Sir *William Douglas.*) If the expenditure on a certain service in a hospital from which the auditor had just come was, for example, £5,000, and, in the hospital he is examining, the same service costs £10,000, he asks himself and he asks the people in the hospital what is the explanation of it. That is how he questions the reasonableness of the expenditure.

Chairman.

85. What does he do with the information he gets?—He reports to the Minister.

86. Direct to the Minister?—Yes, those items which he thinks in his own professional capacity he ought to report. I daresay he can satisfy himself with many things on the spot.

Miss *Ward.*

87. What sort of salaries do these officers carry?—They go up to £1,200 a year.

Mr. *Diamond.*

88. They are not in fact your District Auditors?—No, they are a separate Hospital Audit Service, specially created for the purpose of going round the hospitals.

89. But they are largely recruited from District Auditors?—Many of them were recruited from that Service.

90. And they carry out their functions very much on the lines of a district audit?—Yes, and as the years go on they will acquire a certain expertise of a highly specialised kind.

Mr *J. Enoch Powell.*

91. So that the criteria of reasonableness they are applying in the hospitals are much the same as they would apply in examining the expenditure of a local authority?—I think it is fair to say that.

Mr. *Turton.*

92. If new equipment is required that is outside the annual budget, is authority for that new equipment given by these visiting auditors?—No, they are merely auditors. If the hospital wants new equipment the first question is: was it estimated for? If it was in the estimate, they go ahead. If it was not in the estimate, they would then have to explain the position to the Regional Hospital Board and see what they thought about it, and it comes to the Ministry.

93. Is there a limit, like one had under the Army Act, so that the Hospital Board can vouch for new equipment up to a certain amount without going for Ministerial approval?—I think on equipment as such there is no specific figure, but if it comes to capital expenditure on new buildings, then that is a different matter. We like to know all about that ourselves up at headquarters, because we ourselves have only a certain amount of capital expenditure for the whole service.

94. I was speaking specifically of equipment as opposed to buildings. If a new machine were wanted, for instance, what would be the procedure?—If it were an expensive piece of X-ray equipment, for example, that ought to be in the estimates, and I think it would require a good deal of persuasion before it could be bought in the middle of a period like that, when we are estimating so tightly. But X-ray equipment is supplied centrally, because we buy centrally.

Mr. *Thomas Reid.*

95. Have you laid down any standards of equipment for these hospitals?—No, Sir.

Mr. *Turton.*

96. But if it is a matter of small expenditure do they have to go through the same procedure of getting Ministerial approval, if it is outside the estimate?—If it is outside the estimate at all, yes We held them so tightly this year that they would have had to go to the Regional Board, and they might have had it authorised, but I should have thought generally in this year we are talking about it must have been extremely difficult for them to get it, if it was of any substance.

Chairman.

97. If it was not of substance it would be in the ordinary way within the bulk estimate?—Within the estimate of the Hospital Committee, which will have got in its estimate £*x* for equipment or miscellaneous expenditure.

Mr. *Diamond.*

98. But not an individual item, with each individual small item specified?—No.

Chairman.

99. It would be automatically covered and would only come outside the estimate if the total were exceeded?—Yes.

100. If the total were exceeded well before the end of the year would they come and ask you for a specific supplementary estimate?—They would have had to do that, yes, and in some cases I think in fact they did come.

101-4. Last year, when there was a very heavy supplementary estimate, that is what happened?—Yes.

Mr. *Diamond.*

105. In paragraph 15 reference is made to the difficulty of fitting these budgets into the Parliamentary system of Estimates, and one of the main reasons given is " the fact that the accounts and estimates are on the basis of income and expenditure and these have, for the purposes of the Ministry's Vote, to be translated into cash requirements." Have you sufficient

experience to indicate whether there is any real substantial difference between income, expenditure, receipts and payments as you have seen it so far?—(Mr. *Edwards.*) Certainly there are differences. On the question of Whitley awards, the arrears may be set up as liabilities in the preceding year, and then a mere summation of the income and expenditure budget for the next year will not show us our total requirements. We are having to make special requests to all the Boards for any indication of differences in cash requirements from the total of their income and expenditure budgets.

106. So that they are not going to give you in fact a receipts and payments budget but to indicate any major differences that there would be in the income and expenditure account?—Yes, that is so.

Mr. *Turton.*

107. Do you find that their income estimates tend to be accurate? Take item 32, for example, "From Patients—Single Rooms, etc.". They give an estimate of what patients are going to spend next year on that. Do you find that varies very much in the revised estimates for next year?—They are reasonably accurate.

Chairman.

108. There are two small questions I would like to ask you in order to clear up points in your Memorandum. First of all, in paragraph 3 (*a*) you deal with the income from the endowments fund. I do not think that the amount of that income is anywhere available; I do not think it appears in the estimates, and you do not give it here. Could you let us have a note of that?—(Sir *William Douglas.*) Yes. It is about £600,000. We will certainly let you have a note.

Mr. *Turton.*] Could you also give us a note on (*a*), (*b*), (*c*) and (*d*), the four items of income, so that we can see exactly how far it goes?

Chairman.

109. I think (*b*), (*c*) and (*d*) are included as grants in aid in the Estimates?—Yes.

110. Of course, it is only given in totals, and (*a*) is not shown in the grant-in-aid?—(Mr. *Edwards.*) It is shown in a separate publication of the Endowment Fund, under Section 56 of the Act.

Mr. *Turton.*

111. And (*b*), (*c*) and (*d*) only come in together as one total?—Yes.

Chairman.

112. If you could conveniently show us the break-up of that we should be very grateful?—(Sir *William Douglas.*) Yes.

113. Then there is one small point which needs amplification, at the bottom of page 3, under the heading "Estimates of the Hospital Authorities", where you say: "In both cases the forms include a separate and detailed estimate of the cost of central administration of the hospital authority". Could you say what you mean by "central" in that connection?—(Mr. *Edwards.*) To take the example of the Hospital Management Committee, which is controlling a group of hospitals and has an office for the purpose, the administrative expenditure is the expenditure of that central office. If the Hospital Management Committee consists simply of an organisation for running one hospital, that administrative expenditure will be included in the hospital expenditure and not shown separately. We have not asked for apportionments in cases of that kind.

114. The normal arrangement would be a group of hospitals so that in effect when you speak of administrative expenses in this connection you tend to refer merely to the administrative expenses required to run the group as a whole?—Yes.

115. And the administrative expenses, which may be very considerable in individual units of the group, are not included. Are figures available to distinguish those administrative expenses?—No, Sir, because it is so difficult to know where administration begins and ends and where medical organisation begins and ends. The officers at the individual hospitals are doctors, nurses and so forth; they are not primarily administrators. The administrators are in the Group office, away from the hospital, and that is the administrative expenditure which we show separately.

Miss *Ward.*

116. Is not that provided for in 1 (vii) under "Other Staff"?—No, this estimate is the estimate of the cost of a particular hospital; it is the basic document from each hospital. Then they are all summarised into the estimates of the Hospital Management Group, and it is there that you get shown the separate administrative salaries of that group.

Mr *J. Enoch Powell.*

117. And it would be possible to take out 1 (vii) (*a*) both for regional and national?—(Sir *William Douglas.*) It would entail very onerous work, but it could be done.

Chairman.

118. Would that be a very onerous task, to arrive at that figure? You have a total of between 300 and 400?—I am told it means going through something like 3,000

individual forms, that is really the difficulty, and picking those things out and then summarising them.

Mr *J. Enoch Powell.*

119. Could it be done for one Region conveniently?—It could be done, but the Accountants are rather afraid it might not be illuminating, and there is a great danger of drawing false conclusions from it, because of the curious mixture in an individual hospital as to what is pure administration and what is carrying out a service.

Mr. *Diamond.*

120. What value would you place on such a figure if it were prepared as a guide in the true costing sense of administration versus the rest?—Not very much value, I gather.

Miss *Ward.*

121. Where you have a matron who is the chief matron over the other matrons for a hospital group, does she rank as an administrative person in that sense?—No, we are talking here about secretaries and assistant secretaries and clerks, but not a matron.

122. Take a catering officer for a group. Is that post administrative?—No, we use it in a very restrictive way.

123. Purely clerical?—The office work. It is not exactly clerical; it may be executive work, dealing with accounts, or it may be doing minutes for the group as a whole, and that sort of thing.

Chairman.

124. Does an individual specialist's secretary fall under 1 (vii) (*a*)?—That would be shown in the Hospital estimate.

125. Where would it be shown?—(Mr. *Edwards.*) Under 1 (vii) (*a*).

126. So that in fact 1 (vii) (*a*) does cover all the purely clerical work in the hospital?—In the individual hospital, yes.

127. I wonder whether you could consider getting a composite figure for a region? We quite understand that we must not be misled, that the figure may require a great deal of explanation, but all the same, I think it would be a convenience?—(Sir *William Douglas.*) Very well, Sir; we will look at it for a Region and see what we can do.

128. We do not want to put you to a lot of trouble. That leads me to the next major question I was going to put to you: How far do you find that the Regions as a whole vary as between themselves? We are anxious to enquire into the working of the Regions and we would like to know what sort of uniformity there is, so as to give us some idea whether it is necessary to make a protracted enquiry into several regions or not?—First of all, might I say that we are not particularly striving after uniformity. We are striving after a good service and good administration, and good economical administration. But the essence of the administrative problem as we see it is to leave individual freedom as far as possible to the Management Committees and to allow regional organisations to work out their own solutions to their own problems. That is the basic conception which we are trying to work out, and we are trying to do that and at the same time get a certain control from the Ministry, in other words, we are trying to harmonise authority and liberty, and therefore the answer to your question is that there are variations as between the different Regions; there are variations because the personalities are different, not only of the Chairman but of the senior officers, and because the personnel in the Groups and in the Management Committees are different; therefore there are variations but we hope gradually to get them all working on the same general basis as regards efficiency and economy, and they may translate that in their own way into the services they are giving to the people.

129. Do you think, then, variations are based more on geography or on personality?—A bit of both, Sir.

130. And they would be quite considerable?—I would not like to exaggerate it, but there are differences. I do not think they would be considerable.

Mr. *Thomas Reid.*

131. And you do not think any practical result would come from comparing the cost per patient of the individual in the different groups?—Yes, I think that as we gradually acquire a technique in this matter we shall be able to get more closely at variations in costs as between one Region and another. It is still possible to get a fair degree of uniformity of expenditure on costs and still have a lack of uniformity as regards the service rendered.

132. So comparison would be useful if you were striving for economy?—That is the object of our looking at those Regional Board estimates very closely. We compare not only the content of the estimate, but we compare one Board with another, and that enables us to ask questions.

133. That is what you are referring to in the middle of paragraph 16, really, where you say: "In addition, a review of establishments has now begun by local examination by expert teams dealing in the first instance with the following several fields", and then you enumerate them?—Yes.

134. I wonder if you could tell us just what is happening there, for this reason: that we shall wish to make some enquiries of the Regions and we do not want to cut across the work you are doing ; on the other hand, it may be that what you are doing would facilitate our work and make less trouble on the whole. Could you tell us what Regions have been examined now?—It is a roving commission, going round all Regions. We are not just making a spot check ; we are going into every Region.

Miss *Ward.*

135. And they are all done more or less at the same time, one after the other, are they?—Yes, just as we get the teams started.

Mr. *Thomas Reid.*

136. Who are the expert teams, and what are their qualifications?—Where we are looking at, for example, the establishment of registrars, then the Chief Medical Officer has gathered together a team of distinguished doctors who themselves are specialists, or have been specialists, and who are therefore very knowledgeable on all those professional questions. When it comes, however, to pure administration, then we have our own Organisation and Methods people, and our own administrative staff, who are dealing with that ; and similarly, for nurses we have our own nursing staff dealing with the matter.

Mr. *Turton.*

137. You will have for each Region your cost per patient per annum, I suppose?—(Mr. *Edwards.*) In respect of the financial year which is nearly completed, we are having for the first time a costing return, which is an attempt to arrive on a scientific basis at a yardstick by which to compare hospital with hospital. It takes account of the vacant bed factor, which is so important in these assessments and makes such a difference. It has to take account of the various ratios of out-patients in relation to in-patients, and that is the first step in a true scientific costing of all the hospital beds of the country. Those returns have been discussed and agreed with representatives of the accounting people, they have gone out, and the first return is in respect of the year ending next March, and we shall not have those before about next August. Then, over and above that—it is a general cost per bed—these two bodies who are mentioned, the King Edward Fund and the Nuffield Trust, are going into a much more difficult and detailed costing question, costing per unit, which involves much heavier administrative expenses to secure a return, and raises also very difficult accounting questions, but at the moment that is in embryo ; we have not yet received their report.

Chairman.

138. That is the King Edward Fund and the Nuffield Trust?—Yes.

139. The question arises whether it might be useful for this Sub-Committee perhaps to see whether they could give us some useful information, if you could tell us——?—(Sir *William Douglas.*) It is very early yet. I think they have only just started, so at this particular moment there would be very little of value that they could do.

140. Do you know when they did start?—(Mr. *Chatterton.*) These two bodies are proposing to carry out costing enquiries in respect of the next financial year, 1951-52. At the moment they are doing preliminary investigations to see what adaptations of the present accounting arrangements are necessary in particular hospitals, so that next year they can put their schemes into force, so it is rather early days to expect them to have any views.

Mr. *Diamond.*

141. Just a preliminary investigation?—Yes.

Mr. *Turton.*

142. Going back to the first one, although you will not have any concrete stabilised figures to give us until August next, presumably you have certain figures already available to show from a scrutiny of this Appendix B the estimated cost per patient in each Region?—(Mr. *Edwards.*) Certainly we worked out the cost per bed.

143. Would it be difficult to give us that information? It might give us a general over-all picture if we had that?—It is very important to distinguish the type of bed.

144. I can see that. Until August you really cannot give anything that is of real value, but you can give an indication, surely, by your preliminary figures that you have?—Certainly we could give it but it would have to be coupled with many warnings about the dangers of interpretation.

Chairman.

145. I can assure you of this: that if you give us any information we should wish to ask you further questions about it, and you would then be able to give us any explanations?—If you please.

Mr. *Diamond.*

146. As this vacant bed factor is of vital importance, I wondered whether you have attempted to get any information on that, as to the variations in that factor between different types of hospital, or anything which would enable us to look more intelligently at this information which has just been requested?—(Sir *William Douglas.*) We have nothing very detailed on that.

14 *December*, 1950.] Sir WILLIAM S. DOUGLAS, G.B.E., K.C.B., Mr. J. M. K. HAWTON, C.B., Mr. F. L. EDWARDS, O.B.E., Mr. A. J. F. DANIELLI, O.B.E., M.C., and Mr. W. O. CHATTERTON. [*Continued.*

147. Or whether any information is sent out by your Ministry to hospitals to enable them to reduce this factor in appropriate cases; whether you look at it as something which is such a fundamental part of the cost that you would regard it as within your province to give assistance or advice as to how that factor could be reduced?—Not for the purpose of these estimates. We are really waiting until we have had some experience of the proper costing returns.

Chairman.

148. The two bodies referred to are not directly considering the vacant bed factor?—(Mr. *Edwards.*) No, Sir, they of course are concerned with unit costing. That goes into many more complications—costs in an X-ray department, and so on.

149. Could you say precisely what you mean by "unit" in that context?—Firstly, cost of running the X-ray department in a hospital, etc.

150. It is "unit" in that sense?—Units of service of many different kinds. (Sir *William Douglas.*) Perhaps I should just interject the general observation at this point that this costing has had to come along rather gradually. The first task we had was to get the hospitals running and to provide a service, and then to get rough controls, and we are gradually advancing into the costing field to see what the possibilities of it are, and in that connection you must remember that we took over hospitals at all states. Some hospitals had no accounts at all except the stubs of a cheque book, and therefore to advance straight away from that primitive civilisation to the more complex civilisation of full costings is quite a jump.

Chairman.] I think that is appreciated, Sir William. Has any member any detailed question to raise on this Memorandum, just to clarify it?

Mr. *Diamond.*

151. In paragraph 16 it says: "The numbers and types of principal officers needed by Boards or Committees have been laid down administratively by the Minister from the outset." Could I be told of just one or two types and whether this laying down has been laying down the maximum or the minimum number?—That is the type of officer. What we have said is that the Regional Boards should have a treasurer, a senior administrative medical officer, an architect—if they wanted one. In the early days the Boards wanted general guidance as to what sort of services they should set up. They had various views, from two men and a boy to an elaborate organisation with 300 or 400 people, and we had to give general guidance as to the types of officers they would need.

152. It does say, "The numbers and types of principal officers needed by Boards or Committees have been laid down administratively"?—One chief medical officer, one senior administrative medical officer, one treasurer, two accountants and whatever it might be, varying according to the size of the Region.

153. Does that mean, therefore, that Boards which did not think they required the assistance of a certain type of officer had that answer imposed on them?—No.

Chairman.

154. It was a mere recommendation?—A sort of guidance as to the type of officers that we thought they required.

155. And that is not only Boards but also Management Committees, I think you said?—Yes, that is the same thing.

Mr. *Turton.*

156. This is a most valuable Memorandum on how the Ministry works, but I am faced with the difficulty of the Estimate. All I have is the global figure in B.1, which is the major part of the expenditure. Are we to be given by the Ministry some break-up of that in order to give us a proper appreciation of the problem into which we have to enquire?—(Mr. *Edwards.*) In the Civil Estimates, 1950-51, the break-up is in the Appendix to the Estimate, which is on pages 40 and 41. That is always published with the Estimates.

Mr. *Turton.*] I think that answers my question.

Chairman.

157. I suppose you could let us have the further break-up of that into Regions if we asked for it?—(Sir *William Douglas.*) I think we have already promised to give you something for Regions in the way of a break-up.

Chairman.] I think what we have asked for would cover it.

Mr *J. Enoch Powell.*

158. On paragraph 21, are the areas in which nursing is administered identical with the Regions?—Yes, Sir.

159. So that is just an awkward difference of terminology? Then I have another point. Is there some reason why the Ministry of Works deals with invalid tricycles, which one would have expected the Ministry of Pensions to deal with?—There must be a reason, Sir.

Chairman.

160. Gentlemen, I think that probably the next thing the Sub-Committee will wish to do is to make enquiries from the Regional Committees and organised bodies

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concerned with this. We should not, therefore, seek to worry you again, perhaps, for some little time, though undoubtedly the information we get in the light of those enquiries will lead us to ask you further questions in due course. We are very grateful indeed to you for your memorandum and for coming here today, and we will let you know in due course whether we require any further information apart from what we have asked you today, and when we would like to put further questions to you?—At that stage might there be some way by which we could be told what the various bodies you have examined have said, so that we may be prepared the better to give evidence to you?

161. We will certainly bear that in mind?—Thank you.

Chairman.] You will, of course, be supplied with a report of today's proceedings, and if you would mark any paragraph as "Confidential" or otherwise, appropriate action will be taken.

The witnesses withdrew.

Adjourned till Thursday, 25th January, 1951, at 11 a.m.

THURSDAY, 25TH JANUARY, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. Alexander Anderson.	Mr. Thomas Reid.
Mr. Diamond.	Miss Ward.
Mr. J. Enoch Powell.	

Dr. T. ROWLAND HILL, F.R.C.P., Member of the Council of the Association and Chairman of the Central Consultants and Specialists Committee, Professor P. C. P. CLOAKE, F.R.C.P., Director of the Department of Neurological Studies, Birmingham University, Professor S. J. HARTFALL, F.R.C.P., Professor of Clinical Medicine, Leeds University, and Dr. E. E. CLAXTON, M.B., B.S., Assistant Secretary, British Medical Association, called in and examined.

Chairman.

162. We are very much obliged to you for coming here this morning and for having prepared this very full memorandum* for us. I think perhaps it is right to tell you at the outset that we are a Sub-Committee of the Estimates Committee, that we are investigating the Estimates for the hospital and specialist services, and that we are of course concerned with policy questions but not so much high policy, which we have to accept, as the day to day policy and the proper expenditure of the money which is voted by Parliament. I do not know whether there is anything you would like to say in amplification of your memorandum or in explanation of any part of it before we ask specific questions?—(Dr. *Rowland Hill.*) I think perhaps the matter which is uppermost in the minds of consultants employed in the Hospital Service to-day, and one is thinking of this from the point of view of the cost of the Service, is the danger that appears to us to be increasing almost week by week of over-centralisation of the administration and control in the Hospital Service. We were all brought up in the days when an individual hospital controlled itself; if it had a personality of its own, a tradition of its own. We have become conscious, since the appointed day, of more and more almost day to day decisions in hospital administration becoming more and more centralised, and at the present time we are very apprehensive of the increasing concern with day to day administration of the Ministry of Health in Whitehall. If I may just give one example of that, there is the growing tendency of Whitehall itself to decide the medical establishment of a hospital even right out at the periphery. With our lives being spent in hospitals it makes us feel very apprehensive of the efficiency of such a procedure and of its ultimate economy. My colleague Professor Cloake might like to amplify what I have said by expressing any views of his own.

* Annex 2.

162A. May I just interrupt you? You are speaking now really on behalf of consultant and specialist staff. You are here, I think, speaking for all doctors including the general practitioner?—Yes, we are here with the authority of the Council of the British Medical Association and also we are speaking for the country specialists as well, so that we are speaking for both.

163. Thank you?—(Professor *Cloake.*) I do not think it is realised how great is the increase of pressure put on the staffs of hospitals, not so much medical staff perhaps as the administrative staff, by the need of satisfying the requirements of a distant body that has a supervising or controlling authority. I would like to put it this way. I do not think it is possible to get the best out of hospital staffs unless you are prepared to leave the people on the spot to deal with their day to day problems to a very predominant degree. This is, of course, not new; it is old, but it worked; and it worked with relatively small administrative staffs, and with what was locally felt to be considerable efficiency. If the administrative officer peripherally is restricted both in regard to his time, because so many requirements to be fulfilled are placed upon him from above, and restricted in the same way in the exercise of his own judgment over matters where he has habitually exercised his own judgment you cannot fail to get inefficiency. I am not sure how far you want us to go in the matter, but I could give instances of this if required.

164. I think you have made this point, that the gist of the memorandum and your feelings on this is that the Service at present is over-centralised and what you want is to see a policy pursued which will have the effect of decentralising—is that right?—(Dr. *Rowland Hill.*) Yes, a policy of devolution.

165. You do not suggest for that any alteration in high policy in the sense of an alteration of the law, but I think what you suggest in the course of your memorandum is that financial policy should be altered so as to devolve responsibility to the periphery instead of retaining it at the centre—is that correct?—To alter the emphasis. We cannot devolve all financial responsibility from the centre because clearly the major cost of the Service has got to come from the central funds, but we do feel the peculiar lack of logic which operates at the present time when a hospital can accept monies but cannot do anything to invite the giving of it. That should be put right, and the hospital should be enabled to raise monies locally in addition to its central funds, and in that way obviously obtain for itself a greater measure of local autonomy and independence.

166. Could we perhaps deal with that point first? It is the first point you take in your memorandum. You speak of giving power to the hospitals to raise finance voluntarily. Have you any knowledge in the British Medical Association as to what kind of amount might be raised in that way?—In discussions on this subject over some little period of time it has been thought by people of experience in such matters that it might produce an increase in hospital income of about ten per cent., that is to say in a region where the budget might be one of £10,000,000 it might reasonably be expected—I am speaking of Metropolitan Regions now—that another million pounds might at the present time be raised by the hospitals themselves.

167. Regularly year by year?—Year by year, if they had the right to examine the appropriate appeal machinery.

Mr. *Thomas Reid.*

168. From what class of people would you expect to get this money?—As it was before the war, from all classes. There still remain certain capital resources untapped from which, if appeals could be organised, contributions could be obtained. Apart from that, as shown before the war, large numbers of people are only too willing, we have found at present, to give quite small sums, widows' mites to their local hospitals, not through any undue pressure being brought upon them but because of their desire to help and show an interest in their local hospitals.

Chairman.

169. Have you any evidence on which you base this estimate, or is it merely an intelligent guess?—It is an estimate made by persons concerned with hospital appeal machinery before the appointed day, and who are expert in the matter.

Mr. *Diamond.*

170. Those who are professionally engaged in the matter?—Or engaged in the sense of devoting their lives to the organisation of such machinery. Many people did it voluntarily.

Mr. *Thomas Reid.*

171. Do you think they have fully taken into account the fact that the public now realise it is a State expenditure, and that quite a lot of people feel "It is all right. The State is finding the money; we need not subscribe"?—All that has been taken into account in suggesting that estimate, and in fact a number of attempts were made earlier in the Service to get such machinery going. We have an example where the Hospital Management Committee, for example, were informed by the Minister that no member of the management committee must even belong to the committee

of any unofficial organisation for appeals locally, to avoid what he called "misunderstanding".

172. Could I press this a little further? Is it your idea that the hospital authorities should appeal for funds for a special object which is not provided for by the Government—the extension of a hospital or something else—and that you would get money for that special object, or simply the provision of a general fund?—No, the first which you mentioned. No one would suggest that the State funds should be saved by voluntary contributions going towards maintenance, but there are research projects and at present a difficult position exists in that if any research project is likely to cost any appreciable amount of money at all it has to be put before the Minister in order that the funds may be supplied. We know how often medicine research in the first place has been carried on in an atmosphere of martyrdom, such as the original researches of Ronald Ross into malaria or those of Lister into antiseptic surgery which were carried on in an atmosphere of official odium. The point is this: we feel that what one might call the growing edge of research will be helped if money can be obtained voluntarily for that purpose. In that way research could continue when perhaps the expenditure of public funds upon certain experimental research could never be justified.

Miss *Ward.*

173. Do you want to attach the research to individual hospitals, which is apparently the basis of this proposal?—After all the Cancer Campaign still goes on for research, does it not?—One would go as far as that.

174. Would not the same object be attained from a research point of view if you did it on a voluntary national scale in that way, or must it be attached to individual hospital appeals?—I think my colleagues would probably agree with me that the greatest and most vital research of all is not attached even to hospitals; it is attached to individuals. Take a man like Sir Almroth Wright at St. Mary's Hospital who has done so much work in bacteriological immunity against disease. Funds were invested in him, and it was his genius alone that produced that research. Great research comes from men of genius, from a Lister or a Ross, and what we would like to see still operate in this country is this, that with regard to some great man (like Sir Almroth Wright) of the future in some hospital centre it should be possible for voluntary funds to be appealed for, funds from quite outside the official Service, in order to support his researches.

Miss *Ward.*] I think that is quite a different point, and different from the one raised in the memorandum.

Chairman.

175. Could you say this? Is there any evidence that work of the kind you mention, research work in particular, is being starved of finance because of competing demands or other reasons under the present policy?—In general I should say that that is my impression, that it would be very difficult to-day to embark upon some unusual and enterprising piece of research. So often in the past that has been made possible by public appeals being made to support it.

Mr. *Diamond.*

176. Could I just get back to this suggestion in the memorandum with regard to holding appeals locally to assist local hospital management committees? I am referring to page one of the memorandum. Could I ask Doctor Hill whether he has any particular points in mind whereby the raising of funds in this way would assist in the economic running of the local hospital concerned, because I gather from a previous reply it is not suggested for one second that the raising of this fund should go towards reducing the cost provided by the State of running the hospital, but that it should be in addition to that fund? Could we look at the other side, the expenditure side? Could Doctor Hill tell me whether he has in mind any detailed points whereby the raising of this fund from local flag days and so on would assist in the economic running of the local hospital?—It would I feel assist in this way. If State funds were kept as strictly as possible to the costs of maintenance, including the cost of essential medical and surgical treatment, that I think would be the spirit of the Act; then, depending upon the amount of money which could be raised locally, as many as possible of the patients' comforts and all the other hundred and one little things that are necessary in the running of a hospital, which are not strictly maintenance but which at present of course have to be met out of State funds, or a large measure of them—it would vary from district to district—could be met out of voluntary funds and the State funds confined to strict maintenance, the essential maintenance.

177. These outside funds would go to provide additional amenities within that local hospital?—Additional amenities. I did not mean that they were purely for research purposes, that would only be one of the purposes.

Chairman.

178. Are you really suggesting that they should be used for any other purposes than those for which they can now be used? I think the only suggestion you are making is that the hospital should be free to appeal

to obtain larger amounts than they can at the moment?—To obtain money locally, using whatever measures are respectable to raise money, and to use it like they use the present free monies, for whatever purposes the hospitals think fit. At the present time hospital free monies, which have survived from the take-over, are used by local boards for whatever purposes they think fit and for the type of things which I have mentioned, additional comforts and so forth. (Professor *Hartfall.*) An example of the sort of saving which might arise is this. In Yorkshire the University and the Regional Board are organising a scheme for rheumatism. Funds are coming from the regional board and from the University. The University for two years has been anxious to float an appeal scheme for research into rheumatism, and if such a scheme were successful the contribution from the regional board might be diminished considerably.

179. To that extent it would relieve the Exchequer of expenditure?—Of some portion of it.

Mr. *Thomas Reid.*

180. I was surprised at Doctor Hill's answer when I asked him on what the money was to be spent, and he said 'Research." I should have thought that, if you were going to make a local appeal, it would follow the appeal would be for, say, the addition of a much needed wing to the hospital, something like that, something with an entirely local appeal, as we know several of the hospitals have inadequate accommodation. Supposing an appeal was made for the addition of a badly needed wing to a hospital, that the money would be forthcoming and that the new hospital wing were built, of course it would mean increased expenditure for the upkeep of that wing. Therefore would Doctor Hill admit that it is only quite right that all these schemes should be submitted for the approval of the Minister because they would commit him to additional expenditure?—(Dr. *Rowland Hill.*) I think the referring of these schemes to the centre for approval would certainly be desirable. At the present time, with the free monies which a hospital possesses, comparatively small matters would not have to be reported centrally, but I am sure that if any hospital at the present time spent any of its free money on something big which in the opinion of its management committee might involve Treasury funds or something of that kind, they would report to the centre.

181. I was surprised at the figure you gave when you mentioned the sum of £1,000,00. If your figure were correct, with the great many areas in the country very large sums would be subscribed by the public voluntarily and you would really then get a very large additional medical service from voluntary funds. It would become a big subsidiary to the Government Health Scheme. Would that create difficulties in the administration?—I do not think for one minute we would suggest that this should be outside the policy of administrative integration of the Health Service, not at all. The only difference between what we suggest and what operates at present is that free monies can be given at the moment, and are given in quite considerable quantities, but they are integrated into the Service. In the same way, if those free monies were obtained by being asked for, they would be integrated into the Service.

182. Would it be easier to integrate what you mentioned just now, the extra amenities, and carry on the administration of those amenities side by side with the amenities provided by the State already?—I am sure it could be managed in a most productive and harmonious way. Lying behind all this is not only the consideration of immediate economy but, we know, having spent our lives in hospitals, that if people locally are encouraged to help their hospitals in this way, even if it is only the widow's mite, it is not merely the financial help it gives the hospitals but the intimate personal interest that it helps the people locally to take in their hospitals. I am a member of a hospital management committee, and my colleagues are connected with hospital management. I think we can say that our profession would tell you this at the present time: we think there is a danger of a gradual lessening of that intimate concern and interest in their local hospitals which so characterised our people before the war. There is something of a risk that they will feel gradually their hospital is detached from them, as is the general post office in their town; its management is no concern of theirs; and there is plenty of experience of that since the appointed day. It varies from district to district, but there is the diminishing attendance at annual meetings of hospitals, at public meetings of hospitals and so forth. We feel, as we say in our memorandum, that anything which can be done to build up and increase local interest in the hospital in the sense almost of local proprietorship, a share in its ownership anyway, will in the end be in the interests of enonomy. (Professor *Cloake.*) I would like to show one possible way in which any such fund could be expended with a saving of public funds. We have at the present moment an acute need for a central training school for nurses. The Ministry has declined to have anything to do with it actually. The question is whether the capital for a given year could be utiiised in some small measure for——

Chairman.

183. Forgive me for interrupting you, but is this refusal based on financial grounds or on very different grounds that this is capital expenditure which has got to be dealt with in quite a different way?—It is on the ground that the Ministry will not agree to the expenditure of large sums except for a small number of large projects for which they can find the money.

184. Even though you had the money or the money was there, it may be the refusal would still be there because it involved using capital resources?—Yes.

185. If that is the objection then the point you are making is not a valid one?—I am sorry, but I do not get your point. Do you mean the objection might be that it is not building capital and not meant to do that?

186. That is putting it in a general way?—That is not the reason because we can go ahead with the first instalment if we can find the money for it at the present time.*

187. It may be nevertheless that the Government veto is based on the general control of capital resources?—That is not the way I understand it. I do understand there is no money available for this project. They feel it is a good project but they have not the money to give us for it. That we understand. It is perfectly reasonable. We know the stringency, but I think this is just the kind of thing in which a voluntary contribution could be used. In fact it has been discussed whether some part of the free money of the hospital should not be used for this particular purpose. I think that kind of thing, which is in a sense the responsibility of the Ministry, might easily be financed through, or largely or partly, a local appeal to the public for funds for such a purpose.

Mr. *Thomas Reid.*

188. This Government objection is not that your proposed training scheme clashes with theirs?—No, Sir, it is solely a question of getting a central school for the nurses; the training is all settled. It just happens to occur to me as an example, but I am quite sure, if we took time over it, we could think of many ways in which such monies could be expended usefully with an ultimate saving in what must otherwise fall on Government expenditure.

Mr. *J. Enoch Powell.*

189. I take it your idea is that monies collected in this way would remain with and under the control of the hospital or hospital group which collected them?—(Dr. *Rowland Hill.*) That is so. (Professor *Cloake.*) Yes.

190. If free monies are small in extent then the disparity between one hospital or hospital group and another resulting from that can be tolerated, but if the amount so obtained amounted, according to Dr. Hill's estimate, to £40,000,000 or over per year, then the disparity is very great between one hospital and another. Would that not necessitate the spreading out of the money? I observe the use of the word "integration", which I cannot understand except in connection with some spreading of the funds so obtained. If that were so would it not largely defeat your object of securing a degree of financial autonomy?—I would have said it would stimulate local, if you like the word, rivalry. I do not mean rivalry in any objectionable sense. It would stimulate people to work for their own hospital and to get things of this kind. I do not believe it would have a bad effect. It might mean at the moment that one hospital had some advantage, and another hospital at another time, in regard to the collection of monies. I am not responsible for the figures which Dr. Hill has quoted; I really have no knowledge, but to this extent I agree, and I would like to quote this as evidence that such monies can be collected. The Students' Carnival in Birmingham, where I come from, before the war was held once a year for the support of the hospitals, and the students collected—I would not like to commit myself to figures because I am not good at them—many thousands of pounds each year. That money went to endow beds in the hospitals. Since the war the money has been collected in the same way—but it no longer goes for this purpose; it goes to various other respectable things like the support of convalescent homes and helping to establish homes for the aged, things of that kind. They are charitable and beneficial activities missed almost entirely, but not quite, by the Hospital Service. I think larger sums are collected now than before the war, and you might expect that with the decreased value of money. There are many ways in which you can get local interest in the collection of money for charitable purposes, even though behind the charitable organisation lies the Government responsibility. I still think it would be quite possible to collect considerable sums. I am not prepared to say how much because really all estimates are fundamentally guesses. The whole set-up is new, and nobody knows how far to-day the public would be prepared to subscribe.

Mr. *Thomas Reid.*

191. I understood Doctor Hill's idea was that, whatever these voluntary subscriptions

* *Note by witness:* I have since been informed that objection to the scheme has also been based on the general control of capital expenditure.

were, they would be integrated into the National Service, and would come under the management of the National Service. Do I understand now from you that your scheme is that, if people put up money to support this school, you manage the finance and you manage the school?—Yes, Sir, the school will be a part of the nurses' training.

192. Who will be responsible for the management and upkeep of the school, the State or you?—I take it that what we envisaged was merely the setting up of a building where the training could go on and where the personnel can be all together. At the moment they are scattered between various hospitals where the training of nurses has to be carried on. What we want to aim at is getting a more efficient system within a given building.

193. Who would manage the system after you had started it?—The hospital board.

Mr. *Thomas Reid.*] That is the State.

Chairman.

194. The regional hospital board?—It is the teaching hospital board of which I am speaking. (Dr. *Rowland Hill.*) The Board of Governors. There is, I think, just one point, a correction. The figure I suggested is a very tentative one, although it has been discussed. The figure is in the neighbourhood of £1,000,000 for a regional board which might have a budget of £10,000,000. There are only fourteen regional boards in the country, and so that would give a figure of £14,000,000 not £40,000,000. I think a figure of something of that order before the war was the annual income of a voluntary hospital movement in the country.

195. That included, I think, the weekly subscriptions?—All sorts of things.

196. It of course could not be revived, for obvious reasons?—No. It is of interest to note that some of these contributory schemes are still in operation, like the H.S.A. I notice that, since we submitted this document to you, an old-established contributory fund of this character has reported that in the last twelve months it gave £25,000 voluntarily to hospital management committees and regional hospital boards. I must also comment that, since we submitted our memorandum, although there is no connection between them, you will have observed the decision of the Minister to send out a reminder to people who have voluntarily covenanted to give subscriptions to hospitals.

Chairman.] I am not certain that we are not wandering rather far from the matters we have got to discuss here. Can we come now to this application of block grants?

Mr. *Diamond.*

197. May I ask about one aspect of over-centralisation with which we have not dealt so far? Doctor Hill explained that he regarded the present administration as being over-centralised, and he drew a comparison between the hospital routine in which he had been, I think he said, brought up and the present situation. Do I gather that the hospitals to which Doctor Hill is referring in this document are those which were voluntary hospitals before the war, and is it from those hospitals that Doctor Hill is drawing on his experience?—I have been connected with municipal hospitals and before that with guardians' institutions for as long a period of time as I have with voluntary hospitals, and I should think my experience is about equal between the two. But you must remember that local health authorities with great regret lost their hospitals, and even a local hospital is exposed to the same tendency towards over-centralisation as the late voluntary hospitals.

198. Is that saying the difference is marked throughout, the difference between the smooth and expeditious running of a hospital which is referred to in this memorandum and now or is it the difference between that which is stated to be his experience before the war and the present time where the defect results from over-centralisation? Is that difference alleged to be equally great in the ex-voluntary hospital and the ex-municipal hospital?—I think it is equally great, except of course perhaps with one exception, the London County Council which has the largest local authority hospital service in the world. There was perhaps a certain amount of over-centralisation in that. With the possible exception of the London County Council one would have said that a major health authority like a county borough had no over-centralisation where they had perhaps one, two or three hospitals, for example the City of Birmingham with Selly Oak, Dudley Road and perhaps one or two others. They were not over-centralised in the same sense as a great region like the South-West Metropolitan Region, stretching right down to Bournemouth. As we mention in this memorandum people working on the periphery of that region are very conscious of this rule from a distance.

Chairman.

199. Doctor Hill, to deal with excessive centralisation you propose that the finances of the hospital should be carried out completely by a system of block grant. I think that is the short effect of your memorandum. You propose that a sum should be set aside by the Government for the Hospital Service, that it should be divided between regional boards and boards of governors, and I think you suggest that

in turn the regional boards should subdivide their allocation and make block grants to individual hospitals or hospital groups. That is the suggestion?—That is the suggestion.

200. There should be a double-tier block grant in effect?—Yes, that things at any rate should move in that direction rather than in the other direction where more and more scrutiny of small payments occurs from the centre.

201. That involves very wide considerations, many of which are outside the direct knowledge of your Association?—Yes, certainly.

202. There is one aspect which I think directly affects you, and that is the position of consultants and specialists in such a scheme. Do you suggest that, if a scheme of that sort were brought in, the consultants and specialists should be employed by and paid by the regional boards or by the hospital management committees?—As far as consultants working in non-teaching hospitals are concerned, that is to say those who are at present under contract to regional boards as distinct from boards of governors, there has been no suggestion in our profession at all that that should be altered, and that they should become employees of the local hospital management committee. There has been no such suggestion to alter in that way.

203. You would wish to see them continue to be employed by and paid by the regional boards?—By the boards, yes. I am sure that is the case. That is one feature of the present set-up which consultants have never questioned.

204. You are perfectly content with that?—Yes.

Mr. *Thomas Reid.*

205. How would it be decided what amount of block grant should be given to any area?—I presume that an estimate would be made of their needs and a block grant made accordingly. I suppose an estimate would be made, although this perhaps is really outside our question.

Chairman.] Mr. Reid, I was going to say that perhaps we are putting to these witnesses questions which no doubt they are able to answer, but which they cannot very well answer as representing the British Medical Association. Is that not so?

Mr. *Thomas Reid.*

206. I do not know. I was trying to analyse their proposition about the block grant, and to ask Doctor Hill this. Would it not amount to the same thing if the State decided the amount of the block grant?—Yes, the block grant would have to be sanctioned by the State. I think this is what our profession is really meaning behind this statement. It would mean that some of the growing list of detailed enquiries, a two-way enquiry into quite small expenditure to-day, would be stopped. I think my colleagues will tell you we are all conscious of the extraordinary increase in the amount of work occasioned by these to and fro enquiries over quite small items. That means taking up the time of clerks, more use of paper, taking up valuable time, and its cost must be considerable. If a lot of that could be cut out so that within certain budgetary limits the centre does not have to make day to day supervision of hospital expenditure a great saving should be effected. As far as we can observe from our day to day life in hospitals things appear to be moving in the other direction now. For example, in one hospital of mine certain persons are employed to take inventories, and there came a Ministry instruction recently that two persons must be employed as inventory checkers to check the work of the people who take the inventories. The secretary of our hospital management committee estimates that the cost of those two inventory checkers will be another £700 in salaries. That is one little example. This sort of growth, this rather throttling weed of central inspection and control, is certainly growing, and I think my colleagues may have something to say on that. (Professor *Cloake.*) I think this is the matter we should perhaps emphasise.

Chairman.

207. I do want to be very careful here. I am very well aware that you have a great knowledge of these matters because you are individually members of boards and committees, but I think it would be wrong to ask you questions which you may be able to answer unless they are questions which you can answer in your capacity as members and as representing the British Medical Association. I think you appreciate that and I do ask you to limit your replies in that way?—(Dr. *Rowland Hill.*) Certainly. From that point of view, as doctors, we have been impressed by the delay and the amount of detailed work which occurs when medical equipment has to be ordered. For example, in the old days when all we had to do was to satisfy a local hospital board, the matter could be very thoroughly discussed and settled in perhaps one meeting. Now we are all conscious of the fact that the ordering of very vital medical equipment is sometimes held up for prolonged periods because of the necessity to refer to the centre.

Miss *Ward.*

208. There is a very interesting letter in The Times this morning. Did you see

it? It relates to the very awkward time when alterations have got to be done in hospitals in order to get them done within the budget period. It lays off a ward just at the height of the pneumonia crisis. I think it is a very useful letter. That is the sort of detail that can be covered by your proposals in regard to the block grant?—Putting it another way, we feel from our day to day life in hospitals that there would be less sand in the wheels and more lubricating oil if the finances were put on the block grant system instead of being subjected to detailed scrutiny.

Mr. *Thomas Reid.*

209. What are you suggesting, that when the Minister hands over to an area their block grant he thereafter trusts the local people to exercise due economy and everything else?—That is so.

210. At the same time the Minister is responsible to Parliament. On other sub-committees on which I have served we have found it very necessary sometimes that the Minister should tighten up his control over expenditure where—I am not talking about the medical service now—waste has been brought to our attention, and yet in this case you are suggesting the Ministry officials should say "We hand over the money (in this case to the local committee) and thereafter we wash our hands of it". That is really what you are recommending?—Well, no, I do not think we go to that extent. I think our feeling as medical men would be expressed if I were to say this. We feel that Ministerial responsibility and scrutiny—and we are much concerned with this principle—in their branch of hospital work could be discharged by a process of inspecting as distinct from day to day control and authorisation. No one suggests that a block grant is given to a certain hospital group and is thereafter lost sight of. It is quite proper that the Minister should inspect its expenditure, and if he notices that a particular group is doing things very badly, of course he can step in and stop it. That is a different matter from day to day scrutiny of small expenditure. It is rather analogous, in other words, with the way in which the State assists in the financing of universities, and rather in the way in which a semi-statutory board before the war gave great financial help to many London hospitals, namely, the King Edward Fund. The King Edward Fund appointed an inspectorate who used to visit all the hospitals to which that Fund gave large sums of money—but those visitors were not controllers. They could report back to the King Edward Fund and if they found money had been expended wastefully or improperly the King Edward Fund people would intervene, but otherwise a hospital should be allowed free discretion in expending its block grant.

Miss *Ward.*

211. A review should be taken annually really, and efficiency matter judged on the annual results rather than on day to day administration?—On systematic inspection.

Mr. *Thomas Reid.*

212. You surprised me by saying that petty details are interfered with by headquarters. I cannot understand how headquarters would wish to interfere in regard to the purchase of a stethoscope or something like that?—(Professor *Cloake.*) I think what we have to realise is this: the system has been running for two years; it has taken some considerable time to get going, but it has got going in a way which we personally feel—and it is impossible to speak about this without utilising the knowledge one has about matters which are not all medical details. I am chairman of our medical committee, and many things come to me. I am also a member of the board. If you do not want me to speak about matters of this kind then——

Chairman.

213. I am sorry I interrupted you before peremptorily. There is no objection whatever to your using any information however come by, but I think it is important we should not ask you questions, and expect you to reply to them, about matters which do not impinge on the medical profession side at all?—Yes, Sir. Of course the medical profession in hospitals feels that everything concerning the hospital is its concern. We are just as keen to see economy in our Hospital Service as we are in our own affairs.

214. We all feel that as citizens, but from the professional point of view the block grant obviously may affect the activities of your constituents?—The only point I wish to emphasise in respect of what I regard as so much interference with the detail of administration is the fact that gradually the details of administration are being brought further and further into a centralised system. The autonomy exercised formerly by the house governor and his finance officer was naturally, under his board, absolute. Local purchases, for example—they had to be purchased by the board—were brought with considerable care for a comparatively small outlay. The Ministry appears to have the idea that economy will be effected by central buying. I personally feel, and many people will agree with me, that central buying is no panacea at all. There are many possible objections to it. It may result in gross inefficiency ultimately developing for comparatively small economy, which is offset by the increased

staff which will be necessary to run it. If you have local buying you have your staff on the spot coping with it, as they always have done. If you have central buying you have to have a central office with all its attendant personnel. The economies are often not considerable, and the possibility of getting large masses of material centrally is often small, whereas local purchase, being for much smaller quantities, is possible. There are many objections to it, but on the ground of economy the feeling of many people is that it is not in the end going to lead to decreased expenditure, but probably to increased expenditure with a decrease of efficiency because local conditions are not capable of being taken into account adequately by that method. While I have only spoken on this aspect, detail in such matters is being required in all kinds of other ways. The best instance perhaps I can give you is what resulted from the sending out of an instruction under a wrong number.

215. Again I think this is general administration?—Yes, Sir.

216. If you are relating this to the central purchasing of medical equipment or something of that sort it is all right, but I am rather anxious not to bring in general administration?—I will say no more on that aspect. The only thing I would say finally is that my criticism of such a system would be that it involves a great increase of personnel. I do not know whether any facts exist as to the increase of administration personnel in hospitals since July, 1948, but it is my recollection——

Chairman.] I wanted to ask about that later.

Mr. *Diamond.*

217. In regard to this question of block grants the last sentence in your memorandum reads "At present, inefficiency results from capital and maintenance expenditure having to be enclosed within one annual budget". I do not quite follow that, and I wonder if I could ask you for clarification?—(Dr. *Rowland Hill.*) Capital expenditure above a certain sum of money in the case of non-teaching hospitals is the responsibility of the regional board, but the regional board, so I am given to understand by our professional colleagues who are concerned with these matters, cannot spread its capital plans over a period of years. The capital plans of a regional board have to be compressed within a year's estimate, and of course in hospital work many capital expenditures should be quite long term spread over a number of years. It occurred to us from our point of view as doctors that some of the things which we desire to see increased in our hospitals would be helped if the capital budget were one which could be a five years' budget, for example, as distinct from an annual budget.

218. Do you mean divided into five yearly amounts, or just one amount spent at any time within a period of five years?—More or less the latter part, not having an estimate of how much of it should go each year. Of course we do not wish to speak as experts on that matter, but only as doctors concerned with certain medical capital plans.

Chairman.

219. You are obviously vitally concerned there?—(*Professor Hartfall.*) We find in this connection that towards the end of the financial year our hospital has a certain amount of money which it is anxious to spend; whereas at the beginning of the year we may have difficulty in getting certain equipment through, towards the end of the year we are almost being persuaded to buy it in order that we shall spend up to our budget.

Mr. *J. Enoch Powell.*

220. I take it the essence of a block grant as recommended is that a fixed sum, not expected to be altered, is promised for a certain number of years ahead. A block grant for one year is meaningless?—(Dr. *Rowland Hill.*) Exactly.

221. It must be a block grant guaranteed for a number of years, say five years ahead, in order to produce the advantages which you desire to see?—Yes.

222. Would the British Medical Association be prepared to accept the disadvantages in that system, namely that, instead of looking at the development of a scheme year by year and making financial provision for it, one takes a five year view? You accept the cramping as well as the advantages because clearly, if it is altered every year, it is not a block grant and you lose all the advantages anticipated?—I am sure our profession, knowing the way in which medicine has developed, not in sudden spurts but by steady evolution, would prefer a long term financial arrangement.

Mr. *Thomas Reid.*

223. Supposing an area had drawn up a programme for five years, I presume it would include very often very heavy capital expenditure?—Yes.

224. Therefore you would be asking the Minister—not merely you but all the other regions—to commit himself to a very huge expenditure for five years. Suppose a war then intervene; there are war finances, and the Minister is in difficulties; perhaps the Chancellor of the Exchequer cannot find the money?—I suppose in one sense we are all living from year to year, or even perhaps

from week to week. Our chief outlook is whether we are going to be blown up, but that is rather a different consideration.

Chairman.

225. Mr. Reid, I think this is really a question of general policy. The doctors have told us that from their point of view what they want is continuity and a definite promise. I do not think we can ask them to do more than give their views. What is going to be possible is another matter?—That sums it up very well. We underline the importance of continuity to medical development.

Mr. *J. Enoch Powell.*

226. And it has regard to maintenance as well as capital expenditure because otherwise you will not attain the economy you want to get under the maintenance head?—Yes, but perhaps that is a matter outside our field.

Chairman.

227. I do not think so. I think you can answer that one?—(Professor *Cloake.*) I would answer by saying that we expect supervision, and that we expect development. With regard to capital expenditure the long term block grant would be better. With regard to maintenance expenditure I do not think that is nearly so firmly held by us. I feel that maintenance may very often have to be decided year by year. There might be a very definite hampering influence if you had the development of all your capital plans taking place in the early stages of your quinquennium, and you had not got the maintenance to keep it going.

228. In other words, you would like to draw a pretty sharp line between capital and other expenditure, and you think that might be dealt with on rather different lines?—Yes.

229. You speak of the growth of purely administrative expenses. That is getting very near the borderline of what is in order for present purposes, but I think it would be very useul to the Sub-Committee if you could tell us from a medical point of view how you would define purely administrative staff. Whom do you regard as administrative?—(Dr. *Rowland Hill.*) It has sometimes been expressed by regarding the administrator as someone who never comes near or does not directly serve the patient. Most hospital staff who are concerned in direct service to the patient, like the doctor and nurse, would not be regarded as administrative staff. Staff who do not have that relationship to the patient, those who are concerned with the keeping of hospital accounts, the obtaining of hospital supplies, the keeping of hospital records other than professional records, we would consider as administrative staff.

230. Would you regard cooks in the kitchen of a hospital as administrative?—I think we would agree that normally one would regard those as persons directly serving the patient and one would not regard them as administrative staff.

231. When you say in the middle of page two of your memorandum "We have not viewed with approval the steady increase in the number of minor administrative staff in hospitals and the multiplicity of their office furniture and equipment," there you are not drawing a distinction between doctors, nurses and the rest but between those who are directly serving the patient and those who are not directly serving the patient?—Exactly. We meant by that essentially, for example, the Secretary's staff, including the finance officer and the supplies officer. They are clerical staffs where we have observed such very great growths since the appointed day.

232. Have you any evidence of that as doctors? I am not asking this question of your own individual knowledge, but in the British Medical Association have you any direct evidence that the purely administrative staff as you have defined it has grown out of proportion to the staff directly serving the patient?—Speaking personally, I should have said that in all the hospitals with which I am connected I have observed an astonishing increase in the administrative side. For example, in King's College Hospital, with which I am connected, before the war the house governor of that hospital had a staff of forty persons, clerical administrative staff. He now has a staff of over two hundred, and he himself has told me as one of his medical colleagues that he is shocked at this increase which has taken place. Much of it he considers could have been avoided, if they were not employed upon such repetitive tasks.

233. They are purely administrative?—They are purely administrative. One would call them clerical staff.

234. Suppose a specialist has a secretary, as I think most specialists would have, would you say that is a swelling of the administrative staff?—Most specialists share secretaries, in my experience. I have not seen that side of the matter carried to excess, but I can well understand it might be; and if under the influence of this Service in any particular direction specialists have got too many secretaries it would be an extravagance. I have not myself detected that form of extravagance. (Professor *Hartfall.*) I can give a little information about that where in a teaching hospital in Leeds the medical secretarial staff has grown from ten to thirty, and is costing the hospital, if I may mention costs, £10,000 a year. A medical secretary in part is an administrative officer and in part she is professionally trained to

understand a doctor's terminology and so on, but much of her work is administrative inasmuch as she arranges appointments, arranges documents, marshals patients and so on; not all her work is strictly professional in the medical sense.

Mr. *J. Enoch Powell.*

235. To what do you attribute in that case the increase in personnel, because that increase would not appear to be connected with the organisation of hospital services?—I attribute it to the installation of what I regard as an inefficient appointments system and to the fact that we have now lost in the hospitals our spirit of voluntary service which existed. We now work for a session. We do so many cases instead of carrying on until the work is done. We work until we have done our allotted span. The secretary arranges an allotted number of cases for us to deal with.

Chairman.

236. You say that the swelling of the administrative staff is not purely on the organisational side; it is right through?—In the medical secretariat of which I was speaking I was rather in a special category.

Mr. *Diamond.*

237. Doctor Hill I think has been quoting Mr. Barnes to us in fact?—(Dr. *Rowland Hill.*) Yes.

238. Could I ask whether Mr. Barnes has given you any figures showing the proportionate increase in the clerical staff and the proportionate increase in all other forms of staff in the hospital?—No, he has not. My conversation with Mr. Barnes was entirely his statement to me of an increase in his own staff in his own department.

239. Could I ask whether he has given you any figures with regard, for example, to the increased numbers of clerical workers who keep the records of the out-patients' department, and whether that has had any effect on the queues in the out-patients' department or improved the efficiency of the Service in regard to enabling doctors and consultants to treat out-patients?—He gave me no such analysis of the figures. There was only his general attitude towards the matter. With regard to the figure he looked upon it as a wasteful increase in staff, which he would have avoided had he the power.

Mr. *Thomas Reid.*

240. With regard to the alleged huge increase in staff—there is an increase I daresay—is it because the clerical workers have not got enough to do or is it due to the fact that they have got increased duties under the new system?—I should have said it was a bit of both. Before the war, both in local authority hospitals and in voluntary hospitals, the expenditure of every penny was watched very closely. There was a sense of stringency, and staffs were kept down. Now I think in my experience there has been an increase in staff, and many staffs are not worked as hard as they were before the war, but also there has been a great increase in what in my opinion is repetitive work, which with greater efficiency could be avoided.

241. Unnecessary work?—Unnecessary work. For example, in the hospital group where I am a member of the management committee there is no doubt that there is an excessive amount of committee work. It is not necessary, but it is done because I think some of the people have a lot of spare time and to have frequent committee meetings gives them a sense of authority. To give you one example, the paper upon which committee minutes are duplicated for this one small hospital group, serving a population of 200,000 people, costs £300 a year. That is on paper alone. There seems to me to be a great waste there, which could be, and should be, cut down. In that same hospital group before the war the cooking was well done in the main hospitals with a smallish staff. There has been an extraordinary increase in that staff recently for no good reason at all. For example, the resident staff in the hospital used to be looked after by a group of very skilful and talented maids who made their beds, cleaned their bedrooms and served them at meals. For no good reason at all those maids, the same in number, still look after the bedrooms of the resident staff but they are not allowed to wait at table, and therefore a fresh staff of about a dozen girls in black uniform have all been engaged solely as waitresses. Those are just little examples of the sort of waste which has crept in.

242. I assume those staff did not come without being requested. Who asked for this extra staff?—I have no doubt they were asked for by the official appointed in charge of this department.

243. And the committee above the official granted the request, and they appealed to the Minister for the money?—That is the sort of procedure, yes.

Chairman.

244. I do not want to put questions to you which are outside the medical ambit, but I think it would be extremely valuable to the Sub-Committee if you could say whether you have considered in the British Medical Association how you should divide the administrative cost. I do not know whether you have given that matter any attention, but there have been allegations made in many quarters that the purely administrative expense of running a hospital

has risen. In other words, the money which is going into the hospitals is not going in for the real purpose of enabling the doctors to treat the patients, but to provide something for the patients which is unnecessary for their recovery though it may be agreeable to the patients. Have you given that matter consideration, and could you give us some sort of definition which we might be able to use in considering this matter because we are very anxious to arrive at a conclusion about it?—Our dividing line—my colleagues will elaborate on this if they do not consider I have expressed it fully—would be this: we would regard as administrative staff the staff in the secretary's department of the hospital, and we use "secretary" in the widest sense to include the supplies department and the finance department of the hospital. We would not include in the administrative staff of a hospital those in the employ of the matron, staff employed in cooking food for the patients and taking it to the patients, staff nursing patients or treating them for their illnesses.

245. Maids working in the wards?—We would not include maids working in the wards in the administrative list. Administrative staff are essentially those working in the secretary's department in the broadest sense of the term "secretary's department".

246. So far as the doctors are concerned do they think that there is an excessive number of people working among the maids, cooks and so on, or is this the allegation which you make, that excessive administration expense is entirely confined to the headquarters and secretarial side?—It is entirely confined to the secretarial side.

Mr. *J. Enoch Powell.*

247. The distinction dividing the maids who serve in the wards from those "bed makers" or "gyps" to whom you were referring a little time back, the ones serving the doctors, is that the latter are administrative but the former are not?—I think one would say that, yes, I think so. It is very difficult to draw a very sharp dividing line. I should prefer to draw my sharp dividing line really between the secretarial department and the rest. That is the real dividing line.

Miss *Ward.*

248. I am not quite certain if this is an appropriate question at this moment, but I would very much like to ask, as there seems to be all this increase in administrative staff, if you have any views on the length of time, which does involve a tremendous loss of work in the country, which people have got to wait when they go to a hospital for treatment. I think there is a growing criticism among responsible people who are working in the country that they are expected to give up certainly half a day, or a whole day, when they are summoned to a hospital. It does seem to me that, if you have got an efficient administrative staff, it ought to be possible to cut down on that waiting period. It is certainly a loss to the community, if not to the hospital?—I am sure my colleagues will have something further to say on that point, but as far as I am concerned this is a perennial. Many of the most experienced brains in the organisation have been brought to bear upon this problem before the National Health Service came into being. An appointments system in its various forms for out-patients was introduced before the war into many hospital in this country. The difficulty about the matter, of course, is to gauge how long a doctor is going to spend on each patient. Some patients can be dealt with very quickly; in the case of complex and difficult cases it may take half an hour or three-quarters to deal with one such patient. It is impossible to predict that. If patients could be dealt with in the same way that a booking clerk can issue tickets and if you could make an allowance of so many seconds for each person you could time it well, but you are not dealing with that; you are dealing with sick people. That is the great problem. It has been greatly aggravated since the appointed day—it is not universal—in many parts of the country where there has been a greatly increased pressure in the out-patients' department. The difficulty of gauging the time at which to tell a person to come is bound up with the extreme difficulty of deciding how long each patient is going to take to be examined and dealt with. There is yet a further rider to add. In some ways this problem perhaps is not as great as it may seem, because many patients like to come much earlier than they need, and that fact is especially noticeable perhaps in the big cities. There is no doubt that many people do come as out-patients and enjoy their wait; they come early; they meet their friends; they get refreshment from the canteen; they are warm; and they have the best gossip of the week! We should be very careful not to exaggerate this.

249. I know, but I have just got one particular case in mind of a civil servant holding a pretty responsible position who is afflicted with a very, very severe infantile paralysis, and she has continually to go and have her supports altered and dealt with. She tells me she gets a summons from the hospital to say "Come at (such and such) a time," and no regard is ever paid to the fact that people holding responsible positions cannot just throw up a day's work and go off at any moment on a summons from a hospital. I am talking about responsible people; I am not talking about the ones who go and chatter; I know all that side. I am concerned with people who have responsible jobs and who

are summoned somewhat peremptorily to hospitals. The comment is how can they throw up their work, which presumably is very valuable to the State, and go off just to be kept waiting at the hospital. It is a very difficult problem, but from the point of view of looking after these people who require treatment it is a problem which really should be solved?—I think one can say the appointment system should be under constant examination to be improved in every way of which we can think. It is only in that way that this matter can be eased. There was a time a few years before the war, when the appointment system had not been thought of, when people who arrived at the hospital in the early morning were not seen until four or five hours later. The appointments system was introduced into hospitals to mitigate that. Different forms of it have been tried. For example, there is the block appointment system when perhaps five patients are asked to turn up at ten o'clock, and they are all going to be seen within the next hour. That partly mitigates the difficulty of calculating the time required for each patient. Then there is the precise appointments system whereby one patient is seen at ten o'clock and another at ten-fifteen. Our own profession is fully alive to this difficulty.

250. Do they ever pay regard to the jobs which people are doing, and summon the chattering type in one way and the people who have got full-time appointments in another way?—(Professor *Hartfall.*) I think amongst the hospital population there would be considerable resentment if priorities were introduced.

251. I know, but service to the community has also got to be considered?—The difficulty there is that you have no means of telling what is the patient's job and the value of his job to the community. (Professor *Cloake.*) I am a little surprised to hear a patient is summoned because the usual practice in hospitals is that the patient is told, at the time of attending, when the next attendance will be.

252. That is the same thing?—If they are going to attend at all, surely that gives adequate notice.

Mr. *Thomas Reid.*

253. With regard to staff increases would Doctor Hill admit that the work of hospitals, generally speaking, has vastly increased, and therefore would he admit that since the State took over it was reasonable to expect an increase in staff?—(Dr. *Rowland Hill.*) That has varied throughout the country. Some hospitals surprisingly have had an extraordinarily little increase, but it is true that in many areas there has been a substantial increase. In spite of that increase of pressure in clinical work it is our opinion, as a profession, that the increase in the secretarial staff is excessive, even making allowance for that.

254. You would admit that some increase was to be expected?—Some increase was to be expected in all staffs. (Professor *Hartfall.*) There is another aspect of this. In the out-patients' department we are not as doctors working as efficiently as we were because, under this appointments system which has been discussed, we may indeed find ourselves waiting to see patients sometimes. Appointments are made for two patients to come at two o'clock; they are ill, and both are not there. The doctor then has to sit down and wait until the next patient comes at two-thirty.

255. Was that not always the case?—No, it has not always been the case. A patient—and this is what has always been objected to—may have to wait from two to four o'clock until he sees the doctor. There is a queue of thirty or forty, but the doctor sees them all. The doctor then got through more work. Now he makes a guess at the number of cases he can see between 1.30 and 4.30; I can see twenty-four cases; but in the old days we saw thirty or forty, as many as were there, but some of them had to wait.

Mr. *Diamond.*

256. Are there any figures, save for this statement, that the proportion of hospital staff to-day directly serving the patient is much reduced?—(Dr. *Rowland Hill.*) It is the proportion, not the absolute number. I can only say that was the agreed view of representatives of hospital medical staffs. The precise figures I cannot give you. It is essentially the opinion of the nation's doctors.

257. I realise this question is coming without notice, but if figures could be produced they would be extremely helpful?—I am sure some sample figures could be produced quite easily.

Chairman.

258. I did ask if you had any evidence on that. If you could let us have the figures we would be very grateful?—I think we can supply that information. We will find some sample figures.

Chairman.] Sample or general evidence, but concrete figures.

Mr. *J. Enoch Powell.*

259. There is in the memorandum—if elaboration could be given to us later I think it would help—a very interesting argument that the grouping of hospitals often leads to the opposite of economy. One example is given in the text, and I feel that, if we could be given as many examples

as have come to the notice of the British Medical Association, it might help us at a later stage?—(Professor *Hartfall.*) I can quote one example. If I want a splint for a patient at one hospital the request has to go through the supplies department of that hospital to the supplies department of the other hospital. I cannot get a splint for a patient inside three weeks; it took two or three days before. I suggest that is an example of waste, and the patient is also occupying a bed.

Chairman.

260. I wanted to ask some questions on this matter of the grouping of hospitals, and I think that really comes most conveniently now. On the subject of grouping, first of all I think the general tenor of the memorandum is to suggest that the present grouping is not satisfactory. I am not certain that you go to the length of objecting to large scale grouping on principle. Could you say something on that subject?—(Dr. *Rowland Hill.*) We feel it is an aspect of the Service which would repay a careful enquiry. We think some of the groupings are bad. We even think that in some parts of the country the principle of grouping at all is bad and unnecessary. There is no doubt that in various parts of the country hospitals widely separate from one another with no natural connections have been grouped together under a common committee management, and we have had evidence of waste, delays and inefficiency for that reason. One example was quoted here of the long time which certain repair jobs have taken because they have to be dealt with at the centre of the group twenty-five miles away. We think the principle of grouping hospitals, as well as their teaching application, in various parts of the country should be really sympathetically enquired into.

261. Could that be done without any very serious disturbance of the Service from your point of view?—From our point of view it could be done without any disturbance to our work.

262. Would you state any principles which you think should be applied in considering re-grouping?—Yes. Dealing with a typical district hospital, if that district hospital appears to be self-contained and the sole hospital to do the work in the area it serves, if the drainage area around that hospital is all natural into that single hospital and it is a hospital of some size, it might well be better that that hospital should be independently managed on its own and not artificially grouped with some hospital and district with which it has no natural connection a good many miles away. It might be better, in other words, to have more management committees in the country rather than to have the principle of marrying hospitals together where there is no natural reason for them being married together.

263. That would lead to some duplication of administrative staffs, would it not?—Yes, but that might well be small in each case, with less headquarters staff. The curious position which can be seen in many hospital groupings to-day is this. You take two big hospitals five miles apart, and you decide to put them under one management committee. That management committee needs headquarter offices for its operation, and a group secretary. In many groups throughout the country that group secretary is in his office, and is no longer the secretary of either of the hospitals.

264. He is a mere bureaucrat?—The Minister in one of his original circulars referred to the fact that the group secretary might with advantage be the secretary of one of the hospitals, but in practice in many parts of the country it has proved impossible and the group secretary is a centrally placed bureaucrat. One feels that if that grouping was split and each hospital acted alone, you could do without the group secretary, group headquarters, group staff and all its expenditure.

265. I am rather leading you off the boundary from what is in order, but I think it is necessary to clear up the matter. I suppose you do have substantially less grouping in the rural districts. The question I wanted to put to you was this: how would that affect the doctor's ability to find a suitable bed for a patient?—(Professor *Hartfall.*) I do not think it would be affected at all. The number of beds would not be affected. The occupancy of the beds would not be affected, and the same opportunities for admission or otherwise would exist whether there was a joint hospital arrangement or an individual one. Before the Act came into force hospitals frequently did utilise one another's services in this way without there being any joint management machinery to direct it. In the old days local authority hospitals had a statutory obligation to take patients, which, as far as I know, does not exist to-day. The arrangement was one which worked perfectly. If there was a bed available and a bed was needed it was found. As a matter of fact it was found very often through the hospital bed bureau, which was a voluntary organisation set up by local voluntary fund collecting agencies. Our argument really comes down to this: if you consider the set-up now the regional hospital board with all its officers is something which has been brought into existence and it is working, shall I put it this way, without necessarily increasing in any way the number of beds or the number of patients and so on. It is a new organisation, and the staff is, I was going to say, additional.

266. You are now speaking of the region?—Yes.

267. But the region is not responsible in any way surely for enabling a doctor to find a suitable bed for a sick patient?—No, Sir. I was thinking of it in the much wider question you asked me, how it is that staffs have been increased in this way. The answer is that the same hospitals existed with at least the same staffs, but on top of all that is an organisation which we call the regional hospital board which is something quite new and additional.

268. Leaving regions out of it for the moment, I am merely talking about hospitals and the difficult problem a doctor has in finding a suitable bed quickly?—(Dr. *Rowland Hill.*) As far as the grouping of hospitals is concerned one would say that the grouping of hospitals does not affect that really at all and it does not facilitate it. This problem of getting a bed has been spoken of publicly. After spending all our lives in hospitals we would say this: the most efficient way of getting a bed in a hospital is by direct contact with the individual hospital itself. Structures of bed barriers—central organisations, group admission officers and so on—are merely really an obstacle in the way of a bed. They do not really help, and there is nothing about the grouping of hospitals together which in fact makes a bed more readily available to doctors or patients.

269. That is the universal view of your Association?—That would be the view of the British Medical Association, yes.

270. The doctors are quite satisfied that grouping as such has no effect one way or another?—On the availability of beds, none at all. In fact the doctor in practice, the general practitioner, would rather be able to pick up a telephone and speak to a doctor in the hospital who can find a bed for him than he would to any bed bureau official.

271. Can he do that under the existing set-up?—He can, but in some instances grouping has put up a few bureaucratic barriers between the doctor in practice and the doctor in the hospital.

Mr. *Thomas Reid.*

272. I do not quite understand that. Can a doctor now get straight on the telephone to the hospital where he wants a bed for his patient?—In many parts of the country he can, but in some districts grouping has led to the creation of some special bureau and a telephone number. We have had this complaint from general practitioners in various parts of the country, that when they now want to get a patient into hospital they have to ring up a girl clerk in the bureau and they have the greatest difficulty in discussing the matter with the hospital doctor at all.

273. Was not the reason for that that bureaus would be able to tell the doctor, "There is not a bed at Hospital A, but there is a bed at Hospital B"?—It does not work that way when you have a great pressure on beds. Most hospitals are full right up. A doctor goes to a patient's house and finds that patient has got acute appendicitis. If he could telephone and speak to the hospital doctor, the two of them could discuss the medical details together. If the hospital doctor realises that the case must come in on medical grounds like that he can go into the ward, use his medical discretion and send someone home who was not going home for a few days. The need of the other person to come in is greater than the need of the person already in. It is only by that type of professional collaboration that the greatest use of hospital beds can be made. If you are going to rely upon a bed standing empty, like a hotel bedroom, a patient with acute appendicitis will never get into hospital. It is a matter, if you like, of exchanging a patient from outside with one who is already inside.

274. I appreciate that. An appendicitis case might be threatened with peritonitis and things like that?—Yes.

275. Do you mean to tell me that a doctor who is treating a patient could not establish contact, either through the bureau or direct, with the hospital doctor whom he wants to take over the patient?—In some groups, where this bureau system is in existence, it is much more difficult than it used to be for a doctor to get into touch with the hospital doctor. There is always an administrative barrier between them. Of course the determined doctor will eventually get into touch with the hospital doctor and talk to him; he frequently does, but it is wrong.

Mr. *J. Enoch Powell.*

276. Conversely, does the group system tend to compartment the different groups? What I mean is this: if there are two hospitals, five miles or ten miles apart, and they happen to be in different groups, is it harder to make mutual arrangements than if there were no grouping?—No. One of the advantages of this Service, of course, has been that it has knocked down the old local authority barriers, and in the sense of admission into a hospital some way away from where the patient lives it is easier than it used to be. Before the Act, to get a poor person into a local authority hospital in an area where he did not live was very difficult.

277. It has made that easier, not for administrative reasons but for financial and legal reasons?—Yes, that is right.

Mr. *Diamond.*

278. Is the group system inflexible, or is it the case that groups in fact change their composition from time to time?—Extremely inflexible. My experience is that since 1948 they have been very inflexible. It would mean a major decision by a regional board to alter a group. In London particularly—I do know if my colleagues from the provincial cities have similar views—some of the grouping appears to be wholly unnecessary and leads to a lot of trouble. If you take the Paddington Hospital Management Committee it covers a large area of Central London. It is concerned with the administration of probably a dozen hospitals, large and small, all of which have no natural connection with one another at all. They are not always concerned with the same drainage area, and it appears to be a wholly unnecessary accretion to put on top of such a hospital. It would be far better not to have one big management committee but to have a number of smaller ones concerned with the individual hospitals. The National Temperance Hospital in the Hampstead Road has got no natural connection at all with Paddington Hospital miles away up the Harrow Road, but they have both got the same management committee. I can tell you from personal knowledge that that management committee has done more harm than good ; it is bad administration.

Chairman.

279. Have you made representations to any authority—by " you " I mean the doctors—that this is not conducive to the good of the patient?—On this particular matter, no. We have been so concerned with representations about our own position in the Service that we have not got on to that yet.

280. I think we might discuss boards and committees generally. You suggest in your memorandum that the representation on boards and committees is not satisfactory, and in particular I think you suggest there should be more local authority representation and more direct professional representation?—Not local authority representation, local representation, yes. The theme behind this section of our memorandum is this, that we wish hospital boards could be more locally chosen and less selected by the Minister. It would not be difficult for a local population to choose their own hospital management committee locally. At present, of course——

Mr. *Thomas Reid.*

281. Excuse me, but this puzzles me. How would they choose the committee—by election?—It might be done by the process of election. It might be done by the formation of a local hospital association which anybody who wished to could join. A lot of local hospitals had such an association before the war came along. There has been sufficient experience with local hospital management committees since 1948 to show that the principle of the people choosing their own hospital management committee and the Minister doing less of the selecting would be much better.

Chairman.

282. When you say in your memorandum at the top of page four, " These committees should be in some way chosen locally rather than ministerially selected . . . ", you do not mean that the local authority as such should have any standing?—No. I have put forward one suggestion that if a local hospital association were recognised in each district of the country, an association which anybody could join who was interested in hospitals, and which for example at the annual general meeting elected a management committee for the local hospital, that would be one way of doing it—but there are at least many other ways.

283. You now suggest that the whole committee should be chosen in that sort of way, do you?—Or a large proportion of it. In a State Service one quite recognises, as with a University Senate, where public money is involved, there must be a certain number of persons officially nominated ; but one would like to see the majority of a hospital committee chosen by the district which it serves rather than to be ministerially selected. We are not very much impressed by the method which consists of the Minister, or one of the regional boards, inviting large numbers of nominations from selected bodies, getting in large numbers of nominations and then from that very large selection picking those whom he wishes to serve.

284. This is his responsibility though. Are you suggesting he should cease to be responsible?—We would put it this way. He should scrutinise the names of those elected locally, and he should have the right, as he is the public custodian, to veto somebody ; but that should normally be a nominal thing in the sense that when a Minister receives his Seals of Office from the King he is being appointed by the King, but he is not chosen by the King. The point is this, that by removing so much local autonomy from the hospital it is the opinion of our profession that irretrievable damage is being done to our Hospital Service and to the work of healing the sick. That would be reflected in increased costs as well, because efficiency and economy go together. We would like to see the Minister being much more tolerant about the right of local communities to choose their own management committees, and then we would like to see the management committees of hospitals electing their own regional boards. That seems to be to us the spirit of democracy.

285. The obvious way to deal with this simply would be to call in the aid of the local authority. Do I understand that you are definitely opposed to that?—I think I would interpret our profession by saying we would be opposed to it in the form as you stated.

Mr. *Diamond.*

286. Have you any guiding principles in mind as to certain classes who must be among those chosen, or would it be free to the community to choose whomever they liked?—I should say free to the community to choose whom they liked. That is how it operated in the house governing of voluntary hospitals for many generations. They came from all sections of the community, from the most humble to the most wealthy. Voluntary hospital boards selected themselves in that way for many generations, and they have a great record of hospital achievement behind them.

287. You would not suggest that a material proportion of the members of each committee should be of the medical profession?—We would always stand by this principle, that the medical staff of a hospital should always have some representation on a management committee. The evolution of our hospitals seems to show that was desirable for many generations in some hospitals. They were not always given the status of membership, but they had the entrée, so to speak. In St. Bartholomew's, one of the oldest of our hospitals, right up to the appointed day no member, however distinguished, of their medical or surgisal staff was ever permitted to be a full member of their board, but nevertheless in regard to any medical matter they were always called into consultation.

Chairman.

288. You are now really getting on to the next broad subject, this question of consultation and representation. There is, I think, in your memorandum a certain conflict in that you ask for direct medical representation on the governing body, and then you also ask for consultation between the governing body and medical bodies not on the governing body. I do not think we can possibly go into that to-day, but I think we would like to ask you what is your considered view as to which is the more desirable of them and, if you do not think they come in conflict with one another but that they could both exist, how they could run in parallel?—We should be very glad to discuss that. That is a matter which we consider most important.

Mr. *J. Enoch Powell.*

289. Could we have an indication of the reasons why the medical profession have so clearly set their faces against utilising the local authorities to provide this element?—I suppose it is a historical matter really. The relationships between our profession in the past and local authorities in many parts of the country have not always been of the happiest, especially in the hospital world. Local authorities, of course, were very new owners of hospitals, and if it had not been for the war and the National Health Service our relations with local authorities, as the years went by, might have grown happier. It is true to say that the one thing the medical profession dreaded before 1948, and this applies to general practice as well as to hospitals, was the dread that they would find themselves placed under the local authorities. That dread might have been ill-founded and in the passage of some generations might have been shown to be ill-founded, but on that date it is a fact that it was a deep fear.

Chairman.

290. I think that is a matter about which we can take judicial knowledge. If you could come again at 4.15 p.m. next Thursday, we should be very grateful?—Yes.

The witnesses withdrew.

Adjourned till Thursday next at 4.15 *p.m.*

THURSDAY, 1st FEBRUARY, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. Diamond.
Mr. J. Enoch Powell.
Mr. Thomas Reid.
Mr. Turton.

Doctor T. ROWLAND HILL, F.R.C.P., Member of the Council of the Association and Chairman of the Central Consultants and Specialists Committee, Professor P. C. P. CLOAKE, F.R.C.P., Director of the Department of Neurological Studies, Birmingham University, Professor S. J. HARTFALL, F.R.C.P., Professor of Clinical Medicine, Leeds University, and Doctor E. E. CLAXTON, M.B., B.S., Assistant Secretary, British Medical Association, recalled and further examined.

Chairman.

291. Gentlemen, when we adjourned last week I think I had just indicated to you that we should wish to ask you about those parts of your memorandum which were concerned with consultation and representation. You suggest in one part of your memorandum that the highest standards and greatest economies can only be attained by a readiness on the part of the Government to invite the fullest co-operation from the medical profession in hospital administration and in the formation of policy. I think that really puts shortly the gist of a good deal of your memorandum?—(Dr. *Rowland Hill.*) Yes.

292. Could I ask you this question? Do you place more reliance on discussion by way of consultation or with representation of doctors on the actual management?—The first point which you mentioned is to us by far the most important—by consultation. In fact certain famous hospitals in this country before the appointed day and before the war worked extremely efficiently and happily without any representation of the senior staff on the board of management at all, the board of management however being careful to have full consultations with their staff on all relevant matters. An outstanding example in this country of a famous hospital on those lines was St. Bartholomew's Hospital. There was never any suggestion from the distinguished staff of that hospital that they were suffering because they were not represented on the board of management. Their medical committee, or as it was called for many generations their medical council, was in the full confidence of the management committee and was constantly consulted. To us that is far more valuable than mere representation by one or two persons on the management committee.

293. I take it, however, your are not suggesting that the example of St. Bartholomew's Hospital should be generally followed now?—Not at all, no. We would say the ideal arrangement was the one described and approved by the King Edward Hospital Fund before the war, which was this: a medical committee of the senior staff should be recognised and used as the advisers of the board, and that committee should have one or two representatives on the board of management to act as liaison officers and spokesmen. That, we think, is the ideal arrangement.

294. That is under the pre-war set up of the single hospital?—Yes. (Professor *Cloake.*) I would urge, if I may, that the arrangement which holds now in the teaching hospitals of the country is a very similar arrangement to that, and it is a good arrangement.

295. You are satisfied with the present teaching hospital arrangements in this connection?—Yes. The teaching hospitals, as you know, have a medical advisory committee which is selected by the senior staff from their own numbers, and of those—at least not necessary of those—there are also a small number of members elected, or rather I suppose I must use the word "nominated", by the senior staff and appointed by the Minister to sit on the governing body of the teaching hospital group.

296. Are you satisfied broadly with the representation of the medical profession on the boards of governors, regional boards and management committees? I am not asking you about individual cases, but broadly?—(Dr. *Rowland Hill.*) Our answer would be that on boards of governors, as Professor Cloake has just said, the position is reasonably satisfactory. We can say we are satisfied there. (Professor *Hartfall.*) I agree. (Dr. *Rowland Hill.*) But as regards regional boards and hospital management committees the whole profession is gravely dissatisfied. The medical representation of persons employed by the boards is inadequate on regional boards, and it is inadequate on a large percentage of

hospital management committees. Many months ago we asked the Minister if he would make the representation of consultants on regional boards and on hospital management committees identical with that on boards of governors. He declined to do so at that time, but that is still the policy of the profession.

297. Is there a big difference in proportion?—A very big difference, yes.

298. Can you give us the figures?—As far as boards of governors are concerned, in the Schedule to the Act the Minister allows the senior staff employed by the board of governors to nominate up to one-fifth, and in practice I think he has always made it one-fifth of the governing body. In the case of regional boards, for example, a regional board will perhaps have not more than two, or perhaps even one, consultants under contract to that board sitting on it. Very rarely would it be more than two.

Mr. *Thomas Reid.*

299. What is the total number of the board?—About twenty roughly, or a little over twenty.

Chairman.

300. What do you suggest would be a better figure?—We should say the same as that for the board of governors, up to one-fifth.

301. Up to four in number?—Up to four in number; that is to say doctors who are under contract with that board.

Mr. *Turton.*

302. I notice in your memorandum under the heading of "Joint Consultation" you say it would make for economy. Could you just explain that in greater detail to me?—Yes. Economies can only be made, without damaging the efficiency of a medical service, if they are made under the constant advice of those who are expert in the organisation. For that reason if any medical economies are to be made in a hospital, the staff of that hospital must be in full consultation with the governing body of that hospital. If anyone less expert than that staff were used as a source of advice to make economies, probably the economies that could be made would never be made and other economies which were damaging would in fact be made.

303. I can see the second part, but what I am wondering is this: is it suggested that if you had more joint consultation the medical profession could initiate in their suggestions economies which would be material in cutting down this very large expenditure?—I think so. Hospitals vary and are flexible, and they change in their work from month to month and year to year. Constant contact between the staff and the board of management would permit of suggestions being made from time to time by the staff, which suggestions would have a material effect in securing economies.

Mr. *Thomas Reid.*

304. There is one thing I cannot quite follow: you seem to rely on numbers to get this consultation, but there are doctors on the boards of management and on the regional boards. Presumably the doctors who are on thoroughly understand what is needed. Why do you want a greater number?—You have put your finger on the very heart of the question there. I would say this: the vital point in joint consultation between hospital boards and their medical staff is that the medical staff should be able to put a representative view and discuss a matter. Experience has shown us over many generations that that cannot be done just by one or two members. At our greatest teaching hospitals the medical committee or medical council for many years has in fact been composed of the whole senior staff. The medical council of St. Batholomew's Hospital, for example, is over 50 in number. I think it has some of the same virtues as a representative chamber which has over 600 members. It has the same virtue of representativeness.

Chairman.

305. We are in danger of getting a little at cross purposes here. There are two questions. One is whether there is adequate medical representation on the governing body itself to keep an eye on what is happening, and the other is whether there is adequate discussion between the governing body and the doctors to ensure that the development of policy is done with the full agreement of the doctors and on the best medical lines. I do not know whether we can altogether separate them, but as far as we can I want to deal first with representation on the boards and then come to the question of consultation in the more ordinarily accepted sense of the word. I think Mr. Reid put a question which you said was the nub of the matter, and I respectfully agree. Are there enough doctors on the boards and committees at the moment to keep an effective eye on what is going on and to say "No, you ought really to consult the medical profession before going into that"?—Our answer is emphatically that there are not enough. There are certainly not enough of the doctors who are actually employed in the hospital. Take, for example, one of the metropolitan regions containing perhaps about two

million people and extending from London down to the coast. Perhaps I might take the North East Metropolitan Region where there is one consultant in contact with the regional board. He is a surgeon in Colchester. Even with the changes which have just been made, I think he is the only consultant on that regional board, working in that regional board, the only one in the whole of that enormous region. That is fairly well paralleled throughout the country. That is not enough to produce an adequate liaison between all the consultants of that great segment and the regional board. There is plenty of evidence that since the appointed day misunderstandings and inefficiencies have occurred, and delays have cropped up, which we are sure would have been avoided if there had been better representation.

306. Is it not true, however, that it would be very difficult for a busy consultant to find time to do the work which membership of a regional board itself would require?—It has always been, again for many generations, one of the substantial portions of a consultant's work that he should be an adviser to the body which employs him.

307. Then you had the hospital more or less localised whereas now we are dealing with regional boards?—We can only say that the hospital staffs of this country are very willing and ready to adapt themselves to that, and it would in fact be quite practicable. He would doubtless not participate in all the work of the board, but he would be sure to be there on matters of medical significance.

308. You feel satisfied that, supposing it were decided to have three or four senior consultants in full time practice as members of a regional board, you could find them without difficulty?—Without difficulty, yes.

Mr. *J. Enoch Powell.*

309. Would the increase in professional representation on a regional board from, say, one to five be effective for obtaining the result which you have in mind, unless it were supplemented by some very effective arrangements for briefing those representatives? Is not that another part of what you are asking for?—That is quite correct. We have asked the Minister for that over the last two or three years. We have asked him to give official recognition to an advisory medical committee or council to each regional board, composed of consultants of that region elected by their fellows.

310. That is separate from "joint consultation" as you are using the term in your memorandum, is it not, because joint consultation is presumably consultation between the board and the advisory body?—Yes.

311. Whereas what we are talking about is an advisory body from which the representatives on the board derive their information, views and opinions?—Yes. (Professor *Cloake.*) It is only a question of the regional management arrangement. I think that, if you look at the teaching hospital set up, you will see very much what we are aiming at.

Chairman.

312. In the case of teaching hospitals you have got an easy problem because even the largest teaching hospital has a very small geographical area and relatively a much smaller body than even the smallest of the regional boards?—It covers a smaller area, that is true, but it is not necessarily a much smaller body. I think it always covers a small area of the country, but it is not so very much smaller than a regional board. The principles of representation are no more difficult to apply in regard to a regional hospital area than they are in a teaching hospital. I know that very well because I am the chairman of one of these committees composed of representative consultants from teaching and regional hospitals. We have no falling off in the attendance of members at our meetings because they come thirty to forty miles. A man thinks very carefully before he will accept the nomination, for which the Minister asks, to go on to the regional hospital board, but having accepted it he does his job.

313. How often does this body, of which you speak, meet?—Once a month.

314. You find you have a pretty full attendance, do you?—Yes, Sir.

315. Is that representative of all the medical staff?—The whole regional area sends representatives from each management committee group. That is all medical.

316. That is at regional level?—Yes, Sir.

317. Is that done in all the regions?—Yes, Sir.

318. I think all you are asking here is that a body of that kind should be officially recognised?—(Dr. *Rowland Hill.*) Yes. (Professor *Cloake.*) Yes and no. It is not that body of which we were speaking. It was the general body of consultants employed by the regional board who should have an elective right to appoint a medical advisory committee to the board. That is what we are asking for.

319. I think you speak of a statutory right. I take it you do not mind whether it is statutory or official in some other way?

—(Dr. *Rowland Hill.*) We have told the Minister that we would withdraw our request for it to be statutory if it were *de facto* recognised.

Mr. *Thomas Reid.*

320. You say you have had a lot of correspondence with the Minister. Why does the Minister object to the appointment? He must have explained his reasons to you? —It is, of course, with his chief officials that we have had all these discussions, and their first objection was that, if they were to make this committee statutory, it would produce a great rigidity in the Service. I could not see much point in that myself, but they made a lot of capital out of that and appeared to fear that, if they gave recognition to such medical committees, they might be called upon by other branches of the staff also to recognise similar committees. They appeared to me—I was present at all the discussions on this matter —chiefly to find it difficult to understand the significance and importance of these committees. That is understandable. Their real importance I think is appreciated most strongly by people who have had great experience of hospital life over many years.

321. Did the Minister raise any objection to such committees taking consultants away from their medical work?—Not at all.

Mr. *J. Enoch Powell.*

322. Supposing that such an arrangement as you have outlined were in force, namely, an increased representation of the profession on the regional boards, backed by recognised advisory committees, that would not, would it, in itself work for greater economy unless, as it were, a power of initiation were given to the advisory committee? I have in mind that, while many methods of economy must come to the notice of individual consultants and be available ultimately to such a committee, that would not have any result unless a power of initiation and a power of proposal were in their hands?—Yes. In such committees which existed before the war it was a to and fro process. The board of management would always be ready to receive suggestions from their medical advisory committee. The medical advisory committee was never a passive body which just answered requests from its board of management, and it is certainly the case that such a medical advisory committee should have the right to make suggestions to its board. Of course this is what we have always emphasised as being traditional for generations. Their advice should be nothing more than pure advice, and should not have any force in the committee or in the executive board above it.

323. You feel that the advice which would be forthcoming from such bodies would frequently be exercised in the way of economies?—I have no doubt about that from many years' experience before the war. To maintain the maximum economy was a vital necessity before the war in our voluntary hospitals whose funds were limited, and there is no doubt that great economies were produced without any loss of efficiency by this liaison for many generations before the war.

324. Can you give any examples where economies have been proposed by these committees in their present unofficial form which have not been able to find acceptance or even to be discussed owing to the lack of some such organisation as you are proposing?—No, I do not think so. The point we would make is that in large parts of the country the committees, which we desire to exist, do not in fact exist at all. I would emphasise this, that there are parts of the country where what we want is in fact in operation.

325. Can you name the areas where it is in operation?—I do not know any area of the country where it is really satisfactory and in operation as we would like it as far as regional boards are concerned, but as far as hospital groups and management committees are concerned there is great variation. In certain groups the staff have been unable to get any sort of advisory medical committee recognised by their hospital board at all. There are one or two areas of London like that. If you want me to name a specific example, in the Paddington Region the staff did produce an advisory medical committee which the management committee decided not to recognise or to pay any attention to, and set up instead a medical sub-committee of themselves, of the management committee. On the other hand, to give you the example of a group where it is working well, in the Woolwich area of London almost from the appointed day very satisfactory medical advisory arrangements have been in operation. Another area where it is unsatisfactory is Ilford and Barking. The staff there have got an advisory committee but the hospital management committee do not seem to understand the use which could be made of it, and its advice is commonly ignored.

Chairman.

326. How do you account for those differences—geographically or personally? —Where the majority of the management committee, and perhaps particularly the chairman of the management committee, have had experience of this form of hospital administration before the war they have brought it into operation after the appointed day. For example, the Chairman of the Woolwich Group, Alderman Harris, was for many years Chairman of the Woolwich War Memorial Hospital and well understood the proper way to work

with his staff. In another group perhaps most of the committee or the chairman have had no previous experience of working with a consultant staff. That is true, I think I can say, of the Paddington Group.

Mr. *Diamond.*

327. When you quote the Paddington Group as an example of what you do not approve, namely the appointment of a sub-committee of the management committee rather than representatives of the medical committee, and when you say that you want the medical committee to have powers of recommendation but not to tie the executive, surely what you are saying the whole time, and what this document is saying, is that you do not want larger representation on the regional boards and management committees but you want much more officially recognised and powerful consultation?—That is our strongest wish.

Chairman.] Before you came in, Mr. Diamond, Doctor Hill really did make that point. He said that, although they would like slightly larger representation, that was for the purpose of just seeing that the medical interest was watched, but consultation was the matter about which they really felt strongly.

Mr. *J. Enoch Powell.*] Would it not be of great value to this Sub-Committee, if there have been cases in the example to which Doctor Hill referred where proposals for economy and more efficient working have been put up and not acted upon, if we could know about them? It would obviously strongly reinforce Doctor Hill's argument, and it would be of assistance to us.

Chairman.

328. I do not know whether Doctor Hill can give us that evidence. It would not necessarily find its way to the British Medical Association—unless you have any personal evidence?—I have some personal evidence from the hospital to which I myself belong. I regard the Paddington group of hospitals as a costly group of hospitals, and I think considerable savings could have been made. Better liaison between the staff of that group and the management committee would have resulted in such economies. One hospital in that group, on the staff of which I am, had a considerable staff of people of all grades, including a lot of junior grades, and when they were taken over on the appointed day, owing to the lack of proper liaison between the consultants of that group and the management committee, and the board above them too for that matter, there is no doubt excessively senior gradings were given to a lot of staff. That must have cost public funds in that one hospital alone thousands of pounds a year, which need not have been spent with more skilled advice on those individuals to the administrative body before the gradings were given. There is no doubt that, when a body not very well instructed have to grade certain people, they will tend, I think it is only human nature, to err on the side of generosity rather than do an injustice.

329. To interrupt you, I think the point you are making is this: better co-operation between the medical and the lay sides of a hospital must make it more efficient?—Yes.

330. I think we must accept that, and say that efficiency leads either to better service or better hospitals or both?—Yes.

331. Your case is that you get that co-operation better on the lines set out in your memorandum, as extended by this evidence?—Yes. (Professor *Cloake.*) I would like to say that it also works back the other way. If the medical staff has representation on the board it does naturally become much more identified with the wishes and aims of the board itself. If the aim of the board is economy they are the very people to know why and how it can be effected, and they will carry that back to their own staff, so that you bring them enthusiastically and willingly into co-operation. That is a very important item, this identity of interest, so that the board and the staff do not feel that they are working with different aims, and sometimes at loggerheads.

332. Could we perhaps deal with the other two levels in this connection? You have spoken of the hospital and regional levels. Does the same apply at group level? —(Dr. *Rowland Hill.*) Yes. At group level there can be no doubt that the proper arrangement of our hospitals in the country should be that there is a recognised group medical staff advisory committee. If I had been the Minister with my knowledge of hospitals, I should have put that in the Act. There is one medical committee statutorily recognised in the Act. That is better known as the local medical committee which is the advisory body to the executive council, and that is recognised in the Act. A similar body advising the group of hospitals is just as vital, and should be in the Act. We asked for that as soon as we saw the present Act, and we asked that it should go into the Amendment Act.

333. Why was it refused?—It was refused, I thought, without the adequate attention which we should have liked it to have been given. The phrase used by the chief secretary of the Ministry in refusing it was that if it came into the Act he thought it would make the Service too rigid, and he thought it better——

334. Unofficially does any such body exist?—Unofficially, certainly; in some areas such as those I have quoted it is quite satisfactory, and in others it is most unsatisfactory.

Mr. *Turton.*

335. Doctor Hill has given most of his illustrations from London. Could he or Professor Cloake give illustrations from the provinces or from the rather less populated areas?—(Professor *Hartfall.*) In the Yorkshire area I can cite two where such committees are established and are working satisfactorily, and there is one in the City of Leeds Group 2 where such a committee exists but its efforts are stultified because its advice is completely ignored.

336. Where are the two which are working satisfactorily?—Harrogate is one, and the other is Dewsbury and District Group; both within the Leeds Regional Board.

Chairman.

337. Suppose you take the case where you have got a committee and their advice is ignored. Suppose in fact a committee was set up, whether the hospital management committee liked it or not, they would still only be an advisory committee. What do you think would happen? Would there be a conflict and a battle, or do you think that matters would be smoothed out and the work proceed smoothly?—I think in some instances there have been conflicts and battles. The power is in the hands of the higher committee, and they are quite at liberty to refuse to acknowledge or recognise the advice given; and that makes for frustration and loss of the spirit which we want to see brought into the Service.

338. We are looking for remedies for the inefficiency which must exist in any new service?—(Dr. *Rowland Hill.*) Our feeling about that is this: if the Minister were explicitly to recognise such committees in the Hospital Service as he has in the general practitioner service then members of hospital management committees would realise that in accepting office on a hospital management committee they were expected to co-operate with this advisory committee. At present they are given a complete option to co-operate or not. In the case of executive councils they are bound by the Act to co-operate with their local medical committees, and in fact co-operation is very good up and down the whole country in the general practitioner field.

Mr. *J. Enoch Powell.*

339. When you say they are bound to co-operate, would it be right to say that the local medical committee has certain statutory duties and is not merely advisory?—The Minister has the power to give it various duties, yes.

340. That differentiates it from the proposal which you are making for the Hospital Service?—It is a rather more powerful committee than we are suggesting should exist in the Hospital Service, but in fact ninety per cent. of the local medical committees' power is as an advisory committee flanking the executive council.

Mr. *Thomas Reid.*

341. I have one general question on this point. You have told us that the Ministry has refused your request. I do not know exactly the Ministry set up, but it has at headquarters medical advisers?—Yes.

342. I presume those medical advisers turned down the request?—It is very difficult to judge that. From discussions with the Ministry over a number of years, during the time that Sir Wilson Jamieson was Chief Medical Officer, I am of the opinion that he was very much in favour of the type of machinery which I have mentioned, but of course these Ministry of Health professional members are purely advisory, as you know, and I think the decision not to accede to our request was made by the administrative officers.

343. The civil servants?—The civil servants.

Chairman.

344. Mr. Reid, I do not know whether at the moment we can deal with that?—If I may just say one last remark about this—we should not like this to be misunderstood—in asking for these joint consultation medical advisory committees the profession has no desire to trespass beyond its proper field. We only ask for co-operation. We do not want to exercise any domination; that would be improper, and we have no ambitions in that direction.

345. If I may say so, I think you have put your case with great moderation in this respect. There is one other small point on this matter. You speak of consultation at the highest level, that is to say between the Ministry and the doctors as a whole?—Yes.

346. In your memorandum you speak of the Central Health Services Council, and on page five you say this, "The Central Health Services Council does not fulfil all the requirements of such joint consultation, in that it is in the main an appointed body as distinct from a body representative of staff". Are you suggesting that should be re-constituted?—We were not going as far as that because we knew that would mean an amendment of the Act, and also of course we would not deny the right of the Minister to set up or to appoint any body he wishes to tender him advice. What we do say is that in addition to any such advice he chooses to seek for himself, if

the Service is to be efficient, economical and happy, and with good morale, he must have regular joint consultative arrangements with the profession's own chosen representatives as well as his own choice of advisers.

347. There is consultation going on constantly between the representatives of the Minister and the British Medical Association and the Royal Colleges, is there not?—Yes, there is, but one feels all the time that it is very much *ad hoc*, improvised, unofficial, might stop at any moment and lacks a certain amount of continuity. To give one example, the unfortunate registrar circular, which caused so much discussion and anxiety, would never have appeared had there been proper continuity of joint consultation between ourselves and the Minister.

348. There I think you are complaining of particular actions rather than the set-up?—It was not so much the action. I do not myself really believe this action would have been taken, but I admit that is an opinion of my own.

349. I do not want to embark on very controversial ground?—I would say that in my opinion the joint consultation between the hospital staffs and the Ministry could be much improved, given more recognition and greater continuity. What usually happens is that when we feel worried about something we have to go to the Ministry. We talk it over with them; sometimes they say "Yes" with a certain amount of readiness, and at other times it is difficult to arrange a conversation.

350. You would like the policy modified so as to find a rather warmer reception?—A continuity of contact. We feel it is in the public interest and in the efficiency of the Service that there should be a continuity of contact, constructive continuity, with the profession's own representatives as well as any advisers whom the Minister, perfectly rightly, chooses for himself.

Mr. *J. Enoch Powell.*

351. By "continuity" you mean that it should be regular and official?—Regular, official and recognised. We feel there is nothing in that which is unconstitutional, but we are quite sure the Hospital Service will never work smoothly without it.

Chairman.

352. Now, Doctor Hill, I think you were warned that we would like to know something more about the attitude of the British Medical Association, as representing the general practitioners, to the Hospital Service?—Yes.

353. You say very little about that in your memorandum, but on the other hand there have been many statements made in the Press of the country that the general practitioner feels that he is being squeezed out, to use a colloquialism. Is that the official view of your Association, and can you say on what ground it is based?—Yes. I do not think the view of the British Medical Association is in fact very extreme on this matter. I would sum it up by saying this, that they have deplored the possibility of the complete extinction of the general practitioner hospital. It is the feeling of the Council of the British Medical Association, and I think I can say of the consultants as well, that a certain proportion of general practitioner staffed hospitals in appropriate areas should continue to exist as part of the Service.

354. Taking the hospitals as a whole, has the number of beds in which the general practitioners can treat their patients within their own, I think the word is, expertise increased or diminished since the Service came into operation?—I should have said it had diminished because there was a tendency immediately after the appointed day for many hospitals to be upgraded, and that meant putting the beds in charge of consulting physicians and surgeons. There is no doubt that the number of beds in charge of general practitioners did diminish as a result of that. The British Medical Association would say this, that probably some of that diminution was quite right and proper. A hospital in a big district, serving a big population, should have consultant physicians and surgeons in it, and it was quite a right move to upgrade such a hospital; but the general practitioner hospitals, found perhaps in sparsely populated areas, the cottage hospitals, undoubtedly were reduced in number after the appointed day by this upgrading process.

Mr. *J. Enoch Powell.*

355. Is there a financial aspect to that? I presume the upgrading, at any rate where you consider it unjustified, is an additional and unnecessary expense—is that correct?—It would be more expensive. The staff would be paid much more, and also of course it would mean an alteration in the work. That would mean more equipment and supplies, and a further increase in expense.

356. Is that saying that a service is being provided which is not necessary or at any rate not fully justified, or that for the same service you are paying more because of the upgrading of the hospital?—No. The upgrading would mean a different stamp of work, and that was why it would cost more—not the same service.

357. Yet in a number of cases you consider the upgrading to be justified?—Yes, when there are adequate consultant facilities quite readily available.

358. So there are cases where the upgrading of general practitioner hospitals should be looked at in view of the availability of consultants' services in their area?—That is so.

359. In your opinion economies could be obtained by reviewing a number of such cases?—Yes, I think that is possible. I do not know that they would be very substantial economies, but at the same time the staffing has been a little extravagant here and there throughout the country.

Mr. *Diamond.*

360. Do I gather that would mean a reduction in the number of consultants employed in the Hospital Service?—I should think it would more likely mean their transfer. The total number of consultants in the country to-day is inadequate to give the country a full consultant service as meant by the Act. We have 5,200 consultants, most of whom are part-time, and it has been estimated that to give the country a proper consultant service it needs 7,500 on a whole-time basis. So I do not think it would mean a reduction in the total number of consultants. It would probably mean they would be transferred elsewhere, or offered alternative posts elsewhere.

Mr. *Turton.*

361. I am speaking in non-technical language, but do you think one of the effects of the Act has been that certain small hospitals in rural areas, where prior to the appointed day they dealt with operations, now no longer are allowed to deal with operations, but all their patients have to be sent to a central hospital?—In various parts of the country I think that is true, and has occurred.

362. Has that meant a certain increase in expenditure by reason of their unnecessary transfer?—Yes, I think so, a small increase. I think what has happened more commonly than that has been that at the type of hospital you have mentioned they have decided they will attach consultants to it, and the consultants—this has been undoubtedly an additional cost—have had to travel from a large centre out to that hospital to do the work there. (Professor *Hartfall.*) I could cite a typical example of that. At Skipton in Yorkshire, where there was a well-run cottage hospital, the work of operations, medical work, obstetrics and gynaecology was done by the general practitioners who occasionally called in a consultant, either from Bradford or Leeds, to deal with the more difficult problems. On the appointed day the whole character of that hospital was altered. The general practitioners were forbidden to attend, and a series of appointments were made to that hospital of consultants doing a certain number of sessions. That is a striking example in our part of the world, and it created so much unrest that I think it has been, or it is being, reversed and the hospital is now going back into the hands of the general practitioner largely.

Chairman.

363. You have competing needs, of course. You have got the need for the general practitioner bed, and you also presumably have some considerable need for the specialist bed?—Yes, that is so.

364. The question to be decided is which is the greater need?—That sort of need could be much better judged by the profession than by the administrator.

365. You are saying the profession was not properly consulted?—I am quite sure it was not. (Dr. *Rowland Hill.*) That is quite true. No doubt inadequate consultation with the profession resulted in some of these mistakes.

366. I fancy there may have been a difference of opinion within the profession on that question?—Yes. That is why it is so important that it should always be a representative opinion of the profession which is taken, and not the opinion of one man or two men.

Mr. *Diamond.*

367. As I am not quite clear about Doctor Hill's previous answer about the transfer of consultants could I ask this: in the case of Skipton Cottage Hospital what were the consultants doing prior to their appointment to this cottage hospital and what have they been doing since?—(Professor *Hartfall.*) It varies a little. Some consultants were newly appointed to do the work.

368. They would be additional consultants?—Yes, not only working in this one hospital but doing sessions there, going out a certain number of days per week; others were already established in the area, in Bradford or Leeds, and were asked to do certain additional sessions.

369. Do I gather that in this case of the Skipton Cottage Hospital the upgrading has meant either the engagement of additional consultants or an increase in the use of consultants' time at of course the appropriate charges?—It did. (Dr. *Rowland Hill.*) I think I should like to emphasise here that what is wanted is a balance, a skilfully judged balance. One could not get a worthwhile economy by downgrading a lot of hospitals and turning them into general practitioner hospitals again when in fact the circumstances are such that they should be consultant staffed hospitals.

Mr. *J. Enoch Powell.*

370. In your opinion that balance has by now been exceeded, the balance is tipped against the general practitioner?—It has

been tipped against the general practitioner since the appointed day, yes.

Chairman.

371. We have been told there is a tendency for the general practitioner, who of course gets no more emoluments for treating a patient, to say to a sick patient, "You had better go into hospital quickly", and of course, as the patient has not to pay any more, the patient is perfectly willing to do that. The result has been pressure on the hospitals to accept in-patients without regard to proper priority in view of the general shortage of hospital accommodation. Can you tell us, first of all, whether you know anything about that tendency, and, secondly, how you think the general practitioner could be induced to keep the less seriously ill patients out of hospital?—There is no doubt there has been that tendency since the appointed day. I understand it has varied a little in different parts of the country. It has been worse in some areas than in others. In the London area in particular the pressure on hospital beds increased enormously after the appointed day. It is quite true that all sorts of patients were put to the hospitals, patients who really should not have been admitted. For example, the chronically disabled people kept out of hospitals, or made it more difficult to admit into certain hospitals, acutely ill patients requiring some immediate and urgent treament. General practitioners in the London area have told me that they were only too anxious to give that treatment to many of their patients at home, but such was the volume of work which they have had in their surgeries since the appointed day, the enormous increase in their own volume of work, that they simply have not got the time to treat cases as they used to do before the appointed day. They are forced, therefore, to send them to hospital.

Mr. *Thomas Reid.*

372. In the poorer areas?—(Professor *Hartfall.*) In the industrial areas it is a fact that where the general practitioner has a very large number of patients, and I have met this time and time again, he literally has not the time to do anything but just ask the patient a question, and if he harbours the suspicion that it is something serious he has no time to examine the patient but sends him off to hospital for the problem to be solved there.

Chairman.

373. Without regard to the priorities?—Without regard to the priorities. He has sent the patient off to the hospital, and so our out-patients' departments become cluttered up with material which, if the general practitioner had time to do it, he would never send to us.

374. Have you any remedy to offer?—Yes, the general practitioner should have less work to do.

Mr. *Diamond.*

375. How is that to be achieved—by increasing the number of general practitioners?—(Dr. *Rowland Hill.*) It is a common complaint with general practitioners up and down the country that they now receive in their surgeries a large number of patients who really need not have come to them at all. It is one of the main reasons for the discontent of so many general practitioners to-day. One of them was telling me only yesterday that at his surgery he has many patients who come and ask him to give them a prescription for a bottle of cod liver oil, and when he asks them for what do they want it they say they have not the time to bother about that; they will not be examined; and please will he let them have the prescription quickly.

Chairman.

376. I do not want to interrupt, but we cannot enquire into the General Practitioner Service. I think we can take judicial notice of the fact that the general practitioners as a whole are hideously overworked at the present time. The problem we have to face is that they in those circumstances tend to send too many patients into hospital?—The problem is very much more complicated, as I am sure you realise. There are social necessities. People who used to look after elderly relatives are out at work now, and there is nobody left in the house to look after them. They have got to go somewhere to be looked after. There is no obligation on families to pay anything towards the support of elderly relatives who have been admitted into hospital, and so the hospitals cannot find a place to where the chronic sick patient can be sent. That is one of the bottlenecks now. There is no obligation on relatives to take them back home again, and they are liable to get left in the hospitals. Hospital authorities desperately anxious to have beds available for acute cases find their beds blocked up with such patients now. This is not a very large problem, but it is a real one. Relatives will not have these people back, and there is no hospital for the chronic sick available.

377. Does it not all come back to this initial problem of how are you going to induce doctors not to send the less urgent cases into hospital in the first place?—It is not quite the same thing because sometimes patients are admitted in an acute condition, but when they recover there is no place to which to send them. They are generally enfeebled or they have some chronic ailment which makes it necessary for them to be

looked after. Relatives are either unwilling or unable to have them, and that constitutes a bottleneck.

378. The doctors cannot help that; that is a social problem?—The doctors cannot help that.

379. The doctor's problem is how to get the patient properly treated. He has got no time himself, and you have no solution to offer except to say that we should have more general practitioners?—There is a barrier in the out-patients' department because a patient cannot be admitted into hospital, unless acutely ill, without passing through the out-patients' department first. There he is looked at closely by the admitting officer, and very often the patient goes back to his doctor with advice. Of course it is realised that is a barrier which presents hospital beds being occupied in many cases by unsuitable cases, but an acute case a doctor often cannot get into a hospital because the beds are occupied by the chronic sick or by people who ought to be passed on to other hospitals but cannot be passed on.

Mr. *Diamond.*

380. I really would like to know whether it is being suggested there is no machinery for preventing beds needed for acutely ill persons being occupied by persons who are not acutely ill but simply because their general medical practitioner sends them along or whether in fact the out-patients' department does act as a necessary sieve and allows through only those who are acutely ill?—(Professor *Cloake.*) That is true of the patients who go to the out-patients' department, but a patient who is deemed to be acutely ill does not do so. His needs for admission are so urgent that a direct admission is arranged without the patient passing through the out-patients' department.

381. His needs for admission are so urgent that it does not matter whether his general practitioner examines him or not; it would still be right that he should be sent to hospital?—Yes.

382. But in a case where it was not right, as I understand it, that he should be sent to hospital and the general practitioner would have ascertained that if he had had the time to give him a full examination, do I understand there is no real damage done in the sense of occupying a bed needlessly because there is this sieve of the out-patients' department?—The out-patients' department is an effective sieve in the one group of cases but no sieve at all in the other group. It is true that patients are sent into hospital from time to time in an emergency when in the experience of the physician or surgeon they need not have been sent into the hospital because they do not really need the services which the hospital provides.

383. And because there is no system within that hospital of examining patients, irrespective of whether they are alleged to be acutely ill or not?—(Professor *Hartfall.*) May I take up the matter? There are two methods of admission. One is from the out-patients' department of a patient who walks up and who will not have been examined by a doctor, and, second, the casualty or acute case. In my hospital last week, in my own beds, we admitted one in five of the cases sent up by doctors for acute admission, sending four home. That is the ratio. They were blocked at the casualty entrance. They were presumably acute cases, not out patients who can walk up but cases which came up by ambulance, still not perhaps not fully or properly examined by a doctor who thought they were sufficiently ill to be taken in under an acute admission. One in five examined by the hospital doctor is admitted, and four are sent back because we have no beds and because their condition is such that they can be safely, having been examined, referred back to the general practitioner.

384. That is exactly the question I am asking. I understand that there are no beds because the beds are occupied by the acutely ill patients?—No.

385. One in five, all of whom have got through the sieve?—We take the old man in who has had a stroke in the one in five, but he is in only until his relatives will take him or we can get him into a chronic hospital. There is a certain limit to our beds. If we have a number of those we cannot take in any more, and we also cannot take in the acute cases.

386. The problem is not the patient being admitted who has been inadequately examined by the general practitioner but the problem of the patient who is admitted, whether adequately examined or not by the general practitioner, because the hospital were satisfied that he was acutely ill. He was acutely ill; he recovers, but he has no place to go to from then on?—Yes.

Mr. *J. Enoch Powell.*

387. Is not this your contention, or at any rate one of them, that the size of the holes of the sieve, whether that sieve is the hospital door or the out-patients' department, is determined not by the actual conditions of the patient but partly by social and medical conditions outside the hospital, not under the control of the hospital?—(Dr. *Rowland Hill.*) Yes, that is true. Some year or so ago the Minister issued some statement to this effect, that hospitals should put aside ten per cent. of their beds for chronic patients. That was to meet a social need. It is the case that it has been

impossible for hospitals to refuse admission to some of those cases, and it is the case today, in very marked contrast with the position before the war, that there are many more such chronic cases which can only be looked after in those beds.

388. Is there a financial side to this? I mean in this way: if in fact a certain percentage of the occupants of hospital beds are not persons who, if there were other means of dealing with them, would be occupying hospital beds, are not the overheads both in consultants and otherwise excessive per bed for that reason?—For that type of case, yes.

Chairman.

389. Mr. Powell, I am very anxious that we should not go too far on the very question which has been put to the witness. What I think Doctor Hill has told us is that a fair number of beds in hospitals are occupied by patients who are properly admitted but who for social and not for medical reasons cannot be discharged, and I do not think we can press him any further on that. There is, however, the other side to it, and that is the pressure on the out-patients' department which may after all absorb some considerable proportion of the hospital's means. Can you say something about that being an undue pressure? —The out-patient pressure in many hospitals, though curiously enough not throughout the country, since the appointed day has been very great, much greater than before the war. It is undoubtedly a reflection of the pressure in the surgery of the general practitioner. I am not criticising the general practitioner who is making the very best job he can of his difficult position today, but when he has very heavy pressure in his surgery he is forced to send to the hospital out-patients' department many cases which he need not do if he had more time to spare, as he had before the war, before the appointed day; and pressure has become very great on many hospital out-patients' departments.

390. Can you say from your knowledge what proportion of patients coming into the ordinary out-patients' department of a general hospital ought not really to have gone there at all—fifty per cent. or what? —(Professor *Hartfall.*) I made a rough estimate of the percentage, and I should say twenty to twenty-five per cent. (Dr. *Rowland Hill.*) I should agree with that estimate. I think that would be right.

391. Of the out-patient facilities in the ordinary hospital, between one-fifth and a quarter are devoted to cases which ought not to have gone there. That is your view, and that is a fairly close estimate too?—Yes.

Mr. *Thomas Reid.*

392. Why do they go to the out-patients' department if there is nothing wrong with them?—(Professor *Hartfall.*) I do not say there is nothing wrong with them, but I say they are such minor things that they could be dealt with by the general practitioner if he had time to examine them and make a diagnosis

393. You have no remedy for the overworked general practitioner?—Except to get rid of the certificate signing which he has got to do. That would be the first answer.

394. Are not these certificates necessary? —They may be necessary, but they are not necessary to medicine.

Mr. *Turton.*

395. Is there a home for the chronic sick in or near Leeds?—Yes.

396. Can you tell me what is the cost per patient per bed in that home, as compared with your own hospitals?—No, I cannot. It is quite an exceptional home. It is in Harrogate in point of fact.

Mr. *Thomas Reid.*

397. It is much less?—Yes. There are certain blocks of wards put aside in the big old municipal hospitals which still take the chronic sick cases, but the cost of running that service must be much less than running an acutely-ill hospital service.

Mr. *J. Enoch Powell.*

398. Arising out of that, Doctor Hill rereferred to the suggestion of the Ministry of Health that 10 per cent. of the beds in general hospitals should be set aside for the chronic sick. If it were found, taking one month with another or one year with another, that a certain proportion of the hospital beds were, under present conditions, in any case occupied by persons not requiring full hospital treatment, could not economies be obtained by regarding that proportion of beds as in fact requiring a lower establishment?—(Dr. *Rowland Hill.*) The point is that these cases are in the same wards where the acute cases are, and you could not reduce your staff.

Chairman.

399. I think that is not a question for the doctor really. I think it is a matter really for the general administration of a hospital. A doctor can answer whether it saves their time, having these half-cured patients, but that is as far as they can go? —One certainly cannot reduce one's medical staff because some patients in a ward are chronic cases not requiring much treatment.

Mr. *J. Enoch Powell.*

400. It is only if you could put them in a separate ward that you could obtain such economy?—If in a large municipal hospital

you put aside one section of that purpose, that could be run at a cheaper rate.

Chairman.] Are there any further questions on the general practitioner aspect of the Hospital Service? There are some bits and pieces.

Mr. *Turton.*

401. With regard to private beds you suggest in your memorandum that it would be best if amenity and private beds were amalgamated; and you then end that paragraph by suggesting that "The amenity bed appears to be a fad of the present Government, and should be abolished as a separate institution". I wondered if you would develop those two points?—We think it should be abolished by being merged into the private bed, the merging having a certain modification of the private bed. A private bed in hospitals before the war was quite commonly charged for at a maintenance rate which was less than the actual cost of the bed. In most hospitals before the war they were in fact designed for people of moderate means, and there can be no doubt that, because in the Act to-day there is a section which says the maintenance charge for a private bed must be the actual cost in that hospital, in many parts of the country the cost of a private bed has risen to such a figure that it is beyond the means of most people in that district, and in fact the numbers in use have thereby fallen greatly. The private bed proportion has declined. There is no doubt that there are a certain number of people of moderate means who would very much like, if they could, to be treated with some privacy. Doubtless that is the principle which lies behind the amenity bed. We think the best arrangement, in the interests of the people and of the Hospital Service, would be to reduce the charge of a private bed, and make it perhaps a uniform figure throughout the country. That in some hospitals might be considerably less than the maintenance charge, but at the same time it would permit a patient going into such a bed to be a private patient and to pay the consultants who deal with him similarly modest fees. We agree that for such beds they should be fees of a reduced and modest character. We believe that would bring considerable income to the Hospital Service. Through the closure of and a reduction in number of private beds owing to their high cost the Hospital Service must have suffered an income loss of many thousands a year to offset against this expenditure. I know Professor Cloake is interested in that point, and he will deal with it in a moment. We believe that it is in every way the best thing to do, to produce throughout the country a uniformly moderate price for a private bed which contains all the respectable and legitimate advantages of a private bed with an amenity bed.

Chairman.

402. When you speak of advantages, by that you do not mean the amenity in the hospital is the advantage but the choice of a consultant surgeon or specialist?—The choice of a consultant surgeon, the guarantee that you will be in his personal charge and he will do the treatment himself upon you.

Mr. *Thomas Reid.*

403. Is the idea that the consultant surgeon should be paid by the patient?—He would be paid by the patient; he is the patient's own free choice.

404. You say this is to bring more revenue to the hospital, although you say that to reduce charges may mean supplying a bed below cost?—Yes. At present, of course, a patient who is quite capable of paying, and who would like to think he had to pay, shall we say, ten guineas, goes into hospital and pays nothing at all. We feel that, as long as it is the policy that there should be a proportion of private beds in a hospital, which is of course the Government's declared policy, it would be best that they should be moderately priced beds, and that this insistence that the patient must pay the full cost of maintence should be withdrawn. It is rather like killing the goose which lays the golden eggs.

405. You suggest you would get far more patients of that type and so would make up for the low charges?—That is right.

406. I see a difficulty in that someone has to fix the charge according to the means of the patient. That is a very difficult matter to decide. Who will decide that?—You misunderstood me; I did not say that. There should be a uniformly moderate charge fixed throughout the country for the use of a private bed.

Chairman.

407. I think the suggestion has been made that it should be the difference between the full cost of a private bed and the value of the bed to a patient who went in free. Would that be the sort of figure you had in mind?—That has been suggested, yes. That was suggested by the profession a year or two ago. As a person pays his contribution towards the cost of treatment and has certain rights to-day under the National Health Act, he should have those rights if he goes into a private bed.

408. There is an important aspect to this. A patient who goes into a private bed pays his own medical fees?—Yes.

409. At the present time there is a maximum to those fees, fixed by a schedule?—Yes.

410. Have you any comments to make on that schedule?—Yes. We have had protracted discussions at the Ministry of Health on the schedule. We pointed out to them that this was an impracticable and complicated sort of schedule in which certain operations were mentioned and others not mentioned at all. We got them to agree eventually to withdraw this schedule altogether and substitute some very simple level of fees.

411. Has that been done?—They changed their minds recently and said they regretted they had to go back to the schedule again, but they were willing to discuss all the details of it with us. Our view still is that to safeguard a patient against excessive charges it is not necessary to have a complicated schedule of this kind, in which a large number of operations are mentioned by name and others not mentioned at all. (Professor *Cloake.*) It does not apply to medical cases; the schedule applies only to surgical cases.

412. The schedule applies only to surgical cases?—Yes.

413. A consultant, in the lay sense of the word, can charge what he pleases?—No, Sir. There is a very definite maximum charge laid down, but there is no schedule. It is simply a uniform maximum for all medical cases.

414. A surgical case may involve an immense amount of time and trouble on the part of an individual surgeon?—Yes. One should realise that we used to have the practice of classing operative treatment as minor, medium and major surgery, and there were fees fixed for those. They were always very moderate fees, and they were always accepted both by the surgeon and by the patient. There was no need to lay down a very complicated system of operations and so on with their separate schedule of charges for each. It is quite unnecessary. It is very complicated, and it works actually unfairly. One surgeon can get paid a better fee for an operation which might turn out to be something quite easy than another surgeon can for a complicated and difficult operation.

Mr. *Thomas Reid.*

415. I am not quite clear on this system of the payment of surgeons. If a surgeon performs an operation on a patient who pays nothing, does the surgeon get a fee?—(Dr. *Rowland Hill.*) No.

416. The hospital gets the fee?—There is no fee.

417. In the other case, where a patient pays a fee, it would go to the surgeon selected by him?—That is right.

418. Therefore you have two surgeons operating in a hospital—the surgeon who is attached to the hospital and the outside surgeon who is called in for those who want him?—No. The vast majority of surgeons in the country are part-time, that is to say they are allowed to do private work in the hospital. They will do their hospital work for which there is no fee, and then in the spare time they have got they will treat their private patients in the same hospital.

419. Would any difficulty arise from the fact that the outside man and the surgeon who is attached to the hospital may want to operate at the same time?—It is the same man; outsiders do not come in.

Chairman.

420. It is a question of the time at which he does it—in the public time or in his own time?—(Professor *Hartfall.*) He is always a member of the hospital staff. (Dr. *Rowland Hill.*) We do give an undertaking to the Ministry that the hospital work, which we have contracted to do, we will do, and we will not allow private work to interfere with it. The understanding is that we will do our private work outside our public time.

421. That is working quite smoothly? There have been no complaints on either side?—Perfectly smoothly.

422. No complaints?—Perfectly smoothly.

Mr. *J. Enoch Powell.*

423. Arising out of your earlier reply to Mr. Reid dividing the cost of occupying a private amenity bed (to adopt your merging of them) into two parts—maintenance and consultant charges—I take it your idea is that the consultant charge would be paid by the patient and would go to the consultants individually, and therefore from that source there is no subvention of hospital funds?—No.

424. And that the maintenance charge paid by the patient would only be the difference between the cost, if he were a free patient, and the actual cost?—That was one suggestion which was made some time ago, but it is not our suggestion in this paper.

425. It clearly would not produce the result you anticipate because no subvention would result from it?—No. We are not suggesting that in this memorandum. That was the suggestion made by some person some time ago. Our suggestion in this paper is that the fee should be a uniformly moderate one which could easily be fixed by discussion.

426. But that it would be greater than the difference between the two?—Yes, I think it certainly would be.

427. You think you would induce sufficient people to come in under that system to provide a substantial reduction in the cost of the whole running of it?

—Allowing more public funds to be free to help the poorer people. (Professor *Hartfall.*) The saving to the Hospital Service would be this. With charges of private wings as high as they are, patients who insist on private treatment go to a nursing home and get it a good deal cheaper there. Therefore there has been a mushroom growth of nursing homes which are all full, but I think most of us would prefer to treat our patients in the private wing of a hospital if the charges were reasonable and most of our patients could probably be persuaded to go there. In that sense the private blocks would be kept full and overflowing, as they were before the appointed day, and there would be money saved.

Mr. *Thomas Reid.*

428. What is the explanation of so many people paying for medical assistance which is available free?—Some of them insist on privacy. I think that is perhaps one of the chief reasons. (Professor *Cloake.*) The residuum of independence in the population. It still exists.

Chairman.

429. People are still independent?—Yes.

430. I suppose the fact that you can be operated on by the person of your choice weighs a good deal?—(Dr. *Rowland Hill.*) Yes. (Professor *Hartfall.*) There is a great personal relationship between two individuals, whereas an ordinary patient has not quite that personal contact when he comes in for a certain operation to be done by some member of the staff. It may be done by the senior surgeon, the assistant surgeon and so on, but there is no certainty of the personal factor. (Dr. *Rowland Hill.*) Considerations of that kind probably activated the Foreign Secretary in the operation which ended so very happily.

Mr. *Thomas Reid.*

431. A great trust in his surgeon?—Yes, but of course he selected him and he was operated on in a private nursing home.

Chairman.

432. I think it would be useful if you could tell us your views on the present strength of consultants and specialists, and whether you have any views on the subject of recruitment and promotion, in other words the registrar problem, although I do not want to deal with it at all controversially?—There are 5,200 consultants in the country to-day, of which the majority are part time. One can almost work that out when one knows that the average salary received by a consultant in this country to-day is £1,600 a year. There is no doubt that the number is inadequate to cover the whole country. We all anticipate a steady increase going on. The profession has publicly expressed its disagreement with the Minister in his recent proposal to ration the rate of increase in consultant posts. We feel that the rate of increases which he proposes is most inadequate.

433. May I interrupt you for a moment and ask you to make the assumption that there will be very little, if any, capital expenditure while the present rate of re-armament is going on? Making that assumption would it mean that would be a reasonable rate of expansion for the specialist service?—In the number of consultants?

434. If you can express it in terms of numbers on full-time consultant work, with two half-time men equalling one full-time man?—On the whole-time basis we had estimated that in the next twelve months, judged by the need of the country, if it had not been for the Minister's statement there would have been at least four hundred new appointments of consultants.

435. That is new appointments less wastage of one sort and another?—Yes, less wastage—on a whole-time basis. We feel that a reasonable compromise would have been to reduce that perhaps to a figure of two hundred but that, if one fell much below that, there is no doubt the inadequacy of the consultant service is going to persist for a long time to come. It is the unanimous feeling amongst the consultants' representatives who have been in contact with the Ministry on this matter that the Ministry's proposed estimated figure of thirty new consultant appointments a year virtually means stagnation of the service for an indefinite period.

436. I must interrupt you again. The four hundred figure you gave us was the gross figure?—Yes.

437. The net increase would be something of the order of 280, assuming that wastage by death and one thing and another gave you about 120 a year, which is called an agreed figure. I do not think there is any dispute about that. It is the official figure?—The official figure is 150 vacancies a year, but that means——

438. Making a net increase of thirty?—Yes, in this country.

439. If you reduce your gross figure of 400 to 200 it would make a net increase of 80 in this coming year?—Yes.

440. Are you satisfied as doctors that there are facilities in the hospitals now to allow of an increase of that size?—Most emphatically, yes. There are ample facilities for a larger figure than that.

441. Would you say that there are facilities to allow of an increase of eighty a year over the next three years?—Yes.

442. Without any substantial capital expenditure at all?—Exactly. In fact we do not anticipate that the gross figure of 400

as mentioned would have necessitated any material capital expenditure. The point is that many hospitals in the country today are understaffed or inadequately staffed. They have got the facilities, but they have not got the staff.

443. Are they in conflict with the official view on that?—No, we have not complained at all that it is because there are not facilities that the figure is kept so low. We are not in formal conflict on that matter, but I have heard one of their officials express some views about it.

444. You have not argued on that then?—No.

Mr. *J. Enoch Powell.*

445. Are the figures which you are mentioning on the assumption that the number of registrars will remain as at present or be reduced as proposed, because I understand that the registrars do in fact perform a good deal of consultant work?—I think that point has perhaps been a bit exaggerated, although I think it is true that a certain proportion of the 2,800 registrars do—but probably only quite a small proportion, not a material proportion. In the figure which I suggested we had not in mind any reduction in the number of registrars. We hope to persuade the Ministry to agree to have a further conference with us on this subject, to make them see a bit of logical sense about registrars which they have not seen yet. We would not contemplate any reduction in the numbers. If I may just deal in a sentence with that matter of the 2,800 registrars whom we have in the country today, not a single one of them earmarked for the purpose of being trained to be a consultant, that is a colossal dilution. Everyone of them was appointed because he was needed to do a job of work in a hospital, and if you get rid of him the job of work is not going to be done. With regard to the training system for consultants, about which there has been a certain amount of talk since the Act came into operation, there is no training going on at the present time.

446. That type of work is nothing to do with consultant work?—No. Mr. Messer said in the House of Commons, and this is a very accurate remark, "The basic hospital staffing system which should operate, and does operate over large areas of the country, is the three-tier system—consultant, registrar, house officers; and each has his proper work to do". The registrar might be called the warrant officer of the hospital.

Chairman.

447. The peculiarity of a registrar is that hitherto he has expected to remain a registrar for five years, assuming that he stays the whole course. Are you suggesting that it would be possible to have a permanent or semi-permanent grade of registrar who might remain in that status for ten or fifteen years?—It is the policy of the consultants, and I speak now for the Royal Colleges as well as for the British Medical Association as they have a joint committee on this matter, that there should be no permanent or long term duration registrar post. The registrar has been an officer in British hospitals for a century, and in all that time he has held office in any one post for a period perhaps on an average of not more than three years. The reason for that is that it is not a suitable job for a man to stay in any longer than that. If he stayed in any longer than that he would cease to benefit from the post. He gets worn out by it. Just as the house officer should not stay more than six months to a year in any one post, so a registrar should not stay more than two or three years in any one such post. The registrar either goes up or out.

448. You do feel then that the registrar is not really the third category of doctors in a hospital, but that his status is different in that he is passing through?—He is a temporary officer. Again, since the beginning of the 19th century, the only permanent doctor in a hospital in this country has been the consultant. He is the only man who, once he got there, would stay. He is rather like, although I suppose it is an exaggerated comparison, the Admiral of the Fleet who never retires but is always on active service.

Mr. *Diamond.*

449. Do I understand this correctly, that the registrar does not move from one hospital to another but he moves from the grade of registrar either out of that work or into consultant work?—In the past it has been quite commonly the case for a registrar to do several appointments as registrar in different hospitals. A colleague of mine was for three years surgical registrar at St. Bartholomew's Hospital, then three years at the West London Hospital, and then he managed to win a consultant post—but he might not have done. If he had failed then he would have had to have sought some other future in medicine.

450. When you say that it has worked out on average that a registrar has not been employed for more than three years——?—In any one post.

451. ——was that because he was moving from post to post as registrar, or that he was moving from the level of registrar into the level of consultant?—In the majority of cases they move to another post of similar type. I should think a high percentage of consultants before the war might have spent six, seven and up to ten years sometimes in posts of that sort before they won a consultant post.

452. And they they finally did win a consultant post?—A percentage of them.

453. A large percentage?—I should have said, talking of registrars as a whole before the war, a small percentage. It was fiercely competitive. It was just the few who were called. The philosophy is quite different. The fact that some people now feel that once a man becomes a registrar he should ultimately become a consultant—well, we can think of nothing more damaging to the standards of medicine. The consultant should be drawn from the cream of registrars in an atmosphere of fierce competition, as he always has been.

Mr. *Thomas Reid.*

454. Could I ask a question about this charge to a patient? You make the rather drastic recommendation that those people who could afford it should pay a "hotel" charge for board, for example, when admitted into hospitals. Do you support that? It means that, first, you would have to have a means test and, secondly, is it not rather stiff on people who are paying very heavy taxes for this Service to be told that, in addition to the taxes they are paying—and the richer people are most heavily rated—when they go into hospital they have to pay a hotel charge as well?—The so-called "hotel" charge is not of course the idea of our profession. It came from other sources although we are sympathetic towards it, but we understand that, if a person is disabled and has to go into hospital under the National Health insurance scheme, he will receive certain benefits by virtue of being out of work. It is felt that he might well pay for his board, and even something towards his lodging in hospitals. The Act, of course, undertakes to give him free medical and surgical treatment. Our reason for supporting it is that there is a limited sum which can be spent on the Health Service, and if the population could bear some of their board and living charges in a hospital it would free public money to expand the facilities for the treatment of their disease.

455. What about the means test side of it? Who would decide whether the patient should pay something or not—the doctor?—This was a very old practice operating both in municipal hospitals and in voluntary hospitals, and it was traditionally one of the duties of the almoner. It was not carried out in any harsh way, but the almoner traditionally went into all the social circumstances of a patient and his family before the war and would ask them to contribute according to their means.

456. The system was different before the war. Now we all pay heavily for this Service—£400,000,000 a year. It is rather stiff on the person, who is paying a tremendous amount in income tax and other charges, to be told that he must pay in the hospital?—We only suggest it, as we say in our memorandum, for people who could afford to pay without hardship, and the almoner could easily assess that. It could be some agreed contribution.

Chairman.

457. Mr. Reid, I did not want to ask the doctors to express a view on this except in so far that we have got their view that they would like something of that sort. I think myself the conclusion we can draw from that, if I may say so respectfully to them, is that from the medical point of view they see no objection. I do not know that it can carry weight with us on the social aspect of the matter. It is for the almoners or other organisations to argue for and against?—Yes, it is merely an expression of how conscious we are of the tightness of the budget.

458. Well, Gentlemen, we are extremely grateful to you for coming here and giving us so much help. You will, of course, be supplied with a proof of the evidence which you have given to us. If there are any matters which you feel need correction or if you feel that you have touched on subjects which are matters of negotiation between you and other bodies and which perhaps ought not properly to be disclosed, perhaps you will get in touch with our Clerk and we will see what we can do to meet you on them. Thank you very much?—Thank you very much. There is just one matter which I am rather anxious to record, in case there should be any little misunderstanding about it. We should not wish in any way in our evidence to express the least criticism of the general practitioner in our reference to his inability to examine certain cases thoroughly. It was not that we wished in any way to question their industry or their capacity, but merely to say that it was due to pressure of work.

Chairman.] I think the Sub-Committee understand that very well, and I think the evidence will show quite clearly what you meant.

The witnesses withdrew.

Adjourned till Thursday next, at 4.15 *p.m.*

THURSDAY, 8TH FEBRUARY, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. Alexander Anderson.
Wing Commander Geoffrey Cooper.
Mr. Diamond.
Mr. J. Enoch Powell.
Mr. Thomas Reid.
Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Sir BASIL GIBSON, C.B.E., J.P., Chairman, Mr. L. W. FAULKNER, Secretary, and Mr. J. EVERINGHAM, A.C.A., Treasurer, Sheffield Regional Hospital Board, called in and examined.

Chairman.

459. Sir Basil, we are very glad to see you here this afternoon, and we are very grateful to you for sending us a very full and clear memorandum* if I may say so?—(Sir *Basil Gibson.*) Thank you very much.

460. This Sub-Committee of the Estimates Committee is looking into the question of Hospital Services, as I think you have been told, and we shall wish to ask you questions arising out of this memorandum and on other matters which have been put to us in the course of our enquiry. You will be furnished with a print of the evidence taken today, and if you have any corrections to make or if there is any matter which you think might prejudice present discussions would you please inform our Clerk and we will see what we can do to meet the point? First of all, Sir Basil, is there anything you would like to say in amplification or correction of the memorandum which you have sent to us?—I do not think so. I would like just to emphasise a point which is really fundamental, and that is that when Parliament passed this Act of Parliament it placed the duty to provide these services upon the Minister. The Minister for the purpose of discharging that duty had to set up regional boards and committees of management, but we all act as agents for the Minister. We have no independent policy. The policy is the policy of the Minister of Health. What we do we do as his agents. That is fundamental to the consideration of these questions relating to regional hospital boards. We are not like a local authority having separate statutory powers and separate statutory duties. I mention it because it is frequently overlooked that this particular Act of Parliament, for the first time as far as I know, places broadly on the shoulders of a Minister of the Crown a duty which he has to discharge, and everything we do we do for and on behalf of the Minister. In effect there is a relationship, not quite a commercial relationship, but a relationship of principal and agent.

461. I think the Sub-Committee perfectly understand that, but would it not be true to say that the Minister does in fact give your Board a fairly wide discretion in a number of directions?—In the management of hospitals, yes.

462. I think it will be as regards that discretion that most of our questions will be directed this afternoon?—Thank you.

463. I think it would be convenient if, as far as possible, we began by following the order in which you have taken the subjects in your memorandum which you have submitted to us. First of all you say that the Sheffield Board has 30 members, and in that respect I think it is the second largest Board in the country. Would you tell us whether you think that is the right size, or whether it is too large or too small?—We find it a very convenient size, and we also find it convenient if you have to have regard to some representation geographically.

464. Does the Minister in appointing boards have regard to geographical considerations?—Yes.

465. In any new appointments that he has made since the appointed day, has he sought your advice?—Yes.

466. Has he in fact always followed your advice?—No.

Wing Commander *Geoffrey Cooper.*

467. Could you just say in passing, as a supplement to that question, how a selection of the names you recommend would be made? Would it be done by a vote of the whole board, or how would it happen?—Originally, as indicated in the memorandum, the Minister found his own members of the Board, and he found them largely through his own officers, and particularly through the two or three people who had conducted the survey. When they were conducting that survey they got to know the people who were most interested in the hospitals in this particular area, and the Minister did show to us a list of the people he had before he made the appointments and we said whether or not we had any objection to any particular one of them.

* Not published.

468. Who was the "we" in that case?—I was. I was the only person appointed then. It was then that this list was shown to me. Since then, when there has been a vacancy, the regional representative of the Minister has consulted me, and I have occasionally mentioned the names he has given to me to some members of the Board, but he frequently asks me to supply him with names in which event I get in touch with someone in the district which needs to be represented, and send those names to the regional officer.

469. It is all very casual?—Very casual indeed.

470. It just depends on you almost entirely as to the sort of names which are brought forward?—Upon the Minister's own representative. He is in the region, and he obviously gets to know a lot of people in the region.

Miss *Ward.*

471. You send always a selection of names?—Yes, we never send one only.

Chairman.

472. It might be an appropriate place here to deal with the question of what I think is called medical representation on the Board?—Yes.

473. What numbers of members of the Board are professional men or women?—Eight.

474. Are they all doctors or surgeons?—Yes. Geographical representation does not apply to them so much as it does to lay representatives. They are representing a particular branch of medical knowledge.

475. I was going to ask you that. Are they in fact mostly consultants employed by the Board itself?—Yes, I should say so.

476. Can you tell the Sub-Committee how many of them are actually in whole-time or part-time employment of the Board?—Mr. Ernest Finch is part-time; he is a retired surgeon. Dr. Grout is an active radiologist; he is part-time. Dr. Slack is a general practitioner in the General Practitioner Service; he is not in the service of the Board, but I am told he has a contract with the hospital management committee. Dr. Brown has a part-time contract with the Board, and he is a cardiologist. Dr. McCrie is the Dean of the Faculty at the University; he has not a contract with the Board, but he has an honorary contract with the Board of Governors. Dr. Barber is a retired physician, and I do not think he has a contract. Councillor Miss Glen Bott is a gynaecologist, and she has a part-time contract with the Board. Dr. Drury has a full-time contract; he is medical superintendent of a large mental hospital. Professor Roberts is Professor of Dental Surgery at the University, and he will have an honorary contract with the Board of Governors. I think that accounts for the eight.

477. I think you said that two of the medical members were retired?—Yes.

478. Does that mean there is a certain amount of difficulty in getting active practitioners or consultants to serve on the Board owing to the time it takes?—I should say not.

479. They are chosen simply because they are suitable people to serve?—Yes.

480. And not because they have got time to spare?—I should say so. Dr. Barber has been a very fine physician, and he has only just retired. I should not think he was selected because he had retired.

481. Can you also say whether you have had any representation from, or discussion with, the medical profession or its representative bodies about their representation on the Board?—I can say I have not, and I am sure the Board has not.

482. You do not know—there may have been representations made to the Minister of which you would have no knowledge?—I agree.

483. In the ordinary way I suppose such representations would go direct to the Minister and not come to your Board, as you do not appoint yourselves?—One would anticipate they would.—The Minister's representative would now tell us whom he was proposing to suggest. In fact there will be a retirement of a general medical practitioner in March, and the Minister's representative did submit three names to us. I indicated, after consulting some of my medical colleagues, which we preferred; and we in fact put the three in order of priority. Who has been appointed we do not know.

Wing Commander *Geoffrey Cooper.*

484. What is the constitution of the Board? Is it always a certain proportion of medical men and laymen?—It is generally about one-third.

485. One-third medical and two-thirds lay?—Yes. I do not know whether that is provided for in the Act.

Chairman.

486. It is in the Schedule. Do you find the medical members of the Board tend to serve in any sense as representatives of the medical profession, or are they simply like any other member of the Board, only having, of course, special medical knowledge?—I should say the answer is that they are just ordinary medical members of the Board. There is no attempt to join together to enforce a particular point of view, nor has there been an attempt up to now to do so.

487. Do the profession try to get their views expressed at the Board through the medical members, or do you not find that?—No, we do not find that. Our board meetings are very short generally. We do not have a great deal of discussion at board meetings. The Medical Committee itself meets as a medical committee and submits its minutes to the Board. Every minute which it passes is subject to the approval of the Board, and is submitted to the Board formally.

Mr. *J. Enoch Powell.*

488. You do, however, say at the top of page seven of your memorandum that your Medical Committee is in touch with area consultant committees, and so presumably the view of the consultants represented by those committees reaches the Board through its medical committee?—Exactly. The medical committee is the apex of a triangle, just below which are the specialities. There are advisory committees on every speciality, and below that there are five area consultant committees, all of which give advice to the medical committee of the Board through the senior administrative medical officer. Then in addition a consultative committee, if you like to call it that, holds regular meetings between the official medical staff of the Board, the medical officers of health and the representatives of the local authorities.

Wing Commander *Geoffrey Cooper.*

489. Can you give us any idea of the type of matters on which those area consultant committees advise?—I do not think I can answer that question.

Chairman.

490. I think we had better deal with consultation separately. Are there any further questions on membership of the Board? Perhaps we can now go to the area of the region, which I think is the next major question to which you refer in your memorandum?—It might interest you if I gave you a map of the region.

491. I think it would be very convenient?—(*Map is shown to members of the Sub-Committee.*) I am afraid I cannot let you keep that one—I had to borrow it hurriedly—because it is marked with symbols for each type of hospital, but I can supply one to you. You see the two shaded areas, one in Derbyshire and the other in South Lincolnshire. Those two pieces are not part of the area of the Board, but apart from those two pieces practically the whole of the area within that external line is the region.

492. Sheffield itself, which is your headquarters, is right up in the north-west corner of the Region. You mentioned that point?—Yes, it is the only University town in the Region with a Medical School.

493. Can you say, first of all, whether it is your experience that this Region is of convenient size? Would you like to see a larger region or a smaller region from the point of view of administering at your level?—I think the Region as a whole, having regard to all the considerations, is perfectly satisfactory. It is large. There is this very large agricultural area (*pointing to Lincolnshire*), but if you do not put it in Sheffield Region I do not know where it would go. It must be attached to some area with an urban population.

494. You have had no difficulties because your Region is too large?—No. The only difficulty we have is that there is a lot of running about. It is a big area to cover, the members are distributed, and therefore it is a little trouble to them to come to Sheffield. For that reason, as I mentioned in the memorandum, we have adjusted our meetings to make their attendances at Sheffield as few as possible.

495. Can you give any reason why a smaller region would be less efficient?—I cannot imagine a smaller region being more efficient. If you divided the Sheffield Region and left as a region the Lincolnshire side, it would be, I think, very difficult to work.

496. Why do you say that?—Because first there is no population to speak of, the hospitals are poor, and the district is a very scattered one.

497. You are taking the bit as left out, but suppose you had a region of the same general character as the present one but reduced. Suppose England were divided into twice as many regions as at present, and that re-organisation meant that Sheffield Region was about half the present size. It would have some advantage, would it not? It would be geographically more accessible?—It would be geographically more accessible, but that is all. If you look at the Region as a whole you will appreciate that, although Sheffield is in one corner of it, to divide it in any way would lead to difficulties. There are five centres in this Region to-day. One is Lincoln; another is Sheffield; another is Nottingham; another is Leicester; and another is Derby. There are five real centres of population. You might say that Leicester and Nottingham could go together and form one region, and the rest would form another region; but you would have difficulties with all sorts of things connected with it. There is no medical school anywhere but at Sheffield.

498. You are satisfied that the Region is a satisfactory size?—I am satisfied that this Region is the best region you could get to cover that area. You must take the region with the population in it and the hospitals in it, and if you take all those things into consideration I do not think

you could safely increase the area or reduce it. I think it is as satisfactory as it can be.

Mr. *J. Enoch Powell.*

499. Is a teaching hospital the leading factor? In other words, if there were a teaching hospital at Leicester, would one gain by dividing the present area into two, each based on one teaching hospital?—That is a question upon which one would have to think a very great deal. The centre would be Nottingham, not Leicester. Nottingham has a University now, and it may have a medical school some time, in which event it might be that the region could be divided. But if it were divided I think many difficulties would be created, and the medical school factor is only one of a number of factors.

Chairman.

500. Apart from major re-organisation have you had an adjustment of boundaries of your region at all since it was set up?—No.

501. Is there any need for any such adjustment?—Not as far as I know.

502. If you needed an adjustment to be made, have you got power to take steps about it or would you have to make a recommendation to the Minister?—I daresay we could make such recommendations, but I do not think it would come about that way. The adjustment could only be on hospital facilities, and if we needed facilities for a hospital just over our border there is very little doubt that we could arrange it with the regional board for the adjoining area. None of us regards boundaries as of any moment today. That is subject to what I say in the memorandum about the difficulty of accommodating mental patients due to the creation of the region, but, generally speaking today, if any new problem arose we should never regard boundaries as anything to do with it at all.

503. Leaving area as such for the moment, you have a population within the region of just over four million?—Yes.

504. You are one of the larger regions in that respect?—Yes.

505. But your facilities, measured in terms of beds, are, I think, the lowest in the country?—Yes.

506. Can you say, as a matter of interest, what the explanation of that is?—I have never sought for an explanation. If I had to suggest one, I should say it is the large agricultural area.

507. It is the agricultural area which is deficient in hospitals?—Yes, that is where the shortage of beds occurs and that is where there are difficulties.

508. That is as you found it when you took over?—Yes.

509. So far as the industrial area is concerned it was, if not well supplied, at any rate much better supplied?—Much better supplied. Our first hospital, if ever we build a new hospital, will be at Boston in Lincolnshire—first to provide more beds and, secondly, to remove a lot of very unsatisfactory buildings.

510. I think on page eight of your memorandum you deal with the question of possible increases. "If the staffed beds in the area of the Board were brought to the standard of the country generally, that is to say 992.5 per 100,000 of the population, to repair the present disparity would require the provision of 7,928 additional beds at a cost estimated to be in the vicinity of some £8,000,000". That is in terms of capital expenditure, and I take it that £8,000,000 does not of course include anything for the additional cost of maintaining them?—No. It is based upon £1,000 a bed. An acute hospital bed would cost more, and a mental deficiency bed would cost less. It is taken as an average, just for a rough calculation.

511. In your memorandum you also refer to the need of what might be called repairs, that is to say making good unsatisfactory buildings and so on, and also to the acute shortage of accommodation for mental defectives and tuberculosis cases?—Yes.

512. Can you say, having regard to those additional considerations, what you think it would be necessary to spend by way of capital expenditure to bring your Region up to the average for the country?—I think the £8,000,000 would cover it.

513. The £8,000,000 would cover the whole of it?—If we were brought up to the general standard throughout the country we should be in a very much better position than we are today, and some of the bed provision would relate both to mentally deficient patients and tuberculosis patients.

514. In order to provide sufficient accommodation for all your needs on a reasonable footing, what do you think you would need in addition to that £8,000,000 expenditure?—I do not want to give you an answer at present. We are a new board. We have had a lot of preliminary work to do. We are making a survey of the hospital accommodation which is required to fulfil the needs. We have dealt with mental illness, and have had the scheme approved by the Minister of Health. We have not dealt with general hospitals, and that is a very large and substantial problem. Until that survey is completed we could not possibly tell you in this region exactly what additional number of beds would be required.

515. Would it be fair to say that to supply your absolute needs, not merely to bring you up to the average for the country,

would involve quite a considerable expenditure over and above the £8,000,000?—Yes.

516. It might be as much again?—It might be.

517. But that would be a guess?—I should say it would be at least fifty per cent. more. I should say it would take another £4,000,000 easily, probably more. Today a lot of our hospitals are very old. For example, if you take the Sheffield Royal Infirmary which does not happen to be one of our hospitals, it is supervised by the Board of Governors, the first part was built one hundred and fifty years ago, and there are substantial portions of it one hundred years old. No hospital of that age can really fulfil modern requirements. You can try to improve it; you can probably do very, very good work there, but it is not a modern hospital. If we are going to modernise all the hospitals, which means doing away with these old poor law institutions, then obviously that is a very substantial expenditure of capital indeed.

518. I was not really meaning to go as far as that: I will put what I meant this way, to provide enough beds to put an end to the serious waiting lists?—I have never considered the question. The waiting lists are very substantial, but I have never considered that question.

Miss *Ward.*

519. What is the estimated expenditure for your mental deficiency scheme which has just been approved?—I have not brought the scheme with me, I am sorry. It is a fifteen-year scheme. It is divided into three sections—five years, ten years and fifteen years. I really cannot charge my memory with the figures either as to accommodation or possible cost.

Chairman.

520. It is a phased scheme?—Yes.

521. And it has been approved?—By the Minister.

522. You have every reason to suppose that it will be carried out in accordance with the approved scheme?—Yes, but the periods will now be altered because of re-armament, civil defence and that sort of thing.

Mr. *J. Enoch Powell.*

523. Have you been told that?—No, but one reads the newspapers.

Miss *Ward.*

524. From what you say does that then mean you do not think your Region will be sufficiently well equipped for mental patients until the expiration of fifteen years?—I should think the answer is "Yes", I think so. The need for mental deficiency institutions has not been appreciated quite as much as it ought to have been. The result is that there has not been this accommodation provided. In addition ten years of war has stopped the provision of these institutions. One was started by the County Council before the war, and we are just resuming the work; that was commenced twelve years ago.

Mr. *J. Enoch Powell.*

525. While Sir Basil has mentioned mental provision could I ask him to clear up a point in the memorandum at the bottom of page 8 where it says, "By the division of the West Riding of Yorkshire between the two Boards, the effect has been that the accommodation available in the Sheffield Region for mental and tuberculosis patients is appreciably less than the accommodation within the Leeds Region in proportion to the population", and then it goes on, "The position thus arises that the Sheffield Board are being continually pressed by the Leeds Board to remove patients in their hospitals to hospitals in the Region of the Sheffield Board"? That seems to be the opposite of what one would deduce. If I have made the point clear, it seems to be upside down?—It is not intended to be upside down. The position is this: before the appointed day mental hospitals were provided by the West Riding of Yorkshire Mental Hospitals Board. Sheffield was a constituent authority without any power of withdrawal, and that explains it. Hospitals which were provided happened to be in the area which is allocated to the Leeds Region, and we have only one of the hospitals in Sheffield.

526. That does seem to be a case where the boundaries are having a very appreciable administrative effect?—That criticism I tried to meet by saying boundaries did not matter since the appointed day. This difficulty arose before the appointed day. If there had been no Act of Parliament there would not have been any problem.

Chairman.

527. I think it might be convenient to go from there, before we deal with any questions of finance, to the question of the hospital management committees which are subordinate hospital authorities to you. That would be a fair way of putting it, would it not?—I do not think they would accept that. The Board appoint the chairman and the members, but beyond that the Committees regard themselves as entirely independent subject only to receiving their finance provisions through the Board.

528. I think we shall have to go into that in some detail. It is a very important question?—It is. They regard themselves as independent bodies.

529. First of all, you say that your original scheme proposed twenty-two groups of hospitals?—Yes, it did.

530. That was modified by the Minister to make thirty such groups?—Yes. May I correct that? It should be twenty-nine. We have thirty, but we put on the thirtieth. They put on the seven.

531. This is very important. Your original proposal was twenty-two?—Yes.

532. The Ministry then proposed twenty-nine?—Yes.

533. And you yourselves then added the thirtieth?—Yes. I can explain that quite simply, if it is convenient to do it now. The thirtieth is Sheffield No. 4 which was associated with a former radium institute. It was linked up with the Radium Commission, and all the radio-therapy work for a substantial area around Sheffield was transacted and dealt with through this institute. In order to link up the radio-therapy work in the Region, Sheffield No. 4 was set up and it really controls the former institute. There is a large out-patients' department, and it is linked up with the centres at Lincoln, Derby, Leicester, Nottingham and Scunthorpe. You can almost call them sub-centres or sub-institutes of this one institute. It was desirable to get the whole thing bound up together, and therefore we set up Sheffield No. 4 to do that. The alternative was to form a sub-committee of the Board. We thought this was better because we could put on the committee specialists who are connected with the work.

534. It is a very special case?—It is a very special case, and it has worked wonderfully well.

535. Can you say what sort of principle you applied in arriving at these groups of hospitals?—Yes. We tried to find a centre, and group around that centre a number of hospitals giving a bed complement of something like a thousand.

536. That was your yardstick, was it, a thousand beds?—Yes. You cannot always do it. There is a hospital and three or four more round it. You cannot possibly get a thousand beds, but the situation of the group in relation to any other hospital is such that you cannot attach it because there has been no contact between the two. We tried to take the view that even in one town we could have three or four thousand beds governed by one management committee. The Minister always takes the view that that is too many, and it is better to have something between one and two thousand. It is with very great reluctance that he would approve the setting up of a management committee which controlled many more than two thousand beds.

537. Have you changed your views in the light of experience?—No.

538. Or do you think you were right?—I have not even thought about it. We are working very amicably. One thing we have discovered is that the local hospital is as much an institution as is the local town hall. People regard it as their institution. If they are simply lifted as a group and attached to somewhere else, to an adjacent town with which they have had very little to do, they do not like it. It loses its identity ; it loses its interest ; and if you are going to maintain local interest you must have local representatives ; and that is best achieved by having probably a smaller group round that particular town.

539. Can I ask you this question, which I think will be a little less embarrassing to you perhaps? Has your Board as such ever made any representations to the Minister as regards the grouping of the hospitals for which you are responsible?—Since the scheme, no, with this variation—occasionally we have to transfer a clinic from one management committee to another.

540. Those would be minor alterations? —Minor adjustments.

541. You have rather suggested that a hidebound yardstick relating to the number of beds does not really go far enough, and that there are other considerations of which local patriotism is a very important one? —Very important indeed.

542. I think you have rather suggested that in your own view perhaps not enough weight has been given to local patriotism, and rather too much weight to administrative titles?—That is one point. The Minister's point was from his own experience, and it was our experience, too, that the West Riding of Yorkshire Mental Hospitals Board controlled about five mental hospitals with two or three thousand beds each. The Minister regarded that as too large for one administrative unit, and he probably went a little bit too far the other way. That and the Lancashire Board were considered to be too large, and certainly not satisfactory units. I will say, although I am a Sheffield man, that I agree with him. If I may go off the record for a moment I will say this was not an efficient unit ; it was too big.

Wing Commander *Geoffrey Cooper.*] Why should that be off the record? If we do not have full and fair criticism we shall not get anywhere.

Chairman.

543. I think Sir Basil is bound to give evidence here in his capacity as chairman of a regional board?—I was Town Clerk and Deputy Town Clerk of Sheffield for 20 years. I had a tremendous lot to do with this West Riding of Yorkshire Mental Hospitals Board. I was responsible for the promotion of a Bill to get out of

it, and I failed in this House by one vote. I was very disappointed.

Mr. *J. Enoch Powell.*

544. You do express the opinion in your memorandum that at any rate we should consider, if you will not, a reduction in the number of hospital management committees. Evidently you consider such a reduction is practicable without loss of efficiency?—May I ask where that occurs?

545. On page 10 under subsection (*h*)?—You asked us to suggest economies, and that I think you will find is under suggestions which might lead to economy. Every time you set up a separate hospital management committee you have got to set up a separate set of offices and separate staffs, and you have a separate organisation. Some of these organisations are very small. If you want an economy you could do it by adding two together. We have not said, and I am not prepared to say, which of our 30 should be amalgamated, but if you are looking for economies that is one line which could be explored. That is really all that meant.

546. The difference between 22 and 29 is a reasonable indication of the sort of extent to which such re-adjustments might be pressed without loss of efficiency?—You can put it that way. We suggested 22, but you must remember the Board had only just been formed. We had had no experience of it. We were just forming committees and setting them up. I have not even considered that point.

Chairman.

547. I think you rather suggest that there would be a difference here between the highly populated industrial areas and the sparsely populated rural areas?—Yes.

548. And in a highly populated industrial area I think you did suggest that probably a larger unit than a thousand beds might be quite convenient?—Yes. I have often thought you might take one town and make a hospital management committee for that one town. Take Derby, for example.

549. You think that would work quite well?—You would immediately get adjoining hospitals which could not be attached to any group. You would get isolated hospitals, and you would not know what to do with them.

550. Would you lose any local patriotism in that way?—Not in a place like Derby, I do not think you would.

551. It would rather add to it?—It might add to it. I have often thought it would be a good thing to consider whether you should not have, say, one hospital authority for one town, but then you have always got to think about those country places and they have got to be attached somewhere.

Miss *Ward.*

552. Do you think a reduction of the management committees would be a wise economy—that is quite distinct from being an economy?—I would rather not answer that question. I should want notice of it. I should want to think about it. We have got on very well indeed with our management committees. The members are interested; the people are interested. The work is done reasonably efficiently. I could not say at the moment whether it would be wise to amalgamate any of them. I should want to think that out rather carefully, because you might save a pound and lose a tremendous amount of interest.

553. That is the point at which I was getting?—I could not answer it straight away.

Mr. *Thomas Reid.*

554. There would not be great savings, would there, if you reduced them?—I should not think the savings would be substantial, but there would be savings.

Chairman.

555. Savings in central staff?—Yes, and particularly in these large mental institutions. You might amalgamate mental institutions. We have got a management committee for only one. That might be added to some other management committee, but I do not think the Committee which is now responsible would like it.

Mr. *Thomas Reid.*

556. It would not mean any reduction in the staff of doctors?—No.

557. Purely administrative staff?—Purely administrative staff.

Chairman.

558. Would it be fair to say that your attitude is this: you would not like to see any major re-organisation carried out at this stage, but it is a matter which certainly ought to be kept under constant review?—That would be perfectly fair, I would not recommend at the moment any re-organisation of Sheffield Region.

Mr. *Diamond.*

559. Does the initiative rest with you for altering hospitals within their grouping or are you willing to receive representations made from individual hospitals as to a variation in their grouping?—A suggestion might arise anywhere. Sometimes it would come from the management committee; sometimes it would come from our own staff; and sometimes it would be some member of the Board who would suggest it. But it would be some special circumstances which would lead to it.

560. You would in all cases be prepared, and be able, to give it consideration?—Oh, yes. There is a suggestion before us now for a change in Nottingham, and we are

having conferences with representatives of both hospital management committees and medical staffs, and everybody else interested. We should not make a recommendation to vary a grouping without consulting first everybody who was really interested. I have to make a special point of that.

561. Would you, therefore, accept the suggestion which has been made that the system is extremely inflexible, and that it is a matter of almost insuperable difficulty to get a grouping varied?—The only answer I could give to that is that we have had no such difficulty.

Mr. *Thomas Reid.*

562. In your long experience of this management would you complain of over-centralisation at the hands of the Ministry, or is there sufficient decentralisation?—As an agent I must never complain about my principal.

Chairman.

I think we must take the answer to that question by inference from those we have put to the witness.

Wing-Commander *Geoffrey Cooper.*] Why should we not have a frank opinion about it?

Chairman.

563. I think the witness has very properly said that it is no part of his job to offer direct criticisms. I think we might now come to consider the size and the functions of hospital management committees. Sir Basil, with one exception I think every one of the thirty committees consists of fifteen members?—Yes.

564. The exception, I suppose, is the one to which you referred?—Yes, Sheffield No. 4.

565. Putting that on one side for the moment, do you find that fifteen members form a satisfactory committee to do this work?—So far as we are concerned, yes, but I do not attend meetings of management committees.

566. You have heard no complaints?—No complaints at all.

567. You have had no requests from management committees to enable them to enlarge their number?—No.

568. Is there any power for the number to be enlarged?—Only with the consent of the Minister.

Wing Commander *Geoffrey Cooper.*

569. Or reduced?—Only with the consent of the Minister.

Chairman.

570. That has never been under consideration?—No. We started with a larger number, but after considering it very carefully we came to the conclusion that fifteen was an adequate number. It has been accepted, and no one has ever challenged it.

Wing Commander *Geoffrey Cooper.*

571. Is it the same in most parts of the country?—It varies a bit up and down the country, but fifteen is a fairly average number.

Mr. *Thomas Reid.*

572. They do not cost much in travelling expenses or anything like that?—The management committees, probably not a great deal, but to the Board travelling expenses and subsistence is a substantial expenditure. We can give it. (Mr. *Everingham.*) That is because some members travel a good distance to get to Sheffield. (Sir *Basil Gibson.*) Ilkeston, Leicester, Grimsby, Nottingham.

573. You would have the total travelling expenses for headquarters?—(Mr. *Everingham.*) I have not got it with me, but I keep it separately.

574. You could send it to the Sub-Committee?—(Sir *Basil Gibson.*) Yes. We could send you the expenditure for a year on travelling and subsistence by members of the Board. (Mr. *Everingham.*) I can do the same with the management committees.

575. You do not think there is anything excessive about those expenses?—(Sir *Basil Gibson.*) No, Sir, they are all controlled. The allowances are laid down. (Mr. *Everingham.*) Nothing is paid in excess of what it should be. (Sir *Basil Gibson.*) That is not the question. (Mr. *Everingham.*) They are laid down on a scale.

Chairman.

576. On page 5 of your memorandum, about two-thirds of the way down, you deal with the appointment of hospital management committees, and I think you are really saying there that they are appointed in accordance with a definite plan?—(Sir *Basil Gibson.*) Yes.

577. Local authorities—3; voluntary hospitals—3; medical and dental staff—3; other organisations, including one executive council—6?—That is in accordance more or less with the Schedule to the Act.

578. Do you find that satisfactory?—Yes, I think so.

579. How do you in fact get nominations, if that is the right word, from these various bodies for serving on a committee?—(Mr. *Faulkner.*) I can answer that. We have sent this year, for example, 350 forms of nomination to the organisations which should be consulted within the terms of the Schedule. These organisations are invited to state whether they wish their existing member to continue in service, whether they wish to provide a substitute

or whether they wish to put forward other nominations. Those in turn are considered by the Board's General Purposes Committee which makes its proposals to the Board.

Miss *Ward.*

580. Can you tell us how many organisations?—I could not tell you how many organisations, but the invitations which have been sent are in the region of 350. That is 350 for thirty management committees. On an average we consult with about eleven different organisations for each management committee.

581. They are the same organisations for each committee?—Sometimes. If you have a hospital management committee in a county area you would consult with the county authority in that area, if it is in a borough with the borough, in order to get local authority representation.

Chairman.

582. Do you consult with the subsidiary authorities too, the districts?—Not with the district; with the counties, the county boroughs and the boroughs; not with the urban districts normally nor with the rural districts. If they make strong representation my attitude has been to put those to the Board, and if the Board agree the nominee shall be accepted that is the Board's decision.

Mr. *J. Enoch Powell.*

583. The figures set out here apply only to the original formation of the committees, do they—for example, "voluntary hosiptals, three," that cannot go on?—No, Sir. Since the appointed day those nominations are invited now from the hospital management committees who are successors of the voluntary hospitals.

Chairman.

584. It is a form of co-option?—No, it is an appointment.

585. It is an appointment, but it is co-opted nominations, self-nominations?—(Sir *Basil Gibson.*) Hospital management committees send in such names as they think fit, and they send them in as representing the former owners of the hospitals. There would be no voluntary hospital to-day. That is how it is done.

586. Can you say how far the nominees of those various bodies are in fact appointed? Are they always invariably appointed or are substantial alterations made?—They are not invariably appointed. What we do is this: we have a form like every Government Department, and we ask for particulars respecting the person nominated to be put on this form. There are always many more nominations than there are seats, and those nominations are considered on the evidence set out on the form.

Miss *Ward.*

587. Could we have one of the forms so that we can look at it?—We will send you one.

Mr. *Thomas Reid.*

588. Are the doctors sufficiently represented on management committees?—Yes, we have to include the persons appointed after consultation with the senior medical and dental staff employed at the hospital or hospitals. In a group all the doctors form a group committee, and then that group committee would send in nominations for three seats on the management committee. We should probably accept those without question.

589. You have no complaints or grievance at all on that issue?—No.

Chairman.

590. Do you know as a fact that in a group it is the whole of the medical staff?—We are advised that it is. I know as a fact it is in some cases, of my own knowledge. Of course in the bulk of the cases I do not know of my own knowledge, but we are so advised. (Mr. *Faulkner.*) I think possibly the junior staff might be excluded from that in some cases. The junior house officer of, say, six months standing is not normally a member of the group committee.

591. It would be the senior staff and the registrars?—Yes.

Mr. *Diamond.*

592. There is no falling off then in the number of persons who are willing and anxious to serve on management committees. I gather from what you say that you always have more nominations, presumably with the consent of the nominees, than there are vacancies?—Yes. I would say there has been a marked increase this year in enthusiasm for serving on management committees. I can answer that from my experience, because at present the nominations I have had have not gone before the Board. I have them in the office, and they will go before the Board at their next meeting. It is quite evident there is an appreciable enthusiasm for serving. People like the Townswomen's Guilds are getting very busy now in sending in names.

Mr. *Thomas Reid.*

593. It means a lot of work. Can you explain why people are so anxious to serve?—I cannot, except to account for it by the enthusiasm we have in this country for voluntary work.

594. They take a real interest?—Yes. (Sir *Basil Gibson.*) I think you will always find that people living in industrial areas regard the hospitals as their own, and if

they get on to a management committee or house committee they are very pleased to do that kind of work.

Chairman.

595. You have no difficulty in getting high quality members?—No.

596. Could we ask this in passing?—Do you find the same true of the Regional Board?—It is a little difficult to know of whom to enquire for the Regional Board. Say there was a vacancy in Doncaster, the regional representative of the Ministry would look round himself for the names of suitable persons living in Doncaster or its environment. I should do the same. I should probably contact somebody I know in Doncaster, someone who holds a position of responsibility, and get perhaps three or four names. I should want a great deal of detail about those names, and I should make every possible check I could. Having got them I should send them to the Ministry, and say the Board would be advised to approve of A, B or C; but I have had no difficulty in getting names. I do not think we should have any difficulty.

Mr. *J. Enoch Powell.*

597. When you say a vacancy in Doncaster, I take it you mean that the person who has left the Regional Board was a person who happened to come from Doncaster?—Well, if you look at my map it shows a very large area. What we try to do is to get some representatives from most parts of that area, and if you take Doncaster as a centre, around Doncaster there is a substantial population. We say that substantial population ought to be represented by someone, and therefore we ask the Doncaster people to send us names.

Chairman.

598. Would it be fair to say in respect of your representatives that there should be someone with personal knowledge of that part of the Region's area on the Regional Board?—That is what we want. We like to get two or three from Leicester, two or three from Nottingham, two from Derby and two from Lincoln. That is how we distribute representation. That is how we advise the Minister, and that in fact is how it has worked. That does not include doctors. We regard the doctors as representing a speciality, not necessarily a geographical unit.

Miss *Ward.*

599. Would it be possible, without much difficulty, to let us have a list of the organisations which are asked to send in nominations? I think you did mention the Townswomen's Guilds?—(Mr. *Faulkner.*) Yes, as an example.

600. I would very much like to see the type of organisation?—(Sir *Basil Gibson.*) We can do that. I think that is a voluntary act on our part. I do not think we are under any statutory obligation to do it, but we always do it.

601. To consult or ask them?—Yes.

Chairman.

602. You do raise a very important question in your memorandum of the double membership of chairmen of committees, and I think you say there is a conflict of views there. If you have as chairman of a committee one who is a member of the regional board, he finds himself on both sides of the fence. On the other hand, if you do not have a chairman of a committee on the regional board, you have a loss of contact?—More than that. Members of the Regional Board selected by the Minister were selected by him because of their hospital knowledge and experience. They are really the men who do understand the hospitals in their own areas. The Minister for that reason put them on the Board, but when it came to the question of who was to occupy the chairmanship of the management committee the man of course who had been the chairman of the voluntary body for years obviously was the most suitable person to be chairman of the hospital management committee, if he could find time to discharge both duties. He would have been much disappointed if he had not been invited to take the chair, but now we have asked all those who are on the Board and are chairmen of management committees which office they would prefer, and all of them, except one, say they would prefer to be chairmen of hospital management committees. The result would be that, if I lose all those members on the Board, I shall have very few people with hospital experience. I cannot replace them.

603. Have you been told that you must not have this dual office?—No. I hope I will not be told that. I have not asked.

604. I thought you suggested, in your memorandum at any rate, that it was contrary to the Minister's idea?—It is contrary to the view expressed by Mr. Bevan.

605. You do not know what the new Minister may say?—I do not.

606. You feel this may be a personal view of Mr. Bevan?—We throw the ball back to him because, if we appoint them as chairmen of management committees, it is for the Minister, when the time comes for the re-election of those particular persons, to decide whether he will put them on the Board or not.

Mr. *Thomas Reid.*

607. What were the grounds of the Minister's objection to the dual system?—It is very difficult to put it in short terms.

I think he thought they would get an undue influence on the Board. There have been cases known in local councils where chairmen have got on the finance committee and, by reason of their chairmanship, have been able to exercise a very considerable influence. I think the idea was that, if these men were chairmen of hospital management committees, they would get more and more favourable treatment than other management committees. In fact it does not happen so, but I can only believe that is the reason.

Chairman.

608. I think the argument either way will be apparent to the Sub-Committee?—I think so. To me they are a very valuable window.

689. You are supported by your Board as a whole in that?—Absolutely.

610. You feel it is desirable to allow double membership?—Yes.

611. So far as you know the matter is not yet closed, but it will depend on what the new Minister decides?—The Minister cannot control our appointment of chairmen of hospital management committees. That is our function by Statute, but he can control the appointment of those same men as members of the Board.

612. There may be a very interesting situation arising out of that?—It is possible.

613. As far as finance is concerned your principal function, I think, is to control expenditure, and it might be convenient to take capital expenditure first of all, because I think that is really severable from revenue expenditure. You deal with it separately. As far as capital expenditure is concerned, all capital expenditure within the Region is your direct responsibility and requires the sanction of the Ministry of Health, is that right?—That is correct.

614. Do you deal with it completely separate in your budgetting, or does it get included in the estimates of the hospitals?—I have brought with me a set of estimates. I thought you might be interested to see them. Revenue is in one part of this volume, and capital is in the other. It is dealt with at the same time. The estimates are prepared at the same time and dealt with by the committees at the same time.

615. Capital expenditure is dealt with separately?—Yes.

616. There would be no possibility of a carry-over of any sort arising so far as capital expenditure is concerned?—No, there is no possibility of a carry-over from either revenue or capital.

617. We will have to deal with them separately. The only point I wish to put to you just now is that capital expenditure is what I might call a water-tight expenditure at the present time?—Yes, it is.

618. You have no comment to offer on that, presumably?—No. We think the Minister might very well give us a little more latitude with regard to the amounts. We have to go to the Minister for practically everything of a capital nature. We think that for a small item like £1,000 or £2,000 we might be given a little more liberty, but we do not get it.

619. You are suggesting that you should have liberty within a global figure?—Yes, something like a figure of £10,000. We should like that liberty, but we cannot get it.

Mr. *Thomas Reid.*

620. To the Board, not to a management committee?—No, purely the Board.

Chairman.

621. You are not suggesting you should have liberty to spend over and above what has been approved?—No.

622. But that within an estimate you should have liberty up to a larger figure than you are now given?—Yes. The amount we get for capital expenditure is really too small for our needs, but as I understand it, it is related to the capital commitments of the country. Then we are never able to spend it because of all the procedure in getting approval for this and that; we cannot get a licence; the plans are not quite in order. There are always difficulties, and at the end of the year we always have a capital figure—at least we have up till the present—which we are not able to spend.

Wing Commander *Geoffrey Cooper.*

623. Do you have to get all these approvals from the Ministry of Health, or do you use the same procedure that anybody would have to use if they were trying to get a licence to build a house?—(Mr. *Faulkner.*) The scheme is put to the Ministry of Health, and my understanding is that they take all the procedure necessary in regard to the starting date. They say to us, "Here is the scheme; it has been approved; the starting date will be so-and-so", and at that time we have the all-clear to go ahead.

624. That is all done at Whitehall?—Yes.

625. Is it your opinion that that is an unnecessarily over-centralised method of procedure?—It is, in my personal opinion, yes.

Chairman.

626. That really is a question quite outside this estimate. It deals with the whole capital expenditure of the country?—It does. (Mr. *Everingham.*) We have to get

financial approval of our capital estimate of every scheme, even where they are under £10,000, and that is the step which we would like missed out. We should like that stage missed out for those schemes under £10,000. We had 116 schemes which we brought forward to the commencement of this new year, and they had a capital value of £728,000. Of those there were 20 schemes costing above £10,000 and their value was £473,000. The remainder were all under £10,000. If you make the dividing line at £5,000, then of the 116 schemes thirty-eight were £5,000 and over; their value was £593,000 of the total of £728,000. The work to which we are put in additional schemes of under £10,000 is altogether out of proportion to their value, but they each have to wait until we get approval before we can start them. Even if they are approved financially then there are such matters as timber control, starting dates and so on.

627. The sum in question is for expenditure within the ensuing year?—Yes.

628. This is the sum total for which you have applied?—That is right.

629. Can you say how much of that was in fact approved?—The whole of these 116 schemes were approved.

630. Had you any other schemes which were not approved?—No, because we put our figure in to meet the allocation of capital expenditure which the Ministry gave to us, but if after that first approval of our estimates we wish to change any of those schemes because one is not progressing as fast as we expected and we are not likely to spend the money, we then have to go back to the Ministry for approval to substitute another scheme.

631. Has approval ever been refused?—No, but it takes time, and by the time you get it then it is too late to put to practical value in the year in question.

632. The question I am asking you is this: what is the point, do you think, of the Ministry requesting you to submit these schemes if in fact they always pass them? Would you modify your scheme at all one way or the other?—(Sir *Basil Gibson.*) I think the answer is that the Scheme, before it is actually included in the estimate, has been examined in detail, has been architecturally passed and so on. You need to satisfy the Minister that everything has been dealt with before it is put in this list.

Mr. *Thomas Reid.*

633. By the Ministry officials?—Yes.

634. On what basis is the allocation of capital made?—It is made by the Minister.

635. Upon what does he go?—I could not tell you.

636. It is not a block grant?—I could not tell you.

637. It must be based on some application you make for expenditure?—No, it is based upon what he can allot, and I expect the control comes from the Treasury.

Chairman.

638. You are not consulted as to what you want at all; you are merely informed of the total coming to you?—Yes.

Mr. *Thomas Reid.*

639. That is part of the scheme to keep a ceiling on total expenditure. He might allot you £500,000 when you do not need it at all?—No, he is not likely to do that.

Wing Commander *Geoffrey Cooper.*] You rather thought the point I was making was relative to the whole national expenditure; it was not in fact. I was narrowing it down in this way. There has recently been constituted a Committee on Manpower in Local Government. An inquiry has been made by local authorities—presumably they have consulted with such bodies as regional boards—to see in what way unnecessary expenditure could be cut out. They say there is too much reference by local regional boards or local authorities to their central Government Departments. I was then trying to probe that point to see if that was the experience of his particular regional board.

Chairman.] I think they have answered that.

Miss *Ward.*

640. I think Regional Coal Boards have authority to spend up to £5,000 without reference to the National Coal Board. It is that authority which really you would like?—The position at the moment—I am not complaining about it—is that we have to submit every capital scheme to the Minister and satisfy him first of the needs, secondly that the proposals meet those needs, and thirdly on the estimated cost. Then it goes into the capital estimates. Of the schemes put forward we select those which will meet the amount he gives to us. Then we have got to wait for the starting date, and the result is frequently that the starting date is so delayed that we cannot spend the money.

641. You mean on the basis that you can have no carry-over?—Yes.

Mr. *J. Enoch Powell.*

642. I take it your proposition really amounts to this, that instead of the £728,000 being authorised in respect of particular schemes, £473,000 of that should be authorised in respect of particular schemes and the rest should be a block grant to be expended *ad lib.* provided that no single scheme so covered exceeded in itself £10,000?—That is right.

643. It is not merely a licence to spend up to £10,000 without reference, but it is a licence to allocate £250,000 provided you allocate it as between small schemes?—Yes. What we want to do is to save a lot of this work. After all it is the Minister's duty to provide these services; it is not our duty. Whatever we propose in the way of extensions, alterations or additions must be satisfactory to him. We quite agree we should satisfy him of the need, on the proposal itself, and upon its cost; but once having done that we say "Leave us alone, and let us get on with it".

Mr. *Thomas Reid.*

644. Is it true to say that before the Minister makes his allocation he has before him all your proposed schemes?—I should say he has, yes. We have schemes costing up to millions of pounds. He has plenty of margin.

Mr. *Diamond.*

645. As I understood the figures given by Mr. Everingham it was in fact £250,000 which it was being suggested should be spent purely within the discretion of the Board for that year?—(Mr. *Everingham.*) We send up detailed lists of our capital estimates, and they show the size of the job in two lists—one for those over £10,000 and one for those under £10,000. Those are our first estimates. Later on, if we ever want to alter that, because the work on any one scheme does not proceed as fast as we expected or we do not want to proceed with any scheme, we then have to go back to the Ministry for every scheme. If our return to the Ministry was limited to those schemes which were £10,000 and over, we would then be able to spend far more of our capital allocation in question because it would be more valuable as regards the last £250,000 which relates only to schemes under £10,000.

Mr. *Thomas Reid.*

646. Would not the Minister lose control if you were allowed to substitute one scheme for another?—(Sir *Basil Gibson.*) He would previously have approved the scheme.

647. He would not have approved the order of priority?—No.

Mr. *Diamond.*

648. I do not quite follow this because, if he has approved, in round figures, £750,000 all told, £500,000 in respect of certain schemes costing above £10,000 and £250,000 in respect of schemes costing below £10,000—is that right?—Yes.

649. Is then your suggestion that, if you are unable to spend the £250,000 on schemes costing £10,000 and below, you should spend it on schemes costing above £10,000?—No.

650. I understood Mr. Everingham's point to be that thereby you would have more flexibility and therefore be able to spend up to your £750,000?—(Mr. *Everingham.*) I was only suggesting that, if there are, say, one hundred schemes each in themselves costing under £10,000, we should be able to substitute other schemes also under £10,000 if for any reason the others do not proceed in time.

651. I apologise; I did not understand that?—That was the full import of it, that we should have a variation in regard to schemes under £10,000.

652. With regard to schemes under £10,000, if you are unable to proceed with a particular scheme under £10,000 which was approved, then you would like to have discretion to proceed with another scheme under £10,000 which has not been approved?—That is right.

653. Because it has not been within the total of £750,000 submitted?—Yes. (Sir *Basil Gibson.*) When you say not approved, not approved for capital expenditure; we do not mean not approved as a scheme.

Mr. *J. Enoch Powell.*

654. In that case there would be no point in your submitting schemes costing £10,000 and under at all?—(Mr. *Everingham.*) Yes. I think in the first place we should do so to provide a break-down of the total sum between what we wish to spend on over £10,000 schemes and what would be left for the others. I think that should be done. At present approval of a variation takes so much time. It would only be a variation if we are at the end of the year and we have not been able to do anything at all.

655. Can you give an indication of the proportion of variations which you would expect to get? Obviously if you alter fifty per cent. of the schemes or if you alter five per cent., it makes a great difference to one's outlook on the proposal?—(Sir *Basil Gibson.*) Let me put it this way. We get a capital allocation every year. It is our anxiety to spend that money if we can. Say we have a scheme at Lincoln, and then unexpected developments take place and we cannot go on with that scheme. The Lincoln scheme is estimated to cost £6,000. There is another pressing scheme at Leicester. The proposal has been put before the Minister; he understands it; he has approved the need; he has approved everything connected with it, but it is *not* in that list. We want to bring it out of our cupboard, so to speak, and put it on that list and go on with it. If we could do it at once, we could probably spend the money. There is a delay in getting the Minister's approval to the Leicester scheme taking the place of the Lincoln scheme, and by the time approval is

received there is not sufficient time to put the work in hand and finish it; and so we cannot start it. Unless you can start and finish it before the end of the year, the financial provision disappears. There is no carry over.

656. When you say "unless you can start and finish it before the end of the year", I take it you mean unless you can execute during the current financial year such part of the scheme as was allocated to that year for capital expenditure purposes?—Yes.

Chairman.

657. To help you, is it true to say that you can do what you want now within narrow limits up to £1,000—I think that is what you said?—(Mr. *Everingham.*) No, Sir, we have to send in details on each revision. We suggest the revision should apply to £10,000 and over jobs.

Miss *Ward.*

658. It is really a question of priority?—Yes, we want to be allowed to do it on small jobs.

Mr. *J. Enoch Powell.*

659. You would presumably make adjustments fairly frequently, otherwise you would not be bothering about it at all. If it were only exceptional, you would not mind?—(Sir *Basil Gibson.*) No, Sir. The fact is that we are a young body, and almost every month some new thing starts somewhere, something arises which is unexpected, and you have got to deal with it promptly. It is not as if we had been able to examine every hospital and decided to put on a schedule in a file everything that wanted doing. Items are constantly turning up, and that is how we have to deal with them at the present time.

Miss *Ward.*

660. The boiler system might break down in a hospital?—That is what in fact does happen.

661. Then you find the boilers are finished and you have then got to put in new boilers or a hot water system?—If we ordered a boiler and it was not delivered before the end of the financial year we should have to deduct the cost of that boiler from next year's allocation of capital, although we had sufficient at the time in the current year, because we have no carry-over.

Mr. *Diamond.*

662. I do understand that you are permitted to bring all these under £10,000 schemes, to use your own phrase, out of the cupboard in appropriate cases after approval, but there is some delay in getting approval?—Yes.

663. It is only the delay?—Only the delay.

Mr. *Thomas Reid.*

664. Why does the Minister exercise this control over you and not let you carry out these small works without his authority? What is the object?—That is a question I cannot possibly answer.

Chairman.] Is that not a question to which we can guess the answer? Probably the Minister is only too anxious to help himself; it is another Minister who has an object.

Mr. *Thomas Reid.*] He has very often stated his objections, as for instance the reason why he issued these registrar circulars?

Chairman.] I think this is general Government policy. I do not think Sir Basil can answer that. Are there any other questions on capital expenditure?

Mr. *J. Enoch Powell.*

665. Would your difficulty be met if, instead of there being an annual capital budget approved, there were a five-year budget approved?—Our difficulty would be met at once. If having satisfied the Minister about the proposal, about the need for it and that the proposal met the need, we could then proceed with it as quickly as we could having regard to the money available, the five years would not make any difference. But I do not think we can look forward to five years, but what we do want to look forward to is to be able to do what the local authorities can do. A local authority, if it is building a sewage works, borrows the money. They start the work, and it goes on continuously to the very end. With the Minister—it is Government practice—he gives us so much money, and if we do not spend that money we lose it. Whatever you propose for the succeeding year must stand down because you must take out of the amount first this sum of money which was lost the year before.

Chairman.

666. What happens in the case of a substantial expenditure which is bound to take several years?—The same principle applies.

667. You get an annual allocation towards that expenditure?—That is right.

Mr. *Thomas Reid.*

667. You get an annual allocation towards third years?—We get a re-vote, but not a re-vote plus the money which we failed to spend in the preceding year. That is what we want.

Chairman.] I think that is quite clear.

Mr. *Diamond.*

669. Would your difficulty about carry-over be met if in your view there were, as

Mr. Powell suggested, a five-year period of capital budgeting instead of a one-year period? Do you think on balance it would be to the advantage of your Board that you should attempt to forecast capital estimates for five years and be tied down to five years, or would you prefer the present system of estimating only for one year subject to this difficulty, which we understand, that you are unable to carry over any amount you have not expended?—I should prefer the present system. Our real trouble is this loss of money which we were unable to spend. We want a carry-over, if we can get it.

Chairman.

670. It is rather late to start on revenue expenditure as we shall have to stop at six o'clock, but we might make a start. First of all the present method which governs the control of revenue expenditure, from your memorandum, appears to be what might be called the Civil Service method of estimating. Would that be fair? —The local authority method is just the same. The local authority method and the Civil Service method is practically the same.

Mr. *Thomas Reid.*

671. It is the cash system?—Yes.

Chairman.

672. On page nine of your memorandum you say with regard to estimates, "The existing system has the following disadvantages", and then you set out three subheads, the first of them being this, "Hospital management committees do not know the amount of approved expenditure before the commencement of the financial year"?—That is the position. That is a fact. We do not get our approvals till well after the Budget. The financial year commences on the 1st April.

673-4. In the second subhead you say you find difficulty owing to your having unspent balances of either capital or revenue at the end of a year, and, thirdly, you say that if estimates could be on a block basis it would facilitate your work. I think that is paraphrasing it accurately?—In effect, yes. What we say is this: a hospital management committee should make an estimate; if we approve that estimate, having discussed it with the hospital management committee, we should forward it to the Minister; if the Minister approved it he should place at our disposal that sum of money. We would control the expenditure of that sum of money, and we should be allowed to vary it between various equipment or to save on some of the items. That is what we are trying to do, and that is what we say is intelligent planning. There is nothing new about that; that point has been raised with the Minister on many occasions. We have constant conferences with the Minister, and it has been discussed there.

Mr. *Diamond.*

675. Could you tell us, as it has been discussed, what main arguments are put against your suggestions?—The one which it is impossible to overcome; it is against Government practice.

Chairman.

676. Have they advanced any argument on the merits that has weighed with you and made you feel you should stop?—The only way I can answer that is by saying that having regard to the increases in the estimates the Treasury took a hand in it, and they have introduced some new methods this year.

677. Are those more in accordance with what you suggest?—They are more drastic than what we suggest.

678. I realise that they are likely to be financially drastic, but in fact are they nearer to the system of maximum grant? —No. The two items they have introduced are really exercising a much tighter control over the expenditure of management committees than heretofore.

Mr. *Diamond.*

679. By the Treasury or by the Ministry? —Yes.

680. A tighter detailed control?—Yes. In other words, if the estimate amounted to £100,000 and that was approved by the Minister, what we should like to do would be to say, "We will exercise the control over the management committee in the expenditure of that money", but now the Ministry has gone further and said, "Not only must you not exercise any control at all in the way of approving departures from one item to another, but it must be done by us. The management committee must apply to us for any such authority".

Miss *Ward.*

681. It is cutting the regional board out? —It is cutting the regional board out.

Chairman.

682. I think this might be a convenient moment at which to adjourn?—Before you do may I say this? I have brought with me one form of estimates prepared by the Sheffield No. 1 Hospital Management Committee. If you have not seen those estimates before it is a very good example. It shows the amount of work which is involved in the preparation of these estimates. They have to be prepared in September, and the estimate has to be prepared for a period which, as you know, expires 12 months the following March. We have all this work to do within a comparatively short period. I thought it

would be a rather good idea if you had such an example. (*Specimen hospital estimates are handed to the Sub-Committee.*)

683. I think it is a very good idea for you to leave them with us, because we are bound to be dealing with this subject as soon as we meet again?—I will also leave a list of the hospital management committees, and you will find on each page the number of beds which each management committee controls. I thought that would give you an idea as to size. You will find they vary a good deal. (*Document is handed to Sub-Committee.*) One final document is a list of members of the Board, with their addresses. It will show how they are distributed throughout the Region. (*Document is handed to the Sub-Committee.*)

The witnesses withdrew.

Adjourned to Thursday next, at 10.30 *a.m.*

THURSDAY, 15TH FEBRUARY, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Thomas Reid.
Mr. Diamond.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Sir BASIL GIBSON, C.B.E., J.P., Chairman, Mr. L. W. FAULKNER, Secretary, and Mr. J. EVERINGHAM, A.C.A., Treasurer, Sheffield Regional Hospital Board, recalled and further examined.

Chairman.

684. Sir Basil, before we take up the running where we left off the other day, I think there is a point still to be cleared up on this question of capital expenditure. I am not certain there was not some misunderstanding in our consideration of that. On reading the evidence it seemed to me that you might be saying this: where capital expenditure is proposed you have to take two steps. The first is to obtain approval by the Ministry of Health to any proposed expenditure?—(Sir *Basil Gibson.*) Yes.

685. I suppose on the question of priority, that is to say as between one particular item and another particular item proposed by you?—That would be later on. All proposals then go to the Minister of Health for approval as proposals. We put them on one side until we are ready to get an allocation of capital, and then we select them and submit them to the Minister for priority, but they have been previously approved, that is to say the proposal as such must be approved. If one waited until the priority stage one would then have to do a lot of work, and there would be delay.

686. For the moment, disregarding those details——?—There are two steps, you are perfectly correct.

687. There are two nets through which you have got to get, one the Ministry of Health net and the other is what one might call broadly the Treasury net, that is to say the expenditure as expenditure within the national net?—That is between the Minister of Health and the Treasury and not between the Regional Board and the Minister of Health.

688. Are you suggesting that where, for example, you find you cannot proceed with putting up a wing involving the use of bricks and mortar and instead you wish to switch and put up a heating system involving the use of copper and similar materials, and where the amount is less than, say, £10,000, you should be able to go forward with the switched scheme without getting any further approval at all?—Yes, provided the proposal has already been approved by the Minister and has been included in the list of proposals that have been approved for priority.

Mr. *Diamond.*

689. Do I gather then that the first approval is an approval as a good hospital

scheme for expenditure sometime or other?—Yes, we call it a proposal.

690. That is approved as a proposal in general terms?—Yes.

691. Is not the approval an approval for expenditure within a given twelve months?—Yes, within the allocation which they give to us.

692. It covers a period of twelve months?—That is correct.

693. Your suggestion is that wherever you have a scheme under £10,000 approved for expenditure within that fiscal year and you are unable for any reason to expend your money, you would like to be able to withdraw from the cupboard, as you put it, an under £10,000 scheme which has been generally approved but not approved for payment within that year?—That is correct, in order to spend our capital allocation.

694. Irrespective of the fact, as you pointed out, Sir, whether the first scheme approved for payment during the year mainly related to materials such as bricks and the second scheme mainly related to materials such as copper or non-ferrous metals?—We should select a scheme where the materials were available, or else we should not be able to go on with that at all.

Miss *Ward.*

695. How would you know that?—We know generally with what we can proceed.

Mr. *Turton.*

696. Might I just put this question? For these scarce materials do you have any other system of obtaining licences?—We have to get a starting date from the Ministry itself.

Mr. *Diamond.*

697. That is the very question to which I was coming. At what stage are you directly or indirectly, that is to say by the direct authority of the Ministry of Works or indirectly by that authority being given through the Ministry of Health, made aware of the fact that a scheme is approved for the purpose of using all the materials contained in it?—Only when we get a starting date.

698. The starting date is given to you at the time approval is given to the year's expenditure?—No.

699. That is a further one. There are in fact three stages?—There are three hurdles.

700. When in your evidence you refer to the main difficulty being the delay in getting approval, you refer to the delay in getting a starting date for a scheme which has been approved in principle but neither approved for payment within that particular year nor for which a starting date has been given?—Yes.

Mr. *Turton.*

701. You do not have to apply to the Ministry of Works or the Ministry of Supply for a licence to use scarce materials?—We do not go to either Ministry at all.

702. The Ministry of Health would have to do that?—Yes, we do not go to the Ministry of Works but to the Ministry of Health.

703. If you are then switching from an item in your proposals in order to bring it into your current year's programme, how would you suggest that the application be made for the use of the scarce materials?—I have not even thought about it.

704. It does seem to be a difficulty in your plan?—I agree. What I want to put before the Sub-Committee is this, and this only: we get an allocation of capital which we are unable to expend during a year. It may be that one particular scheme or even two schemes are held up for some special reason, and then we cannot use that allocation for some other scheme. That is what we want to be able to do.

Chairman.

705. You want to do that for the purpose of being able to spend the full amount of capital, and not merely on the ground that it is very inconvenient to have schemes held up?—You can take it that all the schemes which are approved in principle are more or less urgent; I should say they are all urgent, but some are more urgent than others.

706. It is not simply a matter, although no doubt it weighs with you, that a delay of a month or two is a bad thing?—No.

707. It is that you lose the whole of this amount, if it cannot be completed within the year?—Yes. Not only do we lose it but we have to take it out of our next allocation of capital monies.

708. That is the same thing?—Yes. Well, remember that the allocation for one year may not be any greater than the allocation for the preceding year, in which event we have got to take something which we had in for the preceding year out of the next year, whereas we did want to put something else in.

Mr. *Diamond.*

709. You would only lose it once?—I agree.

Miss *Ward.*

710. When you are discussing your schemes in order of priority before applying to the Ministry, is there a tendency to discuss them from the point of view of whether you think it will be possible to get approval having regard to the position of materials and so on or is that absolutely out of your mind?—That is out of our minds because that is a matter which must be dealt

with by the Ministry of Health with the Ministry of Works out of what they call their allocation. We do not know what it is.

711. No, but when you realise that you are going to lose your capital allocation if you do not in fact get your schemes through, would there not possibly be a tendency to think of them in terms of whether you in fact would get approval and a starting date?—I do not think so. We think it is just too bad, that is all.

Mr. *Thomas Reid.*

712. When you draft your schemes you have an order of priority?—No. Well, we have in one sense certainly, but every day a new need comes to our notice, and that need may be even more imperative than something which has already been put in.

713. Generally these schemes hang together, and you would have an order of priority; A must come before B, and so on. If you break that order of priority, would that matter?—Oh, no.

714. There is no difficulty in switching over from a scheme which has been sanctioned to a scheme which has not been sanctioned?—Not from our point of view. There may be from the Ministry's point of view.

Mr. *Diamond.*

715. They may refer to quite different hospitals in different parts of the area?—They could.

Chairman.

716. Could you give us the amount which you have lost in a year?—(Mr. *Everingham.*) I think we usually lose £100,000 out of an allocation of £600,000.

717. It is of the order of fifteen per cent?—It varies from year to year, but it probably does mean that in five years we are only able to spend four years' allocation.

Mr. *Turton.*

718. If you have a system by some miracle of Treasury finance by which you are allowed to carry over, then you would be just as well off without your switching principle?—(Sir *Basil Gibson.*) Yes, we would be very glad to have a carry over. That is the principle for which we are asking.

Chairman.

719. It is a carry over in a rather peculiar sense of the word?—Yes.

720. It is not really a financial carry over; it is a carry over of a sanction for expenditure on particular materials really?—You can put it that way, but we look at it as a proposal. We are unable to proceed with that proposal, as we hoped we would be able to do, in one particular year, and therefore we lose the money which has been allocated to that particular proposal. If we had a carry over we should know that we should probably be able to start it early in the next year, and it would not interfere with the programme for that year.

Mr. *Thomas Reid.*

721. Other areas are in exactly the same position?—It is general throughout the country.

722. Over a period of years then does it matter, because there is a ceiling to the expenditure by the Minister? You may lose one year and someone else lose another year and so on, but the total is the same?—I should not say that. (Mr. *Everingham.*) I would say that we all lose all the time.

723. There is a ceiling placed by the Minister of Health on total expenditure?—We can never spend up to that ceiling. On the present system we can never get to it. We make up our list in the first place and that fills up the whole figure; and then because of various delays we are unable to spend it. There is no carry over of expenditure, and there is no substitution. There are many items, not requiring a starting date at all, which we could substitute, items not requiring materials which are in short supply, such an item as putting in a few bedpan washers at a hospital where they are badly needed. There is no starting date required for that, and in many cases there is no shortage of materials. There is quite a lot of furniture, now classified as capital, which could be dealt with in that way towards the end of each year, if we could possibly substitute it quickly. (Sir *Basil Gibson.*) Those are small schemes. (Mr. *Everingham.*) They are small schemes, but they do make up a total which may be £25,000 or £30,000, and just by doing that it would help to ease future years.

Mr. *Diamond.*

724. To put in bedpan washers you would need a plumber and a bricklayer?—You would find they are available on the site. There are small works departments belonging to hospital management committees, and they can do that work.

725. Are they unemployed then through lack of permission to do the work?—You would take them off revenue work and put them on to capital work for a short period in order to get that capital work done.

726. Then you would not spend your authorised budget approved for revenue expenditure?—There would be a slight saving on their wages on revenue.

Mr. *Thomas Reid.*

727. Are you asserting that the Minister with a ceiling of £400,000,000 makes a big saving every year?—I am certain there is a considerable saving of capital every year. (Sir *Basil Gibson.*) What is this £400,000,000? That is not capital. (Mr. *Everingham.*) That is revenue.

Miss *Ward.*

728. If you had a free choice would you prefer an alteration in the carry over system or would you go for the substitution?—(Sir *Basil Gibson.*) We should like both.

Wing Commander *Geoffrey Cooper.*

729. Does this mean that at the end of each year, if you had the permission for which you are asking, there would be a rush to spend sums which you had left in the "kitty", perhaps even wastefully on occasions?—I do not think you should lay that to our charge.

730. There is a tendency for that to happen in some Government Departments, where it is said "We have this surplus. If we do not spend it we shall not get as good an allocation next time"?—You understand we are not a Government Department. We know there is that danger. (Mr. *Everingham.*) It may happen on revenue, but all the capital items have been carefully considered and I do not think anything would be fed in which would not be absolutely necessary.

Chairman.

731. I think we have got your points?—(Sir *Basil Gibson.*) I am sure you have.

Chairman.] I think the difficulties have been put to you, and you have expressed your views on them.

Mr. *J. Enoch Powell.*

732. We have been talking about schemes so far as though they were all schemes completed within one year. You speak of a possible figure of £600,000 for a year, out of which £100,000 could not be spent. Would not some of the remaining £500,000 be expended upon schemes commenced in the previous or even preceding years?—(Mr. *Everingham.*) Yes, Sir, that does happen. When we have our allocation and we prepare our estimates the first thing to do is to value the work in progress at the beginning of the year, and take that off. Then the next thing is to decide how much of the schemes you are proposing to start in the year will in fact be spent in that year only; and that is how the estimates are prepared.

733. In fact the £100,000 unspent is out of a much smaller actual disposable figure than the total of £600,000?—Yes, Sir. The new figure this year is £247,000 worth of new work which could be fed in this year.

734. It is with that and not with the £600,000 that the figure of £100,000 is comparable?—That is so.

735. The second point I want to get clear is this. You draw a distinction between capital and revenue, but so far as the estimate is concerned, so far as your budget is concerned, they are ultimately joined as one figure. I mean this: there is no question of capital expenditure appearing in the annual statement only in the form of loan charges and amortisation. It is what you are spending on capital out of revenue, as it were. There is not a financial distinction drawn between the two?—There is no question of our raising loans for capital expenditure. A sum of money is given us by the Ministry every year for capital expenditure. There is no question of our having raised the funds in any way.

736. You do meet capital as well as current expenditure out of revenue?—I presume it is allocated out of revenue, but I do not know that for certain. The Government may meet it by borrowing. (Sir *Basil Gibson.*) But in our estimates it is kept separate. We have to submit revenue estimates and capital estimates.

Chairman.

737. I think in your memorandum you mention the fact that local authorities finance capital expenditure by way of loans?—They do.

738. Do you suggest that something on the same lines might be useful in the case of hospital boards?—No, we do not suggest that. What we do suggest is this: the local authority, having got a loan, can proceed continuously with a scheme, and that borrowing power is exercised by them continuously until the scheme is completed. Whether they have regard to that commitment when they settle their capital expenditure for the following year is a question which depends on circumstances every time. The real point about it is that they can borrow and proceed continuously, and complete the scheme as quickly as they can.

739. I think what you suggest is that the local authorities by those means avoid the difficulty in which you are?—They do.

740. I am asking whether you think it might be possible for a similar power to be given to you in order to avoid the difficulty in the same way?—We are not in the position of a local authority.

741. You do not think you could really operate on those lines?—I do not think it would fit into the framework of the Act itself or the principles on which it is worked.

742. I think that disposes of that point. We were just beginning to discuss the question of revenue expenditure, and I think it might be convenient first of all to ask you a question about the penultimate paragraph on page three. "It will be appreciated that, as approximately sixty per cent. of the expenditure of hospital management committees consists of salaries and wages, which are controlled by national awards, effective control over their estimates is reduced to that extent". You do not suggest for a moment, do you, that the question of the number of those employed is out of the control of either yourselves or the management committees?—No, I do not suggest that.

743. If you are spending revenue on anything, you are buying something at a price which is outside your control?—Yes.

744. The position here really is no different from any other expenditure, is it?—We have nothing to do with the awards of Whitley Councils, which do in the end amount to a very considerable addition to what salaries and wages were years ago. This system of Whitley Councils has put up the expenses of hospitals enormously.

745. We are living in a time of rising prices?—That may be, but I am pointing out that so far as that is concerned all we control, as you say, are the numbers we employ. We do watch that very, very carefully. As a matter of fact we suffer from under-staffing and not over-staffing, except that there may be something to review in the administrative departments of management committees.

Wing Commander *Geoffrey Cooper.*

746. Is it not a fact that, when the Hospital Service was brought into being, an establishment was worked out by the Ministry of Health and more or less imposed on all areas, regions and districts?—I do not think you could call it an "establishment". What they said was "You want this man, that man and the other man". They told us who they were, but they did not say we must employ them, although the inference was that we needed them.

747. Was it not in effect this, that someone who was doing secretarial work in quite a minor capacity at a salary of £300 to £400 a year under the old hospital arrangement working for one hospital, was in many instances suddenly made secretary of either that hospital at a higher level or a group of hospitals with a salary of £1,400 or £1,500 a year?—No, Sir.

748. There is evidence to that effect?—It has been said.

Mr. *Diamond.*] On a point of order, are you asking a question or making a statement?

Wing Commander *Geoffrey Cooper.*] I am trying to find out the information.

Mr. *Diamond.*] The information you require has already been before the Sub-Committee.

Chairman.] I am inclined to let Wing Commander Cooper proceed for the moment.

Wing Commander *Geoffrey Cooper.*

749. Have you any evidence of that yourself?—No, Sir. (Mr. *Faulkner.*) Could I just amplify the Chairman's negative? If the secretary of a hospital had been appointed the secretary of a hospital management committee with increased responsibilities, his salary would increase to one which accorded with the Ministry's definition under the points system. What I would like to say is this: the responsibility of the officer concerned increased in proportion to the new salary which he received.

750. Was there any increase after the date when the appointments were made?—No, Sir, I do not think there was.

751. No increase since the time when the Hospital Service first started?—Not to my recollection.

Mr. *Thomas Reid.*

752. How do you proceed in the case of staff either to be increased or decreased during the year, say by the addition of nurses or something like that?—(Sir *Basil Gibson.*) We are always needing nurses. We need not investigate at all, but when there is a request from a management committee for additional staff they have now to obtain the approval of the Regional Board.

753. From where do the additional funds come?—They have to inform us at the time they make their application if they can pay the additional staff out of their current estimates. In many cases they can. They have provided for this additional staff.

754. They have a surplus for an emergency?—Not a surplus. They have provided for the additional staff when the estimates were prepared.

Wing Commander *Geoffrey Cooper.*

755. Is there now a considerable increase in the number of staff under the new system?—Staff is always increasing.

756. The administrative people in particular?—Not necessarily administrative. There are occasional demands, particularly in connection with medical records.

Wing Commander *Geoffrey Cooper.*] Could the Sub-Committee for information have a list of the officers appointed to each region, and their remuneration, in relation to the particular point which is made here?

Chairman.] I think we may be able to clear that up by a question which I was going to ask Sir Basil. We have been supplied with certain figures by the Ministry of Health, and these figures were analysed to show that, taking all the hospitals in the country, on an average seven per cent. of hospital management committee staff consist of administrative and clerical staff. In Sheffield the figure is eight per cent.

Mr. *Turton.*] Does that not in fact include boards of governors, if you look at Table M.12?

Chairman.] It is true that boards of governors are mentioned in the sub-heading, but they are not brought into the average. The average administrative and clerical staff in the employ of hospital management committees of regional boards is seven per cent.

Mr. Turton.] In Table M.8, from which Table M.12 is extracted, the heading of that item is "Hospital Management Committees' and Boards of Governors' administrative and clerical".

Chairman.

757. That is so, but the figure of seven per cent. quoted in Table M.12 is worked out disregarding boards of governors; it says so there. The figure for the Sheffield Board is eight per cent. Sir Basil, can you account for that in any way? Have you any special circumstances in your region which account for the fact that you have this higher proportion than the average?—I should like to see the figures first to find out; I cannot look at them just at the moment. We had a return a short time ago of all the staff, administrative and clerical, of the regional boards throughout the country, when we were the lowest in the country. With regard to hospital management committees I do not think we have ever made a return ourselves. I do not think we have ever got out a statement as to their administrative and clerical staffs, but you surprise me by saying that we are higher than anybody else in the country.

Chairman.] That is not so. There are two others higher than you, as you will see, but you are nevertheless one per cent. above the average.

Mr. *Diamond.*

758. That is at 31st December, 1949?—I will now enquire into it because it is a surprise to me. In regard to regional board staff we are the lowest in the country. I am speaking now of regional board staff. (Mr. *Everingham.*) Which the Board control.

Mr. *J. Enoch Powell.*] Could we also supply Sir Basil with the group figures on Table M.8, on which these percentages are based?

Chairman.

759. I think that would be fair. I think it is perhaps unfair to put these figures to you now and ask you to explain them. Perhaps we can leave the tables with you, and when you have looked into the matter you might let us have a note?—(Sir *Basil Gibson.*) I will send you a memorandum on them.

760. Could you say what steps you do take to ensure that the administrative and clerical staffs of management committees are not swollen? I am sure you have taken steps?—When the staffs were first engaged we had no real responsibility for them, except the financial responsibility which came with the budget. Some time ago—I could not say how long it is—the procedure was altered, and every addition to the staff of a management committee now must receive the approval of the Board. Every case is very, very carefully investigated. For example, if it is in the secretarial departments, the Secretary or a member of his staff frequently goes to the office of the management committee and makes a personal investigation and a report. The same applies to the Treasurer; he has done the same thing.

761. Do you know the establishments to which management committees work?—No, we never have done.

762. When you say "in addition" that means simply an addition to existing staff?—It means additions to existing staff based on an investigation of the particular section where this assistance is required.

763. Suppose that a clerk is found unnecessary by a management committee, where they have had one before; suppose they have worked for some months with three clerks where they had four before, and they want to go back to four again?—They would have to prove the necessity for that.

764. They would have to come back to you?—Yes.

Wing Commander *Geoffrey Cooper.*

765. Is there a tendency with the present method of organisation for it to be essential to employ additional number of administrative people by reason of the increase in the amount of paper work, about which, if one is in close touch with hospitals, there are quite frequent complaints?—There is a tendency, and there will always be a tendency, to increase staff. One of the main reasons is to deal with medical records. There is no standard method of dealing with medical records; it depends on what the doctors want. That means a very substantial increase in staff. I can give you another example which applies

to regional boards, and that is a bed bureau. There is great difficulty in getting patients into hospitals, and frequently the general practitioner has to communicate with more than one hospital before he can find a bed. That is being overcome by means of a bed bureau. We propose to put two in the Region, one at the Sheffield Headquarters and one probably at Nottingham. Those will require to be manned, and that will mean additional staff. Those sort of things are constantly arising. I have given you just two examples, but there are others which are not as important.

Mr. *Diamond.*

766. When you have this investigation and satisfy yourself that an additional person is needed to carry out the work of the particular hospital management committee, do you concern yourself with the question of whether the work itself is useful and necessary or merely whether there is an additional body needed to carry out that work?—(Mr. *Everingham.*) I would like to say on the financial side that we always consider the volume of work done and whether it can be done in any better way in order to reduce the number of staff, but it is a moot point whether we have, or ever have had, any power to lay down the establishment of a hospital management committee. Our power is only available, I think, when they come to us for an addition, and that is why our hands have been tied right from the start in dealing with the establishment of a hospital management committee. I doubt very much whether we have the power now to go to a hospital management committee and to say "You must reduce your staff". (Sir *Basil Gibson.*) May I supplement that by saying that the Ministry themselves are sending round teams to hospital management committees to enquire into staffs?

Chairman.

767. It seems to me that three different sets of people are doing the one job. There is the hospital management committee responsible itself for seeing that its staff is kept within proper dimensions; there is the regional board with some general financial power of control; and now the Ministry of Health are also looking into this and doing the hospital management committee's job. Is that right?—Yes, they are doing it, I think, at the instance of the Treasury.

Wing Commander *Geoffrey Cooper.*] Since we are basing our enquiries on figures which are some fourteen months old, would it be possible, Mr. Chairman, to obtain from Sheffield Regional Board a list which is up-to-date, because it would show if there was any tendency rapidly to increase staffs and it would perhaps give us a better picture?

Chairman.

768. When you have examined these figures, Sir Basil, perhaps you would give us your latest figures showing what the movement has been over the last year?—I will do what I can.

Wing Commander *Geoffrey Cooper.*

769. Could we have it broken down into the number of secretaries, chief clerks, clerks, assistants and so forth who are serving on the regional board and on the hospital management committees?—We will do what we can in that respect. We will give you a memorandum as comprehensive as we can, but you will observe these very requests are those which we get daily from the Ministry and they account for the need for such staff.

Mr. *Turton.*] I suggest, Mr. Chairman, that you ask Sir Basil for a complete proforma rather on the lines of Table M.5 which we have got, so that we can compare his results with Table M.5. That does split up the administrative staff under certain headings, rather on the lines which Wing Commander Cooper wanted.

Chairman.

770. Sir Basil, we will hand you copies of Tables M.5, M.8 and M.12, and perhaps you will regard them as confidential?—Yes. (*Copies are handed to Sir Basil Gibson.*)

Miss *Ward.*

771. With regard to the people who are carrying out the Treasury inquiry, would they ever ask at regional board level whether you have any views on the volume of paper work and all the statistics which have to be prepared? Do they ever ask you whether you could find any means of reducing the number of administrative staff and still maintain efficiency?—The investigation is being carried out by the Ministry of Health's own officials, with outside assistance, and I believe at the instance of the Treasury. (Mr. *Faulkner.*) So far as the Board is concerned the team has been one Treasury officer from the Organisation and Methods Branch and one Ministry of Health officer. So far as the hospital management committees are concerned it has been one Ministry of Health officer with a technical officer from one of the hospitals selected by the Ministry. (Sir *Basil Gibson.*) Obviously we do not discuss the paper work and requirements with them, nor have they raised the point with us.

772. Everybody has views in a big organisation as to the possibilities of curtailing expenditure. Is it a sort of two-way traffic? Do you ever say to them "We think this is perhaps unnecessary", or do you feel there is nothing which is unnecessary?—I would not say there is nothing which is unnecessary, but I should be very chary of raising it with the Ministry of Health.

773. Why?—Because we are part of the organisation. We are only one section of an organisation which has been set up by the Ministry.

Wing Commander *Geoffrey Cooper.*

774. If the overwhelming desire is to be streamlined and efficient, and that is really what we are all after, is it not highly important that people in responsible positions should give their opinions whenever they feel they can help to improve the organisation?—I think I should require to think over that question before I answered it. It is rather difficult, having regard to the mass of things which are handled, to say this particular one is unnecessary.

Chairman.

775. We are wandering rather far away from the point we were discussing, which was the actual method by which your Board can exercise control over the staff of management committees. I have some doubt in my mind on the matter. Mr. Everingham has said that there is no power to lay down anything in the nature of an establishment?—That is correct.

776. On the other hand you have said that before any increase of staff takes place you have to give approval?—That is true.

777. It seems to me there is a conflict there because, if in fact they have to come to you for approval, you can control their establishment?—They come to us for approval of additions, and when they come to us for approval of additions, say to the Treasurer's office, we would not give approval to that if we were not satisfied that they had no more than sufficient men or women in that department to do the work which is necessary.

778. Additional bodies or additional expenditure?—It covers both. If there was no provision in their estimates for this additional staff we should not give approval for it until the provision could be made. They may have to wait till the next year.

779. Effectively you can——?—control additions.

780. At any given point you know what the establishment in a group is, and if you decline to give power to the management committee to make any additions, the existing establishment is in fact the establishment which you control. Is that not so?—You have got to remember that this organisation has been built up from zero in a way which is not common to industrial establishments. When the management committees were appointed they were authorised by the Ministry to engage staff. The Ministry issued a circular indicating what type of staff they would like. Of course there was in the service of the transferred hospitals, both municipal and voluntary, a large body of staff. The Ministry at that time gave quite a wide discretion to management committees to set up the staff they needed for this work. It is only recently, probably within the last twelve months, that we have had power to approve, and refuse if necessary, the engagement of additional staff. I think the two statements are reconcilable. For example, if there was an application for an increase in staff to deal with medical records we should not investigate the treasurer's staff or the secretary's staff, unless the records were attached to the secretarial staff.

Mr. *Thomas Reid.*

781. You have no power to force a decrease in staff?—Only through the budget. We can say they are spending too much money on staff, but then they would say "Whom have we got to dismiss?"

Mr. *Diamond.*

782. I quite recognise that, where you have a tendency for staff to increase and you have power to refuse an approval for an increase, you are in effect controlling staff, but it occurs to me there may be occasions when you may wish to encourage a reduction in staff arising out of a re-grouping. I understand it may be the case that, where you have a re-grouping of hospitals, the staff within the group might require to be altered. A re-grouping which has increased the number of hospitals might conceivably require increased administrative and clerical staff, and another re-grouping might make a decrease possible. Do I gather that you have no power to encourage that reduction except by the budget, which means waiting a time?—Yes.

Wing Commander *Geoffrey Cooper.*] Could I refer to a question which was raised with regard to the Ministry of Health's inquiry into staff?

Chairman.] Before we go to that, are there any other questions which members of the Sub-Committee wish to put on the question of controlling staff, either financially or by establishment?

Wing Commander *Geoffrey Cooper.*] My question is related to that.

Miss *Ward.*

783. Could I just ask one question? It has been said to me by various doctors that in the old days they wrote their own letters and dealt with their own work in relation to patients they sent into hospitals?—That is a fact.

784. Now they all have secretaries, and I think some of them feel perhaps that is unnecessary expenditure, though I have no doubt that, if you wanted to withdraw them, that would raise another point; but I do think that some of them feel that the ad-

ministrative side of their work has grown quite enormously compared with the work they probably did before for their own patients?—That is perfectly correct. On the other hand I have not yet met a doctor who has not asked for secretarial assistance. I certainly do not expect to meet one who wants to discard any assistance he has got, but in the old voluntary hospital days it is obvious they had not time to do all the detailed recording which they do to-day. It is all tied up with this question of medical records.

785. This may be an embarrassing question, but do you really think use is made of all these medical records, or are they just there——?—It depends entirely upon the consultants.

Wing Commander *Geoffrey Cooper.*

786. Following upon that might I just put this question? It may perhaps be answered by Mr. Danielli. When enquiries are made into any organisation it can be done in two ways or in a combined way. If the group of people who are investigating the hospital staffs and so forth deal with the matter so that they just enquire into the actual jobs to see if those are being done efficiently, that is one way of checking to see if you are over-staffed or under-staffed. A further way, which I think should supplement it, is to enquire into the system as a whole to see if certain matters are required. That is the point Mr. Diamond made. To illustrate my meaning, I understand that some of these medical records are in fact not used at all. Unfortunately I had to go into hospital for a short time, and this point cropped up. They are asked now for every patient to make a record on five different forms which have to be filled up in triplicate. It was thought by the medical staff—I questioned them quite closely—as well as the nursing staff that a lot of those records are quite unnecessary; they are never used at all in most cases. In teaching or training hospitals they may be, but there is no co-ordination of these records to make the fullest use of them in hospitals where no teaching is done. I would like to ask if it is not possible for these people going round the hospitals to include that overall method of approach as well as the immediate check of actual staffs?—The only answer I can give to that question—Mr. Danielli can give his own—is that the system of medical records has not been standardised, and it is a subject which I believe the medical staff of the Ministry of Health are considering. I must say that you surprise me when you say they are not referred to, because I was in a hospital the other day where the medical staff insisted upon the records being available, and they were.

787. I am saying that all the records which are taken are not necessary, as I understand it, in this particular hospital?—The system is something which I could not criticise. I do not think anybody, except the consultants themselves, knows what is really necessary.

Wing Commander *Geoffrey Cooper.*] Can Mr. Danielli say whether that aspect of the matter is being checked?

Chairman.] I think not for the moment. We must confine our questions to Sir Basil and his colleagues.

Mr. *Turton.*

788. Who originally laid down the staff establishments of hospital management committees?—I think I said that it never was laid down. The Ministry issued a circular indicating the type of officials required and the salaries those officials should receive.

789. I put my question wrongly. Who first approved the actual numbers of administrative staff held by hospital management committees?—The management committee itself. The number was not approved by the Regional Board, and I do not think—in fact I am certain—it was never approved by the Ministry.

790. It was not approved by the Minister?—No.

Mr. *J. Enoch Powell.*

791. Is it your opinion that if regional boards had the power and the duty to institute the necessary investigations and to fix establishments *ab initio*, to look at the whole matter again, there would be scope for substantial economies in staff?—We think that if we had been charged with the responsibility at the beginning the staffs would have been somewhat different from what they are to-day, and the salaries would have been less.

Wing Commander *Geoffrey Cooper.*

792. You mean smaller, when you say different?—Yes.

Mr. *J. Enoch Powell.*

793. That presumably applies to a review, if you were now given the power to undertake it?—I would not say that because men are now in appointments: they are in the jobs.

Chairman.

794. You have a vested interest with which to contend?—Yes.

Wing Commander *Geoffrey Cooper.*

795. Mr. Faulkner said he was not aware that any increase had been made since the first appointments. Could he check up on that point and let me know?—(Mr. *Faulkner.*) That refers to increases in salaries?

796. Yes?—Yes.

797. I am given to understand that at a time when there was an appeal by the Government to departments to reduce staffs by ten per cent. and to keep down salaries, at the same time the Ministry of Health gave a sanction for increases in salaries which were not altogether justified. That is the complaint, and I would like to know what is the position?—I will get you precise information upon that.

Mr. *Diamond.*

798. Can I refer back to this question of medical records?—I do understand that you as a regional board have a medical committee which would advise you, if necessary, on the need for medical statistics of one sort and another?—(Sir *Basil Gibson.*) Yes, Sir, that is correct. We have one or two members of the staff dealing with statistics.

799. Has that committee ever requested you, or suggested to your Board, that the statistics kept by an individual management committee were excessive and unnecessary? —Not to my recollection, and I do not think they would. Every group of hospitals has a group medical committee. They are responsible or advising upon the management of hospitals and for the treatment of patients. I think they would look rather sternly upon any suggestion of the regional board that the medical committee of the Board should lay down the methods consultants should follow in dealing with medical records. It is purely a hospital matter.

Miss *Ward.*

800. It would be rather difficult to standardise really?—They ought to be standardised.

801. There is a fairly wide variation in the methods of hospital management committees?—Yes.

Chairman.

802. I think we have got to the point when I can put to you rather a wider question. You have just expressed yourself as being in favour of standardisation in one respect, and I think you rather suggested that your Board has not adequate control in a number of directions over the activities of hospital management committees?—I think that is true.

803. Would you prefer that your control should be exercised in detail so that you would in effect be doing a second time over some of the work of the hospital management committees, or would you prefer to exercise it by purely financial means?—I do not think I should want to exercise it purely financially.

804. The point I am putting to you is this: it has been suggested in a number of quarters that it would be a sound way to administer hospitals by giving what is called a block grant. Could you, by means of a block grant system as between hospitals and the management committees, look to an improvement in the administration of the hospitals themselves?—You are putting to me a question upon which there is a division of opinion amongst the chairmen of regional boards. One chairman is very strongly in favour of a block grant, and I am just as strongly opposed to a block grant.

805. Can you give reasons, from your experience as a chairman of a regional board, why you think a block grant would not work?—The simple reason is that this is not a static service. It is a service which has just been commenced. It is a service which has inherited old buildings; it has inherited unsatisfactory equipment; it has inherited a bed deficency; it has inherited a staff deficiency in nurses and to some extent in doctors. I do not see myself how any block grant could be estimated which would cover all these factors. If you had a static service and said here is so much money to run this service, you could possibly do that; but this is not a static service. It has not grown up yet. It needs in my opinion ten years before you could say this service was complete from A to Z. That is the difficulty about any block grant system.

806. You think a block grant would necessarily have the effect of standardising matters?—It would have the effect of restricting the activities of management committees and of hospital boards.

807. Of restricting activities?—I think it would restrict.

808. Activities, but not responsibilities? —No. There is no point in having responsibilty unless you are able to discharge it, and if the money is not sufficient to discharge it you soon get rid of the responsibility.

809. You fear that a block grant would tend to be a standard grant for a long period, and that, as your region was rather behind at the beginning, it would prejudice you. I think that is what you are saying? —I think it would stultify the whole Service. That is my own view. I have very strong views about it.

Mr. *Thomas Reid.*

810. And ossify it?—And possibly ossify it.

Mr. *Turton.*

811. As far as I can see it is conceivable that there may be for a number of years other claims on Government expenditure, and that those will tend to increase. Is your suggestion that, notwithstanding that, the regional boards should make expanding claims on the national revenue?—That I am afraid is a question entirely outside my

province and outside my conception of things. What I say is this: this Service has been transferred from the voluntary hospitals and the municipal hospitals to the Government. Surely the Government want to continue it in at least as good as and I hope a little better, way than it was carried on in the past.

Chairman.

812. I think we ought not to put to you questions which might reflect on high policy?—I agree.

813. But can I put this question which I think is a fair one? Your current total expenditure is of the order of £13,000,000. Suppose for a moment that the national finances were such that it was clearly impossible to continue to spend what we are now spending on the hospitals, and it was decided that only, shall we say, £12,500,000 would be available to spend in the Sheffield Region. Would you sooner meet that position by being told in advance that no estimate in excess of £12,500,000 would be sanctioned, thus throwing on you the burden of detailed cutting down in the hospitals, or would you sooner be told "Here is £12,500,000. You can allocate it as you please between your hospital groups", and leave them the responsibility for adjusting matters themselves?—I would prefer to be charged with the responsibility because any such reduction would inevitably mean a closing of beds and wards, and probably a reduction in staffs.

814. You would like to keep control of that at the centre?—I think the only body to take a decision of that kind would be an impartial body which covers the whole region—that is the regional board. I do not think you could leave it to the management committees to say they will close this ward or that hospital. It would be better that an overall examination was done by an impartial body, namely, the regional board.

Wing Commander *Geoffrey Cooper.*

815. If you are faced with such a problem would the regional board be able to hold itself in judgment sufficiently effectively to say "We really want to get a first-class Hospital Service, and we must cut our staffs drastically in order to enable us to spend more of our funds on improvements"?—I do not see how you can do that with sixty per cent. of the expenditure going in salaries and wages.

816. If you had control over them you might be able to bring them into line?—We could not possibly reduce the number of consultants on that ground. That is not our business.

817. But you could administrative staff? —Possibly, yes.

Chairman.

818. I am assuming you are told that is all that is going to come to you. Which way would you find more convenient?—If we were told the expenditure of our Region was to be £12,500,000 I should prefer that the allocation of the money was given to the regional board, and that the regional board should decide how it should be spent. I am sure you would get a more impartial decision that way.

Wing Commander *Geoffrey Cooper.*

819. There would be a tendency in those circumstances to cut administrative costs as well in order to give a better service?—You could not cut salaries or wages; you could only cut numbers.

820. You might do both?—No.

Chairman.

821. We have considered the possibility of the responsibility being on the management committee or on the regional board. At the present time I suppose the tendency is for any cuts to be decided by the Ministry?—Yes.

822. As between yourselves and the Ministry which do you think is better qualified to make decisions of that kind? —I think the Ministry would have to take a national view of the whole picture. You could not exclude the Ministry from it.

823. Would you think it a good plan that the Ministry should lay down certain rules that cuts are to be made on particular parts of the Service?—I do not think they could do it; the Ministry have not got the information.

824. Could you do it any better? Have you the detailed information of what is happening in the groups?—Within our Region, yes. We could do it within our Region.

825. You know in each group of hospitals what service is perhaps—I will not say in excess of the needs—relatively in excess of the needs?—I am not admitting there is any service anywhere in excess of the needs.

826. I appreciate that. What I am prepared to say is this: if there is to be any reduction, that reduction will be better carried out by the regional board making a survey of the entire region than it would be by any particular hospital management committee or committees.

Mr. *Diamond.*

827. You are, therefore, opposed to the principle of a block grant to individual hospital management committees?—I am strongly opposed to that.

Mr. *J. Enoch Powell.*

828. You think there should be a closer control over the management committees by the regional board—in general terms?—Yes, but I must be very careful about this. The policy of the Board and myself is to give management committees the utmost possible freedom. I am always afraid of controlling a body of men who give their services and who want to regard their services as being usefully occupied. I claim from the Ministry as much freedom as I can get, and I think it is only right that management committees should have equal freedom from the regional board.

829. The point I am trying to get at is this: you have suggested one way in which control of a job, of which you would approve, could be exercised—through a review of the establishments?—Yes.

830. Are there other ways in which a similar beneficial control could in your view be exercised by the regional board over the hospital management committees?—You have used the word "beneficial". The sort of control you have in mind is to effect a financial saving. That is not necessarily a beneficial control. It is going to be a control which is going to be rather unpleasant to handle, and it is going to lead to reductions in many ways. I hope the Sub-Committee will realise that any suggestion of stopping expenditure will be most serious. To-day there are large wards with vacant beds in them, and there are long waiting lists. We are very short of beds for mental defectives and for mental patients. We are very short of sanatoria.

Chairman.

831. I do not think the Sub-Committee in any way wishes to induce you to suggest that to reduce expenditure is desirable. I think all we want to do is to find out from you how you think that, having regard to the financial stringency which is inevitable, the necessary economies can be most efficiently carried through?—May I just answer by saying that I would like to see this Service reduced in cost, but I do not know how you can reduce it having regard to the expenditure which is authorised on salaries, wages and all the other increases. You have got to realise that we burn a lot of fuel; we cannot control the cost of fuel; we can only control the amount that is consumed. There are rates. There is electricity, heating and all sorts of things which we cannot control. If you get down to the actual things—there are textiles and food which accounts for anything between twenty-five and thirty-five per cent. of our total expenditure—which we can control. To-day there is a substantial difference between one hospital and another in food. It has been the Ministry's object to try to improve the Service so far as the preparation of meals and the preparation of special meals are concerned. All that has got to be brought up to a better standard in a good many places.

832. Surely the total expenditure available must be decided by the Government after discussion with the boards and others concerned?—I agree.

833. Once the total is decided by the Government then the next question arises of how the money should be allocated as between the various parts of the Service. Is it not possible that that is best done at hospital level rather than at regional level?—I should say "No". My own view would be that, if there is to be a sum of money spent on Sheffield Region, that sum of money had better be handed to the regional board who would make its own distribution amongst the hospital management committees according to what it considered to be the needs of each management committee.

Mr. *Turton.*

834. Assuming that financial stringency, would it be practicable or desirable for the regional board to make its own appeal in the region for money to be subscribed voluntarily, in addition to any money which came from the Exchequer?—The Instructions of the Minister of Health are that regional boards and management committees must have nothing to do with that.

835. I asked whether it would be practicable or desirable—that is how I put it?—If it comes to the question of issuing voluntary appeals for money, it is better done in the locality. Therefore it is better done by the management committee of a group of hospitals. There is no point in Sheffield Regional Board issuing an appeal to reach people in Nottingham, Leicester, Derby and Lincoln.

Chairman.

836. That is not the responsibility of the Board?—We are told we must have nothing to do with that.

837. You have, apart from the Government grant, an income from the old endowments?—Yes.

838. Can you say what your income was last year?—£26,000 was the part the regional board had.

839. How much of that did you spend?—(Mr. *Everingham.*) All except £500 was allocated to the hospital management committees. May I just say how that works? A sum is allocated to each region, that is to say a certain amount of the income. Half of that income is sent direct by the Ministry of Health twice a year to

the hospital management committees direct. The other half is sent to the board. The board have power to retain ten per cent. of the whole, if they wish, for any purpose like research; otherwise they are expected to allocate the amount again to hospital management committees. We allocate it all now to hospital management committees because we have been striving in the past to build up a fund of £2,500 to retain for any possible research. During last year we reached that figure, and therefore from now on we are allocating everything immediately to hospital management committees, and they get it within a month of our receiving the money.

840. For Board purposes you have not spent any of this money at all?—Only about £20 since the appointed day. (Sir *Basil Gibson.*) You can say nothing, practically.

Mr. *Diamond.*

841. Can I ask on what basis you allocate it to hospital management committees? —(Mr. *Everingham.*) The basis on which the Ministry of Health allocate it is bed complement; we allocate ours on occupied beds. That is the difference.

842. Not staffed beds?—No, occupied beds.

Chairman.

843. Do you know at the region the total amount which went to your management committees?—About £26,000. There is a similar amount from the Ministry.

844. About £50,000 was distributed among the management committees in the region?—Yes, Sir.

845. Do you know what proportion of that was spent?—No, I do not. (Sir *Basil Gibson.*) May I point out that I think this is the answer? The total bed complement in the region is 36,000; the total beds which are available are 32,000. The amount they receive varies between twenty and thirty shillings per bed per annum, and it is supposed to be used for patients' amenities such as newspapers, stationery and things of that kind. It is thirty shillings; that is neither here nor there in a hospital.

846. Perhaps I can give you general figures, and you may be able to obtain figures for your Region in the light of those. The management committees as a whole in the country started the year 1949-50 with a balance of £465,000?—That is capital.

847. No, balance of income. We are only dealing with income?—Yes.

848. They received in various ways further sums bringing their total income from those sources to £2,100,000, in round figures. They invested just on £300,000 out of that, and they carried forward to next year £1,470,000. Therefore, out of this total of £2,100,000 they only spent £345,000, something under twenty per cent. of the total amount available. Assuming that is the general picture in the country and your Region is not exceptional in this respect, do you know why your management committees in fact only spent some four shillings in the £ of what was available to them from this source?—I should imagine the explanation is that they had sufficient money provided by friends or others to meet the needs of the patients.

849. It looks as if there is not a very great deal of financial pressure?—On the endowment fund?

850. On the management committees. This is money available for expenditure on anything they like?—It is intended to be spent on patients' amenities and on research. Those are the two main points; and the income in the teaching hospitals is very much larger than it is in the non-teaching hospitals.

851. I am talking now merely of the hospital management committees?—You are.

852. It rather looks as if, at any rate for the field of expenditure for which this is applicable——?—If you are asking me is there a need for the income from the endowment fund for patients' amenities or for research, I should be disposed to say very little need.

853. In fact all amenities are made readily available by the Associations of Friends of the Hospital generally.

Mr. *Diamond.*

854. From normal sources?—A lot can be charged to Treasury or Ministry funds, but you cannot charge library books to Ministry funds.

855. It is very difficult to draw the line between what is an amenity and what is not. Is a big plant an amenity, and a small bunch of daisies not? In general terms it would appear from these figures and from what you have said that there is no great need to be satisfied out of this amenity fund?—That is my view. I have expressed it before. I have said more than once that the endowment provisions in the Act should be reviewed and possibly repealed. To-day there is no point in using endowment fund monies because capital monies are available, and if you said to the Minister "I do not want your money; I have got this in the endowment fund", his answer is "You may have, but you cannot get materials and wages from both the money which we provide and the money in your endowment fund, and so you may as well leave your endowment fund monies where they are". It comes down to that.

Chairman.

856. I think you have said the need was being met from other sources?—From what is now called Friends of the Hospital. It is a voluntary organisation. It is one which everybody encourages. At Scunthorpe, which is a hospital with three hundred beds, they have this organisation of Friends of the Hospital. At Brigg, which is an old public poor law institution, they need a bed lift very badly. We have not the money for that bed lift, and so the Friends of the Hospital are finding it. It is costing £3,000.

Mr. *J. Enoch Powell.*

857. That is hardly an amenity. That is a scheme for which you might reasonably expect money under the Act?—I agree. It is one of our proposals, but we cannot touch it at the moment. The Friends of the Hospital are finding that, and they are finding other amenities.

Chairman.

858. Have you got any record at the centre of the total amount of money coming in in this way?—No.

859. Could you obtain it without any difficulty?—I could get it.

860. I wonder if it would be troubling you too much if you could give us the total figure of those funds?—(Mr. *Everingham.*) We will give you a memorandum on the endowment income direct from the Ministry and from the regional board, and other income which comes from voluntary sources or other sources to each management committee.

861. If you could do that we would be very grateful. There is no need to break it up as between groups, if you could give us the total figure?—I think we can do that. Anyway we will make an effort to do it.

Mr. *Diamond.*

862. Do I gather that these figures are automatically returned to you? The hospital management committees include them in their accounts for the year, not their estimates?—They are in their accounts.

Chairman.

863. We were dealing with expenditure policy?—Before we leave the subject of salaries may I come back to the point that about sixty per cent. of the expenditure of hospital management committees is on salaries? When we have made our estimates there have been many occasions during the past periods when the Whitley Councils have given fresh awards. From the point of view of our estimates already made and not taking into account those increases the effect is often very serious indeed, because if during a year you are suddenly faced with awards of pay arrears and higher salaries in future to existing staff it can mean sometimes an increase of several thousand pounds in the region; and if you are faced with the problem that that has to be held within your existing estimates it is sometimes almost impossible to do it.

864. Have you ever been held to that?—We have not as a Region because during this past year we have just simply had to say we could not do it.

Mr. *Diamond.*

865. Has it ever been indicated to you that a lack of accurate budgeting in relation to awards, which we recognise are sometimes not only for the future but also back dated will not be held against you at all?—Well, Sir, it is not a lack of accurate budgeting. We were definitely told not to include in our estimates anything in anticipation of future awards. That is a definite instruction from the Ministry.

Chairman.

866. Does that instruction still stand?—It stands every year.

867. There is a small point, which I think might be cleared up, on page four of your memorandum where three paragraphs from the end you say "The Ministry of Supply provide direct certain articles, chiefly medical equipment and X-ray apparatus, which are the subject of bulk purchase. These transactions are recorded by book entry without cash payment being made"?—(Sir *Basil Gibson.*) Payment is made by the Ministry of Health, and it comes into our accounts as a book entry.

868. It is brought into your accounts?—As a book entry.

869. Is that, so to speak, in fact a concealed subsidy to the regional board?—(Mr. *Everingham.*) No, Sir. It comes out of our estimates in just the same way. It is not actually the Ministry of Supply; it is the Ministry of Health, Supplies Division; but the figures are included in our estimates, and the expenditure is shown as an expenditure. It is merely a fact that there is no cash transfer.

Mr. *Thomas Reid.*

870. Are you quite satisfied with this system of purchase, or do you think your board or hospital management committee should have power to purchase articles without going through the Ministry?—(Sir *Basil Gibson.*) We could talk for an hour about the bulk purchase of articles. There is no doubt that certain articles, particularly X-ray apparatus, are better bought by one central authority. The only difficulty we have had in the past has been that, when we have ordered X-ray apparatus and it has been delivered, it has been much larger

than the apparatus which it replaces, with the result that the accommodation which was provided for it has had to be increased. Those are the little things which arise in connection with bulk purchase. You do not know all the details about it.

871. Surely when you are ordering X-ray apparatus you do indicate the size you want?—We indicate the best we can, but it is bought nationally. What I have said has happened on more than one occasion.

872. Apart from a large expensive article like X-ray apparatus, are you troubled at all by not being able to get at once locally some smaller article?—No. We do not believe in bulk purchase; what we believe in is central contracting. That is to say you would have a general contract for an area, and everybody would order on that central contract.

873. And not from the Ministry?—No.

Miss *Ward.*

874. Then you would make an alteration in the present system?—No. The Ministry of Health, Supplies Division, does not extend its activities over many articles yet; it has quite a limited field.

Chairman.

875. I think we are at cross purposes. This paragraph only deals with a very limited range of highly specialised articles?—At the moment.

876. Is there any suggestion that its range should be extended?—I believe the Ministry of Health, Supplies Division, have that in mind.

877. So far as your knowledge as a chairman of a regional board is concerned, it is merely a matter of speculation?—Mr. Everingham tells me they have now just indicated that they may supply us with soap.

878. Does the Ministry get these goods cheaper than you would be able to get them?—I think we could have an hour's discussion on that question because this is the way we should put it. I should argue that, if the Ministry did get a properly organised system of central purchasing, the Ministry would not in my view—I am speaking personally—benefit at all. What with all the other expenses connected with the purchase of goods I do not think they would benefit at all. They have given me figures from time to time; but the difference is a decimal point.

Wing Commander *Geoffrey Cooper.*

879. Since the Ministries do purchase, as we know, for the Armed Forces——?—That is a different story altogether.

880. I do appreciate the difference but is your suggestion that, if a nurses' home were being equipped for a hospital management committee, the furniture in your opinion would be purchased better by the management committee or by the regional board?—By the management committee.

881. What is happening now?—That is what is happening now. Equipping a nurses' home is just one small instance.

882. I just gave that as an illustration. How would you explain a certain case which has arisen where the nurses would like to choose their equipment if they had the chance, because they feel they could pick something which would be comfortable rather than have a more expensive type of chair, which was less comfortable, supplied by the regional board? Is that normal? Would you do a thing like that?—I should not think it is ever done. The furniture is very carefully selected; the matron is generally consulted; and everything is done from the point of view of making it comfortable for the nurses or the persons going to occupy the rooms. What we have in mind is the purchase of textiles such as towels, sheets, blankets, boots, shoes and all sorts of things of that kind, which you need in the regular running of a hospital. We say we can buy those by a system of central contracting better than anybody can buy by bulk purchase.

Mr. *Thomas Reid.*

883. Does not the question largely turn on the trade discount allowed? Does not the Ministry get them at wholesale prices?—So do we.

Chairman.

884. When you say a system of central contracting, is that centralised at your board level or centralised at a lower level?—It would depend. It would depend on the particular article. In some cases it would be a very limited field, such as food. You can buy foods for groups of hospitals, or it might be desirable to confine it to one, two or three groups, just a little area, but for sheets you might cover twice that area. You would have to work it out by trial and error.

Wing Commander *Geoffrey Cooper.*

885. When Sir Basil says the purchase is made at the wholesale price, does he mean that he can go to a shop and get a discount, to the wholesaler or the actual factory?—Every tender we receive comes from the manufacturer. We do not deal with retailers if we can avoid it.

Mr. *Turton.*

886. I want to get quite clear whether the central purchase is done by the regional board or by the hospital management committee, or by the alternative suggestion you have just put up of a certain combination

of group hospital management committees?—The answer is that there is no system in operation throughout the Region yet. It has been a subject which has been discussed for a very long time, but there is no system in operation yet. In Sheffield, for example, two of the hospital management committees have combined with Sheffield Corporation. Sheffield Corporation have invited tenders for goods which are common to the two hospital management committees and to the corporation departments. Those goods are invariably bought from a manufacturer, and they are bought at a less price than they would have been if the management committee did it alone. That is the sort of thing we have in mind.

887. Are you at the present time spending round about £2,000,000 a year on stores generally?—I dare say.

888. At the moment is that all decentralised at the hospital management committees?—Yes.

889. Do you anticipate you could make any appreciable saving if you went in for your different method of bulk purchase?—This subject is like King Charles' head with me, and you must take my answer subject to that understanding. I believe we can save money by a system of central contracting, but by that I do not mean central contracting by the regional board; I mean contracting by groups within regions, and probably reserving some things to the Ministry and some things to the regional board.

Chairman.

890. I think what you are saying is that this is a question which is still largely in the realms of controversy?—It is.

891. You in fact are dealing with it. You are trying out greater and lesser degrees of centralisation, but at the moment you think the probable answer is that this question must always remain empirical?—For a time.

892. For some considerable time?—Yes. I think we could get into a good system within three or four years, but a schedule of goods requires a very careful build-up. It takes a long time to do that.

Mr. *J. Enoch Powell.*

893. When we were discussing staff, which represents sixty per cent. of your budget, we ascertained that the datum line above which increases took place was not within your responsibility and had not been reviewed by you. Does the same apply to any considerable part of the remaining forty per cent.? Are you similarly taking the stores estimates and so on of the group committees and only dealing with requisite increases, or are you able to review the whole of that expenditure critically year by year?—We review the whole of that expenditure critically year by year, and if you look at the estimates which I put in you will see that there is a comparable figure in textiles. It may be so much per patient. There is a certain standard. We can compare that, and do compare that, with other hospitals.

Chairman.] I think the sub-Committee will not wish to pursue this controversial matter further. It is obviously one which it will be in order for them to pursue if they wish, but I do not think we can usefully take it any further.

Mr. *Turton.*

894. The remarks under subheading (*d*) on page ten of the memorandum are I think related to this point, although they are not controversial. Could you dilate a little on this question of "Stores"?—I do not think we could dilate on it. It is our intention to provide proper accommodation for stores as soon as we can. A good many of these hospitals have no storage space at all. They had no methods of dealing with stores, but they have now been introduced.

Mr. *Thomas Reid.*

895. How did they manage then?—You must bear in mind that we succeeded to municipal hospitals and voluntary hospitals, and that they were not commercial concerns.

896. How can a hospital manage without stores? There must be an immense amount of stores used in a hospital?—(Mr. *Everingham.*) The point is that, if there is inadequate accommodation for stores, they are not able to carry all the stocks they really should do in some cases, and in others they had to split stocks of a small nature keeping some in one part and keeping some in another part. It is very, very difficult to control stocks when you have them scattered all over the place; and in some hospitals they could not get a real system of control of what was in stock and what was not. It is very difficult if you have not got proper stores accommodation, and at some of them storage space was almost non-existent.

897. Would you say there is considerable loss or any loss owing to the absence of proper storage and proper records?—I think the opportunities for thefts and possibilities of waste are very much increased if you have not got proper accommodation.

Wing Commander *Geoffrey Cooper.*

898. Previously the municipalities kept the stores for the municipal hospitals along with other stores required for other departments, whereas now you are suggesting each hospital should have its own store, storekeeper and storekeeping system?—(Sir *Basil Gibson.*) No, we are not suggesting that. We suggest we should have a proper

system of stores, and we think it should be applied to particular hospitals or groups of hospitals. What we do say is that some hospitals had no stores at all because the municipality kept all the stores somewhere else.

899. You are suggesting there should be a store at each hospital as well as at the regional board?—(Mr. *Everingham.*) If they are large enough. In some smaller hospitals where they are not far from a larger one, it is much quicker to feed them from the general stores of the larger hospital.

Mr. *Thomas Reid.*

900. Is there a proper system of audit of these stores?—(Sir *Basil Gibson.*) There is now by the Ministry the best audit they can do.

Miss *Ward.*

901. That is mentioned on page four of the memorandum where it details the new system which the boards are putting into operation?—That is correct.

Chairman.] I rather wanted to try to deal with the question of audit of accounts in the remaining half an hour, and I think perhaps this is a convenient moment at which to start. You deal with the question of audit on page five.

Miss *Ward.*] It starts on page four concerning banking arrangements.

Mr. *Diamond.*

902. There is just one point I should just like to clear up there. I gather that the hospital management committees control their finance through a statutory finance sub-committee. I then see that the finance officer is responsible for making all payments. Could I ask in fact who signs the cheques?—(Mr. *Everingham.*) The cheques are always signed, unless they are on an officer's imprest account, drawing money from the general account, by a member of the hospital management committee, and the finance officer countersigns them. There are always two signatures.

903. Any cheques drawn from that account to feed the imprest account would be similarly signed?—That is right.

Miss *Ward.*

904. You say "The banking arrangements of hospital management committees require the approval of the Board and these are constantly under review". Can they alter from time to time? What is the implication of that paragraph?—The system is laid down by the Ministry of Health Circular No. 49/48. "49" relates to the year. There within certain limits a board has power to approve variations from the standard. Every time a hospital management committee wants to make a variation in its banking arrangements from the standard it asks the approval of the regional board, and once that is given it can continue within those new limits until any change again is indicated, and then it must come back to the board again. There are some cases in which the present banking arrangements are not sufficiently flexible, mainly to enable the committee to take advantage of cash discounts, and those require the sanction of the Ministry. Then the board write to the Ministry asking for approval for variations in those cases. I have two such cases now. They are the first I have had as a matter of fact. That is why they are always being under review, because the hospital management committees come to us if circumstances change.

905. I may be quite wrong, but I should have thought banking arrangements would be one of the easiest things to standardise somehow?—(Sir *Basil Gibson.*) You can take it there is a standard practice, but occasionally it happens that the standard requires adjustment or a little variation; but those are small and insignificant. You can rest assured that the banking arrangements are the same throughout the entire region, and in fact throughout the entire country. It is only these little adjustments which we had in mind.

Chairman.

906. Sir Basil, you mention the system of audit at the top of page five of your memorandum, and you say "The Minister, however, has no power of surcharge in the event of expenditure being disallowed"?—That is wrong. He cannot even disallow anything. We spend his money, and all he can say is that we are bad agents if we make a mistake.

907. By "a mistake" you mean if there is a mistake in the accounts or if there is an expenditure which in fact has not been authorised?—I do not quite know what is the meaning of "authorised". Under this set-up everything which we do we do as agent for a principal, and he is responsible for what we do. The authority is for a lump sum. We may do something within that item which the auditor may say we ought not to have done; he cannot do anything about it; he can only report us.

908. What would happen? Let us take an absurd proposition. Suppose a house governor goes mad and provides all the patients with caviare, which is obviously not a proper expenditure?—That is an extreme example, and it is one which would never be done.

909. It would take the expenditure far above the estimate. What would in fact happen? Would the Minister of Health have to provide that sum, and would his only remedy be to get rid of the offending

board or officers?—The sum would be spent before he would know anything at all about it.

910. That is the point?—It would all be spent before he knew anything at all about it. The auditor would call his attention to it, and we should get a very serious rebuke. Probably he would say, "If you do those silly things I shall remove you from the committee".

911. That is his only remedy?—That is his only remedy.

Mr. *J. Enoch Powell.*

912. He cannot recover it?—He cannot recover it.

913. Because the person spending it is his own agent?—That is right.

Mr. *Thomas Reid.*

914. Take another case. Suppose one of your employees was overpaid for a period of six months through a sheer mistake. What would happen then?—If he was an honest employee he would return the money. If he was not then neither we nor the local committee could recover it. The Minister would simply have to bear the expenditure.

Mr. *J. Enoch Powell.*

915. In that case, if the overpayment was due to an employee being placed in a grade in which he ought not have been placed, if he is paid more than his salary under contract presumably the overpayment is recoverable?—It might be recoverable. There are cases where you pay more than you should, and you cannot recover it. Anyway, whatever the position may be, the Minister cannot recover the money from the chairman of the committee, the members of the committee or any person who signs cheques.

Chairman.

916. The committee are not responsible to you directly for expenditure at all?—Provided it is within their estimate we have no control over the details.

917. You may not have approved it, but the committee account directly to the Minister?—Yes.

918. They are not your agents; they are agents of the Minister direct?—They are both. The management committee is the agent of the regional board, but the management committee is also the agent of the Minister.

919. The audit is carried out by the Ministry of Health's auditor?—Yes.

920. You have no auditors at all?—No.

921. Is there no internal audit?—No.

922. There is only one audit, and that is carried out by the auditors of the Ministry of Health?—Yes. It is very carefully done. He spends a long time over it.

Mr. *Diamond.*

923. Are you satisfied that there is in no hospital any system of internal audit, as that phrase is used?—(Mr. *Everingham.*) I have tried my best to encourage internal auditing in some cases within a hospital management committee. Only hospital management committees have powers to carry out any audit; I have none. But wherever a hospital management committee is really large enough and opportunity occurs where something has happened which would not have happened if there had been an efficient internal auditor, I try to get one put in, but it is very difficult indeed. One does not know what has happened in the way of loss until one gets the auditor's annual report. The annual reports of auditors have to be sent to the Board, but any interim report does not. An interim report goes direct to the Ministry, and we may or may not get a copy of it. We do not know at the regional board necessarily what has happened until the annual report comes in, and then if that refers to anything we have a chance to look at it. (Sir *Basil Gibson.*) The answer really is that, speaking broadly, there is no internal auditor or audit staff in any hospital, under the control of a management committe, responsible to the regional board.

924. Or any partial form of internal audit?—No.

925. Is it your view that there should be?—What we should like to do is to carry out the internal audit in a hospital ourselves.

Chairman.

926. You are now referring to your recommendations in effect at the foot of page nine of the memorandum?—Yes. We should prefer to do the audit ourselves because once you get inside a management committee's office an auditor can see a great deal.

Wing Commander *Geoffrey Cooper.*

927. The regional board would have an audit system, and you would send out your people to do the checking at the various hospitals under your control?—Yes.

Chairman.

928. Have you put up that suggestion to the Ministry of Health?—I think we have. I am certain it has been discussed over and over again, but I could not put my finger on any particular time when it was or on any letter in which it was suggested. It is common knowledge at the Ministry.

929. Do you know what the Ministry's objection is?—I think they prefer their own audit, that is all.

Mr. *Thomas Reid.*

930. You propose to abolish the Ministry's audit?—Yes.

Mr. *Diamond.*

931. This would be in replacement of it?—Yes.

932. The advantage to your mind would be that the Board would be enriched by all the knowledge which the travelling auditor would ascertain?—That is the real point. Once we get inside the office of a management committee we know precisely what is going on.

Mr. *J. Enoch Powell.*

933. Also you get earlier information of what is going on?—We get it at once.

934. Is that proposal regarding internal audit related to your recommendation on the central keeping of accounts?—(Mr. *Everingham.*) No, Sir. The existing position is that estimates are controlled by the regional board, but the hospital group committee sends its final accounts, and is responsible, to the Minister. The audit is carried out by the Ministry. There is much to be said for co-ordinating those three under the regional board, because the regional board, being responsible for the estimates, cannot do that properly unless they also keep the final accounts within their own control. I send out to hospital group committees in the course of a year perhaps £12,000,000. I have no further concern on how that is spent, but I am concerned when the estimates come up again, whereas if I had to record the spending of that £12,000,000 I should have my finger on it all the way along. If that was reinforced by an internal audit as well I should not only be able to be right on top of everything that was happening from the financial point of view in a region but also I think I should be able to prevent waste before it occurred—and possibly prevent frauds before they occurred or at any rate catch them very much earlier than they are being caught now.

935. One would facilitate the other. The internal audit would be facilitated by the regional management of accounts?—That is right. I would leave the hospital management committee to complete their own accounts at the moment, and then incorporate them into my final accounts at the end of the year.

Mr. *Turton.*

936. You would require a much larger staff?—No. It is not the suggestion that all the accounts should be done in the office of the regional board. What we say is that their accounts should be done under our direction so that we know what is going on, and then they should be incorporated in our accounts at the end of the year—but the internal audit is entirely separate and not dependent upon that.

Mr. *J. Enoch Powell.*

937. Is the proposal for the use of a uniform punched card system designed to facilitate the co-ordination by the regional board of H.M.C. accounts?—There is such a system in force in some boards; it is not in force in Sheffield because we take the view that every hospital management committee should make up its own mind about how it does its own accounts. Had the punched card system been insisted upon at the beginning right throughout the Service, there is no doubt it would have saved administrative expenditure on salaries, but it has not been done.

938. Would it have facilitated the arrangements for the auditing of accounts which you have in mind?—Yes, definitely.

939. When you say it cannot be done now you are putting everything into the pluperfect tense, and you are referring again to the problem of vested interest which we saw earlier?—Yes.

Mr. *Diamond.*

940. I take it that you well recognise the need for the Ministry audit of your own accounts?—Yes, most definitely.

941. You are referring to the audit of hospital committees' accounts?—Yes.

Chairman.

942. On the physical side of this audit, at the moment the committees' accounts are audited by special auditors who are doing nothing but these accounts?—(Sir *Basil Gibson.*) That is correct.

943. At any given moment there would be auditors of the Ministry at work somewhere within your Region?—Yes.

944. The changeover would not possibly involve any alteration in personnel at all. I think you would probably suggest you would take over some of them?—We would probably take them over. There would be some, of course, who would not be required. We should want the actual auditors themselves, but not the supervisors or principals.

945. In other words there may be an actual diminution of staff?—I think that is possible.

Wing Commander *Geoffrey Cooper.*

946. Would you not require to have qualified auditors on your own staff in that case, or would you use the services of an outside firm?—(Mr. *Everingham.*) That is the difficulty. Many of the audit staff are not qualified. (Sir *Basil Gibson.*) You mean professionally qualified? (Mr. *Everingham.*) Yes.

Chairman.

947. You would have the same difficulty as the Ministry of Health?—I should endeavour to have qualified men. It would be more expensive as regards individuals but I do not think you would need so many in numbers; and you would get a better result.

Mr. *Turton.*

948. What is the practice now?—The Ministry of Health auditors also audit the accounts of executive councils and some other bodies, besides ourselves. They make it their practice to notify hospital management committees and ourselves when they are coming. I have three members of the audit staff with me at the moment, and they will probably spend about a month at regional level.

949. At the hospital management committees how many auditors are in your Region?—I could not tell you how many. Even then they do other work besides the hospitals.

Chairman.

950. It is not your responsibility?—No.

Mr. *Turton.*] You want to assume that responsibility, and I think we ought to have the picture of how you would economise in staff because I find that really hard to understand.

Mr. *Diamond.*] Perhaps we can ask that question when we have the appropriate witnesses before us from the Ministry of Health.

Chairman.

951. I think it is a matter which we can pursue with other witnesses. The regional board is not responsible for the audit at the moment. I think all they say is that, if they took over responsibility, they could do it quite as efficiently as the Ministry of Health?—(Sir *Basil Gibson.*) We could do it as efficiently, and it would be helpful to us in controlling expenditure. (Mr. *Everingham.*) There is such a system in force in Scotland, and it was dealt with at a similar Sub-Committee to this last year. Their conclusion is to be found in paragraph 51 of the Report of the Select Committee on Estimates 1948-49 at page xxi.

952. I was Chairman of that Sub-Committee, and I remember it very well.—There the Minister of Health has designated the regional hospital board as his auditor, and in that way power to audit is given to the regional board although there is a much closer link between hospital management committees and the boards in Scotland than there is in England.

Mr. *Thomas Reid.*

953. As regards getting inside a committee's office and seeing their work, do the reports of the Ministry's auditors, when they are sent to the Minister, also come to you for information?—Only the annual reports. They may or may not send interim reports to us.

954. Would not the detailed reports of the Ministry's auditors, if sent to you, be of great value to you?—They would be useful.

955. That is not done now?—In relation to the interim report on matters which arise during the year as distinct from the annual report to the Ministry, sometimes they send us copies and sometimes they do not.

Miss *Ward.*

956. If they have any reason to criticise a committee's accounts, would they not direct your attention to it in order that you might take up the matter?—Presumably they would. I do not know whether they do it always because I do not know the nature of interim reports which I do not receive.

957. In other words, you are not really kept adequately in the picture?—No. (Sir *Basil Gibson.*) We do not want to criticise the Ministry's audit at all. We get on very well with them, and I believe they do it very effectively. However we do say this: if we did the audit ourselves it would help us. We could do it as efficiently, and it would help to supply us with information.

Mr. *Thomas Reid.*

958. I am not quite clear about that. I would agree that if you got inside a committee's office you would have a much greater knowledge of what was going on, but to do that you would have to appoint your own auditor and get inside?—I agree.

959. What is the difference in that from the Minister having his auditor, so long as that auditor sends a full copy of his report to you?—His report would probably consist of a few pages. If a man visits a management committee and is in constant touch with the treasurer and the treasurer's staff, there is an enormous amount of information conveyed from one to the other which never gets into the report at all.

Miss *Ward.*

960. They discuss details of expenditure?—Yes. (Mr. *Everingham.*) There is one little matter, the question of delay. It would probably take me three months to get a copy of the interim report. I have just recently received copies of the final reports of the auditors, and they are dated two months ago. There would be no delay if the auditor was part of my staff.

961. Are you then ever in a position to compare in detail the expenditure of one hospital management committee with another?—One has just got to that position now because the accounts for the first full

financial year have been closed, I refer to 1949-50, and the finance committee of the Board at their next meeting will in fact be considering for the first time various hospital costs relating to the 1949-50 year separated under the different types of hospitals throughout our Region. They show very considerable variations, and I have no doubt the finance committee will be very interested. But I really have no power to do anything with the hospital management committees about it, except at the time of the estimates.

Chairman.

962. I think what you have in mind particularly is that by having the auditors directly responsible to yourselves you can tell them what is in your mind as regards policy, and indicate to them the sort of things into which you want them to look and report?—Precisely.

963. Thereby you can get a report upon something with which you are particularly concerned at any given moment?—Precisely. (Sir *Basil Gibson.*) There is no doubt there is great variation between one hospital and another. You cannot have common figures because you have got to consider the hospital itself and the general circumstances. You can have a figure which will give you a very good guide, and having got that in mind you can say "This is something into which I must inquire".

Wing Commander *Geoffrey Cooper.*

964. If you obtain this permission to run the audit from the regional board and it gives you this information, presumably you are asking at the same time for a change of policy in the way the organisation is run, because with that information you would presumably wish to act?—We probably would.

965. Therefore you would wish to have more power, or something of that sort, over committees?—We have got to be frightfully careful because these people are all people who are working for the hospitals voluntarily. They are very interested in them, and they must have a measure of freedom; otherwise they will never serve.

Miss *Ward.*

966. It is the interchange of information which might be valuable?—I agree.

Mr. *J. Enoch Powell.*

967. There is a very important paragraph on page ten of the memorandum under subhead (f) where it is stated, at any rate by implication, that a number of supplies officers, group engineers, dieticians, catering officers, etc., are not essential in the prevailing circumstances. I assume it is an implication rather than a statement, but it is the implication clearly. Could we have more particulars of that, if not now then at any rate in writing?—I thought we had discussed fairly fully this question of staff. This paragraph really refers to the origin of the Service when, as I said, the staff was set up under a Ministry circular with ministerial salaries and an indication of what was required. They said you wanted a secretary, a treasurer, a finance officer and a supplies officer. It does not at all follow that they really meant you had to have these people anyway, because in a good many of the management committees there is no supplies officer; his work is done by a clerk in the committee's office.

968. Where you say "The issue of circulars", you mean the issue of circulars at the time of the setting up of the Service?—(Mr. *Faulkner.*) And since.

969. This refers to increases in staff since the set-up, staff which you control, and yet your hand is forced by these Ministry circulars?—(Sir *Basil Gibson.*) Exactly.

970. Can you give us examples?—(Mr. *Faulkner.*) Can I take the example of the Ministry of Health staff dieticians visiting a hospital? They submit a report to the Minister, a copy of which is sent to the management committee, encouraging the employment of a catering officer and dietician at that particular hospital.

971. Although you have the right, when the estimates come to you, to disallow it, their case as against yours is strengthened by this report?—Infinitely.

972. In your opinion, therefore, even since the inception of the scheme there have been unnecessary increases of staff under these heads—I mean "unnecessary" in present conditions?—(Sir *Basil Gibson.*) The word "unnecessary" is very difficult.

973. Then I will use your own words—not essential?—As I explained earlier the standard of feeding in a good many of these hospitals is fairly low, and that is the reason why the Ministry have sent their dieticians and other people to make enquiries. It is desirable that the standard should be as good as possible, because feeding a patient properly is halfway towards his recovery.

Miss *Ward.*

974. Could you control it?—We could.

Mr. *Diamond.*

975. I am not quite clear as to the circumstances in which you would not approve the addition by a management committee of a dietician, which I gather is the case you have in mind. When it is suggested by a management committee, presumably of its own desire, that in the circumstances it would be a good thing to have a dietician, when the suggestion came to the board the board would discuss it with its medical committee or appropriate committee, would the board then regard this suggestion as not a valuable one?—The Minister has

these officials at central headquarters, and they go round. If they did not go round there would probably be no request for a dietician from this particular management committee. The same applies to other staffs, and that is really what we meant. Once a management committee are satisfied that they want this dietician and they are supported by the report of the Minister's own staff, then we should not agree to a dietician being employed until there was provision in the estimates for a dietician. When that was provided and when the estimates were approved by the Ministry, a dietician would be appointed.

Mr. *Turton.*

976. You talk about dieticians and other staff. Would you give instances of the other staff?—(Mr. *Faulkner.*) If I may refer to the question of teams of experts who visit hospitals, quite frequently in my experience those teams of experts have told management committees, and have told the board, that certain of the appointments within that management committee are, in their view, under-graded. That gives the hospital committee the chance to say to the board this appointment should be upgraded, and "We have the views of the Ministry of Health's team which encourage us in that conviction".

Wing Commander *Geoffrey Cooper.*

977. With regard to the paragraph (*h*) on page ten of your memorandum, headed "Number of Hospital Management Committees" is the envisaged reduction considerable or only just an odd one or two?—(Sir *Basil Gibson.*) We have never envisaged it at all. I thought I explained that at an earlier meeting.

Chairman.

978. There are a number of other questions on which we would greatly appreciate your views. There are the questions of professional relations, consultation with the medical profession, your relations with the general practitioners within the area, the nursing question, and charges for beds. I think those are all matters of policy with which you are very deeply concerned. Perhaps we could invite you to return at some later date?—We wish to be as helpful as we can within the limits of our knowledge and experience. If you wish us to come again we shall come.

979. We shall be taking evidence from other witnesses of course, and the best arrangement might be to ask you to come back again perhaps after Easter, in April?—Yes. Just before you close we have a map which we can leave with you. This is a map purely of the Region. It is the same map as you had before, but with a little more information upon it. It is divided into five centres, and it shows how impossible it is, when you sit down and look at it, to split the region into two parts. We have also sent to you a statement of the beds available as at 31st December, 1950. That shows that the total bed complement was 36,811, and that we have 4,631 beds not available. It does not at all follow that all those beds will ultimately be brought into use, because some of them may be abolished by reason of structural changes, but the bulk of them would be. We have that number of beds which we cannot use because of staff difficulties. Immediately we start to man them, up goes our revenue expenditure. I have also sent you a copy of the form, for which you asked, dealing with the constitution of management committees, giving all the details.

980. I think we have received all the other information for which we asked you.—You asked us for a schedule of payments, and you have had that. I think that is all I need say now.

Chairman.] Thank you very much indeed.

The witnesses withdrew.

Adjourned till Thursday next, at 10.30 *a.m.*

THURSDAY, 22ND FEBRUARY, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Thomas Reid.
Mr. Diamond.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mr. F. H. ELLIOTT, D.L., J.P., Chairman, Mr. E. G. BRAITHWAITE, M.A., LL.B., Secretary, Mr. A. F. BLAIR, C.A., Treasurer, and Mr. A. A. HUNT, Assistant Secretary, South West Metropolitan Regional Hospital Board, called in and examined.

Chairman.

981. I should tell you at the start, Mr. Elliott, that you will be furnished with a confidential proof copy of the evidence you give to the Sub-Committee today, and if there are any corrections you would like to make or any matters which you feel might be embarrassing to you if they are made public in due course, will you get in touch with the Clerk to the Sub-Committee and we will see what we can do to meet the point?—(Mr. *Elliott.*) Yes.

982. Could I start by asking you about your contacts with other regional boards?—Well, I have a monthly contact with the other chairmen at the monthly meeting at the Ministry, when all the fourteen chairmen are supposed to come, to see the Ministry officials and the Minister. Mr. Bevan did not come very much, once or twice, but the new Minister was there on Tuesday. We exchange ideas. The official time for the meeting is eleven o'clock, but we meet at ten-thirty to talk over our problems and what we want to put before the Permanent Secretary. Then I have personal contacts, very close ones, with the other three Chairmen of the three Metropolitan Boards. Our offices are all situated at Portland Place in the same building. I am also on very friendly terms with all the chairmen.

983. You are personally acquainted with all of them?—I am very well known to them.

984. Would your officers be personally acquainted with their corresponding numbers in the other boards?—Yes, they would. In fact all the treasurers, I believe, meet at intervals. (Mr. *Braithwaite.*) The Secretary and Treasurer meet every month, before their meeting with the Ministry officials, their opposite numbers in the other boards.

985. Is there what one might call a regional board point of view in the development of hospital policy?—(Mr. *Elliott.*) Undoubtedly.

986. You would at times feel you had a common interest which you would like to see advanced?—We not only have a common interest, but we have a solidarity of communion, one might say.

987. As a rule you are united, are you?—We are.

988. If we might now turn to the memorandum* with which you have kindly furnished us, first of all can I ask you about the size of the Board itself. How many members of the Board are there?—The Chairman and twenty-five members.

989. Are you satisfied that that is a proper size or would you like to have a larger or smaller body?—Well, I am not satisfied that it is large enough. The taxing of the time of men and women with the ability to help in this great enterprise is very great, and we have, as you will see from our memorandum, a large number of sub-committees. I find it increasingly difficult to get my members to serve on these sub-committees. If they are doctors they have no time for their medical affairs; if they are business men they have other affairs to look after; and if they are retired it means almost a full-time job. In consequence, on our board of twenty-six members, a few of them are really doing more than their fair share of the work, more than they would do if they were free agents.

990. To do a proper job on the Board would be, in the ordinary way, a half-time job or what?—I can only speak from the Chairman's point of view. I am at Portland Place every day, and I also try to be at the offices of the Surrey County Council, of which I am Chairman, every day; and it is more than a full-time job.

* Not published.

With regard to many members of the board, they are people who are versed in public affairs, and the board, as a rule, is not their only interest; they are fully employed in this voluntary public service.

991. You think it would improve matters if you had a larger board?—I asked for an addition from Sir William, but it was refused at the time.

992. Of what sort of addition were you thinking?—Three extra members. There is one board in the country which has thirty members; I do not know why. Considering that we are the biggest in the territorial sense, the biggest in the number of beds and the biggest in population, why one of the other boards should have thirty and we have only twenty-five, I do not know.

Mr. *Turton.*] Which board is that?

Chairman.] Sheffield.

Mr. *Thomas Reid.*

993. If you had more members on the board, would that really reduce you work? Do you mean that you would distribute a certain section of the work to sub-committees, or something like that?—Yes.

994. In that connection is your system a system of committee administration?—Yes.

995. Do you think that on big issues which come before your board the committee system as a whole is workable, or should you have the ordinary business system where you really have one person with executive authority in charge of the lot?—You have asked me a very awkward question. The chairman does a very great deal, but he could not work it without a committee system. The chairman has to have the backing of his board in whatever he does.

996. Would you say the chairman is really an executive officer, acting of course subject to the approval of the members of the board?—Yes.

997. It becomes really a full-time job for the chairman?—Yes.

Mr. *J. Enoch Powell.*

998. Do you have in mind that a larger committee would enable you to strengthen your representation on the management committees? I notice there are twenty-nine special and general management committees, and obviously, unless one member of the board is on more than one committee, you cannot be represented on all of those. Is that the point you had in mind?—Not entirely. We have fifty-three management committees, and twenty-five members of the board. It is quite obvious that, unless some members have a plural office, the committees cannot all have a representative of the board on them. I do not think that matters quite so much. What matters is this: we split up into area committees, and it is difficult to find a sufficient number of men and women who can attend these committees without detriment to other work they do. The time element is so important, and of course there is travelling. Several members of my Board, far too many in proportion I think, live in the western area, and from Portsmouth to London and back again——

Chairman.

999. You are experiencing difficulty in suggesting to the Minister names of people of the right calibre for this work?—I do not know whether I am experiencing so much difficulty in naming people of the right calibre for the work, about whom I have enquired, but I am experiencing difficulty in getting them appointed.

Miss *Ward.*

1000. Do you mean from the Minister's point of view?—Yes.

Mr. *Diamond.*

1001. As additional members?—No, even as substitutes for those whose term of office has expired.

Mr. *Turton.*

1002. Do you mean your nomination is not always accepted?—Yes.

1003. Further than that, is it normally refused?—Oh, no, I do not think I could go so far as to say that. Our relations with the Ministry are very good. My relations with Mr. Bevan have always been courteous and cordial, but the fact remains that the calibre of the people whom we are getting now to serve on hospital group committees and on regional boards is going down, because the work is very onerous, and the type of men and women, willing to do the work and glorying in the work, as we all should, is the type which looks upon it as, I will not say as a job, but as an occupation which is not costing him anything and maybe providing him with a little remuneration.

Chairman.

1004. I think I should say this to you, Mr. Elliott. If we put questions to you which you may find embarrassing please do not hesitate to say so. If you care to answer them so to speak confidentially and if you would sideline them in the proof, I do not say we should necessarily exclude them, but we should certainly consider your views on that subject, because obviously you would not wish to reflect on anyone although you might wish to tell us what is the tendency. I hope I have made myself clear?—We are here to help the Service, and perhaps I might tell you this now off

the record. There is a very distinguished man, an expert in tuberculosis, who is a medical superintendent at Midhurst. He is a great friend of mine, and he has an international reputation. I induced him to allow his name to go forward for nomination to the board, and I pressed it with the unanimous consent of every member of the board. We have, as you know, the largest number of tuberculosis beds in the country. That is one of the great scourges of the country. I have no one on the board of this man's calibre, an expert as he is, and it was quite an achievement to get him to say "Yes." He was turned down by the Minister. We have returned to the charge. We have another opportunity now, and I am devoutly hoping that he will be accepted.

Mr. *Thomas Reid.*

1005. Could you say why he was turned down?—Well,——

1006. Was it because he was a doctor, and the Minister wanted laymen on the board?—I think the Minister said he would not have any more doctors.

Chairman.

1007. You disagree with that aspect of his policy?—Oh, no. I think we have too many doctors.

1008. I am not quite certain what you are saying. Are you suggesting that he was turned down on the ground that it would be unlikely he would be able to give to the board the service which would be required?—I do not know. I think we are getting involved there, and I think I had better not say anything more about it.

1009. Can we sum it up in this way? You are not altogether satisfied that you can get the people, who could best do this work, appointed to do it in the present set up. Would that be fair?—Yes.

Mr. *Diamond.*

1010. With regard to the three members you said you would like to have appointed additional to your existing number, is that because of any particular circumstances relating to your region the fact that you have a particular area committee, or is it just related to the size of the region?—It is due to the size of the Region, the large distances in the area, and the fact that we have not enough people to man our sub-committees.

1011. I take it, therefore, you would find that some of your committees and sub-committees are thinly attended from time to time?—Very thinly attended.

1012. Do you keep a record of attendances?—Yes.

1013. Would it be possible for us to be supplied with a record of the number of attendances? I am not asking for any names at all, but the possible and actual attendances on your main committees for the past year?—Yes.

Wing Commander *Geoffrey Cooper.*

1014. Do you think your suggestion of increasing your number from twenty-five to thirty would have any real material effect? Is it not the experience of most people that, if you have a big committee, it takes longer to discuss matters and so forth, and that sometimes a small committee is more efficient?—Yes. Our problem is not so much with the board as with the preparation for the board, which the sub-committees do. Can I make it clear to you in this way? We have an area sub-committee for Surrey, one for West Sussex and——

Chairman.

1015. You have geographical committees and functional committees, is that right?—Mr. Braithwaite, would you explain what the survey committees do? (Mr. *Braithwaite.*) The board set up the area committees very early in its career, because of the size of the region and because it felt there was a need to have members, associated geographically with various parts of the region, serving on the committee and considering matters from that part of the region. It accordingly divided the region into five: one committee in London, with five management committees; one committee for Surrey, with eleven management committees, one committee for West Sussex, with only two; and another committee dealing with the mental health services.

1016. The last is functional?—That is functional, but that committee also serves as one of the area committees for the mental hospitals although it is not treated geographically. Finally there is the western area committee itself.

Mr. *J. Enoch Powell.*

1017. The figures are not the same as those in Annex I. You said West Sussex had two members?—I was referring to the management committees within that area.

1018. On that point would I be correct in inferring from the annex that certain members of the board have to serve on two or more area committees, including therefore those with which they are not connected? You have eighteen members in London, Surrey and West Sussex alone, and you have twelve members (not including the co-opted ones) in the Western Area. Eighteen and twelve equal thirty, which is more than your total number of members?—It is not invariably the rule. The division into area committees

was mainly geographical, but there are members serving on area committees who do not necessarily come from that region.

Mr. *Diamond.*

1019. Are you satisfied that this—I want to use quite a neutral word—number of committees is necessary and that it is not putting more of a strain on your members whom you say find difficulty in attending meetings? Could it not be otherwise organised if you had perhaps no regional committees but merely functional committees?—I think perhaps the best explanation is that, if we had only one committee to consider schemes coming from the whole of the region, many members would have their time wasted in hearing detailed discussion on schemes coming from a part of the region remote from their own and on which they would have little contribution to make, and the agenda for such a committee would be enormous. The idea is that schemes are submitted from management committees to area committees, who have members with some knowledge of the locality and who discuss them in detail, and then they are co-ordinated at the finance and general purposes committee where there is a bringing together in terms of priority.

1020. Would I be right in saying that the only occasion on which the same subject is discussed twice in committee is in respect of major works which go first to the area committee and then to the finance and general purposes committee?—At the moment that is not unfortunately true as some matters are discussed in as many as three committees, but the reason for that is the shortage of money available. We have to give much more careful scrutiny to the priority of schemes, and it is not always possible to forward, say from an area committee which has considered the scheme in the first instance, a proposal which will go straight to the Board. It has to be sorted at an earlier stage by a committee which is looking at its priority and how far we can afford that scheme in comparison with other schemes coming from other area committees.

1021. Are you satisfied, therefore, that the reason for this double and sometimes treble consideration of a given matter arises through the need to have economy in the system and is in no way connected with your plurality of committees?—(Mr. *Elliott.*) I am very much against the setting up of committees which means more paper work and is inclined to bog you down, but it is quite impossible to run fifty-three separate business, each of those businesses having ten or twelve hospitals which means another twelve businesses, with the direct contact, and only the direct contact, between their desires, needs and administration and the Board. For instance, the method of appointment for members of the Board is that all sorts of associations should be consulted and should be asked for nominations. Those are all received and dissected, and then the Minister makes the choice.

Miss *Ward.*

1022. Do you think any trouble arises from a lack of experience in the people who are selected to see over a wide area?—Undoubtedly.

Mr. *Turton.*

1023. Does it not also arise from the fact that your area is perhaps unduly prolonged?—Here is the problem. We have ten members of our Board on the western area and eleven co-opted. The co-opted ones are co-opted from people of experience in that particular area. The consequence is that they are always fighting the Board for as much as they can get of the money which is at our disposal for their particular area, because the co-opted members are not interested in the rest of the region. That is where we have to tread very warily and very cautiously. We have now come to a compromise with them, and we have had to allocate them one-quarter of our capital resources for the year, ask them to use it, let us know their priorities, and then the Board finally decides. We do keep the control, but they have to be allowed to spend the money.

1024. Are you quite satisfied that it is an economic area to work as a regional hospital Board?—Oh, no.

1025. Could it be made so?—I have been to the Ministry first of all with the request we put forward that the Minister should create a separate region for that part. That is impossible because there is no teaching hospital. There may be one eventually at Southampton. Then we suggested we should make it into three area committees, still doing the administration, to save expense, from the Winchester offices but really running it from the Board. Of course that would mean no more centralisation because what they do has to come to the Board, and I think it would make for efficiency and obviate this feeling of frustration which is becoming apparent in all who are connected with the Service. May I read these alternatives, which I think the Sub-Committee has not had? Paragraph 10 of R.H.B. (47) 1 reads in this fashion: "In a few areas conditions will require the appointment of regional committees of a special type, with delegated powers to act for the Boards over parts of the regions. These committees should, the Minister suggests, consist of about twenty members drawn in part from the regional boards concerned and in part from local health authorities, voluntary hospitals, the medical profession and others in the areas covered by the committees. They should appoint

their own officers with the board's approval (who will then be on the staff of the principal officers of the boards); they should possess their own offices, and should in general exercise the powers of the Boards in relation to their areas, subject to the over-riding power of the boards to intervene where intervention seems to be necessary".

Chairman.

1026. For the purpose of the record I think that is a Ministry of Health circular addressed to all boards?—To all the regional boards, and it was issued in the early days. On that we set up the Western Area Committee. After having worked it that way for three years the alternative idea we would put forward—we have not done so yet—is that for the administration of the western area, if it is not made a separate region, the whole area should be divided into two or three areas, with area committees with the same functions as the London and Surrey Area Committees with membership confined to members of the board. The possible divisions would be as follows: (1) Portsmouth and the Isle of Wight; (2) Winchester and Southampton; and (3) Bournemouth, Dorset and Wiltshire. Alternatively, if we could have two, then (1) Portsmouth, Isle of Wight and Winchester; and (2) Southampton, Bournemouth, Dorset and Wiltshire. We might add the West Sussex area to one of them, and thus have three areas in this part of the region—to save paper work. Then, if this re-organisation could be made, we should have four area committees, plus a mental health committee, for the whole region.

Mr. *J. Enoch Powell.*

1027. You feel that, if it is not possible completely to separate the western area and form a new region, it is a mistake to have co-opted members, or at any rate a very large balance of co-opted members, on area committees, and that the area organisation should be much more clearly an agency function on behalf of the board?—Undoubtedly.

Chairman.

1028. Can you say on this question of cutting up the region, apart from the teaching hospital question, if there would be any difficulty in dividing the region in half in some way?—No difficulty.

1029. That is from your point of view?—Yes.

1030. Could you say something about the teaching hospital question? Do you think it would be difficult for a region to be a viable, I think the word might be, body if it had no teaching hospital within its boundaries?—I think it must have a teaching hospital.

1031. You feel it would not in fact be able to function properly unless it had a teaching hospital?—Whether it had a teaching hospital in its own area or not it would have proper liaison with a teaching hospital or teaching hospitals. Our three principal teaching hospitals are St. Thomas's, Westminster and St. George's. Then we have the Cancer Hospital. We have six altogether. We are in very close relations with the teaching part of the Service.

1032. That relationship is essential for the proper functioning of your Board?—Yes.

1033. You could not run a board consisting of the western half of your area without a teaching hospital connected with it?—Well, I would not go so far as to say we could not, but it would not be advisable.

Mr. *J. Enoch Powell.*

1034. Even if arrangements were made for liaison with a teaching hospital in an adjacent region?—That would be possible. That could be done.

1035. I would ask whether in fact, if such arrangements were made, other teaching hospitals than those in London might not be more suitable and convenient for the western parts of your area—I have in mind Bristol?—(Mr. *Braithwaite.*) Each of these teaching hospitals has its own area which it is serving at the moment, and whether it would be large enough to serve an additional area is a matter which would have to be examined.

1036. It is only an administrative difference; there is no difference in the number of bodies or teachers?—At the moment I think the University at Bristol will be serving the South Western Region. I do not think they would come into our region to any extent. (Mr. *Hunt.*) In addition South Western Region has its own sub-area, we understand. (Mr. *Elliot.*) Yes, down in Cornwall.

Mr. *Turton.*

1037. Your Joint Cancer Advisory Committee appears to be based not only on the teaching hospitals of your region but of a neighbouring region—is that right?—Yes.

1038. Therefore there is a precedent for having your committees based on more than one region?—Yes.

Mr. *Diamond.*

1039. On the alternative approach to this problem, having a smaller area and yet having a teaching hospital, have you given consideration to the problem of splitting up your area and splitting up your own teaching hospitals? I understand from you it is advisable to have your area split and

that it is advisable to have a teaching hospital either within the area or capable of consultation with the area?—It does not matter where the teaching hospital is situated as long as we have got liaison.

1039A. As you have teaching hospitals in London and as you have a need apparently to have a separate area not geographically connected with London, is there any reason why it should not be run as an independent area or a southern area run as a separate board joined with one of your London teaching hospitals?—You rather have us there because, after all, that is a medical question. It concerns the flow of students who become doctors, and that sort of thing.

Chairman.

1040. From your administrative point of view do you know of any objection?—No. I am convinced, after three years' experience, that we could run the western area, as we have now been turned down over the regional idea, with three or even two area committees still keeping our administrative offices for the day by day executive functions and so on at Winchester, and thus save distance. We could run it with less expense than we do now, and we could run it with less friction.

Miss *Ward.*

1041. And with less frustration?—And with less frustration because you would not have a solid block thinking they must have the cake.

Chairman.

1042. Could I put a wider question to you? I think what you say leads to the conclusion that your area itself is too large, and that perhaps the area of most regions is too large. Disregarding the teaching hospital question you would rather be in favour of having a larger number of smaller regions in the country?—Well, of course that is a question. I was trained in the County Council of Surrey and I looked after thirteen big hospitals. Mr. Messer was with the Middlesex County Council, and he probably looked after more. We ran our hospitals very well indeed; perhaps I ought not to say that, but they were very well run. Therefore I think, if you are going on to policy, it would have been better to have made the regional areas smaller than they are now, to conform as much as possible to the old county council ideas. London got too big, and in consequence it got too bureaucratic. Its government was remote, if I may put it that way, a remote government because the medical superintendent could not have a bolt put on his door without getting some chit from headquarters. That was going too far, but I think we could with advantage decentralise more than we have done. The problem we have in this Service is this: we are paying lip service to decentralisation all the time, but events have shown that Whitehall is not willing to trust us to do the job and abide by the result, and all the time is wanting to do it again.

1043. You attribute that I think partly to the excessive size of the area in your case, at all events of your region, and I think you suggest, when you cite Surrey and Middlesex as examples, that you would like to see a region of about one million inhabitants, about half the size of the present region. That is a guess, but it is the sort of thing you have in mind. Is that right?—We can handle our large region now, but it would be better if we could give more autonomy to the management group committees. If management group committees knew they were only going to get so much money, they would cut their coat according to their cloth as much as they could, and under our supervision I think we should get a better result than having an examination before the money is spent. The delay causes more to be spent really later one. We should get a better result by giving them that latitude.

1044. Could I put it this way? The more you are a planning authority and the less you are an executive authority, the larger can your region be?—Yes, quite right.

1045. If you are going to have the kind of executive powers that it appears you choose to exercise at present, then your region is too large at the moment?—At the moment, yes.

Mr. *Turton.*

1046. A previous witness from another board did give us their travelling subsistence and loss of remunerative time expenses for the region, which does bear on the geography. I do not know whether Mr. Elliott could get us that information, not now but at some time?—We have those here. That is a very pertinent factor, and it is very important indeed. Having members drawn from places as remote as Dorset and Bournemouth on sub-committees, there is this question of night's lodging, railway expenses and subsistence allowance, and for several of them loss of remunerative time.

1047. What is the annual bill?—(Mr. *Blair.*) For the year to 31st March 1950 the Board's expenses came to £3,270, and that of hospital management committees £7,346. I should like to make one point, if I may. We cannot at this stage divide the Board's expenses, which are unduly weighted by the appointment of the specialists. The expenses of these specialist committees and various other members are payable by the board under

the same head of expenditure, and I should make it clear that the £3,270 I have declared is not entirely for members of the board. I should say the bulk of it is for these specialist committees. (Mr. *Elliott.*) May I say, with regard to the engagement of specialists and registrars, that a very strong demand came from one of my board members that we should hold the selection committee in Dorset. I had to point out that that would mean conveying people, who could probably get more easily to London, to Dorset. They would have to find an hotel; we would have to pay the expenses of the candidates who were on the short list; and we should have to pay the expenses of the University assessors and others who would go down to assist. It shows you how the local idea has to be broken down, and that you have got to look at the area as a whole and draw a balance. It is difficult to break it down you know, but I did break it down.

Chairman.

1048. I personally live in the centre of the Western Area Committee, and I am cognisant of the matters about which you speak?—Yes.

1049. I think that brings us to this question of double membership of the board and management committees. Are any chairmen of management committees also members of the board?—Not by a rule we made, which we have broken temporarily in two instances. The vice-chairman of my Board has very nobly taken care of the St. Helier Hospital for the last few months, there being no chairman, and we have not been able to get a suitable chairman.

1050. That was exceptional and temporary?—Yes. The other one is in the London area where an ex-M.P., who is going to be vice-chairman of the London County Council—he is an excellent member of the board—is acting as chairman of a London group.

1051. I think what you said is that, as a matter of general policy, you do not have duplication?—I do not agree that the chairman of a management group committee should be a member of the board, because it will warp the judgment of the best man. All we want on the management committee is someone from the board who can act as a liaison officer.

1052. How much duplication is there of that kind? Is nearly every member of your board a member of a hospital committee?—Yes, 50 per cent.; our committees have a member of the board on them. A few have more than one.

1053. Practically every member of the board is a member of a hospital management committee?—(Mr. *Hunt.*) With one or two exceptions.

1054. Do you not find there is a certain tendency, inevitable perhaps, for those members of the committee who are also members of the board to look with a friendly eye on matters affecting their own committee?—(Mr. *Elliott.*) Yes, and if they happen to be chairman of that committee they would look with a more friendly eye. It is very useful to the board to have its members conversant with the work of management committees. After all, that is getting nearer to the patient.

Mr. *Diamond.*

1055. Would you say that it also happens in reverse, that it is of advantage to a management committee to have the view of the board explained by a member of the board who is present?—Undoubtedly. I myself serve on the management committee of one of our big groups—Redhill Hospital. I have found it very useful to keep in touch in that way.

Wing Commander *Geoffrey Cooper.*

1056. If, as you suggested earlier, there was more autonomy given either to the hospital groups as now conceived or even thinking in terms of the areas as used by the county councils and so forth, if they were given that autonomy and, in order to keep a check to see that no group was exceeding its power, you had the necessary information coming through to your headquarters, would there be the necessity in addition to that to have the area organisation at all, because it is the axiom of good management that you centralise only your policy making and decentralise your executive responsibility? If you decentralise to the group there perhaps would not be the necessity for the area organisation to be in existence at all?—Mr. Chairman, you would have to have your area committees for settling your priorities, your planning priorities and your long-term policy. You can use area committees as much or as little as you like, but we have found them extremely useful.

Chairman.] I think what your answer comes to is this, does it not: planning and execution cannot be altogether separated, but if your area is too large the separation becomes even more difficult?

Wing Commander *Geoffrey Cooper.*

1057. Would it be correct to say that, if you have your area committees almost entirely for priorities, it does not really need a complete permanent organisation for that purpose?—They are only board members conversant with that particular area.

Wing Commander *Geoffrey Cooper.*] I see that. It means an addition to the organisation, and therefore a further hindrance in the transmission of information and so forth.

Miss *Ward.*

1058. You have to plan through your area committee the development in that area seen over a wide field really?—Yes. and then your area committee people are members of the board, and in planning for that particular area they also know the problems which exist in another area because they are members of the board, and so we get the picture as a whole.

Wing Commander *Geoffrey Cooper.*

1059. I was thinking in terms of seeing if there were some means by which the whole or some part of it could be streamlined without losing some of the advantages which apply to the present system and yet achieving such a saving perhaps in the top organisation running the service that it would be beneficial if simplifications were made. It would be interesting to have your comments upon that?—(Mr. *Hunt.*) I think the area committees do serve a very useful function. They get through a lot of spade work which otherwise more members of the board would have to deal with, and therefore they do in that way save the members of the board a lot of time. (Mr. *Elliott.*) The board inherited from the L.C.C. a great number of mental hospitals, seven of them in the Epsom area. Owing to the financial stress of the times and knowing that the hospitals were to be taken from them, there was nothing spent which could be possibly done without with regard to, I was going to say, even maintenance. One of the consequences has been this, if I may just give one simple illustration. We were suddenly sprung with the problem that at Cane Hill the boilers were at their last gasp. Cane Hill is a mental hospital with 2,000 patients, and £80,000 was required immediately to put this right. We have got to find it from somewhere, because otherwise the hospital would cease to function and we would have nowhere to put 2,000 mental patients. That is a matter where you must send someone down to enquire into it, and it is obviously not the job of the small hospital management committee. It is really detailing one or two appropriate members of the board and the staff to go and report to the board on what is the best thing to do.

1060. In so far as you said a little earlier you thought the Ministry in Whitehall was duplicating work by going over ground which had been adequately covered by the regional board or area committee and so forth, is there perhaps a tendency also for the regional board themselves to go into matters in too great detail which could reasonably be devolved upon management group committees?—We are compelled to do those because of the detailed instructions we receive from the Ministry.

1061. I am going a little further than that, and saying is there in fact some way by which simplification can be achieved? The initial mistake made by the Government was in not giving regional boards control over the establishments of management committees.

Chairman.

1062. May I interrupt you there? We will have to deal with finance and control of establishments, and I think this subject had better be raised under those heads than under this general head which we are discussing now. Can you just clear up one question on the Board itself? Can you tell us what is the medical representation on the board at the present time? I do not want their names; just the number?—(Mr. *Braithwaite.*) We have eight medical members at the moment. One is a chest surgeon; one is a psychiatrist; one is a general practitioner specialist; there are two Deans of the teaching schools in London; there is a pathologist; there is a gynaecologist and obstetrician, and also a surgeon.

1063. Are they mostly in the present employment of the Board or in one of the teaching hospitals in the area?—Two have retired. The two Deans are, of course, with the teaching hospitals, and there are four who are actually employed at the moment.

1064. Employed by the Board?—Employed by the Board.

Mr. *J. Enoch Powell.*

1065. They form the regular members of the medical advisory committee, do they not?—With co-opted members.

1066. With 14 co-opted members?—That is so.

1067. In connection at any rate with the co-opted members I notice you say they include representatives of the teaching hospitals—that you have mentioned—and local health authorities?—Medical officers of health to the county councils.

1068. Are in fact all the county M.O.H.s included?—Not in every case. (Mr. *Hunt.*) Various bodies are represented on the medical advisory committee, but as there would be some eight or nine county councils involved they would not all be represented. There would only be two or three County Council representatives on the Medical Advisory Committee (or its Sub-Committees).

1069. Who selects those? Does the regional board say, "We will have so-and-so and so-and-so"?—(Mr. *Braithwaite.*) The Board itself has the appointment of the medical members.

Miss *Ward.*

1070. Do they send in a number of names on the same principle the Ministry has adopted, from which they just make specific recommendations?—They ask for nominations first from the bodies they feel should

be represented on the committee, and from that list they choose the members who actually would represent them.

Mr. *J. Enoch Powell.*

1071. Do the specialists employed by the Board have a separate consultative or advisory body with which the Board is in contact?—We have throughout the region various bodies which have been set up voluntarily by the specialists themselves, and they have written to the Board on several occasions asking that they should be recognised as the official bodies, but the principle of the Board has been to invite their co-option whenever their advice is required and not to appoint them as specific advisers to the Board. That prerogative has been left entirely with the medical advisory committee to the Board.

1072. Are you satisfied with the relations between the co-opted members of your medical advisory committee and these unofficial bodies or the general mass of specialists whom you employ? Is there machinery for ensuring their views reach you through the medical advisory committee?—Yes.

1073. Could you give us some indication of what that machinery is, roughly?—They would first of all make an approach through their medical committee to the medical advisory committee of the Board on a matter of detail, but if it was a matter of principle they could make a direct approach to the Board who would receive the letter officially and who would perhaps refer it then to the medical advisory committee.

1074. It is on a basis of correspondence. There is no regular interchange of views between the medical advisory committee and any of these bodies?—No. (Mr. *Hunt.*) I think it may be that individual members may find they are co-opted on to the medical advisory committee, but not as direct representatives of these other bodies.

Chairman.

1075. There is no, I think the term is, joint consultation; there is no regular machinery?—There are regular meetings of the consultants in the eastern area and western area of the Board, and their recommendations do come regularly to the medical advisory committee of the Board.

1076. By regularly you mean that as they meet they send them in to you. You do in fact get them pretty often?—Yes.

1077. There is no actual machinery set up for this purpose?—The machinery is there, but they are not an officially recognised body. (Mr. *Braithwaite.*) The initiative has to come from their side, and not from the Board itself. (Mr. *Elliott.*) There is a question of principle involved when you asked whether medical men or others were full-time employees of the Board. I am wondering very much how far one should go with appointing one's own employees to one's board. I know that some of our employees, who are on the Board, can give precious little time to their patients.

1078. Are you having difficulty in getting suitable medical representatives on the Board—I use the word "representative" in a general sense?—Yes.

1079. You are having that difficulty?—We are having great difficulty in getting the right people to-day.

1080. Do you find that, when you do get a medical representative on the Board, he tends to look at matters from a sectional point of view at all?—They are all keen advocates of their own speciality. They give a diagnosis one month—and this is what exasperates me—and next month the diagnosis is changed.

1081. Would you feel quite happy if you had a board from which the professional element was entirely eliminated?—I was talking to two doctors on Monday night about this. One is an adviser on his own board because I would not let him be a member of it, and the other is a distinguished specialist who does sit on his own committee. With regard to management committees I do not think it is advisable for the medical superintendent, the chief doctor in the place, or any employee to sit on that management committee, because the management committee always has the power to call him in and ask for his advice, or it has power, as you know, to let him sit in the room for the whole proceedings. A lot of them have got over this difficulty in order that representation should be given in the widest possible channels, and sometimes it acts absurdly because we have a very big hospital which is in huts and which has had the same difficulties within the curtilage of a mental deficiency institution, and we have to use common boilers and common services. There is a recommendation—I do not know whether it will go through—that a man who has never had anything to do with a general hospital but who is nominated by his association or his trade union—he is a humble employee, I think he is a porter at a big mental hospital—for this particular group. One has to use one's judgment and say, "Do you want a section or a cross-section of the populace represented, or do you want people on your committees or on your boards who can run them?". That is one of the things one is up against.

Mr. *Diamond.*

1082. On your Board itself, not on your management committees, are you of the view that your Board would be able to carry out its functions without medical

members as efficiently as it does at the moment?—No, I think you must have some medical members.

1083. Do you feel that eight is too many? —I do.

1084. Something less than eight?—Yes.

Mr. *J. Enoch Powell.*

1085. If you reduce the number of medical members, would it not be desirable to render the representation of consultants more formal, to give it a greater consistency of organisation?—I think it is always a mistake to dot the i's and to cross the t's too much. There is very adequate consultation at Portland Place with all sections of the medical profession, led by our excellent medical adviser, Doctor Gill, who is known to all of them. Anybody who has got a grievance can come, and anybody who has got an idea can come. They are called in, and there are little sub-committees appointed for every matter, to give advice and so on. I do not think there is any lack of liaison.

Chairman.

1086. Perhaps I might interrupt you and say that this Sub-Committee has received evidence, not in the case of your region but general evidence, that the doctors are not contented with the present consultation between boards and the professional organisations within the regions?—I would agree there is a great weakness in the liaison between the general practitioner and the Board, but I do not think I can agree that is so with regard to the specialists. (Mr. *Hunt.*) Although the eastern area and western area medical committees, to which reference has already been made, are not officially recognised by the Board as sub-committees of the Board, they do have direct representation on the medical advisory committee. Therefore there is continuity all the time.

1087. By representation do you mean that there is overlapping membership, or do you mean that they are people nominating their own nominees?—They are people putting up a panel of nominees, from which the Board selects the appropriate representative.

1088. From which the Board selects the appropriate representative?—Yes. (Mr. *Elliott.*) The Board selects on the advice of its medical advisory committee. (Mr. *Hunt.*) It is the common practice of all these bodies which the Board approaches to submit nominations for co-opted members—these consultants' committees, county councils and so on. In fact we have one G.P. on as well. The nominations for the other we get from the executive councils.

Mr. *Diamond.*

1089. Have you in mind any system whereby consultation between the Board and the general practitioner could be improved or expanded?—(Mr. *Elliott.*) No. I hear both sides. I have a son who is a G.P. If we continue to get rid of the G.P. beds we shall gradually lower the standard of the G.P. and simply make him into an administrative hack. I suppose everybody here knows we have been involved in this Kingston and Malden Victoria Hospital dispute; incidentally we have a cast-iron case if there is anything in planning at all; but I would like to see the G.P. follow his patient to a general hospital and, if the G.P. has to employ a specialist, to help his specialist as a clinical assistant. All the doctors specialists and medical superintendents into whom I have tried to hammer this idea, because to a simple layman like me it is quite feasible, say it is quite impossible. They say it would mean some sort of dual control in a hospital, but I have got as far as this: I have got a promise that if we allow £200 or £300 for a limited number of beds to be equipped in one of the big hospitals the midwives can go and nurse their patients there in just the same way as though they were in their own homes and were paying a temporary visit. Before that promise can be implemented I have to get from the county council side, the public health committee, agreement for the midwives to be used in that way, because there you have one of the weaknesses of the Health Service. I went the other day to a small hospital, and I found the sister in charge of the maternity ward in tears. Her deputy was away, other staff were ill, and she had got five babies sprung on her. I said, "Is there a midwife in this town?"; she said, "Yes"; I said, "What is she doing?"; she said, "She is crying her eyes out because she has got no babies"; I said, "Bring her in"; and the sister said, "I cannot because she is county council and we are regional board". Therefore I am going to try this small experiment to see whether we can have midwives going into hospitals and thus integrate the Service a little. That is a very simple illustration. I do not know whether it ought to be recorded, but that is one of the defects of the Health Act.

Miss *Ward.*] It would be helpful if it could be recorded.

Chairman.

1090. Yes. I do not want to pursue that aspect of the matter now because it rather takes us out of the general line?—I am so sorry I interrupted in that way.

1091. Could I ask you this question? I think you have within your region the largest proportion of staffed beds to population of any region in the country?—Of staffed beds or understaffed?

1092. Staffed beds?—That is because we have more beds.

1093. Are you satisfied that you have enough beds to meet the needs of your area?—I do not know whether one of my colleagues can give you the answer, but if I could equip and staff the whole of the 6,000 beds we have unoccupied for these reasons: war damage, 2,000; wards now in use for other purposes owing to war damage 1,000; unstaffed, 2,500, including 500 T.B. beds—we have 500 T.B. beds in the area unstaffed. You hear all this talk about sending our patients to Switzerland and the trouble we are having, but I have 500 beds in the area unstaffed. Then there are 500 temporarily out of use owing to repairs. That brings the total to 6,000.

1094. The figure which we have is the total bed complement, and in your area it was 64,553. That was, I think, two years ago?—It is 69,500.

1095. You have got to deduct from that figure the 6000 you have just mentioned? —(Mr. *Hunt.*) Of the 32,000 beds in the general and special groups, approximately 26,000 were staffed at the end of 1950 with an occupation of 21,000 patients.

Mr. *Diamond.*

1096. Could we have the total figures in relation to the 69,500?—On page one of the memorandum, paragraph 1, you will see the figure of 32,000 beds in the general and special groups mentioned.

Chairman.

1097. That is the latest figure which you have?—And of those 32,000 beds in the general and special groups 6,000 beds are out of use for the reasons which the chairman has mentioned.

Mr. *Diamond.*

1098. Out of the 37,500?—We have 2,500 out of use (mental).

1099. You have 8,500 out of the 69,500 out of use?—That is so (general, special and mental).

Mr. *J. Enoch Powell.*

1100. Is not the high proportion of staffed beds to population in your region as compared with others due to the concentration of mental beds in your region? —(Mr. *Elliott.*) To a large extent.

Chairman.

1101. Assuming that you could staff every bed which you have, would that provide an adequate number of beds to serve your region or do you think you would need more, and, if so, how many?—I do not think I can answer that. (Mr. *Hunt.*) The answer, I think, is that the number would be regarded generally as inadequate on the standards which the Ministry of Health have set out in R.H.B. (48).1, and also on the standards given in the Gray & Topping Report. The inadequacy would be in the region of anything from 25 per cent. to 55 per cent. (Mr. *Elliott.*) How many beds per thousand of population are you supposed to have according to the Gray & Topping Report?—(Mr. *Hunt.*) It is divided into different specialities.

1102. Could we take the general and special groups together, disregarding mental beds?—According to the Ministry's standards, given as ideal, in that R.H.B. (48).1 we have, I should imagine, at the moment about 55 per cent.

1103. Of beds, not staffed beds?—Of beds.

1104. By comparison with what it is estimated you would need?—Yes, for the general and special groups.

1105. Does that seem to you to be about right, or do you think the estimate is high or low?—The estimate I think is rather high, and the Gray and Topping standards are more realistic. Our figure based on them would be in the region of 70 to 75 per cent. in the general and special groups.

1106. You need about a third as many again, say an additional 10,000?—Yes, Sir.

1107. That is after you have staffed every unoccupied bed which you now have? —Yes.

1108. That is the ideal?—Yes, for the general and special groups.

Wing Commander *Geoffrey Cooper.*

1109. Was there one period when all the beds were staffed?—Never since the Board has taken over.

1110. Beds have always been in excess of staffing?—Yes, Sir. (Mr. *Elliott.*) I do not know the position with regard to the thirteen Surrey hospitals. Were we always fully staffed in Surrey? (Mr. *Hunt.*) Conditions then were very much better overall than they are at the moment.

1111. Is the tendency for the number of unstaffed beds still to increase?—To diminish. (Mr. *Elliott.*) We are getting more nurses. (Mr. *Hunt.*) During the last twelve months there has been a definite tendency for the number of unstaffed beds to fall.

Chairman.

1112. Does the bed ratio vary from one part of the region to another? Is it better in the more populous eastern end and worse in the less populated western end? Is that the position?—It is about equally balanced throughout the region. I think in certain parts of the region the quality of the beds may be poor.

1113. The quality is very poor where? —(Mr. *Elliott.*) In the wilds of Dorset.

Wing Commander *Geoffrey Cooper.*

1114. Does it almost entirely depend upon the nursing position, or do you have domestic staff difficulties as well?—(Mr. *Hunt.*) The domestic situation has been very much easier during the last two years. (Mr. *Elliott.*) It depends on the nurses.

Mr. *Diamond.*

1115. May I follow up this question on the shortage of beds? I understand you would be short even if your total of 32,000 were staffed. As they are not staffed, *a fortiori* you are even shorter. No doubt, therefore, you have turned your mind to the question of unoccupied staffed beds. I wonder if you could give me any details of the proportion of unoccupation in your staffed beds in your various hospitals. That is the first question. The second question is whether you have directed your attention to, and concerned yourselves with, giving instructions to management committees in order to reduce that proportion of unoccupation of staffed beds?—(Mr. *Hunt.*) The Board has on both counts pressed management committees to do their utmost to keep the beds full in the wards which are open, and also to make strenuous efforts to staff the wards which are now out of use. With regard to the figure of occupation in general and special groups, I did say that 21,000 beds were occupied at the end of 1950 out of the 26,000 in commission. That is quite a high percentage really, with admissions and discharges and the divisions into different specialities. In an acute general hospital one would not normally expect a higher occupation than 80 per cent. (Mr. *Elliott.*) We have about 80 per cent. now.

Chairman.

1116. At this moment?—Yes.

1117. You would not maintain an average of 80 per cent. over a year?—(Mr. *Hunt.*) Yes, Sir, and in the chronic hospitals it has got up to 90 per cent.

1118. The chronic hospitals are different?—(Mr. *Elliott.*) That is another problem.

1119. In the general and special groups what would be your average?—(Mr. *Hunt.*) The average was 80 per cent.

1120. Throughout the year?—Throughout the year.

Mr. *Diamond.*

1121. Did you find some hospitals varied considerably from other hospitals?—(Mr. *Elliott.*) Some matrons have a greater ability in securing staff than others.

1122. I am not on the question of staff; I am on the number of staffed beds which are unoccupied, and I understand the 80 per cent. to mean the proportion of staffed beds which were full and the 20 per cent. to mean the proportion of staffed beds which were empty at that particular time, and indeed, as you said, the true average for the whole year?—(Mr. *Hunt.*) In the large general hospitals the situation is about equal over the whole year. It is in the smaller G.P. hospitals and the very much smaller units that you get a wide variation of occupancy.

1123. Is it your view that you could exert a greater beneficial influence on this problem and so enable the Health Service to be more efficient inasmuch as it would provide more beds out of the existing capital equipment, nursing and general facilities?—That is part of the Board's general policy, to co-ordinate all the beds in the group, to see that the beds are properly allocated to the different specialities and used to the utmost. (Mr. *Blair.*) I think it would be correct to say that in an acute hospital I do not think you will ever get it much above 80 per cent., because you have got your beds broken down into specialities and then you get your unoccupied beds. It is not as if they are all dealing with one complaint. You have your specialists, each with their block of beds, twenty and so on; and it is the vacant beds in each of those groups of specialities which add up to that rough total of twenty per cent. unoccupied.

Miss *Ward.*

1124. You cannot ever have them all occupied, can you? You would not want that?—No, but in some cases you can get up to 90 per cent. where you are probably dealing more or less with one category, like, say, the chronic hospital. (Mr. *Braithwaite.*) In relation to mental hospitals, where you frequently have old buildings with very large wards, the medical superintendents have great difficulty in segregating the patients, and they could get a much higher occupancy if they had the type of hospital with small villas and small wards.

Chairman.

1125. That would involve a lot of building?—That would involve a lot of building.

Mr. *Diamond.*

1126. Do you get statistics supplied to you from your various hospital groups or management committees, showing their occupancy ratio?—(Mr. *Elliott.*) Quarterly, and yearly too.

Chairman.

1127. What sort of steps can you take to make better use of your staffed beds?—Constant visiting by officials, conferences, and instructions.

1128. Does the Ministry of Health worry about this question, or does it leave the

problem to you? Is it a central function or a regional function?—They leave it to us. (Mr. *Hunt.*) They leave it to us, but they do ask at regular intervals for the position. I have no doubt they would ask pertinent questions should the figures show that such questions were necessary.

Mr. *Diamond.*

1129. Have you had any guidance from them as to what might be regarded as a reasonable figure in different types of hospitals?—No.

Chairman.

1130. Do you know how your figure compares with those of other boards?—(Mr. *Blair.*) I think I should say it is a reasonable average.

Wing Commander *Geoffrey Cooper.*

1131. Is there any attempt made to check up this figure with the number of people waiting to go into hospitals?—(Mr. *Hunt.*) We get regular returns at the same intervals of people waiting as for the occupation of beds.

Mr. *Turton.*

1132. How big is your waiting list?—The waiting list for the whole region exceeds 20,000 patients.

1133. Twenty thousand patients for all types, mental or otherwise, or not?—For general and special groups.

1134. Twenty thousand out of thirty-two thousand?—Quite a large proportion of those are chest and E.N.T. cases for tonsils.

Chairman.

1135. There is a very much greater delay there than in the other groups?—Probably because of the polio epidemic period last year when a standstill was called in the bulk of such cases.

Wing Commander *Geoffrey Cooper.*] Mr. Chairman, would it be any help if we had figures from various hospitals taken at random just to see the number of unoccupied beds which are staffed and the number of patients waiting?

Chairman.

1136. I think that is really a question of asking for more comprehensive figures from the Ministry of Health. I think those would be more useful than figures for particular hospitals. I think we might now turn to questions of finance. Can we dispose, first of all, of the question of capital expenditure? You make a recommendation on page nine of the memorandum with regard to the approval of capital expenditure. First of all can you say what was the total amount for capital expenditure which was approved in your estimates for last year?—(Mr. *Blair.*) £897,000.

1137. Can you say how much of that you in fact succeeded in expending?—We cannot tell yet. I am referring now to this current year 1950-51.

1138. For last year?—Offhand I think it was about the same figure, and we slightly overspent by about £20,000. I think we were one of the few regions which did.

1139. You overspent your capital estimate. Then why do you make this particular recommendation here, which appears to be designed to cure underspending?—(Mr. *Elliott.*) It is very unsound economics. (Mr. *Blair.*) Frankly, with the delay which occurs in requiring Ministry approval and so on, it is the most difficult thing in the world to control your capital programme. I would say it was by a certain amount of luck that we came so near the figure. I know most other boards were underspent by as much as thirty or forty per cent.

1140. So far as your Board is concerned it does not seem to me that you have anything about which to complain?—It was luck. I should make that point clear. I think we will be underspent this year.

Miss *Ward.*

1141. Perhaps you get in some of your schemes earlier so that they get priority consideration at the Ministry?—You have no guarantee at all as to when you will get approval. I know there are other factors. It is not only the Ministry approval, but there are delays on the contractors' side and various things like that. There is, however, considerable delay in waiting for Ministry approval, and you cannot guarantee that you will get it approved in one, two or three months. Some you will get approved fairly quickly, and other schemes will take longer. Say you have in your capital programme Scheme A, and you know the stage to which you have got. Say the scheme is for £50,000; and you feel you have a good chance of clearing £25,000 this year. You work on the supposition that the scheme will commence in the month of October. That is all very well, but if you do not get the Ministry approval until some time in December you are thrown out of gear, and of that £25,000 you expect to spend this year of the £50,000, a large proportion of it is thrown into the following year because there is no carry over.

Chairman.

1142. That has not happened to you?—No. I should make it clear that it really was luck that we managed to clear our vote. It really was luck.

1143. You do not expect it will happen this year?—I think we will be underspent this year.

1144. By how much?—It is awfully difficult to say at this stage because you are getting contractors' certificates flowing in all the time. This is purely an estimate and a rough estimate, but I should think we will be underspent something in the neighbourhood of £100,000.

Miss *Ward.*

1145. Do you start to get in touch with contractors and to lay your plans on the supposition that you are going to get Ministry approval, or do you wait until you have got Ministry approval before you take any steps?—There is an awful lot of work done beforehand awaiting Ministry approval, but you have got to wait for final approval of the scheme and then they give you what is known as a starting date. (Mr. *Elliott.*) We are bound to incur expenditure. That is why I do not like it to be done unless we have some reason to think that approval will be granted.

1146. If it was turned down what would happen to that expenditure?—It is abortive ; it is wasted, unless it is brought up again some time later when conditions may have changed.

1147. Does that happen very often?—(Mr. *Blair.*) Might I say this by way of illustration? In our capital programme for next year, 1951-52, we have got on paper commitments which will dispose of the whole capital sum. That is on the supposition that the capital programme for this year will take up the whole of the estimated expenditure. If we do not spend it, as I think we will not, immediately there is £100,000, taking that to be the figure, thrown into next year, which in effect makes your next year's programme overspent. If there is similar delay next year it does not matter, but if in any case the work catches up then you have got to start, if I may use the term, to " soft pedal " schemes to try to deal with that, that is if approval has come through ; but all the time it is like a jigsaw puzzle to try to keep within the figure.

Wing Commander *Geoffrey Cooper.*

1148. Are you ever advised by the Ministry as to the reason why some schemes are delayed while others are allowed to go forward? Is there some apparent plan on which the Ministry work, or does it just happen that some schemes do go forward because you are in touch with the people in the Ministry who are working on that scheme?—I think the Secretary could best give you the answer to that. (Mr. *Braithwaite.*) We do not usually know what the reasons for the delay are, but in some cases we have an inkling there may be difficulties about which the Ministry may wish to enquire, but generally we do not know the reason.

1149. There is no apparent order of priority?—No.

1150. In relation to some schemes which seem particularly urgent to you, can you get them through particularly quickly?—We give the degree of urgency. (Mr. *Elliott.*) We have to do a bit of lobbying.

Miss *Ward.*

1151. What did you do in relation to the £80,000 on your boilers?—You must go and tell Sir William that the hospital is going to stop unless something is done.

1152. And then something is done?—Yes.

Mr. *Turton.*

1153. May I clear up one point under sub-paragraph (i) of paragraph (*e*) " Capital Expenditure " on page nine? You say boards should not need the prior approval of the Ministry of Health to schemes below a certain figure. By that do you mean that the Ministry should not approve the work or do you mean the Ministry need not press the inclusion of that particular scheme in your capital expenditure for a particular year?—(Mr. *Blair.*) Can I answer that in this way? In the first stage we submit our capital programme in detail to the Ministry, covering the whole sum which we expect to spend, which let us assume is the estimate, setting out the cost of the various schemes and the amount we expect we will spend in the current year. The Minister then in effect approves our capital programme in broad detail. As we come to consider each scheme over £1,000, although we have had approval in broad detail we cannot go ahead without getting the Ministry's specific approval. That is where your delay starts. On this very point, if we find the programme is delayed a little bit, we cannot even bring in some minor scheme which has not previously been put in our capital programme, even if it is only for an amount of £50, without again getting Ministry approval because it has not been in our original programme.

Mr. *J. Enoch Powell.*

1154. Could you say what part of the £897,000 related to schemes costing £5,000 or less in that year?—I would have to look into that. I do not think I could hazard a guess.

Mr. *Turton.*

1155. Carrying on with the point, my difficulty about this is that it may well be one particular small scheme will involve the use of certain scarce materials whereas another one will not. How are you going to get over that difficulty without the prior approval of the Minister to the inclusion of the scarce materials scheme in the year's programme?—In broad outline—I may have to be corrected by the Secretary on this

point—we have been given the regional allocation, so that would appear to be already taken care of in this case. (Mr. *Hunt.*) The only material for which the Board need get any allocation at all at the moment is for soft wood. Whether control will come back again on steel or not, I do not know.

Mr. *J. Enoch Powell.*

1156. I take it that this question of scarce materials relates only to the starting date, the permission to proceed; it does not relate to approval in particular as part of the budget, or is it taken into account in the budget?—(Mr. *Blair.*) Any scheme over £1,000, irrespective of whether it requires scarce materials or not, requires Ministry approval of that specific scheme. (Mr. *Elliot.*) How long does that approval take? (Mr. *Hunt.*) Anything from a few days to a few months, depending upon circumstances.

Chairman.

1157. From your knowledge of what goes on in the world, is the delay in the case of the applications you make any greater than the delay in the case of applications which are made by other sections of the community?—(Mr. *Blair.*) I would not know, but I do know, dealing with other regional boards, that other regional boards have the same difficulty. That I do know. I cannot speak for the rest of the community.

1158. You have no reason to suppose that the hospitals are in a more disadvantageous position than anyone else?—(Mr. *Elliott.*) I think so.

1159. On what do you base that?—The private contractor or the private firm worry the officials until something is done, or else they threaten to have a question asked in Parliament. There is nothing like a question in Parliament to get things done. The whole Ministry are terror stricken at the idea of a question in Parliament. I am quite sure the delays which occur are greater with regard to bodies like hospital regional boards than they are with private individuals.

Mr. *Turton.*

1160. You have a wealth of experience with local authorities. How do you compare the experience of the Surrey County Council with the South West Metropolitan Regional Hospital Board?—I should say the County Council are just about as badly off as the hospital boards. It is when you get into the realm of bureaucracy that your delays start because it is nobody's business. They will not give a decision. There is nobody who dares to give a decision.

Miss *Ward.*

1161. You think the hospitals really take a low priority because there is not quite the same nuisance value for exerting pressure on Sir William?—I should say that was a contributory factor.

Mr. *J. Enoch Powell.*

1162. Returning to the proposal in paragraph (*e*) on page nine of your memorandum and supposing for a moment, for the purposes of argument, that out of £897,000, £250,000 related to schemes of £5,000 or under, what you are in fact suggesting is that in respect of the £250,000 of the annual capital budget the Board should have complete freedom of action, provided it does not spend it on anything which costs more than £5,000?—(Mr. *Blair.*) Provided, and we are not disputing this, it had previously submitted its capital programme, as it does now, to the Minister. I could add this. I am in rather a difficulty. I feel fairly confident there is more than £250,000 provided for minor schemes. Because of the inadequacy of the capital budget altogether we have had to go in for, if I may use the term, "make and mend" instead of the larger jobs we have not been able to undertake.

1163. In order to obtain the result which you desire it would be necessary to get initial approval, approval in principle, to more schemes than you would in fact be likely to get through in a year; you would have to have a reservoir of approved schemes?—A reserve list.

Chairman.

1164. Would it be troubling you too much to ask you to let us have a note on the question of your capital expenditure for the last financial period, showing the total schemes and classifying them as far as possible according to the total amounts involved, indicating the nature of the scheme, that is to say whether it is a building, installation of boilers or anything of that sort, and giving us a picture from which we could see what this delay really amounts to in your case? I do not know whether I have made that plain?—(Mr. *Elliott.*) Would you like to know the areas for which they are required, to see whether we do spend more on the backward areas?

1165. I do not think that would be necessary. In this connection it is merely how far you are embarrassed by the delay which is involved here?—(Mr. *Blair.*) If we gave you a cross-section it would be useful, or would you like the whole programme?

Chairman.] I would like to see the whole programme. You need not give too detailed a picture. Perhaps it would be asking too much to give the nature of the scheme; perhaps you could classify it according to

the size of the scheme and showing how it has come forward and how approval has been given.

Mr. *J. Enoch Powell.*] Might they also indicate what sums are in respect of part of a scheme? £150,000 over a year may only be a third of the total cost of the scheme. Could they designate which parts are fractions and which are whole schemes?

Wing Commander *Geoffrey Cooper.*

1166. Would it complicate it too much to pinpoint one or more occasions where you have experienced special delay which has caused exceptional embarrassment to you? —(Mr. *Elliott.*) If I can just give an example, take St. James's Hospital. That has probably got the biggest out-patient clientele in the country almost. It has got most inadequate kitchens. It has been very badly bombed, and we have arranged to spend in the nature of £250,000 upon it for very necessary things. In fact it had not got even a refrigerator in the place at one time. I do not know how many thousands of meals they serve a day. We have had to cut that scheme up. (Mr. *Hunt.*) We have had to split it into roughly equal stages of £80,000.

Mr. *Turton.*

1167. Is this at Balham or Portsmouth? —Balham. We have had to spread it over three or four years. That serves as an illustration in point. This particular work has now been taken by the Ministry out of the Board's allocation, and they are going to finance it entirely separately.

Chairman.

1168. The Ministry are going to finance it separately?—Yes. (Mr. *Elliott.*) That hospital has a most capable chairman in Mr. Hugh Linstead. He is one of my best chairmen, and I have been terror stricken because he says he is a prisoner in the gilded Palace of Westminster and he wants to give up the job.

Miss *Ward.*

1169. Mr. Blair said that he is often forced to patch up rather than spend money on total re-equipping. Would he agree that is bad finance on many occasions?—(Mr. *Blair.*) I think it is definitely a true statement, but the capital requirements of the region are so enormous really. It may go as high as £1,000,000, the sum which we will get for 1951-52, instead of £25,000,000 which would be desirable to put everything right. With £1,000,000, as compared with £25,000,000, you can only, if I may use the term, "make and mend" in certain cases. (Mr. *Elliott.*) As an instance, if we were to implement fire precautions throughout the region as we are advised by the fire brigade expert and his crew, we would have no money at all.

Chairman.

1170. I think that every member of the Sub-Committee is fully alive to the fact that you are, and indeed everyone is in difficulties on this question of capital expenditure. However, the particular problem we have to face is whether you are experiencing special difficulties and whether there is any recommendation which should be made which would help you to meet those difficulties. You put forward suggestions in your memorandum. If you can give us facts which show that you have special difficulties by reasons of your set up, then I think it would be helpful to the Sub-Committee?—(Mr. *Blair.*) I would like to make this overall point which is so important. Regional boards are statutory bodies. Members are drawn from all branches of the community, business people and so on. Surely they should be sufficiently competent to have power to embark upon schemes. I think I should make that point because a point has been made about this bureaucratic control. You have got the Board doing it, and then having to await Ministry approval. Surely the Board should have some power over that matter. I think that is the point I should like to make.

Miss *Ward.*

1171. It was said to me by a member of a regional board which will be nameless that, although the board decided it really did not matter, because in the end the Minister got his way, or rather the Ministry did. Is there a little truth in that?—I think there is. In other words, we are bogged down with detail.

Mr. *J. Enoch Powell.*

1172. Would it be possible to get a more economic and rational capital expenditure if you were able to envisage more than one year at a time?—Definitely.

1173. That is implicit in your carry over proposals?—They have asked us for a sort of three year capital programme. I do not know if you are going to deal with this later on. It is an interesting point. It has got to be linked with revenue. There is no use attempting to formulate a three year capital programme unless you have got some idea of the maintenance money forthcoming. I do not want to take you away from your line, but I think it is a point you have got to consider.

Chairman.

1174. I think that is right. We really ought to consider this under revenue. The revenue aspect of it, in a way, is more important?—(Mr. *Elliott.*) There is this point. Capital expenditure must be linked

with revenue expenditure, if you have some system of long term planning, because if you have sixty new beds but no addition to your revenue or no guaranteed maintenance, what is going to be done.

1175. You said the Ministry of Health are in fact asking for a three year programme?—I think I am right in saying that on the capital side they have asked us to put that forward, and they have said tentatively that they hope to be able to carry on as before. We have £1,000,000 this year, £1,200,000 the next, and I forget to what it rises. They have said "Please give us that programme", but we have no guarantee of maintenance.

1176. That is for 1951 to 1954?—(Mr. *Hunt.*) 1951-52 and 1952-53.

1177. Two years?—(Mr. *Blair.*) And a broad indication for the following year.

1178. Does that imply they would envisage a carry over of capital as between those two years?—No, they have never conceded that. (Mr. *Elliott.*) They have never budged from that at all.

Mr. *Diamond.*

1179. Are you saying on the carry over point that it would be an advantage to you to have a budget—I am not talking about envisaging future years; I am talking about a specific budget—covering a period of up to three, four or five years instead of one budget for one year?—(Mr. *Blair.*) I think it would definitely be better.

1180. You would prefer a budget for five years ahead?—(Mr. *Elliott.*) Instead of one year, yes. We should know where we were.

Chairman.] That is not linked to capital. I think Mr. Diamond is suggesting you should have a complete budget.

Mr. *Diamond.*

1181. The two would follow, but I was dealing with capital?—With regard to maintenance, are you going to take to-day the question of the global budget? For my part I look upon that as the most important part of our proceedings.

Chairman.

1182. You make a firm point of that global budget?—I have been to the Minister himself, to the Ministry, and to the King Edward Fund. They are all in favour of it. They wanted me to see the Chancellor. You will never get real economy in the Hospital Service unless you have some such system. I will just give you one little illustration, if I may.

Wing Commander *Geoffrey Cooper.*

1183. You have been enumerating today various difficulties which you have encountered in the course of your year's work. Have you found, either on your own Board or in the committees, group committees and hospital management committees, that there has been a tendency for some people to get such a sense of frustration as to say "I do not think I can contribute any useful service to these bodies; I am going to resign"?—Undoubtedly.

1184. Has that happened to any great extent?—Yes. I think it is going through the whole country. It has certainly happened to us.

1185. What percentage do you think there has been?—I use all my powers of persuasion, and I say "It is going to come all right. After all it is something which you are doing, and you get a satisfaction in doing it," but they all feel frustrated—employees and volunteers. There is a feeling of frustration going through the whole Service. That is my definite opinion.

1186. To the detriment of its efficiency?—Yes, because you lose the people who can do it.

1187. Have you actually cross-questioned any of these people to probe the depth of their feeling and discontent, with a view to seeing what the solution might be?—The solution is not so much interference centrally.

1188. From the Ministry?—From the Ministry.

Mr. *Diamond.*

1189. Do you find difficulty in getting names from which to choose people in order to fill vacancies on management committees and things like that?—The right names, yes. We have to search all round.

Chairman.

1190. Thank you very much, Mr. Elliott. We shall be glad to see you next Thursday at four o'clock?—Yes. If I may speak off the record for a moment I know one management committee which towards the end of the financial year submitted to me for approval a scheme to buy a motor coach costing £1,650. I asked them for what it was going to be used, who was going to drive it, how much the petrol was going to cost, the maintenance cost and where it was going to be stored. No answer was forthcoming on those points. The fact was that they had £1,650 left in, as they called it, the "kitty"; they could get this coach; and they thought it would be a nice thing to take their patients down to the coast for therapeutic treatment. The truth of the matter is that you will not get hospital management committees to economise while they know that any amount they do save will not be carried over to the next

year. There is another point, and it is this: I hope you will give me an opportunity later of relating our experience with the Whitley Councils.

1191. It might be helpful to you if I let you know what I had in mind for next week. The items are these: the question of revenue expenditure, then the question of audit, the question of establishments and the question of the Whitley Councils. I think those are the large questions. There will be no doubt a number of minor points which we shall need to clear up arising out of your memorandum?—Yes.

The witnesses withdrew.

Adjourned till Thursday next, at 4 p.m.

THURSDAY, 1ST MARCH, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Thomas Reid.
Mr. Diamond.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mr. F. H. ELLIOTT, D.L., J.P., Chairman, Mr. E. G. BRAITHWAITE, M.A., LL.B., Secretary, Mr. A. F. BLAIR, C.A., Treasurer, and Mr. A. A. HUNT, Assistant Secretary, South West Metropolitan Regional Board, recalled and further examined.

Chairman.

1192. Mr. Elliott, when we adjourned last week I think we were about to discuss revenue expenditure?—(Mr. *Elliott.*) Yes.

1193. I think it might be convenient, as a start, if you could tell us something about the preparation of the estimates. Can you say how you collect the estimates from the management committees, what kind of check you have of them and how you fit in approval of the estimates by the Ministry?—I think, if you will allow me, Mr. Chairman, I will ask the Treasurer, Mr. Blair, to give you that technical information. (Mr. *Blair.*) Approximately about June of each year the hospital management committees start to have consultations with the various hospitals as to the possible rate of expenditure for the following year commencing on the 1st April following. That is examined by various sub-committees of the hospital management committees, finally approved by the full committees, and now sent to the Board by the 30th September. We have to submit those estimates to the Ministry of Health by the 15th November. We have exactly six weeks in which to summarise all the estimates of the management committees. I would mention that is in theory, because in practice it does not work. In those six weeks we have got to decide what adjustments should be made to those estimates, pass them through the machinery of the Board, the finance committee and the full board, and submit them to the Ministry of Health by the 15th November. Up-to-date we have said it is frankly impossible to do the job in that time, and we have had to say to the Ministry "We will tell you at a later date what adjustments we think we can make in these estimates."

1194. The hospital management committees, while preparing their estimates, are not necessarily in touch with you?—They will approach us for advice. Normally a direction goes out from the Ministry of Health saying in what form the estimates will be prepared, making it clear that they will be prepared on the prices ruling at the present time. Although it may be known that prices will increase they are not allowed to make any provision for that; in other words they are to be prepared on the known facts at the time of the preparation of the estimates.

1195. When the hospital management committee estimates are completed at the

beginning of September, do they send them both to you and the Ministry or to you alone?—They send them to us alone, and then, when we forward to the Ministry the consolidated estimates for the region, we have to send detailed copies of every hospital management committee's estimates. The Ministry do look to the region for guidance because—I mention this quite frankly—they could never consider the detailed estimates of four hundred hospital management committees and—I am guessing—probably two thousand units. They do look to the Board to give them a fair idea of what the figure should be.

1196. Supposing a particular management committee send in estimates totalling, shall we say, £1,000,000. You consider that along with the estimates of the other committees, and you decide in the course of your wisdom that they should only have £950,000. Do you send on to the Ministry of Health the original estimate for £1,000,000 and your comments upon it, or do you send a revised estimate?—We send the original estimate with our comments. The regulations make it clear that the original estimate will be submitted with the Board's, I think the word is, " observations " thereon. So in the case you have cited we would send the estimate for £1,000,000, and we would recommend that the Ministry approves an estimate for £950,000.

1197. Take what happened in the last completed year. Can you tell us to what the total estimates of your committees amounted?—The last completed year would be the year ended 31st March, 1950. Our hospital management committees' actual expenditure was £20,012,576.

Mr. *Thomas Reid.*

1198. When the management committee are framing their estimates, some of them are very zealous people, they like to do a good job, and they would like to ask for a tremendous amount of expenditure to bring the hospital up-to-date, extensions and all sorts of things. What principles guide them in framing their estimates for the £1,000,000 which the Chairman mentioned?—It will vary considerably. You will get one management committee, in spite of all the instructions which may have gone out, approaching it on these lines, " This is the Health Service we desire, and this is the sum we require by way of finance to meet the expenses of that Service ". Another management committee will approach it on different lines, and say, " We know we need 200 extra nurses "—let us take that as an example—" The nurses are not available, but we might get, say, thirty ". They would then provide for an increase of thirty nurses. From the Board's point of view we have to try to see if we can strike, if I may use the term, the happy medium.

1199. Are there any instructions about estimates issued by the Ministry, by you or by anybody? For instance, is there a ceiling laid down or any general instructions?—There are instructions laid down by the Ministry, and also more detailed instructions by ourselves, stating " Do be realistic ". That is the tenor of the instructions throughout. We tell them it is no use, if I may use the term, asking " for the sky " at this stage.

Chairman.

1200. Before the estimate comes to you do you see the finance officer of the committee and criticise his estimates?—No, I do not because, while I have certain discussions unofficially, if I can use that term, you must bear in mind that it is the estimate of the management committee. What the finance officer may think fit may not entirely agree with what his management committee think.

1201. There is no informal discussion before the estimate is completed and sent to you?—In some cases at officer level, but I want to make this point quite clear—they are unofficial discussions.

1202. By " at officer level " you mean between yourself and the finance officer of the hospital?—Yes.

Mr. *Turton.*] Mr. Blair told us that in the last completed year the actual expenditure was £20,000,000, but I was not quite certain if that was a reply to the Chairman's question.

Chairman.] I am going to pursue that.

Mr. *Diamond.*

1203. Before you go back to that, could I just get quite clear the nature of the unofficial discussions which take place between you and the finance officer of the management committees? Do those unofficial discussions relate to the form of the estimates, detailed accounting matters of that kind, or would they perhaps be on the lines of " What chances have we of getting this or that through "?—I should say they would be on both.

Chairman.

1204. In your year to March, 1950, your total actual expenditure by committees was £20,012,000 in round figures?—Yes.

1205. What was the total of estimates submitted to you in September, 1949?—I could not give you that figure offhand, but I could say we were within our estimates.

1206. What I am asking is this: what was the last total of estimates submitted to you by the management committees?—You are not referring to 1949-50?

1207. I am asking you to take the latest year for which you can give those figures? —The latest year will be in respect of the year 1951-52 we are now approaching. The management committees' estimates are £24,844,360.

1208. That is the total of the estimates submitted to you by the committees?—Yes.

1209. When you passed that on to the Ministry of Health what reductions did you propose?—We have in the meantime proposed no reductions. We have told the Ministry that this job will take four or five months of real solid investigation, and to attempt to give a figure within six weeks is humanly impossible; and they have accepted that contention.

1210. The position last September was that you received a number of estimates, which in most cases you had discussed informally at officer level?—Yes.

1211. You passed on those estimates unamended to the Ministry?—Yes.

1212. You told the Ministry then that you had not had sufficient time to consider them properly. Did you make any suggestions at all that there would be reasonable cuts which could be made upon them? —No comments whatsoever.

1213. What happened after that? What was the next you heard about that?—We are still waiting. Forgive me if I am a little bit lengthy. The Board have been fighting this issue with the Ministry for quite a long time. We know there are considerable varying standards between regional boards, because we proved it by last year's figures for 1949-50. I went to the trouble of getting out fairly detailed costs for various types of hospitals in the various regions, and we found as a result that there are considerable variations in the rate of expenditure for various types of hospitals throughout regions. We have argued that, if you are dealing with a large enough number of units, the law of averages should apply. We are quite frankly digging our toes in on this matter as a Board until the Ministry say what the figure is to which we should work, and then, furthermore, we want to satisfy ourselves that the figure, as far as our region is concerned, bears some reasonable relation to other regions.

1214. I quite understand what you wish to do in this matter, but I wonder if you could answer this question. Have you had any figure given to you yet at all by the Ministry, on which the management committees can work, for the year that is just about to start?—None whatsoever. We are anxiously seeking that figure.

1215. So far there is no estimate in existence for the year due to begin in a month's time?—Shall I say there is no figure given to us which is likely to be approved for the year just commencing.

Mr. *Diamond.*

1216. And no figures approved by you as a Board?—And no figures approved by us as a board.

Chairman.

1217. Can you say what happened in the previous year?—Ultimately some figure was approved, but did it represent a reduction on the total which you had put up?—A very slight reduction. It was not a very large reduction. The previous approval—I am now dealing with management committees—was for £22,850,000. That was under the global budget system. We then made certain adjustments by deduction for development schemes not yet due to commence and various other economies, and we finally approved the estimates of management committees at a figure of something under £22,000,000. Then when the revision of the estimates came this year we told the Ministry in effect, "You can knock £850,000 off our revised estimates for the current year." It is one of the points we have made. I do not want to digress, but you can do that under a global budget system.

Mr. *Turton.*

1218. The cut of £850,000 which you show in Annex V was made by you and not by the Minister?—It was made by us.

1219. That was made in the six weeks' period?—No, Sir, we only received our figure from the Ministry for the year 1950-51 in May, 1950. The year had already been in progress two months.

Mr. *Ward.*

1220. That is very difficult for adequate planning?—We have made a definite point of that under suggested economies. You must know your figure before the commencement of the year.

Mr. *Turton.*

1221. What then was the original estimate for the year 1950-51 which you submitted from the hospital management committees to the Minister?—The figure was approximately £22,850,000. There were various wage awards which had to be added to it. I would have to set it out in a fairly detailed schedule to show the various increases that have been incurred since that date, but overall they had cut it to what was equivalent to approximately £300,000 when the wage awards were taken into account. In other words, let us say our £22,850,000 represented really £23,150,000 as originally submitted.

Chairman.

1222. You submitted estimates totalling £23,150,000 and you got back a global sum of £22,850,000?—Yes.

1223. You were able to dispose of that as between your committees to a considerable extent within their discretion?—That is so.

1224. On that figure you made a saving of approximately £1,000,000?—That is so? —(Mr. *Elliott.*) May I just amplify that a little bit. It has been my duty to impress upon management committees, and particularly the chairmen, that in the present state of the national finances they cannot have any more money, it is extremely probable they will have less, and that any rise in the prices of goods, any inflation, will have to be met out of economies in other directions. I think the other thirteen regional chairmen agreed with me, and we put this question to Sir William Douglas. One or two of the chairmen said, "Very well, then we will have to close beds", and Sir William answered, after much thought and discussion with his undersecretaries, "Very well then, you must close beds". I have impressed upon the chairmen of management groups the necessity for getting every fraction of value out of every pound that is spent. I say to them, "You cannot have the things you want; you cannot have the ideals; you have simply got to manage". To enforce that we have got a sub-committee—I myself have been on several of them—visiting in turn all the groups in the area, the chairman and the finance officer, not every member, and we are impressing upon them in detail this fact, "You are costing so much more for drugs than so-and-so of a similar style of hospital". We are hammering it into them all the time. There is for the most part a real and urgent sense of economy, but we have one or two groups who are saying "We must have this because otherwise we cannot carry out the Act". Our finance and general purposes committee were discussing yesterday one particular group which is a very expensive group and has built a little empire around it. We are going to see them in a day or two. With the exception of one or two the groups have been very good. If the global budget system could be introduced—I certainly think that with this system of budgeting in advance, with the terrific time lag, the mischief is done before we know anything—and if the Minister could get from the Chancellor "I can afford to let you have so many millions for the Hospital Service for this coming year" and if the Minister would then allocate that sum to the fourteen regions roughly in proportion to the occupied beds, leaving something in reserve for himself, we should then allocate it with the knowledge that we have now gained in three years of our fifty-three groups, and we should say "That is all you are going to get. See what you can do with it." I am confident that method will produce real economy. Yesterday we were discussing the fact that we have at the moment in hand £400,000 of expenditure which we might spend before March 31st. If we do not spend it before March 31st it goes back to the Treasury. One or two members of my finance committee were congratulating themselves on that, but knowing human nature as we do I have no hope that we shall have a surplus of £400,000 on March 31st because it will be spent. Therefore the global budget and the competition which will then ensue between particular groups at any rate in my region will be a very healthy thing, and I think it is the only way to run the Act successfully.

Wing Commander *Geoffrey Cooper.*

1225. Would it not mean that the region would be given additional powers of resistance which so far the Ministry have not been inclined to let go out of their hands?—A terrific source of expense is the fact that, although we are supposed under the powers the Minister has conferred on us to run, advise and really control the management committees, yet constantly during the last three years a stream of directions has been sent direct to management commitees, nearly always productive of expense, and some of those directions have been sent without the regional boards knowing about them. There has been a little bit of a storm about that. Another matter that has been productive of great expense is this: we were not allowed to control the establishments of management groups.

Chairman.

1226. I am sorry to interrupt you, but I do want to discuss establishments later on. I do not know whether this necessarily comes in here, if so please continue?—Perhaps I will leave it. I wanted just to point this out to you. Owing to the fact that we were not given control, certain administratively built empires, appointments of public relations officers and all sorts of things were made. I have had several somewhat stormy arguments on this subject. We should not have allowed those appointments to have been made. The Ministry, through Sir William, say, "You have got control in the end because you hold the purse, and you can refuse to pay in the budget". By then the mischief is done. These people are appointed, and I know to my cost how very difficult it is, although everyone is appointed under a contract terminable by three months' notice on either side, to get rid of an unsuitable man or woman. The consequence is that we are having to carry that burden and to meet the cost.

1227. When Sir William Douglas says to you that you hold the purse, that does not seem to me to square with what you described before. If in fact the estimates have been approved, you have no option

surely but to pay over the money in accordance with those estimates approved by the Ministry?—(Mr. *Blair.*) Can I give you the illustration which our Chairman has in mind? The Ministry argue that we control establishments through the power of the purse. We argue that while we have the power of the purse, if we think a certain committee is extravagant we can clip their wings, if I may use that term, by authorising a smaller sum, it is extremely difficult. If you know the wage bill cost is excessive, if I may use that term, and amounts to £500,000, I agree you can then recommend to the Ministry that they should only get £450,000—but the staff are already there. We say give us control of establishments first, and the other will follow. They say we have got control of establishments by reason of the power of the purse, which we appreciate, but it is the wrong way round.

Miss *Ward.*

1228. And it makes for a great deal of friction?—Yes, it leaves an ill-feeling.

Mr. *Diamond.*

1229. Under the suggested system of a global budget, as I think you call it, do I understand that in fact to mean a regional budget?—Yes, Sir.

1230. Is it then suggested there should be no estimates submitted to you from your management committees?—(Mr *Elliott.*) No. (Mr. *Blair.*) You would certainly want the estimates to agree priorities. After all, the Ministry would have the problem of deciding the fourteen regional budgets, and having got ours it would be our problem to see that the money was properly and equitably distributed amongst our fifty-three groups.

1231. I understood you to say that from the experience you had you could distribute your regional budget equitably among the management committees. What purpose therefore would be served by the management committees submitting estimates to you?—Am I allowed to say anything off the record?

Chairman.

1232. I think it would be better to give evidence, and if you feel it is of a kind which ought not be published we will certainly consider omitting it, but on the whole I prefer not to have off the record conversation?—The position is this: a management committee in submitting its estimates has, as I mentioned before, a staff problem. It requires another fifty nurses, and we concede it does require them. There is a development scheme, if I may use the term, an extension of services to two wards which it is hoped to re-open. Certain capital expenditure has been carried out. You will get the management committee stating in their estimates, "We think these two wards will come into use on the 1st October, and we think we will be able to get fifty nurses by the 31st March or so". We have found in practice that not one of those timetables is adhered to. Under the present system, because of its rigid form, there can only be one body, the Ministry, approving hospital management committee estimates. Some provision has to be made for this scheme now when the estimates are approved. If the scheme does not materialise and those nurses are not recruited, although proper provision has had to be made for them, it might mean a sum of £50,000 is no longer required. Our experience to date has been that that sum tends to be frittered away on other probably desirable but less essential items. You are saddled with another expenditure of £50,000 and the scheme is not implemented. Under the global budget system we at board level have held back on this scheme, and we have said to the management committee, "When the scheme is ready to be commenced or when you recruit your nurses we will consider a further sum". That is how a good deal of this £1,000,000 has been saved.

1233. You say that transfers between heads of expenditure have been stopped so that, supposing a committee has had approval for an expenditure of £50,000 of the kind you mention and in fact it cannot spend that money, how can it be spent on something else?—Well, you will find in the case I cited—let us take salaries or wages—other staffs are recruited. Although they may not be nurses it is still within the same head.

1234. The head of expenditure will be the general head of nurses, administrative staff and so on?—There are eight heads, and one head covers all staff.

1235. It is only between the eight heads that no transfer is allowed?—Yes.

Mr. *Diamond.*

1236. To get back to my question again, I do not think I have made myself clear. I understand you to say that under this regional budget system you would, out of your experience of the last three years, be able to allocate such sums you receive from the Ministry among the various units below you?—Yes.

1237. If you are able to do that what purpose is going to be served by those units below you submitting their estimates when in fact you are going to allocate the money not according to their estimates but according to your knowledge and your experience gained over the past three years?—I think that, now we are getting this further knowledge, a lot of paper work, if I may use the term, in submitting estimates at management committee level could to a certain extent cease. I think we would still want some form of statement, but the elaborate form which is now used I think

could be dispensed with to a certain extent. We are now getting that knowledge, and I think we know fairly well what a management committee should require.

Mr. *Thomas Reid.*

1238. You would want an estimate from the management committee to arrive at the global sum, because the global sum may change from year to year?—There is that point. After all there is a lot of further expenditure (let us be honest) which we could put into the Health Service, but unless the money is available you would have to cut your coat according to your cloth. If more money was available—there is the point you make—there are other schemes which, while not so essential, are none the less desirable.

1239. If this decentralisation took place and much more financial power was given to the regional boards, then would that not tend to destroy any possibility of uniformity throughout the whole country? One regional board would go in one direction about staff and various other things, and another in another. The Ministry would lose an immense amount of control if it wanted to impose a rough-and-ready uniformity throughout the country?—May I say this? It is my humble view—I want to make it clear that this is a personal opinion—that it is on these broader aspects of policy, the ratio of nurses to beds and so on, which are so important and very costly, that the Ministry is not issuing directions to us as it should be, but it is the detained instructions, which we can handle ourselves, which we are getting. I will give you this one illustration. I should say that overall in our general hospitals we have a nursing ratio of one nurse to two beds. I am now dealing with the nursing staff in a normal acute general hospital. The General Nursing Council and the experts tell us that the standard is getting down to one to one. I can say that you could add £50,000,000 to the Health Service overnight when that standard is reached. No one tells us if we should aim at that standard and, secondly, if we do, that the money will be forthcoming, and I feel those are the matters on which the Ministry should be giving us some guidance. If we get a management committee saying "We can get nurses now", we try to adopt the line of saying "You seem to be quite comfortable now as it is, and if we put you on the one to one basis what will happen to the other hospitals who are now on the one to two ratio? From where is the money coming?", and all the time we are not getting real guidance from the Ministry of Health on the financial side.

Wing Commander *Geoffrey Cooper.*

1240. Was it on the one to two basis before the Hospital Service came into being?—Before the war—I am speaking with no real knowledge—I believe about one to two was recognised as the standard, although they had not that number of nurses.

Mr. *Thomas Reid.*

1241. You are rather bearing out the force of my question. If one management committee has a ratio of one to two and another one to one, under your system the Ministry would have no control. You would have a different system prevailing in different parts of the country with enormous financial repercussions?—No, Sir, I have not made myself too clear. My point is this: a recruiting drive for nurses is going on as far more are required. It is very difficult from our point of view to refuse nurses to a specific hospital. If the recruiting drive was to gain strength I have made the statement that it would cost the Health Service another £50,000,000 if we got up to the one to one basis. There is no guidance from above, and I think general guidance should come from the Ministry on such matters as will the money be forthcoming, what are our standards to be, what is a reasonable nursing ratio, and so on. We seek guidance on those points.

Wing Commander *Geoffrey Cooper.*

1242. Are you asking actually for quite a big change in the system because, as I see it from this chart which you have given us in Annex I, there is a sort of five-tier organisation at present with the centre at the Ministry, the region, the area, the group and the individual hospitals. If what you are saying is correct, it means that the centre function is going to be altered very considerably to deal with main policy matters, which I think would cover your point, Mr. Reid, and then leave the region to deal with the details under that main policy, in which case surely it would mean presumably the centre would shrink in size very considerably because it would only have to deal with policy matters on the basis of information passed to it from the regions in the form of budgets?—I would not know, but that was the intention. (Mr. *Elliott.*) That is correct.

Chairman.

1243. That accords with your ideas?—(Mr. *Blair.*) Yes, Sir.

1244. Can I take Mr. Diamond's question a little further because I think it connects with this? He suggested to you that there might be little reason in management committees submitting estimates to you. I rather thought from what you said that what you intended was rather than in future the committees should submit estimates to you for your approval instead of merely passing them through you to the Ministry for ministerial approval. Is that right? You want control over the estimates of management

committees; you think that control should stop with you, and should not go any higher. Is that right?—(Mr. *Elliott.*) Within the limit of the sum which the Government has allocated to us.

Wing Commander *Geoffrey Cooper.*

1245. Is it not a fact that regional boards are asking also to be placed in a similar position to that of a nationalised industry, which is answerable to the Minister for broad policy on which the industry is given direction, but the field work is done entirely by the industry and not by the Ministry?—That is quite right.

1246. Since you make the point and indicate what your problems are, I noticed in your description that in no one instance did you make a reference to areas. By that do you mean it would be perfectly feasible, reasonable and within the bounds of managerial competence for you to have your information sent direct to you from groups, in which case it would tend to indicate that areas are superfluous?—(Mr. *Blair.*) The areas are not spending committees. They are more concerned with membership and hospital management committee capital monies. We are dealing with the problem of revenue, and that is dealt with through the finance and general purposes committee.

1247. Are they in fact necessary for the purpose of finance?—I could not answer that. (Mr. *Elliott.*) No, not for maintenance.

1248. Yet they are costing some considerable amount of money, taking the country by and large, for expenses and offices?—Yes. I should be very glad indeed to dispense with our western area, which we could run just as well from London, leaving just the office there and not having any committee down there, having a sort of area committee inside the area of the region. We have a Surrey area committee with which I am very familiar. The men who form that sub-committee are all connected with Surrey, and they have the personal approach to the various people who run the hospitals, members of committees, house committees and that sort of thing, and so when anything comes up in connection with Surrey it is put to the Surrey area committee who know something about it. That is one of our problems. We had to start off into the unknown. I personally wrote 1,200 letters to get members for group committees. I did not know all the people to whom I was writing naturally, and we got this intimate local knowledge.

1249. Could you not obtain that intimate local knowledge by having one representative, or more than one perhaps in some cases, at the regional level, in which case it would tend to dispense with the need for the area level at all?—I think we said last time when we were here that we endeavoured to have a regional member on the group committees, but of course we have got twenty-six members and fifty-three committees.

Chairman.

1250. I rather understood what you said as being that you treated areas as *ad hoc* arrangements to deal with the particular geographical difficulties which you had. They are not on a separate level at all?—No.

1251. They are merely a contrivance to meet a particular difficulty?—To ease the work and to give us local knowledge.

Mr. *Diamond.*

1252. As I understand it, it has been suggested that there are two forms of budget, one which is in practice at the moment whereby a management committee submits its desires in the language of money as to how it would like to carry on its hospitals for the next year, and ultimately it is told what desires it can carry out in the way of expenditure. The other form is where, as you have described it, the Chancellor tells the Minister, and the Minister tells each region how much money can be spent in that region. You will then tell each hospital committee, on your experience, the sort of things on which you think the hospital ought to spend its money I gather it is the second method which you are recommending?—(Mr. *Blair.*) That is so. If I can speak quite frankly, I have quoted the figure whereby we have asked for £24,000,000 next year. I mentioned earlier that some committees have adopted the line, "This is the ideal we would like", but others have been more realistic, and if I may speak quite frankly I think in some cases an awful amount of time, trouble and committee work has gone into the preparation of hospital estimates. I can say today that I know those management committees will not get anything like that sum. It was said before that you start at the bottom and work up, but now I think it has got to come down the other way, start at the top and work down. We have the knowledge in the region to know how much each committee should have.

1253. I am not at the moment concerned with the amount spent, but with the method by which it is ascertained. Assuming that in either case the amount to be spent was the same, am I not right in saying that under the first case of build up from the bottom the amount spent by a given hospital would be on the lines it desired to spend it, and under the second case, on the regional budget, the same amount spent by the same hospital would be spent on the lines you desired the hospital to spend it?—(Mr. *Elliott.*) With our overall knowledge.

1254. With your overall knowledge?—Our knowledge of the requirements of the whole region.

1255. That is why I am asking you whether you think your overall knowledge, in all the circumstances, is better than the knowledge which the individual management committee has of its own affairs?—(Mr. *Blair.*) Yes, Sir, for the very reason I quoted earlier, that the standards in preparing estimates vary so considerably. I think one of the duties the regional board has to perform is to see that there is fair treatment of all its management committees in the sum which is available, and in the figure I quoted of £24,000,000 there are some very realistic estimates. I will go so far as to say that some have gone to the other extreme, and they will probably have difficulty in working to the figure they have estimated. Others I know have asked for far too much.

1256. If therefore you had a regional budget and you would decide—you think it is right that you should decide—whether every hospital should have a dietitian or whether no hospital should have a dietitian, you would not be agreeable that certain hospitals, because they thought it was a good idea, should have one and others, who thought it was not, should not have one. You would lay down rules according to your knowledge, as you said, over the last three years?—I think, if I may respectfully say so, you are suggesting a detailed control, and it is not our desire to go down to that level. I am dealing now in broad principles with the overall sums allotted to each hospital management committee. I think that if we claimed a global budget we should be only right in giving hospital committees a global budget, with certain necessary stipulations, as the Minister would probably impose upon us certain stipulations in a global budget, but it is not desired to have, if I may use the term, a detailed control. I argue that, if we have a certain autonomy, we should pass it on to our management committees to a certain extent. I do not think, as you quote the case of a dietitian, it will always be quite to that extent.

1257. I am sorry to pursue this, but I asked this in connection with whether you wanted estimates from your management committees for this very reason, because now you are saying that in return for your regional estimate you would grant one lump sum for the management committee?—Yes.

1258. You would not be concerned how that management committee spent its money. I am asking really whether you want one of two things, both of which have been said. Do you want to exercise complete control over the management committee and the expenditure of its money by your having a global budget or, alternatively, as you just now said, do you want to exercise no control over the granting of the lump sum at the start of the year, merely saying, "There is your money; spend it as you like"?—I have said no control, subject to certain stipulations. One case we will mention later on is the question of establishments.

1259. I am asking about the degree of control?—I cannot say no control. I must say subject to certain conditions, but give them a reasonable amount of autonomy.

Chairman.

1260. Can I just clear up one point? Mr. Diamond put to you the suggestion that under the present scheme the money allowed to the management committees is in accordance with what they consider to be their needs. Accepting that *sub silentio* you rather implied that the Ministry in fact approve the estimates submitted by the committees with only minor modifications. I think that was the implication. Is that a fact, or is that not a fact?—Well, Sir, I do not want to enter into the political sphere, because in the year I quoted you will remember there was a cut made in the early days and then it was hastily withdrawn, with the result that last year's estimates by and large were fairly well approved at the original figure requested. The cut we suffered was approximately £300,000.

1261. In other words your answer is this: what happened in the only two complete years you have had was that there was a substantial cut made in the first of them, which cut was then withdrawn, and for this year you have got no answer at all and, therefore, as a matter of fact you can give us no answer?—I am not quite clear at what you are driving. We had a cut of approximately £300,000 in this current year. For the year we are approaching now we have no clue what sum will be approved, other than the statement submitted on the Vote Account the other day—if that is any guide. I would not know at this stage.

Mr. *Diamond.*

1262. Where you have guidance from the past, is it right to say that these management committee estimates were, by and large, approved by the Minister?—By and large, with the exception of the current year, the year in which we are at present, where we had the global budget system and where we have made these economies. (Mr. *Elliott.*) In a small way the Government made a beginning. In February 1950 the Treasury weakened in its attitude, and we had for the first time something approaching, from the point of view of between the Ministry and the regional board, a global budget. We worked on that, and we made a reduction of £1,000,000. Then suddenly, without any warning, after it had been running for six months and before anybody knew whether it was going to be successful or not, the Government

withdrew it, imposed their control again, and they never even let us know they had sent the circular out.

Chairman.

1263. That was by means of a circular sent to management committees?—Direct.

1264. Could we have a copy of that circular?—They did not wait; nobody waited; there was an awful row about this. Things looked very serious from the point of view of the regional board, I will put it that way, because it was so unfair. We had been doing our level best in the matter, we had been getting our people into line, we had saved this £1,000,000, and then, as a bolt from the blue, this circular went out. May I say that Mr. Bevan himself came and addressed us? We meanwhile were to give as much advice as we could to management groups, and he said he would send out from Whitehall inspectors to go to every group and examine the details of their expenditure. We were already doing that, and doing it successfully. I pointed out to him, "You are simply loading more expenditure on the scheme. What on earth is the good of having two sets of inspectors?".

1265. Was the short effect of this change of policy merely to inform you that any savings which might be made within the region during the course of the current year would not inure to the benefit of the region but would be taken back by the Exchequer?—(Mr. *Blair.*) I should say that the global budget, although withdrawn in August 1950, did not apply to the current year. The Ministry will apply the withdrawal to the next year now commencing, 1951-52. In August 1950 they said, "You will not have a global budget in the next financial year and ensuing years". They could hardly withdraw it half way through the financial year, when it was already working.

Mr. *Turton.*

1266. Your question raises this point, Mr. Chairman. Under the original April decision on global budgets there was no carry over, was there, involved?—They have never conceded that. (Mr. *Elliott.*) They have never given in on that.

Chairman.

1267. Can you say precisely what practical effect this change of policy had? I understand the general change of policy, but precisely what did the Minister by this circular say that he was going to do?—(Mr. *Braithwaite.*) May I read the relevant paragraph of the circular R.H.B.50/80, dated 21st August, 1950? Paragraph 7 is the operative paragraph, and it reads, "As regional boards will know, since the issue of R.H.B.H.M.C.50/16 delegating the approval of estimates of hospital management committees to the boards, the Minister has found it necessary to reserve to himself powers of virement as regards the expenditure of hospital management committees. In present circumstances it is considered that these powers should continue to rest with the Minister, and it follows that the approval of estimates of management committees should also rest with him. The delegation of this duty to regional boards, authorised by the earlier memorandum, is therefore revoked".

Miss *Ward.*

1268. That was the circular which went out without consultation?—(Mr. *Elliott.*) Without consultation with any of the fourteen chairmen, although a direct promise was given that no more circulars would be sent out without us at least having at the same time a copy.

Mr. *Diamond.*

1269. I do not understand that. I thought this was a circular to regional boards?—No, direct to management committees—and to regional boards, yes.

1270. It was sent to regional boards, as I understand it?—To regional boards and also to management committees.

1271. It was sent to both contemporaneously?—Yes.

Chairman.

1272. But without prior consultation?—We were not consulted at all on its terms.

1273. That circular indicates that it was the Board and not the Ministry that had approved the then current year's estimates?—Yes.

1274. I rather thought, from what you told us, that in fact in respect of those estimates you had received them from management committees and transmitted them to the Ministry?—(Mr. *Blair.*) That is so, but then bear in mind that is their original request. You then get an approval either of the request as given in full or a cut is made. In February, 1950, the Ministry gave us this power and said "In approving estimates we will not approve each hospital management committee estimate; we will let you do that. We will approve a round sum for your whole region", which was this figure I have quoted of £22,850,000. Then they said, "You as a board will approve each individual hospital manegement committee estimates within that figure". That is what we say has now been withdrawn.

Mr. *Turton.*] Could we ask Mr. Danielli to let us have a copy of that circular for our papers?

Chairman.] Yes, perhaps we could have individual copies.

Wing Commander *Geoffrey Cooper.*

1275. Mr. Elliott, did I understand you to say in your reply that you had a promise from the Ministry and they would not send out these circulars without at least advising you at the same time?—(*Mr. Elliott.*) Without consulting us first of all and advising us what they were going to do so that we could make any observations.

1276. Why did you find it necessary to ask for that promise?—Because they had done that so many times.

1277. Have you other examples which have caused difficulties? Could you select half a dozen or a dozen of those and send them to the Sub-Committee for information, at the same time indicating the sort of problems which were raised as a result of that happening?—Yes. (Mr. *Braithwaite.*) May I raise a point on these circulars? They have been discussed as well by the officers at meetings at the Ministry, and we have often had to make the same type of complaint as that about which our Chairman spoke. We suggested on one occasion that perhaps the more satisfactory method of issuing directions, to prevent this difficulty, would be for the Ministry to separate the R.H.B. circulars into two categories, those which the Minister obviously would have to issue as directives under his powers to the fourteen regional boards for the sake of uniformity, documents concerning salaries and wages etc. and others which are in the nature of advice. We suggested that the latter should come to regional boards only as an indication of Ministry policy or as the advice of their experts on any given subject, the regional boards being left free to interpret them within their own regions as they thought best.

1278. That is the sort of method which is used in the Armed Forces now, and has been for a very long time; it would not be an entirely new suggestion to make?—That would prevent this difficulty of regional boards considering policy at their own level and then finding it countermanded by a circular of which the regions have no knowledge.

Chairman.

1279. You said "we suggested" in answer to an earlier question. Do you mean your Board or do you mean all the regional boards?—I was speaking then of the fourteen regional secretaries.

Miss *Ward.*

1280. The decision to make representations to the Ministry arose out of one of these consultations between all the chairmen of the regional boards, did it?—(Mr. *Elliott.*) The fourteen regional board chairmen go every month to the Ministry; we meet Sir William and his fellow officials, and we would talk things out.

1281. It was on one of those occasions that you got this agreement?—Yes. May I say something off the record? The Minister himself came to one of the meetings, and he said, "I want you to tell us how we can introduce economies". I said to the Minister, "There are no two ways about it. You expect us to control the hospitals and yet you are not willing to give up control from Whitehall. If you really want to do the thing in an easier way, whether it will save money or not I do not know, abolish all the regional boards" and all my colleagues said, "Hear, hear". We want such a measure of decentralisation as to let the regional boards do what they were instituted for, in the same way as we hope the nationalised boards are going to be able to do their work. We shall decentralise down to the management group committees. We have even got the little cottage hospitals in with their one or two members on these groups. We shall then gradually get a new spirit right through, but it is the hand of Whitehall that is on it. Nobody can make a decision, and every time a decision is delayed, which we know ultimately has to be made, more money is involved. If we want to spend £80,000 on new boilers in a hospital, unless great pressure is put on the matter, we cannot get a decision. Nobody in Whitehall will make a decision whereas the regional boards, the chairmen and their members, although they will make one or two mistakes, will make decisions. We would like the power to make decisions to be given to our management groups. I have talked to one of my chairmen of a hospital group, and I have said, "Look here, you are bound to make a mistake or two, it is human nature, you cannot help it, but as long as you do not make the same mistake twice you will not hear anything about it, but if you do make the same mistake twice you will be hauled over the coals".

Wing Commander *Geoffrey Cooper.*

1282. I suppose hospital groups will wish to get autonomy to some extent under you in turn?—Yes.

1283. Because otherwise they will lay the same charge against you about not getting quick decisions?—Yes, I agree. I think that is all to the good. (Mr. *Hunt.*) I think the Board is of the opinion that if in fact a global budget were given to a hospital management committee it would only be with certain satisfactory safeguards.

Chairman.] I think that really leads us to the next main division of our questioning, and that is on this matter of establishments.

Mr. *Turton.*

1284. Before we get to the matter of establishments, could I just ask this question on finance? If you work a system

of quotas, block grants, would you desire to have the opportunity to raise money by voluntary effort in your hands, in the hands of the group or in the hands of the individual hospitals?—(Mr. *Elliott.*) That is a very difficult question. We are not allowed to raise money now for the hospitals by voluntary effort.

1285. That is why I said "would you desire"—I realise you are not allowed to do it now?—I do not know whether I can give you a direct answer to that question. However I do know this in the old days, if a hospital wanted a new cardiograph machine they would first of all see whether they had got any money, and if they had not they would probably have a flag day to raise enough money to get it. Now we have got the power of the State purse behind us, I do not know—I cannot answer that.

Miss *Ward.*

1286. Do you think that, if that power was restored, it would create a local feeling again in favour of the local hospital? You did refer in your earlier evidence to the sort of feeling of frustration. Do you think such a power would serve to re-create that local pride in the hospital from the point of view of providing amenities and other pleasant little things?—There is still a wonderful pool of volunteers who are looking after hospital amenities. I say to my own wife that she is a blackleg, because for fifteen years she has been spending every other Friday at the local hospital sorting linen. I say to her that people are paid for that kind of work now, but there is that pool of voluntary effort which is not exhausted although we have dealt it some terrific blows. What I think would really help the Service—I put this to the Minister one day—is this: suppose you made a charge of sixpence for every service given under the Health Service—sixpence for an ambulance ride, sixpence for a sitting case riding in a car; sixpence for a visit to the out-patients' department; sixpence for occupying a bed for a fortnight. The mere fact that something was paid would create a different spirit. I know I was laughed out of court, but knowing human nature I think there is something in it. (Mr. *Braithwaite.*) On the capital side there would be just one difficulty which I think might be overcome. If the money were raised on a voluntary basis for a capital scheme it would then be in addition to our normal expenditure. It would be an excellent thing, provided it were used in a way consistent with the general plan for the group or for the region. I think the danger —it has been expressed on the Board—is that the money so raised should be used only at the instance of the immediate local community, and it might therefore upset the larger plan, particularly in times when there is a shortage of materials, a shortage of specialist services and a shortage of manpower. That, I think, is the only danger.

Chairman.

1287. What you mean is that, if you were to raise money in this sort of way, it would be best raised for capital purposes—obviously that would be an attraction locally—in putting up a new wing and so on?—For capital purposes within the plan which has been made for that particular group.

1288. You would need to control it rather carefully from the centre to see that it did not pull your capital scheme out of the straight?—Say the medical plan, rather than the capital scheme.

Miss *Ward.*

1289. Perhaps this would be a good illustration. If you go into some wards they have got very inadequate lockers in which to store the patients' treasures and things, and it would be very much better to have a new modern type of locker. It is quite obvious it is very difficult to agree to that, but you might in fact raise money locally for carrying out schemes of that kind?—(Mr. *Blair.*) That sort of scheme would be quite in order, but you would have to have certain rules and regulations because, just to take the capital illustration of supposing you get enough money to add a new wing with sixty beds to a hospital, the question then is can you run and maintain it. It is the old problem of tying capital and revenue together.

Mr. *Thomas Reid.*

1290. The result would be an additional demand for money from the Ministry?—Yes, to maintain the service. The group add these sixty beds, and then they naturally look to the Minister to service those beds.

Chairman.

1291. In other words, if you were to raise money voluntarily, it would have to be canalised through the regional boards?—Yes.

1292. You would have to keep control of it?—There would have to be some rules and regulations.

1293. Now can we turn to establishments?—(Mr. *Hunt.*) There is one point, I think, which has not been made sufficiently clear in regard to the global budget, and it is that the Board does not divide the total sum of £22,000,000 into fifty-three sums and then give the amount to the individual management committees. The Board holds back a sum in reserve to deal with increases in staff and for development schemes before the division is made.

1294. I think that was understood. The proposal was that a reasonable amount should be maintained?—(Mr. *Elliott.*) The Minister should hold some, and we should hold some.

1295. With regard to establishments you state in your memorandum on page ten that in some cases certain establishments are excessive so that in fact—indeed I think you said this in evidence this afternoon—in some management committees excessive numbers of staff are employed. Could you say, first of all, whether you find that is so among particular classes of staff, administrative, nurses or others, and, secondly, what is the present method of controlling establishment?—I would say first and foremost that it is amongst administrative staffs, staff not connected with the patient, that is neither medical nor nursing. You get an ambitious secretary of a group, and then you have a deputy secretary, then you have a finance officer and a deputy finance officer, a supplies officer and a deputy, a public relations officer—at one place I had to check them on that. Before the hospitals were taken over, particularly those with which I was intimately connected in the county council, we managed without any of that. I think some hospitals have got far too big a staff, because each particular man creates work for someone else.

Miss *Ward.*

1296. Does the staff vary from hospital to hospital?—Very much. At some hospitals they have a secretary who is also the finance officer and who also purchases supplies, and he does it very well.

Chairman.

1297. When you find in a particular group what you think is an excessive staff, what action do you take?—The only action we can take, the men and women having been engaged, as Sir William Douglas told me, is by stopping it out of their budget, and so thereby stopping their salaries. In practice that is quite impossible because the men are already engaged. We go and discuss it with them.

1298. You do advise and guide?—I remember sitting till very late in the evening with a certain chairman and a certain secretary of a group—my medical adviser was with me—and speaking very, very sternly about it.

1299. We have had evidence from another region that that region has express power from the Ministry to stop any additions to staffs whatsoever?—The damage is already done. We have issued a directive, as far as we can issue a directive, to every one of our groups telling them not to engage any fresh staff without consultation with us—but we can only reduce staff by persuasion.

Mr. *Turton.*

1300. What does a public relations officer do for a hospital?—I do not know.

Chairman.

1301. So far as establishments are concerned you have power to stop any further increases?—We have issued what we hope they will take as a directive, that they are not to engage any fresh staff.

1302. But you have power to instruct them, surely?—(Mr. *Blair.*) We have instructed them, but our argument is on what is already there. Could I give you an illustration?

Mr. *Diamond.*] It would be valuable to get the point quite clear, as this would otherwise be a conflict of evidence, whether or not the Board have power to give instructions.

Chairman.

1303. I think that was the point which Mr. Blair was going to answer?—We have taken the power. Whether we have the legal power or not I do not know.

1304. Could the Secretary tell us?—(Mr. *Braithwaite.*) May I give the legal answer, which is not always the practical answer I am afraid? Under Section 12 of the Act it is said, "It shall be the duty of the hospital management committee of any hospital or group of hospitals, subject to and in accordance with the regulations and such directions as may be given by the Minister or the Regional Hospital Board, to control and manage . . ." etc. Under that power either the Minister or the Regional Board can issue a direction but the difficulty is that it has been felt, both by the Ministry on account of the infrequency with which it has been used and by the Board, that it is a power which is intended to be exercised only in exceptional circumstances, and that it is not a power which can be used week by week to prevent for example the appointment of junior staff.

1305. Can I read to you what was said by a parallel organisation? The question (Question 777) put to the Board was this, "It seems to me there is a conflict there because, if in fact they . . ."—that is the management committee—". . . have to come to you for approval, you can control their establishment?", and this was the answer, "They come to us for approval of additions, and when they come to us for approval of additions, say to the Treasurer's office, we would not give approval to that if we were not satisfied that they had no more than sufficient men or women in that department to do the work which is necessary". It was quite clear from the evidence given in that case

that the Board regarded themselves as having complete power to forbid any single addition, and in fact they exercised that power?

Mr. *Turton.*] Additional but they cannot cut down the existing number.

Chairman.

1306. I am not sure that was specifically said?—(Mr. *Elliott.*) Anyway I instigated the direction from the Board to the management committees that they were not to engage any more staff without our prior consent, but that does not affect the question that they have already got these staffs, we having to pay their salaries and wages. It is very difficult to treat them as redundant or to get rid of them.

Wing Commander *Geoffrey Cooper.*

1307. If you had power or took power to have a complete comb through on the basis of expert management advice, similar to the advice obtained during the war, I know by the R.A.F. and I think later by the other Forces, from certain experts who went round and checked establishments, could you estimate in very rough terms the sort of saving which might be possible throughout your region?—(Mr. *Hunt.*) It would vary materially according to the hospitals. I think the point has already been made that the establishments of all the hospitals in our particular region, and in fact throughout the country, vary so materially. The Board has hospitals which are regarded as comparable, and yet the staffing establishment under any particular head varies a great deal. For example, on administrative and clerical, one hospital management committee may have twenty-four and a comparable one in the view of the Board may have thirty-six. With regard to the nursing staff at hospitals some have one nurse to two beds, and in a like general acute hospital there may be a ratio of one nurse to 1.2 beds. The variation continues into the technical, professional and domestic spheres.

1308. That is not quite an answer to the point I was trying to put, which is this: if the matter were dealt with by people who had knowledge of what was appropriate, say a group of people sitting by appointment of the regional board, and they combed right through the organisation, what sort of saving would you expect to be able to make in terms of what is a reasonable staff to do the various jobs?—(Mr. *Blair.*) I think you would have to fix the ratio of nurses to beds first. If you fixed a standard of one nurse to one bed you would have no reduction, but you would add a large sum to the cost of the Service.

1309. I appreciate that, but I am asking you as a Board, if the matter were left with you to deal with and you are asking for more autonomy, on what sort of basis would you work?—(Mr. *Elliott.*) Can I answer in this way? I was the Chairman of the Central Purchasing Committee of Surrey, which bought all the supplies for thirteen big hospitals and for the whole of the rest of the county, the total running into a large sum of money. I had a very tiny staff; I do not think it was ever more than fifteen; and it worked very well in spite of the war. In starting the Hospital Service every group has been encouraged by the Ministry to have a supplies officer, and some of them have a deputy supplies officer. I say "every", but there may be one or two exceptions where the work has been done by another officer, perhaps the secretary. I conceived a plan by which we should have three or five groups with one supply organisation, with a chief and a deputy and the minimum number of clerks necessary for it. I put that to the Ministry, but they had other ideas because they sent to me a gentleman who had bought all the uniforms, I think, for the Army. I had charts drawn up and I showed him the way in which I thought I could do it, but they wanted to buy centrally for the whole organisation.

1310. In the Ministry?—In the Ministry. I think I made my point, but they said it was not possible because they will not understand it is much easier to buy for a county than for a country. There were local means of getting goods, and local goodwill which was very helpful. Might I just give you one instance of how this central buying operated? The medical superintendent, who did the buying for a joint board that we ran for blood transfusions, telephoned me one day and said that he had been buying glass tubes for three shillings and sixpence from a certain channel, and now he had received a direction from the Ministry that he must buy through them; their price was six shillings and sixpence. What was he to do? I said, "You write to the Ministry official and say that you have put his goods in competition with those you are getting now at a cheaper price, and that you have instructions from your Chairman to continue buying in your present channel", which he did, and nothing more was heard of the affair. That is quite a simple instance. I do not know whether it ought to be reported. It shows you the pitfalls of central buying. Therefore I would like, if I had the power, to comb through all the hospital groups of the country, combine them together in little lots of about five groups, have a proper buying organisation for those five groups, and thus I would save a lot of manpower and a lot of money.

Chairman.

1311. I was looking at a paragraph, three from the bottom of page seven of your

memorandum, in which you say this, "It would seem to the Board essential that they should have the power to control the numbers of staff employed by management committees after consultation with management committees", and I was wondering how that tallied with your answer on the financial question of giving the management committees greater freedom under a system of global grant?—That is one of the safeguards which one of my colleagues mentioned. We should of course, until we knew exactly where we were, exercise such safeguards as were reasonable, because secretaries vary in quality and chairmen vary in quality. You have not always got the right man for the right place, and therefore you must have some safeguards, otherwise they may run amok.

1312. Do you wish to have this power to be used sparingly, or do you want power to lay down establishments in each case?—I think we have to guard ourselves against in any way attempting to dictate if we are going to preserve this voluntary effort, because the chairmen and members of the management groups give their services voluntarily and we must give them our confidence. I think that should be preserved, and therefore I would give them as much control over detail as was reasonable and wise. (Mr. *Blair.*) I think it would be best, and it would also answer Wing Commander Cooper's question on the nature of the problem, if I just gave two figures on this question of establishments. We will take two voluntary hospitals, reasonably comparable, one specialist and mainly dealing with women and one normal acute.

1313. These are ex-voluntary?—Yes. They are about the same size, 200 beds and upwards, and I am dealing purely with what I may term "other staff" which is all types of staff other than medical and nursing—such as domestic porters and so on, the whole lot other than medical and nursing. One hospital costs £397 per bed per annum for other staff alone, over £7 10s. 0d. per week, and the other one costs £265 per bed per annum, say £5 per week. No doubt there are different types of wards and all that, but there is such a disparity that we feel we should have some say in the matter. We go to the committee concerned and say, "You are far too expensive on other staff, do try to economise; do try to do something about it", but unless they are willing we merely get back the answer, "We need all of them" and there is nothing we can do about it. We can prevent them adding to the staff, but other than using persuasion there is very little we can do in regard to the staff they have already got.

1314. Supposing you have the power to curb extravagant management committees, what do you imagine you would do if you found those circumstances and they replied, "Sorry, we cannot really manage on less"?—I think again it would have to be carried out by experts. I think experts should go down and be able to decide where the number should be diminished. We at board level feel that the extremes are so great that something should be done about it. I think the Board's contention is that, again on guidance from the Ministry on overall establishments, we should be able to say to hospital management committees, "Your other staff, the whole lot, should number two hundred."

1315. Have you no means now of sending experts down to give advice?—We have, but we have got no right to fix establishments.

1316. No, I am not asking that, but there is this particular case to which you have referred where there is evidence to suppose that the staff is above the needs having regard to what is the position elsewhere. Have you sent any experts to have a look at them and to give them advice?—(Mr. *Elliott.*) Not outside experts.

1317. I am asking what is the difference in what you would do if you had this power from what you are doing now?—We would send experts.

Wing Commander *Geoffrey Cooper.*] Is it not the sort of point which has already arisen in the Armed Forces, I know it has in the R.A.F., where the Air Ministry recruited people with the necessary management and personnel experience and send them round to check all establishments throughout the whole Service? They were then able to make suggestions. Would that be the sort of thing which might reasonably be done, perhaps by the Ministry of Health or by the regional boards?

Mr. *Diamond.*

1318. I hope, Mr. Chairman, we can follow up your question because, as I understand it, the Board at the moment have power, by consultation and persuasion, of limiting and in fact positively excluding additions to staff. The figures clearly indicate that this is a growing service the whole time, and it is very unlikely therefore that there should be decreases in the needs for staff; on the other hand there should be a continual need for increasing staff. Having regard to the fact that you have powers of persuasion, consultation, excluding additions and refusal to pass estimates on existing staff, what further powers are you suggesting should be yours in order to prevent two hospitals with like needs having an expenditure disproportionate to their staff?—(Mr. *Hunt.*) To have the power of actually fixing establishments after consulting the people on the spot.

1319. After consultation, which power you have at the moment. After having divergent views expressed, which has already been given as an instance, you would then like power to say, "You have at the moment 390 other staff; you must reduce that to three hundred and *x* staff"?—Yes, Sir.

Miss *Ward.*

1320. The Ministry of Health is not carrying out any investigation into staff, is it?—(Mr. *Elliott.*) Yes. (Mr. *Hunt.*) They have commenced to do so, but we do not know how far it is going to go.

Chairman.

1321. They are not doing it in collaboration with you?—(Mr. *Braithwaite.*) Unofficially they are. Their officers are consulting us beforehand, but I understand that is not done in every case.

Miss *Ward.*

1322. That is as regards establishments at hospital level, is it?—Yes.

1323. Have you made your representations on this problem to the Ministry for transmission to the Ministry staff who are carrying out this investigation? How do they work?—(Mr. *Hunt.*) We have a number of teams who have been to isolated hospitals in our region, but the scale upon which they can attempt it at the moment is extremely small. I think, excluding the medical team, that the total number of visits made since August, when this first started, probably does not exceed a dozen in the whole of the region, and in probably eighty per cent. of those instances we have had representatives present at some part of the enquiry. In other cases we have sent representatives during the week or period they have been working in the groups or in the hospitals of the groups.

1324. Do these teams appear to be really expert?—(Mr. *Braithwaite.*) Yes, the quality has been very good. The team of which I am thinking has one expert and one person who is a practical person from another region, usually from a hospital but not in all cases. (Mr. *Hunt.*) One team try to cover all domestic staff, but in most cases, it comprises a dietitian or a domestic supervisor, and an official from the Treasury.

Wing Commander *Geoffrey Cooper.*

1325. Would you suggest that, if this job of investigating establishments was conducted by the regions individually, it would be preferable to it being done by the Ministry, on the score perhaps of competition between regions in regard to their standards of efficiency?—I think so.

Chairman.

1326. This can only be done on a small scale by the Ministry at the moment because they have only a limited staff available for the purpose?—They have fourteen regions to cover.

1327. In fact, if you were faced with having to do this job, have you got the staff available?—Not immediately, but it could be covered in time—and in very much quicker time than under the system operated by the Ministry. I did have previous experience in a local authority dealing with hospital establishments in co-operation with the county medical officer, who was the senior officer of that authority for that purpose, and we did find that in a county of approximately one and a half million population with eighteen hospitals, you could fix establishments for those eighteen hospitals, after consultation with the people on the spot, in three or four months.

Miss *Ward.*

1328. Were reductions in fact carried out in that particular case?—The establishments were already under the control of the county council, and therefore reductions as such never really arose, but it did definitely limit the increase in staff in the hospitals.

Chairman.

1329. Do you know if the Ministry does in fact exercise its undoubted powers to control establishments?—Not so far. We understand that the teams which have started their work are going to report to the Minister, and the Minister is then going to fix establishments without any further consultation with the regional boards.

1330. Without consultation?—Without further consultation.

1331. You have been told that?—Yes, Sir.

Wing Commander *Geoffrey Cooper.*

1332. On what date did they start to do this?—(Mr. *Braithwaite.*) I think it was last August. (Mr. *Hunt.*) They did not start going round till about September.

Chairman.

1333. It may be convenient now to deal with the question of audit, because it hinges rather closely with this. I think the present position is that the auditing of hospital management committee accounts is dealt with centrally by the Ministry of Health auditors, and you yourselves have no power to audit at all?—(Mr. *Blair.*) That is so.

1334. I do not think you refer to that in your memorandum?—I think we deal with it very briefly.

1335. Oh, yes. Then are you asking that the auditing of hospital management committee accounts should be conducted by the regional board?—Yes, Sir. In other words, we have asked there to have the local authority system whereby we do the detailed audit and the Ministry of Health carries out the audit in principle, on policy and so on.

1336. I am not quite certain how you would do that in practice. Each management committee presumably has a complete set of accounts showing in some considerable detail how every penny is spent?—Yes.

1337. Those accounts I suppose at some period are consolidated?—We consolidate them as a region for the purpose of the accounts submitted to the Public Accounts Committee of Parliament, but we have no idea what is behind those accounts. We merely get certified accounts prepared by the Ministry of Health auditor, showing they have spent £X on salaries and wages and so on, but as to what is behind that we have no knowledge.

Mr. *J. Enoch Powell.*

1338. You are suggesting the Ministry of Health should merely audit the expenses incurred directly by the regional board, and accept as blocks the audited expenses of the management committees?—No. I think this would be the best way of describing it. The normal routine voucher work and so on would be carried out by the regional boards, and the Ministry of Health would do something like an exchequer audit asking such questions as, "How do you pay your members? What is your system of control? How do you control your cash? Let us have a look at this", just checking here and there.

1339. They would check?—Yes. They would rely on the spade work we had done, and go out for matters of policy and principle.

Chairman.

1340. But the detailed auditing of each management committee's accounts you think should be the responsibility of the regional board and no one else?—I do.

Mr. *Diamond.*

1341. What advantages do you think would result from your having the auditors under your own control?—We get copies of the reports made by the Ministry of Health auditors, but we have had to fight for them. They would not concede that at the start, but we said, "Surely it is farcical. You give us control of the overall budget. It makes nonsense of the whole system of financial control, because from that moment we have no idea how it is spent and yet we are supposed to assess the priority of schemes on which the money should be spent". We do now get copies of these audit reports. I can give you an illustration however—I know it may be said I am trying to shoot down my own case of where the onus should really be—where the Ministry of Health auditors, although they normally do not seek to regulate policy, did criticise the expenditure on carpets and curtains for a matron's flat in a particular hospital. They quoted figures, and the figures were really fantastic. The point is that we heard of that at least a year afterwards. That may be occurring to a lesser degree throughout every management committee. Rarely will they comment on any question of principle; they seek merely to ensure it is a correct payment. But here they felt they had to investigate the position, but had they not we would never have been any the wiser that this management committee was spending these fantastic sums on carpets and curtains.

Mr. *J. Enoch Powell.*] You are merely anxious to get the informal information which would come your way where the auditor in the course of his audit discovers such an expenditure?

Chairman.

1342. You would get the information immediately?—Yes. I feel further it would also make our problem a great deal easier in the final allocation. In other words, we would see where the money was going.

Miss *Ward.*

1343. There is no reason why one matron should be more comfortable than another, is there?—(Mr. *Elliott.*) Except the personality of the matron.

Miss *Ward.*] I do not think that is a reason for additional amenities.

Mr. *Diamond.*

1344. On page eight of the memorandum it is suggested that power should be given to the Board to carry over unspent balances. I see it is suggested that should apply to both revenue and capital. I am not referring to capital at the moment, but only to revenue. Perhaps we can be told some of the advantages of carrying over on revenue account. Why is it that that would result in economies?—(Mr. *Blair.*) I have been brought up in the hard commercial world, and I think there should be a certain amount of elasticity at hospital management level. The point already made is a good one. There is a certain amount of feeling which we are meeting all the time. It concerns the balances on the monthly expenditure statements of management committees, and there is bitterness that the money is lost to them. I am stating, and I have stated I think in Annexe V, that up to December last hospital management committees were showing economies of £450,000

within the figures we had approved centrally. I do venture to suggest that the position at 31st March next will show an entirely different picture.

Wing Commander *Geoffrey Cooper.*

1345. Would you be inclined to let the Ministry relinquish any of the power if you felt that overall you would be able to save a sufficient amount on costs of maintenance and then found you had over-estimated the saving and consequently had to go back, because if so would that not rather defeat the object?—Only in broad principles. I think you do it in your University grants, where the effect of the carry over is taken into account although I do not think it is all lost. I feel that if the committees felt there was some inducement to save it would decrease expenditure on not non-essentials but on items not quite so urgent.

Chairman.

1346. As I understand your suggestion I think the question of carry over links up with the question of global grants?—Yes, Sir.

1347. On the question of a global grant you do not suggest there is really anything much in a carry over?—(Mr. *Elliott.*) Without a global budget I would still fight for a carry over.

1348. Would you carry over items within a particular head, do you want a general carry over power, or for what are you asking?—A general carry over.

1349. You may at the end of the year have saved something on nursing staff?—By the end of the year you have a large expenditure on something else which may be just as urgent; and it continues from day to day.

Mr. *Diamond.*

1350. Then you have got a large expenditure on something else in the following year?—Yes.

Miss *Ward.*

1351. It is a sort of incentive. If you do not get any benefit from it then you would not perhaps take that additional trouble to make an economy?—It is the psychological effect.

Miss *Ward.*] It is rather like the housewife's budget, but I do not expect you know about that.

Wing Commander *Geoffrey Cooper.*

1352. What is the impression you have of the efficiency and so forth of the Whitley Councils in the way of their functions, and can you tell me what increases have occurred in staff salaries since the Health Service was first started?—If you ask me what impression I have gained of the Whitley Councils I say they have been utterly useless. They have been more than a fifth wheel to the coach. When the Whitley Councils were first established—I knew something about—the ideal of the employer and the employee sitting round a table to discuss their differences was splendid, because the employer knew that whatever was granted he would have to pay out of his own pocket, or out of the pockets of the firm, and the employee knew that he would not have anything if the firm went broke. Now where you have got on one side the State, which cannot go broke, and on the other side the employee who knows it, then you do not get financial finality in anything. Further than that the delays in getting decisions by the Whitley Council, as at present constituted for the hospital boards, are appalling. I have here a long list, dating from 5th April 1949 when the Whitley Council received an application for an increase in wages for the skilled washing machine operatives in laundries. That went on until the 6th December 1950 without any decision, and then the Council gave a revised rate for washing machine operatives. Meanwhile, having lost all our skilled operatives and in view of the fact that we had a "go slow" movement because of the natural resentment of the operatives at never getting a decision, the additional cost to the Government has been £7,301 because Sir William Douglas promised me that if I would discontinue my attempts to get an incentive bonus, to which the trade union first of all agreed and then withdrew their agreement although I had it in writing because the Whitley Council could not agree on it, he would see what he could do. Of course a central laundry is really a commercial organisation with two sets of negotiators, trade unions and Whitley Councils. The whole position is fantastic, and therefore I cannot but think that it is a bad thing for the Hospital Service.

Chairman.

1353. Taking the case of those classes of employees who are subject to the Whitley Councils, and presumably that would apply to the majority of those who are in the employment of the Service, how would you suggest their conditions of service should be settled—apart from the Whitley Council machinery?—I think they should be settled by the Government.

1354. Simply by a unilateral decision?—Yes, the Government is the employer.

Wing Commander *Geoffrey Cooper.*

1355. After negotiation with the Government direct by the trade union?—I do not know how many trade unions are concerned.

Mr. *Diamond.*

1356. If there are no trade unions I gather you are suggesting it should be decided by the Government?—My colleagues think I am going off the rails here because they say it is the form of the present constitution which is wrong and not the system, but we have three representatives only on the Whitley Council and the Ministry has eight.

Wing Commander *Geoffrey Cooper.*

1357. Eight officials from the Ministry?—Yes.

1358. In other words, conditions and wage rates are decided amongst the officials?—Yes.

1359. Can you tell me, in regard to any rises of pay which have been made during the last few years, whether the officials have benefited?—(Mr. *Braithwaite.*) We are not suggesting that.

1360. I appreciate that. Is it correct that, when the Whitley Council has sat and a certain problem has been put to it, it has resulted in a rise in wages and salaries of officials?—Yes.

1361. Could we have examples, either at this moment or perhaps you would wish to send them, of rises in the salaries of officials since the Health Service came into being?—I can send them.

1362. That is where rises in salaries have occurred in the administrative posts as well as in the industrial posts?—Yes.

Miss *Ward.*

1363. In fact the problem is that, when the official side comes down, you feel it is representing the view of the Minister as against the employing hospital regional authority?—(Mr. *Elliott.*) I presume so.

Chairman.

1364. I feel in a difficulty about this. Here you are dealing with public money, and I do not see how you could have sitting on the employers' side of the table, if there is to be any discussion at all, anyone but those who are responsible for that money. That must be officials, and I think it must be officials from the Ministry of Health. Is that not so?—Well, Sir, I know the Whitley Council have had this dispute over the central laundry. I feel rather sore about that because I was chairman of the committee which built it. It has been a wonderful show. We had a wonderful morale there because our people always made a lot of money for the county council, and we have a gentleman's agreement now with the county council by which we allow them one-third of our output. We paid nothing for the laundry except outstanding loan charges. It was given to us freely without any argument. It was quite a debatable point as to whether the Minister could take it. We never could get any satisfaction from the Whitley Council. The position became so acute that we had a "go slow" strike.

1365. I think your complaint is directed against the working of the Whitley Council rather than against the constitution?—I am not worried about their constitution, but about the delays. I have been told since that it is the Treasury which imposes the delays, because it does not want to sanction any increases. (Mr. *Braithwaite.*) I think the feeling generally is that the spirit of Whitleyism is directed to negotiation between an employing authority and employees. I think the feeling amongst the boards—and it is a very strong feeling—is that they should have a much larger representation on the management side, but in consultation with the Ministry who could see that the financial implication of any decision was kept within bounds.

Mr. *Diamond.*

1366. How much larger?—At the moment the proportion from memory—it is set out in our evidence—is three regional hospital board members and eight Ministry.

1367. And you would suggest?—I would suggest a complete reversal of that proportion. (Mr. *Elliott.*) I have seen a letter from the Ministry to my colleague, Mr. Messer, in which they are going to pay some attention to that. May I just read this report from our central laundries subcommittee, which says, "The sub-committee recommend in regard to rates of pay of stokers that the Ministry of Health be informed of the dissatisfaction of the stokers at the recent increase given to adult mates, whose rate of pay now exceeds that of the laundry stokers by threepence per hour . . ."—the laundry stokers being superior to the adult mates—". . . and that the Board consider it essential that the rates of pay of all hospital ancillary staff should be dealt with by one body. (The stokers are at present dealt with by the Ancillary Staffs Council whereas the engineering staffs are paid under the rates awarded by the Joint Conciliation Committee of the Heating, Ventilating and domestic Engineering Industry)". We laymen have to wrestle with all these things.

Wing Commander *Geoffrey Cooper.*

1368. Do you have any other form of joint consultation other than through Whitley Councils so that you keep your staff in the hospitals?—Each management committee has a conciliation committee, not on rates of pay but on conditions only.

1369. That is a joint consultative committee?—Yes.

Chairman.

1370. Mr. Elliott, the Sub-Committee are extremely grateful for all the help which you and your colleagues have given. I do not think it will be necessary to trouble you again as we have been fully over your memorandum, but if by any chance we do wish to have any further information from you we will let you know?—May I say that personally I have enjoyed coming here? I hope I have not been too frank, but you have received us with such courtesy and kindness that we felt we must speak frankly whatever happens.

The witnesses withdrew.

Adjourned till Thursday next, at 4 p.m.

THURSDAY, 8TH MARCH, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Thomas Reid.
Mr. Diamond.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mr. E. W. SCORER, O.B.E., Chairman, and Mr. R. W. HOWICK, Secretary, Lincoln (No. 1) Hospital Management Committee, called in and examined.

Chairman.

1371. We are very grateful to you for the memorandum* which you have so kindly prepared to assist us in our consideration of the Hospital Estimates, and I think, before we come to the details of the memorandum, it might be convenient if we were to ask you some general questions?—(Mr. *Scorer.*) Yes, Sir.

1372. I think they may perhaps touch on points you have raised, but they are of a general character. First of all, as regards the area for which you are responsible, have you brought a map with you which would show the Sub-Committee the size of the area?—No, I do not think we have, but we could very soon let you have one if it would help. It is roughly the City of Lincoln in the middle, and it extends north-west for about twenty-one miles to include the town of Gainsborough, which has a population of about 20,000 itself and serves an area with a population of about 35,000, and it goes the other side as far as the little market towns of Horncastle and Woodhall Spa.

1373. Perhaps I can put the question in this way: do you comprise the whole of the City of Lincoln?—Yes.

1374. And the agricultural country all around that city?—A radius from fifteen to twenty miles all round the City of Lincoln.

1375. That would include the town of Gainsborough and a number of other substantial villages?—Yes. Gainsborough itself serves a population of about 35,000 for hospital purposes.

1376. What is the population of Lincoln?—66,000.

1377. Can you tell us whether you feel that is a convenient area for you to manage, or would you have preferred a smaller or a larger area?—I think it is quite as large as is convenient. I do not think there is any other centre to which Gainsborough on the one side and Horncastle on the other side could conveniently be allocated.

1378. This is a convenient catchment area?—Yes, I think you would say it was a convenient catchment area. Would you like to qualify that, Mr. Howick?

Mr. *J. Enoch Powell.*

1379. Are you self-supporting, except obviously for a teaching hospital? Are there any categories of cases for which you are dependent on other hospital group areas for the treatment of your patients?—Yes, there is a radiotherapy centre where they have got a deep therapy X-ray plant for the treatment of cancer, and that is at Scunthorpe which is about thirty miles due north of Lincoln. Of course, for major matters like neuro-surgery or plastic surgery, you have got to go to Sheffield or Derby. You cannot deal with those at a

* Not published.

hospital the size of a county hospital. I think roughly I can put it this way: before the Act came into force the area which we now serve did regard the county hospital at Lincoln as its major hospital.—(Mr. *Howick.*) That is quite correct.

Chairman.

1380. In other words, the position really has not changed very much, as far as you are concerned, by the Act?—(Mr. *Scorer.*) No.

1381. Except that the smaller hospitals have now been directly brought under a single control?—Under the wing of one management committee.

1382. You never thought it necessary to make any representation to the regional board or the Ministry of Health that you would like to change your boundaries at all?—No. (Mr. *Howick.*) No, we have not. (Mr. *Scorer.*) It would be difficult to change them because I do not know to what other major hospital you could allocate either the Gainsborough area or the Hornscastle area.

1383. As regards your committee itself, that consists, I think you tell us, of sixteen members?—Yes.

1384. They are appointed by the regional board after taking advice from various bodies, including yourselves?—Yes.

1385. Can you say whether you think that is a convenient size, or would you like a smaller committee or a larger committee?—Of course large committees are not desirable, but in a case like this the difficulty is that not only have you to cover the geographical area but you have also to cover the various interests. We have two Members from Gainsborough on the management committee, and we have representatives from the Hornscastle side. My view is that it is very important to have local knowledge on the management committee, and that you obtain from people who live in the area of the minor hospitals. You want to cover the whole area geographically, but you also get this difficulty that you have so many interests. You have got doctors, nurses, trade unions and a variety of interests who are consulted by the regional board before they make the appointments. It is not easy to cover the geographical area and also fit in all the representatives of all the different interests. I do not think we could do with a smaller committee. It might be perhaps convenient to ask Mr. Howick what he thinks.

Miss *Ward.*

1386. Do you really mean you would like a larger committee?—(Mr. *Howick.*) No, I would say we would not want a larger committee. I should think that the present size is quite adequate. Members of the committee come from Gainsborough and Hornscastle, and from all round the area. We have naturally to subdivide that committee to deal intimately with the interests of the hospitals outside of Lincoln, so that you must have some representation from the outside areas. The hospitals are not sufficiently near so that, for instance, the management committee could hold their meetings in them; the distances are so great. Twenty-one miles either side of Lincoln is the longest journey, and it is very difficult to get the committee of sixteen members to visit all the hospitals even in turn. It is much better to subdivide that committee.

Chairman.

1387. Into sub-committees?—We have divided them into house committees, of which the chairman is a member of the management committee; and there are at least two members or more of the management committee on each house committee. (Mr. *Scorer.*) You have also got to remember that there are three county councils in Lincolnshire. There is the City of Lincoln. There is the Lindsey County Council which is all the area to the north of Lincoln, and there is the Kesteven County Council which is the area to the south of Lincoln. You have got three local authorities, who all want to have representation on the hospital management committee. You have three executive councils—one for Lincoln, one for Lindsey, and one for Kesteven. You have to take all that into consideration in appointing your members. If you take a place like Leicester where you have got one county borough in the middle of the county, you have only got two local authorities. In some management committees you have only got one local authority and one local executive council to deal with, but in this committee you have three of each.

1388. I think you have really suggested though that there would be no improvement in trying to re-divide the region into areas coterminous with local authority boundaries, as that would lead to chaos for obvious reasons?—Yes. I would say the committee is about the right size.

Mr. *J. Enoch Powell.*

1389. With regard to the grouping of the committee into sub-groups, it does not appear that they correspond exactly with the group house committees. I was a little puzzled by that in your memorandum because, whereas there are special sub-groups for Lincoln, Gainsborough and Horncastle, there does not appear to be one for the Branston Group. Could you say something in explanation of that sub-grouping?—(Mr. *Howick.*) The sub-grouping under administrative officers is not quite same as the sub-grouping for house committees, because there is no administrative officer at Branston—but Branston has its own house committee.

1390. When you say there is no administrative officer, where is the administrative

officer then who corresponds to the Branston Group?—That is taken in in connection with the Lincoln Group.

1391. It is administered with the Lincoln Group, but there are two house committees?—Yes.

Chairman.

1392. You speak of the house committees at the top of page three. You say they have no executive powers, but that it is their duty to take an interest in the welfare of the patients and the staff?—Yes.

1393. Does that mean there are no delegated powers at all which you give to the house committees?—(Mr. *Scorer.*) Very little. The management committee would not be concerned with the appointment of domestic staff, but if it came to the question of the appointment of a matron then that would be done by the hospital management committee, the main committee at Lincoln. It is the duty of the house committee to listen to any troubles there are with regard to the domestic staff. If they want to alter the use of rooms or want any new equipment or anything like that, that all comes before the house committee and then the house committee makes any recommendations—but they have no particular authority to spend any money on their own. Sometimes they do; if it is so very obvious that the thing ought to be done at once, they may be disposed to take the risk and to give instructions for the matter to be dealt with. We have never had any difficulty in that way.

1394. Although they may have no executive powers, they have advisory powers on executive matters?—Yes.

1395. I take it you would normally ask their advice in the first place?—Yes.

1396. You spoke about the junior members of the staff. Do the house committee have any powers to appoint a new maid or new nurses?—As a matter of fact the matron would do that.

1397. She would do that?—Yes.

1398. With their advice?—Yes. If it was thought that additional staff were wanted, then the house committee would make a recommendation to the management committee.

Miss *Ward.*

1399. But replacements would be done by the matron?—Yes.

1400. Who buys the food?—(Mr. *Howick.*) In the smaller hospitals, the matron—those are the hospitals up to fifty beds. In the Lincoln County Hospital we have a domestic supervisor who is responsible for the catering.

1401. Do you control her expenditure or has she got a free hand within certain limits?—No. The domestic supervisor must submit all her requirements first of all to the matron, and the matron submits them to me before they are finally approved. We have no supplies officers in the group.

1402. What I mean is this: do you allocate so much per head per week for the feeding of the patients, or does she send in a weekly or monthly account after she has spent it?—Until recently the Domestic Superior has requisitioned according to her weekly requirements and submitted a monthly report of her expenditure, but now she is given a weekly allocation of money for provisions.

Chairman.

1403. She can spend so much money, and it lies in her discretion whether she spends so much on bread and so much on cake?—That is right.

Mr. *Turton.*

1404. Is that a weekly allocation per patient or per hospital?—The amount is based per hospital.

Wing Commander *Geoffrey Cooper.*

1405. Numbers in hospital may fluctuate, but the money is still given to the hospital?—It is on a per hospital basis. They may be able to save sometimes.

Chairman.

1406. Do you allow a carry forward with that?—Within those estimates, yes.

1407. At some other time there may be fewer patients in the hospital?—Then she effects a saving.

1408. Which she might accumulate till the autumn?—Until there is an increase in the number of patients.

1409. Do you find in fact that at the end of the year there is a deficit or carry over as a rule?—Unfortunately a deficit.

Wing Commander *Geoffrey Cooper.*

1410. In every instance?—On provisions. (Mr. *Scorer.*) That is probably due to the rise in cost. (Mr. *Howick.*) More than anything.

Miss *Ward.*

1411. The scale is not adjusted from time to time when the price of food rises; you prefer to leave it and to deal with it at the end of the year?—We prefer to leave it.

Chairman.

1412. As regards other items of expenditure I imagine that there is really no discretion at all. You give them precise numbers, and the rates of pay in fact are fixed?—They are fixed according to the appropriate salary scales laid down by the Whitley Councils.

1413. Apart from pay and provisions, is there any regular expenditure which lies in their discretion?—I would say, no, apart

from bedding and linen, staff uniforms and hardware and crockery, which are left to the discretion of the Matron, within the estimates.

1414. Can you tell us about the meetings of the management committee itself? How often do you meet?—(Mr. *Scorer.*) Once a month, on the fourth Wednesday in every month.

1415. How many committees have you?—The finance and general purposes committee meet monthly; there is a nursing committee which meets monthly; and each house committee meets monthly. All the reports from the finance and general purposes committee, the nursing committee and the house committees are presented to the monthly meeting of the hospital management committee.

1416. How do you deal with the day-to-day questions?—If it is an administrative matter which is purely routine, Mr. Howick as the secretary would deal with it. If it is something which is not really regarded as being within the scope of his authority to deal with, it would be put on the agenda for the next meeting of the appropriate house committee, the finance and general purposes committee or the management committee.

1417. Do you delegate any of your powers to any of those committees?—The finance committee would take the responsibility of dealing with minor matters. They have done that. I do not think there are any specific terms of delegation to the committees. Those committees are to consider and report, and in some cases they would in fact take the responsibility of initiating work. If it is very obvious that something ought to be done at once, for instance if some piece of the hospital machinery goes wrong, Mr. Howick would take the responsibility of ordering the necessary repairs to be done. There was a large 300-gallon water tank at the top of one of the wards and that was going to fall down, we did not wait for a committee to deal with that. Mr. Howick mentioned it to me, and we said, "That has obviously got to be done; get the appropriate tradesman on the job and get him to deal with it at once". It is no good waiting for a committee to see if the tank is going to fall down; we just did it. (Mr. *Howick.*) I think we can say that as a general rule the management committee authorise all expenditure, with the exception of emergency items.

1418. Emergency items you deal with as best you can, having regard to their character?—Yes.

Mr. *Turton.*

1419. Do the committee confirm that expenditure afterwards?—(Mr. *Scorer.*) Yes, it is reported to the finance committee and the management committee itself at the next meeting. (Mr. *Howick.*) And confirmation is obtained. (Mr. *Scorer.*) We hope they will whitewash us, and they generally do.

Wing Commander *Geoffrey Cooper.*

1420. Could we go to the procedure which is followed by your particular committee when items of expenditure are going to be incurred, maybe for additional equipment for the doctors and furnishings in the nurses' home?—If it was medical equipment it would be considered by the medical staff committee, and they would put forward their recommendation. If it is a question of new furniture or anything like that it would come before the house committee of the management committee in the first instance. Some of us would go and have a look at the matter. It might be some new floor covering was wanted, some new curtains or something like that. Then we should report to the next meeting of the committee that we thought it was desirable.

1421. What happens after that? Do you purchase them from a local shop or do you get tenders?—(Mr. *Howick.*) What happens is that first of all we have a comparative statement from the finance officer, showing what has been spent to date as against estimates, and if there is sufficient to cover the item we call then for three or four prices. In the case of furnishings we go usually to the local firms, that is mainly at the request of the committee that we should deal with a Gainsborough firm in Gainsborough and with a Lincoln firm in Lincoln and so on. We take the lowest price, as a general rule.

1422. How does the system compare with the procedure followed before the Health Service came into existence?—It is very much tighter now than it was before the Health Service came into existence.

1423. Was there no purchasing previously by the local authority through any sort of central purchasing system which they had?—I can only speak from the voluntary hospital point of view on that.

1424. You were in a voluntary hospital before?—Yes.

1425. As what?—Secretary.

1426. Doing a similar job?—Yes.

Chairman.

1427. In the same area?—I was, yes.

Wing Commander *Geoffrey Cooper.*

1428. Is there much difference in your status, responsibilities and salary as laid down by the Ministry of Health?—The position is that I had previously moved from Chichester in Sussex to Reading as an accountant, and then on to Lincoln, and my position then was secretary of the Lincoln County Hospital. My salary on the appointed day was £1,100 per

annum. I am now responsible for the group administratively, and my salary is practically the same.

1429. You are really acting as a sort of purchasing officer to the hospital now?—In the absence of a supplies officer I am nominally the supplies officer, although my deputy in fact deals with the supply side more than I do.

1430. Is that similar to what you did previously? Did you act as purchasing officer before?—Yes.

1431. You are doing that same job still?—Yes, we combine the two.

1432. Have you any additional staff now compared with what you used to have?—Administratively, no. On the financial side, yes. There is a finance officer, and there is an addition of about eight.

Chairman.

1433. When you say "there is an addition of about eight", do you mean to say in addition to the finance officer or in addition to what was there before?—In addition to what there was before at the main hospital, for this reason: some hospitals were controlled by local authorities, and officers were transferred who had hitherto been mainly doing hospital work. We had to take them over, they being necessary to do the work previously dealt with by the local authorities. We have no separate group offices, so that we had to administer both the Lincoln County and the group jointly with the same staff.

1434. Taking the hospitals in the group as a whole, how does the administrative staff now compare in numbers with the administrative staffs that were employed in all the hospitals in the group before the Health Service came into operation?—It has increased, but it is a very difficult question to answer for this reason: we do not know how many people actually in the local authority offices were dealing with the hospital side pre-July 5th, 1948. As far as Lincoln County is concerned the staff remains practically the same. (Mr. *Scorer.*) Some of the voluntary hospitals had no such complete system of accounting as the local authority hospitals had before the take-over. Nor had the voluntary hospitals such a complete system of records of stocks and stores as was necessary, as the local authority hospitals actually had. Therefore we have had to provide an accounting staff to deal with far more hospitals than were dealt with before, and the accounting staff is being increased considerably because some voluntary hospitals had very sketchy accounting systems indeed, and they had no complete system of stocks and stores as was required by the local government order in the local authority hospitals.

Wing Commander *Geoffrey Cooper.*] Mr. Chairman, could we have a note on the actual expenditure which has increased, giving the justifiable reasons why there has been an increase in certain sections, such as stores and so on, as distinct from the possibility that staffs have increased for other reasons which might not be so strong?

Chairman.

1435. Before giving precise particulars could you tell us what is the proportion of local authority hospitals now within the group? If it be only a small proportion I am going to suggest to you that you may perhaps make the comparison excluding the local authority hospitals. I do not know whether that would be helpful. It would avoid that difficulty which vitiates the picture?—(Mr. *Howick.*) There were six local authority hospitals. One, St. George's Hospital, Lincoln, was a former military hospital, and it was not taken over until December, 1948.

Wing Commander *Geoffrey Cooper.*

1436. How many of the other sort?—Six.

Chairman.

1437. If you could kindly supply us in due course with a comparison of what has happened in the best way you can, it would be helpful. I think we shall have to leave it to your discretion. You have the kind of thing we have in mind?—Yes.

Mr. *J. Enoch Powell.*] Nevertheless, in spite of the reasons you give for the inevitability of an increase in staff, you do state as your opinion that economies in staff could be effected. I am referring to page 16 of your memorandum, under the heading "Staff". When you say that have you in mind primarily administrative staff or inferior staff? Could you elaborate on that?

Chairman.

1438. It speaks of anomalies in staffing. Could you indicate what is the nature of those anomalies?—(Mr. *Scorer.*) The only thing I can think of at the moment is the question of the doctors' staffs. They have their medical secretaries. Each doctor likes to have his own medical secretary. The dermatologist says, "I want a secretary who knows all the technical terms of my particular speciality," and when he goes from Lincoln to one of the outlying hospitals he wants to take his secretary with him. Other medical officers say the same. If these doctors could pool their medical secretaries and all the medical secretaries were put into a typists' or secretaries' pool, we think you possibly could do with one or two less. The doctors most strenuously resist any such proposal. The ophthalmic

specialist says, "It is no good giving me a secretary who has been working for a dermatologist, because she just will not understand what I am talking about."

Wing Commander *Geoffrey Cooper.*

1439. How did they manage before? Did they have no secretaries? Did they do it themselves? Is there more secretarial work now?—(Mr. *Howick.*) Yes, because there was practically no records system anywhere in any of the hospitals within two years of the appointed day. The staff of medical secretaries was five at the appointed day; it is now nine. The reason they asked for the additional staff was the fact that consultants are dealing not only with one hospital, but they are also travelling to Gainsborough and Horncastle. They have St. George's Hospital open now, and they wish to take their medical secretaries with them to have a continuity of the note recording and clinical system. They also take their medical secretaries outside the group covered by Lincoln (No. 1) Hospital Management Committee in point of fact. Two of the consultants are taking their medical secretaries to Boston twice a week in the Boston Management Committee area, and they are lost to Lincoln County for two days in each week.

Chairman.

1440. Now you are speaking of consultants who are only part time in your group?—Yes.

1441. And they are doing part time with another group?—Yes.

1442. Do you not stand to score the other way round? Do you not have consultants who use secretaries paid by other groups?—No.

1443. Why not?—We have the main secretarial staff in Lincoln for the consultants. The consultants rather think that they should have what virtually amounts to a secretary each, who should be responsible for all the clinical work of their own departments. The medical secretaries are not purely shorthand-typists. They arrange the clinics; they see that the patients get in to see the consultant; they are at the out-patients' clinics taking notes. All the clinical notes are typewritten. There is a unit system of note recording. That means that when a patient attends a hospital for a first time a record is taken, and the record of that patient is followed up throughout the patient's hospital life.

1444. I do not want to pursue this question unduly because I think it is taking us rather away from the main question, but to sum up I think what you are saying is this: here is an inefficiency in the sense that there is not really quite enough work for these nine secretaries, having regard to what goes on within your group, and that might be improved; and there are probably other smaller inefficiencies if the matter were considered from that angle?—(Mr. *Scorer.*) Yes. I think that, if they pooled their secretaries, they could probably do with one or two less, but it would not make a great saving.

Wing Commander *Geoffrey Cooper.*

1445. In addition do you have ward secretaries to deal with the records of individual patients?—(Mr. *Howick.*) No, Sir. The same secretaries do the whole thing for the in-patients and the out-patients.

1446. Who makes the five copies of the various forms when the patients first arrive?—That is done by the records office, quite separately from the medical secretary.

1447. Is that a new function?—No, that has been going on.

1448. In all hospitals up to now?—Not before the appointed day, no.

1449. What is the number of those?—There was not the same procedure in the local authority hospitals.

1450. What is the total number involved in making these records?—Three.

1451. In each hospital?—No, three centrally. The other staff combine a multitude of jobs. (Mr. *Scorer.*) In some of the small voluntary hospitals they had no complete system of recording at all before the appointed day. Now we have got a system so that, if a patient comes into this hospital and ultimately goes out, and in five years' time he moves to some other part of the country and wants treatment there, then that hospital—it may be in Bedfordshire, Worcestershire or anywhere—can write to Lincoln and say, "Can you give us the hospital history of this patient?". We can supply the hospital history of that patient wherever the patient goes, and the consultant there would have all the benefit of the past records. There was no records system like that at all in some of the small voluntary hospitals.

Chairman.

1452. I do not think we need pursue that. I know of a recent case where a lady had a serious operation, and it was not known afterwards whether she had her appendix out or not. There was a serious case of a lost appendix. That could not occur if full records had been kept?—No, it could not.

Mr. *Turton.*

1453. Coming back to the paragraph in your memorandum, when you talk about the hospital management committee headquarters having certain anomalies, what are the anomalies to which you refer there?—(Mr. *Howick.*) I am referring there to

supplies section. In our group we have no supplies officer. As I said the work is done mainly by my deputy, but I am nominally responsible. A number of hospital groups have quite an elaborate supplies organisation. Auditors come round, and they tell us that certain management committees are undertaking certain records, some of them being quite elaborate. We have a system which was agreed by the auditors, and it is quite effective from the point of view of control. This paragraph was put in in order to suggest that, if a closer watch were kept on supplies staffs especially, it might be possible to reduce some of the rather large staffs that there are. That is talking generally.

Mr. *Diamond.*

1454. You are not talking there about your own group?—No.

1455. You have no evidence of this in your own group?—No.

1456. In your own group you are satisfied that you are not overstaffed or catering for an excessively elaborate system?—Yes, very definitely. We compare very unfavourably for staff with some of the other groups.

Chairman.

1457. You have fewer staff?—We have fewer staff, and we are trying to reduce more. (Mr. *Scorer.*) I think "favourable" is the proper word. (Mr. *Howick.*) We were asked to give any suggestions which might lead to economy in the Hospital Service, which we took to mean generally.

Mr. *Diamond.*

1458. Do I gather that your own scale of responsibility has increased as compared with before the appointed day, whereas your own scale of salary has not increased?—Very definitely. My responsibilities I should think are over double what they were before.

Chairman.

1459. I do not want to pursue the question of staff now as we must discuss the question of establishment later on. To come back to this question of the size of the management committee, it might be convenient in this connection to ask you about medical representation on the committee. How many members of the medical profession are included?—(Mr. *Scorer.*) Five.

1460. Do you find that adequate?—Yes. We have two consultant surgeons, one consultant physician, one chest surgeon and one general practitioner.

1461. They are all working within your group?—Yes.

1462. They are employees of your regional board?—Yes.

1463. Do you find that satisfactory?—Yes.

1464. Do they ever speak from the point of view of their professional interest, or do they speak merely on their professional knowledge?—I would say they give us a great deal of advice from their professional knowledge. I have never found any case in which anyone of them has allowed his professional financial interest to conflict with his duty as a member of the committee in any shape or form.

1465. You spoke just now of the consultants' secretaries?—Yes.

1466. When that question comes up, as no doubt it does, do you find that they take rather a strong point of view?—They take a very strong point of view that each of them should have his own secretary.

1467. That is a professional interest?—Yes.

1468. Do you go outside your immediate medical representation and ask some medical organisation?—There is a group medical committee which consists of all the—who is on that committee, Mr. Howick? (Mr. *Howick.*) Staff above the rank of junior hospital medical officer. That group medical committee meets monthly, and any medical matter is generally referred to them for their observations.

1469. When you say "referred to them", they are not a committee of your management committee in any sense?—(Mr. *Scorer.*) No.

1470. They are quite independent?—They are quite independent.

1471. But you send matters on to them for their comments?—Yes. (Mr. *Howick*) As it happens I am the secretary of the group medical committee as well as secretary of the management committee. It was a position I was asked to take over by the medical staff themselves, because I was the former honorary secretary of the former sub-committee in Lincoln County Hospital. That association is most useful because it does tend to help stop some requests which would otherwise go to the management committee, and it does help to stop some expenditure.

1472. Are you the honorary secretary?—Yes, it is very useful indeed.

Mr. *Diamond.*

1473. Is there any body which brings opposite pressure to the consultants, and suggests to you that it is perhaps not necessary for every consultant to have a separate secretary?—What happened is that this matter was dealt with by the finance and general purposes committee. They invited a deputation from the consultants to attend the committee and give their reasons why they wanted their medical secretaries to be with them. The finance and general purposes committee decided, after hearing the evidence, to let things stay

as they were for the time being, but a request was put in for an additional clerk to do work in connection with the financial part in the dispensary and also work in the physiotherapy department. The general purposes committee have decided that, as there is a vacancy on the medical secretarial staff, not to fill it with a medical secretary but to fill it with a person who deals with those two departments, thus reducing the number of secretaries by one.

Chairman.

1474. Could you define for us in any way the responsibilities of the management committee? Your general duties, of course, are to manage the hospitals, but you are not given *carte blanche*?—No, we are not.

1475. Can you tell us whether your actual responsibilities have been precisely defined or, if not, what do you conceive them to be?—(Mr. *Scorer.*) No, I do not think they have ever been precisely defined. The provisions in the Act are in very general terms, but no hard and fast rule has been laid down as to precisely what a management committee could do, except so far as it is controlled for finance. A hospital management committee appoints a matron of a hospital; that is not a matter for the region; that is left to the hospital management committee. But the total number of staff is fixed by the regional board, and if you say you want additional clerical staff or additional staff for other purposes, you have got to go to the regional board and get the approval of the regional board before you can appoint additional staff.

Mr. *J. Enoch Powell.*

1476. When you say "fixed by the regional board", you mean that increases in it over what it was on the appointed day are subject to the approval of the regional board?—Yes.

1477. You do not, I take it, mean that the regional board can revise your establishments as they were at the appointed day?—(Mr. *Howick.*) No, only for medical house officers.

1478. They are appointed by the regional board?—No, by the management committee below the rank of senior hospital medical officer.

Chairman.

1479. Suppose you have twenty nurses in one hospital. If you wanted to have twenty-two, you would have to ask the regional board?—Yes.

1480. Would it be, or has it ever been done, that the regional board could tell you "in future you are only to employ eighteen"?—It has not happened so far.

Mr. *Thomas Reid.*

1481. Have the regional board any power so to tell you to reduce your staff?—(Mr. *Scorer.*) The point has never arisen. I suppose they ultimately have got control, and they could say "We are going to reduce your finances". They could do it that way. They have got the power of the purse. If we wanted to have a physiotherapist or if we wanted any additional staff of that kind, then we have got to go to the regional board and get their approval.

Mr. *Diamond.*

1482. Apart from the question of additional staff, has there been any consultation between your committee and the regional board, or any specific instruction to you, about reducing the existing number of staff of any category?—(Mr. *Howick.*) No, Sir.

1483. And no recommendations?—No. (Mr. *Scorer.*) The point has never arisen.

Chairman.

1484. I think it might be convenient if we now dealt generally with the question of establishments. Have you had anything laid down for you by the Ministry of Health as regards the size of establishments?—(Mr. *Howick.*) No, Sir.

Mr. *Diamond.*

1485. As regards the minimum size?—No.

1486. Have you ever had it suggested strongly to you, or have you ever in fact been compelled by the Ministry of Health, to appoint people whom you otherwise would not wish to appoint?—I should say, no, except—are you referring to staff necessary to deal with statistics and the cost accounting system?

1487. Any staff whom you would not think it wise or necessary to appoint, but whom you have been compelled to appoint against your better judgment?—I would say, no.

Chairman.

1488. I think there was a circular suggesting the appointment of dietitians?—(Mr. *Scorer.*) Yes.

1489. Had you a dietitian?—(Mr. *Howick.*) No, Sir, and we have not appointed one.

1490. You have ignored that circular?—Yes.

1491. Within your discretion?—Yes. We have a perfectly good catering system as it is.

Mr. *J. Enoch Powell.*

1492. The same applies to the stores officer?—Yes.

Chairman.

1493. You feel that yours is a special case. When you make up your mind that you are going to depart from an edict from on high, do you inform anyone of

your intention so to do?—No, Sir, we have not done. I take it they are merely recommendations that it might be wise to consider the appointment of such staff. (Mr. *Scorer.*) We think we arrive at the same ultimate result with the staff we have got.

Mr. *Diamond.*

1494. Thereby exercising economy?—Yes.

Mr. *Thomas Reid.*

1495. Has your staff been greatly increased since the Health Service came into being?—Yes, for accounting purposes, for stocks and stores purposes, and for hospital records purposes.

1496. All the staff you now have are necessary?—Yes. (Mr. *Howick.*) Very necessary.

1497. The work has increased greatly since the Health Service came in?—Yes, very much.

Chairman.

1498. Have you ever had any instructions from the regional board or from the Ministry of Health as to anything that you are not to do? Have they set any limits on your control of the hospitals within your area?—I cannot think of any at the moment.

1499. Except for the limitation on increasing staff?—That is all.

Mr. *J. Enoch Powell.*

1500. In producing your yearly estimates for the approval of the regional board, on the three occasions so far have they always accepted the sums which you have put forward under the different heads or have they enforced a revision in one or more cases?—They have enforced a revision when the officers attended at the Finance Committee of the Regional Hospital Board.

1501. Although you may have had a shrewd idea of what you could and could not get away with, in fact whatever you have put forward through the regional board to the Ministry of Health has been approved?—No, Sir. The position has been this: the management committee have submitted their estimates; representatives have attended before the finance committee of the regional board, and as a result the most we were cut on the estimates for 1951-52 was £500 on one hospital. On the estimates for the year 1950-51 there was a cut of approximately £4,000 on the total estimate, but there have been cuts afterwards without any reference to the management committee whatsoever.

1502. Those you gather have been made by the Ministry of Health rather than by the regional board?—I would not be absolutely certain, but I should imagine the Ministry of Health have told the regional board to cut by a certain sum its estimates, and that cut has been spread over the individual management committees.

Chairman.] I do not want to go on to estimates as such now. I think we shall have to deal with them separately, but I do not want to interrupt you.

Mr. *J. Enoch Powell.*] Yes, very well.

Chairman.

1503. I think it might be convenient here to ask you this question, Mr. Scorer. I think you are yourself a member of the regional board?—(Mr. *Scorer.*) Yes.

1504. You attend, therefore, the monthly meetings of the regional board?—Yes.

1505. Does that help you in the exercise of your duty?—Yes.

1506. You know in advance what the policy of the regional board is?—Yes, and it enables me to bring matters before and explain things to the regional board, which possibly would not get dealt with if someone from the management committee was not there.

1507. Could you say what sort of things?—Questions of additions to buildings and questions relating to staff.

1508. What sort of questions relating to staff?—The medical staff. Being on the regional board enables one to know what is in the minds of the regional board. The regional board has two hundred hospitals to look after. There are thirty-five people on the regional board, and those thirty-five are spread over the five counties—South Yorkshire, Derbyshire, Nottinghamshire, Leicestershire and Lincolnshire. It is quite clear that the only hospitals about which any individual member of the board knows anything are really the hospitals in his own immediate locality where he lives. The result is that members of the regional board as such are dealing with hospitals which they have never seen; they do not know the personnel. When they are dealing with matters relating to any particular hospital, whether an additional wing is wanted or a new out-patients' department is wanted, whether something should be closed and so on, the members of the regional board are in fact dealing with hospitals which very largely they have never seen. Therefore, if there is no one from a management committee actually as a member of a regional board, the only liaison between a management committee and the regional board is through some officer of the regional board.

1509. The regional board only deals with hospitals in the sense of general planning control, does it not?—Well, that is the theory, but there is no hard and fast rule laid down as to how far the control of hospitals by the regional board should go. When we were first formed the idea was

that the management committee was going to have a lump sum placed at its disposal which it would be able to spend as it thought fit, but owing to the financial control you cannot adapt a house for patients or staff without the approval of the regional board. For instance, there was a block of buildings, a former isolation hospital, which it was proposed to use for tuberculosis. We did put proposals forward for adapting that isolation hospital.

1510. Thus involving capital expenditure?—Thus involving capital expenditure. It takes a very long time to get anything done, and this has been hanging fire for a very long time.

Miss *Ward.*

1511. For how long?—Ultimately, as we could not get accommodation for the nursing staff and as there was a modern block of buildings being used for patients, we decided it would be better to use half of this block for staff and half for patients than to do nothing at all, and so we adapted half the block for the nursing staff and half for the patients.

Chairman.

1512. That is without capital expenditure?—Yes.

1513. Therefore the position is that, if no capital expenditure is involved, you have got pretty free control of your buildings and so on?—(Mr. *Howick.*) No, we have not. All plans have to be submitted to the regional board.

1514. Plans of what nature?—Plans of alterations, extensions or adaptations of buildings.

1515. Even where there is no capital expenditure involved?—Even where there is no capital expenditure involved.

1516. Suppose you wish to switch a ward in the Lincoln Hospital over from general surgical to medical cases?—Then we do it.

1517. Where is the dividing line?—That does not involve any alteration in structure.

1518. That is what I say: alterations in structure are of a capital character?—Yes, but if a ward had to be altered, say for additional sluice accommodation or clinical rooms added to take in a different type or kind of patient, then reference would have to be made to the regional board.

Miss *Ward.*

1519. Has regional board control increased since the appointed day?—I would say, yes.

Mr. *Diamond.*

1520. Could you help me a little more with the distinction between adaptation and capital expenditure? I gather from what you have said that there were cases of adaptation which did not involve capital expenditure but the adaptations had to be approved by the regional board, although if there had been no capital expenditure, as I understood it, the adaptation would not have to be approved by the regional board?—May I give the illustration of the hospital which Mr. Scorer mentioned, Foxby Hill Hospital? The hospital itself has a very modern ward divided into two portions, one a ward containing ten beds and in the other half additional cubicles. There are eight cubicles. Now the nurses' accommodation is in a very dilapidated looking building. The floors in one section were rotten, and it was damp. The management committee submitted plans to the regional board on the 1st March, 1950, to alter the building, to make it waterproof and to make it more habitable. Those plans have just been approved by the regional board, but the work is still not authorised. In the meantime the management committee decided to block off completely the modern ward section from the cubicles, and to put in the ward section ten tuberculosis patients; and the nursing staff actually use the cubicles for living accommodation.

1521. What materials did you use to block off the ward?—We used any materials we could find and obtain.

1522. In your accounts that would not come under the heading of capital expenditure?—No.

1523. Under what head would it come?—Maintenance. We badly needed the accommodation for tuberculosis male patients.

Mr. *J. Enoch Powell.*

1524. When you said in your description of the process that it was only now the plans had been approved by the regional board, do I gather that this capital proposal was not included in your annual capital budget but was an afterthought which had to be dealt with separately?—No, Sir, it was included in our annual budget, in the first one we did.

1525. But it was rejected?—Yes. The regional board determine which capital schemes shall be done within the region, and they allocate so much to each hospital budget; and the regional board determine which schemes within that allocation should be carried out, in other words they determine the priority.

Mr. *Diamond.*

1526. If adaptations of the kind to which you referred have to come within the compass of the head "Maintenance," I take it what you can spend in money is quite limited?—Yes, it is very small.

Chairman.

1527. It might be convenient now to go on to the question of estimates, if that suits the Sub-Committee. Mr. Scorer, can you tell us exactly how your estimates are made up? I think you tell us you begin in January, is that right?—(Mr. *Scorer.*) In September.

1528. When you were making up your estimates for the year which will begin on 1st April, you began to put together your estimates sooner than September last presumably?—(Mr. *Howick.*) Yes. What happens is that we start to get our estimates together about three or possibly four months before the time they are required to be actually prepared. We ask each house committee to go into all the requirements of each hospital in detail, and to put them in order of priority.

1529. There are two kinds, of course. There are improvements which involve capital expenditure in the ordinary way, and maintenance which is revenue expenditure?—Yes.

1530. You ask them to send in both together?—Yes.

1531. Of course, if you get extra capital expenditure, it will show a maintenance increase in the ordinary way on revenue expenditure?—Yes, sometimes.

1532. When do you begin to do that?—We begin about three or four months before the month in which the estimates are required, that is September, and so we would actually begin about July.

1533. What sort of instructions do you give your house committees, that they are to have regard to what is desirable in the abstract, desirable having regard to what seems probable or what?—We ask them to put requirements in order of priority, that is essential items which must be carried out, replacements which must be carried out, and then other items which are not so urgent and could wait possibly a year or longer.

1534. When did those estimates come in from the house committees last year?—They came in during August. They were completed in August, and they went to the August meeting of the general purposes committee.

1535. Were they approved by the general purposes committee then and there, or were they sent back?—No, they were approved then and there.

1536. What was the total amount?—I have the estimates here. That is the total amount for the group as a whole?

1537. The total amount for the group as a whole?—The estimates for 1951-52 show a total expenditure of £483,400 gross.

1538. That being the total of the amounts which came into you from your house committees?—Not necessarily. That includes, of course, all salaries and wages; every item.

1539. It includes the central expenses?—Yes the expenses of Central administration.

1540. What did you do with that after it was approved?—That then was submitted to the finance and establishment committee, it then went to the full management committee, and then it was submitted to the Sheffield Regional Board.

1541. That was submitted in September?—That was submitted in September.

1542. Have you heard anything further about those estimates yet?—We attended a meeting of the finance committee of the regional board in October last, and we have not heard anything more from them.

1543. When you say you attended, they went through the estimates?—Yes, they went through the estimates with representatives from our management committee.

1544. Did they query any particular items?—Yes, quite a number.

1545. Did you agree to any reductions or increases?—That was the occasion when there was a reduction of £500 on one item only. (Mr. *Scorer.*) They asked a lot of questions, like "Why have you put in this?", "What is the necessity for that?". Our answers were apparently satisfactory, and they said, "Do you not think you can reduce this particular item by £500?", and we said, "Well, all right, we will try to reduce that", but apart from that one item there was no reduction at all.

1546. Those are the items under the headings, I think—that is right, is it not?—Yes.

1547. There are nine headings?—Eight headings.

1548. Eight headings, and capital expenditure?—Yes.

1549. Is the summary you have given us inclusive of capital expenditure?—No, Sir.

1550. What was your capital estimate?—We have not submitted an item of capital expenditure for this coming year. The reason is that the regional board have had a list of all the outstanding capital items prior to this, and we could not submit any more—or we did not submit any more.

Mr. *Thomas Reid.*

1551. To go back to the beginning when you are making up your estimates, what technical officer or person frames those estimates? Suppose you wanted an extension to a building or a new building, who actually drafts the estimate technically—it requires an engineer, an architect or someone like that?—(Mr. *Howick.*) The architect has previously been consulted, the architect who gives advice to the management committee.

Mr. *Diamond.*

1552. If I may go back further than that, when you get in your estimates from your house committees you discuss them on your group management committee?—Yes.

1553. Are any special representatives of the house committees present?—No, Sir.

1554. But when you have your estimates discussed by the regional board you yourself, the finance officer and your chairman are present at the discussions of the finance committee of the regional board?—Yes.

Mr. *Turton.*

1555. Is the chairman present, as he appears to be a member of the regional board?—(Mr. *Scorer.*) Yes, but I go to that meeting in my capacity as chairman of the management committee.

Chairman.

1556. And you take your staff with you?—I go with Mr. Howick and the Finance Officer.

Mr. *Diamond.*

1557. Are you a member of the finance committee of the regional board?—No.

1558. Before the house committees have submitted their estimates to your management committee, have any discussions taken place at officer level in any sense?—(Mr. *Howick.*) In all cases.

1559. At what level is the discussion?—In the larger hospitals, with the heads of departments. (Mr. *Scorer.*) We consult the surgeons, the physiotherapists and the matrons and we would find out whether any additional equipment is required in the kitchens or in the wards, whether there are any large sums needed for repairs or anything like that. There is the fullest possible consultation with all the appropriate officers of the hospitals, and all the doctors have an opportunity of expressing any opinions.

1560. That is before the estimates are submitted to your management committee?—(Mr. *Howick.*) Yes, in the course of preparation of the estimates.

1561. When they are submitted do they represent a fair measure of agreement?—Very definitely. (Mr. *Scorer.*) If the matron or someone were to say "The lighting of the physiotherapy department is wrong and I want something altered", we would ask the architect what would be the approximate cost of doing the job, and then we should get the architect's advice as to what sum to put in the estimates.

1562. If any member of the general purposes committee of your management committee, which I gather considers these estimates in detail, requires to ask the sort of questions which you get asked about your estimates when you appear before the finance committee of the regional board, I take it that you, as Secretary, are there to answer questions or you as Chairman?—Yes.

Mr. *Thomas Reid.*

1563. Finally, when you come to the stage of building, do you let out this work on contract?—(Mr. *Howick.*) It is let out on contract.

Mr. *Diamond.*

1564. You do not let it out; you have no responsibility at all?—We have no responsibility at all.

Wing Commander *Geoffrey Cooper.*

1565. When you are going over their estimates that is presumably the chief time when you make your close contacts with the various officials, the specialists, the doctors, the matrons and the people in charge of the domestic staff, what is their general attitude towards the Health Service in making up their estimates, because that is obviously a factor which will make a difference? Are they thinking in terms of putting in a figure which will be on the high side, to be cut down a bit?—(Mr. *Scorer.*) No, I do not think so. I think they realise it is no good asking for too much, and they put in their requests with real moderation.

1566. Do you find that, in the course of the period over which the money is to be spent, if they have estimated in excess of the actual money they are able to spend, they then start thinking in terms of ways and means of spending money additional to what was estimated?—(Mr. *Howick.*) That has really to do with the question of carry over or non-carry over.

1567. When you say that do you mean it is a very material factor, or is it something which is rather seized on by people who order beyond what is justified?—I hope I am not going off the point here, but the position is that the finance officer has been in the habit of producing to the house committees a monthly statement of expenditure to date as compared with the estimates.

1568. That is something new since the vesting date?—Yes. It shows that you have so much left to spend on the various heads of expenditure. Unfortunately he is always a month in arrear, and the amount has to be estimated within as close a measure as he can of what his commitments are. The matrons, with all due respect to them, do think that, if there is a certain sum of money left, they can spend it. Especially towards the end of the financial year, if there is a sum of money left they think, "We did put in our estimates for so-and-so, and so-and-so, and so-and-so. Whether we want them urgently or not we ought to get them so that we shall not lose the money".

1569. You think that is a material factor?—I think it has an effect on the matrons, especially of these small units, asking for

these items of equipment which, although they may not be urgent at the moment, would be required during the following months, and the tendency is for them to ask the committee to approve expenditure within those estimates on items which probably, if they knew it did not matter whether they spend the money now or next year, they might possibly make do with for a few months longer.

1570. That is very descriptive. Do you mean that, even if a carry forward was permitted, the effect over a period of time would be the same, and that, even if they carried out economies for a short period, later on they would absorb the accumulated funds in just the same way as now, although it would be over a longer period instead of a shorter one?—Quite possibly. It is rather difficult to answer that.

1571. Do you really think that, if a carry over was permitted, it would have the effect of economies being obtained in the Health Service over a period of years? —I do.

Wing Commander *Geoffrey Cooper.*] On what basis, because if you accumulate your funds you are still going to spend them? You will not relinquish a portion of them to the Ministry of Health.

Chairman.

1572. I think Mr. Howick is suggesting that it might not be an absolute economy in money, but it would mean a more efficient expenditure of money. As I understand it, that is the gist of his reply?—May I just illustrate the position by one item, uniform materials? Matrons have had stocks of uniform materials, and unfortunately one or two of them have not ordered uniform material, especially during the last two years, because they had stocks in hand. They now find that the delivery period is long, and their stock has practically gone. There are estimates in for the material, but owing to the long delivery period it may not come in during the current year. If the material is not received during this present financial year, although we have got estimated requirements in for next year, the uniform material delivered next year will be in respect of this current year's financial estimates.

Mr. *J. Enoch Powell.*

1573. Could we follow on from what has happened since last September, which is the date I understand when you sent in your estimates for the year 1951-52—is that so?—Yes.

1574. You have not heard yet whether they have been approved or what modifications may be made in them?—No.

1575. In your memorandum, towards the bottom of page 12, you say, "Approval to the estimates from the Ministry of Health is not obtained until nine or ten months of the financial year concerned". I do not quite understand what that means. Does that mean you do not get approval of the estimates which you prepared in August until nine or ten months after that August, or until the year 1951-52 is already nine months gone?—We did not receive approval of the 1950-51 estimates until the year 1950-51 was nine months gone. We actually received it on the 31st January this year.

1576. You have had approval of the estimates?—For the year 1950-51, ending 31st March, 1951.

Chairman.

1577. You will not get your current estimates approved, if it follows last year's policy, until January, 1952?—Yes.

Mr. *J. Enoch Powell.*

1578. On the other hand, the fact that they are approved or otherwise must presumably be known?—No, Sir. We simply assume that they will have been approved.

1579. Do you have unpleasant surprises? —No.

Mr. *Diamond.*

1580. Do you have money to spend for those nine months?—(Mr. *Scorer.*) The difficulty is that you do not know until nine months of the financial year have gone whether your estimates are approved or not. When about nine or ten months of the year have gone, you are then told that your estimate is approved.

Wing Commander *Geoffrey Cooper.*

1581. If you suddenly found it was cut, and cut down considerably, you would be in a difficult position?—Yes. The result is that at the end of the financial year you get a lot of estimates approved, and you cannot actually spend the money because the time for delivery does not permit you to do it. There are only two months left in the financial year and you then suddenly find you can spend some money, but you have got to get it spent in that financial year because, if you do not spend it in that financial year, there is no carry over and you have lost it.

Chairman.

1582. You are subjected to very severe temptation?—Yes.

Mr. *J. Enoch Powell.*

1583. Have you then been deliberately underspending on your estimates in the first nine months, just in case?—(Mr. *Howick.*) May I give you this illustration? At a school for children at Branston—it is virtually an open air school—three stoves in there were almost beyond repair. The stack pipes were coming away from the roof, and they were a danger. That was put in the estimates as an extraordinary item.

Chairman.

1584. Of capital expenditure?—No, an extraordinary revenue item, a replacement. The trouble was that approval of the estimates was not known until the end of January of this year. By sheer good fortune we managed to get stoves before the end of this financial year.

Mr. *J. Enoch Powell.*

1585. During the first nine months of the current year you only allow yourselves to spend money on your normal revenue expenditure?—And on emergency items.

1586. How do you proceed in regard to capital expenditure?—We have no control over capital expenditure at all.

Mr. *Diamond.*

1587. On what basis do you get your money? Are you given a large sum of money once a year or what?—No, monthly from the regional board.

1588. Does that not give you any indication of the amount you are likely to be able to spend?—It is a reimbursement.*

Chairman.

1589. It is a repayment of actual expenditure?—Yes, it is an advance.

Mr. *Diamond.*

1590. For the first nine months every payment you make each month is reimbursed in full by the regional board?—Yes.

Chairman.

1591. I do not want to deal with the question of beds now, but no doubt you have in some hospitals a number of unstaffed beds. Is that so?—Very few.

1592. Perhaps I can take this example. Maybe you can think of others and better ones. Suppose you want very much indeed to staff those beds, there is an urgent need for them, but to do so would involve additional expenditure, on nurses, on domestic staff, on maintenance and everything else. When you are making your estimates do you put in something on the basis that you will be able to staff those beds, or do you assume that you will not be staffing any more beds than are at the moment when making the estimate staffed?—May I illustrate that by the case of St. George's Hospital, Lincoln, which was opened in October, 1950? (Mr. *Scorer.*) It was a military hospital. (Mr. *Howick.*) We based our estimates for staff on the assumption that we should open actually in July, which was earlier than when we did open, but if we require now to open an additional ward we could not do that without a supplementary estimate being approved by the regional board or by the Ministry of Health.

1593. You in fact opened that hospital, or part of it, without having the estimate approved at all?—Yes, that is what it amounts to.

1594. You simply took a chance on it?—We did.

1595. Did you ask the regional board?—We did, yes.

1596. They said "Go ahead"?—"Go ahead".

Mr. *Diamond.*

1597. They refunded your money at the end of the month?—(Mr. *Scorer.*) The chairman of the regional board came and opened the hospital.

Chairman.

1598. That was a rather special case?—Yes.

1599. In addition there must be what you might call normal development. It is quite obvious you are very seriously short of beds and accommodation in the group?—(Mr. *Howick.*) We are.

1600. Do you allow for normal development when sending in your estimates?—Yes, we do, when we think there is a possibility of a hospital having more patients.

1601. On what do you base that, the expectation of the staff you will in fact be able to find or what?—Yes, we do.

1602. In other words, you go ahead as far and as fast as you possibly can?—We think we can open so many beds, and we base our estimate of the number of staff required for those beds and no more. Our target is fixed, to open those beds on a certain date if possible.

1603. When you are looking at your target, is it higher than the one to which you think your ammunition will carry?—No, it is only in relation to what we think we can open, the number of beds.

1604. Having regard to what you can possibly get in the way of staff?—Yes. (Mr. *Scorer.*) In the first year that we occupied St. George's Hospital we opened four wards. We have had a long series of discussions with the region as to what type of patient should next be accommodated in that hospital. The orthopædic surgeon says he wants so many beds for orthopædic cases. The dermatologist says he wants some beds for his patients. The acute medical physician says he wants more accommodation for his. The pædiatrician says, "I have got all these children's cases; I want some beds". The E.N.T. people have a waiting list of one thousand who want their tonsils and adenoids removed, and they want beds

* *Note by witness:* This used to be a reimbursement but the system has changed, and it is now an advance for one month's estimated expenditure.

for them. Ultimately, after a long series of discussions, we got the senior administrative medical officer of the board to come down, and we have discussed it with him. We have provisionally agreed upon what type of patient shall be next accommodated in the hospital, and then we have got to see the matron and say, "We are hoping during the next financial year to open four more wards for certain patients. Can you provide the staff?" The matron says, "All right, if you tell me how many you want, I will see whether I can build up the staff to staff those additional wards."

1605. What do you take that as being worth? She may get them or she may not. You are making an estimate here?—Yes. We estimate what amount of money we shall want on capital expenditure to open four wards, what requirements are needed, what equipment will be needed, what staff will be needed and will there be accommodation for that staff, and then we have got to put in the estimate all that capital expenditure and an amount for the revenue expenditure required for the maintenance of those four wards. That is what we put into this year's estimates, but they have not yet been approved.

Miss *Ward.*

1606. Suppose, just for example's sake, that in doing all that you over-estimated, and then your estimates were accepted in total. You would then have a balance of money in hand, would you not?—Yes.

1607. Then what would happen to that balance?—If it was not spent by 31st March we should never see the balance again. It would go, and it would be lost to us.

1608. In effect, to safeguard the year's position, the tendency would be to over-estimate?—No, we do not over-estimate.

1609. If you felt you required additional beds and the matron said she could in fact staff the additional beds which were necessary, you would not be quite certain in fact whether she could get the staff and you might in fact over-estimate really?—Yes. We might then in fact over-estimate, and that might be the position for six months. We might say we will have another eighty patients in this hospital, and we would estimate for the staff required for them, but if we did not for six months have those eighty patients in the hospital then we have clearly over-estimated.

Wing Commander *Geoffrey Cooper.*

1610. In view of the fact that Mr. Howick has had experience in hospital work of a similar nature to that which he is now doing, could he say if the attitude in preparing estimates now, in view of the fact that the country is responsible for the finances of the hospitals, is expressed by a tendency to step up requirements and to be a little lavish in making requests compared with the time when the hospitals were run by voluntary subscription or by local authorities?—(Mr. *Howick.*) May I answer in this way? The smaller hospitals especially were in a very bad state of repair. The equipment was very poor in the majority of cases. The matrons, who were the chief officers in the hospitals, had to "make, do and mend" on account of the lack of financial means. When they knew that the Health Service had come into being and that management committees were taking over they naturally wanted their hospitals to be brought up to standard, and the management committees wanted to bring them up to standard. Therefore more money had to be spent on repairs to fabric, furnishings and equipment. During the last year requests have fallen considerably. I think I can say that most of the matrons especially, and they are the people directly concerned with the nursing side of hospitals, have co-operated very well indeed in the main in trying to effect all the economies possible. Of course there still is that tendency to think, "Oh, well, the State will provide".

1611. I see the point you make with regard to the attitude, but what is the position concerning actual items of expense? Have they tended to increase, I mean not only the physical matters but also personnel? Perhaps I can make my question more clear by an illustration. Is this the sort of thing which is occurring? Before the take-over a matron or a housekeeper might have been responsible for engaging staff and therefore, because funds were limited, staff was kept to an absolute minimum, whereas now is there a tendency to say, "A certain type of establishment has been laid down. We have a kind of personnel officer to engage staff, and we are entitled to additional domestic, kitchen and other staff"?—As far as our group is concerned we have made no changes in procedure at all, and we have appointed no additional staff in that way.

1612. There has been no request from the small hospitals which may have been understaffed in wards or in other work as compared with similar hospitals. There has been no tendency to put that sort of thing right?—No. We have tried to carry on the hospitals more or less in the same way, and with the same staff as far as possible.

1613. What would you say your total staff increase has been over the whole area, administratively—we did touch on that earlier?—May we get those figures out for next week?

Wing Commander *Geoffrey Cooper.*] Yes.

Chairman.

1614. To sum up what you have just said, would this be fair: with regard to a number of hospitals in the group, if not all of them, after the war and having regard to

the falling off in your other sources of revenue, there was a great deal of arrears to be made up?—Very definitely.

1615. Apart from the fact that there has always been a shortage of beds and hospital facilities in your particular area you find there is a great desire not to waste money, but at the same time there is a very natural desire to extend the Service in order to meet the tremendous demand which in fact exists for it?—Yes.

1616. That, I think, is what you really said in answer to Wing Commander Cooper?—Yes.

Mr. *Thomas Reid.*

1617. That is as regards your attitude, but what is the position in regard to the public attitude? Are they using these hospitals unnecessarily, thereby causing you much greater expense? Are they attending the hospitals when they could be treated easily at home by their own doctor for minor troubles?—(Mr. *Scorer.*) No. I do not think you could possibly say that, because the admission of patients into hospitals is in the hands of the particular consultant, and the particular consultant knows which are the most urgent cases. For instance, the consultant surgeon may say, "I know this gentleman has been waiting eighteen months to enter the hospital for an operation for hernia. If he goes carefully I think he will be all right for another six months. I have another case which I know is more urgent, and I will therefore have the most urgent case admitted". I do not think there is any possibility of people, who do not actually need hospital treatment, getting into hospital.

1618. The allegation is frequently made that hospital beds are occupied by people who need not be there, and so the really urgent cases are kept out?—No, that is not so.

Mr. *J. Enoch Powell.*

1619. However you do say on page seven of your memorandum, "There is a tendency on the part of the general practitioners to refer patients to the hospitals for the treatment of minor medical and surgical conditions which could be and were formerly treated in their own surgeries"?—That is referring to out-patients.

Wing Commander *Geoffrey Cooper.*

1620. If you were to get out figures for the running of hospitals prior to the commencement of the Health Service and you compared them with the estimates you are now sending in to the Ministry of Health, the latter would presumably show quite a substantial increase?—Yes.

1621. In your opinion would that increase be due to additional essential facilities to the public in the main, or would it be due to some additional expenses which the hospitals have had either imposed upon them or suggested to them by the Ministry of Health under the new organisation?—No, I should say mainly the former. (Mr. *Howick.*) It is difficult for me to answer that. May I try to get you some comparisons?

1622. Could you get the figures for previous to the commencement of the Health Service and compare them with your present estimates?—I will try. It may not be easy, but I will for some of the hospitals.

Wing Commander *Geoffrey Cooper.*] I do recall your main point that in some measure the repair work was very much in arrears and that some of the hospitals were not of such a high standard, very often because they had no money, and thus that would impose some additional expense. Possibly you could indicate the additional expenditure which is related directly to additional facilities and services given to the public.

Chairman.

1623. I think, Wing Commander Cooper, you have to draw inferences from the financial position. As we have gravitated towards the question of beddage and the waiting list we might possibly say a word about that before we finish this evening. Can you tell us, first of all, the total number of beds, staffed and unstaffed, available within your group?—If I may give you an all-round figure, the total number is approximately 800.

1624. That is including unstaffed beds, is it?—No, that is excluding them.

Miss *Ward.*

1625. The eight hundred are staffed beds?—(Mr. *Scorer.*) We have no vacant beds which are not staffed.

Chairman.

1626. You have enough staff to man, or perhaps I should say "to woman", all your beds?—(Mr. *Howick.*) The total bed complement of the group is 969.

1627. Of those about eight hundred are actually staffed, is that right?—I should say, yes, seven to eight hundred.

1628. Then you have about 169 unstaffed beds?—The figures showed a total bed complement, as at 31st December, 1950, of 969 for the group. Unavailable beds, closed due to lack of staff or temporarily closed for other reasons, totalled 426, and of those fifty were infectious diseases beds.

1629. That is of the closed ones?—Yes. They are unoccupied beds, although they are staffed. One hundred and fifty of those were at St. George's Hospital, but those beds are now available. The staffed beds total between seven and eight hundred.

1630. You have over two hundred beds which cannot be occupied because of the shortage of staff?—Yes, and also through not being able to open more wards at St. George's Hospital due to lack of capital monies.

1631. Could you say whether those beds could be made available, if the staff were available, for any purpose, or would some of them be necessarily limited for particular purposes, such as mental cases?—Owing to staff limitations we could not open any more beds anywhere at all.

1632. I realise that, but of the beds which you cannot open could you in fact make them available for any purpose or are some of them in a mental hospital?—We have no mental hospital in the group.

Mr. *J. Enoch Powell.*

1633. Are any of them in the isolation hospital? Is that an example?—The isolation hospital is the central isolation hospital for Lincolnshire, and it must be kept staffed.

Mr. *Thomas Reid.*

1634. If you equipped these beds with staff, would they be used and are they necessary?—They are very definitely necessary. The waiting list at the present time numbers 2,257.

1635. Could you give us the break-up of that?—Yes. Medical—70 waiting: dermatology—20 waiting; gynaecological—188 waiting; children 2; the pædiatric department has only just started; orthopaedic—51; ophthalmic—142. E.N.T., tonsils and adenoids—1,107; E.N.T., other cases—142; and other surgical cases—535.

1636. Are you putting forward a request for an increase to meet this necessity in the estimates, or are you making deliberate economies although you know that these services are necessary?—The only possible means of increasing the number of beds available is by further extensions to St. George's Hospital.

Chairman.

1637. Involving capital expenditure?—Involving capital expenditure.

Mr. *Thomas Reid.*

1638. You are refraining from putting that forward?—We have put forward a scheme.

1639. What are the numbers of staff per bed, or beds per staff?—I cannot tell you offhand.

Mr. *J. Enoch Powell.*

1640. Would it be true to say that, if the tonsils and adenoid cases and the other surgical cases, which presumably are non-urgent surgical cases, were eliminated from your waiting list, the relationship between staffed beds and persons awaiting admission would not be an unreasonable one? It would take 1,600 out of the 2,257, leaving you 600. Would that still be an unreasonably inflated waiting list in relation to the number of beds?—No. I do not think it would.

1641. Really the apparent disparity is concentrated under those two heads, E.N.T. and other surgical?—Yes. The difficulty, so far as Lincoln is concerned, is that at the Lincoln County Hospital—the complement officially is 200 beds, but we are actually running up to 220 patients in—at least eighty per cent. of the patients admitted are acute medical or surgical patients, and they take priority over the waiting list patients. Therefore you are adding to the waiting list because you must take these acute cases in.

Chairman.

1642. You can only just keep down the acute cases?—We can take in the acute cases at the expense of people on the waiting list.

Miss *Ward.*

1643. It is a cumulative waiting list?—Yes, that is the trouble.

Mr. *J. Enoch Powell.*

1644. That number of other surgical cases, 535, is mounting, is it?—Yes, very definitely. We try to keep the figure down, but for every two or three cases put on the waiting list only one is taken off.

Wing Commander *Geoffrey Cooper.*

1645. Could you let us know in a number of hospitals how the staff works out as compared with the number of beds?—(Mr. *Scorer.*) The comparative number of staff as against the number of patients?

1646. That might help?—You wish to know whether it is two staff to one patient, or what proportion?

Wing Commander *Geoffrey Cooper.*] Yes. in one or two hospitals, so that we can get comparative figures.

Chairman.

1647. I think the best thing would be for you to supply us with a note showing the number of staff, you employ, divided into medical staff, whole time, and part time because they are not employed by you strictly; nursing staff, whole time and part time, if you have any part time; domestic staff, and administrative staff. I need not go on. If you could give us that broken up as between different hospitals it would be helpful, but I do not want to put you to a great deal of trouble. It is only to give a general picture. We have some general figures for the country, and we would like to see how they compare in individual cases?—(Mr. *Howick.*) Yes, that can be done.

The witnesses withdrew.

Adjourned till Thursday next, at 4 p.m.

THURSDAY, 15TH MARCH, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.
Mr. Diamond.
Mr. J. Enoch Powell.
Mr. Thomas Reid.
Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mr. E. W. SCORER, O.B.E., Chairman, and Mr. R. W. HOWICK, Secretary, Lincoln (No. 1) Hospital Management Committee, recalled and further examined.

Chairman.

1648. I think it might be convenient to start today by discussing the question of audit, which follows logically from where we finished last week. On page five of your memorandum you tell us this: "The Ministry of Health auditors attend periodically. They do not confine themselves to purely financial matters but tend to regard it as within their province to investigate matters of administration." I wonder if you could amplify that a little, Mr. Scorer?—(Mr. *Scorer.*) I think what we feel is that the Ministry of Health auditors are inclined to say we should not do this or we should not do that as a matter of policy, and they do not confine themselves, strictly, merely to the auditing of the accounts and the figures as we think they should.

1649. The implication I think contained in this sentence and I think in what you have said, too, is that you regard the Ministry of Health auditors as going rather far in their duties?—Yes, Sir.

1650. Do you not find their comments helpful?—I think we find their comments helpful. (Mr. *Howick.*) Their comments are helpful. In the main I would say, yes. They have checked up on the methods of keeping minutes, for example, and committee procedure, which I felt was hardly under their jurisdiction.

1651. You mean matters entirely unconnected with finance?—Matters unconnected with finance, yes.

Mr. *Thomas Reid.*

1652. But connected with efficiency?—I would say, yes.

1653. All efficiency is connected with finance. On this question of audit, when I was dealing with official accounts I was always very grateful if a really competent auditor went a little outside the ordinary accounting process and gave me tips and hints in his report. Of course these auditors do not merely go through your budget; they go all over the country?—Yes, Sir.

1654. They must see things done in different ways in different parts of the country, and therefore they would be able to bring to bear on your part of it great experience. If I was in your shoes I would feel inclined to welcome this. In America the ordinary auditor does not do as he does here. The manager of a big business in America makes full use of the auditor's knowledge outside his range of accounts?—(Mr. *Scorer.*) I think what we might say with regard to that would be this: we do not always feel quite sure that the auditors are thoroughly familiar with the actual day-to-day work of managing a hospital, and one is therefore a little bit inclined to say, "Here is a gentleman who is a very good auditor, but he does not appreciate the practical problems of the day-to-day work of managing a hospital and hospital administration." I think that is perhaps what you feel, Mr. Howick. (Mr. *Howick.*) That is the point. I have always had no hesitation in asking auditors for advice on any financial systems to be put in force, and in fact they have been consulted before doing anything as a general rule, but in some matters I find the auditors we are getting have very little or no experience of hospital work whatsoever and they do make some suggestions, which they think should be carried out, which are simply not practicable.

Chairman.

1655. Is it your impression that these suggestions are the personal suggestions of the auditors in question, or do you think that they are told there is a certain method of keeping minutes, or whatever it may be, presumably by the Ministry of Health, which they lay down for you?—No, I would think they are their own personal views expressed.

Chairman.] The impression therefore really is that the people who are doing this audit tend to be—I do not want to use a harsh word—something like busybodies?

Mr. *Thomas Reid.*

1656. Officious?—Yes, I would.

Wing Commander Geoffrey Cooper.

1657. Are they in any way trained as auditors with auditors' qualification?—I think they are.

1658. What sort of qualifications have they? Is it simply because they have been doing the job for a long time or have they professional qualifications, such as a Member of the Institute of Chartered Accountants?—We do not know what qualifications they have, but I think it would be a long experience in public accounts.

Mr. *J. Enoch Powell.*

1659. Is the reason why you have included this observation in your remarks that, when these comments of the auditors reach the Ministry of Health, they result in instructions being given which reduce your expenditure, which increase it or which hamper your operations?—No, Sir.

Chairman.

1660. It is merely officiousness?—It is merely officiousness, yes.

Wing Commander *Geoffrey Cooper.*

1661. Do they do it pleasantly?—In the main, yes, pleasantly.

Chairman.

1662. On purely financial questions do you find them helpful?—Very helpful.

1663. Do you think there could be any improvement on that side of your work?—I do not think so. The only matter with which I am personally concerned is that they do tend to play off a management committee with far more staff than we have against our own because that committee has a more elaborate system of either bookkeeping or stores records, mainly stores records, than we have.

1664. In other words, the officiousness tends towards heavier administrative expenses?—Yes, it does.

1665. The auditors are in fact appointed by the Ministry of Health, and they have no responsibility to the regional board—is that correct?—That is correct, I think, yes.

1666. As far as your accounts are concerned, you have no direct responsibility to the regional board?—Yes, we have to submit all accounts to the regional board.

1667. The accounts after audit?—They always require a copy, that is all.

1668. Would you prefer to have regional board auditors? Do you think that would be a better arrangement?—I do not think it would. I do not really think it would matter at all, as long as we could be told exactly how far we were to act upon what we were told by the auditors. I am thinking now of one point made during the last audit, and that was the question of appointing an internal audit staff within the hospital management committee.

1669. That was a question which was raised by your own committee?—No, this was raised by the auditors.

1670. They suggested to you that you should have your own tame auditor constantly at work, is that right?—Yes.

1671. What was your reaction to that? Perhaps I should ask Mr. Scorer that?—(Mr. *Scorer.*) I think our reaction would be that we have not got the staff to do it at the moment, and we think we should have considerable difficulty in getting the regional board to approve the additional staff which would be required. We have got thirteen hospitals in our management committee. It might be an advantage if we did have some system of internal audit, but we do try to keep in as close touch as possible with the people who are actually dealing with the accounts on the spot at these outlying hospitals. So far as the local government authorities are concerned the experience is that an internal audit is of very great value. If we had such a system here it might be of value, but it would undoubtedly cause more expense. We have not put the proposal to the regional board that we should like to have an internal audit staff.

Mr. *J. Enoch Powell.*

1672. Mr. Chairman, in your last statement that Lincoln would prefer Ministry of Health auditors, was it your impression that the witnesses were as strong as that or that they said they would not mind which it was?—I think you are putting it a little bit high. If the region said, "We are not going to have any more Ministry of Health auditors; your accounts are going to be audited by the region", I do not think we should mind.

Chairman.

1673. You are indifferent?—Yes.

1674. You would not mind who audited your accounts?—So far as our accounts are concerned we do not care who comes and audits them, whether it is the regional board or the Ministry.

1675. I suppose you must accept the position. If your auditors are going to be officious to the extent at all events of definite suggestions to improve your efficiency, do you think those suggestions would best come from the Ministry or the regional board?—I think regional board auditors would be more likely to appreciate the difficulties of hospital administration rather than Ministry of Health auditors.

1676. Would it be helpful to you, when you have an audit by the Ministry of Health auditors, for the regional board to have someone present who could see what was going on?—Yes, I should not see any objection to that.

1677. You would not object?—No.

Mr. *Diamond.*

1678. Those are both external auditors. As to internal auditors, although you said

it would be of value, you do not think the value to be as great as the expense you would have to ask the regional board to approve?—I think the answer to that is "Yes". I think the expense would not be justified because we do keep a considerable amount of watch over the accounts and the finances of the outlying hospitals. All the accounts of the minor hospitals are paid through the monthly meeting of the hospital management committee, and I do not think that the finances of the minor hospitals could go wrong at all by reason of our not having an internal audit.

1679. Who signs the actual cheques?—(Mr. *Howick.*) A member of the management committee and the finance officer, or in the latter's absence myself as group secretary.

1680. Any member of the finance committee?—Yes.

1681. It does not have to be the chairman or anybody charged with particular responsibility to the finance committee?—No, Sir.

1682. Is it the practice to go to any member who is conveniently available to sign cheques?—It is.

1683. Does he have all the vouchers put before him or does he rely on the authority of the persons who have already signed the cheques and on the finance officer?—The vouchers are placed before him. (Mr. *Scorer.*) A complete schedule of all the bills to be paid is circulated to the whole of the hospital management committee, and any member of the hospital management committee can ask a question about any of the accounts which are being paid, either in connection with the main hospital or any of the subsidiary hospitals.

1684. Are the estimates approved by the finance committee before the cheques are actually signed in payment of the expenditure incurred? I am talking about individual estimates, for example, for small items which are within the finance committee's powers to order. Are those items approved first as estimates, and perhaps at a subsequent meeting the payments approved, or do they come to the finance committee for the first time as payments to be made?—Some of the accounts are in accordance with estimates which have been approved. Considerable numbers of accounts are paid in emergency through the General Account in order to obtain discounts, etc., and a schedule is submitted to each monthly meeting of the hospital management committee. We have an Office Drawings account through which salaries and wages are drawn under the signature of the Finance Officer or Secretary. These payments are also approved by the hospital management committee each month. These arrangements are in accordance with regulations approved by the Regional Board.

1685. Transfers from the main account to this petty cash account are approved by the finance committee?—Yes.

Wing Commander *Geoffrey Cooper.*

1686. What do the separate hospitals feel with regard to the method of payment? Do they have a chance of knowing the full details of any expenses which they themselves have incurred, both with a view to suggesting, if they can, suitable places at which to purchase their needs or alternative methods of supply?—(Mr. *Howick.*) Yes, Sir, they do. Also they all prepare their own schedules of accounts, so that they know exactly what is happening.

1687. So that any member of the hospital management committee could be provided with full information with regard to any expenses which a particular hospital incurs?—Yes, very definitely.

Chairman.

1688. Have you asked the regional board if they would let you have sufficient money to maintain an internal audit?—We have not.

1689. Have they said anything to you on the subject at all?—No, Sir.

1690. It is merely a recommendation from your auditors, so far as you know, spontaneously?—A strong suggestion. The feeling we have is that we are creating people all the time to check someone else.

Miss *Ward.*

1691. Why do you think they made the suggestion?—Because other management committees have appointed internal auditors in the region.

1692. Within the region?—Yes.

1693. Has that matter never actually been discussed at regional level, because there does not appear to be any sort of uniformity?—There is no uniformity at all.

Chairman.

1694. Yours would be one of the smaller budgets within the region?—It would be.

1695. Therefore, a committee with two or perhaps three times your expenditure might find an internal audit much less expensive relatively?—Yes. (Mr. *Scorer.*) I think in answer to Miss Ward's question just now that the reason auditors would suggest an internal audit would be that they come after the work is all done when they would not find any mistake in the accounts, anything wrong in the system, or anything like that until some months, or perhaps a longer period than that, after something had gone wrong whereas, if you have got an internal audit and you have got someone who can go into anybody's office and ask to check his petty cash or to see anything he wants to see at any moment, you may

find something going wrong, and you can catch it at once before anything actually does go wrong. That is the merit of internal audit.

1696. That is viewing it from a very narrow point of view. Surely the suggestion was that your internal audit should be directed rather to long-term efficiency. Am I right about that?—No. I have always regarded an internal audit as something which would prevent anything going wrong with the accounts, to prevent any misappropriation of funds or anything like that, because a person who would be subject to internal audit would never know when the internal auditor was coming to check on him.

1697. Have you ever had your attention drawn to defalcations or serious error in your accounts by the existing auditors?—(Mr. *Howick.*) No, Sir, never.

Mr. *J. Enoch Powell.*

1698. I think there are thirty hospital management committees in your region. Are you in fact the smallest of those in respect of your budget outlay?—No, Sir, we are not.

Mr. *Diamond.*

1699. There is a halfway house in internal audit—I do not know what has been suggested to you—without necessarily going to the extent of having a staff wholly and exclusively occupied entirely on audit, whereby certain officials might check certain other officials and so on. Has that ever occurred to you, or perhaps that is already in operation?—That is already in operation.

Chairman.

1700. I wonder if you can tell us this. On page four of your memorandum, in the first paragraph, you say this under the heading "Normal day-to-day requirements", "Heads of Departments must submit requisitions for goods, or work to be done, to the Administrative Officer who is responsible for scrutinising the requisitions and investigating any excessive, or seemingly excessive, requirements". Can you say what you mean by the word "excessive" in that context? Do you mean having regard to the policy laid down, or something which seems to you to be improper?—No, Sir. Some heads of departments, especially on the catering side, have a habit of ordering, or endeavouring to order, more than is absolutely necessary for day-to-day requirements, which we know is unnecessary. In other words they are stockpiling, and it is with a view to eliminating that. Bed linen is another item where, if you are not very careful, if it is left to the matron, the matron will order far more than she needs deliberately to build up a reserve.

Mr. *J. Enoch Powell.*

1701. Which would normally result in economy under present conditions?—Under present conditions it would definitely, I am certain.

Chairman.

1702. You could not do it because it would interfere with your general financial arrangements?—We could not do it on account of the limitation in the estimates.

1703. But suppose you found that certain expenditure, though not in the nature of stockpiling and not in any sense improper, was nevertheless more than the other establishments were spending on that same item, would you regard that as excessive?—We should, yes, at the time. The administrative officer would have to investigate, or consult with the head of the department, as to why the quantity was ordered and satisfy himself that it was genuinely necessary.

1704. Do you lay down any standards on items like bedding and so on? Have you given yourself any rules?—No, we have not because there has been so much required in the nature of replacements, which have been building up over a period of quite a number of years during the war, that it has been very difficult to lay down any standard or quantity.

Miss *Ward.*

1705. Do you have a certain number of sheets to each bed, and a number of blankets to each bed?—Yes.

1706. Is that the same in every hospital in the group?—No, it varies according to the hospital.

1707. It varies according to the medical requirements?—Yes.

1708. But there is a sort of scale worked out of what is a suitable, so to speak, linen cupboard—that is rather in its narrow sense—to keep stocked?—That has been generally agreed among the matrons themselves in the group. There are group meetings of matrons.

Chairman.

1709. Do they refer their recommendations or decisions, or whatever they may be, to the main committee for consideration?—The matrons hold quarterly meetings, and they submit any recommendations to the proper committee, either the finance and general purposes committee or, if they wish, to the appropriate house committee.

1710. That would cover the whole range of day-to-day ordering?—Generally, yes.

1711. Items like the quality of the sheets and the quantity of food?—Yes.

1712. It is by that machinery that the committee itself keeps control of the day-to-day ordering?—That is right. (Mr.

Scorer.) Then we have a committee of ladies who go through those estimates. If the matron says, "I want a lot of new curtains for the nurses' home" or something like that, then we have a committee of ladies who are members of the committee. They meet the matrons, select what material they think appropriate, and approve the prices which will be included in the estimates.

1713. Mr. Scorer, can you remind me what fraction of your total expenditure goes on day-to-day requirements?—I do not remember offhand. Have you got that, Mr. Howick?

Mr. *Thomas Reid.*

1714. While you are finding that, will you tell me if these ladies are members of the committee or not?—They are members of the management committee.

Chairman.

1715. They are all members of the management committee?—Yes.

1716. The lady members of the management committee get together as a party of housekeepers?—Yes, and if the matron says "I want so many pairs of sheets or blankets" then they have samples from different firms before them, and they decide in consultation with the matron which samples shall be selected.

1717. I think perhaps it might be difficult to give a quick answer to the question I asked just now. I was looking at the table with which you supplied us some time ago, and I do not see that you can extract from it very easily that information? —(Mr. *Howick.*) It is rather difficult.

1718. Can you tell us perhaps what the order is? Is it 20, 30 or 40 per cent., in round terms?—I should think it was between 30 and 40 per cent.

1719. In other words, salaries and wages and day-to-day ordering together comprise the vast bulk of the hospital expenditure?—Yes.

1720. It is, therefore, extremely important to keep closest possible control over them—It is very important.

1721. I wonder if you could tell us about your pay beds and your pay bed policy. Within your group what proportion of beds are Section 4 beds and what proportion are Section 5 beds?—(Mr. *Scorer.*) I would start by saying that there are no pay beds at all in the main county hospital.

1722. No Section 5 beds?—No Section 5 beds or Section 4 beds in the hospital, but there was a private nursing home which was taken over by the regional board. That is worked as a pay bed ward of the County Hospital, and that is all Section 5.

1723. You have no Section 4 beds anywhere within the group?—Yes. (Mr. *Howick.*) There is one at the John Coupland Hospital, Gainsborough, and there is one section 5 bed at the War Memorial Hospital, Horncastle.

1724. That is almost negligible?—Yes.

1725. Taking this group of Section 5 beds, can you tell us what you charge for those beds?—The current charge is, roughly, fourteen guineas a week.

1726. That is assessed in accordance with the Act as the full cost of the bed?—That is the full cost.

1727. Including a share of all overheads? —Yes.

1728. How many beds are there?—Thirty-seven altogether, of which 14 are maternity.

1729. Apart from the maternity beds, is the proportion of beds occupied at any given moment higher than or lower than that in the rest of the hospital?—Do you mean between maternity and general beds?

1730. No. I want to exclude maternity for this purpose because the proportion of occupied beds in a maternity ward is always lower, I think I am right in saying, than the general run?—Yes.

1731. I really want to know whether the demand for pay beds is full?—The demand for pay beds is full, yes.

1732. You could always fill all your pay beds?—Always. In fact there is a waiting list for them.

1733. Is it higher than the demand for other beds, on the whole?—No, Sir, I would not say it was.

Miss *Ward.*

1734. The same average?—I should think so, yes.

Chairman.

1735. Do you ever get complaints about the amount charged?—We have not had so far.

1736. Because yours is a relatively low charge?—It is, yes, compared with quite a number.

1737. Are they always filled by patients from your own catchment area?—I would say, yes. I have heard of no other patients being admitted from outside areas, unless it was an accident case or a sudden emergency.

1738. Have you ever considered having a larger number of pay beds ?—No, Sir, we have not.

1739. I gather from what you say that you could fill more pay beds?—We could, but at the Lincoln County Hospital there are no facilities for pay beds. There is no accommodation.

1740. That is assuming that a pay bed has got to be a single bed in its own room? —Yes, or a double-bedded ward. There is none at all.

1741. Probably the possible increase is not very great?—I should say not, not so great. It would not be great enough to warrant building a block, for instance, for pay beds.

1742. I was thinking in terms of economy. As far as the pay bed is concerned it does not cost the public anything?—No, quite.

1743. If you had a large demand for pay beds, you might think it proper to increase the number because presumably you would be merely pushing people into beds which have got to be paid by the public?—That would definitely be the effect.

1744. On the whole you think the proportion of pay beds you have now is about right, having regard to the demand in your area?—(Mr. *Scorer.*) I think that, if we had sufficient money to spend on what would be required to provide additional pay beds, we should prefer to spend it on something else.

1745. In other words, the number of pay beds you have got is strictly limited by the accommodation available at the moment? —Yes.

1746. And that avoids any other question? —Yes.

Mr. *J. Enoch Powell.*

1747. It actually reproduces the pattern, as it was before the appointed day?—Yes.

1748. You have not made any major transfers from paying to non-paying since the appointed day?—No. There were no pay beds in the County Hospital, and there are no pay beds in the County Hospital. This was purely a pay bed institution, and it has remained a pay bed institution.

1749. Have you considered the possibility of an intermediate grade. I do not know whether that is Section 4?—Yes.

Chairman.] It is not quite the same.

Mr. *J. Enoch Powell.*

1750. I had in mind what we have described in the past in this Sub-Committee as the amenity bed?—(Mr. *Howick.*) That is Section 4.

1751. I wondered if that had been considered by your management committee? (Mr. *Scorer.*) No. It was rather urged upon us that a proportion of pay beds in this nursing home ought to be amenity beds, that is Section 4 beds, but there was such a demand for the full Section 5 pay beds that we resisted that demand, and ultimately it was agreed that all beds should remain Section 5 beds for full paying patients.

1752. From whom did that pressure come?—(Mr. *Howick.*) Originally from the Ministry of Health. (Mr. *Scorer.*) Originally from the Ministry of Health because our proposal to make all the beds in this home Section 5 beds was put up to the region. The region submitted all their proposals for pay beds throughout the whole of the region to the Ministry, and the Ministry made the suggestion that a proportion of these Section 5 beds ought to be Section 4 beds, but after considerable correspondence and discussion the Ministry accepted our view and agreed that they should all be Section 5 beds.

1753. Do the same physical obstacles exist to the creation out of your free beds of a proportion of Section 4 beds as confront the increase in the number of Section 5 beds?—They do.

1754. They are the same factors?—Yes. (Mr. *Howick.*) One difficulty was that, if we could have created Section 4 pay beds in the pay bed block, it would have meant appointing a resident medical officer, and there was no available accommodation for a resident medical officer because it is separated from the main hospital by a distance of, roughly, a mile.

Chairman.

1755. Your policy has been dictated by the hard facts of life and not by any general considerations of what would be best?— No, Sir. One other point is that, if the City Maternity Home in Lincoln is full, we have no hesitation in sending patients into the maternity side of the pay bed block, if there are beds vacant. That has been done on many occasions.

1756. Have you in fact, by the way, got a very long waiting list for maternity beds? —Yes, we have.

1757. Now turning to the question of consultants, I think you have given us the number of consultants who are working in your area and I think you told us that that number is decided by the regional board?—(Mr. *Scorer.*) Yes.

1758. Are you satisfied with the number you have, or would you like an increase?— I think we should like an increase in some departments. For instance, we should like another orthopaedic consultant.

1759. Supposing you get another orthopaedic consultant, have you room for him in which to work?—No.

1760. You would not like him?—We should like him plus the room for him in which to work.

1761. I am assuming for the moment that you are limited to your present buildings and that there is going to be no very great capital expansion for some time?—Yes.

1762. Having regard to that could you find space for another orthopaedic consultant?—No. The orthopaedic consultant

has to do his clinic in the physiotherapy department, and that means that, when he has his clinic on Friday afternoon, the work in the physiotherapy department, the massage department, has to stop. There is no room for the orthopaedic consultant to hold his clinic in the ordinary out-patients' department clinic, and so he has to go into the physiotherapy department. That difficulty would only be increased if we actually had another orthopaedic consultant. The orthopaedic consultant at the present time has anything over a hundred cases at an out-patient's clinic, and it goes on very late.

1763. Suppose you had another consultant, would you in fact find a place for him at the expense of something else?—I think that is a matter about which we should consult the medical committee. We should discuss it with the doctors to see if we could not work it in somehow, but I do not know how we should do it at the moment. We have not considered it, and I have no plan in my mind where we could put another orthopaedic consultant. If we were suddenly told we could now have another orthopaedic consultant, what I think we should do would be to consult the medical staff, the medical committee, to see what we could do.

Miss *Ward.*

1764. You have put "plans have been prepared". What exactly does that mean? —(Mr. *Howick.*) Plans for a new out-patients' department have been prepared.

1765. For a whole new department?—Yes.

Chairman.

1766. That involves capital expenditure? —Yes.

1767. And of course, having spent more capital, you would want men to man the accommodation?—(Mr. *Scorer.*) Yes.

Mr. *J. Enoch Powell.*

1768. Is this establishment the same as it was on the appointed day, or does it include increases?—(Mr. *Howick.*) There is an increase of a paediatrician. You are referring to consultants?

1769. Yes, at the bottom of the list?—And also a cardiologist.

Miss *Ward.*

1770. You have got quite a lot of requirements under the special problem affecting your group?—The position is that all the consultant work is based on Lincoln County Hospital for practically the whole of Lincolnshire, with the exception perhaps of Grimsby.

Chairman.

1771. How many registrars have you got?—We have got one surgical registrar, an anaesthetic registrar, and we have seven other resident medical officers.

1772. Not registrars?—Including the area laboratory, but not registrars.

1773. You have only two registrars in the strict sense of the word?—I am sorry, we have also a gynaecological registrar who also deals with the City Maternity Home as well.

1774. You have only three registrars altogether?—Yes, and at the laboratory at the moment there is a senior pathological registrar and what was a junior registrar.

1775. That makes a total of how many? —That makes a total of five registrars, of which two are purely pathological.

1776. Then you have not by any means an excessive number of registrars?—No, Sir, and that number I understand is being cut eventually.

1777. Have you been told you are going to suffer some cut?—Not officially, but it has been hinted.

1778. Unofficially?—Yes, unofficially.

1779. What is the cut to be?—We are being reduced to a surgical registrar. What grading the other resident officers will get we do not know yet.

1780. Do you mean that instead of five you will only have one?—As registrars, that is trainee specialists.

1781. Yes?—At the moment the trainee specialists are not supernumerary to the establishment. In fact the surgical registrar acts as house surgeon as well.

Mr. *J. Enoch Powell.*

1782. Were the people who are now these five registrars or their predecessors so employed at the appointed day, or has there been an increase in their number since the appointed day?—There has been an increase in the laboratory.

1783. That is the two pathological?—Yes.

1784. Which I think you said originally was——?—The area laboratory which serves Central and Southern Lincolnshire.

1785. It serves the area of several hospital management committees?—Yes, Boston, Grantham and Scunthorpe.

1786. If I might refer to the two additional consultants who have been appointed since the appointed day, I think you said a paediatrician and a cardiologist whom I cannot find in your list on page three of the memorandum?—I am sorry, that has been omitted. The position is that the cardiologist has just recently been moved, and the post has not been filled yet.

1787. There is a new establishment since 1948 for a cardiologist?—Yes.

1788. The question I wanted to ask you was this: before the appointed day where was the work being done and by whom, the work which is now being done by the consultant paediatrician and consultant cardiologist?—No cardiological work was done at the Lincoln County Hospital, and if any of the consultants wished to have the advice of a cardiologist the patient was sent to one of the larger centres.

1789. Does that apply to the paediatrician or in fact was that work not done at all?—That work was not done at all except by the other consultants in their own speciality.

Chairman.

1790. So far we have been dealing with consultants and others who are in contract with the regional board?—(Mr. *Scorer.*) Yes.

1791. You have among your medical staff a number who are in contract with you. I think it is right to say that the resident medical officers are your direct servants?—Yes.

1792. Who controls their number?—(Mr. *Howick.*) The regional hospital board.

1793. They tell you precisely what you can have in that way?—Yes.

1794. Are you satisfied that number is right, or would you like more or could you do with less?—The position is that if we could get the establishment we would have sufficient, but we cannot get the establishment. (Mr. *Scorer.*) We cannot actually find the men.

1795. You are under establishment?—(Mr. *Howick.*) We are under establishment. We are two resident officers short.

Mr. J. *Enoch Powell.*

1796. Does that mean you have two resident officers fewer than on the appointed day, or has the establishment been increased since the appointed day?—We have two fewer; we cannot get them, and it is creating grave difficulties in the hospital. The present staff are finding they are having to work very long hours.

Mr. *Diamond.*

1797. What is the difficulty—lack of suitable applicants or inadequate remuneration?—Lack of applicants.

Chairman.

1798. Do you know as a matter of fact whether that is generally the case in your region, or is it peculiar to your area?—No, Sir, it is generally the case in the region.

Mr. *Diamond.*

1799. What suggestion would you have to make for increasing the number of applicants? Is there any particular cause for the lack of applicants?—I think the difficulty has been the difference in status of registrar grades and house officer grades.

Chairman

1800. Your house officers would mostly be young fellows who have just finished their training?—Yes, but there have been so many registrar posts created. In other words, in existing establishments, instead of calling them house surgeons, they took the name of registrar. They were put on a higher grade. I think the term "registrar" at that time was a misnomer.

1801. Now it is fairly strictly defined?—Now the registrar will be a trainee specialist and will be supernumerary to the establishment.

Mr. J. *Enoch Powell.*

1802. You have a net reduction of resident medical officers plus registrars, taken as one class. Together you have a net reduction of two?—Yes, but I understand the registrars whom we have at the moment will go as registrars but that they will be replaced by, I think the term is, senior resident medical officers.

Chairman.

1803. Are they your appointees?—They are our appointees. The registrar will be the appointee of the regional board, and he will be supernumerary to the establishment.

1804. What you expect then to happen is that you will have a certain number of your registrars taken away from you by the regional board, and you will be allowed to appoint up to a certain total of resident medical officers which you will not be able to achieve because of the national shortage?—That is right. That is the position.

1805. It might be convenient at this moment to ask you about this table with which you have provided us. I am looking at the table which deals with the staffing, where the top line shows the number you have at present and the second line shows the number employed immediately before the Act came into force?—(Mr. *Scorer.*) Yes.

1806. On the whole there has been a fairly substantial increase all along the line?—Yes.

1807. To some extent that is accounted for by St. George's Hospital?—Yes.

1808. But by no means wholly. For instance, I see under "Ward Orderlies, full time", you are now employing 80 as compared with 34 before the Act. Can you account for that?—(Mr. *Howick.*) Under the heading of "Ward Orderlies" you will see that at the Lincoln County Hospital there are twenty-one cadet nurses. There is

a cadet nurses' training school for girls leaving school, to bridge the gap between the school leaving age and taking up a career as a nurse. Those girls have to do four hours a day school work, and they are employed at other times in all the departments of the hospital, with the exception of the wards. They are treated as ward orderlies, but they are not paid as such. (Mr. *Scorer.*) They are counted in with the ward orderlies, but they are not, strictly speaking, ward orderlies. What we found was this, that with a girl leaving school at, say, sixteen, the parents said to her, "You had better start to earn your living." She cannot become an ordinary trainee nurse until she is 17½. What is she to do between 16 or 16 plus and 17½? We have started this cadet school, and those girls, when they leave secondary school at 16 or 16 plus, come to this cadet school. Their general education is improved if necessary. They help in the children's ward; they help in the dispensary; they help in the kitchens; but they do not do anything in the way of nursing. When they have turned 17½ then they go into the ordinary preliminary training school and become nurses. In that way we do catch a large number of girls who, if they did not come to this cadet school, would either become typists or go into some business, and they would be lost to the nursing profession. We have had fifty girls, since we started this a little over a year ago, through that cadet school, all of whom have gone into the nursing profession.

1809. They are presumably good workers?—Yes.

1810. Why is that not reflected in a reduction of those who were doing this work before you got the cadets?—They do not take the place of the ordinary ward orderlies.

1811. Are they doing useful work at all?—Yes.

1812. In addition to anything you had before?—(Mr. *Howick.*) They do reduce the actual number of full time employees in one way. They do no scrubbing or that sort of thing, but they do act as runners. They help in the dispensary; they help in the X-ray department; they also feed the babies in the children's ward, although they are not allowed to nurse.

1813. How much do they get paid?—They get paid £52 a year, and we keep them.

1814. So that they are getting the equivalent of something over a £100 a year?—Yes.

Miss *Ward.*

1815. They do not live in?—Yes.

Mr. *J. Enoch Powell.*

1816. Taking the nurses and ward orderlies together and making allowance for what you have explained to us in regard to cadet nurses, there is still an increase in the nurses of approximately twenty-five per cent.?—Yes.

1817. And in the ward orderlies an increase of something approaching one hundred per cent., even making allowance for the cadet nurses. How far is that due to an increase in the number of staffed beds, and how far is that due to other causes?—The position at the Lincoln County Hospital is that, although there is a complement of 200 beds, on the 12th March last there were 211 patients in there. Previously there were not sufficient nurses to work a 96-hour fortnight. Nurses were working long hours, and the staff has been built up with the object of the nurses working a 96-hour fortnight, and to do that it has been necessary to put on ward orderlies to undertake duties in the wards which were previously undertaken by student nurses.

1818. It represents a reduction in the number of nurse hours worked per annum?—Yes.

Chairman.

1819. That has absorbed not only the increase in nurses but also the increase in ward orderlies?—It has.

Wing Commander *Geoffrey Cooper.*

1820. Have you altered the system at all in regard to the number of staff required per bed? In other words, are you being in any way more lavish now than you were before the scheme came into force?—No.

1821. To what do you work?—We would try to work to 1.5 per bed for the general hospitals.

1822. What is your figure now?—1.6 for Lincoln County, and that is the best staffed hospital in the area.

Mr. *J. Enoch Powell.*

1823. Out of curiosity could you explain to how you get 211 patients into 200 beds, a feat which Procrastes would have envied?—By pushing the beds closer together. We deal with acute emergency work at the Lincoln County Hospital, and we cannot refuse patients.

1824. In fact three patients occupy two beds?—In other words, yes, or the space of two beds. (Mr. *Scorer.*) Strictly speaking you should have six feet between the centre of each bed, but you push the beds closer together to give the extra bed.

1825. In fact there are 211 beds, but only by a breach of the standards?—Yes.

Wing Commander *Geoffrey Cooper.*] Could I refer to the column headed "Administration," and ask if we could have an explanation of the increase in the figures there?

Chairman.] That is from twenty-nine to thirty-eight.

Wing Commander *Geoffrey Cooper.*] They are fairly highly paid people who fill these administrative posts.

Mr. *J. Enoch Powell.*

1826. Could you take that in connection with your explanation regarding administration in the notes, because I think there must be some error in your first paragraph headed "Administration" there which says, "The pre-5th July, 1948 figures shown were for the administration of the Lincoln County Hospital only. The current figures for the Lincoln County Hospital are only for that hospital . . ."?—(Mr. *Howick.*) That was rather badly worded, I am afraid. The position is that we tried as far as possible for current figures to extract the number purely on Lincoln County Hospital work for comparison purposes, but it is very difficult because we work the group headquarters from Lincoln County Hospital and we combine the work of the hospital with the group.

1827. You have produced an artificial figure in order to be comparable for the Lincoln entry?—That is right. As far as administrative staff is concerned the trouble is that hospitals administered by local authorities prior to the appointed day were administered centrally. They had no staff actually at the hospitals, and therefore the staff which were dealing for over 50 per cent. of their time with hospital work were transferred, and we took them over to continue to deal with those hospitals.

Chairman.

1828. The figure of 29 is not an accurate figure?—It is not an accurate figure.

1829. There could be added to that number parts of bodies which you have now lost?—Yes, it is very difficult to compare.

Mr. *J. Enoch Powell.*

1830. There is really no substantial increase because it is mostly absorbed by St. George's, which was not open before the appointed day?—Yes.

Chairman.] Under the heading of "Cooks and Kitchen Staff" you have gone up from 19 to 33. That seems a little startling.

Wing Commander *Geoffrey Cooper.*

1831. Does this heading "Administration" include the clerical work and everything, or are there still people doing work of an administrative nature but only part time?—That covers clerks and everybody.

1832. It is comprehensive?—Except for headquarters staff the main increase in administrative staff has been in medical secretaries.

1833. That is the point you made earlier where economy might be effected, in your opinion?—We think so.

Chairman.

1834. We did discuss that at some length. Could you give us an explanation of the increase in the number of cooks and kitchen staff?—Only I think at St. George's Hospital, probably five.

Chairman.] There is an increase of 14, and St. George's accounts for five of those.

Mr. *J. Enoch Powell.*] But there has been a reduction of two at Lincoln, and so there is only a net increase of three by the opening of St. George's?

Mr. *Diamond.*

1835. An increase of two?—There is an increase at the City Hospital and Sanatorium.

Mr. *J. Enoch Powell.*

1836. I am sorry, it is an increase?—That is the isolation hospital, and that probably accounts for it. They had to get extra staff in last year when the hospital was full.

Chairman.

1837. That was when you had poliomyelitis?—Yes.

Wing Commander *Geoffrey Cooper.*

1838. Have you got a full-time personnel officer who does the engaging of staff now, work which was previously done by the matron or housekeeper?—There is a domestic supervisor who deals with the domestic staff and engages them.

1839. Is that something which has been suggested to you by the Ministry, or is it something which you yourselves have considered to be essential?—That was in operation before the appointed day.

1840. In all cases?—Yes.

1841. What suggestions have been put to you by the Ministry for increasing staffs, suggestions which you have either complied with or not?—The suggestion of the appointment of catering officers, dietitians, with which we have not complied.

Chairman.] That was dealt with last week.

Mr. *J. Enoch Powell.*

1842. With regard to works and maintenance, and referring particularly to your explanatory notes to this table, your present staff now includes eight painters, two plumbers, one electrician and two labourers who have been appointed since the appointed day. Does that mean that more work is being done by, as it were, direct labour than before the appointed day?—(Mr. *Scorer.*) Yes. (Mr. *Howick.*) It does, and coupled with that there again the local

authority hospitals had the use of local authority staff who were withdrawn on the appointed day.

1843. So far as you can isolate the hospitals which were not local authority and therefore to which that does not apply, are you of the opinion that employing your own staff on these jobs has resulted in a net economy?—I am certain of it.

Chairman.

1844. How far does this increase really reflect the pressure on you not to make capital improvements?—I did not quite catch that.

1845. You are in difficulty about getting anything in the nature of capital alterations or improvements approved?—Yes.

1846. How far can you do something to meet your difficulties in that respect by using this additional staff?—We cannot. The only exception we made to that, and that was at the expense of maintenance work accumulating, was to get St. George's open. (Mr. *Scorer.*) The maintenance staff only do maintenance work. They only do repairs and so on, but when we were getting into St. George's we took the electricians off ordinary maintenance work. We sent them down to St. George's, and they put in a complete new equipment for the electrical lighting of St. George's. That was work which was really of a capital nature, but we did get that work done by our own maintenance staff.

1847. That is the only capital work which you have done with your maintenance staff?—Yes. (Mr. *Howick.*) The trouble is that some of these hospitals have had no internal painting done since long before the war, and so the painters, for instance, are going round and doing that job. It will take several years even to get round and finish what they are doing, because unfortunately they keep coming up against snags. They go to wash down a wall, and plaster falls off. That is happening all round, and it is caused through unavoidable neglect owing to the war years.

1848. I think we appreciate that difficulty. Can I refer now to page seven of your memorandum? First of all there is a small correction which needs to be made, where you say, "The Secretary of the Group Medical Committee is also Secretary of the Group Medical Committee"?—That is incorrect. It is a mistake in typing.

1849. Could you say what that should be?—"The Secretary of the Management Committee is also Secretary of the Group Medical Committee".

1850. That is what you told us last time. A little lower down you say this, "This is no permanent organisation at the present time for securing discussion on matters which affect the National Health Service as a whole. We have in mind such matters as the after-care of patients discharged from hospitals, the liaison between the midwifery service and maternity homes, the welfare and hospital treatment of old people and the ambulance service". Could you tell us whether you have any particular kind of organisation in mind to meet that difficulty?—(Mr. *Scorer.*) This question is now being discussed by a committee of the Central Health Services Council, and I think they will make their report before very long. The sort of position you find is this: the local authority is responsible for providing the domiciliary midwifery service, the midwives, and it is its duty to provide an inspector for the midwives. The hospital authority is responsible for the provision of maternity beds. That means that an officer of the local authority, that is the county council or the county borough, can come and inspect the midwives in the hospitals. Actually I do not think they do, but they have got a right to do it. The question as to the number of maternity cases which should take place at home and the number which should take place in maternity homes is a matter on which there is a very great difference of opinion, but there is no tie-up at present between the authority which is responsible for providing midwives in the private homes and the hospital authority which is responsible for the running of the maternity service in the institutions.

1851. What you are referring to here is what is now being discussed at a high level within the Health Service, and not to any special difficulty which you are experiencing in Lincoln?—Yes. The Ambulance Service again is another matter. Practically every person who wants to go in an ambulance either wants to get to a hospital or from a hospital, but the hospital management committee has no control over the ambulances. The ambulance service is provided entirely by the local authority.

Chairman.] It might be convenient if we deal now with the ambulance service.

Mr. *J. Enoch Powell.*

1852. Can I just put this question on the midwifery service which was mentioned? Is it your opinion that if there were better co-ordination between a local authority and your management committee, the waiting lists for maternity beds to which you referred could be appreciably reduced?—(Mr. *Howick.*) No, I would not say that but I think from an administrative point of view, if there was a greater tie-up between the two branches of the same service, it would be more convenient.

1853. If there was an administrative improvement surely that would show improvements in a quicker turnover?—Well, it might do, but I do not think it could.

Chairman.] Could we now turn to the ambulance service? You deal with that at great length on page fifteen of your memorandum.

Miss *Ward.*] Will we be coming back to the question of the out-patients' departments after this?

Chairman.

1854. Yes. You suggest that it would be more efficient if the ambulance services were really transferred from local authorities to the hospitals?—(Mr. *Scorer.*) Yes.

1855. I wonder if you could enlarge on that slightly?—(Mr. *Howick.*) The difficulty in Lincolnshire is that there are three or four local authorities involved, and there are something like five different depots in Lincolnshire. Most of the patients drain to Lincoln. On occasions you have as many as five, six and seven ambulances arriving, some bringing patients over the same route. They come in with patients but they go back empty, in spite of the fact that there are patients waiting to go back possibly to a village through which that ambulance must pass, but because that ambulance is controlled by another authority they will not take those patients away.

Mr. *Diamond.*

1856. The driver refuses to take a patient and drop him on the way?—Yes.

Chairman.

1857. Have you made any attempt to put a better order into this system?—We have tried to, with very little success.

1858. What have you done?—The only success we have had is not at Lincoln, strangely enough, but at Woodhall Spa, the rheumatism centre for treatment at the baths. There it has been possible, I think because of the fact that there is only one clinic and there have been a series of journeys mapped out to cover the route. The trouble is that at the Lincoln County Hospital you have clinics running throughout the day, and it is not easy to map out routes for every patient or to get an ambulance authority to bring patients from one area into the hospital, because you may have four or five patients from one village but they have got to see different specialists at different times.

1859. What is the system which is employed at the moment?—At the moment the ambulance is controlled by an officer at a depot, in the case of Lincoln and in Lindsey——

1860. I am sorry to interrupt you, but can you tell us how an ambulance is ordered?—To bring a patient into hospital it is ordered by the patient's own doctor, or in an emergency by any other person in authority.

1861. Is that done through you at all?—No, Sir.

1862. When a doctor in a village ten miles out of Lincoln wants a patient brought in to Lincoln for treatment, he orders the ambulance direct from the local authority headquarters. Is that correct?—Yes, Sir, not the headquarters but the depot. There is a difference because in the Kesteven area all ambulances are ordered through the headquarters at Sleaford, and not through the depot. In the Lindsey area the ambulance is ordered direct through the depots.

1863. In each case on a doctor's certificate, or not?—They should be in each case on a doctor's certificate, that is for patients coming into hospital.

1864. And for patients going out of hospital?—For patients going out of hospital they are ordered on the certificate of a doctor.

1865. In either case are you consulted about this?—No, Sir.

1866. You have no knowledge at all?—We have no knowledge at all.

1867. Have you asked to be consulted?—I cannot say we have.

1868. If you made representations to the local authorities concerned would they not perhaps be willing to listen, in view of the fact that it would economise?—I am sorry. We have had a meeting with the local authorities in connection with the ambulance service to try to get this straightened out, but the tendency was for the local authorities to blame the hospital out-patients' departments for the excessive use of ambulances. On the other hand the hospitals say the general practitioners are to blame.

1869. It was not a very helpful meeting?—Not a very comfortable meeting.

Mr. *J. Enoch Powell.*

1870. Before the appointed day, in the case of local government hospitals, was there the same lack of co-ordination? Is this a new problem, a partly new problem or one that has always existed?—I think this is a new problem created by the great demand for transport that there is now.

1871. It is not new administratively; it is only new in degree?—New in degree, and it is more difficult in administration because you had in the main the local authorities controlling the ambulance service whereas at Grimsby, for instance, they had their own ambulance service attached to the hospital.

1872. Do you not have some ambulances for inter-hospital transport?—Not our own ambulances, no, Sir. If we want to transfer a patient from one hospital to another within the group, we have to contact the local authority.

Mr. *Thomas Reid.*

1873. Is that the system everywhere?—I could not say. (Mr. *Scorer.*) The local authority is the ambulance authority everywhere.

Mr. *Thomas Reid.*] Do they not keep ambulances at hospitals in various places?

Chairman.] Perhaps I might interrupt you there. I think evidence was given before another Sub-Committee of the Estimates Committee to the effect that certain hospitals had their own ambulances.

Mr. *Thomas Reid.*] I was on that Sub-Committee.

Mr. *Diamond.*

1874. Are you suggesting that, if you had the ambulance service under the control of the hospital, you would be able to devise a more economical service just because you would have a more efficient person in charge of the distribution of ambulances, a more conveniently situated depot or how would you overcome the problem?—I think we should have the ambulances stationed at the hospitals. That would mean certainly some capital expenditure in the provision of ambulances and the provision of adequate accommodation. What a number of local authorities have done is to say, "We will make the ambulance service part of the fire service", and the depots of the Lindsey County Council are in fact the depots of the fire service. The officer who is in charge of the fire service is also in charge of the ambulance service. The reason for that was that the County Council said, "Instead of having two separate completely independent services, both with vehicles which may be standing waiting for a call, like the fire service or accident service, we will have one service and one man in charge of it". If we had control of the ambulances and the ambulances were based on hospitals, it would certainly be more efficient, and as far as we can see there would be a saving in the ambulance service concerned. Whether a saving would result if this were divorced from the fire service altogether, I cannot say at all. It might be that, if you had two totally independent services, an ambulance service based on hospitals and a fire service based on depots, with people standing by and vehicle maintenance and so on completely separate, the total cost would be more, but I cannot say about that.

Chairman.

1875. Would it help you if you had a firm rule that ambulances could only be ordered through your hospital?—I do not think so. Suppose you have a doctor ten miles out in the country and he wants to get a patient into hospital, it would create more delay if he rang the hospital and then the hospital had to get into communication with the depot where the ambulance was. It would be quicker for him to do it direct, would it not?

Mr. *Diamond.*

1876. Would it not be possible none the less to have more co-ordination between the local authority and the hospital officers to try to avoid the return empty loads?—(Mr. *Howick.*) I think the point is that the ambulance service is mainly to bring patients to hospital.

Chairman.

1877. Mostly out-patients who are not urgent cases?—Yes. The tendency on the part of the general practitioners is to give certificates for ambulances when they are not necessary.

1878. Would it not help you if, apart from urgent cases which would be in the discretion of the general practitioners, there was a rule that ambulances could only be ordered through your own office? You would have to have additional staff, of course, to do that?—Yes, that is one of the problems.

1879. Suppose you were allowed the necessary additional staff?—Then it would be much better administratively.

1880. I should have thought you could make a very large saving?—I think you could, a saving in mileage and in telephone calls.

1881. And a heavy saving in staff on the ambulances themselves?—I think you could.

Mr. *Thomas Reid.*

1882. If each hospital had its ambulances would not that surely lead to an increase in the total number of ambulances? If you have them controlled from a central point you can surely do the work with a fewer number of ambulances than if each hospital had its own, and surely that would be a cheaper system than each hospital running its own?—My idea would be for the ambulances in the main to be concentrated at a key hospital where the main service for ambulances was required.

1883. If that was in a central position, but that is not always the case?—No, but in Lincolnshire that is the case. You have the Lincoln County Hospital right in the centre.

Chairman.

1884. I think Mr. Howick's view is that he would sooner have the ambulances right under his control, although it is admitted by Mr. Scorer that that would involve some capital expenditure because you have to garage them and so on?—(Mr. *Scorer.*) Yes.

1885. Subject to that I think both the witnesses feel that they would like to have

more control. It would probably be impossible to take full control in the emergency type of case, but in the non-emergency type of case it might be possible to organise the service through the hospital office. Is that a fair summary?—(Mr. *Howick.*) That is a fair summary.

Mr. *J. Enoch Powell.*

1886. You would not be in a position to attempt the intermediate solution which has just been outlined by the Chairman, unless the local authorities who owned the ambulances were prepared to use them to collect patients from other local authority areas. That seems to be the administrative key?—That is the key I think to the whole problem.

Mr. *Thomas Reid.*

1887. Your ambulances are connected with the fire service. Is that the case everywhere?—(Mr. *Scorer.*) No, I believe in Nottinghamshire that the fire service and the ambulance service are completely separate.

Chairman.

1888. You at any rate are faced with that particular difficulty?—(Mr. *Howick.*) This may not apply in a concentrated area, but in a scattered area where distances are great—and we have many patients coming in from at least twenty miles or more into Lincoln—it does seem folly that one ambulance cannot bring a patient in because that patient is in an area covered by another authority.

Chairman.] I think we understand quite clearly your difficulties.

Mr. *Thomas Reid.*

1889. Is this ambulance service being abused as regards your hospitals? Are ambulances being used when they need not be used?—In some instances it is being abused, quite definitely I have had many reports brought in to me about patients being brought into hospital by ambulances, and they have gone into the town and done their shopping. That is a very genuine grievance of some patients who say, "So-and-so can be brought in by ambulance; why cannot we?"

Mr. *Diamond.*

1890. On a doctor's certificate?—On a doctor's certificate.

Chairman.] I want to leave the ambulance service, because I think it is important to deal with the question of out-patients in the minutes that are left. I believe you wanted to ask a question, Miss Ward.

Miss *Ward.*] I just wanted a little more explanation of the difficulties which appear to arise in their out-patients' department.

Chairman.

1891. You are in great difficulty with regard to out-patients because of the extreme shortage of accommodation—that is the governing factor?—Yes. (Mr. *Scorer.*) When the appointed day came we had sufficient accommodation for one consultant to see patients. We took away a considerable portion of the waiting room accommodation, and divided that up so that we could get two out-patients' clinics going at the same time. That has resulted in the waiting room accommodation being very much overcrowded, but it does enable two consultants to see patients in their clinics at the same time.

1892. Have you tried to buy additional accommodation?—It would be very inconvenient to have the accommodation anywhere but at the County Hospital. If we had a completely new out-patients' department it might be possible, but it would not be possible, I do not think, administratively to divide the out-patients into separate buildings.

1893. Suppose you bought a house somewhere not very far from the hospital and you used that as the out-patients' department for all purposes, would that not be better than the present arrangement where you really have not got any room at all?—Yes, if we could find a suitable house. The hospital is on the very outskirts of the town, and I do not know of any suitable house.

1894. I quite realise that what you want is an out-patients' department at the hospital?—Yes.

1895. I am not trying to suggest that you should prejudice your claim to that in any way?—I understand.

1896. But as a temporary measure would it not be possible to meet some considerable part of your difficulties if you could find an existing house?—(Mr. *Howick.*) It would do, if you could find the house. We are already using the lecture room of the cadet nurses' school for a clinic on two days a week, which is most inconvenient, and it is to be increased to three days a week. (Mr. *Scorer.*) We should also want accommodation for the records department. That is an integral part of the out-patients' department.

1897. It would obviously be inconvenient?—Yes.

1898. Your difficulty there is that you know of no accommodation of a size suitable for this purpose?—If we could find within a quarter of a mile of the hospital a house where we could get the accommodation we wanted it might be possible to do something, but I do not know of any such house. (Mr. *Howick.*) There is not any house.

1899. Have you estimated the capital cost of doing what you want at the hospital?—We have not estimated that. (Mr. *Scorer.*) It would not be less than £20,000 to £25,000.

1900. Does that not have a very high priority on your list of requirements?—Yes.

1901. This is to provide direct treatment for the patients?—Yes.

1902. You have not put it at the top of your list?—Yes. (Mr. *Howick.*) It takes first place.

1903. Are you not required to make some sort of estimate of the cost when you put it in your list of priorities?—(Mr. *Scorer.*) I think the position is that the regional board were told that we want this, but we are not supposed to go to the extent of getting an architect's estimate until we have got the approval of the regional board.

1904. This project has not yet been approved?—No, Sir. If the regional board said to us, "Well, we agree that you are very high up on the list of priorities, will you instruct an architect to get out an estimate and submit sketch plans?", then we could very soon do that, but we have no authority to incur that expense until we are told to do so by the regional board.

1905. What was the total amount of capital expenditure you had approved last year? Do you remember, roughly, in round figures?—(Mr. *Howick.*) Roughly £9,000.

1906. This is really something like two years' capital expenditure?—It is.

1907. It would not all be spent in one year?—What we had to do was to submit a list of requirements in priority to the regional board for the years up to 1952-53, and the regional board select what schemes they think within that list.

1908. You have said this is No. 1?—We have said this is No. 1.

1909. The regional board have so far said "No"?—Yes.

Miss *Ward.*

1910. It would make a difference to the whole scheme?—It would make a difference to the whole scheme, but the trouble is that at the Lincoln County Hospital all the consultants are concentrated there for practically the whole of Lincolnshire. As you will see from the figures quoted for the out-patients' clinics, the attendances are so big that the consultants cannot see patients at any given time. The appointments system has become a farce. The only alternative is for the consultant to see fewer patients and stick to a timetable so that the waiting room is not crowded and so that the patients have to wait far less time at the hospital; or they can do as they are doing now and see all the patients they can in an afternoon. They crowd out the out-patients' department, and patients in the country bitterly complain because they lose even their last bus and they have to take whatever conveyance they can to get home.

1911. Have you told us the total number of out-patients now going through the department in the course of a year?—I have given you that.

Chairman.] Yes, that is on page eleven of your memorandum.

Mr. *Diamond.*

1912. Could you give us an idea of the time patients have to wait?—(Mr. *Scorer.*) Patients are asked to come in this way: three at nine o'clock; another three at 9.30 a.m.; another three at ten o'clock; another three at 10.30 a.m., and so on. If the consultant gets one case which takes him half an hour to deal with, then the whole timetable is out of gear.

1913. In fact if one were doing a spot check what would one find as being the maximum waiting time on a given afternoon?—It is not unusual for us to get complaints that people have been waiting three hours before they are seen. (Mr. *Howick.*) I myself have checked up on various days in the out-patients' department, and the general complaint is that they are kept waiting, especially for the orthopaedic clinic, anything up to six hours.

Chairman.

1914. Looking at the figures for 1950 in the last column on page eleven, if you had better accommodation would those figures be enormously increased? Are large numbers of people, who ought to be seen by specialists, not seen because it is not possible?—That does happen on occasions. I have heard general practitioners say that it is no good referring patients to the hospital because they cannot be seen.

Mr. *J. Enoch Powell.*

1915. On the other hand perhaps our witnesses can expand a little on the very important third paragraph in their statement on page seven under the heading, "Out-Patients Facilities". "There is a tendency on the part of the general practitioners to refer patients to the hospitals for the treatment of minor medical and surgical conditions which could be and were formerly treated in their own surgeries"?—(Mr. *Scorer.*) I think what we had in mind was this: a farm labourer gets his hand caught in some agricultural machinery or something like that. Formerly I think he would have gone to his general practitioner; the general practitioner would have attended to it and told him to come again in two days' time to have it dressed. Now the tendency is for the general practitioner to say, "I am very busy; the hospital service is available to you; go into the hospital". The man comes to the hospital; he is seen by the house surgeon; the house surgeon says to him "Come again in two days' time and let us see if it is going on all right"; and in that way the out-patients'

department is very much more congested than it was formerly.

1916. Have you discussed this problem with your medical committee?—(Mr. *Howick.*) We have, yes, frequently. Also in the casualty department, which is also used for daily dressings, the tendency is for patients to come for injections regularly to the hospitals, injections which previously would have been done in the general practitioner's surgery.

Miss *Ward.*

1917. It is not possible to get back to more attention in the surgery?—The casualty officer has been instructed to refer any patients back to their own doctors when he thinks the patients could be dealt with by them.

Mr. *J. Enoch Powell.*

1918. Is that happening on any considerable scale, or does he only do it occasionally?—Referring back?

1919. Yes?—I really cannot say how much at the moment. We keep a monthly record of patients attending the casualty department for the first attendance and re-attendance, and it remains fairly stationary at the moment.

1920. That would tend to show that the number referred back is very small?—Is fairly small, yes.

Mr. *Diamond.*

1921. Would the provision of additional space, which you would presumably endeavour to use to cope with the additional out-patients, really solve the problem of this extremely long waiting time, or is it not the question of organisation within the existing space?—No, it would solve it to this extent. If there was more accommodation, instead of having two medical clinics a week we could have three, possibly four, because two consultants could sit at the same time. In other words the consultants, we hope, could be persuaded to undertake additional sessions, which I think they would want to do.

Chairman.

1922. You have registrars. I take it——?—They do help.

1923. You could deal with a certain number of people by the registrars, for simple cases and so on?—Yes.

Mr. *Diamond.*

1924. Is there no system you can devise, even an appointments system which occasionally breaks down but one which would not result in a waiting time up to six hours?—Take the case of the physician. If he had two sessions a week instead of one or three sessions a week instead of two, he could see the same number of patients that he has to see now but he would see fewer at each clinic. That would cut down the waiting time of those people.

Miss *Ward.*

1925. In other words, it would be easier to make appointments if you have a little more time available?—Very much easier.

1926. And much easier to plan it?—Yes, but we have no accommodation for any more than two clinics to be held.

1927. There is very little accommodation in which the patients can wait?—I am getting complaints now that patients are crowded, and in fact I have actually seen them sitting outside the door.

Chairman.

1928. Could you tell us something about your income from endowment funds? You get an allocation, I think, which comes from the regional board?—(Mr. *Scorer.*) Yes.

1929. How much did you get last year?—(Mr. *Howick.*) For the group, in round figures, about £500 I should think.

1930. Did you spend that?—I would say "Yes." It goes into a gift and endowment fund, and I would say it was spent.

1931. Did you have a carry forward?—We have a balance in that fund of something like £7,000 at the moment.

1932. Is that because you are saving for some particular purpose or because you do not know on what to spend it?—No, Sir. The difficulty is to know what to spend it on which should not be provided by the Exchequer.

Mr. *Diamond.*

1933. You try to make quite sure that you are using Exchequer money first before you commit the error of spending your own?—We would like to use our own. In fact I have asked for it to be used, but we have been told even by the regional board that if we use our free monies they have got to be used for amenities for the patients and staff; and even if we could use them to, say, add a piece on to the out-patients' department we could not do it without sanction from the regional board. Then we are told, "If you put it up out of your gift and endowment money, you must maintain it from your gift and endowment money."

Chairman.

1934. Suppose you want new curtains. They are an amenity as well as being useful. Would you regard those as proper expenditure?—I would myself, but that view is not shared by some other members of the committee.

1935. Have you ever got a ruling on that?—No, Sir.

1936. Have you tried to get a ruling on that?—Yes.

1937. You have so far failed?—There is a divergence of opinion. (Mr. *Scorer.*) There is a reluctance undoubtedly by many members of the committee to spend the gift and endowment money on matters which would normally be defrayed by the State.

1938. Is there anything which the State is not in fact providing?—Clearly wireless headphones and items like that you can really regard as amenities, but some people would say that was part of the normal equipment of a ward and ought to be paid for by the State.

1939. Does the State pay for wireless headphones?—(Mr. *Howick.*) Not in our group because there is a Friends of Lincoln Hospital Association, and they have very generously undertaken to provide the whole lot throughout the hospitals.

Chairman.] Is there anything that the State has refused to provide in the nature of amenities?

Miss *Ward.*

1940. Such things as bedside lamps with attractive shades?—We have not done that. We would like to improve some of the nurses' resident accommodation in some of the hospitals. It is quite grim in some of them. We would very much like to use the money on refurnishing some of the nurses' quarters, which quite frankly are bad. They are not at all conducive to the recruitment of nurses, but the feeling is that you must not use the money for that purpose.

Mr. *Diamond.*

1941. The feeling is where?—In members of the committee.

1942. Is there any case of any ordinary revenue expenditure, which you have incurred and put through your accounts in the ordinary way, having come back either through the Ministry of Health or in any other way, saying "You should not have paid this; this should have come out of your amenity fund"?—No, Sir.

Miss *Ward.*

1943. Suppose the issue of china in the nurses' home for afternoon tea or whatever it may be is at a certain standard, would it not be possible to get more attractive china perhaps costing more, and put half the expenditure to the proper hospital account and half of it to the endowment fund; and the same would apply to curtains, cushions, carpets and all sorts of things?—It could be done.

Mr. *Diamond.*

1944. Would it be done with the unanimous approval of your committee?—No.

1945. Is there a tendency for endowment monies to be saved?—Yes.

Mr. *J. Enoch Powell.*

1946. For what sort of purpose do the other members of the committee, who take the view other than your own, contemplate this money being spent?—I would say the provision of flower vases and things of that type. I am very serious about that. (Mr. *Scorer.*) They have got a sort of inhibition against spending voluntary monies on anything which ought to be provided by the State. It is a matter of principle. If you say to them, "This money is accumulating. On what are we to spend it?", they say, "Something will turn up, we do not know at the moment, but this is a matter of principle. The State has said it is going to provide, and the State ought to provide it. We object to having our voluntary monies spent in that way". I personally agree with Mr. Howick. I think before long we shall accumulate so much money that we shall be inclined to say to the regional board, "Look here, if you will find half the cost of a new out-patients' department, we will provide the other half", but the regional board does not like that. One hospital management committee at our regional board meeting wanted to provide something; they wanted to spend about £5,000 on some project, I forget what it was; and the regional board said, "If you provide that out of your own free money, you will have to maintain it out of your own free money".

Mr. *Diamond.*

1947. That was the end of that?—That was the end of that.

Chairman.

1948. You are getting a fairly considerable private income from gifts and donations?—(Mr. *Howick.*) Yes.

1949. To how much does that amount in a year?—(Mr. *Scorer.*) We not infrequently get legacies of £200 to £300, residues of estates and so on.

1950. In wills made since the coming into operation of the Act?—Yes. (Mr. *Howick.*) There have been one or two, not a great many.

1951. You still do get some?—We are still getting the benefits from wills made prior to the Act.

1952. Is it your experience that there are still quite a lot of people who would like to give money to the hospitals?—At the moment the Friends of Lincoln Hospital Association, which was formed from the former voluntary contributory association, collect a penny per week quite voluntarily from the people in the Lincoln works, and over the year that brings in over £1,000 a year. We do not touch that at all. We

have no dealings with it, but if they say, "We want to give you so-and-so", we say "Thank you very much".

Mr. *Diamond.*

1953. In kind, not in cash?—Not in cash.

Chairman.

1954. That is things like wireless?—They have installed complete wireless services.

Mr. *J. Enoch Powell.*

1955. Suppose you put it to this organisation that there was this out-patients' department and there was no chance of it being built by State money for the next three or four years, do you think they would be prepared to launch, and the local inhabitants would be prepared to support, an appeal for funds both to build and maintain that department?—May I speak only for Lincoln at the moment because Lincoln seems to be rather peculiar as far as hospital interest is concerned, but I think that, if it were generally agreed that free monies or, shall I say, gifts to hospitals were allowed to be used for any hospital purpose, and we did say, "We are in difficulties; we cannot for financial reasons provide this", I am certain we should go a very long way towards getting sufficient in from voluntary sources probably to put up a building for out-patients.

Mr. *Thomas Reid.*

1956. You are not allowed to tout for money though, are you?—No.

1957. You approve of that, do you?—No, Sir, I think the voluntary spirit is still there, and I am certain people would give to the hospitals.

Mr. *Diamond.*

1958. Would it be a great incentive to give to the hospitals if people knew their money was accumulating at 1¼ per cent.?—No.

Chairman.

1959. Thank you very much indeed for assisting us?—(Mr. *Scorer.*) If there is anything with which we have not supplied you, information or statistics, if you let us know we will certainly do what we can.

1960. Your evidence has been extremely valuable. I do not think we shall need to trouble you again, but if there is any matter perhaps we can write to you?—We shall be at your disposal if you want any more evidence.

The witnesses withdrew.

Adjourned till Thursday, 5th April, at 10.30 *a.m.*

THURSDAY, 5TH APRIL, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. J. Enoch Powell.	Mr. Turton.
Mr. Thomas Reid.	Miss Ward.

Mr. A. J. F. Danielli, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mr. A. W. N. Addison, Chairman, and Mr. E. H. Hurst, F.H.A., Secretary, Portsmouth Group Hospital Management Committee, called in and examined.

Chairman.

1961. Gentlemen, we are very grateful to you for having prepared this memorandum* setting out so fully your views on this subject. Could we perhaps begin by asking you some general questions about the set-up?—(Mr. *Addison.*) Yes.

1962. What is the number of members of your group committee?—Twenty.

1963. Are you satisfied that that is an appropriate number, or would your prefer more or less?—No, I think it is quite a good number. I do not think it is too many, and I do not think it is too few. I think it works very well.

1964. If you had more it would be a cumbersome body, and if you had less you would not be able to man your sub-committees?—That is the trouble. A small committee is very useful sometimes, but

* Not published.

you could not man your sub-committees unless you certainly had that number. So far we have found it quite successful with that number.

1965. You have two kinds of sub-committees, as shown in Appendix 1?—Yes.

1966. Is that your own idea, or was that suggested to you by the regional board?—No, I think it is our own idea. It is our own set-up. Do you mean because we have house sub-committees?

1967. You have functional sub-committees dealing with particular functions, and you have the geographical sub-committees dealing with particular hospitals?—That is so.

1968. Do you find that set-up works satisfactorily? I think you indicate that it does?—Yes. I am very keen on the house committees of these individual hospitals, because I am quite sure it would be almost impossible to work without them in a big group like ours and it does give the local people considerable interest in their own hospitals, particularly the outlying ones. It keeps up the interest which they had before.

1969. Are those committees fully manned by members of the management committee, or are there co-opted members?—There are other members. There are only a few members of the management committee on each house committee.

1970. But so far as the functional sub-committees are concerned?—Those are manned by members of the management committee.

1971. Do members of the management committee find it difficult to get the time to attend all these committees?—They do of course, but they seem to manage it very well. We do not have a great deal of difficulty about that.

1972. You do not get complaints?—No.

1973. You do not have difficulty in finding volunteers to serve on particular committes?—No, we have not up to date.

Mr. *Thomas Reid.*

1974. Is the interest in the committee growing or decreasing since the Health Service came into being?—Which committee?

1975. Is the interest of the members of your committee and sub-committee growing or decreasing?—I should say growing. They are certainly no less interested.

1976. They take a keen interest?—Definitely. That is why I am so keen on house committees because it enables them to take a very keen interest in their local hospitals. It works very well, I think.

Miss *Ward.*

1977. Do the house committees comprise most of the people who were concerned with hospital management before the Health Service?—Yes, they do. If you take the Royal Hospital, Portsmouth, which was the old voluntary hospital, the members of that house committee were all members of the Royal Hospital management committee before the appointed day.

Chairman.

1978. I was going to ask you next about the appointment of your members. I think the system is that the regional board asks for a number of recommendations or nominations, and then appoints from those. Do you find in fact that the board appoints those nominated or recommended to it, or does it choose elsewhere?—They have in every case, except one, accepted our nominations. On one occasion we recommended a certain gentleman to be a member of the management committee, but they appointed someone else.

1979. That was your own nomination from the management committee itself?—Yes, and it was not accepted, but in every other case they have appointed, after the first kick-off, the people we have recommended. We have not had many vacancies since then. I do not know how many; I should say about three.

1980. There have been re-appointments?—There have been re-appointments, but then they have always re-appointed the sitting members except when they resign. We had one who resigned on account of health, but otherwise the sitting members have been re-appointed in every case.

1981. With that one exception they have always taken your advice?—Yes.

1982. Was there good reason for that exception?—I think so. We recommended a doctor actually who was chairman of one of the house committees, but I think they felt we had got enough doctors on the committee already.

1983. You did not agree with it, but you felt it was a valid reason?—Quite.

1984. You are speaking now of your own nominations, but of course there are nominations coming from local authorities and others?—Yes.

1985. Do you know if the same is true of them?—I should say so. There have been so few vacancies since the appointed day that once they have been appointed we have always agreed, except on this one occasion. I do not know about the local authorities really. (Mr. *Hurst.*) I think in one year the local authorities virtually nominated the people who were retiring, and they were automatically re-elected. (Mr. *Addison.*) That is so.

1986. At all events, as far as you know all the nominations which have been put forward have been acted upon, except in one case where there was some reason for departing from it?—Yes, I think so, and of course I think there was another reason in that particular case as well because the one who was appointed to the committee was a member of the regional board who lived in the district.

1987. Perhaps this might be a convenient moment to ask about how far you have overlapping membership with the regional board?—We have three members of the regional board who are members of our management committee.

1988. That is a very high proportion, is it not?—I do not know at all. That is what we have got. (Mr. *Hurst.*) It is fairly high, yes.

1989. It must be quite exceptional to have three members of the regional board on a management committee. The total number on the regional board does not allow, I think, for as much as one over the whole of the South-West Metropolitan area?—(Mr. *Addison.*) No. I do not know how we have managed to collect three, but we have.

1990. Do you find that a useful thing on the whole?—I think it is.

1991. Could you say why?—I think that our cases are represented fairly well on the regional board.

1992. Are you yourself a member of the regional board?—No, they will not have chairmen of management committees on the regional board.

1993. But three of those who sit under you sit over you, so to speak, in another capacity?—Yes, but I do not find any difficulty about that at all.

1994. That does not embarrass you?—No.

1995. On the other hand you find them helpful at any rate?—Yes, they are very helpful.

1996. Can you tell us about the professional membership of your committee, and how many professional members you have?—We have got an ear, nose and throat surgeon; we have got a general physician consultant; we have got a general practitioner; we have got a radiologist; and we have a dentist.

Chairman.] You have five professional men out of the twenty?

Mr. *Turton.*] I make it seven. I am merely going by the qualifications, and there are seven with medical qualifications in your list.

Chairman.

1997. There are seven members out of the twenty who are medically qualified in one way or another. Do you find that enough or too many?—I think it is too many really. I think there are difficulties in having, for example, consultants on the management committee. I agree they should be consulted. They should definitely be in an advisory capacity, but difficulties may arise in having consultants as members of your management committee because we do not employ them—the regional board employ them; we do not pay them—and cases may arise where we may find they are not really doing the job. I am speaking quite plainly.

1998. They may have conflicting interests?—Yes. If we do find—I do not say that we shall but we may—that a particular consultant is not pulling his weight, it is a very invidious position, particularly for the Secretary, if that particular man is a member of your management committee.

1999. On the whole does the professional opinion agree with the view you have just expressed?—No, I do not think so. I think a good many of the doctors would like to run the whole thing.

2000. In other words you find a certain amount of pressure coming from the professional side all the time, pressure which you have to resist?—Definitely.

2001. I think you do say that you have full consultation with the professional bodies?—Yes, and of course one entirely agrees with that.

2002. That is on page eleven of your memorandum at sub-paragraph (iv) where you say you are advised on professional matters by three bodies?—Yes, and that is quite apart from the membership of the committee.

2003. Perhaps we might ask you about those now. There is the medical advisory committee. Who appoints that?—The doctors themselves.

2004. You do not interfere in any way?—Not at all.

2005. Do you consult them on every matter which may affect them?—Yes. Everything affecting the doctors is sent to them for a report.

2006. Have you ever had any complaints from them that they have not been fully taken into your confidence?—I do not think so, no.

2007. As far as you know they are quite happy about consultation?—I think they are, yes. I cannot remember any complaints about it at all.

Mr. *Thomas Reid.*

2008. Have you a special sub-committee dealing with them?—No, their recommendations come direct to the management committee.

2009. Is that all done in writing or are there interviews?—The Secretary very often goes there at their request, and that is very helpful. Since he has been going to this medical advisory committee it has been of great help. We are getting rather better solutions to our difficulties. They are put better.

2010. The parties understand each other much better than if the whole matter is done in writing?—That is so. (Mr. *Hurst.*) There are five members of the management committee who can add verbally to what the doctors have said in writing.

Mr. *J. Enoch Powell.*

2011. Has it ever been suggested that your Secretary should also be the secretary of the medical advisory committee?—(Mr. *Addison.*) Not quite like that. At one time they would not have the secretary anywhere near them at all, but since Mr. Hurst has been here I am glad to say they have agreed to his being there certainly on two or three occasions. (Mr. *Hurst.*) On nearly all occasions. (Mr. *Addison.*) On practically all occasions. That is a very good thing. (Mr. *Hurst.*) I would like to add something, if I may. Before I came to Portsmouth I did act as secretary to the medical advisory committee.

Chairman.

2012. It is a fairly common practice?—(Mr. *Addison.*) It has been difficult with us, as I say. I think the reason why they would not have him was to a certain extent personal as regards the then secretary, but since Mr. Hurst has been here he has virtually been acting as the secretary of the medical advisory committee. (Mr. *Hurst.*) Yes.

2013. Would it be fair to say, reading between the lines of what you have told us, that you inherited a certain amount of friction, that you have made it your business to smooth it out and that you are hopeful that it will disappear completely?—That is so.

Mr. *Turton.*] Going back to the membership of the hospital management committee, in sub-paragraph (iv) on page eleven you specify that you have got five of the consulting medical staff as members of your group committee, one dental staff, one general practitioner, one matron and one ex-matron. In fact nine out of your twenty members are on the professional side.

Mr. *Thomas Reid.*

2014. That is most unusual, is it not?—(Mr. *Addison.*) It is very heavy.

Chairman.

2015. That is not necessary under the Statute and the regulations?—No.

2016. Have you ever made any representations to the regional board on that score?—No.

2017. Would you consider it proper to do so?—(Mr. *Hurst.*) It is rather difficult when half your membership are the people concerned is it not? (Mr. *Addison.*) It has got to come from the management committee. One cannot do it in any other way, and I cannot see them doing that.

2018. Do you know if in fact the matter has ever been raised?—No, it has not.

Mr. *Thomas Reid.*

2019. You are satisfied with the arrangement yourselves?—As I said just now, I think it may lead to some embarrassment at times, but we get on very well. The management committee is a very happy committee, and everything goes along quite smoothly. We do not have any friction at all about anything. That is the only danger I see, that we may have members of the management committee who have conflicting interests.

Chairman.

2020. You are satisfied with the individuals concerned, but you view the broad situation with a certain amount of apprehension?—That is so.

2021. Can you tell us about the house committees, of which you have ten? What powers have they got?—They have the day to day running of the hospitals, and they deal with the sort of minor things which crop up in the day to day management of the hospitals which they run. They look after the provisions, the feeding of their particular hospitals, and then at the beginning of the year we give them an allocation of money and we get from them their recommendations as to what repairs and maintenance are required at their individual hospitals. The building sub-committee has just been round now to all the hospitals to fix priorities as between hospital and hospital, but the house committees do put up their recommendations as to the work they want done at the individual hospitals.

2022. Do you delegate any of your powers to them? Have they any power to spend money?—No, they have only got power to recommend what shall be done with a certain proportion of the money.

2023. The actual spending is taken care of by whom?—The finance committee. From the financial point of view everything has to go through the finance committee before it is approved.

2024. How often do the house committees meet?—Once a month unless it is necessary to meet more often.

2025. Have they any sub-committees themselves?—One has, St. Mary's, because that is a very big hospital.

2026. Beyond the monthly meeting do you know in fact whether they concern themselves daily with the affairs of the hospital?—Some of them do very much indeed.

2027. They would be in and out of the wards?—Oh, yes.

2028. You encourage that?—Yes, certainly.

2029. Can you tell us about the area which you cover? What is the size of the catchment area of your group?—We are very big. Do you mean by districts or in square miles?

2030. Could you give us some general indication? Do you cover the whole of Portsmouth?—We cover the whole of Portsmouth, Gosport, Fareham, Petersfield, Emsworth and Havant.

2031. You cover a fairly substantial agricultural district as well as the town of Portsmouth?—Yes. Petersfield is roughly 18 miles from Portsmouth. That is the farthest point away. Emsworth is about 12 miles, and Fareham is about the same.

2032. You go right up to the Sussex boundary?—At Emsworth, yes.

2033. You include Fareham, so you go some way in the other direction?—The other side of Fareham. Actually patients do come into the Emsworth hospital area from the other side of the border, as well.

2034. Do you find that a convenient area to administer?—I think so, yes. It is a large one, of course.

2035. Could it be divided in any other way? Would it be possible conveniently to enlarge it or to divide it?—I do not think it could be. I do not know quite where, if you cut anything off, you are going to put it. If you cut off Petersfield it would go to Winchester or somewhere like that, which is just as bad or rather worse.

2036. You have only one large general hospital in Portsmouth?—Two. We have got St. Mary's, which is the old municipal hospital, and the Royal.

2037. They are both in Portsmouth?—They are both in Portsmouth.

2038. So that the area you serve has a natural drainage into Portsmouth?—Yes, it does.

2039. Whatever arrangement you had you would have to have some connection between these outlying towns and villages and Portsmouth itself?—Yes. I do not think you can alter it.

Mr. *Turton.*

2040. Could you explain why you are adding the Queen Alexandra Hospital on the 1st April of this year?—We are going to take it over on the 1st July. I am sorry, but I did not quite catch the question.

2041. Can you explain why it is being added to you?—In the first place to give us more beds, and the other point is that the Ministry of Pensions have never filled it.

Mr. *J. Enoch Powell.*

2042. What was it before?—A Ministry of Pensions hospital. Of course, it was originally built as a military hospital before the First World War, and then between the wars it went over to the Ministry of Pensions. It was then offered to Portsmouth absolutely on a plate, both to the Corporation and to the Royal Hospital, and both turned it down at that time. We have been trying to get it ever since the appointed day.

Mr. *Turton.*

2043. There is another small point on the hospitals. We have been presented by the regional board with a pamphlet for last year, and the beds in that are very different from the beds in Paragraph A of your memorandum. The Royal Portsmouth you give as 205, and they give it as 305. They give St. Mary's as 1,049, and you give it as 837. Could you explain that?—(Mr. *Hurst.*) I think the answer is that the extra number of beds are beds which were in the Queen Alexandra Hospital, about which we have just been talking, which were contracted for through the Ministry. We had the use of those beds, which were attached to those particular hospitals.

Chairman.

2044. You tell us there is a deficiency in beds of 63 per cent. in your area. That is calculated on what basis?—On the Ministry of Health's memorandum. It is the ideal, of course. (Mr. *Addison.*) It is an ideal which is really impossible of attainment, I think, but still we are very short. That is the sort of yardstick on which everybody bases their shortage. I do not think we shall ever get it up to that.

2045. You are that much short of the ideal?—That is right.

2046. How does your shortage pinch you in practice?—By long waiting lists at the hospitals.

2047. What is the size of the present waiting list? Have you any figures?—We have got about 3,500, something like that, on the waiting list.

2048. What does that mean in time?—It depends. (Mr. *Hurst.*) Anything from four weeks to eight months for some types of cases.

Mr. *J. Enoch Powell.*

2049. Are the majority of those 3,500 tonsil and adenoid cases?—About 900 are tonsils and adenoids.

Chairman.

2050. You have over 2,000 other types of cases?—Yes, chronic sick, tuberculosis, and the other sort of cases.

Mr. *J. Enoch Powell.*

2051. Could you roughly indicate the number of chronic sick included there?—(Mr. *Addison.*) I think it is quite impossible to indicate the number of chronic sick waiting for this reason, that the doctors have just given up hope of getting them in, except in urgent cases, and they just do not put them on the waiting list. We have got a waiting list for chronic sick cases, a large list, but it does not represent the number of chronic sick awaiting admission.

2052. I meant out of the figure of 3,500 which you mentioned?—I beg your pardon. (Mr. *Hurst.*) Probably about 200 of those, very roughly. I am speaking without the information in front of me.

2053. And the tubercular would be how many?—Much about the same probably.

2054. Two-thirds of the cases are still of a character which could be described as acute. Is that fair?—Yes. There is a fair amount of what we call cold surgery, hernias and that sort of thing, which can wait.

Mr. *Thomas Reid.*

2055. What is your system of priority in admitting patients?—It is assessed medically mainly, and socially.

2056. Does the question of confinements enter into this? Is there a large number of people entering for confinements?—(Mr. *Addison.*) We are pretty well off for maternity services, and I do not think there is anything serious there at all.

Chairman.

2057. In the figure of 3,500 which you have given, none would be maternity?—I do not think so because we have got very good services for that. We have got a large maternity unit at St. Mary's, Portsmouth. We have got Northlands Home at Emsworth; we have got Blackbrook House at Fareham; there is the Blake Maternity Hospital, Gosport; and there is another one at Petersfield which is called The Grange.

Mr. *Thomas Reid.*

2058. Would you say the maternity services have been abused by people who come to have their babies in hospital when they need not?—Oh, yes.

2059. You would say so?—Oh, yes.

Chairman.

2060. Have you ever considered changing the use of any of your accommodation?—Of the maternity units to the other?

2061. That is one which occurred to me, but I am asking you the question generally?—No, we have not because we have only had two of these maternity hospitals quite recently, and at the present moment we are finding they are pretty well used.

2062. If you have got very heavy pressure applying to certain classes of patient and not ample but relatively ample accommodation for other classes, would it not be a good plan to change the use of some of your accommodation?—It is a matter which one can consider but the difficulty is the consultant sessions. You cannot go and use a maternity home, for example, for operations and things of that sort.

2063. There would be no theatre?—There is no theatre; there is just the labour room. (Mr. *Hurst.*) The regional board will not allow us the extra consultants, such as surgeons and physicians. We feel we could cope with the additional number of patients.

Mr. *J. Enoch Powell.*

2064. You are really saying that the limiting factor in admittance to hospitals is the number of surgeons and consultants?—Senior medical staffs. (Mr. *Addison.*) To a certain extent it is, undoubtedly. We could do more surgery work at Petersfield, for example, if we had the surgeons to do it.

2065. Even with the existing beds?—Yes.

Chairman.

2066. You have only twenty?—Yes, but we could send more serious cases out there than we do at the present time. (Mr. *Hurst.*) A further important point is that is we had more physicians, even one more physician, our turnover rate in chronic sick alone would save us a considerable number of beds. The medical staff are quite sure about that.

2067. More consultant physicians?—We are not giving them the intensive care which we would like to give them, and therefore beds tend to be clogged longer. We could treat them more intensively. We have not got sufficient medical staff to cope properly.

2068. Your limiting factor at the moment is medical staff. Would you say that comes before either beds or even nurses?—We are fairly well off for nurses. Nurses are not the limiting factor. Consultant sessions are the key factor with us at the moment.

Mr. *Thomas Reid.*

2069. On this question of maternity services I understood you to say just now that it was being abused?—(Mr. *Addison.*) No, I do not think so.

2070. Did you not say that some of these people could have had their babies at home?—Well, of course I suppose it is possible. I do not know. I have not been into that side of it, but it is possible. I did not say it is being abused at all.

2071. Poor people, who have no servants, would naturally like to go to hospital. They have nobody to look after them as a rule. What is your principle? Do you accept anyone who comes along?—(Mr. *Hurst.*) We have a priority system. The first priority is on medical grounds; the second priority is on social grounds, housing conditions and so on. The almoner goes into the social conditions of each applicant for admission.

2072. From the point of view of public health it would be a good thing if most, if not all, women came to hospitals for their confinements?—(Mr. *Addison.*) There is no doubt about that.

2073. It would lead to more expense if they all did?—Yes.

Mr. *J. Enoch Powell.*

2074. Have you made representations to the regional board on the fact that consultants' time is your limiting factor?—Many, many times. (Mr. *Hurst.*) We have been told in fact that they entirely agree with us, but the money is not available. We have letters to that effect. In some cases the sessions are urgent, but they have no money.

Chairman.

2075. It is purely a matter of finance?—(Mr. *Addison.*) That is what they say. They agree we want these additional sessions, but the money is not there. That is what they have said this past year.

Mr. *J. Enoch Powell.*

2076. What increase, if any, has there been since the appointed day in the number of consultants on the one hand and other medical staff on the other?—(Mr. *Hurst.*) There has been an increase no doubt. (Mr. *Addison.*) It is rather difficult to say the number. (Mr. *Hurst.*) There has been a change in the nature of the service, particularly in the municipal hospital which has been considerably upgraded from what virtually was a chronic sick hospital into at least a half acute hospital. There is a greater demand for services because of the Act, and it has resulted in more acute work.

2077. There is no comparability between the positions before and after the appointed day?—I do not feel so (Mr. *Addison.*) The only hospital you could compare would be the Royal because the work there has been the same before as after the appointed day. I do not think that has been altered.

Chairman.

2078. About the same number of specialist hours are available?—I should say, probably, yes, I think so. That is my impression of the acute hospital, but I do not know about St. Mary's now because, as the Secretary pointed out, it was upgraded from what was practically a chronic sick hospital before to a half acute hospital.

Chairman.] Could you say something about the outpatients' position? I think that would be convenient at this stage. How many outpatients a year pass through either the whole of your hospitals or any particular one?

Mr. *Turton.*] You give us the three-monthly figure of 78,368 on page 14 of Appendix 3.

Chairman.

2079. You give a figure of 78,000 for the third quarter of 1949, but can you give us any comparable figures for a later quarter?—(Mr. *Hurst.*) They are much about the same. There is a slight increase of about five per cent. in the last quarter. There is not very much difference.

2080. Is your outpatients' accommodation adequate for your needs?—(Mr. *Addison.*) No. We have got a scheme at the Royal for an entirely new outpatients' department. The outpatients' department was entirely demolished by enemy action during the war, and we have been existing in a ward which has been partitioned off for consultant rooms and the rest of the ward is the waiting room. The casualty department is mixed up with it, and we have got a new casualty department actually being built. The scheme for the outpatients' department has been approved, and it comes in the programme for the year, I think, 1952-53.

2081. Is there outpatients' accommodation available in all parts of the area?—No. St. Mary's have got a very bad outpatients' department. It is an old air-raid shelter.

2082. Anyone in Portsmouth could get out-patient treatment?—Yes.

2083. But when you get to outlying areas like Emsworth and Petersfield what is the position?—At Emsworth we have got outpatients, but we really want new accommodation there. We have had to improvise, using rooms which really were used for children.

2084. Apart from the accommodation being unsatisfactory is there such a shortage that you cannot see all the out-patients you should?—(Mr. *Hurst.*) I think the outpatients' problem is being dealt with fairly well, except that people do have to come fairly long distances into Portsmouth sometimes.

2085. It is very inconvenient, but there is not such an acute shortage. It is the demand for beds which really you are not meeting?—(Mr. *Addison.*) Yes.

Mr. *J. Enoch Powell.*

2086. Do you find that general practitioners are sending people to hospital as out-patients when in your opinion they could and should be dealt with by the doctors in their own surgeries?—(Mr. *Hurst.*) As a purely personal opinion, in some cases I think, yes. Daily dressings, for example, at some of the smaller hospitals are very, very heavy. It is doubtful whether we should do them, the general practitioner or someone else.

2087. Have representations been made on that point to the medical advisory committee?—Yes. It is limited, I think. It is nothing very serious.

Mr. *Thomas Reid.*

2088. Do some out-patients come unnecessarily for the treatment of trifling things?—Again it is very difficult to assess. When a patient is sent to us the physician may be in some doubt. There may have been a good reason for the patient coming to us. All cases in the main are referred to us by the general practitioners. (Mr. *Addison.*) They do come in from the doctors.

2089. Do out-patients come unnecessarily for a consultation when there is really nothing wrong with them?—Yes, I think they do.

Chairman.

2090. You would not see an out-patient except on the recommendation of a doctor. You would not let him in at all?—No. (Mr. *Hurst.*) I think there is a tendency, now that the general practitioner seems to be so pressed, for us to get a larger number of out-patients.

2091. You do notice a tendency that way?—Yes.

2092. It is not an abuse, but it is a tendency?—Yes.

Mr. *Turton.*

2093. When you are so short of accommodation can you explain to us why you decided to close down thirty-four beds in Langstone Sanatorium?—(Mr. *Addison.*) Yes. Langstone Sanatorium is absolutely unsuitable for any patient to be kept there at all. It has been condemned by the Ministry, and it was condemned by our own doctors. It was used by the Corporation, as you see, as a sanatorium, but it was a most dreadful place. It is an old huttage of the First World War. It was put up by the Americans. The sewerage is all wrong; everything is wrong about it. The place leaked, and you could not make it fit for people to be kept there. We moved the patients from there partly to St. Mary's Hospital, Portsmouth, and partly to the Infectious Diseases Hospital. It does reduce our beddage, but all the doctors said "You keep them there at your peril". There was a terrific outcry in the Press about it as a matter of fact.

2094. An outcry in what direction—about the continued use of Langstone?—Yes.

2095. It could not be repaired and made habitable?—No, you would have to build an entirely new place.

2096. Now it is being used for cows?—At the moment it is not being used at all. It is used for stores of a certain kind.

2097. I am merely reading that it is being used for farm purposes?—There was a certain amount of land. Actually the Corporation had a scheme for building a new sanatorium on the site, but then a new medical officer of health came along and said it was entirely the wrong place to build a sanatorium. When we took over from the Corporation there was not a sanatorium worth the name or any other accommodation for tubercular patients.

Chairman.

2098. Can we now turn to staffing generally? You have told us that your main bottleneck is medical staff. Would it be troubling you a great deal to let us have some figures to show the medical staff position since July 1948?—No, we will do that.

2099. I do not want to trouble you to get out a very detailed statement, but perhaps you could let us have some statement to show what has happened since then?—Yes.

2100. Perhaps you could do the same for nurses and let us know what has happened with regard to your nursing situation?—We are fairly well off for nurses in Portsmouth. I think that is attributable to two reasons. One is that we are a garrison town, and the other is that the matrons of the two big hospitals are very good recruiters. They treat their nurses extremely well, they treat them properly I mean, and the facilities for nurses are as good as they possibly can be. For those two reasons I think we are pretty well placed.

2101. Can we now turn to the more difficult queston of administrative staff?—Yes.

2102. You say this in sub-paragraph (ix) on page eleven of your memorandum, "In our opinion, a strong case exists for experiment and research into 'staff efficiency' in the hospital field. Business methods should

be studied by administrators in the hospital service to see what aspects can be applied . . . ", and so on. By implication you rather suggest that hospitals have difficulty in using their administrative staffs efficiently. Is that implication correct?—I do not know that you can go quite so far as that. What we feel is that it might be improved by research and by an improvement in personnel. I think there is an awful shortage really of good administrators in the hospital service, and that it would be a very great advantage if there was some sort of system of training hospital administrators in the same way as they are in other professions.

Miss *Ward.*

2103. Do you think they are not there or that the salaries and conditions do not attract them?—I think it is a bit of both. I do not think they are there at the moment.

2104. It is a new type of service which has got to be built up?—Yes. I think some scheme of training would be a great advantage to attract the fellow who has a good education and mental ability. He could then be trained as an administrator.

2105. Do you think you get the right type of people, who can be trained, in the semi-trained category?—I think the Secretary knows more about that than I do. (Mr. *Hurst.*) There is some difficulty about it. People for our administrative staff are recruited mainly from our junior clerks, very few of whom we find seem to have the right aptitude for hospital administration.

2106. Do you think there are incentives in the Service to attract the right type to enter?—No. The incentives are definitely not there. For the chief administrative officer of a hospital with three or four hundred beds, which is quite a fair-sized show, the salary is only about £500 or £600 a year, and we feel it is not at all suitable.

Chairman.

2107. That salary is a Whitley Council decision?—Yes.

Mr. *J. Enoch Powell.*

2108. When you refer to the substantial economies which in your opinion can be made under the heading of staff, those substantial economies would be purely in administrative staff?—No.

2109. Or also in domestic staff, or where?—Domestic principally, porters, engineering services, all the operational services other than medical and nursing ; and I would say even in medical and nursing if we looked into more modern methods of organisation.

2110. Your contention is that, although you employ these people and are responsible for paying them, you have not the time or the opportunity to make the investigation which would enable you to dismiss or transfer?—(Mr. *Addison.*) That is right. (Mr. *Hurst.*) I think we should say this. The administration of hospitals, although a lot is said about it, is limited. We have a large number of people working in hospital management in administrative and clerical staff, but ninety-five per cent. of those people are doing clerical duties and not administration itself. They are not carrying out managerial functions.

Chairman.

2111. When you speak of administrative duties you mean at the top, in the rather higher sense of the word?—People who can use their brains and do not have to be told what to do in petty numbers.

2112. Managerial functions?—Managerial functions rather than routine functions.

Mr. *J. Enoch Powell.*

2113. Have these people, the clerical, manual and semi-manual, to whom you have referred, increased since the appointed day?—Clerical, definitely I would say.

2114. And so in the case of the others you feel they were inflated already before the appointed day?—They have increased slightly, but no much.

2115. But the economy which you would anticipate from a thorough examination is greater than the increase since the appointed day?—I think so. I think there is a big field there. It is a big field.

Mr. *Turton.*] Could we have figures for the clerical increase to show us how much bigger it is?

Chairman.

2116. I do not think you have supplied us with that. Would it be troubling you too much to let us have comparable figures?—(Mr. *Addison.*) You mean before and after the appointed day? It does not compare at all because the set-up is so different.

Miss *Ward.*

2117. From the appointed day to now surely is what we require?—I beg your pardon.

Chairman.

2118. If you could give us your figures as soon after the appointed day as they became clarified, which would be sometime at the end of 1948, then perhaps a further figure in 1949 and a further figure for 1950 so that we can see what has happened over the last three years, it would be of great help to us?—We could certainly do that.

Mr. *J. Enoch Powell.*

2119. Under the clerical head have the increases been mainly in clerical assistance for the medical staff or in the clerical workers required by the new administrative structure, or both?—(Mr. *Hurst.*) Both, but I should say slightly more on the medical side.

2120. Have representations been made on that to the medical advisory committee?—Yes. Actually we have a sub-committee, what we call the medical records committee, which looks after all the clerical medical staff.

Mr. *Thomas Reid.*

2121. What has been the response by the medical side to your suggestion for retrenchment?—Varied. (Mr. *Addison.*) We do have this medical records sub-committee, and the medical records officers supply the clerical assistance to the consultants and so on from a pool. The consultants do not have their own individual people. (Mr. *Hurst.*) It is frightfully difficult to discuss it with the consultants who are considerably overworked, and if they cannot get clerical assistance—

2122. Then they get all the clerical work?—Obviously it is policy to give them a reasonable amount of clerical assistance to enable them to get on with their job which they should be doing.

2123. You have talked about the administrative and clerical aspect. All these hospitals are run on a similar basis all over the country. Has anything been laid down as to the form of books to be kept, and has any attempt been made at a uniform system of administration throughout the country?—The finance accounts system is reasonably uniform. There are standard headings and so on, although each group have a certain amount of flexibility in the exact books they use. Otherwise there is not much standardisation.

2124. You are left to devise your own system of working, of keeping records and all the rest of it?—Yes.

2125. Do you think that could be improved?—I think there is room for improvement.

Chairman.

2126. You have no staff establishment, have you?—No, there is no staff establishment for the group. (Mr. *Addison.*) Do you mean laid down by the Ministry?

2127. Laid down by anyone?—No, we have done it ourselves. We have laid it down.

2128. As a self-denying ordinance?—Yes. We have gone into this very carefully, and we have decided what we consider to be the right establishment for each hospital, for administration and for everything else. That has been gone through very carefully, and it has all gone on to the regional board.

Mr. *Thomas Reid.*

2129. That is as regards the number of staff?—Yes, and individual jobs of course.

2130. The number of staff largely depends on the system worked in all these big undertakings of a governmental character, but there is very often great room for improvement because of the superfluous work which is being done. Have the Ministry taken any steps to eliminate that sort of thing or have they left you to your own devices?—(Mr. *Hurst.*) In the running of our internal affairs we have to give all sorts of returns to the regional board and to the Ministry. (Mr. *Addison.*) That is not your point.

Mr. *Thomas Reid.*] No.

Miss *Ward.*

2131. Following on that, surely that would be covered by the last paragraph on page five, which perhaps you could elaborate? "We are not impressed with the Ministry's team who visit to examine establishments—these 'flying' visits can do no more than pinpoint any obvious overstaffing". That surely is the link?—The Ministry's team comes round, but they can only spot the very glaring cases. There is no chance for them to go into the thing properly. You have got to go and work in a group really to see what the difficulties and the troubles are.

2132. Do you think they are a waste of time then?—No, not entirely, but they do not do as much good as one would hope.

Mr. *J. Enoch Powell.*

2133. Do the Ministry's auditors ever make suggestions or offer views on these subjects?—(Mr. *Hurst.*) Occasionally, yes, not so much though. I think, if I may say so, the whole trouble is that, except at hospital management committee level, there are very few practical hospital administrators who know an awful lot about the running of hospitals. That is my own view.

Miss *Ward.*

2134. You do not think the Ministry's flying teams would know really anything about the running of hospitals?—They do because they are half hospital people usually. For instance, the man who comes down to look at the administrative staff is usually a hospital management committee secretary plus someone on behalf of the Ministry, and they obviously do know something about it.

Chairman.

2135. But they do not know much about your own hospitals?—I think they can find out an awful lot.

Miss *Ward.*

2136. Do the flying teams make any representations to the management committees about their staffing?—Yes, they have on the medical side. They said we should have more medical staff.

2137. On the clerical side of the medical staff?—No. I have not had them in Portsmouth. I had them in another group, and they did make a recommendation there. The medical people accepted it. There were two or three reductions, particularly on the medical secretarial staff, which were carried into effect.

Chairman.

2138. So far as establishment is concerned your present numbers are presumably those who are there as a result of a historical process. They are not laid down. They are simply the jobs which are there?—Yes. We have made a complete review of all our administrative and clerical staff for our own satisfaction, and we are reasonably satisfied in the present set up that they are necessary.

2139. The numbers you have actually got are the numbers you found yourself with, and not because someone in advance said, "You will need so many for this and so many for that"?—That is right. (Mr. *Addison.*) It is the number we have found necessary to run the show.

2140. Supposing you wish to increase your staff in some way, another clerk, more ward maids or whatever it may be. Do you just do that, or do you get permission?—We are supposed to get the permission of the regional board before we make any additional appointment at all.

2141. When you say "supposed", do you mean you do not do it?—We do do it, but I think it is rather nonsense that we have to go to them before taking on a ward maid or personnel like that.

2142. Presumably they give you the sanction?—No, they do not, not automatically.

2143. You have always got sanction?—We have up to now.

Mr. *Thomas Reid.*

2144. You have nothing in the Hospital Service corresponding with a Government Department where they have an Organisation and Methods Branch which is continually going round to eliminate useless staff, overlapping, waste and all the rest. That is the first question I ask you. The second is this: have you ever recommended a reduction in your staff?—No, we have not.

2145. What about the O. & M. system? Is there anything corresponding to that? —(Mr. *Hurst.*) No. That is what we were rather suggesting in our item on staff. There ought to be some practical organisation which can go round to the groups. We have been discussing that with the regional board, but we are told the money is not available. We should have a complete survey by such an organisation as O. & M. or some industrial concern.

2146. That would be a Ministerial function. There should be persons who can compare the various management committees and all the rest, and be able to tell you what should be done. You would have no objection to that?—No, as long as it is at Ministerial level and not at regional level.

Miss *Ward.*

2147. It is the flying teams who you think are no good?—Yes. We want a permanent practical team of people who know about the running of hospitals.

Mr. *J. Enoch Powell.*

2148. It would be easier for you to make reductions in the establishment if they were recommended from outside than if they came from you?—Yes.

Chairman.

2149. You have internal vested interest? —Naturally.

2150. Which it is difficult to overcome? —Yes.

Mr. *Turton.*

2151. You have no figures for your pool of medical secretaries?—We have not many; there are very few.

2152. You do not have complaints that the dermatologist has to use a secretary who is more used to ophthalmic terms?—We have had complaints, but they are tapering off. We are educating them a bit. We have all our people under what we call a medical records officer. We have two of them in the two larger hospitals, and it is their job to share out these facilities among the different medical staff.

2153. If you did not have that medical records department and pool, would you not have to have more medical secretaries? —Yes.

Mr. *Thomas Reid.*

2154. You suggest that some of the staff are not properly qualified. How does your committee find out who is not qualified, who is not efficient and who is efficient? Have you a system of confidential reports

such as they have in the Government Services?—We are considering that now. What I meant was rather that they are competent for the job they are doing and the job for which they are paid, which is mainly a routine function, but we have not the money available for the more managerial type of administrator.

2155. Who is doing that work now—incompetent men?—Men who are not as good as they might be.

Mr. *J. Enoch Powell.*

2156. You are contending that, if you had to pay more to fewer people, there would be a net economy?—Yes.

Mr. *Thomas Reid.*

2157. It struck me that, if you had a fairly well educated man and he went into an administrative executive post, he might be an awful fumbler at first but, if he has got anything in him, with a reasonable education—it is a very specialised branch of administration—he surely could learn it and improve?—(Mr. *Addison.*) The right type certainly could. (Mr. *Hurst.*) A fair amount of training is involved, but it would not take a long time. The difficulty is that the system tends to put the staff into water-tight departments—the finance department, the supplies organisation and so on. People do tend to keep to water-tight compartments. The type of person for whom we are looking should have had experience of all departments and should know what goes on throughout all the hospitals.

2158. It is very hard to get people with such experience?—That is why we suggest some sort of training or apprenticeship in the Hospital Service.

Mr. *J. Enoch Powell.*

2159. Whose organisation is it which produces these compartments? Is it something within your control to some extent?—Not normally.

2160. Is it due to the method of estimating or financial control? Could you enlarge on that?—It is broadly in the finance department where the finance has grown into something special within the Hospital Service. It is rather vertical than horizontal. The finance officer of the management committee seems to have much more in relationship with the treasurer of the regional board than sometimes with the hospital management committee. There is a vertical cleavage as well as a horizontal cleavage. They do tend to become water-tight compartments if we are not careful.

2161. Is this connected with your contention that there is a great deal of unnecessary manpower put into the detailed estimates?—We feel so.

2162. That is a related point?—Yes, we feel so.

2163. The clerical and administrative staff on the finance side has been inflated by factors which you do not believe are assisting your own administration?—(Mr. *Addison.*) That is so.

Mr. *Turton.*

2164. Have you a dietitian?—We are just appointing one now. We have not had one before.

2165. Do you find you have worked very badly without a dietitian?—We have catering officers at the big hospitals. We are quite good. The one at the Royal particularly takes a tremendous interest in the particular diets.

2166. Why have you appointed a dietitian?—Because we think we can improve matters by doing so. (Mr. *Hurst.*) We have always had one dietitian in the group. This is really a replacement, the theory being that a dietitian is more of a medical appointment than a catering appointment.

Chairman.

2167. Is it a full time appointment?—Yes. At the diabetic clinic, instead of the physician having to spend time telling the patient what he should or should not eat, the dietitian does that.

2168. Is he a medical man?—No, he has a dietetic qualification. He is a medical auxiliary.

Mr. *Turton.*

2169. Were you not encouraged by the Ministry of Health circular to appoint a dietitian?—Yes.

2170. Was it in consequence of that circular that you made the appointment?—No. We have not made the appointment; it is only under consideration whether we should or should not. As a matter of fact we have the Ministry's dietetic adviser coming down to our group to spend a month with us, to tell us how to go about matters.

Mr. *Thomas Reid.*

2171. You prefer a dietitian to an additional medical officer?—There is a considerable difference in the cost. A dietitian costs about £400 a year; a consultant about £3,000.

Chairman.] It is a full time job for a dietitian?—Yes, there is no doubt they can save an enormous amount of medical manpower, besides their catering function.

2172. You have got work within the group which will keep him fully occupied, and nearly all his work will in fact relieve *pro tanto* one or more consultants?—Yes.

2173. It is an economy in the long run?—It is.

2174. You are satisfied?—(Mr. *Addison.*) Yes.

2175. In fact your shortage of medical manpower has prevented you showing a reduction by reason of the appointment?—(Mr. *Hurst.*) Yes. I would like to make this point. We were asked whether we would rather have a dietitian than a consultant. The fact is that consultants are paid by one authority and dietitians by another. Even if we saved money on staff it does not mean to say we could have an extra consultant in place of the money because it is financed separately. That is one of the difficulties.

2176. A dietitian falls on your Vote and a consultant on the regional board Vote?—(Mr. *Addison.*) That is right.

2177. You spoke just now of the interference—I do not use the word offensively—from higher authority. I think you indicated you would like some measure of interference by the Ministry but not by the regional board. Do you find in fact that the regional board tend to interfere in the day-to-day management?—They are beginning to, I think. Now that they have got over the usual sort of initial teething troubles, their gradings and other matters finished and their sort of larger planning done, they are tending now to come and interfere with management matters.

2178. Do they give you specific instructions?—Sometimes.

2179. Occasionally on detail matters?—Yes, I think we might say that.

Mr. *Thomas Reid.*

2180. You object to that?—Yes, we do.

2181. Could you explain why?—We think we are a responsible body, and that we are capable of running our own show in the best possible way. We do not want interference from the regional board in matters of detail; it is not necessary at all. (Mr. *Hurst.*) I think we feel they are not always sufficiently experienced to give us advice.

Mr. *J. Enoch Powell.*

2182. Could you give some concrete examples of the sort of subject on which this takes place?—It is mainly in discussing finance. We have the regional board treasurer who would go into great detail, and in most cases we can give a complete answer—but there are some in-between matters.

Chairman.

2183. At what stage does he butt in?—At various stages.

2184. Could you give a concrete example of the sort of expenditure in which the regional board might interfere?—To give a typical example, we have been told that all the grounds in our hospitals should show a profit. We think that is possibly desirable, but not therapeutically desirable completely. In any given hospital we feel we want a certain amount of lawn and a certain amount of flowers.

2185. That would be by cultivating it?—Completely. From our experience it is not always possible to do that, obviously.

2186. How far does the regional board treasurer interfere beyond a general exhortation? Does he tell you what you ought to do precisely—that you have got to have so many hens?—Not in great detail.

Mr. *Thomas Reid.*

2187. Does he make you do it whether you like it or not?—The money can be cut accordingly. That is the trouble, is it not?

2188. He has the power of the purse?—Yes.

2189. On the other hand we hear all over the country—it is in the newspapers—that there is a great need for tightening up control, and of course the people who would control you would be the regional board. What would you say to that sort of general criticism which you read everywhere?—(Mr. *Addison.*) My own personal view is that the regional boards could be washed out entirely. I think we would be much better controlled direct from the Ministry. The Ministry have got their proper department to do this. They deal direct with local authorities and other people. To my mind it is just another cog in the wheel, that is all. The Service could do very much better if it were controlled direct from the Ministry, and there you can have as much control as you like.

2190. Take the question of finance. The regional board deal with a much bigger area than you do?—Yes.

2191. Claims come in for additional expenditure every day, your claim as against the claim of some other management committee. Would you say that a body like the regional board, controlling a bigger area, would not be a better judge of that than the Ministry, or would you say the Ministry could deal with it without the intervention of the regional board?—I think so, yes. I do not see why the Minister should not deal with it. They can assess it just as well as the regional board can.

Mr. *J. Enoch Powell.*

2192. What reason have you for supposing that the Ministry would interfere less with you and would impose a less onerous control than the regional board?—I cannot say whether they would or not. The regional board have to go to the Ministry afterwards for practically everything, and why the dickens should we not deal direct with the Ministry? Take the case of plans for buildings. What happens at the moment is this: we locally have to produce a sketch plan.

Chairman.

2193. You are now speaking of capital expenditure?—Yes, at the moment. We produce a sketch plan by a properly qualified architect or someone, and that then goes to the regional board's architect. He then cuts it about and does not agree with it. He tells us, "The Ministry's architect would never agree to this; he would never agree to that". We cannot go direct to the Ministry's architect and really talk to him about it. We are the people who are going to use the building. We do not know whether the Ministry's architect would agree or not, if it was put to him properly.

Miss *Ward.*

2194. You feel you can put your own case better to the Ministry than by putting it through the regional board?—Absolutely.

Mr. *Thomas Reid.*

2195. I think at the back of your mind is the point that, whatever faults the Ministry have, they have the qualified persons and the regional board have not?—Absolutely.

Chairman.

2196. Could we now take capital expenditure? You have prepared in this appendix a number of schemes of capital expenditure?—Yes.

2197. Those have been sent up to the regional board—is that right?—That is right.

2198. They have been approved in principle as desirable things to be done?—They have.

2199. I think there is no detailed estimate in respect of them, or have you submitted those?—We have to the regional board now.

2200. In respect of those schemes?—(Mr. *Hurst.*) As near as we can because we are not allowed to employ an architect or anyone, but we have agreed with the regional board a round sum in each case.

2201. Does it rest with you to choose the order of priority of those schemes?—No, the regional board.

2202. Do you make representations to them?—We must be fair. They have agreed broadly with the order in which we have placed them.

2203. This is the order in which you wish to see them done?—Yes. They have agreed broadly with that order.

2204. Take the year which has just passed. You had a capital allocation for that year; I think that is right?—(Mr. *Addison.*) Yes.

2205. Did you have any difficulty in spending that allocation?—(Mr. *Hurst.*) It was slightly behind schedule.

2206. What was the total amount?—Roughly about £80,000. I could not remember the exact figure.

2207. It was that sort of figure?—Yes.

2208. How near to that did you get?—We are not quite sure because the year has just ended. I should think it is something under that, but on the other hand schemes for next year, schemes which have been approved for next year, have been pushed forward.

2209. They are not borne on the 1950-51 Vote?—Yes. Overall we shall more or less balance. Schemes which were lagging behind have been offset by schemes which have been pushed forward.

2210. Have you any complaints about the method of authorising capital expenditure? At the moment I am not asking you about the total you are allowed because we all complain of that?—(Mr. *Addison.*) I do not think we have. (Mr. *Hurst.*) We have been treated very fairly by the regional board. (Mr. *Addison.*) I do not think we have got any complaints at this stage at all.

2211. When you put up a scheme it is treated fairly, and on the whole it goes through within the permitted limits?—I think that is the case now. I do not think we were treated fairly at the beginning because we got off to a very bad start for various reasons, but I think we are being treated properly now.

2212. The Sub-Committee has been told in other cases that there is difficulty about the small capital estimates, and that on the whole management committees would like to be given greater latitude to switch small schemes. Is that your view too?—Yes, I think it is. (Mr. *Hurst.*) The machinery is awfully slow. From the time a scheme is first considered, approved by the hospital management committee for submission, until it has gone through all its stages is very long.

Mr. *Turton.*

2213. That is a different point from the one the Chairman is asking about switching, is it not? It struck me that in a quiet,

clandestine way you were doing your own little switch. Apparently work which was approved for next year was somehow being brought into this year?—That is with the permission of the regional board.

2214. Then perhaps I should withdraw the word "clandestine". There is a certain flexibility so that you can bring into the present year work which has been approved for a subsequent year?—(Mr. *Addison.*) We have managed to do it.

Miss *Ward.*

2215. When you say you have managed to do it, what do you mean?—We have persuaded the regional board to agree to it. (Mr. *Hurst.*) A typical example is that in most schemes, besides the building, there is equipment to purchase, and often by the timing of the purchase of the equipment one can get it into one year or another, whichever suits the regional board better. I think that is the main reason.

Chairman.

2216. What is your difficulty with the regional board in this connection? You spoke earlier about your objection to having to deal with those who were not directly responsible for making the authorisation, and you referred to capital expenditure. It seems that the system is not inflexible, and that you have been able to spend up to the permitted limits. I am not certain that your two statements do not conflict in some way?—I think it is the machinery which we feel is cumbersome, rather than the spending of the money.

2217. You feel it is unnecessary to have to go to the regional board?—Yes. They have only got to go to the Ministry in turn and explain all the same sort of things which we have explained to the regional board.

Miss *Ward.*

2218. You mean that you think you would get a quicker answer if you went direct?—Yes.

Chairman.

2219. Would not the regional board, with their policy consideration for the region, be the better people to advise the Ministry?—Presumably.

2220. You do not know anything about that, do you?—We know a fair amount about it, but we feel the Ministry itself could have the same sort of policy ideas.

2221. It would be better to have all those functions centralised?—We think so. (Mr. *Addison.*) Yes.

Mr. *Thomas Reid.*

2222. You know the objections which have been raised about the whittling down of local government functions. Would there be any objection on those grounds to the abolition of regional boards? If you had a regional board committee would it not give you a certain amount of local representation, in addition to the area committee?—I do not know whether it would or not. From the point of view of the good of the Service I think the regional board is just another cog in the wheel.

Mr. *Turton.*

2223. Would you have the same view if this particular region was split in half?—That would help a lot. In our region we have got the Western Area Committee, to which we have to submit matters as well as to the regional board. Matters go from us to the western area committee, then to the regional board and then to the Ministry.

2224. Does every proposal for capital expenditure have to pass through those three channels?—Yes. It is a very large region. What we feel is that very often London is rather aloof. At the beginning we had a terrific fight.

Mr. *J. Enoch Powell.*

2225. Would the members of the regional board who are on your committee, from their experience on your committee, agree with the views which you have just been putting forward?—I cannot speak for them at all. (Mr. *Hurst.*) You mean in regard to splitting the region into two?

Mr. *J. Enoch Powell.*] No, on the abolition of regional boards, because after all you are not two completely separate bodies. You have three members of the regional board on your own committee. They must see these difficulties as clearly as you do. I am wondering whether they would agree with that point of view?

Mr. *Thomas Reid.*

2226. Before you answer, might I just add this? Would these three members consider that the regional board does perform useful functions? It is the same question?—(Mr. *Addison.*) I am not speaking for them. I think they probably would because they are members of it.

Chairman.

2227. I think it is a difficult question to put to the witness?—I do not think it is possible for me to answer that, but they are all agreed—I can say this very definitely—that this Western Area Committee could really be a separate board, and that we should not have this large regional board administering our district through the western area committee.

Mr. *J. Enoch Powell.*

2228. From your point of view the fact that there is no teaching hospital available

for the western area causes no difficulty?—No difficulty as far as we are concerned, no.

Miss Ward.

2229. Do you have on your committee the automatic substitution and re-election of personnel as they do on the regional board?—Yes, every three years. You are appointed for three years by the regional board on to our committee.

2230. Have they carried out a substitution in your group?—As we said before they practically re-elect the sitting members except when vacancies have occurred, and few vacancies have occurred.

2231. I do not say that this would necessarily be the position, but it might be that you would have a new regional board dealing with an experienced and older, so to speak, group?—(Mr. *Hurst.*) Presumably the new regional board would be mainly composed of people on the parent regional board, the South-West Metropolitan Regional Board, who are mainly concerned with the western area. They would be the nucleus.

Chairman.

2232. I think that is rather outside the knowledge of these people. Can we now deal with revenue expenditure? You have told us a good deal about the preparation of estimates. On page six, in (i) and (ii) of sub-paragraph (*a*), you speak of the dates by which the estimates have to be prepared, and at the end of sub-paragraph (*a*) you say, "So far as the South-West Metropolitan Regional Hospital Board is concerned, both these dates have, in practice, been changed to the 15th September". Those are the dates by which the original estimates and the revised estimates have to be received by the regional board. That is right, is it not?—Yes.

2233. Can you say why that was done?—We are not quite clear about it. The only reason we can think of is so that they have both lots at the same time and can consider one in relation to the other.

2234. That is the revised estimates for the current year and the new estimates for the coming year?—Yes, so that they can see both together and compare one with the other.

2235. That is inconvenient for you because it doubles your work at a difficult time?—At a crucial time, yes.

2236. In the next sub-paragraph you say, "The Regional Board undoubtedly takes notice of the monthly statement of expenditure rendered by Hospital Management Committees and is not necessarily guided fully by the Hospital Management Committee's revised estimates". Could you explain that? It is a little difficult to follow?—We have to give monthly statements, as you know, to the regional board and to the Ministry of running expenditure, and in discussions with officers of the board we have found this monthly statement appears to figure quite largely in estimating and so on. On the other hand, particularly in the later months of the year, there may be goods, ordered in the early part of the year, falling heavily in that period. In other words, the monthly statement is not necessarily a good indicator of the rate of expenditure.

2237. Because of seasonal variations?—Yes. We know lots of items which will perhaps be heavy in certain months, which the monthly statement would not show at all.

2238. You are suggesting that the monthly statement ought to cease, are you?—Not that it ought to cease but that it ought not to figure too largely in consideration of the estimates, and the revised estimates particularly.

2239. How does that affect you?—(Mr. *Addison.*) What we are suggesting is that the finance people at the regional board pay too much attention to these monthly statements of expenditure and not enough attention to the revised estimates.

2240. Does that affect you in any way?—It might affect us either way. What we say is that the monthly statement is not a true statement of the expenditure which is likely to occur throughout the year.

2241. How does that affect you?—(Mr. *Hurst.*) When we submit the revised estimates, although within the total of the estimates for the year, we may ask for a switch between different headings. The regional board have refused on occasions to do that although there is no increase in the total expenditure, mainly on the basis of our monthly returns.

2242. They have pointed to your monthly return as evidence against you, but have you no opportunity of discussing that with them?—That did arise in the discussion. That was the answer.

2243. Can you not explain what the situation really is?—We have, but the decision was not altered.

2244. You are not suggesting that the officers of the regional board are obdurate and wooden-headed; they are open to argument and discussion, are they not?—I think this was just one of the points which we felt should be mentioned, it is not a serious one, but this monthly statement does not serve the particular purpose that it is thought to serve; it has a limited purpose.

2245. Does it give you a lot of trouble to prepare?—It is one of the extra things we have to do. It all adds to the burdens of the clerical staff in the group.

Mr. *Turton.*

2246. Does that go to the western area committee?—To the western area committee, and to the regional board as well.

2247. It is prepared in triplicate—to the Ministry of Health, to the regional board and to the western area committee?—Yes, but that does not really matter; we have to prepare it.

2248. But do the comments come both from the western area committee and from the regional board?—Mainly from the regional board.

2249. Mainly, but do they also come from the western area committee?—Occasionally, yes. That is another difficulty. The regional board treasurer is at the main board, but the assistant secretary, who looks after our day-to-day affairs, is at the western area committee in Winchester.

Mr. *Thomas Reid.*

2250. Is not the fact that you have to prepare a monthly statement of expenditure a useful check on your services?—(Mr. *Addison.*) Yes. We think it is a good thing to prepare it, but what we are trying to make out is that too much attention is paid to it by the regional board finance people.

Mr. *J. Enoch Powell.*

2251. In fact the revised estimates which you submit are often modified unreasonably, and insufficient attention is paid to your revised estimates?—(Mr. *Hurst.*) We feel so.

2252. The money which anyhow you are going to spend would be better spent if your revised estimates were submitted later in the year and less altered?—(Mr. *Addison.*) Yes.

Chairman.

2253. Do they assist you with advice or otherwise in the preparation of estimates?—(Mr. *Hurst.*) No, we prepare the estimates. We discuss them fully with the officers of the board when we have prepared them.

2254. You say you prepare them before?—Usually before, except that they give us some general advice by saying that the expenditure must be limited on this and that, but broadly we prepare them before we discuss the estimates with the board.

2255. When the estimates are submitted the regional board already know on what they are based and so on?—Yes.

2256. You are suggesting that they turn back on themselves, so to speak, and insist on going back to some other consideration altogether—is that right?—Yes. It is a little difficult to explain because there are continual discussions, and one never knows quite whether one is discussing the estimate of current expenditure or what.

2257. With whom are these discussions carried on?—Mainly with the regional board treasurer.

2258. As between you personally?—No, not always between myself and the treasurer. It is often between our finance officer and the regional board.

2259. Would you tell us exactly what does happen?—We have got the regional board treasurer coming down to-morrow . . .

2260. Personally?—. . . to discuss the estimates. This is how that arises. He will come down to-morrow.

2261. One individual?—One individual, to discuss the estimates for the coming year. I have the message secondhand through the finance officer, and we have not the least idea what particular aspect or what particular items he wants to discuss. There will be a discussion for two hours.

2262. With whom—Mr. Addison and yourself?—He just says he wants to speak to me and the finance officer at the moment. The whole point is that we are not prepared. What usually happens is that we are told that such and such a hospital is spending much less than we are at so-and-so. "We think you should manage on less than that".

Mr. *J. Enoch Powell.*

2263. These estimates which he wants to discuss are the estimates for 1952-53?—No, the estimates for the current year from to-day, 1951-52. We submitted our estimates some months ago, of course.

Chairman.

2264. They have not yet been approved?—No. I understand the regional board have been told what is the overall sum of money they have to spend, and the regional board treasurer in turn will discuss with each management committee what sort of allocation they might expect.

Mr. *J. Enoch Powell.*

2265. These are the estimates of which you obtain the original confirmation about May this year and the final confirmation about January, 1952?—Yes, which is always another difficulty. There are always some months gone in the year before we know what we have to spend.

2266. In other words, what you call in your memorandum "budgetary allowance" I take it is the provisional approval of the estimates for the current year?—Yes.

Miss *Ward.*

2267. Does the regional board treasurer discuss with the individual hospitals, apart from discussing with the group?—Only on rare occasions when there is something special about one hospital, in which case we go to that hospital with him.

Chairman.

2268. Could we take the estimates for the year which ends to-day? Those estimates were prepared by you and submitted in September, 1949—is that right?—That is right.

2269. What was the total of those estimates? Have you got that figure?—I have not got it with me.

2270. Could you give it to us in very round figures?—Very roundly, just under the £1,000,000 mark.

2271. Those estimates left you to go to the regional board and to the Ministry. I think you said they went to both?—Yes.

2272. When did you next hear anything about those estimates?—I was not there then, but speaking from my experience elsewhere, some fairly long time. I have only been in Portsmouth for six months. The estimates for this current year have been with the board some six months, and there has been no discussion about them.

2273. Do you know in fact what was the figure, roughly again, which was finally approved for the estimates for the year which has just finished? I do not know if Mr. Addison could charge his memory with that?—(Mr. *Addison.*) No. I cannot. (Mr. *Hurst.*) As far as I know it was about £60,000 less than the actual estimates.

2274. There was a cut?—Yes.

2275. Do you know who made that cut? —The regional board presumably. They made the cut as far as we were concerned.

2276. It was notified to you by the regional board?—Yes.

2277. You do not know whether the regional board did it as an act of policy on their own account, or whether it was imposed on them by the Ministry?—We do not know.

2278. That is not known?—No.

2279. You only know that it was cut? —Yes.

Chairman.] When you came to prepare the revised estimates for the same year what was the addition to the original estimates?

Mr. *Turton.*

2280. Is it not a fact that this officer was not present at that time? I do not quite see how he can answer when he has only been with this management committee six months?—I know about the revised estimates.

Chairman.

2281. I think he must be familiar with the estimates on which he is now acting. I am talking about the current year which ends to-day, and he has told us that there was a cut before his day of £60,000 as compared with the original estimates?—In very round figures. It may have been of the order of £40,000, £60,000 or £80,000.

2282. The revised estimates were put in about the time that you came to Portsmouth?—Yes.

2283. What was the increase of those revised estimates on the original estimates? —There was no overall increase because there was a switch. We were suggesting a switch between certain heads of expenditure.

2284. There was no overall increase at all?—No.

2285. The net total was about the same as the original estimates?—Yes, but we wanted a switch. It was almost certain we were going to be over-expended on a certain head, and we wanted to increase that and decrease another head.

2286. Can you tell us the headings and amounts affected?—I could not offhand. I can let you know that next time.

2287. Could you let us know that?— Yes.

2288. Can you say where the cut of £60,000 was made? Was that before you came, or is it within your knowledge?— Not offhand. I could find that out.

2289. Will you find that out for us?— The amount of £60,000 may not be completely accurate. I would rather check it.

2290. Whatever the amount was, would you let us have a note of the headings to which the cut was applied?—Yes.

Mr. *Turton.*

2291. With regard to the revised estimates which you submitted on the 15th September 1950, have you had any communications with the regional board between that date and the visit of the regional board finance officer to-morrow? —No.

Chairman.

2292. You do not know, as far as his visit is concerned, whether it is in connection with last year's, this year's or next

year's estimates?—The finance officer told me about the visit yesterday. It was arranged between him and the finance officer in the region. We have been told that the region's allocation on the whole is £1,500,000 less than it was last year, and that we will all have to accept our share of the reduction.

2293. You imagine that some consideration will be given to that?—That is presumably so.

Mr. *J. Enoch Powell.*

2294. In regard to this matter of switching—this may be a separate point—you say at the top of page nine of your memorandum that the cash basis actually results in switches taking place, or perhaps I have misunderstood it. I am referring to paragraph (vi) (*b*) (i) where apparently, if expenditure rises under one head as a result of a salary award for example, you have to cut expenditure under another head, quite apart from a revised estimate, or have I misunderstood the paragraph?—Yes, that is so. (Mr. *Addison.*) Yes, that is so.

2295. Who decides that?—If you have an increase in salaries by an award you have got to find the money from somewhere. We are not given any more money. We have just got to cut something else.

2296. You do that without a revised estimate?—(Mr. *Hurst.*) Shall we say there is £100,000 allowed for salaries and wages in any one year? Then there is a retrospective award which also becomes payable to the staff on the 6th April. That falls in this year and obviously will depress our total, although it really relates to the previous year.

Miss *Ward.*

2297. What can you cut if your estimates are relatively correct? Do you cut on the food for the patients, on blankets, on cleaning or what?—On the system as it is we are supposed to cut on wages.

Chairman.

2298. This is all hypothetical; let us bring this down to something concrete. There was such an award in the case of nurses last year. That put up your bill for nurses' salaries. From where did the money in fact come?—It came out of the wages heading. We had budgeted for one or two additions to staff in various places, with which we obviously could not go forward.

2299. You in fact found the money by reducing your staff—is that right?—We did not actually reduce the staff, but there were one or two posts which were not filled when they became vacant.

Mr. *J. Enoch Powell.*

2300. Surely that was not sufficient by itself to cover the extra expenditure?—We had also budgeted for an increased staff in some directions, and that was not fully implemented.

Mr. *Thomas Reid.*

2301. You did that on your own initiative?—Yes.

2302. Without authority from anybody?—Yes.

Mr. *J. Enoch Powell.*

2303. That is a switch, as it were, within a head. It is not really a switch at all. It is just inside the same head?—That is because of the difficulties of relating cash transactions to what an accountant would call an income and expenditure account.

Miss *Ward.*

2304. By not appointing staff whom you in fact thought were essential, you really reduced the efficiency of the group. That would be the interpretation?—Yes. We have a long list of staff, and we feel that some of them ought to be appointed.

Chairman.

2305. You were faced with a sudden bill demanding a substantial increase in cash payments. You had to look round for that cash, and you had a little bit under that head for staff whom you had not yet taken on or for whom there were vacancies?—Yes.

2306. Did the burden ultimately fall on that head as a result of the cash transaction? In other words, did you never in fact take on those additional members of the staff, or did you put in a supplementary estimate?—No, because there is no provision to put in a supplementary estimate. We did make a saving ourselves from other sources. We have appointments vacant now which we still feel we should fill.

Mr. *J. Enoch Powell.*

2307. You made an adjustment from other sources under the same head?—Yes.

2308. But in the paragraph to which I was referring you speak of the adjustment being made under other heads. For example, you set off salaries or wages against purchases for stock. If the knowledge that it was necessary came to you in the first quarter of the year it would either take place by way of a revised estimate or you would have to get a separate authorisation for it from the regional board. Is that so?—Yes.

Chairman.

2309. Have you in fact ever taken from cash paid to you to acquire stock in order to pay increases in salaries?—Not really. This was one of the minor difficulties, shall we say. We are not awfully concerned about this.

Miss *Ward.*

2310. It gives a feeling of insecurity?—Yes. It was one point which we felt ought to be mentioned, rather than stressed unduly.

Chairman.

2311. You have taken, as you are allowed, your money provided under a head of expenditure for other purposes under the same head of expenditure?—Yes.

2312. On page four of your memorandum, paragraph (iii) "Action on receipt of original approved budgetary allowance", under (*b*) of sub-paragraph (*a*) you speak of "A process of 'getting into reverse' may be necessitated because over-expenditure as compared with the proportionate amount of the allowance has already occurred at the date of the notification of the allowance". Have you in fact ever found yourself in the position of having over-expended, or is that again an apprehension of what may happen?—I think we did on one occasion. I was not there at the time, but I believe the provisions head was overspent and we virtually did have to cut down on the standard of feeding in one case. (Mr. *Addison.*) That was so.

2313. You had estimated for a larger sum than was finally authorised. That would be in this cut of £60,000 to which you referred?—(Mr. *Hurst.*) Yes.

2314. As the estimate was not approved until the year had partly elapsed you had overspent before you knew what the position was?—Yes.

2315. How did you recover that?—We did reduce the standard for a time. (Mr. *Addison.*) St. Mary's Hospital was overspent actually. It was gone into by a sub-committee, and it was found that we really could reduce on provisions without affecting the patients to a large extent; and so we did in fact.

2316. In other words you did not complain of the cut; you came to the conclusion that it was a reasonable cut?—In that case, yes. We did find that economies could be made with regard to feeding at St. Mary's Hospital, without affecting the patients.

2317. You were in a little difficulty for a time because you had overspent on the basis that you did not know what the position was?—Yes. It may happen in a case where we could not effect a process of getting into reverse.

Miss *Ward.*

2318. Under the heading of "Uniforms" at the bottom of that same page, what are "systematic condemnations"?—(Mr. *Hurst.*) What we mean is that as soon as a uniform really wears out it is condemned straightaway.

2319. That cannot be systematic because some people can wear a uniform longer than others?—No, automatic would have been a better word. In many hospitals in the past it has only perhaps been done once every three or six months, and then you get a heavy expenditure falling on that particular period. We spread it over all the time.

Chairman.

2320. On page seven you are dealing with the question of budgets in total, carry forward balances and the carrying across between subheads, and in the last sentence of sub-paragraph (*b*) you say, "When no or very little notice is taken of such revised figures when first forwarded, we wonder why we are bothered to produce them at all". I think the first figures are the original estimates under subheads, is that right?—Yes.

2321. Are you suggesting there that you ought not to have to produce detailed estimates at all?—No, I do not think we are saying that.

Miss *Ward.*

2322. Why do you say ". . . these revised estimates which are apparently not used"?—That was the point we were mentioning just now. We were not suggesting at all that estimates should not be produced, of course not.

Chairman.

2323. I am not quite certain what you are suggesting in that paragraph?—May I just read it again because we prepared it in some haste?

2324. I think it is a difficult and technical point, but an important one?—I think what we mean to bring out there is that we ourselves should have some authority to switch between headings. I think that is the point we were trying to make, rather than to put up a revised estimate.

2325. In the first place you should put up detailed estimates under heads as you do at present. Suppose those estimates, which come to, say, £1,200,000 in any given year, are approved. Suppose you find that, although you are not going to exceed that total, you will exceed it under some heads and save under other heads, is it your suggestion that you should not be required to submit a further estimate at all?—Provided we are not going over the total expenditure.

2326. Yes. I quite see you are suggesting you should be allowed to switch automatically, but are you suggesting you should be allowed to switch without informing the regional board of the details of the switch which you will make?—I think so, yes.

Mr. *J. Enoch Powell.*

2327. I personally thought the paragraph meant this: you should be allowed to make revised estimates later in the year. You are quarrelling with the two months out of which you have been chiselled by the regional board?—Yes.

2328. If you could start to make your revised estimates in September and tender them in November, you feel that more notice would be taken of them and they would be of more use to you?—Yes, the later the better really.

Chairman.

2329. You would not suggest that you should be allowed to carry across between heads without at any rate informing the Ministry of Health?—We do not mind the Ministry of Health, no.

2330. It is the regional board you object to here. It does not make any difference. In one case you send the revised estimates to the Ministry with a copy for the Board, or you may send the revised estimates to the Board with a copy for the Ministry?—Yes. I think there is a wide feeling that it really links up with the whole global sum in principle. If we are given a sum of money and told to make the best of it, there are adequate safeguards on top of that somewhere at the Ministry level.

Chairman.] It is really part of that.

Mr. *Turton.*

2331. I am not quite clear myself what the proposals of this hospital management committee are on the global sum. How would that sum be initially fixed—by (*a*) the Ministry or (*b*) the regional board?—We feel it should be fixed by the Ministry.

2332. From what evidence?—On the basis of the estimates we would put up, on the normal basis as we do now, but I should think the Ministry would obviously look at them very, very closely. When they were satisfied they would give us what sum of money they thought fit, and subject to suitable safeguards at Ministry level—an inspectorate of some kind—we should manage ourselves within that sum of money.

2333. You would still submit your original estimate by the 1st September, is that the position, and after that the Ministry at some date would give you a global figure?—Yes. We would prefer to go further than that. We would prefer it to be fixed for some years, if possible two, three or even five years, so that there would be an incentive to save in one year and spend it in a subsequent year.

Mr. *J. Enoch Powell.*

2334. But you would estimate by heads?—Yes.

2335. But the revisions which you would make as between heads should not be subject to Ministerial consent?—(Mr. *Addison.*) That is so.

Mr. *Turton.*

2336. Under that system would you continue to submit monthly statements of expenditure?—(Mr. *Hurst.*) I think that would still be reasonable. It would still give a reasonable amount of information to the Ministry.

2337. Would it also be necessary to submit revised estimates for each year?—I do not think that would be necessary.

Chairman.

2338. Suppose the re-armament programme goes on, as is not impossible, and prices continue to rise and there are further substantial increases under various heads involving you possibly in an additional £100,000 or £200,000 a year, what do you suggest you would have to do?—In any one year or in a number of years? Do you mean over a longer period or a shorter one?

2339. Let us assume that your full estimate for next year is approved as a global sum, and you are given £1,250,000. In fact your estimates are falsified not because of any action on your part but because of rising prices, and to do what you estimate you have to do will involve you in an expenditure of £1,400,000 How are you going to meet that situation?—I think we would obviously have to discuss with the Ministry the existence of that increase as such. The situation actually arises now, whether we have a global sum or a fixed amount according to the estimates which have been put up. It is one of the difficulties we foresee now. I think that, other than pointing out the marginal increase to the Ministry and the reasons for it, either the Ministry will give us more money to maintain the same level of service or the level of service will be cut. I think that is a policy decision the Ministry must take.

2340. You are asking, if it is the other way, that you should keep the balance and apply it according to your own ideas?—Yes.

Mr. *J. Enoch Powell.*

2341. You say it is a policy decision for the Ministry on how economies should be effected under the other heads, but how can they make that policy decision if you can switch between heads without their authorisation?—We are not increasing the expenditure in any way without their authorisation.

2342. No, but you say the manner in which the economies are to be made and the manner in which that deficit is to be

taken up over the other heads is a policy matter to be decided by the Ministry. How can they decide that as a matter of policy if it is in your hands to switch as between heads?—I think there are two different issues. One is an issue if we were running normally, and then there is the extraordinary issue which is increased prices or wages.

2343. Which is abnormal?—Yes.

Miss *Ward.*

2344. If you made your estimates, say, over your five years and you knew that if you made an economy you could keep the money saved, that would be an incentive as you say in your memorandum, but what safeguard would the Ministry, that is the taxpayers, have that you would not overestimate with a view to having a balance to expend as you liked at the end of the period?—There are three safeguards. First the original estimate put up is carefully scrutinised by the Ministry. Secondly the Ministry's audit would throw up automatically any extravagance and so on. I would then maintain that we need a third system. You may call it an inspectorate, or an efficiency audit if you like, by practical people in the various sections of hospital work, people who would come round as a team from the Ministry.

Mr. *Thomas Reid.*

2345. You would not admit that the regional board would help the Ministry in this matter at all?—I would think the bulk of the experience would be with the Ministry rather than with the regional board.

Chairman.

2346. Suppose that there was such a scheme but that the allocation was made by the regional board and not by the Ministry, would you feel happy about that?—We would feel happier if the Ministry did it.

2347. I understand that you would prefer the Ministry to do it?—The next best thing is the regional board.

2348. You would prefer that you should know where you stood, even if it is at the discretion of the regional board, than the present situation where you do not know where you stand at all for three-quarters of the year?—(Mr. *Addison.*) That is right.

Miss *Ward.*

2349. Do you think it would make it easier to estimate efficiently if any additional charges, such as Whitley awards or increased prices, arising out of the rearmament programme, were borne so to speak by the Ministry on a percentage basis throughout the country?—(Mr. *Hurst.*) I think it would. We do foresee most of these not prices but wage awards which we know are being negotiated over long periods. It would be much better to estimate over a period of years.

2350. And it would do away with the feeling of insecurity?—Yes. It is not insecurity, but I think it is bad in principle. The incentive rather—I am not suggesting we do it—is to spend up to your estimate rather than to save on your estimate.

Mr. *Turton.*

2351. Will this global figure include capital as well as revenue expenditure?—I think revenue expenditure in the first place. Capital expenditure is different. We can see that capital considerations have got to be spread over a wider field. We would obviously like to know what we can spend on capital schemes, but we can see there are certain difficulties there.

2352. In fact your capital expenditure is programmed out over a number of years, is it not?—Yes, but if capital and revenue were linked together there is an added incentive to a hospital management committee to save on revenue to invest in capital schemes.

Mr. *Thomas Reid.*

2353. You do not propose to do that without the consent of the Ministry?—No. Each capital scheme obviously on other grounds has to be presented to the Ministry.

2354. You would not spend money, which you had saved, on capital expenditure without the approval of the Ministry?—No, but if we knew that the Ministry were likely to look at a scheme sympathetically if we could show a saving elsewhere, there would be an added incentive.

Chairman.

2355. Supposing you were given an allocation for the year on the general basis you recommend here and at the end of the year there was a small deficiency, do you think that deficiency could be made good in some other way than by calling upon public funds? I do not know whether Mr. Addison has any ideas on that subject. It has been suggested to us, for example, that money could be raised locally by voluntary subscriptions and so on. Would you regard that as possible?—(Mr. *Addison.*) I should think it is possible, but I should not think it is very desirable—not now.

2356. On the whole you would be opposed to that?—Yes, I should.

2357. You notice no pressure to give money to hospitals?—No. We get a certain amount for amenities both under legacies and otherwise, but I should think

an appeal for funds to make up a deficiency in running the hospitals would not be received with much favour.

Mr. *J. Enoch Powell.*

2358. Would you say the same if the purpose of the appeal was some clearly defined item of capital expenditure?—I should think that might be possible, certainly. If we could show that by raising a certain amount of money we could give some service which was not available at the present time and would not be available for some time, it might be possible to raise money for that.

2359. In your group, of course, the limiting factors are much more on a revenue than on a capital basis?—Yes. (Mr. *Hurst.*) And every new capital item increases the revenue account.

Mr. *Turton.*

2360. What amenities funds have you got, Mr. Addison?—(Mr. *Addison.*) Each hospital has got an amenities fund. We get a certain amount from the Ministry, from the free monies and so on, and the money, when it is received, is allocated to the various hospitals in proportion to their needs really.

2361. Do you know offhand the total in your area?—No, I do not. (Mr. *Hurst.*) In the free monies account it is only about £2,000 or £3,000.

2362. Is that all spent every year?—(Mr. *Addison.*) Yes.

Chairman.

2363. You do spend the whole of the income?—Yes. I go round and try to encourage them to spend it.

2364. You have some difficulty in getting it spent?—Sometimes.

2365. On what sort of things is it spent? —All sorts of things. Additional chairs and things for the nurses; chairs for the patients; wireless sets.

2366. Items purely in the nature of amenities?—Definitely.

2367. On page nine you speak about prodigious advertising costs?—Yes.

2368. Can you tell us the total of such costs in your area?—(Mr. *Hurst.*) I am afraid I could not tell you that offhand. I can send that to you. May I just add one point? All the management committees have agreed, and the region have agreed, to place a block advertisement for nurses in the nursing journals.

2369. You speak of bulk advertisements? —Yes.

2370. You speak in one place of bulk advertising and in another place about block advertising?—It is the same thing really, I think. What the management committees do is this: they send to the regional board a note of their vacancies, so many sisters, so many staff nurses, so many student nurses and so on. The whole thing is then made into one advertisement for the region; it is put into a block.

2371. For the whole region?—For the whole region.

2372. Not even for the Western Sub-Area?—No, for the whole region. There is a block. Actually the four Metropolitan Regions do this. There are four blocks, which take up one page, in the nursing papers. There is no doubt that there is a very considerable saving because sisters, for example, only come from other hospitals, and they read the nursing papers. They only want to know what sister vacancies there are and where they are. If each hospital inserts an advertisement for a sister the cost is probably about seven or eight times as much.

Mr. *J. Enoch Powell.*

2373. It is published as a list of situations vacant?—Vacancies for sisters at such and such a hospital and such and such a hospital, instead of four long advertisements in each case. We have only got halfway. The four Metropolitan Regions have done that and they are showing a considerable saving in money, but the difficulty is that we still get individual advertisements for vacancies in other regions who are competing for staff, and that has put us in an unfavourable position. What we suggest is that the block advertisement system should be extended to all regions, and that we feel would show quite a saving in money.

Chairman.

2374. On pages nine and ten of your memorandum you deal with the Hospital Eye Service. Can you give us any idea of what the size of that service is in the Portsmouth Group?—At the present time?

2375. At the present time?—On our hospitals alone, rather than on the Supplementary Eye Service?

2376. The Supplementary Eye Service is not your responsibility in any way?—No. At the moment I could not give you any figures for this. We issue a fair number of glasses. I should think, roughly, about sixty to eighty a week, but that is very much without reference. We are supplying a fair number of glasses.

2377. As you know the scheme of the Act was that the Eye Service should be the responsibility of the hospitals, and the Supplementary Eye Service is a temporary device because of the inadequate facilities within hospitals?—Yes.

2378. Here I think you suggest you could do a great deal more of the work than you are in fact doing. What is your limiting factor?—Frankly the incentive is not there. If we employ additional opticians and use additional medical equipment it means that, as our estimates have been approved, we have that much less money to spend on other things. Overall we are showing a considerable saving of money in the Eye Service.

2379. You can do the work provided you have got the money to do it?—Yes. We suggest there should be some system of transferring the money saved in the Supplementary Eye Service over to us. We would not need all of it; some of it could revert to the Treasury.

2380. You are not short of accommodation?—I think we could find a certain amount of accommodation.

2381. Have you got the ophthalmologists?—We should need more consultant sessions in ophthalmology, more opticians, a certain amount of equipment and a certain amount of room. It is not awfully space consuming.

2382. You would need some capital expenditure?—Some, not very much though.

2383. Have you formed any views on this at all? Have you made any estimates?—We have not because frankly we are in such a position that we have not put an awfully high priority on this, because we have got so many other things to do and because the incentive is not there to do it.

Miss *Ward.*

2384. You think it would be the very thing which would help in a saving of money to the Government?—Yes, because every pair of glasses which is supplied by the Hospital Eye Service instead of the Supplementary Eye Service shows a saving of £1 4s. 0d. a time.

Mr. *J. Enoch Powell.*

2385. That is a net saving?—Yes.

Chairman.

2386. I think everyone would agree with you that it is the policy, but it is generally stated that the hospitals cannot do it because they have not got the facilities. You are telling us yours have the facilities?—If the hospitals were told "For every extra thousand pairs of glasses you do a year you will have £X extra to do it", which after all will be saved on the Supplementary Eye Service, there would be an incentive, and I feel quite convinced that all the hospitals would get on and do much more about it.

Mr. *J. Enoch Powell.*

2387. It is not completely net?—No, but there is a saving. £1 4s. 0d. may not be the exact figure, but there is no doubt it is much cheaper to do it in the Hospital Service.

Chairman.

2388. Could you get the opticians? Your medical staff presumably could not do the work?—I think some groups are getting opticians. We have just appointed one. We are making a reasonable start with this. In fact we have now got two.

2389. Can you employ opticians for testing within the present Act and regulations?—Yes, under medical supervision.

2390. You think you would get the opticians all right?—I think so. There is a certain amount of difficulty naturally, from more sources than one.

Mr. *Turton.*

2391. What is the position with regard to pay beds in your area?—There are some pay beds.

2392. What proportion of your beds are pay beds and what proportion amenity beds?—Off the record, roughly half and half. We have a little more amenity beds than pay beds, but there are very few of either, about twelve and eight, something like that, quite a small number.

2393. Out of the two thousand beds there are only twelve pay beds?—Yes, roughly.

Chairman.

2394. Only twelve pay beds?—Roughly, something like that.

2395. What is the charge you make for those now?—It varies at different hospitals, somewhere around £12 to £13.

2396. That is on the statutory basis, including a full proportion of the overheads?—Yes.

2397. Supposing you had three times that number, could you fill them?—There is not an awful lot of pressure in our group for private pay beds.

2398. Is there much pressure for amenity beds?—A fair amount.

2399. On the whole the demand is higher for amenity beds than for pay beds?—Yes.

Mr. *Turton.*

2400. Are you satisfied that the Ambulance Service is working economically and well in your area?—We have had a number of joint meetings. We had one the other day, with the ambulance service people. We think it is a bad principle that one authority should provide the pool, and that another authority should be the principal user, the principal orderer, requisitioner or whatever you like to call it.

2401. Is there any wastage in ambulances coming from the area of one local authority not being able to take patients

from the area of another local authority?—We have not had undue difficulty.

2402. That does not arise with you?—No, we are fairly content.

Mr. *Thomas Reid.*

2403. Do people use ambulances unnecessarily?—Well, it is difficult to answer really. It is a matter of opinion more than anything. (Mr. *Addison.*) It has not been suggested at all. We had a meeting with the ambulance people the day before yesterday, and no suggestion at all was then made about the ambulances being used unnecessarily. The meeting was really to make arrangements to try to speed up the turnover of ambulances, when they bring patients to hospital to get them away again as soon as possible.

Chairman.

2404. You have no direct knowledge of the wasteful use of ambulances?—No.

2405. It is not your responsibility?—(Mr. *Hurst.*) No. We only hear things which I do not think we should repeat.

2406. All you can say is that they are not used as efficiently as they could be, having regards to the needs?—(Mr. *Addison.*) Yes.

2407. Also there are times when you are in difficulties, and at other times you find people come rather surprisingly long distances?—Yes.

2408. That is within your knowledge?—Yes. The idea of this meeting was to try to speed up the turnover so that, when the ambulances came to the hospitals, we should get them away again so that they would be available for another case as soon as possible. It was a question of stretchers and blankets mostly.

2409. We have asked you to let us have some further information. Perhaps you will kindly let us have that in due course?—Yes, we will.

2410. You will be supplied with a proof copy of the evidence you have given to-day. If there are any corrections you would like to make would you get in touch with our Clerk, Mr. Taylor, and we will do our best to see that they are put right. Otherwise I think I would like to thank you on behalf of the Sub-Committee for your memorandum and for coming here to-day?—Thank you.

The witnesses withdrew.

Adjourned till Thursday next, at 10.30 *a.m.*

THURSDAY, 12TH APRIL, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.
Mr. Thomas Reid.	

Sir HAROLD BOLDERO, M.A., D.M., B.Ch., F.R.C.P., Registrar, and Doctor F. AVERY JONES, M.D., F.R.C.P., Member of the Council, Royal College of Physicians, called in and examined.

Chairman.

2411. Sir Harold, for the purpose of the record would you say what is your position in the Royal College of Physicians, and introduce the gentleman you have brought with you?—(Sir *Harold Boldero.*) I myself am the Registrar of the Royal College of Physicians, and that I suppose might be described as the executive officer responsible for the College under the President and the Council. That is not my only occupation in life. I am also associated with a teaching hospital, of which I have been Dean for a good many years. Doctor Avery Jones, on my right, is a physician who spends nearly all his time at a big and very efficient ex-county hospital, now of course a regional hospital. We both have a little experience of the administration of this Act, because I am on a regional board and also on a hospital management committee and Doctor Avery Jones is on another hospital management committee.

2412. You both have personal knowledge of the administration of the Health Act, and you are here today as officers of the Royal College of Physicians?—Yes.

2413. Can you say for whom the Royal College of Physicians can be said to speak? Do you speak for the consultants and specialists particularly, or for the whole body of the medical profession?—In answering that question may I also draw your attention to the fact that this is a composite College document? I have spoken as if it might be mine; it is not; it is a College document. In replying for whom the Royal College of Physicians stand it is not easy to give one simple answer. The Fellows of the College are elected without examination from the ranks of the members, and, broadly speaking, members of the College are those who have passed examinations of a consultant status, that kind of level. That is to say the vast majority of the members of the College who are in active medicine are on the staff of hospitals. They are not, broadly speaking, in general practice; and as a College we certainly do not represent general practice. If we represented anyone we might claim to represent the consultants and hospital medical staff.

2414. This document is prepared from the point of view of the medical staffs of hospitals?—Yes.

2415. That would be a fair way of putting it?—Yes.

2416. This Sub-Committee is looking into the Estimates for the hospitals, I think I should tell you, primarily from the point of view of the method of administration and financial control. We therefore wish to put questions to you to elucidate your views on that aspect of the matter. We do not wish to stop you expressing views outside that field, but rather has it a bearing on those two aspects? First could we start with the doctor's part in the administration of the hospitals? Can you tell us what is your view of the present medical representation on boards and committees? —Do you mean is it satisfactory? What is our position?

2417. Do you think it is large enough? Do you think that the present proportion of doctors on boards of governors, regional hospital boards and hospital management committees is adequate or more than adequate?—You will realise this is not in the document, and therefore in replying to the question I am answering for myself.

2418. I understand?—My own personal view would be that it was numerically satisfactory on those bodies you have mentioned.

2419. I think it works out in the ordinary way at about twenty-five to thirty per cent.? —Yes, Sir.

2420. You think that would be enough? —Personally, yes.

2421. Do you think that the quality of man chosen from the profession to sit on these boards and committees is right? Do you think the Minister has exercised his choice well in that respect?—Broadly speaking, yes, Sir.

2422. On the whole you are satisfied with that aspect of the lay-out?—At the present time, yes.

2423. You speak in your memorandum* on page two of the difficulty which has arisen by reason of the interference of increasing committee work with the other duties of the senior staff of hospitals. It is the second paragraph from the top?—Yes. I think the medical profession working in hospitals are in a dilemma in this because the number of committees has greatly increased since the operation of the Act, and most of us are very anxious that the more efficient members of our profession should serve on those committees—but they are very time consuming; and it is, frankly, a dilemma.

2424. Do you see any solution to that dilemma?—No, Sir, because I see no prospect whatever of reducing any committees in any walk of life.

Mr. *Turton.*

2425. Do you mean committees of hospital management committees, committees of regional hospital boards or others?— I am speaking of all committees—in individual hospitals, regional hospital boards, hospital management committees and so on.

Chairman.

2426. Would it help you at all if your representation—I do not want to use that word in its strict sense—or your membership of committees was less but your right to be consulted was greater? We have had evidence that organisations representing the medical staff have not always got what has been called statutory status, and are not always consulted as much as they should be?—(Dr. *Avery Jones.*) I would agree with that. I think the senior medical staff committee of a hospital should have a recognised position in relation to the hospital management committee. I think they should be free and able to send a representative to the management committee to discuss any particular projects they wish. I sit on the management committee of my own hospital, but I sit there as an individual and not as a member of my staff. I do not represent always their views.

* Annex 3.

2427. I think no member represents their views in the sense that he is a delegate; he always sits as an individual. I think that is right, is it not?—Yes. I feel that the staff should have greater statutory recognition and should be consulted as freely as possible, particularly on questions of weighing up priorities between medical projects.

2428. Have you any knowledge, either personally or through the College, that there has been a failure to recognise or to constitute staff consultative committees? —I think that term is used in two connections. Staff consultative committees may refer to the staff of the whole hospital.

2429. I meant the medical staff?—I do not know of any myself, no.

2430. Sir Harold, have you any knowledge?—(Sir *Harold Boldero.*) Yes, Sir, but that was the fault of the medical profession itself in not being prepared to give up their individual medical committees in each hospital. All the medical and surgical staff, that is to say the senior doctors, should have a seat automatically on the medical committee of each hospital, but as hospitals have been grouped we also want a group medical committee, the one about which Doctor Avery Jones has been speaking, to be a counterpart of the hospital management committee. In other words, that would be the effective committee, and the individual hospital one would not.

2431. Such a group committee does not always exist?—It does not always function, shall we say?

2432. You would attribute that to a certain reluctance on the part of the medical profession to serve on the committee rather than to a lack of goodwill?—You asked me if I knew of any instances. I do know of one instance where an individual hospital was unwilling. They thought it would belittle the power of the medical committee in the individual hospital.

2433. Can you suggest a remedy for that? Would you say that some regulation should be made requiring such a committee to be formed?—The answer is yes, because on more than one occasion I served on the medical negotiating committee when this was a Bill, before it was an Act, and we still have meetings with the officials of the Ministry of Health. We have asked a good many times that it should be made statutory or that it should be written in somewhere.

Wing Commander *Geoffrey Cooper.*

2434. The answer given by Sir Harold a short time ago was to the effect that the tendency was for the best medical advisers not to serve on these committees because they absorbed so much time. I think you rather tended to deprecate the committee system, and yet you felt it would be more or less inevitable?—I have conveyed more than I meant.

2435. Would you like to qualify that?—I said it was a risk that owing to the number of committees the better medical man might say, "I am a doctor; I am not going to waste my time on committees." I did not mean to say it had happened yet.

2436. If you had the opportunity, however, of devising a system which would result in each individual hospital having first of all the most effective and comprehensive advice that it could have and at the same time be individual, and therefore perhaps do its job more efficiently than is possible with a hierarchy of committees, could you devise a system? Has your College thought out at all a system which might achieve the results of individual efficiency to a greater degree than seems to be possible now?—I am speaking largely for myself on past decisions of the College because it has not discussed this particular aspect in the last three or four years, but if I am asked how I would arrange it if I was a dictator I would say that I would make the medical committee, which corresponds at whichever level we are considering to the hospital management committee, the regional hospital board or the board of governors of a teaching hospital, a statutory committee, and I would make it necessary for the executive committee, that is the board of governors, the regional hospital board or the hospital management committee, to consult them compulsorily on all matters which directly or indirectly concerned the work of the medical and surgical staff. I would then put very few doctors on the executive committee, whatever it is—board of governors, regional hospital board or hospital management committee.

Chairman.

2437. To amplify your answer, in the case of the hospital management committee you could presumably have the medical staff committee comprising the entire senior staff. I think that was the suggestion you made?—(Dr. *Avery Jones.*) Consultant staff.

2438. Would you not include the registrars?—(Sir *Harold Boldero.*) No, Sir.

2439. Not at all?—(Dr. *Avery Jones.*) No.

2440. Would you give them any status, or would you give them a separate committee? —I think the best arrangement is for a meeting to be held at intervals with the registrars by one of the senior staff, and they should have the right to bring subjects up for discussion at the senior staff committee. Most of my colleagues feel that

those who have the responsibility of the hospital, those who have a permanent interest in the hospital, should be the members of that official medical advisory committee.

2441. When you get into the larger sphere of the regional board would you still have every consultant employed by the regional board a member of that committee? How would you constitute that?—(Sir *Harold Boldero.*) That is quite impracticable owing to the numbers. There would be about six or seven hundred on that committee in some cases. The way I would do it is this: I would make every medical member of that regional board serve on the medical committee, plus some elected from among the consultants employed by that board.

2442. You would have that on an elected basis?—Some of them. The medical members of the regional board I would have as *ex officio* members of the medical committee.

Mr. *Turton.*

2443. I thought your idea was to remove the medical representatives from the executive committees and to put them upon this medical advisory committee. If you do that you would not have them on the regional hospital boards and on the hospital management committees?—I said reduce them. (Dr. *Avery Jones.*) I would not agree to eliminating the medical members of the executive management committee because I do feel they serve a very useful function in guiding the deliberations of the lay committee. I think they can do so even better than the medical representatives coming up from a group medical committee.

Chairman.

2444. I do not think it has been suggested that there should be no representation. The point you made was that it was burdensome, perhaps unnecessary, to have so many, and that I think is borne out by the evidence generally?—It is burdensome because each committee produces sub-committees. You start off with one committee, and then you will find yourself with four or five sub-committees, which of course does take up a lot of time. The organisation I myself envisage is each hospital in a hospital management unit having its own senior staff committee, with its chairman and all the consultants serving on that committee, that medical unit advisory committee being recognised by the hospital management committee and sending its chairman to their meetings and the meetings of their appropriate committees, general purposes, finance and so on.

Wing Commander *Geoffrey Cooper.*

2445. When you say "unit", you mean hospital group?—No, I mean the individual hospitals, and here I am thinking chiefly in terms of the bigger hospitals in the unit. You may have a hospital management committee concerned with four or five hospitals, some of them very small—those admittedly could be disregarded; they need not have a separate committee—but where you have a 500-bed or a 600-bed hospital I think that should have a unit committee with its chairman coming up to the hospital management committee. Then, in addition to that, you can have, and I think it is advisable to have, a group medical advisory committee. Items can be referred from the management committee back either to the unit or to the group committee, and again the chairman of the group medical committee could come back to the management committee to join in the discussions.

2446. With regard to this sequence of committees which you have described, which was non-existent before the Health Scheme came into force, is it actually required in order to improve the standards of efficiency generally in the hospitals or is it made absolutely essential by the system?—It has two purposes. The unit committees keep the senior medical staff together and working in cohesion, so that they have a sense of responsibility for the unit as a whole. The group medical committee is extremely valuable as a co-ordinating influence within the group.

2447. I think you mean that it is something which is essential in order to improve the general standards of the Health Service anyway?—Both essential to improve and maintain the standards. The group medical committee is very important to link the various hospitals in a group together. Until recently they have been working as isolated independent units under the Health Service. Grouping them into management committees the tendency is to get each group working together, and in order to get that cohesion you do need this group committee. There is one other possibility which has been put forward, and that is that one should have a group medical adviser, an official medical adviser, for each management committee. That is an alternative possibility.

Chairman.

2448. An adviser appointed by whom?—An adviser appointed by the management committee itself. It has been found sometimes that it is difficult to get a clear expression of opinion from a group committee, and there are some people who feel that instead of or as well as a group committee there should be a group medical adviser.

2449. Is that the view of the College?—No, I do not think so It is personal.

2450. It has neither been accepted nor rejected by the College?—No Sir.

Wing Commander *Geoffrey Cooper.*

2451. What I am driving at is this: it has been suggested on more than one occasion that committee work is increasing all the while, and it may increase to the point where it does become a hindrance rather than a help to the Health Service. One wants to keep committee work down to the minimum. Can you see in line with the description which you have just given us, taking the scheme as a whole from the Ministry downwards, a means whereby some of the stages of committee work can either be reduced or eliminated?—I think you have got to have the management committee set-up with its committees. In fact I personally feel that the more responsible a management committee feels for its finances the more efficient it becomes. I do not see any alternative to having the H.M.C. and its various sub-committees.

Chairman.

2452. There is one vital point in this: do you quarrel with the principle that those medical men who serve on committees and boards should be appointed by the Minister, or are you suggesting they should be in fact representatives of the profession?—(Sir *Harold Boldero.*) The College has always held the view that they should be nominated by the section of the profession concerned. We have kept quiet since the Minister has so often put on the people that the medical profession would have put on.

2453. In other words, you think that you should have the responsibility, but you are satisfied in practice with what has happened since the Act came into operation?—So far, broadly speaking. (Dr. *Avery Jones.*) I agree with that. (Sir *Harold Boldero.*) But we are not satisfied with the principle.

Miss *Ward.*

2454. Do you think it would be a protection if there was an alteration in the established practice?—I am not speaking about any particular Minister, but so long as someone sitting in London, who gets advice whence we know not, chooses some doctor in a country area to represent the other doctors there, we do not think he is competent to do that. We think the name should be put up to him. We do not mind the name being put up to him so long as that one is appointed, and, broadly speaking, so far that has happened.

Mr. *Thomas Reid.*

2455. Who puts up the names now?—The regional board, the board of governors; and the management committee put them up to the region.

Chairman.

2456. The medical profession is consulted?—It is. For a board of governors where a hospital is directly under the Ministry, the Ministry officials consult the University concerned. They consult the individual hospital concerned and a good many other bodies; in fact, if one wanted to be critical—I am not, because the appointments have been, broadly speaking, entirely satisfactory—so many bodies are consulted that it seems to me that the person responsible, the Minister of Health, could put on anyone he liked.

Mr. *Turton.*

2457. If you had your way and the medical representations on boards and management committees were limited, it would become all the more desirable, would it not, to have the medical profession nominating?—Yes.

Chairman.

2458. Could we turn now to the technical aspect of the matter? Would you say that the present number of consultants in the Service is adequate?—The College's view, quite definitely, is that there is a shortage of consultants throughout the country.

2459. Can you say what you consider that shortage to be?—Numerically or by specialities?

2460. Overall—or is it impossible to answer in that way? Would you have to classify them?—It is taxing my memory, that is all. I do not think I can remember. I believe there are 5,200-odd consultants at the present time.

2461. Some of those are part-time, of course?—Certainly.

2462. I think the figure which has been given officially is that there are now 5,000 and some hundreds, mainly part-time, and the figure to be aimed at is the equivalent of 7,000 full-time. Do you quarrel with that figure?—No, Sir. It is a more generous supply of consultants than the number for which I would have pleaded. I think it is very desirable. I would support that. (Dr. *Avery Jones.*) I would also support that. From my experience in a regional hospital there is no doubt a great deal of consultant work has now to be done by the registrars, particularly the senior registrars, and as a long-term policy we cannot envisage the existing ratio between consultants and registrars. We must have more consultant posts in the future and fewer senior registrars and other grades of registrars, otherwise we will not be able to place them at the end of their training. From the public viewpoint I have no doubt myself—I will not quote an exact figure—that a substantial increase in the existing number of consultants is needed to saturate the public demand. There is no doubt the public demand has very much increased on the hospitals in the past few years.

2463. Could you say, assuming for the moment that there is going to be little or nothing available by way of capital expenditure, whether there is adequate accommodation and other facilities available to enable a substantial increase of consultants to work in hospitals?—(Sir *Harold Boldero.*) I think the word "substantial" is the point. There certainly are facilities, opportunities and the need for men now without any further expenditure of capital, but not I think to the equivalent of perhaps whole-time and part-time representing 7,000 whole-time.

2464. That would involve considerable capital expenditure?—The full number I should think would involve a capital expenditure of considerable size, but somewhere between the present and the ideal I would think could be absorbed at present. It is guesswork, of course.

Mr. *J. Enoch Powell.*

2465. The limiting factor at present in the amount of hospital treatment which can be given is personnel, and particularly consultant personnel, and not space or equipment?—Primarily personnel I would say, and, secondly, space and equipment. (Dr. *Avery Jones.*) It is surprising how much more work can be got out of a hospital, wards or out-patients, if one has adequate staff, and staff who know how to set about the investigation and treatment of the common conditions.

2466. Would it, for example, make possible a quicker turnover in the occupation of beds?—Without a doubt. An increase in consultants could be affected to a certain extent by replacing a number of present posts of senior registrars as consultants, and so you do not have an absolute increase in the salaries of consultants; you can offset the salaries of some of the registrars.

2467. In fact the senior registrars at present are doing consultant work?—They are already doing consultant work.

2468. In that case how do you get extra consultant manpower by simply changing their title and remuneration?—Well, you will have to have some increase in house staff to go with those consultants. (Sir *Harold Boldero.*) The Sub-Committee will be aware that the Ministry has issued a note that the number of registrars shall be substantially reduced.

Chairman.

2469. That is another matter now *sub judice*?—The issued of their paper is not *sub judice*. Their action and how far they implement is definitely *sub judice*.

Mr. *J. Enoch Powell.*

2470. As I understand it, Doctor Avery Jones' argument is that the net increase in medical personnel, which would in any case be necessary, should take place at a lower grade than that of consultant. That is the point?—(Dr. *Avery Jones.*) No. To get a stable medical population of consultants, I think you need more consultants and fewer registrars. There is an excessive number of registrars in training at present when compared with the probable number of consultant posts coming up, and in order to get an equilibrium you want to increase the consultant posts. Many of these men are already trained as consultants, and in future you should reduce the number of training posts. I see your point. We are not increasing the actual number of consultant hours to the public by that manœuvre, but we are creating a much more stable consultant medical population.

2471. You in fact agree that, in order to obtain the more efficient use of equipment and space, it would be necessary, however it is managed, to have a net increase in medical personnel?—Yes.

2472. But you argue that the net increase need not take place at the consultant level, but that it could take place lower down with an upgrading above, as I understand your argument?—Yes.

Chairman.

2473. Could you tell us the position as regards out-patient arrangements at the present time? Is there an excessive demand for out-patient treatment, having regard to the facilities available?—I will give you the picture of my own hospital with regard to out-patients. There has been a steady increase in out-patients in recent years. In 1943 we had approximately 8,000 new patients coming to the out-patients' department of the hospital. Last year it was 24,000 out-patients, a three-fold increase. A very considerable part of that increase has taken place in the last two or three years. In fact last year it was the biggest single increase we had. That increase, as I see it, is a perfectly legitimate increase. The patients coming up are patients with doctors' letters. They are suffering from troublesome conditions which merit hospital investigation. We find it very difficult to deal with an increase of that order, particularly in relation to X-ray facilities, but nevertheless, as I see it, it is a perfectly reasonable demand from the public on the hospitals. The demand, I think, has increased partly as a result of the improved standard of medicine by general practitioners, and partly by the better public education in health. I think patients today expect to be X-rayed when they have dyspepsia whereas before the war they did not dare mention it to their doctors, even if they thought about it. I think the doctor-patient relationship has probably altered. I think today the public are much more prone to ask the doctor to send them to hospital whereas, before the war, they were a little nervous and frightened, and they did not do so.

Mr. *Turton.*

2474. Is it not also due to the fact that the general practitioner is so overworked that he has not got time to make the full investigation that he had before the Act came into force?—I am quite certain that is another important factor. The work of the general practitioner has greatly increased, particularly in relation to children and wives, and doctors are only too anxious and too willing to send patients to hospital when so many people are waiting in their waiting rooms.

Chairman.

2475. Your evidence is though that on the whole the patients you see as out-patients are cases which are properly sent to hospital?—They are all patients whom I myself, if I were a general practitioner, would send to hospital, and that is the experience of all my colleagues. The type sent up is a perfectly reasonable hospital case.

2476. You really have no reason to think that the facts bear out the proposition that the general practitioner is getting rid of his patients on the hospital in cases where he should not?—No. I think the cases sent up are reasonable propositions, but I have no doubt that with the combination of being a little overworked and the public demanding investigation they are sent up sooner than they might have been before the war.

2477. There is evidence of a pressure, but the tendency is not anything which could be called deliberate abuse?—As far as I am concerned it is a desirable trend. I to-day deal mostly in gastro-enterology and diseases of the stomach, and to-day I see far more patients with a short history of weeks or months of stomach trouble whereas before the war it was unusual to get patients with short histories. They had usually had five or ten years of stomach trouble. In other words, we are beginning at the hospital level to appreciate how much ill-health there is in the community.

Miss *Ward.*

2478. It would lead to economies in the Health Service in the end?—I think so.

2479. The earlier diagnosis?—The earlier diagnosis and more efficient earlier treatment are, I think, most desirable.

Wing Commander *Geoffrey Cooper.*

2480. Would either Sir Harold or Doctor Avery Jones care to comment on the point of the general practitioners not being able to follow their cases through into hospitals? Does that have a harmful effect, suddenly to change the advice with a completely fresh group of people, at a time when a patient goes into hospital?—I personally think two heads are better than one. I think that if you have a problem patient it is better to get independent advice by someone looking at the case afresh, and I think the patient benefits from having a second independent opinion. For that reason I welcome it.

2481. Is it at all harmful to the general practitioner standard of performance not to be able to follow his patient more closely in hospital?—I think the general practitioner should have a closer link up with the hospital in that there should be good facilities for social contact with the hospital staff. I am expressing a personal opinion. I would like to see a regional hospital like my own giving dining facilities and club facilities for local practitioners so that they could drop in for a meal and discuss a case with us, visit one of their patients, and go off on their round again. I think that sort of link up would be very useful to both sides.

Chairman.

2482. Does that exist in any case?—I do not know of it, no.

2483. Do you know in fact if there is power to do that?—It could be done perfectly well by any management committee.

2484. You suggest there should be a dining room—and perhaps a library?—Yes, I think that is another point. I think many hospitals are now developing a medical library. It is a very desirable move, and I think it is entirely reasonable that local practitioners should have access to that library. There is one other aspect of this problem. I think G.Ps. have a reasonable claim to direct access to the pathological department and, to a lesser extent, the X-ray department. I know the more energetic practitioners are worried and perturbed by their difficulty in investigating cases themselves, and I think it is quite reasonable for them to be able to get a blood count or an X-ray of the chest, or something like that, themselves before sending the case to the consultant. It does mean an extension of the pathological department and the X-ray department because, already in most cases, both are over-burdened, but it would have the effect in the long run of reducing the amount of out-patient work. The local practitioners would be able to investigate their cases themselves, and with the higher level of training of practitioners to-day I think it would be reasonable.

2485. There is scope for allowing the local practitioner into the hospital to do work within his own expertise?—No, facilities, access to the departments, so that he can ask for a blood count to be done on Mr. X. At the present time, if he wants a simple investigation done, that patient must

be referred to the consultant in the out-patient department and be seen by a consultant or registrar. I must admit that a proportion of the cases looked at do not really merit a consultant's opinion. They are cases for investigation rather than consultant opinion. If one did have direct access for the general practitioner to the path. and X-ray departments, you would reduce to a certain extent the pressure on the out-patient department.

Mr. *J. Enoch Powell.*

2486. Is the limitation in the availability of these facilities personnel or material? That is to say you said there was already pressure on these departments, and this would further increase it. Is that primarily pressure upon the material and space or upon personnel?—It is primarily on material and space.

Wing Commander *Geoffrey Cooper.*

2487. Do you think it is a service which could in fact be offered by most hospitals already, or do you think it is something extra?—It is something which could be offered on a limited scale. We already do it on a very limited scale to practitioners we know, but we are unable to offer it to every practitioner.

Mr. *Turton.*

2488. Doctor Avery Jones said there had been a 300 per cent. increase in out-patients. Are the indications of what is happening now showing that that percentage increase is growing, or is it stable?—No, it is unfortunately still increasing.

2489. What is your anticipation of what is going to happen in the next two or three years on this line?—It is very difficult to foresee. I suspect it will continue. The curve will begin to flatten out in the next two or three years, and should do judged by the tremendous increase we have experienced. Last year was the biggest single increase in any one year, which does not suggest that the curve is beginning to flatten out—in fact the reverse.

2490. Is that the common experience in other regions? Sir Harold, could you say that?—(Sir *Harold Boldero.*) In other hospitals, yes, Sir. The amount of investigation, particularly pathological and X-ray, which is necessary is a constant problem. I can only support what Doctor Avery Jones has said, differing to this extent: I do not think it right that the practitioner should have to get pathological examinations done at hospitals, and X-rays will never be done at hospitals only because nearly five times the volume of this particular type of work is now being done, and that is only catching up with scientific development I think. That is not being done for the general practitioner. There should be simple facilities for simple investigations to be done by general practitioners, to save the hospitals, and they will have to be set up at health centres or some other place outside the hospital.

Chairman.

2491. You are deploring the absence of health centres?—Not all aspects of them. I am deploring the absence of these facilities for general practitioners.

Wing Commander *Geoffrey Cooper.*

2492. They are not provided. It means that the general practitioners will fall back in the knowledge and experience which they should have?—Yes, it means that the attitude of medical students, in whom I am really interested, the future doctors, will be " You must avoid going into general practice at all costs."

Wing Commander *Geoffrey Cooper.*] Could I ask Doctor Avery Jones this, as he mentioned he was a specialist in stomach troubles? It is often agreed now that these are often caused by mental worries, attitude to life and that sort of thing. Is there any sort of process being introduced into hospitals of screening patients as they come in so that they do not go through a tremendous amount of treatment of a purely physical nature to get rid of a trouble which is entirely mental? I myself was in hospital recently, and I am told that they do now raise a card for the various aspects of each disease—and one of these is the psychological aspect of it. It may well be that, if it is viewed from that standpoint, instead of persons going through a long course of hospital treatment they could in fact remain in their own homes, get a better slant on things, and that would have the desired effect. One of the doctors told me that a very big proportion of people are coming into hospitals now, when the facilities are greater, people who did not come before, people who are in fact suffering from all sorts of home, business and other worries which really were not suitable cases for hospital treatment so much as being taken in hand by someone who understood them.

Chairman.] I think we really come to that when we come to ask questions about what is said on page four.

Miss *Ward.*] I suppose it is true to say also that the nation is becoming more health conscious?

Wing Commander *Geoffrey Cooper.*] Or it is more sickness conscious?

Miss *Ward.*] No, to take time by the forelock I would not call sickness conscious.

Chairman.

2493. I do not think we can argue those points out now. This is really getting into the financial question, and we are now dealing with the position of the consultants in

hospitals. Could I move forward a little from the question of out-patients to the question of interference with other essential work? How far is this tremendous demand on the services of consultants interfering with necessary research and development work?—Is the question whether the amount of pathological and X-ray work which has to be done interferes with research?

2494. Yes?—Definitely.

2495. With regard to the pressure of patients on hospitals, is that interfering with research and development work?—I would have thought that in all good—that means active—hospitals the factor about which you are now asking must be operative, that men and materials are being used for investigation and treatment at the expense to some extent of research. May I ask Doctor Avery Jones, who is one of that limited number on both clinical and research work, to speak to your question?—(Dr. *Avery Jones.*) I think so. I would agree with that. There is no doubt that greater pressure on the X-ray department and on path. department is greatly limiting the facilities which those departments can offer for clinical research in hospitals. With great difficulty I have persuaded my X-ray department to allow me one session a week for a certain research project, but I could very well do with three or four sessions. There is just no possibility of getting them with the increasing number of claims on that department. As you see in the figures quoted in our memorandum they have gone up from 6,000 in 1939 to 22,000 last year, which is a very substantial increase on the accommodation which is virtually the same; there has only been slight enlargement.

2496. That tendency must be obvious. In fact are the boards and committees taking active steps to ensure that this pressure does not interfere too much with research work?—(Sir *Harold Boldero.*) You cannot when your maintenance and your capital grants are cut. It is a matter of spending money. To put in another X-ray plant you have got to build the room for it, pay for the X-ray plant and you have got to staff it.

2497. Does research necessarily involve capital expenditure of that kind? I thought it involved the use of manpower rather than that?—I beg your pardon. I thought you meant to overcome the disadvantage that research is being squeezed out by the daily work?

2498. Yes?—The only solution to that is to spend money, is it not, on more men, more space and more machines?

2499. That is to meet both, but within the limits at present available is there an active effort being made to ensure that research is not altogether prejudiced?—(Dr. *Avery Jones.*) I think the emphasis is almost entirely on the care of patients and in dealing with the demands from the local public. The responsibility for research, although it is within the Act as part of the responsibility of the regional hospital boards and management committees, in practice is left to the Medical Research Council and to the medical foundations. There is room for very great improvement in the attitude towards research in regional hospitals, and I think it will come. I think the regional hospital boards and management committees have been so busy getting their own house in order that the research aspect has not yet received all the attention it deserves. I think it will come, and already six out of the fourteen regional boards in the country have organised research committees. Those committees, I am quite certain, will take the view which you suggest, that they should try to make certain that there are material facilities for research in their region and at the same time providing the men and the money to do the work.

2500. Do you think that is the right way of tackling this problem?—Yes. I think one must accept the primary responsibility for the care of the patient and leave that as the primary responsibility of the regional boards, but let them on top of that graft on the research interest and research activity. That does mean, I think, having a research committee at regional hospital level, and at the same time perhaps providing small sums easily available at hospital management committee level. It will come.

2501. I wonder if you could tell us something about the problem which has been exercising the minds of most of those in hospital administration, and that is the position of the teaching hospitals in the present set up. In Scotland the teaching hospitals are part of the general machine and come under the regional boards. It has been suggested to this Sub-Committee, and discussed elsewhere, that that is a sounder principle than keeping the teaching hospitals separate as they are in England. Has the College any views on that subject?—(Sir *Harold Boldero.*) Yes, Sir. It has expressed very definite views when the present Act was a Bill, or on one of the earlier ones. I do not think that, if we re-opened that question now, we would get a different answer from the one I am now going to give you. Teaching hospitals value the position in which they are under this Act, that is to say direct responsibility to the Minister, and not as one unit in a region. I think why we value that is that we think our interests and responsibilities will be diluted if we are one unit in the far larger organisation of the region. I serve on the regional board and I serve on the board of governors. I am in a hospital. For

example, the under-graduate teaching hospital, of which I am a member, has more autonomy and more power to do the things which it believes to be right than it would have—I am not comparing it with a regional hospital—if it were one unit of many in the region.

2502. The complaint made is that the strong position of the teaching hospitals has tended to make them a *corps d'élite* drawing off too much of the cream. Do you think there is any truth in that?—I am not sure from where they draw the cream, except that the Army accept the necessity, if you like—I am not claiming we are a *corps d'élite*—that the standard set by a spearhead, which is allowed to spend more money on this, that and the other, particularly on research, is a proper justifiable situation.

2503. Can you tell us how the teaching hospital fits into the region? Perhaps I will put it this way. The suggestion was made to us in the case of one region that it was excessively large and inconvenient to administer, but that it was impossible to divide it into two because there was no teaching hospital in one part of the area. Do you think that a region could function without having a teaching hospital within its area?—Oh, yes, Sir.

2504. Do you perform any particular function for the regional board?—Might I answer the question by putting this, "Do we perform a particular function?" That is one of the reasons why we do not want to be in the region. Our primary reponsibility is the teaching of undergraduates—I am speaking of undergraduate schools, not the teaching of existing doctors, post-graduate work—and, quite frankly, sometimes it is at variance with the primary duty of treating patients. Let me give you a very simple instance. A consultant is seeing his out-patients, and if he is at the same time teaching a class of students it will take him so many minutes longer to complete seeing twenty patients. That is not in the interests of the patients, because he could have seen twenty-one or twenty-two in that time. There is no real conflict as regards the other angle of it, other than the way that your time and money is spent. The regions are not interested in under-graduate teaching primarily; they have got a different duty. One other angle is that certain types of illness are more necessary for undergraduate teaching than other types of illness.

2505. You then dispute the proposition that you could not have a satisfactory region without a teaching hospital inside? You think the region could get on perfectly well completely viable?—Shall I put it this way? A region which had a good start in efficiency could conduct, and does conduct, its business perfectly well without the presence of an undergraduate teaching hospital. (Dr. *Avery Jones.*) You could take the example of the Middlesex County Council before the war where they had a complete and reasonably efficient medical service for the whole of Middlesex. Admittedly you had got the teaching hospitals in the background to which to refer patients if necessary. I agree with Sir Harold. Although I work in a regional hospital, I value the independence of the teaching hospitals. I think there is a lot to be said for having some hospitals outside the region and free to develop on their own particular lines. I do feel that there is increased scope for co-ordinating the regional boards and the teaching hospitals. That is being done in some of the regions outside London, but I do think personally there is a greater scope in the Metropolitan area.

2506. What form of co-ordination do you contemplate?—I contemplate a link-up of the junior staff. At the present time registrars in regional hospitals are competing against registrars in teaching hospitals for senior posts, and naturally the people in teaching hospitals, working with better-known men, win most times. On the other hand the regional hospitals need registrars for developing their services. I think one should establish some liaison—I know it is going to be difficult in London—between regions and teaching hospitals for exchange of staff. I think that is one aspect. Perhaps Sir Harold would like to comment on that. (Sir *Harold Boldero.*) I entirely support that, and it has happened in some regions. It is happening quicker the further you get from London, roughly. It is a simpler problem, incidentally, in the country. I am quite sure that all the teaching hospitals will agree with what Dr. Avery Jones has said, because the teaching hospitals can learn and obtain valuable assistance from the regional hospitals in the teaching of their students. I personally believe there is a good deal more co-operation between regional hospitals and teaching hospitals than is popularly known. Your Sub-Committee is aware that the teaching hospitals are sending their nurses to sanatoria—where the sanatoria could not enrol their own nursing staff and so on—thus enabling more beds to be opened; and our nurses are learning how to nurse tuberculosis and so on.

2507. As far as the regional board is concerned it does not derive so much benefit from teaching hospitals as the teaching hospital can derive from the regional board hospitals?—That may be.

2508. The region can get on quite well without any direct connection with a teaching hospital. I think that is the gist of your evidence?—Sight is not being lost of the fact that it is better to see the picture in the provinces more particularly than in

the Metropolitan area. There the teaching hospital is really in that region the apex. There the hospitals are not so developed—I am talking about the provincial regions—as the Metropolitan hospitals before the war, and therefore the teaching hospital could contribute a personal example much more to those more backward local authority hospitals than was true in London.

2509. I want to turn now to the question of hospital costs. You make the point that hospital costs have risen in this country but that they have also risen in a number of other countries. Have you any comparison at all to show how far they have risen relatively here?—I have not got the figures with me.

2510. You make the comparison at the top of page 3 of the memorandum where you say that in America in particular hospital costs have already risen very steeply?—Yes.

2511. You do not know how far they have risen in this country in proportion to the general rise: you have no figures?—I have not got the figures with me; I have seen them.

2512. Are there figures available?—I do not know how reliable they are. Do you know the answer? (Dr. *Avery Jones.*) I do not know. They have certainly gone up three times in Sweden, for instance. I am just thinking in terms of my own hospital which before the war spent about £450,000, and to-day spends about £700,000.

Wing Commander *Geoffrey Cooper.*

2513. Mr. Chairman, would it be worth while getting a sort of rough check of those tendencies from the Ministry?—(Sir *Harold Boldero.*) The Ministry have got the figures.

Chairman.

2514. I wondered, as some figures have been given here, whether the College had got rather fuller figures which would be most interesting to the Sub-Committee. Have you any such figures?—I think I could undertake to give them. They would be only quotations from the Ministry of Health.

2515. If that is so, it would be more convenient that we asked the Ministry of Health direct?—Yes.

2516. Part of this increase may be due to wasteful expenditure. I am not asking you to agree or disagree whether or not it is, but clearly part of it might be. On page 5 of your memorandum you give an example of the sort of thing that may happen, where you suggest that possibly £10 bottles of plasma are being used when 3s. 6d. bottles of saline could be used for the same purpose?—(Dr. *Avery Jones.*) Yes, Sir. I think that is just to illustrate the general principle. People working in hospitals have no idea of the cost of the remedies and investigations with which they are dealing. I am quite certain it is true that many of the junior staff have no idea of the cost of an X-ray or the cost of a bottle of blood or plasma. They do not weigh up the costs against the particular need for their action.

2517. Has there been a change in that respect since 1948? Is there a tendency to more sheer waste?—There is no improvement in the information available to medical staff on the costing of various aspects of hospital life. (Sir *Harold Boldero.*) If I may explain it in a slightly different way, it is nothing new because of the introduction of the Health Act. There is still the difficulty of making the junior medical members particularly of hospitals economise. Every housewife I imagine has the same problem in making the cook economise. It is exactly the same. Leaving out for the moment whether there has been an unnecessary increase in extravagance—I have never experienced that, I do not think—this is an illustration that one of the ways of helping the administration of each hospital would be by a knowledge of what a bottle of plasma did cost. It is perfectly true that there are lots of junior people at regional hospitals who do not know that it costs the nation £10 for a bottle of plasma. That is why the illustration is there.

2518. How do you suggest that practical policy can bring it home to those concerned?—It requires constant vigilance by the senior people—this has happened before—and rewards for the senior people.

Miss *Ward.*

2519. What sort of rewards?—Being allowed to retain balances. (Dr. *Avery Jones.*) Not personally; for the hospital.

2520. Quite, but how would that in fact add to the national economy if balances were retained?—(Sir *Harold Boldero.*) It would add to the national economy in my judgment by making all of us who work in hospitals responsible for the cost of the hospitals indirectly, apart from Whitley and its machinery which is a major problem about which we cannot do anything.

Wing Commander *Geoffrey Cooper.*

2521. Can we not?—The individual cannot. I think it assists here to examine the attitude of mind. It does not matter where you work in the hospital. It is attitude of mind towards your job, whether you use three or two pieces of paper to do it. There must be some benefit accruing to the attitude of mind which only uses two instead of three pieces because it is more bother.

2522. Is it not part of the job of the chief executive of each hospital, who seems to be the secretary, to educate his people;

it is part of the job of a general manager in a factory to educate his people?—I would accept that.

2523. There is training in industry for that; it is all part of the joint consultation. That attitude of mind to which you referred can surely be cultivated by taking some specific steps. Is not the problem perhaps this, that the chief executives in each hospital must be trained in this attitude of mind?—To some extent I am sure that is true, but your chief executive wants some assistance.

2524. Does he want some incentive?—He may.

Miss *Ward*.] In other words, you would like to see in any hospital that the result of the joint efforts of the hospital was known and could be compared with other hospitals which perhaps had not developed that point of view quite so highly.

Chairman.

2525. I think this was your suggestion, Sir Harold, that if you set an overall limit you will automatically give the senior members of the hospital the necessary inducement to ensure that their staffs economise. At the moment or hitherto the position has been that if money was required it could be obtained. If it was not spent you did not keep it anyhow, and it is that tendency which you want to counteract. Is that right?—Yes, Sir. From our point of view, if money was not spent, if it was saved, it was lost.

Mr. *Turton.*

2526. Your suggestion is that balances unspent should be kept by the individual hospital, by the management committee or by the regional board?—I would say it should be kept at the level of the teaching hospital or the hospital management committee, by the people who are doing the work. I think there is a difficulty about my thesis because it is a very young Service. I am responsible for a medical school; we have funds, as you know, but quite a high proportion in some cases is Treasury money—but to give you a fair picture they are little over half our total expenditure. We decided on what we will spend our money. A lot of it is fixed, as is everybody's. We decide not to have so many porters or so many assistants; there is to be this or that. I would be very unhappy being a responsible executive officer if I had to economise by simply dictating to heads of departments that they had to have one less assistant. It does not get you anywhere.

Wing Commander *Geoffrey Cooper.*

2527. Is not the whole of the Hospital Service run under a system of budgetary control and yet the comparable figures at the end of the period are not made available to all and sundry, marrying the results with the intentions which were put forward for the budgetary period?—Yes, Sir.

2528. You advocate on page three of your memorandum that the final result should be made known to the individual hospitals as early as possible?—Yes.

2529. The global results as published by Parliament are no advantage or have no effect in achieving this particular objective. It would be achieved, or more likely to be achieved, if the hospital accounts were published as early as possible after the end of the period, in comparison with the budgetary intention. That would provide some incentive. Is that really what you are putting forward?—That is one of them.

Mr. Turton.

2530. Could I repeat the same question? Does that mean for the individual hospitals or for the hospital management committees?—I would say the management committee—it is the smallest unit—and the individual teaching hospitals. (Dr. *Avery Jones.*) Yes. There is very little general knowledge of cost, even by those working within hospitals—I am quite certain of that. Even the majority of my fellow consultants have no idea of the cost of any of the services which they are providing because information is so difficult to obtain. It does come to our hospital management committee, and that is about all. There is no circulation within the hospital; there is no reference back to the unit advisory committee. The doctors are working completely in the dark, at least our doctors are, as far as the costs of the hospital are concerned. I personally feel that if one were able to get over the cost of parts of the hospital service it would help, and people would have a better understanding of the Service.

Chairman.

2531. Would it be fair to put your proposition in this way? At the moment the question which management committees ask themselves is do we want two more hands in the kitchen or not, and the only test they have is whether or not they can get the money for it. You are suggesting that the question should be put to them in this way: "We have got the money; are we going to spend it on two more hands in the kitchen, two more porters or two hands somewhere else?"?—Yes.

2532. If you pose the question in that way they are more likely to spend the money wisely. Is that the way you put it?—I think so. I think there is scope for more balancing of one item against another. I am just expressing a personal view. I do not think a system could be devised which would be more successful in inhibiting a

tendency to economy as the budgetary system for hospitals. There is no conscious extravagance of which I am aware, but nevertheless personally I feel that, if we were not working under the strict budgetary system, if we were not having to account for these individual headings, if we were not losing our savings under each heading at the end of the year, there would be a very different attitude towards the spending of money, and there would be a much greater balancing of one item against another. Psychologically I think the present system is unsound. I believe that, if a management committee had a block grant and were responsible for providing the services with that money, with the region in the background with a contingency fund, it would work very much better.

Wing Commander *Geoffrey Cooper.*

2533. If the effect of that block grant system, which you propose might be introduced instead of the present budgetary system, were to mean that some groups or management committees tended to build up a fund—it might be they would wish to build an extension or see some quite big scheme carried through—that of itself would also mean that that economy, if the Ministry were to come along and say "You are building up big funds; you presumably have some major object in view by so doing; we are going to cut your block grant", would in the long run have a similar effect to the budgetary system?—I do not think so, personally. I think that at the present time one virtually works and thinks in terms of one year ahead. Really one should be thinking in terms of four or five years ahead. If one can build up a reserve fund, so much the better. I know of nothing more irritating than trying to be responsible for hospital finances—I am on the finance committee—without having a contingency fund. I am quite certain that every big industrial organisation has a contingency fund to meet the unexpected. We have not. We have got to have everything budgetted in advance. It is quite impossible and impracticable accurately to budget a year or so ahead for hospital services. The result of that is that mainly unconsciously one must get a certain amount of over-budgetting. (Sir *Harold Boldero.*) May I elaborate for one moment about the block grant, because I am sure you Sub-Committee has heard a great deal about it? The University Grants Committee works on that principle, but there is a difference in that the University Grants Committee is not the sole source of income of a University unit like the Treasury is to the hospitals. There are difficulties, but I myself believe that the block grant system in a few years' time will be the proper solution. This is a very young Service, but when it has been going a few years and getting more stabilised administratively and otherwise that will be the proper solution. But it does mean that the block grant system can only work if there is a great deal less control from the centre, and therefore in a young Service, where you wish to get direction from centre in appropriate development, the block grant system is terribly difficult to work. You cannot be told what to do, and yet have your own private money to spend.

2534. Does that not happen in the education system run by the local authorities? You have the block grant system, and yet no great interference from the centre?—I have not enough experience to say.

Mr. *Turton.*

2535. Is this proposal for a block grant limited to expenditure on revenue purposes, or does it also include expenditure on capital purposes?—(Dr. *Avery Jones.*) No, I think one ought to budget for capital work on a five year basis. In the old county council days, before the Health Service was taken over, I think in fact it was more than five years. I would just like to modify what I said about the block grant. I would not recommend it as general policy throughout the country. I think there is scope at present for trying out the block grant system in a few selected management committees to see how it works and to find out what are the snags. It may be that snags will be found which will mean the system is much less effective than one might imagine.

Wing Commander *Geoffrey Cooper.*

2536. A pilot scheme?—Yes.

Chairman.

2537. We are asking these witnesses matters which fall within their personal knowledge rather than within their knowledge as members of the College?—(Sir *Harold Boldero.*) Absolutely.

Chairman.] I do not want to put them in difficulties of that kind.

Mr. *Turton.*] All these suggestions are in the memorandum.

Chairman.

2538. I think there has been a tendency to trespass. I do not want to take the witnesses too far away, but I think we may fairly ask them if the present dispensation has indicated to them as doctors that the priorities have got out of shape. Can you say whether you think there has sometimes been an excessive expenditure in some directions while you have been unable to get the expenditure which you think is required in others?—I would reply for the teaching hospitals that the disproportion is not apparent. We have been very well treated. The pinch is only just beginning.

2539. In other words, you have had so much money that you have been able to get what you wanted?—With one qualification. The annual money for teaching hospitals I would have said has been adequate to allow them to do what they wanted to do, but what they would have liked to have done would have been to have spent capital sums on buildings and construction work. (Dr. *Avery Jones.*) Maintenance in the regional hospitals I would have said was certainly adequate, but the pinch has been on capital.

2540. That of course is a different problem altogether?—Yes.

Wing Commander *Geoffrey Cooper.*

2541. Would you like to make any special recommendation or suggestion on the scope of the presentation of accounts to which you refer at the foot of page three? It would mean the publication of statistical tables. It would mean that a brochure would have to be issued by each hospital management committee so that everybody throughout the Service in that district could have full information each year?—I think that is a technical question which has been studied by the King's Fund. I think an answer could be obtained from them.

Wing Commander *Geoffrey Cooper.*] Mr. Chairman, would it be worth getting that?

Chairman.

2542. In fact I understand that the study is going on now. I do not think there has yet been a report. We were talking about the question of keeping patients unnecessarily in hospitals, and that of course would be one aspect of your priorities getting out of line. You deal with that specifically on page four of the memorandum, and you refer to three groups of patients who are occupying beds and who need not be there?—(Sir *Harold Boldero.*) For whom alternative arrangements could be made, but under present conditions probably they ought to be there.

2543. Do you suggest, as that follows immediately on some financial comments, that they are in hospital because you lack the financial pressure to get them out. You do not suggest that in words, but there is an implication of that? That implication is not correct?—No.

2544. The first group you mention consists of those who might be treated at home if domiciliary care were adequate. Can you give any sort of idea of the number involved under that head?—(Dr. *Avery Jones.*) I think it is very difficult to give a precise answer. Many of these are the elderly patients where a little more assistance by home helps would expedite their return home, or alternatively might have prevented admission to hospital if such help had been available at an earlier phase.

2545. From the doctor's point of view, when a patient is known to the consultant responsible to be fit to go home if care is available, what does the consultant do about it? What can he do about it?—He can get the almoners to contact the local medical officer of health to arrange a home help.

2546. Having once said that the patient can go home now, is the doctor responsible any more?—He is responsible for his bed, and for seeing that the bed is well used, but there is often inevitable delay in getting patients home, partly because some relatives are not anxious to have the patient home again or because the domestic circumstances are such that they live alone; and one has to keep the patient a bit longer until he is able to fend for himself.

2547. Who makes the ultimate decision? Is it the almoner or the consultant? Can the consultant say, "This patient has got to go home", and that is an end of the matter?—(Sir *Harold Boldero.*) In my hospital the consultant has the ultimate decision. (Dr. *Avery Jones.*) Yes.

2548. At the moment the consultant is in a difficulty because he is often confronted by the almoner who says, "This patient cannot go home; there is nowhere for him to go"?—Yes, or the ward sister.

2549. The matter really rests there at the moment. It simply is an impossible decision to take. That is really the position?—Yes.

2550. Is there any machinery for ascertaining what the available care at home may be?—Through the medical officer of health who can send a health visitor to the home.

2551. Is there any conflict between the consultant and the medical officer of health?—I do not think there is any conflict. I do not think there is often sufficient link-up in a district between the hospital on the one hand and the medical officer of health on the other. It does raise a very big issue. I think there is scope for much more local co-ordination of services than exists at present. We as consultants have very little knowledge of the difficulties in the district. If there was a better liaison with the medical officer of health and the local G.P. on the local help services, I think those difficulties would be better known, and to a wider circle. One might be able to get the hospital difficulties over to the local authorities, and vice versa.

2552. The second class is where the patients can be discharged to another form of institution which would be less expensive, but again the responsibility would rest on the consultant, would it?—(Sir *Harold Boldero.*) Yes, Sir.

2553. Again he can only take this decision after receiving advice from someone else. Who would that be?—Again from his sister who might obtain it from the lady almoner, or from his personal knowledge. For example, for a long time some of the old voluntary hospitals, and particularly the teaching hospitals, had what they called a convalescent home. That was primarily started so that the patient should be sent out who had had this or that done, and who only had to be in bed or fed and rested for a few weeks. They could not go home, and they were sent to such places.

2554. The institutions to which you refer here are institutions within the Hospital Service?—Yes, Sir.

2555. The responsibility here is wholly within the hospital. It is a different problem in this class of case?—What we meant to say was that a bed in an acute general hospital would cost £20 to £22 per week, but you can run institutions of this kind for perhaps £8 to £9 a week and do all for that that is required for that group of patients. Therefore you effect an economy in money.

2556. But here the limiting factor is simply the number of beds available in institutions?—There are very few.

2557. It is quite different from Class A?—It is quite a different problem. The Class A people can go home; they only want someone to bring up their food to them.

Miss *Ward.*

2558. Is there not also a great shortage of almoners? I know quite large hospitals where there are no trained almoners in the true sense, and therefore that surely is an added complication?—That is only a matter of time, is it not? The number of almoners employed by the Ministry of Health has gone up enormously compared with what it used to be.

Chairman.

2559. Class C more resembles Class A. Those would be patients who can go home, but you say here they do not go home because of the lack of out-patient facilities. I think your evidence earlier was that that means in effect consultant manpower?—(Dr. *Avery Jones.*) I think that is dependent very much on the level of out-patient facilities both personnel and structural. If you have got too few consultants and if you have got inadequate accommodation, the natural tendency is to shoot the patients into hospital and investigate them, whereas if you have got more time and more space to go into out-patients more thoroughly much can be done as an out-patient.

Mr. *Turton.*

2560. You are suggesting here in certain cases hostel accommodation for a limited period. Would that be very much cheaper than hospital accommodation?—I should have thought so with hospital beds at £16 a week or more, £20 a week. I should think hostel accommodation would be very much creaper. You would not require very much in the way of nursing supervision. This recommendation I think would hold particularly for patients in the provinces where they may be coming 30 or 40 miles to a central hospital. The problem there I think is rather different from the problem we have at present.

2561. You really mean that the hospital has to lodge them for the night; it is not for any form of treatment. I misunderstood. I thought you meant they were going to have treatment over some days?—It would enable tests to be taken the following morning, or on three consecutive days which is quite commonly needed.

Mr. *J. Enoch Powell.*

2562. There are two points—accommodation and the preparation of the patient for testing, and at present that can only be carried out in a hospital bed, where necessary at all?—Yes, but it could equally well be carried out in a much cheaper hostel. I think this applies particularly for centres outside London.

Chairman.

2563. Taking these three classes of cases, it seems that both Class B and Class C involve an expansion of the Service to make it more efficient, but Class A is the only one which has got to be dealt with by better administrative means. You do not suggest any definite measures which might be taken?—I think the question of Class A really depends on the facilities available in the district. Those facilities, depending on the work of the medical officer of health, are quite outside the ambit of the hospital. We are entirely dependent on his energy in that direction.

2564. We have discussed the hospitals within their present general set-up. Can you say whether you think that general set-up is broadly satisfactory, or would you like to see improvements? Do you think that the regional hospital board is fulfilling a necessary function and, if so, the right function; would you like to see some alteration of the functions of regional boards and management committees; or would you perhaps prefer to see the management committees directly responsible to the Ministry as are the boards of governors in the case of teaching hospitals? Are you satisfied as doctors with the general set-up?—(Sir *Harold Boldero.*) I think the answer very broadly is yes. The set up of the regional administration and the teaching hospital administration, in our judgment, cannot be benefited. I do not see an alternative way which would avoid over-centralisation or throw the teaching hospitals into the

regions, both of which we feel are most undesirable.

Mr. *Turton.*

2565. By that do you mean that one main function of the regional hospital board is to connect the teaching hospitals with the hospital management committees? —No, Sir, not quite. The main function of the regional board——?

2566. One main function of the regional hospital boards is to connect the teaching hospitals with the management committees. You suggest that, if you did not have regions, then the danger would be to throw out the teaching hospitals?—I am sorry. If you did not have a regional organisation at all you would get excessive control from Whitehall for your small units such as hospital management committees.

2567. At the moment is there not a superfluity of control—both the Ministry and the region are checking the expenditure of management committees?—I beg your pardon. You are talking only of finance?

2568. On the financial viewpoint?—But I think it is true only of finance, is it not?

Chairman.

2569. Under the block grant system which you suggested do you conceive the principle would be that the Government would make a block grant to each regional board, and that then each regional board should make a sub-block grant to management committees?—Yes, Sir.

2570. You do contemplate that?—Yes, Sir.

2571. And not a direct grant from the Ministry to each management committee? —I would answer that by saying "Yes."

2572. The first of those two?—Yes.

2573. To the regional board to be subdivided?—I suggest the block grant be made to the regional board and to the board of governors of teaching hospitals. The regional board would then make sub-grants, out of their block grant, to the hospital management committees. That is what happens in the University of London from the University Grants Committee. The University Grants Committee makes a grant to the University of London, and the Court of the University of London makes a subgrant out of that to the individual colleges or institutions of the University.

2574. The region keep enough of the block grant to meet their own expenses, payments of consultants and so on?—Yes.

2575. And possibly something by way of reserve?—Yes.

2576. And then distribute on the same general basis as they themselves receive? —Yes.

Miss *Ward.*

2577. You would not favour the elimination of the regional boards?—No, I should be alarmed.

Mr. *Turton.*

2578. Would the audit of the expenditure of that block grant be left to the region or to the Minister?—I am not sure what the answer to that is. That would have to be done at the lowest unit receiving the block grant.

2579. That would be the internal audit, but I am talking about who would audit the expenditure of that block grant—or would there be no audit?—I am not sure about audit. Audit, I think, is a technical term.

Wing Commander *Geoffrey Cooper.*] Would you follow the local authority custom of having an auditor who goes round to all the hospitals, in the same way as the local authorities have their accounts audited, or would you have it done as the Ministry audits are now conducted? I think that is the point.

Mr. *Turton.*

2580. The Ministry have their local government audit service. At the moment, under the present scheme, the accounts of hospital management committees are being audited directly by the Ministry of Health? —Yes.

2581. Under your plan, as I see it, the size of the block grant for a particular hospital management committee would not be decided by the Ministry of Health but decided by the regional board?—Yes.

2582. Therefore I ask who is going to control the expenditure of the hospital management committee—the Ministry of Health or the regional board?—(Dr. *Avery Jones.*) It is difficult for me to answer because I do not really know the implication of the question, but I should have thought that, if the region were making the grant, they would do the auditing. (Sir *Harold Boldero.*) I did not realise that auditors controlled expenditure.

Chairman.

2583. I am getting a little confused in regard to the question which has been put. I think the question is really this; not on the question of audit but on the question of the ultimate control of the method of expending the money, is that responsibility to rest with the Ministry or what? (Dr. *Avery Jones.*) The grant giving body. The Ministry as regards the regional boards and the boards of governors of teaching hospitals, and for the management committee the regional board concerned.

Mr. *J. Enoch Powell.*

2584. Do you envisage that this system would be combined with estimating? That is to say, would the group committee put

up estimates showing how they proposed to expend the money, and then the regional board would be responsible for seeing that the groups expended it according to the estimates or not?—(Sir *Harold Boldero.*) I suggest the answer is that the regional board would arrive at the size of the grant based on the estimates of the hospital management committee. The hospital management committee has to put its estimated expenditure under certain headings arranged by the board. They like or dislike this or that. They take that into account. They also take into account whether the committee underspent or overspent last time the block grant which was made, and therefore they control expenditure most effectively by the size of the grant they make.

2585. When you say they would like or dislike this or that element in the estimates put up to them, do you mean that they would insist upon those estimates being altered until they liked them or that they would simply take account of them as one reads a book? There is an important difference?—I think the answer is that the management committee's budget is the amount they get, and therefore the people who are giving the grant, the regional board, if they did not approve of an estimate of so much for such and such a purpose, would not include that in the grant they gave.

2586. If they thought there was too little on one head or too much under another, they would be quite powerless by that method?—Yes, that is where you lose central control.

Mr. *Turton.*

2587. If they took into account unspent balances, surely there would be no advantage over the system you have at present?—It depends how severely they take them into account. The University of London allows and encourages the units of the University to save reasonably—not to build up a colossal sum to build a new school of course.

Chairman.

2588. How do you contemplate it would work in a particular case? Let us take a part of the Service which is not essential or universal at the present time. I do not know whether the blood transfusion service would not be a good case in point. Suppose in fact the Ministry of Health desired to have such a service universal in a group. Suppose that was their broad policy. They make a block grant to the region, and I suppose that in making that block grant they could stipulate with the region that it was on the basis that there should be a universal blood transfusion service in every group?—Yes.

2589. Do you contemplate that the region would be bound to pass on that instruction and only make a block grant in turn on the basis that they get a guarantee from each group committee that they will have such a service, or do you contemplate that, if a group committee said, "We in our discretion think that money would be better spent on other good and more necessary items", they should be able to snap their fingers at the Ministry?—That, of course, is a weakness in the block grant scheme which people are advocating or, as I said earlier, the lack of central control, but I do not believe the fear is as great as need be. May I give an instance? I am speaking for a budget which receives a block grant from the University Grants Committee, and has done for a long time. In the House of Commons the Chancellor of the Exchequer said—I am talking about two years ago—that academic salaries should go up to a certain level. He did not come and see that we raised them. We need not have put them up to that level, but everyone of us did at once. I think that, if the Ministry of Health wanted a blood transfusion service and they put it as one of the desirable things in making their grant, you would get it every time. I do not think that any responsible body would say, "We will not spend this money on a blood transfusion service". There is the risk, of course.

Mr. *J. Enoch Powell.*

2590. You are assuming that it is extra money?—No. In the particular instance I give there was an extra grant of money. There was additional money received for academic salaries, and therefore that was not a good instance because I am an advocate for extra budgetary payments to hospitals if the costs of items beyond their control increase. How to include for that in the budget is another matter.

Chairman.

2591. You contemplate that the Ministry of Health should not be able to give instructions to management committees, but that they should be able to issue what I think are called directives which would always be acted upon in fact?—Which is happening. (Dr. *Avery Jones.*) The function of the local hospital management committee is to provide an efficient medical service for the local public. I am quite certain that if the Ministry wanted certain extra services developed, and made a reasonable request for them, the majority of—in fact, all—hospital management committees would accept that added responsibility. (Sir *Harold Boldero.*) The members are only in office for three years. The Minister appoints them all.

Mr. *Thomas Reid.*

2592. We have been talking about the allocation of money from the Ministry to the regional board, and by the latter to

hospital management committees. I do not think you have yet answered Mr. Turton's question on a totally different point, and that is auditing. Who is to audit these accounts? Is it the Ministry, is it the regional board or is it the hospital management committee who are to appoint the auditors in each case?—I do not know that I mind. I do not think I have strong views if the auditors are independent people.

2593. It is very important because if the Ministry audits it is one thing, it is a centralised audit, but it is quite a different matter if the boards and management committees do their own auditing?—I think I am getting out of my depth. I am thinking of the ordinary books of a college of a university where the audit is done by Price, Waterhouse and Company or some similar firm, and where the expenditure is set out under the broad headings demanded by that university.

2594. That is an outside auditor who is brought in to do the job, but who instructs Price, Waterhouse and Co.? Who employs Price, Waterhouse and Co?—The College of the University concerned; in this case the hospital management committee.

Mr. *Turton.*

2595. There is a difference between myself and Mr. Reid and you who envisage a species of control proceeding from that audit whereas, in our local government audit, it may well happen, as indeed it has in the North of England lately, that the auditor reports on certain expenditure which he thinks to be wrong; that balance is brought to the attention of the Government and disciplinary action taken. That is the difference between us?—Thank you for explaining that. I had the idea that the auditor was there to see that nobody swindled—not to see how they had spent the money.

Wing Commander *Geoffrey Cooper.*

2596. What would have happened under the old system is this: the separate hospital accounts would have been audited by an independent firm of chartered or incorporated accountants and then there would be a local government audit under government auditors. The audit would be split into two, and I suppose the present system would presumably still apply?—At present, speaking to that point, I understand that the Ministry of Health would be said to be doing that audit in the way of the teaching hospitals. In the hospital with which I am familiar they have made 10 or 15 comments, and the Ministry have asked the board of governors, who are the people responsible for spending the money, to comment, and also the auditor, I understand, to comment; and those have gone back. If the auditor said "This was an improper way of spending some of the money", and the board said, "We are responsible; we consider it is a perfectly proper way", what the Ministry would do I do not know.

Chairman.

2597. You contemplate within the four corners of your scheme that the responsibility for auditing any particular set of accounts should rest with the body whose accounts they are, and that the auditor should be responsible to that body?—Yes. They are responsible for the expenditure, and the auditor sees that it is correct.

2598. Could we turn now to one other matter with which I think you are probably more particularly concerned, and that is the question of private patients in the hospitals? You do not deal in your memorandum with the question of charges made by consultants in the case of private patients. Are you satisfied with the present arrangements?—Broadly I suppose the answer is yes.

2599. You have got no particular criticisms to make?—It is a very complex subject. I think perhaps, if it were to be elaborated, that one would like the individual, who wishes to go into a private room and who wishes to have a certain individual operate on him, that is to say the private patient, to have some sort of financial contribution from the Treasury to whom he has paid insurance all the time.

2600. I was not thinking of that aspect of the policy. We have had evidence that the present method by which the fee charged by the consultant is arrived at is unsatisfactory, and indeed I think it has been described as unworkable. Are you satisfied with that position?—You mean the schedules?

2601. Yes?—We want those schedules modified.

2602. You are dissatisfied with those schedules?—Yes, Sir.

2603. Can you say what you suggest as a reasonable alternative?—I cannot at the moment, but if you would wish it I could send you a paper on that because the doctors in the hospitals are now pressing on the Ministry, and have been for some time, their desires on the point to which you are referring. I have not got them in my head, but I can send you the facts.

2604. We have received evidence that, where the person is willing to pay for his own accommodation and, of course, to be treated by an individual consultant or surgeon of his choice, the burden on him is now very heavy indeed, that he has to pay the full statutory cost of the bed, consultants' fees and everything else?—Yes.

2605. It has been suggested to us that there are in some hospitals a number of empty private beds. Have you any knowledge of that?—I know there are some empty private beds.

2606. Do you think that an alternative method of levying a charge on private patients would be more satisfactory? Has the College given any consideration to that matter?—Yes, Sir, to this extent, that we do not see why the individual who seeks to be a private patient and to choose his own doctor should not have some contribution from public monies into which he has been paying. At the moment he is cut right out; he is not given anything at all if he goes in as a private patient. Could he not have a grant-in-aid, I think the phrase is?

2607. Then as regards your own particular angle of this, you are not satisfied with the method of assessing the consultants' fees?—No, Sir, we do not like the schedules.

2608. Have you made any representations for improvement?—Yes, Sir.

2609. You have. Are you discussing those at the moment with the Ministry of Health? —Yes, Sir.

2610. If the matter is actually under discussion it might be undesirable for us to ask you questions about it?—Unless it would hasten an answer from the Ministry! We have been talking to them for months.

2611. Perhaps we can ask you this. It was on your own initiative that the matter was taken up?—Yes, Sir.

2612. As far as the Ministry of Health are concerned they would let the matter rest if you would let it rest?—Yes, Sir.

2613. In those circumstances I think it would be perhaps useful to everybody if you would let us have a memorandum on it. It is a technical matter?—It is very technical really. The main point is this: the schedules say that a specific operation, for example appendicitis, should be so much, and that a different kind of operation should be a different sum. We want no schedules at all. We want the law of supply and demand, or whatever other law it is, to work—it always used to—in which the surgeon makes his own arrangements with his own private patient.

2614. These are patients who choose themselves voluntarily to go into hospital and to make a payment?—Yes.

2615. Your case is why should there not be free bargaining?—A free arrangement between two individuals.

Mr. *Turton.*

2616. If the cost is prohibitive now, might it not be even more prohibitive if you fix the cost?—The surgeon is cutting his own throat, if that is true.

Wing Commander *Geoffrey Cooper.*

2617. Could I make a reference to page six of the memorandum where you make reference to efficiency and economy, particularly in relation to various officials in the new Hospital Service? You say, "The organisation of the hospitals into groups has diminished the status of the former hospital secretaries." Some of them used to do the job for love or for very little money in the past. You say further on that the tendency in future will be to bring nonentities into the system, resulting in reduced efficiency. Would you like to comment on that, and let us have perhaps in greater detail what your experience has been?—(Dr. *Avery Jones.*) Speaking from my own experience, we have a group secretary, and then under him there is an assistant secretary for each of the hospitals. The assistant secretary really corresponds to the former, as far as the municipal hospitals are concerned, steward, and formerly the steward was a very powerful personality in the hospital. He was responsible for maintaining efficiency amongst the manual staff, the porters and so on.

2618. Would he tally, from your description, with the managing director of a company?—No, Sir. There are really two aspects here. I think one has got to distinguish between the old municipal set up, which I am at present discussing, and the former voluntary hospital. As I see it, personally, the status of the old steward—now called the assistant secretary—has declined. He is not so much a power in the land, and I do not think the manual side of the hospital necessarily runs as smoothly as it might do. The secretary for the group has become a committee secretary, and not a manager. To that extent we are in the ex-municipal service, I think, the losers. We have not got the same managerial aspect of control as we had formerly. Admittedly we had the chairman of the public health committee who did act as the business manager of the hospital.

2619. He was not a full-time man?—No, a member of the county council.

2620. Have you got some suggestions to make to improve this defect to which you refer? Do you think each hospital should have a responsible manager, or whatever his title may be?—The general principle, I think, is right, but I think one does need one person who really feels a personal responsibility for seeing that that particular organsation is running efficiently.

Chairman.

2621. Are you suggesting that the small unit hospitals should be directly responsible to the management committee, instead of to the regions through the group secretary? —No. There are two aspects here which I must try to separate. The main point I would like to make is that any big organisation, a big factory or a big hospital, needs one person who really feels a vital need to make that organisation as efficient as possible, and of course you have that in industry in your managing director. What I am suggesting is someone comparable to

the managing director for the big hospital. At the present moment you have the secretary for the group, and he is really becoming more secretarial in function rather than managerial.

2622. How are you going to check that process?—The help, I think, must come from the chairman of the management committee, and I think you really want to try to build up the position of the chairman of your management committee to correspond with the managing director of a factory. That again is a personal opinion. It might mean having an honorarium attached to the post so that an individual could give much more time and thought to the position. I have no doubt—in fact I know—that many chairmen of management committees are very busy men who have many other commitments, and they are not strictly comparable to the managing director of a factory.

Wing Commander *Geoffrey Cooper.*

2623. Would the case be met perhaps by having your chairman still in his present position and taking general policy in his stride, as chairmen of companies do, whereas the secretary, if he was really made the chief executive, irrespective of the size of the hospital—he would be a bigger or a smaller man according to the size of the job and the pay received—would be the responsible man in charge of day-to-day management affairs and he would then correspond to your managing director?—I think a tendency back to the managerial aspect and away from the secretarial aspect of his work would be desirable. I think that may come. I think King Edward's Fund have recently set up a staff college for administrators, and I think that an improvement in this direction may result.

2624. Who is the administrator in charge of each hospital? Which post does he fill? Is he the secretary?—The Secretary.

Chairman.

2625. In charge of each hospital is the assistant secretary?—The assistant secretary.

2626. You do not quarrel with the general grouping of hospitals?—No.

2627. You do not quarrel with the general proposition that there must be a secretary or other named official in charge of the whole group?—No.

2628. And that each separate hospital should have an assistant secretary or other named official responsible to the secretary?—No, I think the set up is satisfactory. My point has been that the present arrangements have diminished the status, and therefore the efficiency, of the assistant secretary, and at the same time they have not introduced anyone comparable to the managing director.

Wing Commander *Geoffrey Cooper.*

2629. In other words, the secretary of the hospital management committee has committee responsibility instead of responsible management?—Yes.

2630. Responsible management is the axiom of good industrial organisation whereas committee responsibility is the worst?—Yes, that is so.

Mr. *Turton.*

2631. I have noticed that, in the increase of administration staff in the Hospital Service, there has been a very great increase in medical secretaries, clerical assistants to the medical profession. Is there any way of cutting down that increase in staff and expenditure?—That increase of course usually is dependent particularly on the increase in out-patients, and on the increase in the standard of note taking, record keeping, by the hospitals, and both those are increases which have just had to be made. The medical secretaries are performing useful work. I think one might effect a slight saving here and there by a greater use of dictaphones. Whether having a secretarial pool would help or not I do not know; personally I do not think it would. I think one does need the personal service of one secretary. I do not think the increase in the number of medical secretaries in hospitals is an unreasonable one.

Chairman.

2632. Sir Harold, we are very grateful to you and to Doctor Avery Jones for coming here this morning and giving us so much of your time. You will in due course receive a confidential proof copy of the evidence you have given this morning. If there are any corrections to make or other comments, if you care to communicate with our Clerk we will see what we can do to meet your comments. Thank you very much indeed?—(Sir *Harold Boldero.*) Thank you for what you have said.

The witnesses withdrew.

Adjourned till Thursday next, at 10.30 *a.m.*

THURSDAY, 19TH APRIL, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. Diamond.
Mr. J. Enoch Powell.
Mr. Thomas Reid.
Mr. Turton.
Miss Ward.

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mrs. B. HASTINGS, Chairman, Mr. P. H. BUSHELL, Chairman of the Finance and General Purposes Committee, Mr. C. G. BURRELL, Secretary, and Mr. G. H. CHILVERS, Finance Officer, Stepney Group Hospital Management Committee, called in and examined.

Chairman.

2633. Mrs. Hastings, I should perhaps tell you right away that you will be supplied with a confidential proof copy of the evidence you give to the Sub-Committee today, and if you have any corrections or points to take up would you kindly do so with our Clerk and we will see how far we can go to meet them?—(Mrs. *Hastings.*) Yes.

2634. There are some general points on which we would like some information about your group before we turn to the memorandum* which you have kindly prepared for us. First of all can you tell us what is the area covered by the group of hospitals administered by your committee? —(Mr. *Burrell.*) The acreage do you mean?

2635. Could you indicate the sort of area? Have you brought a map of some kind with you?—I have not. It is 1,700 acres in Stepney, with a 100,000 population.

2636. Is it roughly the Borough of Stepney itself?—Yes, bounded by the Borough of Stepney.

2637. It is precisely the Borough of Stepney?—Yes.

2638. Is that a natural hospital drainage area?—(Mrs. *Hastings.*) I do not quite understand what you mean.

2639. In the ordinary way, assuming that you had no boundaries but that the population was free to go where it pleased to hospital, would you expect to find that your hospitals would cater for the population of Stepney itself?—I should think so, on the whole. St. George's is geographically one of our hospitals, but that is almost on a little island site at Wapping.

Mr. *Diamond.*

2640. That is the one right on the river? —Right by the docks. Occasionally the bridge is up, and geographically it is very difficult for people to get there.

Chairman.

2641. That is not in the Borough?—Yes.

2642. I do not understand why it is difficult to get at it. You say there is a bridge? —It is difficult to get at for the rest of Stepney; it is rather cut off. There are bridges which are hauled up when boats are going through.

2643. It is an inconvenient place for a hospital?—Very inconvenient, but there are a great many new flats being built there, there is a big population, and it is almost essential to have a hospital there.

Mr. *Thomas Reid.*

2644. It could not very well belong to any other hospital management committee, could it?—No, I do not think it could really.

Chairman.

2645. You say at the very end of your memorandum that it would be more economical if small groups of hospitals in adjacent districts were amalgamated. Does that mean to suggest you are not altogether satisfied that the area covered by your group is a substantial one?—We are quite satisfied about that. It was just a suggestion for economy, that there are one or two groups which are quite small and each has to have a large staff. That was just one of the rather long term suggestions for economy that there could be more amalgamation and so save staff to a certain extent. We have no grievance about it. It has no personal feeling. We are quite satisfied as we are. It was just a suggestion for long term economy.

2646. You feel it might be more efficient if there were some re-distribution?—I do not think it would be more efficient; I think it might save money. I do not think it would deal with efficiency at all.

Mr. *Turton.*

2647. Could you give examples of the hospital management committees about which you are thinking?—Bow, roughly; that is a small one.

* Not published.

Chairman.

2648. You cater for a population of 100,000?—Yes.

2649. Would your neighbours cater for a similar sized population?—I could not tell you. (Mr. *Burrell.*) Approximately, yes.

2650. On the whole the hospital groups in East London tend to be very small?—(Mrs. *Hastings.*) They vary. (Mr. *Burrell.*) No, Sir. Some including ourselves are rather small groups compared with Hackney and Bethnal Green, but my comment as regards Stepney is this: we have the London Hospital in Stepney, and I would suggest that caters for the majority of the acute work in Stepney.

2651. The teaching hospital caters for a large proportion of the population?—Yes.

2652. So that in fact your population is substantially less than 100,000?—Yes, if you put it that way. London caters for people from all over London, and it attracts people. I think it is very true to say that our local general practitioners tend to send their acute work to the London Hospital rather than to our hospitals, which means that our hospitals have to deal with a larger number of chronic sick than they would normally apart from the London Hospital.

2653. If it were not for the London Hospital there would be far greater pressure on your beds?—(Mrs. *Hastings.*) Yes.

2654. That seems undoubtedly so?—(Mr. *Burrell.*) Yes.

Mr. *Turton.*

2655. What is the position as regards Bethnal Green? Is not that even more allied to Stepney than Bow?—No, Sir, because Bethnal Green has probably a higher population than Stepney. In Stepney we have a lot of waterfront docks, on which buildings cannot be put.

Chairman.

2656. Turning from the area to the management committee itself, what is the actual size of your committee?—Eighteen.

2657. Do you find that a satisfactory number, or would you prefer it to be larger or smaller?—(Mrs. *Hastings.*) I think it is a very good number.

2658. Are any of the members of your committee also members of the regional board?—No.

2659. Are you yourself?—No.

2660. Do you know whether there is any overlapping membership, in the case of your region, between the board and the management committees?—I think there is some overlapping. I could not tell you the facts of it.

2661. There is none in your case?—No.

Mr. *Thomas Reid.*

2662. Do you find the members of your committee zealous? Do they attend meetings and take a real interest, or is the interest subsiding now?—No, they are very keen, and they are prepared to take trouble to an extraordinary degree really, I think. I do not think we have any passengers. They are all very good.

Mr. *Diamond.*

2663. Do you have any difficulty in staffing your house committees?—No.

2664. I gather you have appointed committee members to house committees?—Yes.

2665. You have had no difficulty in getting volunteers to serve on them?—No difficulty at all. We have just increased our number to make vacancies for local representatives from the Trades Council and the W.V.S.

Mr. *Turton.*

2666. How many medical men are there on your hospital management committee?—Four. There were six, but there was a feeling in the regional board that we were a little bit overweighted with doctors.

2667. I put my question wrongly. When I said "medical", I intended to include dental, as well?—We have no dentists.

Chairman.

2668. Could you give the break-up of your committee from the point of view of outside interest—how many local government and how many professional? Have you got those figures with you?—(Mr. *Burrell.*) We have one councillor from a neighbouring area, Ilford actually.

2669. You have no member of Stepney Borough Council on your committee at all?—(Mrs. *Hastings.*) One of the new members is a councillor from Stepney, and there is one from Shoreditch.

2670. You do not cover Shoreditch; that is a neighbouring area?—Yes. He was an old member of the committee at Mile End before the appointed day, and I think that is how he got his interest.

2671. The position is that only one member of Stepney Borough Council is a member of your hospital management committee?—Yes, that is so. That is a recent member.

Mr. *Diamond.*

2672. Is that fortuitous, or was he in any way put forward by the local authority?—I do not think he was put forward by the local authority. He again was connected with Mile End for many years before the appointed day. He was put forward by the London County Council.

Chairman.

2673. Were any of your hospitals local government hospitals before the appointed

day?—Yes, Mile End and St. George's. London County Council do you mean?

2674. Mile End was a London County Council hospital?—Yes. That is the biggest hospital, and St. George's was also one.

2675. The bulk of your beds were in local government hospitals?—Yes.

2676. Have you any L.C.C. members on your management committee?—(Mr. *Burrell.*) No, Sir, not the London County Council ; we had one.

2677. The old connection with the local authorities has been almost completely broken?—Except for our chairman. She was chairman of Mile End Hospital. (Mrs. *Hastings.*) For about 15 years under the London County Council, but I am not a councillor.

2678. You were the old chairman under the London County Council?—Yes.

2679. In the old days, when it was an L.C.C. hospital, what proportion of those who administered the hospital were actually local government members—could you say? —No. It seemed to be run from County Hall centrally. I could not tell you that exactly. In those days my husband was the county councillor for that district, for Stepney, and he was also chairman of the Hospital Medical Services Committee. In that sense you might say there was some connection, but the day to day management was done more or less from the staff work at County Hall.

Mr. *Diamond.*

2680. Perhaps you are referring to the officers, but would not the chairman of the committee be appointed by the L.C.C.?—I should think so. It was done on a political level in those days. According to the strength of the party so you were appointed, and the chairman was appointed by the party which happened to be in power.

Mr. *Diamond.*] Mr. Chairman, I hope you are going to follow up your question about the way in which members are drawn on to the committee. So far we have only been told the way in which they are not.

Chairman.] Would you ask that?

Mr. *Diamond.*

2681. From what sources are your members drawn? I gather you, Mrs. Hastings, were the Chairman of the Mile End Hospital, and you continued in that sense?—Yes.

2682. Are there any interests which are represented on your management committee —local authority interests, W.V.S. or any other particular interests—or is it just a question that you have gathered around you a number of people who you think are useful people to serve on a hospital committee?—I think originally it was the regional board who asked for nominations from all the public bodies of which they could think, and they chose from amongst those originally the members. Since then we nominated so many. We are asked to nominate, and sometimes I think they still take nominations from these different organisations. The regional board choose the members.

2683. Are your own nominations from a particular source?—No. My own personal ones are people generally I know. When I knew that Miss Dreyer, the principal matron of the London County Council, was retiring, I asked her straightaway if she could come on the committee.

Chairman.

2684. Does she live locally?—Near County Hall.

2685. She has got no local connection?—No. Very few have really, except for about four of us. (Mr. *Burrell.*) She has a local connection in that she was principal matron of the L.C.C. who were responsible for Mile End Hospital and St. George-in-the-East Hospital.

2686. She has no local personal connection?—(Mrs. *Hastings.*) No. Until lately we had two local magistrates, Mr. Abrahams and Mr. Gibson, and a local general practitioner.

Mr. *Turton.*

2687. Until lately—those two are no longer on your committee?—One is not, but Mr. Gibson is still. Mr. Abrahams retired this last time. The new member, Mr. Bermel, is also local. Mr. Samuels is a J.P., but he is a Shoreditch man, not Stepney.

Chairman.

2688. Would it be troubling you too much to let us have sometime, if you have not got it here, a list of your members by name, showing their residence, profession or other qualification?—Yes, certainly.

2689. I use the word "qualification" to mean the nature of their activities?—Yes.

Mr. *Diamond.*] Perhaps they could also show if they were appointed by the regional board or nominated by the committee.

Chairman.

2690. Would you also show by whom they were nominated in the first place?—Perhaps I had better mention that one of our members, Major Green, has been Chairman of the London Jewish Hospital, which is in our group, for many years. That is his point of approach. I will do that for you certainly. Do you want to know who nominated them?

2691. Whether they were nominated in the first place by your committee itself, by the local authority or by any other bodies whom the regional board were bound to consult before making the appointment. The appointment is made in every case by the regional board?—Yes.

2692. I think your committees are of two kinds. You have functional committees and you have house committees?—Yes.

2693. From the chart shown on page one of your memorandum I think you have one large finance and general purposes committee, which I suppose really is the executive committee?—Yes.

2694. That seems to deal with everything; it winnows items before they go to the main committee—is that right?—Yes.

2695. Then there are three functional committees—one which deals with establishments; one which deals with supplies; and one which deals with works. Is that right?—Yes.

2696. Do you find that an adequate number?—Yes.

2697. I think you state that they meet once a month, regularly. Is that all the meeting they do?—The supplies committee meets twice a month. There was so much routine detail work that it held up orders too long to have only a monthly meeting. When the supplies officer wanted sanction for a certain order it held it up too long to have only a monthly meeting, and so the supplies committee meets once a fortnight. Except for that the others meet once a month. There is also a little sub-committee of the finance committee. Perhaps you would explain what they do, Mr. Bushell. (Mr. *Bushell.*) Before the finance and general purposes meeting we have a small committee of three of us to go through all the accounts to check everything before it is submitted to the main committee. Every invoice is checked, and the cheques are signed against the invoices. That work is done before the meeting of the finance and general purposes committee.

Mr. *Diamond.*

2698. When you say "three of us", do you mean three officers or three members?—Three committee members.

Chairman.

2699. You have a house committee for each of the six hospitals within your group?—(Mrs. *Hastings.*) Four hospitals.

2700. There are four hospitals, and there is a clinic and a group laboratory?—The clinic and the laboratory do not have committees.

2701. You run them direct from the main committee?—Yes.

2702. Is the clinic not in the nature of a hospital?—No. The situation is very complex between the different authorities It is partly L.C.C. authority; and it is partly the authority of our group. It is a little bit complex. We pay 9/11ths of the costs, and they pay 2/11ths for the domiciliary work done by the Council.

2703. This is a joint responsibility?—It is a joint responsibility.

2704. Does it work well?—Yes. I do not feel we are quite coping with the work. I do not feel quite satisfied that we ought not to be doing more. I believe it is a very good clinic, but I do not think we are tackling——

2705. You make the point on page seven of your memorandum that you are desperately short of tuberculosis accommodation?—Sanatorium accommodation.

2706. Does this clinic provide any accommodation at all?—No, it is purely a clinic. Nor does it provide examinations for X-ray, but a screening apparatus is on order. Patients have to go to Mile End for any operative treatment or for X-ray.

Mr. *J. Enoch Powell.*

2707. In fact you use it as an out-patients' department?—Yes.

2708. Is that because your other hospitals are deficient in that respect, or how did it arise?—It was there before the appointed day. The clinic is a very nice building, built originally by the local borough council, and we have just taken it over.

2709. The local authority do have the use of it for their general practitioner service?—No.

2710. For what do they use it?—(Mr. *Burrell.*) Nothing at all. The after-care work is the responsibility of the borough council. (Mrs. *Hastings.*) The health visitors come there to see the patients.

Chairman.

2711. When you say they come there to see the patients, you have no patients sleeping in the clinic?—No. We have sixty-four beds in the two main hospitals for patients who are waiting for sanatorium treatment.

2712. For tuberculosis patients?—Yes.

2713. You said that the local authority has some share in the clinic itself?—Yes.

2714. What use do they actually make of the clinic?—I think it is purely from the domiciliary point of view. The health visitors come there to see the patients and to hear the doctors' reports. They have a sort of liaison there. It is purely from the out-patient point of view.

Mr. *Diamond.*

2715. You allow them to use the premises, and they contribute to the overheads accordingly?—Yes, although I am not sure that is so. I do not know really. I think it is partly theirs; they do pay so much.

Chairman.

2716. Do they pay the money to you, to the Ministry of Health or to the regional board?—To us.

2717. They pay you for the services you render to them?—(Mr. *Burrell.*) Yes.

2718. In effect you are helping them to discharge part of their responsibility for domiciliary work?—We supply the offices and equipment, that is all—the area space, heating and lighting. This was originally built by the Stepney Borough Council. The tuberculosis service in Stepney was run by the borough council. When the National Health Service came into being we on our part were responsible for the medical treatment of tuberculosis, and the Stepney Borough Council, now the London County Council, are still responsible for the care in the homes. Their health visitors and social workers still remain at the clinic and we are paid £200 a year for the use of the rooms, heating, lighting and cleaning.

Mr. *Diamond.*

2719. It is in fact a subletting of your rooms at hours when you do not require them at a charge which contributes to your rent and other overheads?—That is so.

2720. It is not a question of sharing a service to the same patient?—No, Sir.

Chairman.

2721. You are landlords and not partners—that is really the position?—Yes.

2722. The clinic itself is run directly by the main committee?—Yes, Sir.

2723. Could you say something about the group laboratory. Is that purely a laboratory?—(Mrs. *Hastings.*) Yes.

2724. What sort of laboratory work is done there?—It was originally a group laboratory because it did the work for four other hospitals—Hackney. (Mr. *Burrell.*) St. Andrew's, Bow, and a certain amount for Bethnal Green.

2725. It did work for hospitals outside your present group?—Yes.

2726. Does it still?—To a certain extent.

2727. Do you get any rent for that?—No, Sir, it is for other hospitals.

2728. There is no transfer at all?—No, Sir.

2729. You get fully paid, as you must, by the Ministry of Health?—Yes.

2730. There is no transfer. This is not a question of outside authority?—No, Sir, it is all for hospitals within our immediate area. As far as payment is concerned it would be for the consultants' visits or somethink like that.

2731. It is doing laboratory work for all your hospitals, and for a number of hospitals outside the group?—That is not really true. It is doing work for Mile End and St. George's, but the London Jewish Hospital has still retained its old system. Our pathologist does not do work for the London Jewish Hospital, but he will when our new laboratory is built. The East End Maternity Hospital pathological service is still retained by the consultant who was there before the appointed day. (Mrs. *Hastings.*) I think the word "group" really came from the old days when it was a group laboratory. (Mr. *Burrell.*) The L.C.C. had group laboratories to cover various areas, and this one I believe covered Hackney, Bethnal Green, Bow and Stepney.

2732. This is an old L.C.C. group laboratory?—Yes, it is at the Mile End Hospital actually.

2733. It is incorporated in the building?—Yes, Sir.

Mr. *Turton.*

2734. What will happen when you build your new laboratory? Will this continue?—(Mrs. *Hastings.*) It is an addition to the present structure. (Mr. *Burrell.*) What will continue?

2735. You said you are intending this year to build a new laboratory?—Yes.

2736. I asked what was going to happen to this old group laboratory when your new one is in existence?—(Mrs. *Hastings.*) It is an extension of the present one.

2737. It is not quite correct to say that it is a new laboratory; you are rebuilding the present one?—Enlarging it. We are putting in two more floors.

2738. When you have got this structural work completed, will the whole new structure serve not only the hospitals in your management committee area but those in the areas of the other management committes you have mentioned?—I could not tell you that. (Mr. *Burrell.*) It will, until the other management committees are able to create their own group laboratories which they are doing now.

Chairman.

2739. Do you offer these facilities to the other hospitals, or have they some right to take them?—It is a carry over of the L.C.C. system. (Mrs. *Hastings.*) When they were a group laboratory for these other hospitals.

2740. You have got to estimate for this service?—Yes.

2741. The estimate must depend to some extent upon the volume of the work?—Yes, it must.

2742. If you control it completely you know roughly what the volume of work is likely to be, but if someone else has a right to make demands on you are you not in difficulties?—It is just as it was before; we expect about the same volume of work that we had from them before.

2743. If you get more than that with which you can cope, you would simply say, "I am very sorry; we are full up; we cannot do this work"?—I cannot tell you what happens then. (Mr. *Burrell.*) It means that they work and work until they do do it. (Mrs. *Hastings.*) I do not think we would throw it back on the other people at all.

2744. You have been able to do the work you have been asked to do with your existing facilities?—Yes.

Mr. *Turton.*

2745. All the hospitals which are served by this group laboratory are in fact within the area of the North-East Metropolitan Regional Board?—(Mr. *Burrell.*) Yes, Sir.

Chairman.

2746. As far as house committees are concerned what powers do you give them?—(Mrs. *Hastings.*) Very little. The terms of reference are the day to day welfare of patients in the hospitals and suggestions. We rely on them very much for suggestions. It is very difficult to have close touch with the hospitals from outside, from the hospital management committee, but at the house committees hospital management officials can make contact with those people who really know what they want in the way of improvements.

2747. Do they advise you on matters other than welfare?—No.

2748. Suppose there is an urgent need for a new lift, would they perhaps make representations to you?—They would that way.

2749. Suppose they thought it would be more convenient to switch round two wards, would they make that sort of suggestion?—Anything like that they would.

2750. Really, although their terms of reference are welfare, their function is to decide——?—That would count as welfare, if you were to switch wards around, if it was going to be better for the patients.

2751. It might be for the convenience of the medical staff or for all sorts of reasons?—I would not like to say anything like that would not come forward. I think it would. It would come under "suggestions". If the doctor who was there had any of those ideas he would probably put them through his house committee.

2752. Suppose they thought it was necessary to add to the domestic staff, which is something which happens fairly often, do they make representations to you about that?—That would be referred to the establishments committee.

2753. Would the house committee take that sort of question up with you?—I think so. (Mr. *Burrell.*) Yes.

2754. In other words, they exercise a general advisory supervision over the hospital?—(Mrs. *Hastings.*) I think it is very difficult to define where welfare ends. You may say the domestic staff would be welfare.

2755. If you were speaking about the Welfare State then everything of course would be welfare, but I am talking about the comfort and convenience of patients?—They do go very much further than that. It is rather the housekeeping of the hospital.

2756. The day to day management?—Yes.

2757. On any matter of day to day management they would take an interest, if necessary, and make representations?—They make suggestions.

2758. How do they put those to you?—They come on their minutes.

2759. The minutes would go to the finance committee?—We all receive the minutes. They would refer matters to different committees, and certain matters they refer direct to the hospital management committee. Certain suggestions go to the works, establishments or supplies. If they thought the sister should have more uniform they would send it to the supplies committee.

2760. Have they any power to buy anything or to sell anything?—No powers.

2761. Or to take on staff or to dismiss staff?—No.

2762. None?—No.

Miss *Ward.*

2763. All the recommendations go to the hospital management committee, and then you know what the finance committee has farmed out to other committees?—Yes, the final ratification comes from the hospital management committee.

Mr. *Diamond.*

2764. Can I just be clear on this point? Either the management committee or one of the sub-committees of the management committee does see not only the suggestions of the house committees but the whole of the minutes of the house committees?—Yes.

Chairman.

2765. Can you tell us something about the adequacy of your accommodation? You said that you were serving a population of

100,000 and that you were, so to speak, sharing that population with the teaching hospital in your area?—Yes.

2766. You have approximately 1,000 beds?—Yes.

2767. Are those all staffed?—The staffing is more of a difficulty actually, than the beds.

2768. Is that the total number of beds or the total number of staffed beds?—(Mr. *Burrell.*) The total number of staffed beds is 820.

2769. How many unstaffed?—It is very difficult to say. (Mr. *Chilvers.*) Nearly a hundred.

2770. I am sure you have been asked by the Ministry of Health to give the exact figure?—(Mr. *Burrell.*) It is a hundred beds equipped, but then we have some empty wards which we have never equipped or made available because of the difficulty of getting staff.

Chairman.] It is that about which I am asking—how much accommodation?

Mr. *Diamond.*] Is it not 99 according to your own schedule?

Chairman.

2771. It is approximately 100?—Yes, Sir.

2772. If you had the staff you could handle another 100 patients without difficulty?—Yes, Sir.

2773. Can you say how far your 820 staffed beds go towards meeting the needs of the locality?—(Mrs. *Hastings.*) We have not got waiting lists in the hospitals, except at the London Jewish Hospital, and that is fed from all over England because of its religious basis. That is the only hospital with an appreciable waiting list.

2774. For all services?—I think so, except for E.N.T. which have accrued owing to the polio outbreak.

Mr. *Diamond.*

2775. And tuberculosis sanitoria?—Yes.

Chairman.

2776. E.N.T. and tuberculosis?—Yes.

2777. They are the ones in which there are arrears for special reasons?—Yes, and at the London Jewish Hospital from a religious point of view. (Mr. *Burrell.*) They have 138 waiting. (Mrs. *Hastings.*) That is a special matter.

2778. You have a very high proportion of Jews among your population?—Yes, in Stepney but not at Wapping. They come from all over the country when they want the ritual carried out.

2779. In your two principal hospitals, which together comprise some 700 beds, you would have a mixed Jewish and Christian population?—Yes. St. George's tends to attract the Christians more. Wapping is very much an Irish district, and Stepney is Jewish a good deal.

2780. You would admit Jewish patients to that hospital?—Yes, a great many of them are Jews.

Mr. *J. Enoch Powell.*

2781. Do the number of staffed beds plus the existence of the wards in which there are no beds at all, and the fact which you have given us that your waiting lists are negligible, show that the pressure upon hospitals in your area has declined over the years?—I do not think so. I think it is partly that in the past the consultant staffing—this is my own opinion—has not been quite up to the standard of the London or one of the other hospitals, and I think local doctors have tended to send patients to the London Hospital where they get more consultants. As you know, under the old scheme it was all done from within the hospital, and you just called on outside if you were in a difficulty. Now we have appointed consultants more plentifully, and we think that probably more patients will be directed to us.

2782. Were the hospitals ever fully used, or was there always a surplus to the needs? Were these wards ever used?—I should say they were full. (Mr. *Burrell.*) The population of Stepney before the war was 200,000, and therefore they were fully used before the war. Not only that but patients from all over London were directed by the L.C.C. to various hospitals.

2783. Have you been asked to take into account the future prospective population intended by the London Plan?—That is 100,000.

2784. That is your present population?—Yes, that is what the town and country planning people say.

2785. There is no prospect that you will again ever want the full accommodation which was once available and used?—We ought not to need it any more. (Mrs. *Hastings.*) That is the aim of their report, but I cannot help thinking that there is going to be a great need for beds.

Chairman.

2786. Do you think the idea of the Ministry of Local Government and Planning may be defeated by events?—(Mr. *Burrell.*) Yes. One hospital has been lost. St. Peter's has been demolished by bombs.

Mr. *Thomas Reid.*

2787. There is no abuse of your hospitals by the public: the public using them are necessarily doing so?—It is very difficult to say. I think the abuse rather comes from the sons and daughters of elderly

people who are not prepared to take their mothers and fathers home, so that they will never go home.

2788. You have a lot of aged people?—Yes, Sir. (Mrs. *Hastings.*) They are our biggest problem.

Mr. *J. Enoch Powell.*

2789. If you have this surplus of space have you considered using some of the wards as transit wards, or do you regard yourself debarred from doing that by the structure of the Health Act?—(Mr. *Burrell.*) Our biggest hospital, Mile End with 450 beds cannot expand without rebuilding because that is their total accommodation. We cannot do anything there. St. George's is upon an island at Wapping, and it is terribly difficult to get nursing staff there at all. Someone will have to look after those people in transit. It is hard enough to get nurses to nurse the sick people, apart from old people. (Mr. *Bushell.*) Can I say this about our beddage or occupied beds? The London has large waiting lists, and I personally know of a case now where a man has been waiting since November, 1949, that is eighteen months, with sinus trouble, and the London Hospital cannot attend to him. He came to me to see if I could do anything. That is a case where very likely he will go into Mile End.

2790. Are you in fact there working in watertight compartments? From that do you deduce that owing to the boundaries of your group you are not in fact offering facilities, which you might be, to relieve greater pressure in other group areas? Are the group boundaries serving as a bulkhead?—The group boundary is wide, but the attractive hospital in our area is the London Hospital.

Mr. *Diamond.*

2791. Is there not regular contact between you and the London Hospital with regard to the pressure on beds?—No.

2792. Does the matron there get in touch with your matron, or the medical officer?—I may say that the only time they try to push anybody on to us is when they have someone aged seventy or over—the chronic sick.

Miss *Ward.*

2793. Or when they have got to find an emergency bed?—Yes. If someone of seventy years or over meets with a street accident they do not want that person at all. (Mrs. *Hastings.*) They know they will never get them out again.

Mr. *Turton.*

2794. Mr. Diamond asked a more specific question. Is there regular liaison between you and the London Hospital?—No.

2795. There is none at all?—No.

Mr. *Diamond.*

2796. Neither official nor unofficial?—(Mr. *Bushell.*) No. (Mrs. *Hastings.*) No regular liaison.

2797. May I ask through you if any of your officers are in regular contact with the officers of the London Hospital?—(Mr. *Burrell.*) I worked at the London Hospital for twenty years before I came to Stepney, and so I am in contact with the officers—but not as you mean it, may I say?

2798. No contact on your official business?—No, very little.

Chairman.

2799. You have personal friends there whom you contact?—Yes.

Miss *Ward.*

2800. Under the old system of L.C.C. control did you find it easier and were there less watertight compartments, or do you find the new organisation simpler and more efficient?—(Mrs. *Hastings.*) Personally I think the new set-up is much more efficient. Again I do not know whether I am saying the wrong thing, but I always felt the patients were not getting quite the best medical treatment in the hospitals, that it was not quite up to the best voluntary hospitals and the teaching hospitals.

Mr. *Diamond.*

2801. That is before the appointed day?—Yes.

2802. Is it not a fact that then St. George's, for example, where I happened to be on the committee some years ago, did receive patients from a much wider area than Stepney alone?—I could not tell you that.

2803. Or did Mile End, of which I gather you were the chairman, then receive patients from a much wider area than Stepney?—I could not tell you definitely, I am afraid.

Chairman.

2804. It is certainly true now that with negligible exceptions you only cater for the population of Stepney?—There is no definite catchment area. (Mr. *Burrell.*) That is not really true because we had six months ago a lot of empty maternity beds, and we have been taking people from Chelmsford and Brentwood.

2805. Who arranged that?—It was arranged through me. The Secretary for Chelmsford said that they were in a tight position for maternity beds, and had I any maternity beds to offer.

2806. The regional board did that?—Yes, Sir.

2807. Do they do that at all regularly, or was it just a casual arrangement?—It has been done a lot lately over the last twelve months.

2808. For maternity cases?—They know we have 120 beds, which is high for our requirements as a group.

2809. Is that limited to maternity cases?—It has been because those are the only beds we have really available in excess of our requirements. (Mrs. *Hastings.*) Have we not always been fed by Dagenham a great deal? (Mr. *Burrell.*) Yes. The East End Maternity Hospital has always taken forty per cent. of the Dagenham mothers into the hospital.

Mr. *Turton.*

2810. Could you clear up the position of the London Jewish Hospital? You say you get a great many patients from outside your area. What sort of proportion in the London Jewish come from outside the area?—I should say roughly fifty per cent. at least, because the Jewish population in Stepney has decreased whereas at Golders Green, Stoke Newington and Hampstead it has increased.

2811. Are there not hospitals in Bethnal Green which have a similar structure?—No, Sir. Only two hospitals in the country have a similar structure to the London Jewish. In other words, they feed them as their religious order demands.

Chairman.

2812. I notice in the appendix, where you give the comparative costs of feeding patients per head per week, it is much higher in the London Jewish?—Yes, Sir, that is for religious purposes. They are not allowed to eat rabbit, or some other meats.

2813. That is the explanation?—Yes, Sir. (Mrs. *Hastings.*) You have to get special kosher cheese. (Mr. *Bushell.*) You will find there is no bacon supplied.

Mr. *Thomas Reid.*

2814. As regards the maternity hospital it is rather surprising to hear that you have surplus beds. In most places the maternity hospitals are not able to receive all their would-be patients. Do the mothers come for their confinements to your hospital, or do they have their children at home as a rule?—(Mrs. *Hastings.*) The population has gone down in Stepney. There has been a big decrease owing to the war.

Mr. *Diamond.*

2815. Did I gather that you make a regular routine report to the regional board showing what vacancies you have or anticipate, or was it just a matter of chance that the regional board got in touch with you saying, "As you have got a big maternity hospital have you by any chance any free beds?"?—(Mr. *Burrell.*) It is more than a matter of chance. They do know we have 120 beds.

2816. They do not know from month to month or from week to week what your position is?—No, Sir.

2817. Do you volunteer that information?—Not unless they ask.

2818. In a maternity hospital you have some idea in advance of how many beds are likely to be occupied. If you see the possibility of some of your beds becoming free do you volunteer that information to the regional board, to London Hospital or to any other hospital outside your area?—We tell the regional board what are our bookings for Mile End. We tell them we are low for three months, "Can you send us some cases?". We need cases to teach our midwives. They must do a certain number of cases. We must have the cases. We do not want to keep the beds empty.

2819. I realise that. Nobody wants to keep them empty, and the question I am asking is very much to that point. Is there sufficient regular contact to see that your beds are as fully occupied as beds in neighbouring hospitals? I gather from what you say that that is not so, and that on this particular occasion to which you refer the regional board happened to get in touch with you, that you on the second occasion gave advance information, but that there is no regular machinery for notifying any central organisation of your prospective bed position?—No, Sir. We send to the regional board once a month a return showing how many beds we have occupied, but that will only be on a specific day in the month. In other words, you are asking for a daily bed report, are you not, or something like that?

2820. I am just asking what the position is?—There is a monthly return on one day.

2821. With regard to the 820 staffed beds, do you keep records of how many of those staffed beds are unoccupied from day to day?—We have a daily record.

2822. Could you give us any idea of your bed percentage as at your different hospitals or group of hospitals?—At the Mile End Hospital the general bed occupancy, for the month of April, was 91 per cent., for maternity beds, 99 per cent. At St. George-in-the-East the general bed occupancy was 86 per cent. At the London Jewish Hospital it was 90.5 per cent. At the East End Maternity Hospital the bed occupancy was 87.3 per cent.

2823. Are those average percentages?—I should say so, yes.

Chairman.

2823A. Over the month?—Yes. They are the average over the year too.

2824. Would they be representative for a year?—Yes, Sir.

Mr. *Diamond.*

2825. I think you said your maternity hospital had a bed occupancy of 99 per cent.?—That was at Mile End. In the other one it has a bed occupancy of 87 per cent.

2826. Is there any essential reason, fundamental and unavoidable, for the difference in that percentage?—Well, Sir, before the appointed day, as you probably know, quite a lot of Stepney people went to live at Dagenham, Barking and so on, and the mothers came back to Stepney, to the East End Maternity Hospital, to have their babies. We had an arrangement with the Barking Medical Officer of Health that he should send those cases to us. They have dropped quite a lot in the last three months, which means in effect that, with the upgrading of the Barking and District Maternity Hospital, people are going to the local hospital rather than come to Stepney.

Miss *Ward.*

2827. When they have resided at Dagenham they are less likely to want to come back to their old haunts?—They will have lost the continuity. It will be the daughters of the mothers who used to be in Stepney.

Chairman.

2828. The parents have died or moved away, and there is no particular reason to go back?—(Mrs. *Hastings.*) As a matter of fact there is something rather in the nature of a slump in maternity cases just now. So many hospitals cannot fill their wards now whereas, about a year ago, they were all crying out for more accommodation. The same thing is happening at Hammersmith. You may know about it. They cannot fill their maternity wards. I think it is just temporary.

Mr. *Diamond.*

2829. There is a fall in the productivity percentage?—I do not know what the causes are. (Mr. *Burrell.*) The war did that. I think No. 23 demobilisation group caused a great demand for maternity beds. A man wanted his wife to have a baby, but now they have to economise ; they probably cannot afford a baby any more.

Chairman.

2830. Your experience is that on the whole there is not a very great demand from your people for maternity beds?—Yes, Sir. (Mr. *Bushell.*) For the time being.

2831. Could we turn from beds to staffing? As far as consultants are concerned, are you adequately staffed?—(Mrs. *Hastings.*) I would not say so, no, but it is improving.

2832. What is the total number of consultants allotted to you now?—(Mr. *Burrell.*) In actual bodies we have sixty-three, but some are only doing a quarter session.

2833. Sixty-three whole time and part time?—Yes, Sir.

2834. What sort of proportion is that, and what would you think would be desirable? —That is a very difficult question to answer.

2835. Can you answer very roughly? Are you thinking of twenty per cent., fifty per cent., doubling the number or what?—(Mrs. *Hastings.*) We want more. We would like to have a resident anaesthetist to be able to deal with an emergency in the group.

2836. You would like some more, but you would not like to say just how many?—I would not mind saying if I had the facts just under my nose, but it is a little bit difficult to say offhand. We have certainly asked for people, but we have not yet got them.

2837. What is your out-patients' position? Have you got a tremendous pressure on your out-patients' department?—No, we want to build that up. In the past, quite frankly, people have not sent for an opinion where perhaps the general practitioner was just as well qualified as the man dealing with the appointment.

2838. I should tell you that this Sub-Committee has had evidence that there is a tendency on the part of the overworked general practitioners to send patients to out-patients' departments in order to get rid of them themselves. I am not asking you to accept that as true or otherwise ; all I am asking is whether you have any experience of that sort of thing?—No. In fact we rather want to encourage the general practitioners to send us more cases. Our consultant service is rather new, and we want to build it up. It has not got perhaps thoroughly known in the district, and patients are automatically sent to the London Hospital. We want to build up our consultant service into a first-class one, and to get cases to come to us as well.

2839. What you are saying is that you are really overshadowed here by a large teaching hospital?—There is an old tradition that we were an L.C.C. hospital and that we did not deal with out-patients, so that doctors have got into the habit of sending their patients to the London Hospital.

2840. Is there great pressure on the out-patients' staff of the London Hospital?—(Mr. *Bushell.*) Yes. I often visit the London Hospital by walking there, and as you enter the main receiving hall it is just jammed right full with people. You never saw so many people in all your life.

2841. Have they ever approached you and made any representation that you relieve them of some of this pressure?—(Mr. *Burrell.*) No, Sir, and they are never likely to do so, because they want all their work for teaching their students.

2842. They cannot do more work than that for which they have facilities?—(Mrs.

Hastings.) That is why they would like us to take over more of their chronic sick.

Miss *Ward.*

2843. They would relieve themselves of their chronic sick and keep the cases which you want to build up your consultant service?—Really, yes. (Mr. *Burrell.*) That is what they want to do.

2844. Is the sort of problem which you have ever put up to and discussed with the regional board? Where does the regional board come into a problem of this kind, because the general overall plan would come from the regional board?—They are quite free from the regional board. They are a law unto themselves.

2845. Yes, but if you could not build up your consultant service because you were having the wrong type of patient sent to you, surely the regional board would be able to make a suggestion?—(Mrs. *Hastings.*) I think it is just a matter of supplying such a good service that they will come to us. I do not think we have any grievance with the London Hospital. We do not want to say that people must not go to the London, but we want to make our service so good that they will want to come to us.

Mr. *Thomas Reid.*

2846. You have never put this matter before the regional board?—No, I do not think we have actually.

Chairman.

2847. Have the regional board ever asked you about this?—(Mr. *Bushell.*) No. (Mrs. *Hastings.*) We have perfect freedom to raise it because I go to these chairmen's meetings to which I am always invited. I have not happened to have done so, but there is no reason why I should not. There is great freedom, and expressions of opinion are invited. The Secretary goes to the secretaries' meetings, and all the different principal officers have meetings in which they are asked to air any difficulties. So it is our own fault if we have not put this difficulty forward.

2848. I am not trying to apportion the blame to anyone, but I am trying to find the facts. The facts are that you have this problem, and it has not been taken up either by you or by the regional board?—No, we have always looked upon it purely as a problem of getting our hospitals first-class. I think we have always felt it was up to us.

2849. Apart from medical staff how are you situated for other staffs? You are probably short of nurses, as everybody is?—Yes.

2850. I am sure you have a difficulty because of the nature of your locality, the accommodation shortage and so on?—Yes, and we were hit very badly in the London Jewish Hospital when co-op. nurses were made impossible.

2851. In paragraph 5 on page 3 of your memorandum you say, "The Hospital Management Committee decides how many staff and available beds there are likely to be during the ensuing year, and how many more they aim to open, fixing to the best of their ability in all the known circumstances a target date for the opening of new beds". You are suggesting there that you are definitely going ahead with a policy of increasing your staff and opening further beds?—Yes.

2852. During the last two or three years have you regularly increased your staff and opened beds?—Yes.

2853. Could you give us any figures to show what the increase has been?—I think the increase is shown in the document. (Mr. *Burrell.*) It is for tuberculosis beds, but not for general beds. (Mrs. *Hastings.*) About 200 beds I think we have increased.

2854. I do not think you give us comparable figures. Could you give us comparative figures for the last two or three years, showing how your staff has altered, either increased or decreased, by classes, that is to say, nurses, domestic and so on, and the number of beds?—Yes.

2855. I think it would be desirable, in view of the different nature of your hospitals, to show it by hospitals. If you are able to give that information to the Sub-Committee, I think it would be valuable?—Yes.

2856. You have in fact increased your staff?—We have increased the staff.

2857. You have done that by the deliberate policy of the management committee itself?—Yes. About the first year we were always getting requests, rather wildly, for increases in staff. I think everybody's idea then was, "Now we can really spread out", and we began to realise that we must have establishments fixed on which to base these increases. Everybody wanted extra staff.

2858. Were you not given any limit by the regional board?—I do not think we were, definitely. I think their view was this: "You are doing the job; it is for you to do it".

2859. You could take on anyone you liked, provided you could find them?—(Mr. *Bushell.*) Provided we had the money. (Mrs. *Hastings.*) Apart from the medical side, we should probably be called over the coals later on if we were extravagant.

2860. Do the regional board set any limit now to the number of staff you engage?—No. We have to estimate under the different heads, and if we get the money for it that is all right.

2861. The only control exercised over you now as regards staff is whether or not you can pay for them, really?—Yes.

Miss *Ward.*

2862. Can I ask you a question on the supplies officer? I see you say that there are frequent visits by the supplies officer to the hospitals. Do you have with the regional board the same sort of system in regard to supplies which you used to have in the old days with the London County Council? In the old days they purchased centrally, did they not? Has that system changed, and if it has changed do you think it is for the better or worse?—I am speaking for myself now and not for the committee, because I do not think they want bulk purchasing, but I think that, when they gave up the bulk purchasing system of the London County Council, they gave up a very good thing; and I think we have replaced it with a much more wasteful system. That is my own personal opinion.

2863. Perhaps I should not express this opinion, but I think that in the old days they did have a very good central purchasing system for London—that is my own impression?—Yes.

2864. I have heard that stated?—I think so, and, if we could still have the freedom to choose what we wanted from that central store, I do not think it would become too bureaucratic. I think we could buy much more cheaply and better, because the experts would see that we had good stuff.

2865. Are they the same supplies officers as in the old days, or are they new people?—Actually ours was the Steward of St. George-in-the-East, but the post was advertised and we just chose the best man.

Chairman.] I think it might be convenient now if we were to go through the points which have occurred to Members of the Sub-Committee on your memorandum, and the first of which I have a note is on this question of central bulk purchasing.

Mr. *Turton.*

2866. Could I just ask one general question before that? What is the size of your budget, as I cannot find it in your paper?—(Mr. *Bushell.*) For this last year it was £535,000.

Mr. *Diamond.*

2867. Going back to your increase in staff, do I gather that was done as a deliberate matter of policy, that it was left very much within your own discretion and that you were not prevented from increasing your staff by the regional board except within the terms of financial control? The facts, as I understand them, are that you have a diminishing population in Stepney, diminished by fifty per cent. from 200,000 to 100,000, and that you have no excessive waiting lists, in fact quite the reverse in certain cases, a tendency for empty beds. Could you tell me, therefore, on what general principle you adopted the policy of deliberately increasing you staff?—(Mrs. *Hastings.*) May I just correct one statement there? I do not think it is a diminishing population. It was owing to the war that it diminished, but I say it is increasing now rapidly. I do not know the figures. (Mr. *Bushell.*) I do not live in this area but I have worked in this area for thirty-one years, and of course they suffered very severely during the bombing. Since 1948, however, there have been lots of flats erected everywhere, and the population is increasing rapidly.

2868. Is that reflected in the pressure on waiting lists? I gather that at the moment you have not got waiting lists?—(Mrs. *Hastings.*) We have more beds, but we have not got waiting lists—that is quite true.

2869. I was wondering if you could help me on the general principles which prompted you deliberately to increase your staff?—(Mr. *Bushell.*) I am not on the establishment, but I can say that some of the departments were terribly understaffed. We have tried to cut out overtime as much as possible and to work normal hours, and that was the only way we could do it. We were understaffed.

Chairman.

2870. You found yourselves understaffed after the war?—Yes, when we took over.

2871. To return to bulk purchasing, that is not perhaps a very happy term because it has different connotations, but you are in favour, so far as your group is concerned, with wholesale purchasing by the group committee, making the goods so obtained available to any of the hospitals in the group?—(Mrs. *Hastings.*) Yes.

2872. Does not the same argument apply rather further? What would you say if the regional board said, "In future management committees are not to purchase certain articles. These will be purchased centrally by the regional board, and made available to all groups within the region"?—I should think it was a very good idea.

2873. You would have no objection to that?—No.

2874. Is that done at all?—No. (Mr. *Burrell.*) There is a certain amount of bulk purchase by the Ministry of Health not through the regional board.

2875. The Ministry of Health do occasionally buy certain classes of goods?—You are thinking of medical appliances?

2876. Yes?—No. They have recently started the bulk purchase of rubber gloves and various types of surgical requirements.

2877. This is the Ministry of Health?—Yes, but not the regional board.

2878. So far the regional board have done nothing?—No, Sir.

2879. Has it ever been suggested that they should?—Not by us.

2880. I suppose that anything which could be done by the regional board could be as well done by the Ministry of Health as far as you are concerned?—(Mrs. *Hastings.*) I am not quite sure whether that would not be too big and too centralised. I do not know.

2881. You are not horrified at the suggestion that there is scope for extension of that principle?—I think it would be one more way in which economy could be effected, personally.

2882. What kind of things would you suggest might be acquired in that way?—Beds and equipment for hospitals. I should think it could be tried out with what you might call furniture and things of that sort, equipment generally. I do not know about food; I am not quite sure there. I should think it could be gradually extended to cover most things.

Mr. *Diamond.*

2883. Do you include linen there?—Definitely.

2884. Food would be difficult?—(Mr. *Burrell.*) Food might be difficult in regard to quality. If you buy it for the country, it means that someone is going to get the best and someone is going to get the worst. Food is rather a personal matter, is it not?

Miss *Ward.*

2885. I suppose also to some extent the question of different types of food would come into the category of the catering officer and the dietitian. They might supply it according to their own ideas?—I do not think it would be popular. Whether it would be good or bad I do not know, but I do not think it would be popular.

Chairman.

2886. Do you bulk purchase food within your group?—Yes.

2887. Such as potatoes?—We do not bulk purchase those but we have a contract with one firm to supply each hospital. The catering officer sends the orders to that firm.

2888. Your hospitals are fairly close together?—Yes, Sir.

2889. Would that work if your hospitals were twenty or thirty miles apart?—It would with this particular firm because they are hotel suppliers and they supply a tremendously big area.

Mr. *Thomas Reid.*

2890. How long does the contract last?—Twelve months.

2891. With regard to system of purchasing by the regional board I would like to ask Mrs. Hastings this: would there not be the likelihood of delay, and would not the regional board, in order to avoid delay, have to have a big store somewhere for holding all the goods they purchased so that they would be able to deliver them as soon as they were wanted?—(Mrs. *Hastings.*) Yes.

2892. In a big area a central store would mean a lot of transport between that store and the various hospitals?—Yes.

2893. Still you think it would be a good system?—I think it would. As a matter of fact, when we took over on the appointed day, one of the things about which we were asked concerned the continuation of the L.C.C. Stores, and if I remember rightly not enough of the groups wanted to support them.

2894. This system in London is one thing, but in a big rural area I can see great difficulty?—So can I.

2895. In the case of London you think it would work?—I think in London it would, but because of the difficulties in other areas I do not think it is quite applicable.

Miss *Ward.*

2896. It would mean retaining a special type of purchasing system in an area within an area really?—Yes. I can quite see there would be difficulties in rural areas and in widespread areas.

Chairman.

2897. Your evidence is that you find this useful and economical within your own group for certain classes of goods, and on the whole you would like to see it increased but having regard to the particular needs of particular areas and the particular types of goods. That is really what it comes to, does it not?—Yes.

Miss *Ward.*

2898. What is the position in regard to medical stores, for instance, cotton wool, bandages and that sort of thing? How are they purchased—by each individual hospital or purchased centrally?—Centrally.

2899. By the group and not by the region?—Yes. (Mr. *Burrell.*) We buy the supplies. (Mrs. *Hastings.*) I do not think there is anything in the region. It is all done by the group.

Chairman.

2900. Turning to paragraph D, "Difficulties", on pages four and five you make a number of points there. Perhaps I should tell you those points have been brought to the attention of the Sub-Committee, and if we do not cross-examine you about them it is because we are very conversant with them. There is a question I would

like to ask you though. Are these matters which have come to your mind naturally in the course of your administration of these hospitals, or have those been suggested to you from outside?—No, they are purely our day to day experience.

2901. This is your own experience, and nothing else?—Yes.

2902. You do make one very interesting comment, sub-paragraph (vi) at the top of page five, about the Ministry's practice of announcing wage awards with retrospective effect. You state there that such awards can only be met by curtailing other expenditure?—Yes.

2903. Has that actually happened in your case?—(Mr. *Chilvers.*) Yes it has. (Mrs. *Hastings.*) It is very awkward when these retrospective awards are given because the money has to be found from somewhere. We do not get extra money.

Miss *Ward.*] It cannot make for efficiency.

Chairman.

2904. What size of sums have been involved?—(Mr. *Chilvers.*) Mainly it is frustrating. You cannot carry out your plans to open beds and so on when——

2905. I understand what you are saying, but what kind of money sums have actually affected your group? Have you suddenly had to pay out £20,000?—A figure of about £6,000 to £7,000.

2906. From where in fact did you find that money?—We had to curtail the recruitment of staff to some extent, and at the same time to cut our maintenance programme, in order to hold back enough money to pay the arrears when the time came along to pay them.

2907. You found you were able to do it?—We were able to do it by curtailing our development, as it were.

2908. Did you try to put in a supplementary estimate?—We have not had to do that, no.

2909. You have not tried that?—We have managed without having to do that.

Mr. *Diamond.*

2910. This payment of arrears was of the order of about one per cent. of your total budget?—Approximately.

2911. That gives an idea of the amount of stringency caused in other directions?—Yes.

Chairman.

2912. It may be convenient to go from that to the point you raise a little later on page six of your memorandum on the subject of Whitley Councils, which links rather with that. In the course of the paragraph you say, "The management side should consist of members of Boards and Committees who are aware of the present day needs and requirements as well as of the conditions prevailing in the outside commercial and industrial world". At the present time have you any knowledge at all of what goes on in a Whitley Council?—(Mr. *Bushell.*) No, nothing.

2913. You have no knowledge?—No knowledge.

2914. I suppose you know in advance that a claim is being made?—For the catering people?

2915. For an increase of wages in the ordinary way?—Yes. (Mr. *Burrell.*) We would only know through the union members of our staff who tell us.

2916. You know unofficially?—Yes.

2917. Unofficially you do know that a claim is going forward?—Yes.

2918. Are you consulted at all?—No, Sir. (Mrs. *Hastings.*) There is no direct liaison at all. (Mr. *Bushell.*) We do not know anything until the award is made.

2919. You have absolutely no representation on the Whitley Council?—(Mrs. *Hastings.*) No.

2920. If there is an increase you have to find the money, and you have not had it refunded to you?—(Mr. *Bushell.*) We have never asked for a refund; we have managed, but we have not managed as we should have liked to have done. (Mrs. *Hastings.*) There is no provision made for refunding.

2921. The responsibility for finding this money is that of the Ministry of Health. I do not think you could claim to have any control. I am not certain whether you suggest that perhaps you ought to be given control here. On reflection would you say that you should be allowed to nominate the members?—The awards are rather unrealistic. We very often feel that the awards are made by people who do not really realise the implications of their decisions.

Miss *Ward.*

2922. They do not reflect the hospital side really?—No, and the difficulties we have in competing with the outside world, competing even with different regions a little bit. A wage is laid down at which we cannot get the people.

Chairman.

2923. You are not consulted at all?—No.

2924. In no way at all?—No.

Miss *Ward.*

2925. On the complaint which is made about the King Edward's Hospital Fund suggesting the salary for your catering officer, is there never a sort of general conference at regional level when the whole

problem of catering officers could be discussed, what is a fair wage, and at what wage you could attract a good catering officer? Do those sort of points in relation to the whole scheme never come up for discussion at the chairmen's conferences?—I think that at the chairmen's meetings we all air our difficulties about it, but we have to go by the awards of the Whitley Councils. That is something which is just beyond us.

2926. Would you never be able to put a considered point of view from the region to the Ministry?—I really cannot tell you. This very difficulty has been brought up at the chairmen's meetings.

2927. I am sorry to press you on this matter, but supposing you were present and you put forward the point of view expressed in your memorandum, would the chairmen at their meeting never say, "We will put up this point to the Ministry and see what they have got to say about it" —because it does raise a very important point?—Yes, it does. I could not say exactly, but I should think it would then be decided between the chairmen at regional board level, and if they all decided they had the same difficulty they would put it forward. (Mr. *Burrell.*) That has been raised at the secretaries' meetings. (Mrs. *Hastings.*) And at the chairmen's meetings.

2928. Have you ever put up a joint memorandum to the Ministry?—Not on catering officers specifically.

2929. I am thinking not only in relation to catering officers but over a wider field? —(Mr. *Burrell.*) The secretary to the regional board has taken the opinions of the secretaries and put them to the board, and they have been put to the Ministry—but actually it was not on salaries and wages questions so far as I know. (Mrs. *Hastings.*) I think these Whitley awards are rather watertight. I do not think we can do much about them.

Chairman.

2930. At the moment you cannot do anything as you have no knowledge of them and you are not consulted; that is the end of the matter?—That is just the way it goes. We take them as an act of God. We cannot do anything.

2931. On the other hand you obviously feel very strongly about this. You draw comparisons in sub-paragraph (vi) and you comment on those comparisons, suggesting, I think, that the National Health Service scale is very inferior from the point of view of the employee to the Catering Wages scale?—It makes it almost impossible.

2932. Looking at your table I am wondering whether the comparison is so adverse to the National Health Service as all that, because there is substantial superannuation payable under the National Health Service whereas there is none under the Catering Wages Regulations?—I am afraid that does not always mean quite so much as it ought to mean to the people who apply. They would rather get a bigger weekly wage. They feel, "I will never want that superannuation; I shall get married (or something)". The fact that they are getting superannuation does not mean so much as it ought to mean.

2933. I suppose you are here considering particularly the payments to female domestics, female cooks and so on, and many of them are not in the least interested in superannuation?—No, they feel they will never be old. I think you do when you are young. (Mr. *Bushell.*) They are more interested in what they are going to get this week.

Mr. *Thomas Reid.*] Is the regional board not even consulted about these wages and salaries? Are they completely in the dark?

Chairman.

2934. I do not think we can ask these witnesses that question?—(Mrs. *Hastings.*) I do not know that.

Mr. *Diamond.*

2935. Could I come back to the question of the difficulties you express in regard to the system of estimating, at the bottom of page four, and could I ask you, without wishing to embarrass you in the slightest, to give me your own experience on the two points about which you comment there? In sub-paragraph (i) you say, "Present system of rigid centralised financial control exercised by the Ministry is not conducive to economy. The practice of approval of individual vote heads coupled with the regulation that savings on a particular vote head must accrue to the Exchequer while over-expenditure on any particular vote head will call for an explanation by the Hospital Management Committee leads inevitably to unrealistic estimating". In so far as your committee has made estimates, would you say that they have been unrealistic?—In the first year we were terribly realistic and then, when the next year came in and it depended on the last year, we perhaps felt we had been a little bit too careful. We do not say we had been in fact; it is not perfectly rigid; but there is that temptation to feel that, if we shear this too finely, next year we will be "in the soup".

2936. You do feel in fact that had there been a different system of centralised financial control your estimates might have been a little keener?—I think it would make for more responsibility.

2937. In sub-paragraph (ii) you say that the inability to carry forward balances of unexpended money may invite the expenditure thereof on non-essentials up to your authorised limit. Have you experience in your committee of that?—(Mr. *Bushell.*) No. We can see that that could happen. (Mrs. *Hastings.*) I would not be quite sure that there has not been just a little tendency like that towards the end.

2938. I would be very grateful if you would be quite frank about it, because it is nice to get hold of the people, about whom the criticism is being made, to find out whether they are in fact rendering themselves liable to that criticism?—I do not say unnecessary things in any sense, but I think perhaps things which are not so important as the original ones we wanted. There is a little feeling like this, "It is a pity to let this money go. We shall be sure to want something else. Let us get that rather than lose the money".

Chairman.

2939. Can I ask a specific question? Suppose that towards the end of the financial year you have a surplus under one head and no surplus under another head. There are two things you require—one purchasable under head A, on which you have a surplus, and one purchasable under head B on which you have no surplus. You would greatly prefer to acquire the article under head B, and if you were free that is what you would get because you are sure it would be of greater advantage and to the benefit of everybody, but because you have a surplus under head A you say, "If we could get that sum transferred we ought to get the article under head B, but as we cannot make the change then let us get the article under head A". Has that ever occurred to you?—Not in the case of anything which we really would not feel we would want at some time, but we would not want it as badly as the article wanted, if we could get it, under head B.

2940. You have at times bought the less urgent article because you have been driven to do that by this system. Has that actually happened?—I think it is true. I do not think we can deny that. (Mr. *Burrell.*) If we place an order in June for linen and then we get a note from the manufacturers to say it cannot be delivered for nine months, it comes into the next financial year. Therefore we might have £1,000 there which we want to spend on linen. It is reasonable to say, "What can we buy?", but I am not saying they do.

Mr. *Diamond.*

2941. The question I am not asking is what you think it is reasonable for other people to do in hypothetical circumstances. The question I am asking is this: what have *you* done yourselves in these circumstances, without wishing to embarrass you in any way, because it is your own experience which is so valuable to this Sub-Committee? Have you in fact been short under one head, as the Chairman has said, and had a surplus under another head, and used part of that surplus for goods which you would not otherwise have acquired or on non-essentials?—(Mrs. *Hastings.*) Not goods which we should not otherwise have acquired, but things which we did not want as badly as the ones we could not get.

2942. Therefore on non-essentials, as you defined them just now?—Not so urgent. I do not think we should ever put down on our requirements things which we considered as non-essential. I think it is unfair to ourselves to agree to that, but things we do not want as urgently, not so useful, as the things we cannot get.

Miss *Ward.*

2943. In other words, you cannot have your own priorities?—That is really putting it in a nutshell. (Mr. *Burrell.*) May I give you an instance? The Committee felt they needed a dish-washing machine at one of the hospitals. We had not the money for that in our maintenance, but we had it under some other head. Actually we did buy the dish-washing machine last year. That might be regarded as non-essential as you look at it, but so far as we are concerned it is something which is highly essential. (Mr. *Bushell.*) It saved us a lot of labour.

Mr. *Diamond.*

2944. That is an example of your reverse procedure, is it not? That is an example of the latitude which you have in spite of this rigidity. You meet expenditure which really falls under one head from another head?—(Mr. *Burrell.*) We have not got that authority.

2945. I thought you said you had bought it?—We wrote and told the Minister that we wanted to do this but, although we have done it, we have not yet heard from the Minister.

2946. Where will you show it in your accounts?—That is up to the finance officer. (Mr. *Chilvers.*) We shall overspend on one sub-head and save on another. We shall not have overspent in total, but if we had freedom to use our £500,000 without this rigid control under subheads, we could be quite honest and get what we wanted without having to get Ministry approval every time.

Miss *Ward.*

2947. You have used the money more economically and to better advantage?—Yes.

Chairman.

2948. Is this rule more honoured in the breach than in the observance? Do you in fact take the latitude which you think

you ought to have and sin in that way, or do buy goods which are less important than those which you think you ought to have and sin in that way? You have a choice of sins, but when it happens it may not be one in fact?—(Mr. *Burrell.*) We will just by chance this year have a little money over on one head, and not enough on the others. That is an isolated instance. We asked permission of the Minister. (Mr. *Bushell.*) At the financial meeting we have our rate of expenditure put down in twelfths for each month, and before authority is given for the purchase of any item first of all we look to see if the money is there. If the money is not there then we do go into the question of whether it is essential or not, and if it is not so urgent as all that we simply say, "You must wait". We do try to keep very strict control of our spending under the headings.

Mr. *Diamond.*

2949. In fact you are saying that, if it is divided under heads, you are bound by the amount under each head and you do not exceed the vote (unless you can help it) under any head, which means that it does control your expenditure under each head up to the estimated amount?—Yes.

2950. That is not consistent, is it, with what this paper is saying, that if you had freedom to put all your heads together in one pool——?—It would be much better for us.

2951. Would the expenditure be less?—(Mr. *Burrell.*) May I say——

2952. I think the gentleman who has just made the statement will be able to answer my question?—(Mr. *Bushell.*) We should spend our money just the same, but I think we should spend it more wisely.

Chairman.

2953. Just the same amount of money?—Our money would be spent just the same.

2954. "Just the same"—do you mean on the same things or that the same quantity of money would be spent; there is a difference?—The same quantity of money would be spent. With the present-day pricing you have estimated for a certain amount; you get a quotation for a certain amount; but when the goods come in they are invoiced at the price ruling at the time of despatch. It is a different thing altogether really when you are agreeing to a purchase; you must just bear that in mind.

Mr. *Diamond.*

2955. You say you bring to the notice of your finance committee each month to what the one-twelfth availability amounts?—Yes.

2956. In your experience, as you get towards the end of your financial year and people realise that a surplus will be there, that you will not actually spend the whole of the twelve-twelfths, has it ever happened that a member of the committee has said, "We have some money available; what about spending it on something else?"?—The finance committee could not spend it like that; it has got to come from the other committees first.

2957. Do those other committees know that the finance committee is running up the possibility of a surplus on a particular head?—They would know the financial position. It is reported at different times. (Mrs. *Hastings.*) Actually we had a surplus under one head recently, and we asked the permission of the Ministry to transfer it.

2958. Was it refused?—(Mr. *Bushell.*) We have not heard.

Miss *Ward.*

2959. What happens if permission is not given for this dish-washing machine?—It has happened. (Mrs. *Hastings.*) I am afraid occasionally we have to take a chance.

Mr. *Diamond.*

2960. You presumably bought this dish-washing machine in effect not because you regarded it as non-essential but as very essential?—Yes. (Mr. *Burrell.*) We had gone into this very thoroughly; it was not a wild thought.

2961. It is not an example of the wording in sub-paragraph (ii) of "D", "The inability to carry forward balances of unexpended money may invite the expenditure thereof on non-essentials for the sake of spending up to approved totals . . .", is it?—(Mrs. *Hastings.*) I do not think "non-essentials" is a good word perhaps there.

Chairman.

2962. "Less essentials" are the words your want?—Yes.

2963. Could we put it this way? Supposing you had been given a lump sum for all heads, do you think that your purchasing last year would have been substantially different from what in fact it was?—I do not know. (Mr. *Chilvers.*) No, I do nothink it would have been substantially different. (Mr. *Bushell.*) It is just being tied down under heads which makes it just a bit difficult at times.

Mr. *Diamond.*

2964. Difficult to spend or difficult to save?—Difficult to spend and save.

Miss *Ward.*

2965. If you thought there was going to be an increase in the price of blankets, which appears to be inevitable, it perhaps would be wise to lay in a stock before the price rises, but if you had spent all your

money under that head you could not in fact lay in that stock?—(Mrs. *Hastings.*) No.

2966. It is rather a deterrent to good housekeeping——?—(Mr. *Bushell.*) Yes.

2967. —if you keep your eyes shut to what is going on?—(Mrs. *Hastings.*) I think it is a great deterrent. (Mr. *Bushell.*) That is the point. (Mrs. *Hastings.*) We have the responsibility without the full facilities.

Mr. *Thomas Reid.*

2968. Under the present system do you have considerable savings at the end of the year on some heads?—(Mr. *Bushell.*) On some heads we save, but we have never saved a lot. We have been very careful. We spend quite a lot of time preparing our estimates. There is nothing done in haste I can assure you, but all sorts of things occur. We have got to allow for rising costs.

2969. If you had the new system of a general block grant for you to spend as you please, would that affect your system of estimating? At present you estimate under the various heads. Would it lead to an increase in expenditure if you had the block grant system?—No, I do not think so. For example, if you wanted to buy a piece of furniture or something this last year and you found you were just running out under that head, that might be done by works.

Chairman.

2970. There are eight heads of expenditure, are there not?—Yes.

2971. When you are making your estimates in the first place you would in any event keep your expenditure under heads, and you would put in an estimate under each head of what you think you would need?—(Mrs. *Hastings.*) Yes.

2972. Do the regional board interfere—I do not want to use an offensive word—help you in the formulation of your estimates at all?—(Mr. *Bushell.*) No, I do not think so. They do not touch them. We just make our own estimates and submit them, and then, if they are not satisfied, they would come down.

2973. Your estimates, when they leave you, are genuine estimates of what you think you will need under each head, and the heads are relatively what you think they should be to one another?—Yes. I can quite see the point you are putting, but I do not want to be tied down to those heads.

2974. Needs will alter during the course of the year—I understand that?—Yes.

2975. But originally, as far as the estimates are concerned——?——they are shown under heads.

2976. You are not told that under some particular head you have got to keep your estimate down to below a figure which you think is reasonable. You may be told when the estimate is approved that a less figure is approved than you think is reasonable, but that is at a later stage?—(Mrs. *Hastings.*) We are given an entirely free hand by the region.

2977. Then the regional board exercise no control at all?—(Mr. *Bushell.*) When they have had the estimates they have come down and gone through them with us; they have asked why this, why that; we have given the necessary answers, and they have been satisfied.

2978. That is in September of each year?—Yes.

Mr. *Thomas Reid.*

2979. As regards capital expenditure would they interfere?—(Mr. *Chilvers.*) The regional board do the capital expenditure. (Mr. *Bushell.*) We do not touch that at all.

Mr. *Diamond.*

2980. If you have the system of block grants to which reference has just been made, would you propose to work out your estimates with the same care under different heads?—Yes, we must. To start your estimates you have got to start at the bottom; you have got to start at the beds; you know what staff you want for your beds; and everything works from the patients.

2981. The estimates would be built up in the same way just the same?—They must be built up in that way.

2982. Would you say then that the freedom to spend within the total of your estimates should be a freedom which should be granted to the regional board or to you?—I would like it left to us.

2983. You would merely have to satisfy the regional board that you had not exceeded your total estimates?—Yes, to give them details under the heads.

2984. Which might show that under certain heads you had spent more and under others less?—It would still all be spent under the heads, but we do not want to be tied down to the heads.

Chairman.

2985. Have the regional board ever cut down on an estimate before it has gone to the Ministry of Health?—(Mr. *Chilvers.*) Yes. They did last year.

2986. Substantially?—Not substantially.

2987. Can you say what heads were cut?—Salaries and wages I think was the main one.

2988. On the basis that you had too many bodies or that you proposed to pay them too much?—Anticipating too many,

I believe. I think they thought our anticipation of opening so many wards with so many beds was an optimistic one, and that we would not require the money for salaries for which we asked because we would be very lucky to get the beds opened in the time we thought we could.

2989. That took place in September before the estimate went on to the Ministry for approval?—Yes.

2990. Did you accept that, or what happened?—(Mr. *Bushell.*) We called all the hospital heads together and told them that we had had a cut. We asked them if they would co-operate with us by saving wherever they could, and we suggested——

2991. Under that head?—Yes, and we suggested, for instance, bandages. Do not use yards when a foot will do; lighting; and certain——

2992. May I again interrupt you? You said the regional board had imposed a cut on you under the heading of "Salaries and Wages". What steps did you take, when that was notified to you? Did you suggest cutting down on bandages and items which do not come under that head?—No, but besides salaries and wages there was a cut. (Mr. *Chilvers.*) I think the regional board had a certain amount of money, and they decided they would have to impose a cut of two and a half per cent. The amount cut is on salaries and wages, but you get corresponding reductions of course in the amount of provisioning; you will not want so much for uniforms, and so on. You revise your estimates so that you put in a revised estimate with a smaller amount for salaries and consequential smaller amounts on the other heads too.

2993. In other words, this was a general cut?—In effect, but it did arise out of the original cut in salaries, on the staffing, and it leads to cuts in the other items as well. They all depend on the beds and the staff. (Mrs. *Hastings.*) As far as the salaries and wages cut was concerned I believe we got all the heads together and took them into our confidence as to what overall amount of money they could spend on nurses. It was a little bit more put up to them on what they had to spend, and if they could save on something then perhaps they could have a little more on something else, for staffing. (Mr. *Burrell.*) Otherwise they were told three nurses would cost two sisters; they could have either. (Mrs. *Hastings.*) There was a little more negotiation between them. If they wanted more staff nurses and more domestic help, then they could have so many more domestics at the expense of less staff nurses. They could go into that themselves. We found that by taking them into our confidence matters were much more co-operatively run.

2994. Have you had that estimate approved yet?—(Mr. *Chilvers.*) In January of this year.

2995. Was it approved as finally agreed between you and the regional board?—That came through the regional board from the Ministry of Health. That was in January. The year was nearly over then.

2996. You put up an estimate which was criticised by the regional board, who pretty well insisted on certain reductions being made. You then went into the matter and you suggested certain reductions?—Yes.

2997. You sent that back to the regional board who apparently accepted it?—Yes.

2998. Then it went to the Ministry of Health?—Yes.

2999. When it came back to you from the Ministry of Health, was the amount approved that agreed by you with the regional board in September?—Yes.

3000. Without any substantial variation at all?—Yes.

Mr. *Diamond.*

3001. It was approved two months prior to the end of the financial year?—Yes.

Mr. *Thomas Reid.*

3002. To return to the block grant system, suppose you get a large sum of money approved for an extension to one of your buildings. Would you like to be authorised not to spend the money on that extension but to spend it on salaries, bandages or something else totally different?—That would be capital expenditure, which of course is being handled by the regional board.

3003. You would leave out capital expenditure from this; you want a block grant for the other subheads?—(Mr. *Bushell.*) Yes, we do not get capital expenditure now.

3004. As I gather from this paper your relations with the regional board work out very harmoniously on the whole?—(Mrs. *Hastings.*) Very harmoniously.

3005. As regards yourselves the existence of the regional board is very useful?—It works very well, I think. The officers are always very anxious to be helpful in any way. They do not interfere unduly.

Miss *Ward.*

3006. You do not think it would be simpler if you acted directly with the Ministry and had no regional board?—No, I do not personally. (Mr. *Bushell.*) I think that by acting with a regional board you do just get that little bit of personal touch.

Chairman.

3007. You feel the regional board help you, on the whole?—(Mrs. *Hastings.*) Yes.

3008. They act as mediators with the Ministry—that is your impression?—Yes.

3009. You suggest, I think, that the Ministry exercise some control over you direct through their audit. Is that correct? Am I right in thinking that you suggest that?—On what page is that?

3010. Page six?—That is really our only direct relation, I think, on the audit.

3011. That is your only direct relationship with the Ministry of Health?—Except that the principal regional officer attended one of the meetings.

3012. When your accounts are being audited they are done by the Ministry of Health auditors?—Yes.

3013. Do they make suggestions to you while they are auditing?—(Mr. *Bushell.*) They have made suggestions.

3014. Are they mere financial auditors, or do they recommend changes with a view to efficiency and so on?—They have made statements or comments. (Mrs. *Hastings.*) More with the idea of economy than efficiency. (Mr. *Bushell.*) They have made comments, but there has been nothing drastic or anything really to worry about at all.

3015. Suggestions?—Just suggestions.

Mr. *Thomas Reid.*

3016. You are quite satisfied with the work of the ministerial auditor in preference to your own auditor or an audit by the regional board?—The present scheme seems to be working satisfactorily. I will say that before the auditor comes down the committee do all the checking that is necessary, believe me.

Chairman.

3017. Turning to another matter on page six, you speak of consultation with the local general practitioners. Was that started on your own initiative?—(Mrs. *Hastings.*) I believe it actually was the initiative of one of the members of a Hospital Management Committee who was a general practitioner, and she felt the local general practitioners did not know what we were doing and were not drawn into the picture at all. We had a very successful meeting with the local G.Ps., and we propose to have another shortly.

3018. How many G.Ps. attended?—About forty or fifty, and then they put their grievances.

3019. Are there minutes of that meeting?—(Mr. *Burrell.*) Yes, Sir, there is a verbatim report of the meeting.

3020. Is it a very lengthy report? Could you supply us with a copy?—It consists of ten pages.

3021. Could you tell us briefly the nature of the complaints which were raised?—The G.Ps. brought up the question of representation on house committees; they discussed the question of X-rays within the group; they also spoke about physiotherapy and so on; they raised the question of laundry for the old people in homes, people who were not fit to do their own; they raised the question of out-patient sessions in the hospitals, they wanted more; and they raised the question of operations for tonsils and adenoids, which has been discussed; and the admission of patients.

3022. They were all points raised by the G.Ps.?—Yes, Sir.

3023. Did you raise any points with them?—(Mrs. *Hastings.*) We gave them a general survey of the improvements in the hospitals, mostly.

3024. Had you any suggestions to make as to what they might do to help you?—We wanted them to send cases to us.

3025. Did you think there was a certain amount of keenness on the part of the G.Ps. to attend this meeting?—Yes, I think so.

3026. It is the only one you have had?—Yes.

3027. You are going to have another one, and you intend to hold meetings regularly?—Annually.

3028. Do you think you will get continued interest of this sort?—I think so. It was a little social event as well. I think they rather enjoyed it. They came and had refreshments in the evening; there was a little party; and then they talked.

3029. Do you allow G.Ps. freely into all your hospitals?—I do not know. I should think they would be, if they wanted to. (Mr. *Burrell.*) They ask the medical superintendent if they can come and see Mr. Brown.

3030. Do they come?—Very rarely, about two or three only.

3031. Have you got any G.P. beds?—No, Sir.

3032. Have you had any requests for such beds?—No, Sir.

3033. Did the G.Ps. at the meeting make any such suggestion at all?—(Mrs. *Hastings.*) No.

Mr. *Diamond.*

3034. What was your reaction with regard to their request for additional representation on house committees? Did you promise anything? I imagine that is what they were saying—they wanted more representation and not less?—(Mr. *Burrell.*) It was raised by one of their number, and he is on a house committee now.

Chairman.

3035. On page eight of your memorandum you make the rather horrifying suggestion that it may be necessary to direct nurses. Could you perhaps enlarge on that?—(Mrs. *Hastings.*) I think that was rather a long-term suggestion.

3036. Is that due to the fact that you have difficulty in getting nurses?—(Mr. *Burrell.*) For one hospital, yes, Sir.

Mr. Diamond.

3037. Is it the question of competition with the London Hospital, the teaching hospital in your own area, to which you are referring; otherwise I do not quite understand it?—Not actually. A teaching hospital will always attract more nurses than it wants, but the L.C.C., I believe, used to direct nurses. That was what we had in mind more than competition with the teaching hospital.

3038. You say, "Whilst it is understandable that each matron should desire to recruit her own trained staff, nevertheless it does result in well situated modern hospitals being overstaffed at the expense of the older type of hospital in overcrowded industrial areas". Were you there drawing on your own experience or giving the general conclusion?—(Mr. *Bushell.*) I think it is general. (Mrs. *Hastings.*) Actually the Mile End Hospital is a more modern hospital, and for years the matron there has been very active in recruiting. Therefore, of course, she gets more trained nurses whereas St. George-in-the-East, which was closed down for a great part of the war and which is geographically in a much more difficult position, has had lately directed to it a number of student nurses from Ireland; otherwise they would not have come there. We are improving the nursing conditions and the nurses' home, making it more tempting, and the present matron has built up her numbers from, I think, about twenty-six to forty-one, but it has been very, very uphill work.

Miss *Ward.*

3039. It is the direction of student nurses really which you are suggesting?—Yes.

Chairman.

3040. From your experience would you think that, if you imposed anything like a general direction on nurses, it might have a very bad effect on the recruitment of nurses?—I think we mention that. We hope it would not. I think it is more a suggestion. We do not feel that now is the right moment, but we were just wondering if in the future anything like that could be done.

Miss *Ward.*

3041. Because you have such a struggle?—(Mr. *Bushell.*) Yes.

Chairman.

3042. Later on, on the same page, you comment adversely on the system of hospital authorities keeping their own maintenance staffs?—(Mrs. *Hastings.*) Yes.

3043. Is that due to the fact that you have found in every case it is cheaper to get the work done by contract?—Yes.

3044. That is your experience?—Yes. I think it is too small an item economically to have your own maintenance staff. You have to have a lot of building facilities. (Mr. *Bushell.*) It is the equipment.

3045. It is no more than a statement in answer to my question. You are not suggesting that other hospitals who might find otherwise should be prevented from keeping their maintenance staffs?—(Mrs. *Hastings.*) From our experience we find it does not make for economy. That is all we can say.

Mr. *Diamond.*

3046. Are you saying that you would completely eliminate your electrician or that you would not carry a large staff capable of doing a large building contract?—We are really thinking of decorating more than anything else.

3047. In regard to maintenance of electrical equipment——?—You must have that.

Chairman.

3048. A little later you speak of the centralisation of certain services in the regional board, and you enumerate a number of services. Do you think the regional board might have a larger administrative function than they have at the moment?—I think those things could be centralised economically. We spend quite a lot on our local architect, for instance. I think the regional board could probably do it more economically centrally.

Mr. *J. Enoch Powell.*

3049. Is there not a regional board architect?—Yes, but they are terribly busy with all the regional planning, and I do not think they could cope with all these small items.

3050. It is consultation?—It is consultation. You dare not take a decision on a tennis court or anything of that sort, or walls which want repairing, without consulting an architect.

Chairman.

3051. Your architect is a part-time employee?—We just employ him when we want him. (Mr. *Burrell.*) We pay him the fee for the job.

3052. It seems to me reading this that it might be really—I will not use the term

"admission"—a statement that your area is rather too small?—We only want the advice of an expert, and I think that could be done centrally for all the groups more advantageously, but we are only concerned with our own group of course.

3053. The experience of your group is that you are not large enough to maintain independently a number of stated services?—We could not employ a whole-time architect.

Mr. *J. Enoch Powell.*

3054. These are services which were previously centralised by the London County Council in respect of the two municipal hospitals?—Yes.

3055. Do you not find it is possible to get a good deal of that professional work done voluntarily?—No.

3056. Do you think that is because there is no voluntary tradition in your area?—No, I do not think so. On an expert matter like that you could hardly expect it to be done in that way. (Mr. *Bushell.*) I do not think architects work voluntarily. I have not known one yet. (Mrs. *Hastings.*) I do not quite see why you should expect them to do that.

Miss *Ward.*

3057. Could you elaborate a little the points you make on page eight about the sick pay regulations? You say that there should be separate qualifying periods for part-time and full-time staff for drawing sick pay?—We do feel that there is abuse of the sick pay regulations.

3058. Particularly among the domestic staff?—Yes, and more among the part-time than the whole-time. In fact sometimes you almost feel them thinking, "I have been working so many months. I ought to have another week off".

3059. Do you think that other hospitals have the same experience?—Yes, they do.

3060. You think that is a general complaint?—I can remember in the old days people were brought before us as being absent, and it was felt it was not really quite genuine.

Chairman.

3061. So far as your whole-time staff are concerned I suppose you would call them permanent employees and there is every reason for having a sick pay scheme for them, but so far as the part-time staff are concerned is there any reason why hospitals should have a special sick pay scheme?—I would not like to answer that. (Mr. *Burrell.*) We feel that the part-time employee is a person who has not such a pressing need to work as the full-time employee, and therefore she is more choosy. She will come and work for us for a while, and then leave. We have had at least eight or ten cases of people who have worked for us for four months, then taken their full entitlement to sickness benefit, and left. (Mrs. *Hastings.*) We have had cases, which have really been confirmed in the hop season, of people who have gone to their doctor and said they had been sick all night; they have got a doctor's certificate; and they have gone hopping.

3062. You would not find that with your full-time employees?—No.

3063. What I am asking is why do you have a special sick pay scheme?—(Mr. *Burrell.*) We are not suggesting that. (Mrs. *Hastings.*) They must have something. We must give them some sickness benefit.

3064. I quite see that you must for your full-time people for whom you have a real responsibility, but the part-time employees are for the most part pretty casual, are they not? They are people who are employed for six months or a year, or do you find that you keep them a long time?—(Mr. *Burrell.*) They stay a long time. They are not like casual workers, here today and gone tomorrow. Our part-time employees stay much longer than people in casual work. (Mrs. *Hastings.*) So many are married women with children, that is the difficulty.

3065. They are full-time part-timers?—(Mr. *Bushell.*) Permanent part-timers.

Chairman.

3066. They are catered for under the National Health Insurance, are they not?—They come under National Insurance, but then, as long as they do not work more than a certain number of hours every week, they only pay the accident part. They pay about threepence per week. (Mr. *Chilvers.*) It is laid down by authority that ancillary staff, temporary staff and part-time staff, who are paid proportionately, shall be given so much paid sick leave after two months. They know that to the full, and they take the fullest advantage of it.

3067. This cannot be a special hospital problem; it must apply to Government Departments?—I think it does.

3068. And hotels of all sorts and descriptions?—(Mr. *Bushell.*) Outside Government Departments a part-time employee is only paid for the actual time he or she works.

3069. What is the reason for having a different system in the hospitals?—Because it is laid down in the regulations.

3070. As far as you are concerned you think it would be better not to have sick pay benefit for part-time employees?—That is so.

Mr. *Diamond.*

3071. Until you are satisfied that your part-timer is a permanant member part time?—After 12 months they will set up a certain standard of health, and then you

have an idea of what it will be. They set themselves a standard, and then you can use that standard——

3072. You want a longer qualifying period?—Yes.

Mr. *J. Enoch Powell.*

3073. Would you say there is a local interest and local pride in the two main hospitals with which you are concerned, leaving on one side the Jewish Hospital as that is something special?—(Mrs. *Hastings.*) I should not say it was very striking. I do not think it ever was. There are very few leisured people there. There are very few people in Stepney of the type who served on linen guilds and did things in the hospitals. They are all very busy people.

3074. The local people of whatever class do not look to those hospitals as particularly their possessions?—Yes, definitely, I think. (Mr. *Bushell.*) They will not do something for nothing. (Mrs. *Hastings.*) They would not make voluntary workers. They would feel quite loyal and patriotic about their hospitals, but a great many of them would not have the leisure or the point of view to do a lot of voluntary work.

3075. I was not so much thinking of voluntary work as of the financial side?—We have Friends of the Hospitals, the League of Friends of the Hospitals, who do meet in the different hospitals, and the London Jewish Hospital does get a lot of money from that source.

3076. If there were some particular project with which you were concerned at one of your hospitals and it could be fairly represented that by local and voluntary effort it could be achieved much earlier than otherwise, do you think that there would be the professional and financial support and interest forthcoming if it was put to them in that light?—Not in the group as a whole. I think that, if you perhaps put that to the London Jewish Hospital, they would go forward in that way.

Chairman.

3077. You mean getting it from the Jewish community, but then Stepney is very special in that way?—Yes.

Mr. *Diamond.*

3078. So is Wapping?—Yes.

Chairman.

3079. Mrs. Hastings, we are extremely grateful to you for coming, for bringing your colleagues, and for answering so many questions?—We look upon it as being a great privilege to be asked to come, and it is so nice to be able to say what one thinks.

The witnesses withdrew.

Adjourned till Thursday next, at 10.30 *a.m.*

THURSDAY, 26TH APRIL, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Turton.
Mr. Diamond.	Miss Ward.
Mr. J. Enoch Powell.	

Mr. A. J. F. DANIELLI, O.B.E., M.C., Liaison Officer, Ministry of Health, in attendance.

Mr. L. FARRER-BROWN, Secretary, and Miss D. M. LIVOCK, A.C.A., Accountant, Nuffield Provincial Hospitals Trust, and Captain J. E. STONE, C.B.E., M.C., F.S.A.A., Consultant on Hospital Finance, King Edward's Hospital Fund for London, called in and examined.

Chairman.

3080. I think you are separately carrying out two inquiries into the question of hospital finance?—(Mr. *Farrer-Brown.*) Yes.

3081. Could you say exactly what your inquiry is, Mr. Farrer-Brown?—Yes, Sir. Our interest started in 1949 when we invited the Radcliffe Infirmary, Oxford, to co-operate with us in a pilot study of the way in which the principles of cost accounting as used in sections of industry might be applied to hospital work. Miss Livock had been Accountant to the Radcliffe Infirmary some years before, and had introduced there a system

of departmental costing. Our 1949 experiment was really a pilot to see how far the idea of "standards" could be grafted on to the system of departmental costing which was there practised. From the experience we had of that pilot study we came to the conclusion that it would be valuable if we could have a wider practical experience on three issues: (1) how far departmental cost accounts with "standards" would be a valuable aid to financial control in hospitals; (2) what special adaptations had to be made to suit hospital conditions; and (3) what was the cost of the system and whether that cost really was worth while. We sent a memorandum to the Central Health Services Council indicating this, and subsequently we received an invitation from the Minister to conduct a study in co-operation with the King's Fund. We agreed to do that on certain understandings: first, the two bodies should have complete freedom in the manner in which they carried out experiments because we really wanted to find the facts so far as that was possible; second, we should both of us work independently in the two sets of hospitals which were chosen, but that we should submit a joint report, and in so far as conclusions differed every attempt should be made to give a fully reasoned explanation of the differences of view; and, third, we further agreed we should submit a report after one year's operation of the experiment, which was fixed then for 31st March of next year. In our case we have won the co-operation of seven hospital groups in different parts of the country. Those groups have been chosen with a view to getting as wide a range as possible of the different types of hospitals, and if it would interest you I can detail the range and types which we have. Would you like that now or later?

3081A. As you think most convenient?—Perhaps I can give them very roughly and very quickly. We have nine teaching hospitals within our groups, two acute general hospitals, one children's hospital, two maternity hospitals and the rest are special. Then in the case of the non-teaching groups, in which there are thirty-seven hospitals, we have included acute general, cottage hospitals, ex-public assistance institutions still dealing mainly with the chronic sick, tuberculosis, maternity, infectious diseases and mental.

3082. Are these all provincial hospitals scattered all over the country?—Yes.

3083. Not in Scotland?—None in Scotland. We have had informal discussions with the Scottish Department, and they know fully our approach to this problem. At officer level there are discussions with all the actual groups who are co-operating with us, and, if I may just interpose this here, that co-operation exists in a real sense. The groups are very much part and parcel of what is going on. They are all in England, in different parts. Our aim has been to get different sections of the country, to get the range and types of hospitals, and also to get groups in which the form of grouping varies. Some are obviously more widely distributed from the centre than others. That seemed to us important because it may bear upon the actual form of the cost accounting system which is most desirable.

Mr. *Diamond.*

3084. Could you tell us how many hospitals all told?—Forty-six hospitals within the seven groups, of which nine are teaching hospitals and thirty-seven are non-teaching.

Chairman.

3085. That is forty-six buildings really?—Hospitals under separate hospital management committees. I think that would be a rough description. (Miss *Livock.*) No. buildings.

Mr. *Diamond.*

3086. House committees?—(Mr. *Farrer-Brown.*) Yes. We started preliminary work in September, 1950. Our aim was to introduce into each of these hospital groups an experimental system which was simple in operation—that seemed to us very important—and which by suitable adaptations in each case could be grafted on to the existing accounting system of the hospital with the minimum amount of change and disruption. We intended for the purposes of this experiment that the method of costing should vary, if necessary, from group to group so long as the basis for allocating expenditure and the units on which the costs were to be based were uniform throughout; otherwise we did not see the need ourselves for a uniform system of cost accounting for general use. Indeed it seemed to us that a non-uniform system might really be a necessity because the groups varied very considerably.

Chairman.

3087. What degree of uniformity was there between these various experimental systems? You spoke of an experimental system as though it was quite uniform, and then you said you did not try to impose a uniform method?—I am going to ask the Accountant, if I may, when we come to the technical matters, to be good enough to tell you that because she is the one who is directing this from our point of view. I might blunder in a lay way. (Miss *Livock.*) It is the methods which will vary, but the results will be all on a uniform basis. It is the way of arriving at the final figures which will not be the same in every hospital. (*Mr. Farrer-Brown.*) Perhaps you would like Miss Livock to elaborate that later.

3088. I think that would be convenient. It was a very important point, and it raised

a difficulty in my mind?—We would attach importance to it ourselves, but it arises in our view from the fact that the groups do vary greatly. They vary in size; they vary in the degree of centralisation that is possible. The distances of individual hospitals from the centre of the group vary greatly. For a large group mechanisation of accounts and all that implies may be possible whereas for a small group manual methods may have to be retained. Some groups have central stores; in others the stores are spread over a larger number of hospitals. These variations may be desirable according to differing local circumstances. For those reasons we feel there is nothing to be lost, and indeed much to be gained, by applying the principles in modified ways for each group to suit their circumstances so long as the basis of allocating expenditure and the units on which you calculate costs are uniform throughout. Then you can compare hospital with hospital in the final results. The differences suiting local needs do not militate against those comparisons. We have in fact got through the stage of agreeing with the finance officers and financial committees of our hospital groups on the manner in which this experimental system shall be grafted on to their accounting systems. We started off by a full survey of the existing accounting system in each group of hospitals and the departments which were to be costed, and there was quite a lot of discussion with the local people on how costing was to be introduced.

3089. Is that initial survey now complete?—The initial survey is now completed.

3090. You have the results of that?—Yes. We followed that up with meetings with the various hospital management committees and others concerned so that they were fully informed and fully with us. We also had a conference with the chairmen, secretaries and finance officers of all the groups at Oxford last January to make quite sure that everybody was agreed on how the experiment was to go forward and on the units which were to be applied. We have still one or two units relating to some of the very special departments to be agreed. In particular the radiology, radiotherapy and pathological departments are very difficult ones on which to agree the actual unit of cost. If we take the pathological department I gather there are about 236 different types of examination of material, listed in the E.M.S. List, and different laboratory tests which the pathologist could undertake.

3091. You have completed your initial survey?—Yes.

3092. With those two exceptions you have now got complete agreement as to the unit of cost to be taken?—Yes, Sir, for this experiment. As from the 1st April the actual operation of the experiment began, with the two exceptions I have mentioned. We shall work, as far as we are concerned in quarterly periods watching the experiment evolve. From April to June we shall be concerned mainly with the snags which are thrown up from the initial introduction of the scheme. We may have to modify some of the tentative decisions reached. That is stage one, which will be the difficult stage, smoothing over the introduction. The early part of the next quarter, which is from July to September, will be spent in examining the cost statements which we get in the first quarter, raising questions where there seem to have been departures from uniformity on the principles on which we have agreed there must be uniformity. This second quarter will be the first normal period of the cost experiment at most hospitals. During this period we shall settle in final form the presentation of the costs for various purposes, that is to say to management committees, to the various departmental heads and so on. In the next quarter, October to December, we hope we shall be getting costs produced which will be yet more reliable in view of the modifications introduced in the earlier period. At this stage we hope to reach the state where we can begin to think of inter-hospital comparisons and the fixing of standards for future use both as a means of financial control and as a basis for the preparation of annual estimates. The final quarter, January to March, 1952, is the period when we shall have to digest these results of practical working and begin to decide the lines upon which we are to report to the Ministry. Again at that stage we hope that the experience we have gained in previous quarters will enable us to settle with greater confidence the various units and standards upon which we are working. You will see it is a staged experiment, and I would, if I may, just emphasise that we feel it is only by perhaps laborious practical experimentation that we can get any worth while guide on the degree to which this technique can be a useful instrument in the hands of those responsible for hospital administration, if they know how to use it; because, as I think possibly you will agree, cost accounting in itself cannot effect any economies. It is merely an instrument which, if it is used with understanding by the administration, may give pointers to the sections of hospital work which would repay detailed examination.

3093. You are speaking now of the use which can be made in your report within each hospital or group of hospitals. Are you also having regard to the use which could be made of it on the wider field of national finance, in other words in arriving at the appropriate total of money which should be allocated to regions or possibly to the Hospital Service as a whole?—Yes, Sir, we believe that both will come

about. I think our feeling at the moment is that it can come about in the process of time as we gradually establish the accuracy of this instrument in indicating where examination of the arrangements in a particular part of a hospital should be made because the system of cost accounting, as I understand it—I would like, with your permission, to ask Miss Livock to elaborate this in a moment—does assume a certain degree of efficiency, and as you get your various hospitals using this system variations will tend to put you on notice, and you will say "That place at least needs examination in detail." You may find from an examination that the variations in the costs which you have been getting are reasonably explained by differences of lay-out and by differences in the type of work. There are various things which cannot be covered, but we should begin to arrive at a stage where we have an indication (which we have not got now) of where there is apparently a lack of efficiency. As far as we can see the present system of hospital accounting does not really give you any worth-while pointers, and it is that search for pointers that we are on. At the moment our feeling is that there is no short cut to them. We have gradually to build up a body of experience, a body of knowledge, from a close study of hospital work and all that that means. If it is not irrelevant to your consideration we would, if we might perhaps later, mention that we feel there are also other ways by which you can approach this problem, ways which are complementary, but I think that would be our general approach. Do you agree?—(Miss *Livock.*) Yes.

Chairman.] Thank you very much indeed. I do not know whether it would be more convenient now to ask Captain Stone if he would tell us the angle of approach from the King Edward's Hospital Fund.

Wing Commander *Geoffrey Cooper.*

3094. Could I ask one question arising out of Mr. Farrer-Brown's concluding statement? When you said you felt the system you were working was only one manner of approach and that there were others complementary to it, what had you in mind? Had you anything specific in mind which you would like to mention? Did it include such matters as time and motion study, joint consultation and so on?—(Mr. *Farrer-Brown.*) They were certainly in my mind.

Chairman.] I think those are questions which will follow when we have heard a general statement from the three witnesses.

Mr. *Turton.*

3095. I am not very clear on this. Does the scrutiny of expenditure in regard to one particular building include an element for (*a*) the expenditure of the hospital management committee on that building, and (*b*) the expenditure of the regional hospital board on that particular building?—(Miss *Livock.*) It is difficult to answer that at the moment. In the experiment we shall try the breaking down of hospital management committee expenditure into hospitals, or taking out of the hospital costs the cost of administering, adding that to the management committee cost, and arriving at a cost for the group. We have not settled yet which method is going to give the most useful result.

3096. When you talk about "the group" are you talking about the region now?—No, the hospital management committee.

3097. Is the regional hospital board expenditure, as directed to particular hospitals, included in your examination?—Yes, as far as it is applicable to a definite hospital management committee. (Mr. *Farrer-Brown.*) Would it help here to give the names of the seven groups?

Chairman.

3098. I think it would.—The United Bristol Hospitals; the United Manchester Hospitals; Aylesbury and District Hospital Management Group; Cheltenham Hospital Management Group; Huddersfield and District Hospital Management Group; Reading and District Hospital Management Group and Pewsey Hospital Management Group. The latter is brought in for the mental defective colonies and their problems.

3099. That is Pewsey in Wiltshire?—Yes, Sir. I think that probably does give the picture of the kind of group, and the level at which we are studying.

Mr. *Diamond.*

3100. This is your own grouping?—Yes.

3101. There is no existing grouping, is there, for all these?—Yes. Each one of these is under a management committee.

3102. They are in all cases management committees?—They are all existing committees. That seemed to us important because we want to graft on to their system.

Mr. *J. Enoch Powell.*

3103. You are only examining the operating cost. No capital element enters into your examination in any way?—(Miss *Livock.*) Not at the moment.

Chairman.

3104. I think it might be convenient now, Captain Stone, if you would deal with the matter in the same way from your angle?—(Captain *Stone.*) The King's Fund started taking an interest in this some years ago, and in 1946 revised what was then known as the Revised Uniform System of Hospital Accounts. That system was on a subjective basis, very similar to the system now

in use by the National Health Service. The King's Fund made grants to hospitals, and it felt the information which it was getting from these costs, prepared from these subjective headings was not what it desired. For example, all the subjective headings were broken down to the cost per occupied bed. That did not convey very much to the Fund. You may have two hospitals each with one hundred beds. One may have two operating theatres ; the other may have three. One may have a very good X-ray department, well staffed, and with up-to-date equipment ; another, with the same number of beds, would probably have a very poor department, yet both were compared on a cost per occupied bed. The Fund felt that really to get down to the problem it was necessary to re-organise the accounting system and put it on what we call a departmental or functional basis. If I might bring in a note here, I notice you are using the term " cost accounting ". By using that term in the hospitals we antagonised very many of what I might call the lay administrators, who had the idea that cost accounting was a commercial term and that we were commercialising the hospitals, which was a very bad thing to do. You may think there is nothing in it, but it did get around so that we now prefer to call it functional or departmental accounting. We find that our reception in the hospitals is very much better when we refer to the term " departmental accounting ". I agree with you that it is a joke, but in the hospital world it has assumed a certain seriousness ; they do not like the term " cost accounting ". (Mr. *Farrer-Brown.*) We have not found that at all. (Captain *Stone.*) It has got a sort of commercial touch about it. After the meeting at the Ministry with our friends the Nuffield Trust we selected a number of groups. We have not selected so many of the teaching hospitals. We are mainly working in the groups, our reason being that the teaching hospitals have got really good finance officers. We feel that if basic principles are prepared they can introduce the system. I agree also with the Nuffield that we do not want a rigid system, but we must have basic principles applicable to every hospital. At the medium size and smaller hospitals the finance officers are not of the same standard ; they have not got the same knowledge and experience ; and so we are concentrating more on the hospitals where the knowledge and experience of the finance officers is not so good.

3105. When you talk about the " medium size hospital ", do you mean the medium size group or are you talking of individual hospitals?—Individual hospitals now, running about 250 to 300 beds.

3106. Is it not a fact that every group would have a reasonable finance officer?—The finance officers of the groups are not of the same standard as those in the teaching hospitals. Our grouping is this: we have sixty-two hospitals altogether. There are two teaching hospitals, one is King's College Hospital and the other is St. George's Hospital. There are four hospital management committee groups, one in each of the four London Regions The one in the North East Metropolitan Region is the Colchester Group ; in the South-East Metropolitan Region it is the Tunbridge Wells Group ; in the North West Metropolitan Region it is the West Herts. Hospital Management Committee ; and in the South West Metropolitan Region it is the St. Helier Group Management Committee. Altogether that gives us a total of sixty-two hospitals. We have a staff, and we appointed that staff for certain reasons. We have two hospital accountants, two local government accountants and two industrial accountants. The idea was to get as good a cross-section of knowledge and experience on costing as we possibly could. We felt that to rely upon hospital accountants would not give us the information we wanted. They have been criticised very much in the past for their lack of knowledge, or I should say for their lack in keeping that knowledge up to date. They were quite content to carry on with the subjective headings system of accounting, and they took very little interest in what we call departmental accounting. The local authorities, on the other hand, have developed really good accounting systems, and in industry of course they have gone the full 100 per cent. We thought that by having a team of that sort we would get the best of all worlds. It is necessary in cases to push the hospital accountants, and it is necessary to pull back the industrial accountants. Our monthly conferences are really well worth listening to, as you can imagine. The industrial people want to go all out ; the hospital people want to hang back a lot ; and local authority people want to keep a middle course. Again the manner in which they have made their investigations has been most helpful. They have approached the problem from different points of view, which again is very helpful when we come to review the information they get out. It will also include what we call a time and motion study ; we feel that is essential. My own view is that it would be difficult to introduce a departmental system until the whole financial system is re-organised, but I do not think that, once we have got the system, it would be difficult to put into operation. But we shall have to change the organisation. I feel that is the weak spot at the present time. You or some of your colleagues may be asking this question later: if you introduce costing, what is the cost of costing? We have been asked that many times, as you know, and if I give you the answer now it may anticipate the question. It all depends on the existing organisation, the existing system of accounts and the calibre of the staff. That

varies considerably in the various hospitals. In some hospitals it is extraordinarily good, and very little change will be necessary. We can in some cases develop a departmental system almost immediately; in others the whole structure will have to be changed.

3107. When you put to yourself the question "What is the cost of costing?", do you mean the cost for the purpose of performing the present survey or the ultimate cost?—The cost of the ultimate scheme, the cost of working it once it is put in operation. Many people have said, "We agree with a costing system for hospitals, but what is it going to cost? It is going to cost you very much more than the existing arrangements". We disagree with that statement. We will go into the reasons for that, if you like to ask the questions. The whole matter turns on the existing organisation and the calibre of the staff. In many cases I feel it is necessary to re-organise completely. In 1946 the Fund drafted a scheme of departmental accounting, and that was sent to the Ministry. Later on the Ministry set up a small committee to go into this matter. I was appointed a member of that committee, and we thought that during the transitional stage it would be better not to burden the hospitals with a more elaborate system of accounting but to retain what is known as the subjective analysis method. That gives certain results, but as most people now know it does not give the results which enables a hospital to control its expenditure. It also does not give the information which enables hospitals to put forward reliable budgets. I think most budgeting to-day is on an estimated basis rather than on actual costs obtained by costing the various departments in a hospital. I do not think many hospitals would know the cost of their kitchen or their laundry. I think that if you are going to budget for a hospital laundry or kitchen you must first of all know what it has cost in the past and what amount of work you anticipate it will do in the future—so much more provisioning or less. Then you will prepare, as I mentioned, what will be a standard cost, and that will go into your budget, and your monthly or quarterly returns of actual expenditure or actual cost will be put against that standard. By means of budgetary control plus your costing you have got a means of control. Moreover this figure would be used for the budgets which are submitted to the Ministry, and I think that the Ministry would get very much better figures than it does now. Moreover, if it is necessary to make cuts—as we all know it has been necessary—we should know where they could best be made without impairing the efficiency of the hospital or affecting in any way adversely the treatment of the patient. At the present time cuts must be made on an arbitrary basis and no one knows exactly where they can be made to the best advantage or to the least disadvantage of the hospital. I think departmental accounts will give us all that information. We are working very much on the same lines as Nuffield. We are carrying out investigations. We have not yet completed our work of getting the information, but we have had full 100 per cent. co-operation from all hospitals.

3108. You have not yet completed your preliminary survey?—No.

3109. You have not got agreement as to the unit cost at which you should aim?—We have got agreement on that, but we have not finished collecting the data to convince us that the sort of ideas we have in our minds at the present time are the right ones. We have gone three-quarters of the way, but I would prefer, before saying that our ideas are right, to go the other quarter to see whether any variation will have to be made following the further information we receive. I say that because the hospitals differ so much. We have not up to now come across two alike out of the sixty-two we are investigating.

Mr. *J. Enoch Powell.*

3110. You have not yet reached the point which the Nuffield Trust reached on the 1st April?—That is so. We have had some difficulty—Nuffield may have been more fortunate in this respect—in getting the right people. We were delayed two or three months by that. We had a large number of applications, but we were very keen on getting people with the research attitude in mind, people who were prepared to get their teeth into it and go right through with it. There are several so-called investigators who do give that service; they give you a lot of information; but when you start asking questions you find that you have got to start and do it all over again yourself. We wanted people who would go and get the information whatever happened. We were delayed a little for that very reason, but I am very glad we did because we have now got the right type of people.

Miss *Ward.*

3111. How many are involved in this?—There are four new appointments. I have two from my staff working part time on this.

3112. About half a dozen?—Four full time, and two practically half time.

Chairman.

3113. Those would be the actual researchers. You would presumably have a number of people doing the clerical work?—There are a number typing and copying. I suppose the sheets of information we have got now would stand *that* height from the floor. This is a terrific task.

3114. Could you give some sort of estimate of the cost to you of carrying out

this survey?—That is very difficult. You would have a typist engaged on this work for, say, an hour, and doing other work in the meantime. We are dealing with the clerical side of this investigation in with the general work of my Division of the King's Fund. The actual cost, apart from the clerical work, is the salaries of these four new assistants plus the half time salaries of the people on my staff. It is not easy to give an exact figure. The Fund's attitude is that, if it is a job worth doing, it does not matter what we spend on it to get the results.

3115. Perhaps that was rather an impertinent question?—No, not at all. If it is a job worth doing, it does not matter what we spend on it. Let us get down to it. I think that is the right attitude to take. After all we can spend what we like ; we are not a Government Department ; nobody can call us to order for it. We shall finish in about six weeks, and we hope to get ours ready in August or early September. From then on we shall run almost on the same timetable as Mr. Farrer-Brown. It is anticipated we shall be able to make a final report to the Ministry at the end of next year.

3116. I rather understood from Mr. Farrer-Brown that this was really a joint enquiry, and that you were going to produce a joint report?—Yes, that is so.

3117. Does that mean that in fact the publication of the joint report will have to be delayed until you have both completed your studies?—(Mr. *Farrer-Brown.*) I am afraid that is an issue we have not in fact faced. It was agreed that the two bodies would co-operate together in resolving their conclusions while carrying out two separate inquiries on their own. I do not think we have really faced the issue of what happens if we reach our conclusions at different times. I think it does mean we shall have to delay—unless Captain Stone is prepared to report in a less period than a year. We want to give it a year's run. (Captain *Stone.*) We shall catch up with you.

3118. What I was really wondering was this: is there any difference at all in the method of your approach except that in fact, because you have got different people doing the work, there may be minor differences? Are you both really aiming at identically the same end, but working towards it in a different way?—(Mr. *Farrer-Brown.*) We may be using different methods, but that does not affect in any way the validity of the experiment. Indeed it may add value to it in so far as we have tried out a variety of ways of getting at the same target. (Captain *Stone.*) That is why I wanted this diversity of knowledge and experience in my team. We shall get the same result in the end, but ours will go in in August or September and I think we shall then catch up. We shall be adopting the same method, first running for a period of three months and then seeing what alterations have to be made. We can then either modify or perhaps elaborate it in certain cases. Then at the end of the time we can say "This is generally the system which can be introduced into hospitals." (Mr. *Farrer-Brown.*) Could I interpose one point here? I think we are not yet quite convinced that it is necessary to have a complete overhaul of the hospital accounting system. We are rather inclined at the moment to think that, when we have got a little more experience of hospital accounting, it may be possible to graft a satisfactory system on to the existing hospital accounting system. We would agree entirely that the value of this technique does depend in the end upon the quality of both the members of the hospital management committees, who have got to use and understand these results, and the officers. Unless they understand it and know what to do on the pointers then it is of no value at all. If they understand it then we hope it will be shown to be of worth-while value.

Mr. *J. Enoch Powell.*

3119. You have both already formed the impression that a raising of the calibre of finance officers in the Hospital Service, even though that might involve additional expenditure on salaries, would in the end be an economy?—I find it a little difficult to give you a direct answer to that because the finance officers in the hospitals with which we are dealing have been good, as every bit as good as, I am sure, the finance officers to be found in some of the teaching hospitals here in London. That may be just our good fortune, and we hesitate at the moment to express any view about the general level of finance officers. I had in mind not only the quality of the finance officer—he clearly has got to have the ability to apply this system well—but I also had in mind the other people concerned with the administration who must understand what the results of the system mean. You can have this system and your administration can just let it lie fallow and not make any use of it, because if a particular figure indicates that a department ought to be looked into that department has to be looked into with understanding because it may well be that the difference of cost is fully justified. It may not be due to inefficiency. Likewise the departmental heads in a way have got to be cost conscious and interested in following their own figures so that, if there are variations, they themselves begin to investigate. That there must be good quality administrators and finance officers as a general principle we would have no hesitation in accepting, but, as I say, we have been lucky. (Captain *Stone.*) I hope I have been understood. I

hope you have not got the impression that the finance officers who are co-operating with us here are of the wrong calibre. We have been equally fortunate in that respect. The reason I made that statement was that, when we advertised these appointments, we received a number of applications from finance officers who obviously did not know their job. From my point of view every finance officer we have got on this investigation I would be prepared to take on my staff to-morrow. They are 100 per cent. efficient, but as regards some of the people who applied for the appointment I would not give them house room.

Chairman.

3120. I wonder whether the explanation for the slight difference between the experiences of the Nuffield Trust and the King's Fund is that in the provinces, as a rule, the hospital group is not immediately overshadowed by a teaching hospital. In London the position is rather otherwise, and probably you find the cream tends to be drawn into the teaching hospitals?—I think that is so. (Mr. *Farrer-Brown.*) I think that is very likely.

3121. Would it be convenient to ask if Miss Livock could give us something from her point of view? I imagine you can tell us exactly the machinery that you are using to make this inquiry. Would it be convenient to ask you that, or would you prefer us to put questions to you?—(Miss *Livock.*) Yes, I will do that. We have appointed two accountants to help me in this inquiry, and I am personally engaged approximately half time on this investigation. I have got one man working in a group in the North of England, and the other man in the South of England. In the early stages I personally visited every group and every hospital to get the broad picture. Then one of my assistants stayed in the group for some time to get the detailed picture of the present accounting system, and of the hospital, its services and its departments. Then they came back again into the office, and together we planned the grafting of departmental costing on to the existing system. I have not attempted to alter the existing systems to any great extent because I was anxious to get the experiment going at the earliest possible moment. It seemed to me it was more important to get something going, and afterwards to judge the results of the varying systems according to their cost and efficiency. We took our plan back to the finance officers, discussed it and got their co-operation, and in most hospitals they started work on the 1st April.

3122. Could you give us any idea of the nature of the unit costs you have agreed in principle? Would that be possible in the course of your answer?—Very broadly, yes. We have arrived at the departments to be costed. We have given each of the hospital management committees a list of the expenditure which ought to be allocated to each department, and the unit of cost to be used. For example, for a ward-cost the unit is obviously the in-patient day; and so on for each of the many departments.

3123. How far did you find difficulty because of overlapping? It seems to me that almost each of these units you have taken may be affected by other units?—That is a problem that we have not yet met. We are going to meet it, but we have not got to that stage yet. We are in the early stages arriving at, technically speaking, the prime cost of each department, charging up the actual materials used and the cost of the staff actually working in each department of the hospital.

3124. Could I put a specific question to you? You mentioned "ward cost". I think Captain Stone also mentioned the cost of the laundry and the cost of the kitchen. Clearly the patient in the ward has laundry and food. How do you appropriate those items if you are costing ward, laundry and kitchen?—At the moment all we are doing is arriving at the cost of the laundry. Our unit of cost is either pieces or pounds washed. We can then at a later stage charge on to the ward the cost of the pieces washed.

3125. The same would apply to food?—Yes, but it is a later process, and we have not yet arrived at that stage.

3126. In the meantime you are eliminating from the ward your other unit costs which fall under some other unit heading?—Yes. (Captain *Stone.*) We are doing that. We are costing the laundry and all these other departments because we feel you cannot get the cost per patient day unless you get all these charges charged to the ward. (Miss *Livock.*) Ultimately. (Captain *Stone.*) We are working from the service point of view rather than the ward point of view. We are finding out the cost of the boiler house, the bakery, the laundry and the kitchen, and we are charging those to the various wards and other departments. Provisions are charged in the same way. One difficulty we are having is in getting a unit cost for the laundry. We are going perhaps a little beyond you here, although you may be doing this later. You are taking pieces or pounds washed at the laundry. We do not like that. It can so easily be wangled, and I am using that word deliberately. You say per 100 pieces washed. It may be per 100 hand towels or per 100 sheets. We are going to weigh those—blankets—10, sheets—5 and gradually bring it down to hand towels. The same with meals. Usually our cost has been per meal served. That is not in our view the right way. We would bring in two costs—the cost of the food that is served, and then the cost of

serving the food. It is a very easy distinction to make, and not difficult to work out in principle.

3127. Clearly there will be differences of that kind?—We want those differences. (Miss *Livock.*) We are doing the same thing, but I thought it was rather a detailed matter for our discussion here.

3128. My question was aimed at ascertaining the nature of the approach. I think those are illustrations of the sort of things you are doing, and slight differences there may be?—(Mr. *Farrer-Brown.*) Obviously in the last resort there is a degree of arbitrariness in the weighting method. One has got to have a lot of discussion and experience. Maybe errors will be made at the beginning, errors which can be adjusted later. (Miss *Livock.*) Also any unit of cost can be wangled!

Mr. *Diamond.*

3129. I would like to ask whether the Nuffield Trust has found that any extra cost has in fact been involved in altering the system of accounting by varying the staff in order to cope with the work which is at present being done?—(Mr. *Farrer-Brown.*) It does vary a little bit between one hospital and another according to the nature of the existing organisation. Much has turned on whether or not the hospital had a satisfactory system for recording stores issues. Some hospitals had nothing worth talking about, while others had a very satisfactory one. Where there was a satisfactory one, so far there has been scarcely any addition necessary in the staff. At the moment I think our experience is this: on average, one additional person per group. The increase has not been startling yet, but there have been variations.

3130. Is it intended that this costing information should be prepared in addition to or as part of the existing accounting of the group, and is it intended that the annual totals shall be reconciled in any way?—(Miss *Livock.*) Yes, Sir. They will be reconciled. They will appear under the subjective headings as we are naturally anxious to keep that information going. They will also appear under departmental headings, arriving at the same total of expenditure for the group.

Chairman.

3131. The two sets of costs are both being kept independently of one another?—Yes.

Mr. *Diamond.*

3132. On the assumption that what you refer to as the Ministry cost will be on an income and expenditure basis, not a cash basis?—Both of them. (Captain *Stone.*) That is already so.

Mr. *J. Enoch Powell.*

3133. Will the results be in such a form as to point to conclusions in regard to establishment as opposed to operating costs?—(*Miss Livock.*) We have not got the results yet, and therefore it is difficult to answer, but they will be able to show in part all the cost which is of interest to anybody. (*Mr. Farrer-Brown.*) That is salary or wages, or do you mean numbers?

3134. I had this in mind. An employee in any grade may be working efficiently or inefficiently, and no doubt your results would throw that into relief. On the other hand the system of administration or operation may be such that a higher or lower establishment is employed. Would that difference also be thrown separately into relief?—(Miss *Livock.*) Yes, I think it would. As I say, until we have experimented with using our results it is a rather difficult question to answer.

Mr. *Diamond.*

3135. With regard to your departmental costs there are some expenses in fact, I take it, which do not fall within any particular department at all, and which you describe as indirect costs—or whatever title you like. Have you in your preliminary enquiries come to a satisfactory conclusion as to the method of allocating those indirect costs?—Not yet, no, because I am anxious to get an idea of the size of those costs—whether they are a large part of the expenditure or a minor part. I hope it will be a minor part.

3136. The endeavour is as far as possible to allocate all costs on the basis of direct costs?—Yes.

3137. Coming to a much more fundamental question, the whole purpose of this is to compare hospital with hospital and to provide information which intelligently looked at can be of great use?—Yes.

3138. It is quite easy to understand, taking this ash tray as an example, that when you are costing that article that forms a very convenient unit, and everybody knows how to compare (*a*) the cost, and (*b*) the product. The product is that particular article reproduced ten or a hundred thousand times. I was very interested when you said you had agreed on your units of cost. I was wondering whether you had gone into the further field of product, that is to say, good health. It seemed to me that, unless you had given that considerable thought, it may be you were not getting the most significant units of cost. With regard to your in-patient day, the public would be interested to find out, in addition to that unit of cost, whether it resulted in the patient at the end of the way walking out into the air or being put in his coffin. I was wondering whether you have given that matter thought, because of course in a normal commercial costing one takes no account of what are generally called social costs, whereas here you are costing what is a social service,

and there will, therefore, be a quite fundamentally new and different approach?—(Mr. *Farrer-Brown.*) Yes. Our attempt at the moment is to see how this method of costing has to be adapted to suit hospitals as they are now. We are very conscious of the fact that there are whole hosts of more important questions. For instance, are the present methods, which are accepted as good in a hospital, necessarily the most efficient. If we look at how methods have developed in hospitals, doctors have said, perfectly properly in the fulfilment of their responsibility, "We want this done in this way." We all know that each doctor has his own particular preference for methods. It is not his job in fact to decide whether that is the most economic and efficient way; his responsibility is to see that the patient is cured. None of us I think at the moment can say that the existing methods, which are accepted as good, are necessarily the best. Indeed the Trust have just got one or two small instances which are leading us on to explore that ground further. For instance, we went into an eye clinic in the Midlands. It was regarded by the doctors as a very good eye clinic. It was an out-patient one. The team lived with the medical staff, saw all the work, and in the end produced a report which was accepted gladly by the medical staff who were interested in this matter. It showed that by re-arranging the way they did their work, designing very simply a new kind of consulting room in which the equipment was as it should be, we could cut staff by 16 per cent. and economise space by 30 per cent. I am not implying that is a criticism of that clinic, I know you will understand that, but I give it merely as an indication of the way in which we can, in full co-operation with the doctors and nurses, find ways of doing present good medical work yet more efficiently and economically. I venture to think that it is only in that rather slow, laborious and detailed study of each process which goes to make up the life of a hospital that we may in total find a way of effecting worthwhile economies while retaining the standard of medical care which is desirable. I will take another instance—a dresser in a hospital. This is the case of a man who is a dresser, and who in 158 working minutes was able to treat nine patients. We discovered that in that time he spent only one-third of it actually treating the patient, and two-thirds of it walking about the room picking up material or doing things like that quite unnecessarily. By a simple re-arrangement of his functions and his equipment you can probably increase the number of patients with whom he can deal, without undue strain on him and with no danger to the patient, by something like 200 per cent. Again a very simple illustration, but I think it is a true example of what could be effected by what must be admitted to be a very laborious business, because you can only make sound recommendations if you live in the hospital sufficiently long to understand it and to win the help of the doctors and others. You have to work through them. The lay-out of buildings is obviously another important matter bearing indirectly on the cost, and there we have a team which is studying, and has been for some years, the functions and design of hospitals. We hope to have the good fortune to have two experimental units, one in Scotland and one in Northern Ireland, put up within fairly short periods where we can in fact study operations, the organisation of nurses, because they bear upon that; and in fact to compare the cost of running these better designed, better laid-out and better planned units with some of the others.

Mr. *Turton.*

3139. Why do you not have an experimental unit in England?—We could not get it. As soon as it was known we were hoping to have such a unit the telephone wires between Edinburgh and London became red hot. We have had the utmost co-operation from Scotland, and similarly Northern Ireland. We shall hope to give the full value of our knowledge to our own country. If I am not going outside my limit, may I just touch on one other matter? I know this will be very much in your minds. The hospital, after all, is only part of the health service, but it is the most expensive part. We ourselves feel that there is a great deal of work to be done in considering how, without detriment to the patient, without lowering the standards, the work which is now done in hospitals could be done as well as, or better, outside, by the other agencies. I would suggest that is largely a question of studying the areas and studying the medical needs, and then by pilot experiments finding ways in which the work done expensively in hospitals could be done as well as but less expensively outside. If I may take an instance which——

Chairman.

3140. If I may interrupt you, are you now expressing a view which has come to you in the course of this study, or is this in fact an object of the survey you are making?—No, Sir, the costing enquiry is one of our studies as part of an integrated series. The overall aim is to find how the best possible standards of medical care can be given most efficiently and economically within the means of the community, and to do that we started a series of separate investigations, each of which plays in one to the other.

3141. If you could say something on that I know the Sub-Committee will be interested?—We have started a job analysis of nurses, realising that nursing was a fundamental matter. We have done a highly detailed study of what in fact

nurses do, because most arguments I think it is safe to say about nursing and the education of nurses are based upon impressions and not proved facts.

3142. That would be nursing generally—not nursing purely within the walls of a hospital?—We have got two parts—hospital nursing and public health nursing.

Mr. *J. Enoch Powell.*

3143. Did you say that was completed?—No, Sir, but it is reaching the last lap.

Miss *Ward.*

3144. Do you include in that industrial nursing?—No, unfortunately we have had deliberately to exclude that, to keep within the bounds of what we could cope with within a reasonable time. The trouble in so far as these studies are concerned, is the amount which we, as a private body, can cope with within a reasonable time, to give results which would be valuable. There is the one dealing with the functions and design of hospitals which involves doctors, nurses, architects and so on. I hope that we will have a report out in a year and a half's time as a first stage. An experimental ward unit I think may be in operation perhaps in the middle of next year so that we shall have our own actual experience, although we have great co-operation there too from the official agencies. Then we have this one on cost accounting. We have three experiments we hope to pull off very soon in health centres, to gain practical experience there. We are also doing a study, or just beginning a study, of the kind of grouping arrangements which general practitioners have made themselves, believing that, if health centres are beyond the means of the community for a time, it is worth while knowing what the doctors themselves have done to dovetail their work individuaally with those of their colleagues in the area, why they did it, what difficulties they found, and what good they think they got out of it.

Chairman.

3145. This is a parallel inquiry?—Yes, they are all part of the series. Then we are also beginning to discuss with the authorities in a particular area how we could carry out pilot experiments on a modest scale designed to show that the work now done in hospitals can be done outside. I hope that in that connection we may carefully study the care of the chronic sick of all ages, the arrangements for maternity cases—both urban and rural—and mental health because there is a feeling in the minds of some people that by better organisation and co-ordination the stay of certain mental patients could be shortened if arrangements for home care could be improved and better used. Those are the kinds of problems. The discussion is in its early stages, but I think it bears upon our general aim to search out ways by which we can make unnecessary the use of the hospital, that being the expensive part, without lowering the standards. I hope that may help, and that I have not gone outside the bounds.

3146. Not at all. Can I ask this very general question following up the one put by Mr. Diamond just now? Can you attempt to measure the social output at all in this connection? Have you any yardstick, particularly in connection with the inquiry into hospitals, of the effectiveness of the hospital not purely from the economic point of view but from the point of view of the amount of treatment and the value of the treatment to the patients?—It is a dangerous matter on which to hazard a reply, but I would have thought that at the present time we really could not. For one thing a follow up of patients over a period of six months or a year is clearly necessary, and I do not think anybody yet has really decided what should be the standard. Even if you were able to do that, and to do it over a year I think it is beyond our resources at the moment, except possibly a small pilot study. It is something into which we have been anxious for some time to get our teeth but we have not been able to up till now, and as far as I know there is no real measure yet.

3147. It is conceivable that the most efficient method of doing any operation, so far as the economic aspect of it is concerned, would be from the social side?—Yes, I think that is true. A person might remain in hospital for a week longer and at the end be better; at the same time the position may be the reverse; if patients went home quicker for certain complaints, they would in fact get better quicker. I think it is only by a lot of trial and error in the various sections of hospital work that you can decide that. We are lacking, rather lamentably, knowledge about the job of caring for the sick and up to now there has been very little study of it. Really it is a colossal task.

Miss *Ward.*

3148. You are now going to examine the link between the local authority and the hospital?—The local authority, the general practitioner, the hospital and the home.

3149. Then you would have to take into account the variation in the standard of services, not the overall which is, so to speak, laid down. You would have to examine the variation in the standard of local authority administration of the services which they ought to be rendering?—Yes.

3150. Which does raise a very, very important problem?—It raises a very complex problem, and you have to go about it by a series of practical experiments. We are not connected with but interested in the one at Cambridge for home nursing, under

which the patients are discharged from hospital after an operation much earlier than is conventional. They go back to their homes provided they are suitable, and if domestic help is needed it is arranged through the local authority home help service, provided the general practitioner is prepared to assume responsibility and always on the understanding that, if there is a relapse, the patient can go back to hospital. General practitioners are even taking out stitches. That is an experiment, but if it works and provided the patients do not take longer to recover than they would if they stayed longer in hospital there is a way of getting an improvement of the kind one wants. I am not sure if I have made my point clear, but it seems to me there is a rough and ready method as compared with present standards.

Chairman

3151. That experiment is purely an examination of the social output?—Yes.

3152. It has two aspects—the economic and the social?—Yes.

3153. Are both being examined and then comparisons drawn, because that is the real nub of this question?—So far as is possible an attempt is being made to get towards a measurement of the social, but I would not like to say we shall be able to do it. We must explore every avenue ; we are groping ; we are trying.

Mr. *Diamond.*

3154. I do understand that the results which you expect to obtain will have to be used with discretion, understanding and sympathy, but nevertheless I would be glad to know if the witnesses are able to say now that they are satisfied that the information on the functional basis will undoubtedly be more valuable than the information obtained on the hitherto subjective basis, taking into account their own estimate of the additional cost of preparing information in that way?—(Captain *Stone.*) I have no hesitation at all. I would like to take out your last words there about additional cost, because I am not convinced that it does make for additional cost.

3155. If any?—That is all right now.

Wing Commander *Geoffrey Cooper.*

3156. You did refer to the fact that your particular organisation had got previous experience in approaching hospital management in the way in which you are now doing. Does that mean you have got fairly comprehensive statistics and other information, reports and so forth, which will enable a comparison to be made by what might in the past be considered an exceptionally well-run institution compared with the standards being aimed at now in the Health Service?—Until the coming into operation of the National Health Service the Fund prepared an annual statistical summary. Each hospital which received a grant from the Fund, and practically the whole of the voluntary hospitals did, had to submit their accounts to the fund, and from an examination of those statistics were prepared. They were all on this occupied-bed basis. They acted as a guide, but no more than a guide. It did not follow that, if the cost was high, that hospital was extravagant, or that if the cost was low it was not. We enquired into the high ones but we also enquired into the low ones as well, because it was possibly showing that the hospital was not giving good service. We got that information sent to us, but it was all on the subjective basis. In my opinion it was not broken down low enough. Take provisions. There was a cost per occupied bed for provisions, but there was no distinction made between provisions for the staff and provisions for the patients. There is a very big difference between those two. You should break it down lower still. Provision for staff should be divided into provisions for doctors, nurses and domestic staff because the cost in that respect for doctors in normal times was much more.

3157. Your answer is that the information which you have from your previous experience is not going to be a lot of help for comparison purposes in the survey you are now doing?—It will be of no use at all.

3158. Another point is the calibre of the people who are in the various jobs you come across during the course of your investigation. Just as an illustration you quoted the difficulties you had in obtaining the people you wanted. I take it that because you are rather organisational conscious, if I may use that rather clumsy phrase, you did take rather more careful steps in your selection. You made it in some respects a scientific process of selection?—I think it is fair to say that.

3159. Are you taking that into account or making suggestions along those lines? Will you in the case of the hospitals, in view of the need there seems to be in public undertakings of all types to get the right people into the right jobs, be devising a system of selection which is going to help in that direction?—Personally I think that will form a very important part of the report. We find it is not so much the costing which is going to be the difficulty ; it is the re-organisation and the staffing arrangements. Take the case of stores accounts. Very few hospitals have got a complete set of stores accounts. Unless you have got stores accounts you are not going to get very good cost accounts. The calibre of the officers in some of the hospitals—I am not referring to the hospitals we are investigating—is not very good as appeared from the applications we received, and that is why we took such a long time in selecting our people. We interviewed very many

applicants, and we found quite frankly they had not got the knowledge they ought to have for a job of this sort. Quite a number of them were already finance officers in hospitals. That is something which worried me a lot. The organisation has got to be changed first. Take the salaries and wages procedure. We find the manual system in use where machines would be a big advantage ; and we find machines in use where the manual system would be very much better. We have taken a time and motion study. We have used the clock card or time sheet, and we have worked right the way through. We have got out the time engaged in each job by each worker. We have also studied the forms used, because a big economy can be effected in stationery. A tremendous saving can be effected in that way. Not only that but in order to get an efficient costing system you must have a stores procedure, an examination of invoices and accounts, and a method of working out departmental accounts. It has been said that because you are going to have an additional system, therefore it must be more costly for the hospital. You will have the subjective system and a separate costing for the departmental system. That does not follow at all. I am hoping we can work the one set of accounts in much the same way to give us the two sets of figures. I think that is possible. (Miss *Livock.*) Yes.

Chairman.

3160. I think you said, Captain Stone, that you were hoping to produce recommendations as regards re-organisation and similar matters generally, and not recommendations purely concerned with cost accounts?—(Captain *Stone.*) Yes. Unless you have a good organisation it is no good trying to introduce cost accounts.

3161. In the report you are preparing will that contain some general recommendations? Have you contemplated that?—It must do so. It must deal with organisation as well as with the actual accounting. (Mr. *Farrer-Brown.*) That is one reason why we have rather carefully compiled reports of existing systems which we have found in each of the hospitals we went into, before we touched anything, so that we have got a base line. I think in the first instance our recommendations may show the changes it has been necessary to introduce in the hospitals in which we have worked.

3162. Changes other than merely changes in accountancy?—Yes, changes which are necessary if the cost accounting system is to be useful. (Captain *Stone.*) We have not at the present time made any alteration in the accounting system of hospitals. That was arranged with the Ministry. That is one reason why it has taken such a long time to get the information. The clerks working on that system have got out the additional information which we required. They have all played the game very well indeed. We have had 100 per cent. co-operation. The task will increase when we put in the experimental system. When they have to work the existing Ministry system and the new departmental system it has been agreed that any extra staff they want during that period will be paid for, but ultimately I think, when they get the departmental system, it will not add to their cost and in my opinion they certainly will not need any increase in their staff.

Wing Commander *Geoffrey Cooper.*] It has been suggested, rightly or wrongly, that numbers have gone up rather unnecessarily since the hospitals were taken over by the National Health Service.

3163. Will there be any means whereby, on previous available information a hospital was considered to be efficiently run and staffed only to the minimum requirements, similar information will be made available as a check under the new departmental system?—It is rather difficult to say. The changeover has been so made that it is almost impossible to say that for one or two doing the job before three or four are doing it now.

3164. If you see that the number has increased you will comment on it?—Undoubtedly. It would be difficult to say that because you have a new system you need extra staff.

3165. Would you like your inquiry to go into the realms of the rather tricky one of amounts paid to people in various positions?—We are anyhow.

3166. Because it has been put to me that, whereas people have been receiving £200 to £250 a year for doing a particular job, they have been taken on under the new system and paid £1,000 or more a year for doing a similar job?—I can give you an instance. It is not an individual hospital which we are investigating, but one where I was personally called in to give some advice. The deputy finance officer was getting £650 a year keeping what is known as an analysis expenditure journal. I would put a clerk at £250 a year on that job. That is one actual instance, but I think it happens in quite a lot of places.

3167. In this survey which you are making you will obviously focus attention on cases where there is waste of money. That means essentially not only dealing with the particular instances where it is found, but also taking steps generally to see that people appreciate the need of becoming cost conscious?—Yes.

3168. How is that going to be done?—They have got to be educated in the items which are brought to light. It is no good putting in a mass of documents unless some use is made of them afterwards. We have had so much experience in the past of reams and reams of statistics being prepared, and nobody had got the slightest knowledge of how to use them afterwards.

When we get this system in operation we have got to take the finance officers in the hospitals and the members of the committees and gradually educate them up to it. I think one of the snags in the past has been that the finance officer generally has been keen on putting forward an elaborate statement—it is a little empire building. We propose to put forward just a few figures, just to whet their appetites, so that they say, "You have given us this; we want a little more; we have not got sufficient information". You say it is a rough guide only, and gradually you build up a series of forms showing what they really want to know. I think we want to develop our system in that way. We want to start slowly. Mr. Diamond mentioned the question of overhead expenses. In the early stages I think it would be a big mistake if we were to ask the hospital to allocate all their overhead expenses to the ward itself; but if we could allocate what we call direct expenditure, the expenditure for which the head of every department could be held responsible, then we are getting down to something really valuable. If you allocate all sorts of things to a ward and tell the sister that is what her ward is costing, she will look at it and see maintenance of buildings, rent, rates, taxes and so on, and she will say "Those are nothing to do with me". (Miss *Livock.*) May I interpose here to say this? When I was the Accountant at the Radcliffe in 1937 I was doing departmental costing there of this kind, and at the end of each quarter I took the cost statements round personally to the departments and discussed them with them. They welcomed it, and their interest was gratifying. They took notice of all changes in costs.

Chairman.

3169. You do not expect any difficulty at all in getting the interest and the co-operation of all those who will be concerned to use your figures, but the question is whether they will have the intellectual ability?—(Captain *Stone.*) You have got to educate the members of the committees about that.

Wing Commander *Geoffrey Cooper.*

3170. Are there any means whereby your very excellent ideas, as they emerge in the course of your investigation, will be adopted and carried through?—I think we shall do that by a series of meetings. We did meet the secretaries and the finance officers of the hospitals concerned, and we outlined the purpose of this. There was a feeling at first that this was a whip put into our hands by the Ministry, and that there was going to be an investigation into their organisation with a view to cutting down their costs. We explained that this was not so, and we gave them in outline an idea of some of the things which would happen. It we could only meet the committee members and explain the purposes of these costs and that it is not by operating a costing system that all the ills to which the Service is subject at the present time would go; they do not, they will welcome the information. It is only one element in the constitution of social health. But if we could get these costs it will help considerably towards a solution of that problem. Previously we have not got the information; we are just beginning to get it. I agree with Mr. Farrer-Brown that we must start slowly and work this up. There is the question of convalescence homes, homes for the aged, medical records and so on in all of which the King's Fund has taken a very active interest; they are all bound up with it. This is one factor in the whole matter. We are not viewing it purely as a costing investigation but as a part of a larger investigation.

3171. Can I just ask one further question about out-patients? If you get a great increase in the number of out-patients, which I understand has occurred, this being a free Hospital Service, it will obviously reduce your costs. It has been admitted by the doctors themselves that many of the patients need not have come there, and that they have been largely psychological cases. Is your enquiry going to take that sort of point into account because otherwise it might rather upset your findings?—(Miss *Livock.*) Ultimately I think we have to try to find a method of arriving at a picture of the work done in the departments.

Chairman.

3172. It is the same question of how you are going to measure the social output?—(Mr. *Farrer-Brown.*) We are trying to get the first measures of what is going on, and then explore them.

3173. For the remainder of the time could we discuss a question on which I think the Nuffield Trust will be able to assist us most? As between different parts of the country you have got your different conditions. Mr. Farrer-Brown has already described the variety of groups with which you are concerned. When you have completed your survey do you expect that you will be able to draw true comparison for the country as a whole? Suppose you are comparing a 200-bed hospital in a mainly rural area in Yorkshire with a similar size hospital in an industrial area in the Midlands. Will you be able to say within reasonable limits what the comparative expenditure should be to do the same work?—Taking the same type of hospital as you have done?

3174. That is the first thing?—That is the first thing. You must compare like with like. Secondly, and this is subject to any modification which Miss Livock may on technical grounds feel it necessary to add, I do not think we shall be able to

say that the cost of doing this particular piece of work can, and must be, this particular sum. What we may be able to say, I think, is that, if there is any significant variation from the common mean, "There is a hospital which ought to be looked into carefully". On that further examination you may find there is a perfectly reasonable explanation for the difference. But equally well you may find that there is some less efficiency in that place than is to be found elsewhere. Is that a clear answer to your question? I want to avoid giving the impression that you can say, "It is going to cost X shillings to do this piece of work, and that is the standard price for the whole country".

Mr. *Diamond.*

3175. Having got your mean, a wide variation from which would give cause for inquiry, would that be a mean which would cover both the industrial and rural hospitals in widely differing districts or would you have a mean for the industrial hospital and a mean for the rural?—That is in fact one of the matters we have still to find out. We believe the survey will tell us that, given the same type of job in each case. That is why we have distributed the enquiry in the way we have, because we shall in some months' time begin this task of comparing costs. We can from our own knowledge then say, "There is a difference here. What is the explanation?", and we hope to be able to show the safety margin in using these figures for the whole country.

Chairman.

3176. We are concerned, of course, here to look into the estimates. Estimates are one of the items which concern us under what is going to be the future policy as regards allocating sums of money to various parts of the country for the Hospital Service. We were struck by the figures supplied to us. Whereas the average cost of a bed in the South West Metropolitan area is over £500, the average cost in the extreme north of the country is about £350. There may be, of course, many factors explaining that, but will it be possible to arrive at any scientific basis for assessing those factors and then to say, "If you were to make a fair distribution of the money available, it should be on these lines"?—I think it will because cost accounting will in fact begin to show up the main heads under which these differences have occurred. That will be the first thing—whether it is under salaries or under purchases. (Miss *Livock.*) The cost of feeding each patient; the cost of X-rays; the cost of the boiler house. Wherever a difference occurs within two hospitals it will be shown. (Captain *Stone.*) At the moment you have got your figure of £500 in the south and £350 in the north. You do not know where that difference is occurring, whereas with your departmental cost accounting you will begin to see where this difference occurs.

Mr. *J. Enoch Powell.*

3177. Unless the units on which you eventually settle are universal means, they will be valueless?—(Mr. *Farrer-Brown.*) Yes.

3178. Because the factors, which would have been introduced and classified if you had regional means, would be themselves subjective?—Yes. I am very grateful to you for mentioning that. That was the point I tried to make at the beginning. There must be uniformity of the unit of cost.

Mr. *Turton.*

3179. Have you gone far enough with your researches to be able to judge whether the unit cost per bed, as worked out at present, is at all reliable?—We do not think it is at all reliable. (Captain *Stone.*) No, it is not. (Mr. *Farrer-Brown.*) It just does not teach you anything.

3180. Your private bed charge is based on that present ascertainment of costs?—(Captain *Stone.*) Your present cost is based on so many different factors. Your cost per bed has been including expenditure on the boiler house, but you may have a boiler house burning coal, you may have a boiler house burning oil fuel, and you may have a boiler house somewhere in the Midlands where they get coal very much cheaper than you do in London—but everything is on a cost per occupied bed basis at the present time. I think it is the most unreliable unit of which one could possibly think. Your Chairman mentioned that the average cost of a hospital bed in the south was £500 compared with £350 in the north. In a schedule of these differences you will have each different unit cost, and you can compare them. You will be able to compare department by department right the way through. It will be a comparison of like with like, and you will be able to see where differences arise. At the present time in these sums of £500 and £350 you do not know where to look for the difference, but by breaking it down into the functional activities of departments you can compare like with like right the way through till you find out where the differences are, and that will be a guide for your inquiry into particular items.

Chairman.

3181. Do you expect that guide will be really sufficiently reliable to be capable of use by the money-finding authority in deciding where to apply available funds?—It is much more reliable than the present method. It is not 100 per cent., but it is certainly very much better than the existing method. (Mr. *Farrer-Brown.*) Yes. (Miss *Livock.*) Until we have this, it is awfully

hard to judge. (Mr. *Farrer-Brown.*) I think it is necessary to recognise straightaway that this is not going to be a scientific formula which will give us the answer to our problems of distributing. I think all we can claim is that, by having a much clearer picture of the differences, you will be able to do the business of distributing the money on surer ground than now. I believe that is going to be a very real gain because right through the system it will begin to give a greater degree of precision in the preparation of estimates, in the comparison of estimates and in general consideration of costs.

3182. Do you contemplate that the preparation of estimates will continue to be necessary on the same sort of basis as at present? In other words, will it always be necessary in allocating money to a particular group of hospitals first to obtain an estimate of what that hospital expects to spend in the coming year or series of years and then to apportion the money by additions or cuts as the case may be, or do you contemplate that the time will come when you can say that, having regard to the physical conditions of that hospital and the known standards in the country, a particular sum should be an appropriate sum for that hospital?—(Miss *Livock.*) I think you are asking us to forecast our results.

3183. It is too soon for you to answer that question?—I think it is. (Captain *Stone.*) It is the type of thing we want to do. (Miss *Livock.*) I hope so.

3184. You think it is possible?—(Mr. *Farrer-Brown.*) We would not rule it out, but we would like to be a little more sure.

Miss *Ward.*

3185. With this general survey do you also think you will be able to arrive at where capital expenditure would be best spent? Captain Stone gave the analogy of the boiler house. It might well be that it would be advantageous to spend money on the proper type of boiler house, irrespective of the allocation to the regions for capital expenditure. It is a different sort of approach to the problem of capital expenditure?—Yes.

3186. Do you think that will emerge?—Yes.

3187. Again, to take the analogy of the way the dresser ought to go round the hospital, you could find out whether the older types of hospitals should be aided more quickly from the general allocation of capital expenditure?—(Captain *Stone.*) Quite.

3188. I can see there can be some quite different allocation of capital expenditure from the point of view of efficiency?—That is so. (Mr. *Farrer-Brown.*) There should be.

Mr. *J. Enoch Powell.*

3189. It will help to establish priorities on capital expenditure?—(Captain *Stone.*) It will. (Mr. *Farrer-Brown.*) It is as a picture of pointers to the directions in which it is going to be most profitable to look, that the system gives the most meaning to me. It may not be a highly sensitive pointer, but it is at least a useful pointer.

Chairman.

3190. At present you mean there is no pointer?—Not one worth following.

3191. The allocations of money, as far as you know, are either arbitary or historical?—(Captain *Stone.*) Yes. (Mr. *Farrer-Brown.*) And possibly a combination of both.

Miss *Ward.*

3192. Taking the general picture do you think that in the long run we ought to be able to get better value for money, because it is not only a question of saving but of getting full value for the money expended?—(Captain *Stone.*) Yes. (Mr. *Farrer-Brown.*) That is our interest too

3193. That is your general approach?—Yes. (Captain *Stone.*) This costing for costing's sake is not any good at all; it must give us information we can use.

Chairman.

3194. There is another aspect of this matter on which we have not touched directly. You did mention, Mr. Farrer-Brown, the form of grouping of hospitals The efficiency of the Service must depend to some extent on whether the hospitals are grouped in convenient units of convenient size, and of course the same is true of regional hospital boards and the extent to which the regional board is to be brought into this. Have you given any consideration to that matter in the course of your survey?—(Mr. *Farrer-Brown.*) Not directly at this stage. It is fairly clear, I think, that views about the most economical size of hospitals should come indirectly from our digestion of the facts we gather, but, of course, what we say can only be deductions based upon our experience of seven groups.

Mr. *Turton.*

3195. When you say "the most economical size of hospital", do you mean the group or house committee?—The hospital group. The size of hospitals I think is a very difficult issue. It is one we should try to tackle, but it is going to be several years——

Chairman.

3196. You are dealing with the question of your own grouping?—As an indirect result of this particular study.

Miss *Ward.*

3197. And the size of regions?—No, I would rather not say that. (Captain *Stone.*) We are not.

Mr. *Turton.*

3198. I thought you said, in reply to one of my earlier questions, that a certain apportionment of the regional expenditure for particular hospitals was being done for you?—(Miss *Livock.*) Only an apportionment of their expenditure directly arising from the group, such as medical salaries and the medical staff work in the group, but not of regional expenditure generally. (Mr. *Farrer-Brown.*) We are not doing cost accounting of the expenditure directly of any regional hospital board as such.

3199. Is there not something really fallacious in this? Let me take a hospital in the South-West Metropolitan area. When you are getting your cost of administration, ought you not to be considering not merely the cost of the house committee but also the cost of the area committee and the regional board? You have got an extra tier in that administration. Is not that going to make your results rather fallacious unless you look at that?—(Captain *Stone.*) That is going away from our terms of reference. Our terms of reference are to find out whether it is possible to introduce a cost accounting system in the hospitals. With a view to finding out what the hospitals are costing we shall want to know from the regional board the amount paid in salaries to the medical staff. They pay them, and not the hospital management committee. But we have got no right to enquire into the expenditure of the regional board as such, nor its administrative expenditure I think. We have not done it anyhow.

Mr. *J. Enoch Powell.*

3200. It is conceivable that the manner in which a region is organised could affect the administrative expenditure which ought to be undertaken by the group?—I would agree it should be done.

3201. It may be a factor which will be thrown up by your comparisons although you are not examining it directly?—Yes. (Mr. *Farrer-Brown.*) It will be, because teaching hospitals in fact will be carrying administrative expenses which the hospital management committees will not be, so that we shall get our comparison. We get a certain clue. One of the saving factors may be the proportion which the cost of the administration of the regional board bears to the total cost that is being examined I am not sure, but there may be something there which would have to be looked into rather carefully.

Chairman.

3202. You are not at the moment?—Not as regards the regional hospital board.

3203. Have you considered the question of audit at all? Do you favour a purely internal audit system or do you favour an audit by the Ministry or by the regional board?—(Miss *Livock.*) We have not really considered it. (Mr. *Farrer-Brown.*) We have no view on that as a Trust at the moment.

3204. There again something may come out, but it would be incidental?—Incidental as to whether or not it was necessary for this particular system.

3205. Have you any views on the question of publication of hospital accounts?—(Captain *Stone.*) I certainly think they should be published.

3206. That would be a personal view?—I put that view forward as applying to the Fund. I think I have sufficient authority to do that. We have for the last two or three years lacked statistics concerning the hospitals. We are all completely in the dark. During this investigation we have got more information than we have had from any other source. Before the Act came out the British Hospitals' Association published every year a book giving the statistics. The King's Fund had its annual statistical summary, which I think was accepted by most bodies as authoritative, but since the Act the hospitals have stopped sending their returns to the Fund, and there is no central organisation existing apparently to compile those statistics. We do miss them very much indeed.

Wing Commander *Geoffrey Cooper.*

3207. Do you think the accounts should be published hospital by hospital to keep up the local interest in what was happening?—The group should publish the accounts of their hospitals.

3208. The individual accounts?—Yes. (Mr. *Farrer-Brown.*) May I put one qualification on that? I think the hospital accounts in their present form would not tell anyone very much. I think what we need is the full publication of factual information, financial and otherwise, which is really informative, about what is going on, and thus be able to form proper comparisons with other hospitals. That would be of value to members of hospital management committees and regional boards and to others, and also informative to the public at large. In my own mind the build up of that has still to come. That is one of the things we are really striving to achieve. I do not believe much good comes from the present accounts. They are broad figures which do not help very much. That would be my own qualification.

Mr. *Turton.*

3209. Does that criticism extend to the accounts of the British Hospitals' Association?—The old ones, yes. They were the best we had, but as has been indicated by Captain Stone and others they were misleading.

Chairman.

3210. They would still be misleading?—They would still be misleading.

3211. Because of the variations in the treatment of accounts?—They do not allow enough for these perfectly proper variations. (Captain *Stone.*) I think I disagree with you there. They were good until we got all this information. We are going to be some years before we can get all the figures, but if we can have some figures now we would be getting something—and they can develop from those. We are all going to be kept in the dark until we get these figures. We get certain statistics published in the annual report of the Ministry. I know they are not adequate, but we do get certain information from them. They give us a clue where enquiries can be made. Where a group sees it has spent a little more than another, they carry out their own enquiry. If these figures had not been published, they would not have been able to have done even that. All they can do is to send round to the various hospitals and get copies of their accounts, but I do not think they have all got sufficient energy or initiative to do that. With published figures in front of them they start an enquiry of their own. I would like to get something out as soon as possible. If we do not we shall all be getting into a state of apathy and not bothering to do anything about it.

3212. Miss Livock and Gentlemen, we are extremely grateful to you for coming here. The information you have given us is invaluable for our inquiry, and we shall make due use of it?—(Captain *Stone.*) I am sure we were very happy to come.

The witnesses withdrew.

Adjourned till Wednesday next, at 10 *a.m.*

THURSDAY, 31ST MAY, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Thomas Reid.
Mr. Diamond.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.

Mr. F. L. EDWARDS, O.B.E., Accountant-General, Ministry of Local Government and Planning, Mr. J. E. PATER, Under Secretary, Hospitals Division, Mr. J. P. DODDS, Accountant-General, Mr. W. O. CHATTERTON, a Deputy Accountant-General, and Mr. A. J. F. DANIELLI, O.B.E., M.C., a Deputy Accountant-General, Ministry of Health, called in and examined.

Chairman.

3213. Mr. Edwards, we have a memorandum here which was prepared in the old Ministry of Health?—(Mr. *Edwards.*) Yes.

3214. It was prepared at the end of last year, and you, Sir William Douglas and others gave us some evidence on that memorandum, you will remember?—Yes.

3215. I wonder whether it would be convenient to start by asking you whether, since that memorandum of evidence, there have been any changes in policy which you ought to mention to us, that is to say, modifications to be made to what is stated in that memorandum and to your evidence? Do you know of any such?—I think not, Sir. Of course, we have had a further year's practice, in the sense that we have now approved estimates of the hospital authorities for the year 1951-52; but that was essentially merely a continuance and development of the procedures which were explained in this memorandum.

3216. So that what is stated in the memorandum still holds good?—I think so. I do not recall any changes.

3217. You have, however, now finally approved the estimates for the current year?—That is so. Perhaps I ought to qualify that to some extent: the approved estimates of the hospital authorities are all known to them, at least informally. The formal approvals, in some instances, may not yet

have finally gone, for special reasons, but the amounts of money they are to spend in the year are all known.

3218. They are all known to the various hospital groups?—Yes.

3219. I think I am right in saying that there have been what are generally known as cuts, in most cases?—Yes.

3220. That is to say, reductions made by you in your approved estimates on the original estimates submitted to you through the Regional Boards?—That is so.

3221. Now, can you tell us by what method those cuts were made?—In the first instance, the hospital authorities submitted their proposals under clear instructions that they were not to include contingencies or anything of that kind; and they were to make estimates upon the basis of the prices prevailing at the time those estimates were prepared. We had, therefore, to add to those figures a sort of central reserve for contingencies and a global addition for increases in prices since those estimates have been prepared.

3222. Prices would include, of course, wages and salaries?—Oh yes. On the other hand, there were certain proposals in those estimates which we did not feel able to support, and which we cut out of them before forwarding them to the Treasury. The net effect of all that was that the expenditure which we proposed to the Treasury was £25 million more than the revised estimates of the year then current and just closing. In the final outcome, the figure which the Government agreed was £15 million more than the revised estimates; in other words——

3223. May I interrupt you again. The £25 million figure would be the actual estimate which reached you through the Regional Boards less particular prunings which you thought unnecessary?—That is so.

3224. But not involving any general cut?—Yes, with also the general additions which I have mentioned. The Government accepted a final figure of £15 million more than the revised estimates; in other words, they made a cut of £10 million.

3225. That was a general cut?—Yes.

3226. It did not indicate to you any particular matters which they thought ought to be cut; it was merely a reduction in the total figure?—Yes. Then, having had that decision of the Government, we called into consultation all the Regional Hospital Boards and the Boards of Governors—14 Regional Hospital Boards and 36 Boards of Governors—though in a few instances the cuts were so small it was done by correspondence, but in all other cases it was done by oral consultation; we told them the basis of the cuts and we heard all their observations, and we then made final adjustments and notified the allocations by letter.

3227. Before those consultations, did you suggest to individual Boards or groups the amount that you had in your mind to cut them individually, or did you merely state that there was to be a general cut and ask for their observations?—We started off by explaining that there would be a general cut, and then how we proposed to apply a proportion of the cut to them.

3228. Giving a particular figure?—Yes. We explained the principles of allocation over the whole nation, and we heard their observations. We then went back and thought again, and gave them our final decision by letter. Those letters went out about the 22nd March, and they had then to carry out the cuts in their own Regions. The basis of the cut was this: they had submitted to us, in the first instance, their revised estimates of what the expenditure would be in the year then current, side by side with their proposals for the forthcoming year 1951-52. It was clear to us by that time that their statements of their revised expenditure for the year then current would not, in many cases, be reached. They had said "We shall want £X millions" for the year then current and closing, and "£X millions plus £Y millions" for the next year. It was clear to us by then that what would be needed for the country as a whole for the revised estimates was £X-5 millions, but the underspending was not evenly distributed; there was a very large underspending in certain Regions and practically none in two or three of the others.

3229. Can you say what was the cause of the underspending?—In a generalisation, I would say that in the previous year, the year then closing, we had made no cuts at all, broadly speaking; and some hospital authorities had made very large claims for money and had got away with it. They had asked for more than they really needed.

3230. The primary cause was overestimating in the previous year?—I think so. As a generalisation, certainly it was. There was £5 millions of underspending. We cut that away, as a first stage of the cut. Then we compared all the Regions on the basis of their expenditure in 1949-50; that was the last completed year of ascertained fact. It was useful to go back to that year for another reason; and that is that in the succeeding year, as I have said, they had made varying demands and none of them had been cut. We therefore used the year 1949-50 as a base year in these comparisons, but we had to take account of the fact that since that year the various Regions had provided additional beds, but not all to the same degree. So we adjusted their expenditure to 1949-50 by reference to the additional beds which they had all provided since that period, and that adjusted 1949-50 expenditure was the base, and we compared what additional

money they were all asking for by reference to that base ; and the percentage additions varied very considerably. They varied from the lowest at 7 per cent., to the highest, at 31 per cent.

3231. Would you say what areas?—The lowest was one of the Metropolitan Regions, when so adjusted ; the highest was the Oxford Region. Having regard to the cut which had been suffered, we could not accept it that the high demands could be satisfied in full. We took a norm, which was about the sixth-lowest, and allowed a percentage addition of about 15 percent. over the adjusted 1949-50 expenditure, and said that any percentage higher than that was excessive in the circumstances and could not be allowed. That the the proposal which we put to them—a first-stage cut of the expenditure which was obviously not needed, and then any excess percentage over adjusted 1949-50 expenditure after the first-stage cut ; and we listened in each case to their observations. Of course, they all said that was not enough, and they wanted more money ; but various Regions had special difficulties which that system would impose upon them, and we took account of those special difficulties in four instances.

3232. Could you tell the Sub-Committee what the special circumstances were in those four instances?—One of them, which stands out a long way, is that the Northern Region, and to some extent the North-Eastern Region of the country, had been areas of great depression throughout the period between the wars, and their hospital provision was lower per thousand, and was a lower standard for hospitals than in the rest of the country. East Anglia said to us that they were largely a rural area, which again had very little hospital provision, and again of a poor standard. The South-Western Region said much the same. We gave to all Regions a little more than we had initially proposed to them. We gave them all a let-up, but we gave a much greater let-up to those four Regions, the Northern, the North-Eastern, East Anglia and the South-Western Regions.

3233. The basis of your cut originally was what you might call the practical necessity of maintaining the existing hospital establishments?—Yes.

3234. But that you modified that in particular instances to meet the peculiar needs of those Regions which were under-hospitalled?—Yes.

3235. That is the broad principle?—Yes. All Regions are getting more money than the previous year, but some Regions are getting a bigger share of that than the others.

Mr. *Thomas Reid.*

3236. In making these cuts, did you make a distinction between the current expenditure and capital expenditure?—I should have said that I am dealing throughout with current maintenance expenditure. Capital expenditure is dealt with on an entirely different basis.

Mr. *Diamond.*

3237. Could I ask Mr. Edwards this question. I am quite clear that the amounts to be spent in 1951-52, as he said, are now known, and that therefore any complaint which we may have received (the Board were under great difficulty in that they previously did not have approval to their estimates until three-quarters or more of the year had elapsed) is now, at all events, no longer valid for 1951-52?—That is so ; they know at least informally. In many instances they may not have received the final official letter which underlines that, but they all know. We had explained the allocations to the Boards and given them letters with the final decision on the Regional totals in March. In the interval, the Boards had been discussing it with the committees, and you may have noticed in the local Press in various directions complaints by individual hospital management committees that the amount to be allocated to them is not enough. There are various points of detail like that on which argument is still proceeding, but subject to that degree of qualification, they all know the amounts they are likely to have this year.

Chairman.

3238. Mr. Diamond put the question regarding complaints from the Boards only. The complaint which reached us was not from the Boards but from the committees. Do the individual committees now know precisely what they will at least get this year?—I think so ; but after having discussed it with the Boards, we left a considerable discretion to the Boards as to how they handled the matter with the hospital management committees, but I think they have all discussed it with their committees.

3239. So that the committees have been warned but not necessarily finally informed?—Yes.

3240. I wonder if you could supply us with a short statistical table, showing the allocations to Boards and, if possible, to committees of the estimate for the current year?—Yes.

Mr. *Diamond.*

3241. I was only anxious to make it quite clear that this information notification of the amounts to be spent was in fact for all practical purposes as useful to the Boards as the formal approval of the estimates?—I think so. We are very conscious of this criticism, that in past years parts of the year have gone by before the approvals have been issued. We think, as a matter of fact, that the complaint has been overstated. I have myself seen it said about the year 1950-51, when, if you remember, we gave regional totals to the

Boards and left the Boards to approve the figures of the committees; so that we cannot speak authoritatively; and I have heard it said that an individual management committee has not known the amount approved for nine months of the year. But they certainly knew at least informally the amount allocated to them, because they were making monthly returns to us, comparing their expenditure to date with the appropriate proportion of the approval, and no one said "We do not know what the amount approved is".

3242. I am directing my question to this distinction between approval of the estimate and informal indication of the amount which can be spent. For practical purposes, after all, somebody in the Board signs a cheque, and if he is notified that he can spend that, that is what he is presumably interested in. Could we therefore be told: What is the difference between that advice of a fact and the formal approval of estimates?—It is not quite like that. The Board do not sign one global bulk cheque and the committee then have the money.

3243-6. No?—They get running amounts from month to month. Taking the Oxford Region case, for example, they were the quickest off the mark. We saw them, with all the others, early in March. They had a letter allotting them a sum after that, and they were the first back with their proposals for allocating the sums—within a week, I think. Yet formal approvals for Oxford have not gone out because they were arguing with us about one particular hospital establishment which they are taking over, saying that the Regional total is not enough to carry this additional load. Apart from that, all the Oxford Region know their sums; I have seen in the hospital journals, an analysis of the allocation of that money to the Oxford Region. But the formal letters have not gone out yet, because they are still hoping to persuade us to give them a little more money.

Mr. *Turton.*

3247. I gather from what Mr. Edwards said that this cut is directed at current expenditure, and that capital expenditure is excluded; is that right?—Yes, Sir, but there has been a cut in capital expenditure.

3248. In addition to the £10 million?—Yes.

Chairman.] I think we can talk about that separately.

Mr. *Turton.*

3249. Yes. Then I gathered that apart from the £5 million overspending or overestimating, the other £5 million was dealt with on the basis you have explained, with beneficial treatment towards those hospitals which had not had all the capital expenditure which the others had had in pre-war years. I do not quite follow why the fact that they are deficient in pre-war capital expenditure should make those hospitals more worthy to get more current expenditure?—It was not wholly lack of capital expenditure between the wars, but the whole standard of provision in the old depressed areas, which were so far behind in hospital practice. I remember, when discussing these estimates with the representatives of the Boards, that the Senior Administrative Medical Officer of that Region pointed out to us that the hospitals in that Region had been so starved of money that there had been very few specialist medical officers in the hospitals. The standard of specialist provision was far below the standard for the rest of the country, and they had been slower off the mark in providing a specialist service in their hospitals than the rest of the country. All that sort of thing, of which we were very conscious, justified the larger allocation to that Region, rather than some lack of capital provision in buildings.

Chairman.

3250. You speak of the depressed areas now; and previously you spoke of the depressed and the mainly rural areas. I think it is both classes of area that were behind in that?—Oh yes, indeed.

Wing Commander *Geoffrey Cooper.*

3251. I have one small point in connection with the Chairman's request for a statistical table which would show the way in which the allocations have been made of funds for the Regional Boards. Would it be feasible for you to include some dates when the amounts were agreed. You have made a qualification that sometimes formal agreement is not made until all the details are acquired; and perhaps you could put a qualifying note showing where the date when the final agreement was made, to show the reason why there was so much delay?—Yes, we will do our best.

Mr. *J. Enoch Powell.*

3252. Have you reason to believe that the informal notification which the Boards receive is not passed on, or is not passed on quickly, to the hospital management committees? I ask that question because we were told by at least one hospital management committee (it is page 129 of the evidence, on the 8th March, 1951) that they had heard nothing about the estimates which they had submitted in the previous September for the year 1951-52?—I have no reason to believe that any of the Boards have not fully consulted their hospital management committees by now. I can believe that that was true, and indeed fully true, on the 8th March, because the Cabinet decisions as to the cuts were not made until after the 8th of March, and we could not proceed until the Cabinet had come to a decision. We are entirely governed by policy decisions in the Cabinet, and indeed we started the discussions before the

Cabinet decisions were final, so it was not until the middle of March——

3253. And that is a difficulty which you are likely to be confronted with for many years?—Yes, Sir; it is a problem with which we are grappling at the moment, in an attempt to get Ministers to ante-date this; but it is altogether too premature to go into that.

Mr. *Thomas Reid.*

3254. The Cabinet has to consider your Department's estimates in conjunction with the others before deciding on what can be done?—Yes, Sir. We should like to persuade Ministers to give a decision on this earlier than the rest; that is the difficulty.

Chairman.

3255. Would not you say that, so far as hospitals are concerned, the normal Civil Service method of budgeting is not altogether appropriate?—It is certainly very difficult, Sir.

3256. I think you really indicated that in your previous memorandum?—Yes, we did.

3257. Are you trying to work out a new system?—Yes, we are, though it is altogether too premature to say anything about it now.

3258. No doubt you are well aware that evidence has been given to this Sub-Committee in favour of what is generally called the block grant system. I think what you have told us this morning rather indicates that your minds are moving in that direction?—Well, of course, different people mean different things by "block grant". I do not know whether you would like me to go into that?

3259. Let me put it in this way: First of all, you are moving in the direction of allocating a total pre-determined sum to the hospitals and dividing that sum between the Regions in accordance, if not with a formula, at any rate with a pre-determined policy?—Yes.

3260. And I think you suggested that you are really leaving it to the Regions to sub-divide their appropriate allocations between their various groups?—Yes, Sir. I ought, perhaps, to have added that we require the Regions to come back to us and tell us how they propose to work their allocations.

3261. How far are you leaving a free hand to the Regions?—Very largely. This year I do not think we shall differ from them in any respect; but we do hold that final decision and we might disagree with them. We have put it to them that this is a partnership, in which they must be the guides of us as to how the sums should be allocated, and it will be surprising if we have to disagree with them about it; but we do hold the final decision; they have had to put these figures back to us and we have had to agree them.

3262. In the discussions on this, which have no doubt been almost acrimonious at times, have you had direct contact with the groups or have you left that to the Regions?—Entirely to the Regions.

3263. You have not had communication with the groups?—No, Sir.

3264. If a particular group writes and complains that their amount is inadequate, do you refer that back to the Region?—(Mr. *Chatterton.*) We have not had any such complaints. (Mr. *Edwards.*) You said, Sir, that the discussions had no doubt been acrimonious at times; I think I can honestly say that they were entirely amicable.

3265. Perhaps "acrimonious" was the wrong word—"strong"?—I think they all appreciated the frankness with which we explained the difficulties of the situation and the need for the cut. They went out of their way to say that they appreciated the way this had all been explained to them before the Budget. We had to have an understanding with them that there would be no public announcement until after the Budget.

Mr. *Thomas Reid.*

3266. Would you say that the existence of the Regional Boards is absolutely necessary in making allocations to the hospital committees, and that it would not be possible for you to deal direct, in this matter of the allocations of money, with the hospital management committees?—I would not like to say that it would not be possible. Certainly we have used the Boards, and my own preference would be for some regional machinery in close contact with the needs of the Regions for that allocation.

3267. Have you a knowledge of a great many more hospitals than the hospital managements committees would have?—Yes.

3268. And they are able to assess the needs of the bigger area?—There must be some machinery for assessing the needs of the area.

Mr. *Turton.*

3269. That means that you have not got the knowledge of the finance departments of the Management Committees?—We could not attempt in Whitehall the detailed knowledge which is held in each Region.

Mr. *Thomas Reid.*

3270. And you consider that a good system of decentralisation?—Decentralisation there must be.

Wing Commander *Geoffrey Cooper.*

3271. The Chairman raised a question in regard to the possibility of the block grant system being adopted, and you rather sidestepped that by saying "That depends what

you mean by 'block grant'." Have you in fact studied the rather precise experience and methods employed by the universities grant system?—Yes, Sir—although I should not have called that essentially a block grant system. We, in the Ministry of Health, have very great experience of the block grant system. We were the devisers of it, from 1929 to 1948. We claim to know all about the block grant system. May I make some general observations?

Chairman.

3272. Yes?—In the system of approvals, with these qualifications and limitations which are in the system, which we apply by the financial regulations with the concurrence of the Treasury and in our approvals, we have simply operated this system of financial control which Parliament has imposed upon all government departments for 300 years or more. We took it for granted that those were the only conditions under which Parliament would allow us this very great sum of money, about £250 million a year. If this Sub-Committee, as representative of the will of Parliament, were to say: "We do not think all these controls and restrictions are necessary," the Ministry of Health is not here to object in the slightest.

Chairman.] I do not think, Mr. Edwards, that even if we expressed such a view, you would feel able to act upon it right away.

Wing Commander *Geoffrey Cooper.*

3273. I do not think Mr. Edwards really answered my question. I did direct it to the precise system which I understand has been functioning rather effectively in the universities, and it is something which has in fact been mentioned to us as being a good scheme?—Yes.

3274. Therefore, if you have any knowledge of the way the university grants are working, can you comment upon that, in so far as it is relevant to the Chairman's question?—Oh yes. Put into technical terms, the system of government financing for the universities is a system of grants-in-aid; that is to say, it is not tied down to an annual allocation. It is not subjected to close, detailed accounting by the Public Accounts Committee, which applies in the ordinary way to voted moneys; and if a grant-in-aid is not spent within the year, that is no concern of Parliament; the university can carry on saving it and spend it in future years. That system of grants-in-aid for small sums is well-known throughout the departments. We should be only too glad to persuade the Treasury and Parliament to give us more grants-in-aid rather than the ordinary voted moneys; but the grant-in-aid to the universities is merely £23 millions, as compared with £250 millions for the hospital service, quite a substantial proportion of the budgetary charge. We certainly assume, and the difference in scale is so great, that Parliament is not likely to agree to a suggestion (a happy one from our point of view) that we should be handed £250 millions of money and not required to account in detail to Parliament for it, and be able to keep our savings.

3275. Are not you in fact making deductions which are not altogether justified? Although in the university grant system they are not accountable to the Public Accounts Committee, there is no earthly reason why, if the principle is right and the method is effective, it should not be applied with certain modifications. It has been put to us by a number of witnesses that it would be in the interests of the service, they say, in efficiency and economy, if they were given the opportunity of receiving, or knowing what they are going to receive in terms of money, and then have an opportunity, if necessary, of carrying that forward for a period, or having it available for a period longer than one year, and carrying it forward if necessary. What is your opinion on that?—As I said in my general observations, the more Parliament would be willing to relax its ordinary requirements in accounting, the happier we would be.

Chairman.

3276. Do you feel that, if in fact Parliament did relax its requirements in that respect, and you were able to make something in the nature of a grant-in-aid to the hospitals, in fact you could, under a system similar to the present one, rely on the Regions and the committees to behave responsibly and not to waste money?—I think so. I think the record of the last year is a very heartening one. I have no reason to believe that if Parliament did give us a grant-in-aid there would be any difficulty or wastefulness of any kind.

Wing Commander *Geoffrey Cooper.*

3277. But it was assumed that Parliament would have to make some relaxation of its method of control; but I do not see that that is a necessary deduction, because although the Public Accounts system works in a certain way now, there is no reason why it could not extend its enquiries down into the Regions, in which case there would be similar public accountability, if not an actual check on the yearly amounts which are allocated?—As a departmental witness, all I can say is that I would see no difficulty in operating a system of grants-in-aid of that magnitude. I have no confidence whatever that the Treasury and Parliament would agree to give us grants-in-aid of this sort, but we should be only too happy to work to that system, and we should certainly welcome any recommendation from this Sub-Committee to that effect.

Mr. *J. Enoch Powell.*

3278. I notice that you base the justification of the present system upon Parliamentary control. Would it be possible, in the present stage of the hospital service, either for the Ministry to allocate rationally to the Regional Boards, or for the Regional Boards to allocate to the Management Committees, without some such system of estimating as in fact exists at the present moment?—I certainly think that you must start with estimates prepared by the hospital authorities. I am not sure that you need to start with such detailed estimates as we have at present; but I do believe, if I understand the drift of your question aright, that in allocating sums of this magnitude, you must start in some way with proposals from the hospital authorities.

3279. Then, even under the present system, could not the estimates be simplified, much in the same way as you have suggested?—Yes, indeed. In fact, that is covered by what I was saying earlier, that we are attempting to solve some of the problems of the hospital authorities in that way, but that it is much too early yet to say much about that.

Chairman.

3280. I imagine that you had that very much in mind when you invited the Nuffield Trust and the King's Fund to carry out their present investigations?—Well, to some degree, although that is on costing on a unit basis. The problem of estimating is one we are much discussing with the Regional Hospital Boards.

3281. The two fit very closely together, however?—Yes.

3282. If you had a proper system of costing, it would enormously assist your system of estimating, would it not?—Yes, Sir, although I do not believe that costings in themselves will ever dispense with the need for proper estimates from the hospital authorities. The costing yardstick is an awfully good way of testing the estimates, but it will never do away with the need for them, I believe.

Wing Commander *Geoffrey Cooper.*

3283. You are basing your departmental opinion on the size of the sum which is involved. In view of your comment that you have experience in making block grants to local authorities, surely over the years the amount involving in allocating sums to local authorities has been quite as large as this amount which is involved in the hospital service?—Yes, but the block grants we made to local authorities were not grants-in-aid in the technical sense. They were voted moneys. The essential point about those block grants was that they were a global distribution of money in accordance with a mathematical formula.

3284. Yes, but the important thing is this. It applies in the case of allocations to local authorities, that they were able to carry forward the moneys from their allocations; and the desire is, and the feeling has been expressed, that they could do their job better if they had the opportunity of looking ahead for, say, five years?—Yes, Sir. Of course, the fundamental difference between grants to local authorities and the financing of these hospital authorities is that these hospital authorities are entirely carried upon voted moneys, whereas the grants to local authorities are merely subventions in aid of their own funds, so that any moneys voted to local authorities, within the whole gamut of the £400 to £500 million paid by the ten or more Departments which make grants to local authorities—that all goes into the general rate fund, and loses its identity. The problem there is entirely different from the one we are dealing with here with bodies which are simply agencies of the central government.

3285. I suppose if funds were capable of being gathered in locally, to some extent, either from voluntary sources or otherwise, a somewhat similar system would arise; the two would be merged, and then there would be a carry-forward; and then there is a very similar system?—I agree. Sometimes the analogy of the B.B.C. is thrown up against us; it is assumed that we should have an organisation like the B.B.C., but the B.B.C. has its own funds. It relies only to a very limited degree upon voted moneys, and where it does rely upon voted moneys it is subject to all those controls like the hospital service.

Mr. *Thomas Reid.*

3286. You said just now that you were only too willing to get a big sum from the Government and carry out this expenditure; but is that possible under the Parliamentary system? Take the present time: I dare say the Government attitude would be quite different in regard to the vast expenditure on rearmament; you are not like a finance company, one unit; you are only a part of the huge government machine; and therefore I suggest to you that it is quite impossible to abolish the Parliamentary system which you have now, and to replace it by a system by which the Government would give you a sum of money, because the Government could not fix the sum. Just now we found out that the Cabinet deals with the thing, and the reason why the Cabinet deals with it is because they have to consider other Departments, and therefore the analogy of a single unit is quite misleading, is it not?—I entirely agree; and if Parliament were willing to give this as a grant-in-aid for the

National Health Service, I should begin to wonder whether I could not have it for some of the other Votes. Why should one be allowed it and not the other? I should be only too glad to have that for the Housing Vote, for example.

Mr. *Diamond.*

3287. We have received a lot of evidence alleging that the present system tends to lack of economy, namely that when committees are getting towards the end of their accounting year and know that they have a certain sum of money to spend, the very fact that they know that unless they spend it within that fiscal year the right to spend it will be lost, tends to make them incur expenditure in a rather more haphazard way than otherwise they would do. They hurry about it, and the money is used less economically than would otherwise be the case. Apart from any principle of Parliamentary control, could you let me have your views on that argument?—We are very well aware of that argument. You rather shut me off in the first limb of my reply, which is that if this is a system which tends towards extravagance here, then it tends towards extravagance on all voted moneys which are goverend by the same principles. But is there really likely to be much in it? We tie them down to figures under the approval headings; that is to say, they get one figure for drugs and dressings for all the hospitals in that group; another for provisions; another for uniforms, clothing, etc.; three figures for salaries—medical salaries, nursing salaries and other salaries. Now, is it likely that they are going to use up more drugs and dressings, that the doctors are going to apply more dressings merely because they have a figure for that and they may as well spend it? Or are they going to put more food on the plates of the patients because of the figure they have for food? We know the argument, but I doubt if there is much reality in it in practice. Where it probably does operate is in capital expenditure. If an authority has been given a figure for capital expenditure within the year, the thing may not be going well, there may be all sorts of delays in the contract and so on, and they have the fear that they will have to get a re-vote of it the next year, and there is the greatest tendency to try and get that capital expenditure within the year; but do we not want every incentive we can find for quick capital expenditure?

Chairman.] I do not want to deal with the question of capital expenditure at the moment.

Mr. *Thomas Reid.*

3288. Following up Mr. Diamond's question, I assume you are given so much money under each heading; that can be abused unless the Management Committees are forbidden to transfer from one head to another. Do you forbid the transfer from one head to another?—Yes; they must come for approval for transfers. The approval is first of all by the Boards, and we have told the Boards that if they are absolutely convinced that it is necessary to make the transfer, they can give the approval at any time themselves; but that, by and large, they should not give those approvals until the revised estimate stage.

3289. That means it is another move in the direction of decentralisation?—Yes.

Chairman.

3290. And in the general direction of what is known as the block grant system, so far as the Board is concerned?—Yes, in that sense of the block grant.

3291. Could you apply the same to the unexpended balance question?—It is a clear rule with all voted moneys that the amount which is voted by Parliament is a maximum and issues from the Exchequer only to the extent that it is expended. We have not regarded ourselves as in any way entitled to say that if they do not expend it they can keep it and use it for other purposes in another annual vote period.

3292. The argument you have put forward against virement between heads is not applicable in the case of a carry-forward of unexpended balances?—No.

3293. Clearly, where you get a body like a hospital committee, which sees the possibility of some hundreds or thousands of pounds going down the drain unless they spend it, there is a fairly strong inducement to be rather careless in the expenditure of money towards the end of the year, which would cease to exist if you allowed them to carry it forward to the following year?—We have not regarded ourselves as authorised to do that. There is that distinction. Virement between sub-heads is exercised by the Treasury, and within strict limits. If the sums are substantial, the Treasury will require the Department to come back to Parliament with a re-adjusted estimate. We operate that system in a precisely similar way as regards the Boards and the Management Committees. But the carry-forward of unexpended sums in a Vote is not allowed to any department where the system of grants-in-aid is not in operation; and therefore we have not regarded ourselves as allowed to do that in the case of hospital authorities.

Mr. *Thomas Reid.*

3294. You are working on the cash system, where on the 31st of March everything closes down. Is that right?—Yes.

3295. Several of the witnesses who have come before us have expressed objection to that. Do you think that the cash system is right, or that people should be allowed to carry forward their unexpended balances and carry on expenditure without further approval from somebody? Is the cash system, as we have it in England and in the Dominions and Colonies, a sound system?—I would say (whatever my own opinion would be; and it agrees) that that is decided for us by the reports of the Crick Committee, which examined this whole issue.

Chairman.] I think this question goes rather outside our ambit.

Wing Commander *Geoffrey Cooper.*

3296. Could I ask if you have got evidence, or are taking steps to get evidence which might suggest that, because a certain amount is allocated, because that has been budgeted for and agreed with you, the determination then becomes effective to spend up to the absolute limit, because otherwise they feel that if their budget another year is put in, it will be cut by the amount they have underspent? It is the same old thing which tends to take place in government departments, too. They feel that if they do not spend the money, their budgets will automatically be cut. Are you taking any steps to verify whether that is a valid criticism?—I cannot point to any precise steps we are taking, but we are watching the situation generally, and I am bound to add that my experience inside a department does not support the view that we do spend near the end of the year——

Wing Commander *Geoffrey Cooper.*] I was not saying near the end of the year.

Mr. *J. Enoch Powell.*

3297. Would the tendency towards abuse not be greatly lessened if the two measures which you have mentioned, of earlier approval of the estimates for the following year and less detailed estimates, could be brought about?—I certainly think they will help. There is one point which I omitted to mention, and which I ought to bring out at this stage. It was a feature of the budgetary discussions we had with the Boards this year that we suggested to them that they should set up, each of them, a regional reserve; and it is, of course, important to them to see that the individual hospital management committee does not spend up to its allocation near the end of the year, merely in order to use it up, because they have very small regional reserves to meet the inevitable excesses which occur in some cases.

Chairman.

3298. What is the nature of this regional reserve? First of all, what kind of proportion does it bear to the regional board; is it 1 or 2 per cent., or what?—I have not worked it out. Some of them asked us for guidance, and we rather declined it. We pointed out certain liabilities they were liable to meet; that is to say, we were aware of certain Whitley Council negotiations impending, which would certainly impose a charge.

3299. Was that last year or this year?—This current year.

3300. Would it be possible to get figures for us to show what the 14 Boards have in fact decided to set aside as a reserve?—Yes, we can do that.

3301. And can you tell us, off-hand, how that reserve is itself sub-divided between the headings? This is money voted by Parliament. It must, therefore, be appropriated to various heads of expenditure within the service. Does it remain so appropriated in the hands of the Region when they have made a reserve of it?—Is there not some misunderstanding there? This reserve, and all the advances of the Boards, come out of simply two subheads of Vote, one for England and another for Wales. There is a separate subhead for Boards of Governors, so that there is no question of allocating their reserves under various subheads. It is simply one figure.

3302. It is simply money?—Yes.

3303. And in their hands it would be available to be applied to meet any increased demand in any subhead?—Yes, under any approval heading of the hospital authorities' expenditure.

Mr. *Diamond.*

3304. Within that year only?—Yes—only.

Mr. *Thomas Reid.*

3305. Does the Regional Board try to prevent an excess of expenditure by the management committees? Does it keep a check over them?—Oh, yes. In this system of monthly returns of the expenditure running throughout the year, one copy comes direct to us, and the other goes to the Regional Hospital Board; and it is the duty of the Board, in the first instance, to take up with the management committee excesses under any approval heading, to ensure that that will not mean an excess over the whole approved budget.

3306. So you consider that that is another case where you think the approval of the Regional Board is necessary?—Certainly some machinery must be there to watch the expenditure.

3307. You could not, from Whitehall, supervise this excess of expenditure?—I should not like to undertake it.

Mr. *Turton.*

3308. You said it was possible to allow a transfer from one subhead to another under the Treasury and Parliamentary regulations; but is it not a fact that until the 31st March of this year you did allow Regional Boards to use the saving in one subhead of expenditure to set off the overspending on another, and that that authority ceased on the 31st of March of this year?—With respect, I do not think so.

3309. I am only quoting from evidence which has been brought before this Sub-Committee, and which I think your Department has seen?—The initial financial regulations conferred upon the Boards power to agree transfers between one approval heading and another by Management Committees. At some point of time we withdrew that power from the Boards, and said that we would exercise it centrally. In the approvals of this year, we have said that we will exercise it jointly, at the revised estimate stage in the autumn, but we have given to the Boards a power to agree to transfers earlier without reference to us, if they are satisfied.

Chairman.

3310. You went the full distance first of all; you withdrew the full distance in the second place; and now you have taken up an intermediate position?—Yes, Sir.

Mr. *Thomas Reid.*

3311. Why did you withdraw the original system?—That is part of the record. In the very first period of months of the hospital service there was a supplementary estimate of £22 millions, in 1948-1949. In 1949-1950 there was a supplementary estimate of £45 millions for the hospitals, part of the enormous supplementary of £89 millions; and as a result of that, various measures of centralisation were imposed. It was part of that process.

Mr. *Turton.*

3312. I think the Sheffield Regional Hospital Board stated in evidence that up till the 31st March, 1951, they were allowed to transfer a saving under one subhead to another, but that from that date the Ministry alone can approve such transfer, the varied procedure being designed to secure economy. That is not accurate, is it, because now you have a dual power of control: the Regional Board and the Ministry, acting jointly, from the 31st March, 1951, can approve such transfers?—That is so. I am not in any way impugning whatever evidence they gave, but at that time they had not seen what we proposed to have for 1951-52.

Chairman.

3313. It was correct when it was stated, but it is not correct now?—That is so.

Mr. *Turton.*

3314. But in fact the change took place on the 31st March, 1951?—Yes. Well, we put this as one of the features which we had in the budgetary discussions in March.

Chairman.

3315. We have spoken about the Whitley increases, and it might be a good plan to deal with this question of the Whitley machinery in parenthesis. There have been complaints that the employers side of the Whitley machine is really monopolised by the Ministry, and that that has put the actual employers, the hospitals, into difficulties. Are you aware of those complaints?—Yes, Sir. Mr. Dodds, who has succeeded me as Accountant General, was formerly Assistant Secretary to the Whitley division, and this is his own particular piece of work.

3316. Could you tell the Sub-Committee about that, Mr. Dodds?—(Mr. *Dodds.*) Yes, Sir, we are very familiar with that sort of complaint. I think possibly it may have been a little exaggerated. It is not the case that the Ministerial representatives monopolise the management side of the councils, but the Regional Boards certainly have felt that they ought to have the larger representation compared with the Ministry, and that is a point which is now under discussion with the Boards; there are meetings proceeding and the matter is not finally settled; but I would like to say that the Ministry have felt throughout that the Minister ought to be strongly represented on those councils because the bill for salaries and wages is of course a very substantial proportion of the hospital bill; it is about 60 per cent.; and it is therefore felt that the Ministry should have strong representation in the interests of public economy, and also in the interests of keeping the salaries and wages in the service in reasonable line with other parts of the public service.

3317. I have seen in the Press that the result of the present system has been that the Whitley decisions have tended to be treated not as an actual rate but as a minimum rate. Is that not correct? And that certain hospitals have been offering higher payment than has been agreed by the Whitley machine?—By and large, the Whitley rates are followed in the hospitals. We have had a number of cases brought to our attention where excess payments have been made, and just two days ago the Public Accounts Committee was enquiring into that point; and in the evidence given on behalf of the Department we told the Public Accounts Committee that we were aware of those cases, and that it was the intention of the Minister to lay before Parliament a regulation which would tighten up the control of those cases.

3318. Is it not really an inevitable result of having the Minister in control of the

employers side while the hospitals are in fact the employers? You said yourself that the Whitley machine tends to bully the hospitals. If you gave the hospitals more responsibility, they might treat the decisions binding upon them?—Yes. Although the hospitals may feel that they have not sufficient representation on the Whitley councils, they are strongly represented. It is not the case that the Whitley councils consist of ministerial representatives alone. I do not know whether any actual figures would be of interest to the sub-committee?

3319. What kind of figures?—The sort of composition of a Whitley council.

3320. I think we have had some of those, but it is quite clear that there is a very substantial ministerial majority?—Oh no; a typical Whitley council would consist of six Ministry of Health representatives, two representatives from the Department of Health for Scotland, making eight in all; it would consist of four Regional Hospital Board representatives (including Scotland), two representatives of the Boards of Governors, who are also representing the hospitals, and probably six to ten representatives of the L.C.C. and the local authorities associations and the executive councils, who also have a substantial interest in salaries in the National Health Service. So that it would be very exceptional for the Ministry to have a majority. There is a strong representation, but not a majority.

3321. At any rate, this matter is very much in your minds and there are discussions on that proceeding?—Very much so.

3322. With a view to modifying the present set-up?—Yes, it is all under discussion with the Boards at the moment.

3323. Now turning to the question of capital expenditure, I wonder if you could tell us this, Mr. Edwards. We have had a great deal of complicated evidence about the system of giving approval to capital schemes. Could you tell us clearly what exactly the method is, avoiding, if possible, the use of the word "approval" which seems to mean different things in different contexts?—(Mr. *Pater.*) Might I deal with it?

3324. Yes?—I think one must distinguish first between two different processes on the approval of capital works, which tend to get a bit confused. The first is approval, as it were, for the purposes of the hospital service; and the second is approval for the purposes of the national control of capital expenditure. I am thinking there not of the investment programme, but of the control of building. On the first side, our rule is quite simple; the capital expenditure is a matter for the Regional Boards and Boards of Governors, not for the management committees. The Regional Board is at liberty to spend on actual individual work projects up to £10,000 without coming to the Ministry; over that amount, each individual project must come to the Ministry for approval. The same is true of the Boards of Governors of the teaching hospitals. That is the position for the purposes of the hospital service. For the purposes of building control, all proposals over (I must confess that the exact figure escapes me for the moment) I think it is £1,000, have to come to the Ministry for approval; and we are then engaged in this task of going through the national building control machine to get starting dates and so on. So that for the purpose of the hospital service the limit for each individual scheme is £10,000; and for the purposes of the building control the limit is £1,000.

3325. At the beginning of the year there is, of course, a capital estimate submitted, and that estimate has to be approved as any other estimates; and that would be approved in complete detail, I imagine?—Yes. I was going on to that. The next point was that. That is the position on the approval of individual schemes. In addition to that, there is the control of overall expenditure on capital works through the approval of the overall capital estimate. There, our practice has differed as time has gone on, and as both we in Whitehall and the Boards at their end have gained experience of working this scheme. What I am now going to describe is what is the present practice, which was not the practice in 1948-49. The present practice is that we learn from the Investment Programmes Committee and from the Cabinet what is the building ration for the hospital service.

3326. That is in the nature of a block grant really, then?—It is in the nature of a paper statement of the amount of capital resources that we have to be able to use up during the year in terms of money. It is capital resources expressed in terms of money.

3327. Yes?—We then divide that into three unequal sums; the first and largest sum is what we will allow the Regional Boards and Boards of Governors to spend themselves. The second and smaller sum is a separate share, set aside for what we have christened "large schemes," that is to say capital works which will cost more than £50,000, whose construction is probably going to extend over two or three or four or even more years, where some kind of inter-regional priority has got to be established, because we are dealing with such small amounts. So we have this second sum which we devote to those large schemes, trying to balance up the relative claims of Coventry and Plymouth, we will say. Then we have a very small third sum which we

keep in reserve, on paper, to meet any unforeseen catastrophe; the sort of thing we have in mind is if, for example, an orthopaedic hospital is destroyed by fire.

3328. What is the total of these sums?—In round figures, £10 millions.

3329. And how would the three divisions work out?—Roughly, I think it is £8½ millions, £1 million and £½ million; that is the order of it.

3330. Yes; thank you?—Then, in order to arrive at the particular schemes to which these various amounts should be devoted, we have asked the Boards, and they have, of course, for their own purposes, acquired over the past three years a fairly good idea of where the capital expenditure is most needed in their Regions, and they have produced programmes giving the priority of the various jobs that want to be done. They produce for our approval a list of the works, calculated to cost in total the ration that we have given them, and if they wish including as an omnibus item, within that total, an aggregate of the small schemes under £1,000. That list is finally approved, some time around this part of the year, perhaps even a little later, but as in the case of maintenance estimates the Regional Boards concerned know pretty well what it is they are going to be able to spend money on. There are only details left for approval, at any rate. We also get from them their claims within the central pool of the larger schemes I have mentioned; we get those as early as we can. The request for all this information was made in August of last year for the year 1951-52, and we have, during the winter months, been working on the information they have given us, and we have picked out the large schemes which we think we can go ahead with. We have told the Boards concerned what those are, and we have asked them to get on with preparing detailed estimates and so on.

Chairman.] Thank you very much indeed. I think that makes the position much clearer, Mr. Pater.

Mr. *Turton.*

3331. I am not yet clear about it. I have the picture when it is initially fixed, but then if, at the end of the year, in the case of the first-category scheme, the Regional Board has not expended its share of the £8½ millions, is it allowed to carry forward that expenditure into the next year?—Unfortunately, no; and I am not sure how it would help them, because the figure here is not really cost at all; it is the share of building resources that are allocated to this particular service by the Investment Programme Committee.

3332. My second question, which is really germane to that, is this: Are they allowed to switch from one approved scheme to another approved scheme without coming back to you—and presumably they have a table of approved schemes?—If the scheme is a small one, yes.

3333. Under £1,000?—Under £1,000, yes.

3334. But if it is over £1,000 and under £10,000, are they allowed to switch from one approved scheme to another?—I think the answer is "No"—yes, I am told the answer is "No".

3335. Would it be difficult to give them consent, and would it have any dangerous implications?—I think there would have to be some limit. Whether the present limit is too low or not, I am not sure; but the difficulty is that the sums with which we are dealing are in aggregate so small that the Board, if it is given a free hand, might find that in fact it was under pressure to devote capital to less urgent schemes to the neglect of more urgent schemes.

3336. But surely the Regional Hospital Boards are best able to know where a shortage of labour and materials is likely to occur in their Regions, and it may be that one scheme which was eminently desirable cannot be completed in the financial year, but that another scheme which is in a secondary category could be, because there was not a great shortage of labour and materials for that scheme?—I am not sure that they are in the best position to know where the shortages are. I am not sure that they are in the best position to know what other demands are going to be made on the labour and materials available; that is the difficulty.

Chairman.

3337. Are you free agents in this matter?—In which matter, Sir?

3338. In this question of transfer between one scheme and another. It is really Ministry of Works policy, is it not?—We are not free agents, because for any individual scheme costing more than £10,000 we ourselves must have approval from the Treasury.

3339. I am only for the moment dealing with schemes costing up to £10,000—ignoring all schemes above £10,000, of which we have had no complaint at all. Are you in complete control so far as those schemes are concerned?—Oh no, because we run into the building control machinery at once.

3340. You say, even up to £10,000?—Yes, anything over £1,000.

3341. As regards anything over £1,000, you are not free agents, because you have got to get outside sanction from another department, the Ministry of Works?—Yes.

we have to secure the authority of either the regional body or the central body which is charged with the allocation of starting dates for all building work.

Mr. *Turton.*

3342. But surely you have already got that sanction up to the share of the limited total for that Region?—I think we are confusing two things, the control of the total amount, and the control of the individual job. We have control, of course, through the total amount of cash expenditure; but over and above that we have this second set of controls on the actual undertaking of the individual job arising out of this building control machinery; and that is where we run into trouble.

3343. Do you think that the bar to transferring from one under-£10,000 scheme to another is causing delay and difficulty to Regional Hospital Boards?—Oh yes, certainly.

Chairman.

3344. You are aware that fairly substantial sums are failing to be spent because of this difficulty?—Certainly.

Mr. *Diamond.*

3345. Do you think there would be more delay, leading perhaps to chaos, if each individual scheme were allowed to be switched in this way, and new schemes attempted to be started calling for materials and labour resources which might not even exist?—I think there would be complete chaos, especially now that the Defence Programme is under way.

Chairman.

3346. As far as this type of capital expenditure is concerned, is it almost wholly bricks and mortar and building labour, or are there cases in which substantial quantities of other scarce materials are required?—There is a fair consumption of steel and timber.

Mr. *Thomas Reid.*

3347. And equipment?—And equipment, yes.

Chairman.

3348. Would it be possible to differentiate within these under-£10,000 schemes, to say that a substantial class of them is purely building?—I think the difficulty arises not so much on materials as on labour, and therefore a distinction between building and other schemes would not assist very much.

3349. But, as far as labour is concerned, if you are within your grant total, you would not be making demands which could compete, provided that that total is a proper one given to you in the first place?—Is not the position this, that in a particular place at a particular time—say Birmingham in October—you might be competing for labour very seriously?

3350. So that you really think you would be in difficulty in pressing the Ministry of Works to give you greater freedom?—I do.

Mr. *Turton.*

3351. Is there any contact between the Regional Hospital Boards and the Regional Offices of the Ministry of Works in these matters?—There is no formal and direct contact, no; that is to say, it is the Ministry of Health's own Regional Officers who conduct the argument on behalf of the hospital service in the Regional Building Committees, but there is plenty of informal contact, of course.

Mr. *Thomas Reid.*

3352. In the case of these small works, is it necessary that a petition to the Ministry of Works should come through you? Could not the Regional Boards deal direct with the office of the Ministry of Works to get sanction?—Regionally?

3353. Yes?—That, I am afraid, I could not answer off-hand.

Chairman.

3354. You are the sponsoring Department?—Yes.

3355. You would have to be in on it?—Yes, but I think that is not really a matter which I know enough about or which is in our hands.

Chairman.] Yes, I appreciate that.

Mr. *J. Enoch Powell.*

3356. I am not quite sure about the significance of the dividing line of £10,000. I understand the £1,000 dividing line, that is to say the Ministry of Works dividing line between those schemes in respect of which larger estimates are required and those in respect of which they are not required; but what is the significance of the £10,000 dividing line, because I understand that both above and below the £10,000 dividing line Ministry approval for the substitution of one scheme for another has to be obtained. Does the £10,000 dividiing line mean anything at present?—It means very little indeed, but it does mean two things. Perhaps I might make one preliminary remark: The £10,000 limit was fixed in the optimistic expectation that the day would come when building control would vanish, and that the £10,000 would then be the only dividing line between schemes needing Ministry approval and schemes not needing Ministry

approval. That, of course, has not happened, and so that reason for the £10,000 limit has gone. But the underlying principle on which the £10,000 was based was to fix some sort of figure which would roughly divide the schemes between those which were not likely to involve matters of hospital planning policy and those which were.

3357. But at present ministerial approval, both in principle and for asking for a commencement date, is required above and below £10,000?—Yes.

3358. So that it is meaningless in administrative practice at the present time?—Well, except that we ourselves have to seek Treasury approval for all schemes of over £10,000.

Mr. *J. Enoch Powell.*] Yes; so that we have a £1,000 Ministry of Works dividing line, and a £10,000 Treasury dividing line.

Mr. *Turton.*

3359. We have been told by one Board that the result of this rather inflexible system is that 15 per cent. of their capital expenditure budget cannot be spent. Is that an unusual proportion do you think?—I am afraid that is not a question which I can answer off-hand. The figures could, no doubt, be looked up, but I am afraid I have not the information available here. I know that there are proportions of capital of most Boards left unspent at the end of the year, but I do not know the size.

Chairman.

3360. It does not shock you; and you know it is fairly substantial?—I know that in some cases it is fairly substantial, but it is their own fault in many cases for being so slow off the mark at the beginning of the year.

Mr. *Turton.*

3361. They say that is the fault of your Department and your inflexible system?—Both contribute to this unhappy state of affairs.

Chairman.

3362. Are you taking any steps to improve the situation?—Well, the system that I have tried to outline at the beginning is a distinct improvement on what has happened so far, and I think that at both ends, both in the Region and in Whitehall, we are both of us getting used to the processes through which we have to go in order to get a capital programme flowing smoothly.

3363. The system is getting more flexible by use, is it?—Yes, we are all learning the rules rather better.

3364. But, as far as your Department is concerned, you would not be worried by some recommendation that everything should be done to make this system more flexible still?—No, indeed.

Mr. *J. Enoch Powell.*

3365. Am I right in thinking that at present there would be no practical effect in substituting one scheme for another over the £1,000 limit? Between £1,000 and £10,000 there would not be a gain in time or in any other way to the Regional Boards?—If that could be done, there would, of course, be a gain in time; but that would be a question, would it not, of giving to these particular people a liberty from building controls not enjoyed by anybody else?

3366. But from your point of view?—From our point of view, no.

3367. You say this Ministry of Works £1,000 limit is nothing whatever to do with the Ministry of Health?—Yes.

Chairman.] I do not think it is fair to put to this witness questions on Ministry of Works policy.

Mr. *J. Enoch Powell.*

3368. I only wanted to elicit that there is no Ministry of Health policy involved in this?—Perhaps there is one small point I should mention. On these schemes of under £10,000, our general principle is that we do not examine them as individual schemes in detail. We simply let them go through, as far as we are concerned. But we do get a list and brief description of what these schemes are for our own purposes, as distinct from Ministry of Works purposes, from the Regional Boards, and we do get our technical officers (that is to say, not only the architects and the engineers but also our local staffs) to look through these lists and pick out any which, because of the nature of them, it seems desirable to look at in detail, from the planning point of view. So it is not completely true to say that we should not mind if there was complete freedom between £1,000 and £10,000; there might still be a few odd individual schemes about which our technical experts would say: "We should like to see them when the detailed schemes come along, because of planning problems".

Mr. *Turton.*

3369. But, under the present system, there are a large number of schemes approved—far more than are carried out in the current year?—That is approval in the "Pickwickian" sense.

Chairman.

3370. You are not the bottle-neck; you very often look like it, but it is in fact not your approval?—No. (Mr. *Edwards.*) Until the current year, capital expenditures on the

hospitals and the maintenance expenditures were in one subhead of the Vote, so that if there was underspending of capital, from my point of view I was happy and relieved, because there was almost always likely to be overspending on maintenance expenditure. The practice of Parliament is not to give us any relaxation of control because throughout the Vote this year capital is now to be distinct from revenue, and they are in different subheads. In the case of small sums like Subhead B.9 " Bacteriological Service ", capital expenditure is completely separate from current.

3371. But that is, of course, for quite special reasons outside the ambit of your Department?—It is a result of the recommendations of the Crick Committee.

Mr. *Turton.*

3372. Has there been any cut in capital expenditure this year?—(Mr. *Pater.*) Yes. In the actual estimate there has been a cut of £1 million—from £11 millions to £10 millions.

Mr. *J. Enoch Powell.*

3373. I take it that the sums which enter into the capital figure appearing in the estimates for a year have no necessary relation to the value of the work undertaken in that year? What I mean is this: Are the sums appearing in the estimates an estimate of bills on capital account which will have to be paid within that 12 months or something else?—(Mr. *Edwards.*) That is part of our problem, that the hospital authorities' accounts, both capital and revenue, are on income and expenditure. We have to translate that into cash requirements for the year, and the Vote is concerned with the cash to be spent within the year.

Mr. *Diamond.*

3374. That does not present a particular problem so far as capital expenditure is concerned. There is not a great deal of difference between the hospital authorities' accounting and your accounting as far as capital expenditure is concerned?—The Northern Region said they had no doubt that they were certifying sums due under contracts much quicker at the end of the year than the beginning; in other words, they were running down their creditors very much quicker and that was disturbing the amount allowed for capital.

3375. Is there a clear and easily understood (by the Regional Boards) dividing line between capital expenditure and revenue expenditure in terms of replacements, maintenance and so on; because we have had evidence that, as they had had no approval to a particular piece of work which might have fallen under the category of capital expenditure or maintenance, they used their own staff and called it maintenance, although it was indicated to be capital, on a small scale?—That could not, I think, happen now. In the early periods we had not issued a definition; now we have defined with some precision the difference between the two, and we could put in that circular.

Chairman.

3376. I think we would like to see that?—If you please.

Wing Commander *Geoffrey Cooper.*] Relative to this question of capital expenditure, referring back to evidence we had at Questions 1716 to 1717, it is suggested there that there was difficulty found in spending the budget allowance on capital items; and the case given to us there was that out of some £600,000 which they were granted as an allocation, they lost some £100,000 in the course of a year, because they could not get the schemes approved in that period. Can you comment on that, and let us know to what extent that is the general experience——

Chairman.] I think we had that before you came into the room.

Wing Commander *Geoffrey Cooper.*] That was covered, was it?

Chairman.

3377. Yes. Now, as far as estimating in the narrow sense is concerned, have any members of the Sub-Committee any questions to ask? If not, we might turn to the question of the accounts. I have one question to ask you, and that is with regard to the recommendation that hospital authorities' accounts should be published. At the moment I think that the hospital accounts are not published?—We have no objection; indeed we would strongly support the suggestion that there should be local publication of hospital accounts. We think that there should also be coupled with them the publication of the auditor's report. That is the suggestion which the Treasury and the House authorities make. That puts us in some difficulties, because auditors' reports are rather free in their language. They are not designed for public consumption; but since that is the requirement which is imposed——

3378. Is that a statutory requirement?—There is nothing in the Act about it. We consulted the Treasury and informally the House authorities, and that was their suggestion.

3379. But if you had difficulty about including the auditors' comments, could you not ask for two sets of comments, one designed for the private use of the Board and the other for publication?—Well, we have it in mind that it might be desirable to amend the Statute at a suitable opportunity on this point; and I think that, as a result of this requirement, auditors will be a little

more careful in the way they draft some of their comments, because they will understand that in the future, until the Statute is amended, their reports may be published. That is as far as we have looked into it. We have satisfied ourselves, by informal means, that there would be no objection to the publication of these accounts in advance of their publication to Parliament.

3380. But the only publication to Parliament, surely, is the very much condensed Statement?—Indeed, yes. I think they would not object to local publication of individual hospitals' accounts, because it really did not conflict at all—but they do impose a condition that it shall be coupled with the auditors' reports.

Mr. *Thomas Reid.*

3381. What is the objection to the publication of the auditor's report? In government accounts all sorts of strictures are passed by the Comptroller and Auditor General; does that do any harm?—No, Sir. You understand the Comptroller and Auditor General is completely protected against any possible action for libel; whereas ours would not be.

Chairman.

3382. I think we could understand that if the unprotected auditor knew that he was going to have his comments made public; it might severely cramp him in carrying out his duties properly?—Yes.

3383. Therefore I suggested to you that there might be two sets of comments, one for the private use of the Board or the Committee, and the other set intended to be for public consumption?—Yes, I am obliged to you, Sir. Something of that kind will have to be worked out.

3384. Subject to that, as far as you are concerned, you have no objection to the publication of the accounts?—No. Indeed, we would welcome it.

3385. Do you know of any objections on the part of the hospitals and others?—No, Sir, we are not aware of any. We have had many requests from them: "Could they publish them, and would Parliamentary privilege be affected if they did publish them?"

Mr. *Diamond.*

3386. But of course, unless they were published before their publication to Parliament, they would tend to be so out of date as to lose a good deal of their usefulness?—Yes, indeed.

Chairman.

3387. Turning to the question of audit, the auditing of hospital accounts is done exclusively by the Ministry auditors, is it?—Subject, of course, to the test of the Comptroller and Auditor General. He has complete power to go as far as he wishes. I do not think he goes very far; he mainly relies upon the audit of the Ministry auditors.

3388. The evidence which reached us was only concerned with the auditing done by auditors appointed by the Ministry, who work on hospital accounts and nothing else?—That is so.

3389. I was not aware that the Comptroller and Auditor General did carry out any detailed audit of hospital accounts?—I think you will find that, in his comments in the summary accounts, he will refer to various test checks which he has made; but he certainly relies very largely on seeing all the reports of the Ministry's auditors.

3390. Now, when you are carrying out the audit of a group's accounts, you short-circuit the Regional Hospitals Board completely?—With respect, I should have said not. We send a copy of the Annual Report to the Board.

3391. But after the audit is completed?—Yes, indeed.

3392. You do not bring the Board in in any way during the actual audit itself?—No, Sir, we do not.

3393. Have you ever considered whether that might not be desirable?—Well, Sir, we have had representations from some of the Boards that they should themselves conduct the audit of the Management Committees.

3394. Yes, I was coming to that?—I think the main objection to that is an administrative and practical one, that the audit of the hospital management committees, is only one part of the service. We, as a Department, have to ensure that the Boards themselves, and also the executive councils, who are similarly issuing our moneys, are subject to audit. The system is to have one uniform system of audit applying to the hospital management committees, the Boards and the executive committees. That gives you a reasonably large and manageable audit field. The reason which the Boards advance for having the audit of the management committees in their own hands is that this would give them a lever for financial control of the management committees. Well, Sir, we have to be a little watchful about that; it is natural that the Boards want to extend their powers over the committees. We, as a Ministry, are equally interested to see that the management committees retain to every legitimate degree their own autonomy and freedom.

3395. Is that really quite the question? The control has got to be exercised by someone, and it is a question of whether

it is going to be exercised by the Ministry direct or by the Ministry through the Boards?—Yes, Sir; now, come back to my practical reason, that to make one uniform audit field you want to have the audit of the management committees done by the same people who do the audit of the Boards and the executive committees. May I add that I am myself somewhat conscious of a good argument by the Boards that they may sometimes be kept by a Committee somewhat spare of information as to how the management committee is getting along. It is the same sort of trouble which we have had over the years in local government too—the relationship between the county councils and the district councils, where the district councils are doing delegated services. They need some right of inspection of the books. That is a different problem from necessarily having an audit; and it might be necessary to have something of that sort without an audit.

Mr. *Turton.*

3396. Earlier today we were discussing the allocation of global totals to hospital management committees, and you said, in reply to me, that it would be quite impossible for the Ministry to carry that on because they had no detailed knowledge of the hospital management committees' accounts, and that the Regional Hospital Boards had that knowledge. Now that we come to audit, it appears that the Hospital Management Committees' accounts are audited by the Ministry of Health; the Regional Hospital Boards do not see those accounts for some considerable time; and therefore in fact a detailed knowledge of the accounts is possessed earlier and in more detail by the Ministry than by the Regional Hospital Boards?—No, Sir. With respect, I do not think that is quite the position. Audit, after all, is only one instrument for making one self cognisant of the financial position in the first instance. The Boards are dispensers of cash in monthly advances to the committees. They get in that way a current account of the position of the committees; and it is only, I suspect, in a few cases of difficulty and friction, when the Boards are saying: "Give us some further powers to obtain knowledge of the accounts of the committees". That is a very difficult question of policy.

Chairman.

3397. May I interrupt you? We have seen two Regional Boards; they were chosen at random; but one of them said emphatically (and the other, I think) that they felt that they were kept out of the audit, and would like a good deal more finger in the pie. We rather assumed that that feeling was fairly general. I gather from what you say that there are other cases?—We have had certain representations, but I would not like to imply that all the Boards are pushing this; the Sheffield Board certainly did; they made a representation of that kind to me in the budgetary discussions, but I do believe that that is the same trouble as the county councils have with the district councils on delegated services—simply a right to see the books, which is very different, indeed, from conducting a detailed audit.

Mr. *Diamond.*

3398. I was impressed by the evidence which came before us, that there were two respects in which the employment of an auditor gave great benefit to the employer: first, that you got the information as it was arising, as it was being made clear, and therefore that if any question of alteration of instructions or more detailed control was necessary, that decision could be made immediately; and secondly, you became aware not of things which were going wrong, but of how things were going right; just in the same way that an auditor comes in and examines a lot of things; he does not confine himself to finding out the things which have gone wrong; and although he may make written comments on things which are going wrong, he would be in the habit of reporting to his employers the general way things are going. I have been impressed by your evidence this morning of your Department's desire to give considerable control to the Regional Boards; and they would be able to do two things which clearly, on your evidence this morning, they cannot do at the moment: (*a*) know what is going wrong as it is going wrong—because you told me that they only know that after it has gone wrong; and (*b*) know the things which are going right, because that information would only reach the auditors' employers in verbal reports?—Firstly, we send a copy of the audit report at once; it does not wait until we get the comments on it; but that is only one instrument by which the Boards know. Almost all the Boards have monthly meetings with their finance officers on the management committees. They do not rely upon audit reports for knowledge of how things are going right; and then they are very much concerned with the monthly returns of expenditure, and are charged with the duty of making enquiries whenever matters arise as a result of those monthly returns. They are not relying on the audit weapon.

Chairman.

3399. Can you tell us what sort of number of auditors are employed by you in the country as a whole? Do you allot them to Regions?—They are stationed in districts throughout the Regions.

3400. So that in fact they are already localised?—Yes. The total staff in the

Regions is 270; that is in England and Wales.

3401. And they are split up in the groups between Regions?—Yes.

3402. And there would be something like 14 or 15 in each Region, I suppose?—I suppose so, yes, Sir; and of course they are responsible for all these audits of boards, executive councils, management committees, and also Moss-side and Rampton, which are technically run directly from here, are audited by them.

3403. Would the whole staff in the Region be engaged on one particular audit, or would they be broken up on several audits?—I think they would probably be broken up.

3404. So that probably, at any given moment, there is a group being audited and there is some scope for connection between the Regional Boards and the auditors of Regions. I understand your sense of responsibility, but there is a responsibility on the part of the Boards too?—I have not heard it suggested that there is any difficulty in informal connection. What these Boards have suggested, when they have made the point to us, is that they should appoint and control the audit of the management committees.

Chairman.

3405. In the case of Sheffield we were told that the management committees account for their expenditure direct to the Ministry and not to the Regional Board.

Mr. *J. Enoch Powell.*] The South-Western Metropolitan Regional Board said that in fact in one case of waste it took them a year to hear of it; and they said they had to fight the Ministry of Health for copies of the auditors' report.

Chairman.

3406. Could we have a comment on that from the witnesses?—I certainly would not wish the Sub-Committee to think that this is the normal position. It is not in my mind as to what this case was, but I am not aware of any difficulty or delay in the sending of reports. This may have been part of the teething troubles in the early days.

Mr. *Diamond.*

3407. Your main argument against the employment of the auditor by the Regional Boards was one of general good administration, and you could not get useful audit boards concentrating only on the audit of management committees. In view of the number of auditors and the likely number in each division, if you were to exclude Regional Hospital Boards and executive committees from the scope of certain of the auditors, would not there be left sufficient work to make it a reasonably efficient audit group?—I have no doubt you could make sure, but it does seem a more effective use of manpower to have one audit service. It is a very important aspect to have a great diversity of work; the more you confine the audit service to a particular type of work, the more they lose interest. That is one of the troubles we have in the hospital audit system; it is too much concentrated on one type of work to get the interest which they would get in district audit.

Miss *Ward.*

3408. You did say that there was no difficulty about informal contacts between the Regional Boards and the auditors. Have the auditors got any guidance as to cases where they feel that there is anything which would be worth while drawing to the attention of the Regional Boards, or is it just a matter of whether informal contacts occur?—I am not aware of any instruction that they should bring anything of particular interest immediately to the notice of the Regional Hospital Boards. If this Sub-Committee thought it worth while, I think there would not be the slightest difficulty in putting it to the auditors: there seems to be a hiatus which ought to be avoided. My own experience is that these auditors know the Regional Hospital Board Treasurers very well, and I would assume that they would mention any points of special interest under any audits they conducted.

Chairman.] I do not think we can carry this matter further now. I think the Sub-Committee do feel anxiety about this, and that the position is not altogether satisfactory, and that we are likely to put in a recommendation that there should be a change made. If you have any further thoughts on the matter, we might discuss it further on another occasion; but I think it is fair to tell you that we are likely to make a recommendation. Thank you very much, gentlemen.

The witnesses withdrew.

Adjourned till Thursday next, at 10.30 *a.m.*

THURSDAY, 7TH JUNE, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Mr. Diamond.
Mr. J. Enoch Powell.
Mr. Thomas Reid.
Mr. Turton.
Miss Ward

Mr. F. L. EDWARDS, O.B.E., Finance and Accountant-General, Ministry of Local Government and Planning, Mr. J. E. PATER, an Under Secretary, Hospitals and Specialist Services Division, Mr J. P. DODDS, Accountant-General, Mr. W. O. CHATTERTON, a Deputy Accountant-General, and Mr. A. J. F. DANIELLI, O.B.E., M.C., a Deputy Accountant-General, Ministry of Health, recalled and further examined.

Chairman.

3409. We dealt fairly extensively with the more strictly financial side of the matter last week, and I hope this week we may be able to deal rather with the organisation on which this financial question depends. First of all the Sub-Committee, in the course of the evidence which it has received, has been told on a good many hands that there is a tendency on the part of the Ministry to centralise the organisation of the hospitals at the present time. Could you say whether in fact that is deliberate policy or the accidental outcome of current events?—(Mr. *Pater.*) I would have said it certainly was not deliberate policy, and without chapter and verse I would be very reluctant to accept the statement that it was happening.

3410. You deny it altogether. We have had some evidence of that. I think you have seen the evidence given to us by the regional boards and the hospital management committees, at all events?—I have not myself seen the detailed evidence, no.

3411. We have received a number of comments, and in particular we were told by the chairman of one regional board that he had made a protest at a meeting of regional board chairmen at which the Minister was represented, and all his colleagues indicated approval of his sentiments, that there was a tendency to over-centralise?—That does not surprise me. If I may put it this way, the object of the organisation is two fold. It is to pool together into a single service what were a large number of unrelated hospitals, and it has simultaneously to do that with as much decentralisation as possible. There is, I think, an inevitable tension between those two objectives all the time, and it must be largely a question of opinion whether at any given level or at any given time there is too much centralisation, in order to get the services together, or too little centralisation. The tendency of the regional boards is naturally—I do not think anyone is to blame; I think it is human nature—to suggest that the Ministry attempts to centralise too much and to control their activities too much. The tendency of management committees is to complain that the regional boards are guilty of exactly the same error.

Mr. *Thomas Reid.*

3412. The system of administration through regional boards and management committees is totally different from the system of direct administration from Whitehall, is it not?—Yes.

3413. In fact the whole system is one of decentralisation?—Yes.

3414. On matters of detail these regional boards and hospital management committees naturally wish to have their own way, and not be interfered with?—Certainly.

3415. I take it, from the evidence you have given and we have heard, that really you wish to put as much responsibility as you possibly can, without destroying the scheme, both on hospital management committees and regional hospital boards?—That is so.

3416. You have no wish to grab for power in Whitehall?—Certainly not. Indeed I would say that on many occasions we have defended the independence of management committees against regional boards.

Chairman.

3417. Do you regard that as really your function? As between regional boards and management committees is it not possible that the right thing is to allow them to adjust their respective relations, you standing aside?—I would not have thought so. I would have thought the Minister's responsibility extends to seeing that decentralisation does not stop at the regional level.

3418. That is the Minister's policy as regards organisation generally, that they have got a direct responsibility to the management committee as well as an indirect responsibility through the regional board?—Yes.

Mr. *J. Enoch Powell.*

3419. Does your experience so far lead you to think that the regional boards themselves perform a useful function?

What I mean is this: they are bodies which in a certain sense are representative, though of course they act as the agents of the Minister. Is the interpolation of a quasi-representative body between the management committees and the Ministry satisfactory or not necessary in view of your experience?—I would not like to say that a regional board with exactly the functions of the present bodies is essential, but I would myself believe that some form of regional body is essential for the planning of the regional hospital services.

3420. What sort of functions had you in mind which the regional boards have at present, which in your view they should not have, or vice versa—that was implied in your answer?—I am not sure I would like to go into that in detail, but the conception has always been that the regional board is primarily a body which determines what services are necessary in its area, in its region, and plans how those services shall be provided. If you did not have a regional board I think you would have to have some kind of regional advisory body to tell the Minister from its own local regional knowledge what was the best way of doing that job.

3421. Do you believe that there would be administrative advantages in substituting for the present regional board some body of an advisory character?—I think there would be both advantages and disadvantages.

3422. Would you compare the present organisation for its advantages and disadvantages with that of another Ministry in which the place of the regional boards in the Hospital Service is taken by a regional officer of the Ministry?—That is not a wholly accurate parallel, is it? I would have thought that there is no regional officer in a department carrying out the local planning functions, for example, of a regional board.

3423. If I might explain what I mean, if you take the functions of planning, since you have mentioned planning, the regional planning officers do exercise both an advisory and, I think, an executive function between the local planning authorities and the Ministry. They do perform that work of co-ordination in a region for which you say some regional body is necessary. It was that which I had in mind?—I am afraid I am a little hazy on the planning organisation, but my impression was that the sort of job which is done by the regional board is done on the town planning side really by the large local authority, not by the department's planning officer.

Mr. *Thomas Reid.*

3424. The county council?—Yes.

Mr. *J. Enoch Powell.*

3425. If I might try to make my point clearer, there must, I take it, be some such interposition between hospital management committees and the Ministry—you would agree?—Yes.

3426. It is a question, I put it to you, whether that interposed stage should be in the nature of a board of a quasi-representative character or whether it should be of a delegated ministerial character, like a regional officer. It was those two possibilities I had in mind?—If I might express an opinion, I myself would say that, if the present regional board disappeared, it would be necessary to replace it by both those things. Some of its functions would best be carried out by a regional officer of the Ministry with delegated powers, some by an advisory committee, but the point I was trying to make was that some sort of regional body would be necessary as well as anything the Department itself could provide by way of a regionalised officer.

3427. You would not object in principle to the separation of the advisory and executive functions, which at present are combined in the regional board?—There are advantages in having them combined. I would not like to say more than that.

Chairman.

3428. Are you aware that there seems to be some confusion in the minds of regional boards as to where they stand in this matter? They are at times in difficulty because they are not certain whether they themselves have the initiative in executive matters or whether they are merely carrying out ministerial policy in a more democratic sense. You are aware of that at the Ministry?—Yes.

3429. Are you considering any measures to try to get over that difficulty?—Yes, there are innumerable devices which make sure we know what is in their minds all the time. We have fairly regular meetings with the chairmen of regional boards, and with various groups of officers—the secretaries, the treasurers, the senior administrative officers and the medical officers. Meetings take place, generally speaking, monthly in all those four groups.

3430. I think your reply to Mr. Powell's question just now indicated that you felt here you were starting some new form of organisation?—At the outset?

3431. At the outset, that the regional board is something hitherto unknown to organisation in this country?—Yes.

3432. That is your view, is it?—Yes, I think that is so.

3433. You are not trying to model it on anything which exists now?—No.

3434. And you are alive to the difficulty of this dual role?—Yes.

Miss *Ward.*

3435. Can I just follow up the point you are making? It is really a new development of the policy of central government when in fact you say you have to defend, for instance, hospital management committees against regional boards, because if you go back to the days of, for instance, the county councils responsible for certain functions in relation to urban district councils, if my memory serves me rightly it was very unusual for a central government to take the part of an urban district council on responsibilities which are really overlooked by a county council, so that with the building up of this new Hospital Service central government has taken on a new or fresh responsibility really?—Broadly I think that is true. The administrative structure of this Service is something entirely new. I know of no parallel anywhere else.

Mr. *Thomas Reid.*

3436. I think this is rather important. I suppose you would agree that simplicity is to be aimed at in administration, and that "too many cooks spoil the broth". We have been told by one of the management committees that it would much prefer to deal direct with you because you know what you are talking about, implying that the regional board does not. The committee said it found it much better if it could deal direct with you. The dual procedure through regional board and management committee is, of course, clumsy. If all matters from management committees came through one of your officers not sitting in Whitehall would he not be able to decide on the planning, or is the idea that you want to rope in as many people as possible representative of all local interests and local feeling? Following up the question which Mr. Powell asked could you have an officer of your own on the spot dealing direct with the hospital management committees and cut out this dual system of administration?—I would myself suggest it is important in arriving at a plan for a region not merely to arrive at the right answer, but to secure the maximum of local agreement that it is the right answer. That I think can only be done by invoking the aid of some form of regional body.

Mr. *J. Enoch Powell.*

3437. Your last reply related primarily to planning?—Yes, I was thinking of planning.

3438. Would you not agree that some, at any rate, of the sense of delay, even of frustration, which appears to be felt by some hospital management committees might be avoided if they dealt direct with an organ of the Ministry which could answer their questions or give or refuse assent direct instead of indirect?—That is possible.

Chairman.

3439. Could you tell us what is the existing regional organisation of the Ministry, apart from the regional hospital boards?—We have in each region a principal regional officer who is an administrative officer, and who is concerned not only with the Hospital Service but with the other responsibilities of the Ministry of Health in the region, other services for which the Ministry is responsible.

3440. The region here being identical with the hospital region?—No, the Civil Defence region.

3441. It would be quite different?—Yes. In relation to the Hospital Service the officers' responsibilities are divided according to the hospital region. I am afraid I was rather confusing. The officers themselves are based on the Civil Defence regions, but in relation to the Hospital Service their responsibilities are parcelled out between them according to the hospital regions. In addition to that principal officer we have, not necessarily in each region, for each region a principal medical officer.

3442. Now you are speaking of the hispital region?—I am still speaking of the Civil Defence region, but there again the responsibilities are allocated according to the hospital regions. May I give you an example?

3443. Please?—There is a Civil Defence Region based on Reading, and our principal regional officer lives at the Civil Defence region headquarters at Reading. That is his base of operations. That is where his office is. But in relation to the Hospital Service his responsibilities extend not over the area of the Civil Defence region but over the area of the hospital region in which Reading is situated.

3444. The South West Metropolitan Region?—No, the Oxford Region.

Mr. *Thomas Reid.*

3445. Would it be fair to sum up the question like this, that if you cut out the regional board and handed over its functions to civil servants stationed in the area you would get more efficiency but you would lose contact with the unofficial population in the district?—Yes, I think that is so.

3446. You would think it is essential to rope in a great many representatives of the people in the area for the sake of getting popular support for the Service?—I would think that the very minimum is a regional advisory committee.

3447. The members are not elected?—No. They include representatives from the region; they are not elected representatives; they are appointed on much the same basis as the present regional board.

Mr. *Turton.*

3448. Surely the result of such a change would be to increase your contact with hospital management committees?—Yes.

3449. Would you not by that method obtain the local knowledge which apparently you lack at the present time?—Yes, Sir, that is possible. I am afraid I was not really addressing my mind to that point, but simply to the minimum which would appear to be needed in the way of a regional body.

Miss *Ward.*

3450. On the evidence you have given, without exaggerating in any way, is your information based on what is happening in several regions or have the difficulties as such which have arisen been concentrated on perhaps one or two regions? Is it the general view or is it a rather circumscribed view, if I may put it that way?—No, I think it would be fair to say that the sentiments expressed to this Sub-Committee by the regional boards' witnesses have been felt to a greater or lesser degree in all the regions, but certainly more keenly in some than in others.

3451. Is it perhaps due to personality rather than to weakness in structure?—That may be so.

Chairman.

3452. I think it might be convenient if we examined for a moment the actual functions of the regional boards. First of all, as regards finance, the boards I think have no real responsibility other than a purely advisory one as regards estimating?—(Mr. *Edwards.*) They are certainly charged with the duty of reviewing estimates and backing them when they submit them to the Ministry. They do not, of course, prepare them in the first instance.

3453. Their function there is purely advisory?—I think I can say, yes, if I follow the point you are making. They have to review the estimates when submitted to them, and, if necessary, amend, and then submit to the Ministry.

3454. They have to forward the estimates as submitted by the management committees, do they not?—Oh, no, Sir. They are fully empowered to make cuts.

Mr. *Thomas Reid.*

3455. Are you aware that some of the management committees—one at least—complained to us that in carrying out these functions the regional boards often showed lamentable ignorance of local conditions known only to the management committees?—Well, Sir, I suppose that sort of statement can always be made by a local body against a body of wider jurisdiction.

Mr. *Turton.*

3456. Do you not think that is true in a region such as the South-West Metropolitan Region which extends for a very long distance across England?—Yes, I should accept that there is more probability it might be true there than in a more compact region.

3457. Surely the fact that they have had to split that region into areas is evidence that they are not getting the local knowledge at headquarters?—Yes, I should accept that, but of course something in addition to local knowledge is needed in the functions of the regional boards.

Miss *Ward.*] Is it not also a function of the regional board to see that there is a uniform development or expansion of services?

Chairman.] I do not want to stop you, but I am trying to examine in their order the detailed functions of the regions. I had hoped members of the Sub-Committee would examine the witnesses now on the question of estimating, and then go on to deal with the others in detail.

Miss *Ward.*] I though that question did fit in here on the finance side, but I will leave it till later.

Chairman.] If it relates to the estimate function of the region, please put it. I do not want now to go on to the general planning question.

Miss *Ward.*

3458. I did not mean on general planning. I mean that an effective part of the functions of the regional boards would be, when the estimates come in, to see in fact whether the money was being spent relatively uniformly from the point of view of the Service?—I would certainly admit that as one factor, but I would not like it to go on record that the only thing we are desiring is uniformity.

3459. No, but uniformity in its proper sense and not in its narrow sense?—Yes. It is certainly desirable as one feature, in that one area should not get excessive development over another.

Mr. *Thomas Reid.*

3460. Following up Miss Ward's question, how can a regional board decide the standard of expenditure? It is only you, with a knowledge of the whole country and all the regions, who really can decide that. I think you told us that the north-east was completely backward compared with some other district. No area board could settle that question; it is only yourselves who can settle that. I am still pressing this question whether the regional

board is really necessary or competent to do those things?—Are there not two different features here? Miss Ward's point was one feature, that we would desire within limits reasonable uniformity within the region. We are well content, speaking for the country as a whole, with the job which the regional boards have done in that respect in these current estimates. They did make cuts in quite a number of management committees' proposals before they forwarded them to us in an attempt to ensure that no particular management committee got too far ahead with development money, but then of course we have a completely different and separate function to ensure that a particular region does not get ahead of other regions.

Mr. *Thomas Reid.*] Quite so.

Mr. *J. Enoch Powell.*

3461. You are referring primarily to capital estimates?—No, I was thinking primarily of maintenance expenditure.

Miss *Ward.*

3462. You could regard food as one item of maintenance expenditure, and one hospital might have a higher ideal in regard to food and thus want to spend more on it. Then you would get the complaint that in one hospital you were better looked after than in another?—Yes, exactly. In the maintenance expenditure there is a considerable item for developments. That has been a feature of the Service ever since the appointed day. It has been developing and improving, and in that respect of course the regional boards have to watch that it does not get lopsided.

Chairman.

3463. This function of the regional board could be perfectly well performed in a purely advisory capacity, could it not? You get an estimate coming in from a management committee. You say it is open to the regional board actually to cut that estimate?—Yes.

3464. Of course it would give exactly the same result if, instead of making a cut in the estimate, the regional board forwarded the estimate with its comments made in an advisory capacity, saying that in its opinion, having regard to the area as a whole, "This estimate is rather high, and this one is rather low"?—Yes, but you see what that would mean. Three hundred and seventy-eight management committees would all be sending delegates to Whitehall for about a fortnight before the beginning of the financial year, all arguing their estimates with us.

3465. Do you in fact not argue estimates at all with the management committees?—No, Sir, not with the individual management committees. We argue with the fourteen regional boards and the thirty-six boards of governors; then they go out to the regions and argue with the management committees.

3466. Do you never argue the estimates of a management committee with that committee direct?—I had envisaged that we might this year have such controversy between a regional board and a particular management committee that we should be the appellate tribunal, but it did not happen in any one case.

Mr. *Thomas Reid.*

3467. These regional boards cost a considerable sum of money, do they not?—Yes, Sir, but of course the boards also have functions of their own. They have executive functions in blood transfusion and so forth, and they have their own estimates to make. They are not merely planning functions.

Chairman.

3468. As regards capital expenditure, that of course is wholly controlled at the centre at the present moment, is it not, not because you desire it to be so but because that is Government policy?—Yes, Sir, in its global total, but based on proposals which are submitted by the regional boards. The regional boards, having considered the amounts which we are able to allow them, put up their proposals for the best use of that money.

3469. So that you say there the capital expenditure plan is merely one aspect of the planning function of the regional board?—Yes, Sir.

3470. On the question of establishments of management committees, I think we had better take that from the start. The original arrangement was that management committees were completely free to take on what establishment they thought necessary within their estimates. Is that correct?—Yes.

3471. After a time a ceiling began to be put on the establishment by action taken by the regional boards. Is that again correct?—(Mr. *Pater.*) You mean apart from the ceiling inevitably imposed by the estimate?

3472. Yes, the estimate was merely a financial ceiling?—In one of two instances I think that is so, and in a sense that is the inevitable effect I think of the ceiling provided by the estimate. I mean that the management committee, in justifying to the regional board its estimate of £X for salaries and wages, may be asked to say what are the numbers and types of staff for which the sum of £X is required.

3473. We were told it was a little more than that by the management committees whom we have seen. I think they all said they were not allowed to take on any extra bodies without the express permission of the regional board?—That I think is true in some regions, but not in others.

Mr. *J. Enoch Powell.*

3474. Would it be true to say that on the appointed day the staffs taken on by the hospital management committees were determined historically; they were the staffs the hospitals happened to have?—Yes.

3475. And that since then increases have been regulated by the regions either by means of the estimates or apparently by means of direct examination and criticism?—Yes, I think that is so.

Chairman.

3476. So far as the Ministry is concerned, has that been done entirely by the regional boards on their own initiative?—Yes.

3477. Or have you given any instructions that that should be done?—No, if there has been any deliberate restriction on the numbers in the establishment, that has been a piece of private enterprise by the regional boards concerned.

Mr. *J. Enoch Powell.*

3478. Are you satisfied that the regions generally over the country have, since the appointed day, exercised as much criticism, taking the general and fundamental view, of the establishments as they could have done or should have done?—I think it varies quite considerably from region to region. Some of them have, and some have not.

3479. Are you satisfied that the establishments at present are as rationalised as they could and should be?—No, Sir. That is why we have ourselves got various teams of people going round inspecting the establishments of regional boards themselves and of management committees, and reporting to us what they find.

3480. When you obtain the results of those investigations and have arrived at your decisions, presumably any reform instituted will be instituted from the Ministry and the regional boards will be merely, I will not say a post office but, agents as between the Ministry and the hospital management committees in carrying it out, except in the case of staff employed direct by the regional boards?—We try to do those things together.

Chairman.

3481. There were complaints from the two regional boards we have seen that in fact the Ministry, by direct instructions sometimes or certainly by advice to management committees, were stultifying their own arrangements as regards establishments. Do you know anything about that? For instance, a particular management committee might be advised to take on a dietitian, and the regional board might think there is no need for a dietitian, but the management committee, armed with the advice, and the express advice, of the Ministry that they ought to have one, are able in effect to override the opinion of the regional board?—I should like to be shown the evidence of that having happened.

3482. It seems very likely that it does happen, if you do in fact give advise direct to management committees about establishments?—To the best of my knowledge we have never done that, and certainly we have never done that without the knowledge of the regional board.

Mr. *Diamond.*

3483. Is it your practice to circulate perhaps printed information as to what in your view is good practice in hospitals generally as to the employment of a dietitian, a costing clerk or a stores clerk?—Yes.

3484. In a general way?—Yes.

3485. That information is distributed to all hospital management committees as representing the view of the Ministry as to what is good practice?—Yes.

3486. But not in any specific detail with regard to a particular person in a particular management committee's employment?—I should have hoped not.

Mr. *Thomas Reid.*] Have you issued an instruction that the way to get work done is to keep down staff and to keep down correspondence? That is too drastic, is it?

Chairman.

3487. May I draw your attention to a question put to the Chairman of the South-West Metropolitan Regional Board, and his answer? It is Question 1225. Mr. Cooper asked, "Would it not mean that the region would be given additional powers of resistance which so far the Ministry have not been inclined to let go out of their hands?", and the reply was, "A terrific source of expense is the fact that, although we are supposed under the powers the Minister has conferred on us to run, advise and really control the management committees, yet constantly during the last three years a stream of directions has been sent direct to management committees, nearly always productive of expense, and some of those directions have been sent without the regional boards knowing about them. There has been a little bit of a storm about that. Another matter that has been productive of great expense is this: we were not allowed to control the establishment committees of management groups". There is a chairman of a regional board saying quite expressly that you have—I would like to use a neutral word—interfered on the establishment question direct, and that the regional board has really been short-circuited?—With respect, I would still like to have chapter and verse produced of the occasions on which this has happened.

Mr. *Diamond.*

3488. You think that when he refers to the "stream of directions", he is referring to the general advice which you circulated to all interested?—There is no doubt at all that what he is referring to there are the general circulars which are sent out by the Ministry, all of which go to regional boards too, and the detailed application of which, in the case of a particular management committee, depends far more on the regional board than it does on the contents of the circular.

Miss *Ward.*

3489. Are copies of every directive sent to regional boards at the same time?—Yes.

3490. In fact you think that evidence does not reflect the policy of the Department?—It certainly does not reflect the policy of the Department, no. I should have said it was a rather highly coloured statement.

Chairman.

3491. Would it not be better perhaps to send these instructions, directives, advice and so on to the regional boards, leaving them to pass the advice on to the management committees?—That has been considered, and the conclusion reached was that it would not be advisable because the responsibility of the Minister is to produce a National Hospital Service. Any device of that kind would inevitably, I suggest, lead to the creation of fourteen regional hospital services.

Mr. *J. Enoch Powell.*

3492. Have you not then the situation that the function of exhortation is vested in the Ministry but the function of control is vested in the regional board, and have you not an unnatural division of functions resulting from that?—I am really disturbed by the word "control". I am not quite sure it is true to say that the regional board have control.

3493. They have control, I understood, in the sense that they can pass or not pass the estimates which involve the expenditure in response to the Ministry's advice?—Yes.

3494. So that the functions of advising and of dealing with the results of the advice are separate?—I would suggest they are not separate. The power of the regional board in relation to the estimates surely regulates the application of any piece of general advice. That is the way it has worked out.

3495. Would not the advice be more likely to be sound and practical if it were given by the same body which had to deal with its consequences?—That depends on the content of the advice. The advice of which we are speaking concerns questions of general policy, and it is advice of a general character.

3496. The effect of that advice, as attempted to be put into operation by the hospital management committee, is screened from the Ministry by the interposition of the regional organisation behind which you have already said you do not pierce?—We do not pierce for the purpose of scrutinising the estimates, but we pierce it for a great many other purposes.

Mr. *J. Enoch Powell.*] I meant for the purpose of the estimates.

Mr. *Diamond.*

3497. Before circulating this advice do you attempt on as many occasions as you can to get the views of what the regional boards might themselves feel about such advice before it is circulated? Do they share in any sense in producing the advice or is the normal practice that the first time they see the advice is when they see it being circulated to them at the same time as it is being circulated to hospital management committees?—As far as possible we consult regional boards in some form or other, normally through one or more of these monthly meetings to which I have referred, either of chairmen or of officers. In any individual case the amount of consultation will vary, and in some there will be no consultation at all because it is a question of Government policy which has just got to be promulgated. But for the most part there is consultation as much as possible, and indeed on many of them we try to get advice not only from the regional boards, the chairmen or officers, but from certain officers or indeed sometimes members of management committees, and of course from the boards of governors of teaching hospitals.

Mr. *Thomas Reid.*

3498. You depend a lot on your regional officers before you issue these circulars, do you not?—Yes.

3499. Or officials?—Yes.

Mr. *Turton.*

3500. Going back to the dietition, you did in fact send out a circular to hospital management committees recommending the appointment of dietitians?—As a general principle, yes.

Chairman.

3501. Could I draw your attention to a paragraph in the memorandum submitted to us by the Sheffield Regional Hospital Board? It is sub-paragraph (*f*) on page ten. It is headed, "Detailed control by Ministry", and it says, "The issue of circulars providing encouragement to hospital management committees to appoint officers such as supplies officers, group engineers, dietitians, catering officers, etc., leads to additional expenditure which may not be essential in the prevailing circumstances. To a less degree the same objection applies

to expenses involved in study, refresher courses, conferences, etc." There is the Sheffield Regional Board complaining in effect that its general supervision of the planning of hospitals within its area is being upset by the direct interference from the Ministry with hospital management committees?—There again I think the reference is to advice given in these general circulars, not to specific cases, not to correspondence on specific appointments. I am quite sure there has not been correspondence on specific appointments.

Miss *Ward.*

3502. I do not think that was ever suggested. It was on the appointment of dietitians as such, not on specific appointments?—Yes.

Mr. *Diamond.*

3503. Would you really be surprised if, as a result of your sending out advice, for instance, to a management committee regarding the appointment of a dietitian, that management committee, being wholly satisfied it was good advice, desired to appoint a dietitian, and the regional board, being wholly satisfied it was bad advice, refused to increase the estimate to provide for the appointment of that dietitian? Would that be really surprising, and imposisble to contemplate?—It would be extremely sensible.

3504. It would represent a different point of view between those who drew up the advice which was circulated and that particular regional board?—Yes. May I put it this way? I think the underlying conception has always been that the control of management committees' appointments by regional boards would not extend to the control of individual appointments, but simply to the general control of the expenditure of the management committee on salaries and wages so that, to take a foolish example, if a management committee decided that it would dismiss half its nurses and employ instead clerical officers, that would be entirely within their competence and within their discretion, provided that the financial estimate was adhered to. The Ministry's policy therefore has always been to discourage regional boards from interfering with individual appointments by management committees. The appointment of officers by hospital management committees is a function conferred on them by regulations made under the Act. The regional board control has been seen as being exercised through the estimates, as overall control of overall expenditure on staff.

Mr. *Turton.*

3505. If that is so and it is the responsibility of regional boards to have an overall control of the staff, why it is that the Ministry of Health send circulars on staffing direct to hospital management committees?—On the dietitian, for example, what surely is happening theer is that the Ministry is saying, "We regard it as the best way of organising hospital catering to have dietitians". That is what the Ministry is saying.

3506. If that be so, that advice or recommendation should be sent to the regional board and not direct to the hospital management committees?—I am not sure that I see why.

3507. Because I understood you to say, two questions back, that it was the function of the regional board to exercise a general control on staffing?—Through the estimates.

3508. Through the estimates?—Yes.

3509. If that is so is it right for the Ministry to give what may be contradictory advice on staffing direct to hospital management committees?—What I am trying to suggest is that a general circular saying that the appointment of dietitians is the best way of running hospital catering is not advice to an individual management committee to appoint a dietitian. It may already have got one, or it may not have the money to spend at the moment on appointing one.

Chairman.

3510. May I interrupt you? Do you regard it as part of the function of the regional board to take any action as regards the actual appointment of a dietitian by a particular management committee? Is that part of its function at all? From what you say I rather think you consider it is not the function of the regional board?—No. I think it is not the function of the regional board, except as deriving from the approval of the estimate for salaries and wages.

3511. As far as establishment is concerned your view is that the regional boards should not interfere at all; this is purely one aspect of the estimates?—Yes. May I put it this way? Suppose a management committee wished to appoint a dietitian—this is reducing the matter to its simplest terms—and the regional board thought it was wrong, the way the regional board should attempt to prevent it would be by saying to the management committee, "We are going to reduce your estimate for salaries and wages by the cost of a dietition". It is then still open to the management committee to appoint a dietitian, provided it can find the money within the overall estimate for salaries and wages.

Mr *Turton.*

3512. Is it irregular for a regional board to approve new additions to staff?—Within the estimates I think it is.

3513. Some regional boards are doing it?—I understand that one or two of them are.

3514. You have issued no directive from the Ministry asking them to desist from doing that?—No.

Mr. *J. Enoch Powell.*

3515. Is not this a very clumsy method of controlling the rationalisation of establishments?—Yes, Sir, I think it is, but I think also, if I may say so, that it is the only way in which the management committee can be given that degree of independence in running its own affairs as has been the object.

Chairman.

3516. Are not hospital management committees trying to serve two masters at the same time, and masters who may have different views? You are trying to control them direct from the Ministry in giving them advice on whom you think they should employ, and you are also trying to control them through the regional boards by the general financial control. You say yourselves—it is obvious from the evidence—that there may be a sharp conflict of view between the Ministry and the regional boards' policy, and the management committees simply do not know where they stand at all. Is not that the position?—I do not think so, no. I would suggest that the distinction I drew before is a good one by way of general advice on the value of having a dietitian and the appointment of a dietitian by a particular management committee, but the management committee knows perfectly well where it is because the regional board will inform it, when the regional board refuses the estimate of the management committee if it thinks the management committee is applying wrongly the general advice it has received.

3517. If that is the position, you ought to give that advice through the regional board surely and not direct to the management committee?—But the regional board is fully aware of this advice too.

3518. I am not suggesting it is not aware of the advice, but that the advice should come through the regional board. If you are going to give the regional board powers to control the establishment through the estimate, then you must give the advice through the regional board and let it deal with the whole situation; otherwise you get an impasse?—Could I just——

Miss *Ward.*

3519. Could I just add this? Would not that position tend to make the hospital management committee lose confidence in the regional board? If the hospital management committee feels the Ministry is behind it, it destroys the confidence which the management committee might have in the regional board, which surely would not be the wish of the Ministry?—There is a risk of that, yes, but I would suggest it flows from the original dilemma which I posed, which runs right through this structure, the dilemma of trying to reconcile the demands of a national service with decentralised administration.

Mr. *J. Enoch Powell.*

3520. When you arrive at the conclusions which you hope to about rationalisation of establishments, do you envisage putting them into force by means of similar circulars of advice to hospital management committees, by bringing financial pressure to bear on regional hospital boards or in some other way?—When an establishment has been arrived at for a particular management committee what we have contemplated is that the regional board and the hospital management committee will be told, and that thereafter any increases in that establishment would be a matter for approval by the regional board.

Miss *Ward.*

3521. Is an establishment arrived at after the Ministry have seen that all the various posts which the Ministry think are important are covered by the establishment, or what would happen, when the establishment was fixed, if the Ministry suddenly had an idea that there ought to be some additional expert officers on the establishments of hospitals if such appointments had not been included in the original establishments?—We have not quite got to that stage yet, but what would happen on the picture I have just drawn would be this: there would be no question of additions to the establishment of any new specialist officers, which the Ministry might think would be a good idea, without the approval of the regional board.

Mr. *Diamond.*

3522. Have you in any case imposed a particular specialist officer on any management committee, or advised so strongly on appointing a particular officer as to be tantamount to imposing such an officer upon them?—I am not aware of any such case.

Chairman.

3523. The Sheffield Regional Hospital Board was asked to give us an example, and in reply to Question 970 Mr. Faulkner said, "Can I take the example of the Ministry of Health staff dieticians visiting a hospital? They submit a report to the Minister, a copy of which is sent to the management committee, encouraging the employing of a catering officer and dietician at that particular hospital". Question 971, "Although you have the right, when the estimates come to you, to disallow it, their case as against yours is strengthened by this report?": Answer, "Infinitely"?—Yes.

3524. That is putting the difficulty I think pretty clearly, and this is presumably a specific case to which the witness was referring?—Yes, I was not aware of that one. I would like to look into that.

3525. Could we come now to the question of appointments of members of hospital management committees? Is it the policy of the Ministry to give the regional boards a completely free hand with the appointments of these committees?—Yes, Sir, it is the statutory function of the regional board under the Act.

3526. Because here again the regional boards feel that there is at least pressure being put upon them to comply with ministerial policy?—I beg your pardon. I misunderstood. I thought you meant individual appointments, the selection of individuals to serve. It is the case that we have suggested to the regional boards broad principles that they should follow in making selections.

3527. The question arises directly in the problem of dual membership?—Yes.

3528. I think it is ministerial policy that members of regional boards ought not to be members of management committees Is that correct?—With respect, I do not think that is so. It has been suggested that it is undesirable on the whole for members of regional boards to be chairmen of hospital management committees.

3529. The Minister's policy is particularly against having chairmen?—Yes. Might I elaborate that?

3530. If you would?—The reason for that is threefold. It has been suggested on some occasions that the result of a member of a regional board being the chairman of a management committee is that the management committee is simply controlled by the regional board, it is bound hand and foot to the regional board, and that the chairman behaves not as the chairman of the management committee but as the delegate of the regional board in his activities on the management committee. Secondly, the converse has also been suggested, that in some cases the chairman of the management committee in his capacity as a member of the regional board does not take a regional view at all but takes a narrow parochial view, and even if he does not himself advocate the cause of his own management committee he is suspected of doing so by all the other management committees. The third reason is the purely practical one of time. The time needed to be the chairman of a management committee is quite considerable; the time needed to play a full part in a regional board is quite considerable; it is only the very exceptional person who can find the time to do both.

3531. As against that I understand that at least one regional board is of opinion that its gain from dual membership outweights the objections you have mentioned?—Yes.

3532. We were told that the regional board in question was intending to appoint from its number chairmen of its hospital management committees?—Yes.

3533. Will you simply accept that, or would you feel that was a matter in which——?—I think we would accept that.

3534. There you are giving advice, and no more?—Yes. We have said that in our view the balance of advantage lies the other way, but I do not imagine we should interfere if a regional board in fact took the other view.

3535. Could you tell us something more about the role of the teaching hospital in the region? The question has come up acutely in the case of South-West Metropolitan Region where the size of the region is such that the extreme westerly part of it cannot very easily be administered from London?—Yes.

3536. I gather that the objection to any alteration of that region is the fact that there is no teaching hospial in that part of England. Can you tell us why it is felt to be essential that there should be a teaching hospital in any particular region?—I think this goes back to the provisions of Section 11 of the Act itself where, in defining the hospital regions, the Minister is required to secure "so far as practicable that each area is such that the provisions of the said services in the area can conveniently be associated with a university having a school of medicine".

3537. I think the words are merely that the Minister should do so as far as practicable?—Yes.

3538. In this particular case it may not be practicable?—Yes.

3539. Can you tell us how in practice you have found the existence of a teaching hospital within a region important?—I would not like to put it purely in terms of a teaching hospital. I think I would put it, as the Act does, rather in terms of a university with a school of medicine and a teaching hospital together. They represent the natural focus for a large number of highly specialised services, services which can only be efficiently based on a large population. The teaching hospital, which is the main centre of research and the main centre of the most highly specialised services, constitutes a natural centre for the hospital services of any region. For that reason the object has always been to define the regions in such a way as to focus on one of those natural centres.

3540. Taking the case of Dorsetshire it is associated with teaching hospitals in London. To that extent you obey the letter of the law, but can you say really that Dorsetshire is a natural centre for any teaching hospital? Is there any real relationship between patients in Dorsetshire and the teaching hospitals in London?—Indeed, yes, Sir. I think you will find that the normal place to which patients, in need of the kind of highly specialised services which I have been mentioning, naturally look is London.

3541. Would it not be possible, if that is so, for a teaching hospital to be outside the geographical boundary of the region?—Yes, from that point of view it would.

3542. Have you considered the reorganisation of South West Metropolitan Region so as to divide it perhaps into two, associating the western half with one of the teaching hospitals which are now within the whole region?—The provision of services and the flow of patients are, I think, only one aspect of this association. The other is the participation of representatives particularly of the university and the school of medicine, rather than those of the teaching hospital, in the planning and organisation of the hospital services. Supposing therefore the western part of the South West Metropolitan Region was constituted a separte region, I think it would be essential for the regional board concerned to have on it university representatives from London. That would mean, I imagine, that certain representatives would have to serve on both regional boards, because the mere fact that one said, shall we say, the Westminster Hospital and its Medicine School was to be the one earmarked for Dorsetshire, as it were, would not in fact divorce Westminster Hospital, and could not, from the services, or from taking an interest in the services nearer London. You would in fact be making a much larger call on the time of a limited number of people for the planning and organisation of services for what would then be two regions.

3543. You have already divided London into four regions?—Yes, but no particular group of people is being asked to serve on two regions.

3544. If you divide the whole area, that is the four metropolitan regions, into five regions, why should that present any particular difficulty?—I am sorry, I thought you were suggesting that the western part of the South West Metropolitan Region should be associated, like a sort of captive balloon——

3545. That is what I am suggesting. That has been suggested to us. I am trying to find out the objection?—The point I was trying to make was that in making an association of that kind you could not in fact dissociate the people whom you would be asking to serve on the board of the new region from an interest in the intervening territory and in the services provided in the intervening territory.

Mr. *Diamond.*

3546. I do not quite follow that. Are there not enough hospitals to go round then? Is it not a fact that there are two teaching hospitals, one of which could serve the adjoining part of the South West Metropolitan Region and the other one serving the non-adjacent and distant western half?—The point I was trying to make was that, taking the Westminster as an example, it would be quite unreasonable, merely because you have said Westminster Hospital and its School of Medicine are to be the protectors of Dorsetshire, therefore to say they must not have any patients from Surrey or Hampshire.

3547. Certainly?—Therefore they would still retain an interest, and I think it would be essential for them to take part in the planning and organisation of services for Surrey and Hampshire.

Chairman.

3548. You do not say that St. George's or Westminster Hospital is not to have any patients from Middlesex?—No.

3549. They are in different areas?—Yes, perfectly true.

3550. There is no new problem there at all, is there? You would merely assign to one particular hospital an area which did not actually surround it, that is all?—Yes. Of course it is perfectly true that the flow of patients to teaching hospitals in the south-west area is from the south-west.

Mr. *J. Enoch Powell.*

3551. Are there more teaching hospitals than regions?—Yes.

3552. Considerably more?—Yes, in the London area.

3553. But only in the London area?—Elsewhere there is one teaching hospital in each region.

3554. Therefore outside the London area you apprehend a situation that, if there were more than one region corresponding to one teaching hospital, the experts associated with that teaching hospital would have to do double advisory duties?—Yes.

3555. You feel that applies in the London area also for geographical reasons?—Yes.

3556. The natural association of a hospital with the territory around it, whether or not it is officially connected with that area?—Yes.

3557. Are you aware that it was expressed to us in evidence, both on behalf of the Royal College of Physicians and on behalf of a hospital management committee, that it was not necessary for there to be one

teaching hospital per region? For example, the Registrar of the Royal College of Physicians, in reply to Question 2503 "Do you think that a region could function without having a teaching hospital within its area?", said, "Oh, yes, Sir"; and the same view was expressed by a hospital management committee?—Yes.

3558. Do you think it is possible that undue weight has been attached to this question of the association of a teaching hospital with a region? Do you think a more satisfactory division of the country into regions from all other points of view could be attained if one was prepared to sacrifice or prejudice the advantages of this particular association?—I would not have thought so. I think it is quite true that it would be possible to have a region without a teaching hospital in it, but my association I suggest—I come back to the point—is not an association with the teaching hospital so much as with the university and the school of medicine. Their part is to play a highly expert role in the planning and organisation of the hospital services. If the country was split up into a larger number of regions, you would in fact be asking a strictly limited number of persons to serve on a larger number of bodies.

Mr. *Diamond.*

3559. A certain amount, except for London. You said there are spare teaching hospitals in London. In London there is more than one teaching hospital per regional board area?—Yes.

3560. If you split up one area, which at the moment has two London teaching hospitals, into two and gave each one London teaching hospital, you would obviously have one of those hospitals outside the new area, but there would be one hospital for each area?—Yes.

Mr. *J. Enoch Powell.*

3561. Do you not think that the extra burdens which might be imposed upon, after all, a very small number of admittedly highly specialised persons is a tenuous reason for a geographical division which may impose, on the other hand, more burdens on a large number of people by virtue of the larger geographical area centralised upon one as a single region? Do you not think that one factor, which is the only one I think produced, is rather a tenuous one to be the guiding principle in the sub-divisions of the whole country?—That depends I think on what you conceive to be the role of the regional body. If the most important role of the regional body is the planning and organisation of the services, then I think the most important factor in defining the area of its responsibilities is the natural flow of patients to a particular centre, and the organisation of the services focussing on that centre.

3562. Is not what you have just said an additional reason for separating the planning and the advisory aspects of the present regional board from the executive aspects?—That is a possible conclusion, yes.

Mr. *Turton.*

3563. Do I take it you are satisfied with the present area of the South-West Metropolitan Regional Board?—No, Sir, it would be to everybody's benefit if there were a teaching hospital and a school of medicine at Southampton.

Mr. *Turton.*] I do not think that is an answer to my question.

Chairman.

3564. I think it is an answer. I am not certain that it is not the answer you wanted. Mr. Pater has really said that, apart from the teaching hospital question, he would like to see the South-West Metropolitan Regional Board split into two?—That is surely made clear by the fact that from the very outset the Minister advised that the South-West Metropolitan Region Board should have for its western area a committee with a specially large amount of delegated power.

3565. Are you satisfied that that arrangement is really working well?—No, Sir, but I would not like to say what are the reasons for the lack of success in its working.

3566. Can you suggest really any objection to making that western area committee into a separate region, associating it with one particular hospital in London (which you would disassociate from the old South-West Metropolitan Regional Board) and giving it a special representative from London University and from that particular teaching hospital?—No, I think not except, as I say, I do not think really that any of the medical schools concerned would willingly cut their ties with the rest of the South-West Metropolitan Region, which is what in effect they would be invited to do.

3567. Have you explored that possibility?—No.

Miss *Ward.*

3568. Is that tradition standing in the way of progress?—No, I think it is just the way the communications are run. The fact is that the London teaching hospitals are, broadly speaking, grouped round the various main-line termini, and that very largely determines from where their patients come.

3569. It might be put this way. The suggestion which has been put forward perhaps is the inevitable result of a national health service, and the alteration in ties is for the benefit of the whole?—Yes, and indeed I think to some extent that is happening. The fact that the teaching hospitals in London and the medical schools in London have been identified with particular regional areas is, I think, having the effect

of breaking their ties with other areas, which ties existed before the Health Service. To give an example of it, the fact that the Westminster, the hospital about which we have been talking, is identified with the South-West Metropolitan Region is weakening its ties with the north-west with which it used to be connected.

Chairman.

3570. If you carried that further and associated to it one of the three or four teaching hospitals in the South-West Metropolitan Region, you might find it developing strong new ties with Hampshire and Dorsetshire, ties which were more valuable than the rather diffused ties it has now with the whole of that lizard of a region?—Yes, Sir, but, as I say, I find it difficult to believe that it would willingly cut its ties with the intervening territory.

3571. You have not asked any of them, and so we cannot press that?—No.

3572. Could we come now to the question of the grouping of hospitals within the regions? I think it is the policy of the Ministry to aim at groups of, roughly, one thousand beds?—Yes, roughly.

3573. That was the policy originally, I think. Is that still so?—It has never been that. I would not say it has ever been tied to a particular number of beds.

3574. That is regarded as the desirable number?—Well, I would have said that was merely one of the factors. It is a rough yardstick, but it is nothing more than that. I would not have said it had been the main factor in determining the constitution of hospital groups.

Mr. *Turton.*

3575. Have you not taken the line of opposing the constitution of a management committee's area with more than two thousand beds?—No, Sir.

3576. It would be quite inaccurate to state you have ever opposed that?—It may well be that in a particular case we have said that a group which happened to have more than two thousand beds was in our view too large, but we have certainly never attempted to lay down any ceiling of two thousand beds.

3577. Some regional boards take the view that from the point of view of local patriotism it is a good thing to have a larger beddage—forgive the word—(*Cries of "No", and "More beds"*)—in a hospital management committee?—This question of local patriotism is very difficult. I think it is fair to say that our main principle in advising and in attempting to steer the original formation of hospital groups was, first of all, to produce a group sufficient to have some kind of local soul of its own and, secondly, a group that was not so large that the members of the management committee could not really from the practical point of view be expected to know what was going on in the hospitals in the group. If you apply the first principle to a town like Sheffield you might say that would mean all the hospitals in Sheffield should be in the same group, but you would then it seems to me be opposed by my second principle which is equally important; you would have such a large aggregation of large hospitals that it would be difficult for the members of the management committee really to know what was going on.

Chairman.

3578. I think the impression which the Sub-Committee has gained from the evidence is that, broadly speaking, the grouping of hospitals has been satisfactory, but on the other hand we have received evidence that in some cases it might be improved?—Yes.

3579. We have had the general statement that hospitals in a town like Derby, for example, might be made into one entire group, notwithstanding that the number of beds would be far in excess of the standard?—Yes.

3580. We have other examples. For instance, we are told that Paddington is not very happily grouped. Can you tell us whether you have in mind the re-grouping of hospitals? Is that constantly under consideration?—There has been no review of the original grouping so far, no. I would not like to say that we regard all the present groups as satisfactory. Indeed, when the groups were originally made, we disagreed with the proposals of the regional boards in a number of instances, but took the line then that they might be right and we might be wrong, and, although we thought they were wrong, we would give their ideas a trial. There are three groups which, as I say, we would probably like to revise. We have felt so far that the system has not really been going long enough to justify any attempt to break up groups or to re-distribute groups, and that is rather borne out I think by the report of the committee of the Central Health Services Council which looked into this matter, that it was a little early to start.

3581. There is no machinery at the moment for amending groups?—There is machinery, but it is not in motion. At any time either the regional board or the Minister can set in motion the revision of groups.

3582. You had no strong representations that alterations should be made?—No, Sir.

3583. It is not in any way the policy of the Department to resist proposals to alter the grouping, if they come along?—There have been some instances in which groupings have been changed. There are other

instances in which suggestions have been made for re-grouping, which we have disagreed

Mr. *Thomas Reid.*

3584. The final decision rests with the Minister?—Yes.

Mr. *Turton.*

3585. Is it not very hard to have a yardstick for grouping?—Yes, that is why I rather hesitated about this figure of one thousand beds. We have no real yardstick. One must look at each group on its own merits, I think.

3586. One of the factors you must take into consideration is whether there is a hospital catering for the population in the same area as the hospitals under the hospital mangement committee?—I am not quite sure that I follow.

3587. Take the position in Stepney. They have got the London Hospital very near. That would mean really, would it not, that it would be desirable to have a rather larger area under the hospital management committee there because many of their patients would not be drawn to their hospitals but to the London Hospital?—Yes, but, if I may say so, I would be guided rather not by the size of the area so much as by the number of hospital units.

3588. Mr. Edwards, what control does the Ministry exercise over capital work, on a new hospital in particular, to see that undue waste does not occur and that the work is expeditiously carried out?—(Mr. *Edwards.*) I think that is rather a question for Mr. Pater. (Mr. *Pater.*) The actual conduct of the work on any particular job is not under the supervision of the Ministry but of the regional board, or if it makes that arrangement—it is entirely at the discretion of the board whether it does so—under the supervision of the local hospital committee. There is a monthly return made to the Ministry of Works by contractors, showing the stage which the job has reached, and that is made known to us and of course to the regional board which is supervising the job locally.

3589. You have no control over the detailed expenditure on new works?—As the job goes along?

3590. Yes?—No.

3591. I have given one particular instance which I would like you to examine. Do you know a place called Kyre Hall?—I have some information on it.

3592. I think it was a hospital which belonged to the Union of South Africa?—It was taken over by the South Africans during the war.

3593. The work on that particular building has, I think, been proceeding now for a very considerable number of years?—about two years, I think.

Mr. *Turton.*] Mr. Chairman, would it be possible for us to have a note on the whole expenditure and the progress?

Chairman.

3594. Could you let us have that?—Certainly.

Mr. *Turton.*

3595. I think that is probably the easiest way of dealing with this. As Members of Parliament you appreciate that we get complaints of extravagance which require investigation?—Yes.

3596. I think it would be helpful if we did have a full note of your whole expenditure?—Certainly.

Chairman.

3597. If you could let us have that fairly soon, Mr. Pater, it might be convenient because then, if there are any questions arising out of it, we could dispose of them next Thursday and we should not have to trouble you again?—Yes.

3598. There is only one other question which I want to deal with while Mr. Edwards is here, and that is the question of the charges made for private beds. I do not know whether that is a question for you, Mr. Edwards?—(Mr. *Edwards.*) No, Sir. I think that is really Mr. Pater's (Mr. *Pater.*) I think it depends a little on the question of——

Chairman.] Then I think we will leave that till next week. Are there any purely financial questions which any Member of the Sub-Committee would like to put to Mr. Edwards while he is here, as he cannot come along next week?

Miss *Ward.*] Was there not some question which arose out of a different point of view in regard to the appointment of maintenance engineers, and whether that was being done in the most economical way. I think it was the appointment of a group engineer for maintenance purposes over an area.

Chairman.

3599. I think that would be rather a matter for Mr. Pater than Mr. Edwards?—I think it would.

Chairman.] It is the duplication of technical officers in regional boards and management committees.

The witnesses withdrew.

Adjourned till Thursday next, at 10.30 *a.m.*

THURSDAY, 14TH JUNE, 1951.

Members present:

SIR HUGH LUCAS-TOOTH in the Chair.

Wing Commander Geoffrey Cooper.	Mr. Turton.
Mr. J. Enoch Powell.	Miss Ward.
Mr. Thomas Reid.	

Mr. J. E. PATER, an Under-Secretary, Hospitals and Special Services Division, Mr. J. P. DODDS, Accountant-General, Mr. W. O. CHATTERTON, a Deputy Accountant-General, and Mr. A. J. F. DANIELLI, O.B.E., M.C., a Deputy Accountant-General, Ministry of Health, recalled and further examined.

Chairman.

3600. Since our last meeting the Sub-Committee has received a letter from the Chairman of the South-West Metropolitan Regional Board. Mr. Elliott was cross-examined by us on the question of the carry-over of unexpended balances, which matter we have also discussed with you, and he expressed himself as of the opinion that the inability to carry forward balances did lead to rush expenditure at the end of the year. He has now supplied us with figures in this letter, and if you have a copy before you you will see it is shown that up to the eleventh month of the year there is a fairly substantial underspending by the management committees in his region, but that for the twelfth month, March, that underspending is reduced by some £300,000. It looks, therefore, as if there is a strong tendency to increase expenditure in the last month of the year. Do you know if that is general?—(Mr. *Chatterton.*) I should think that may well be general, but if I may make a comment there is an alternative explanation of this sudden drop in the last month of the year. Hospitals are supposed, in doing their monthly returns, to take account of accrued liabilities. All of them do not do so, or at any rate only do so in part, but at the end of the financial year, when they have to start their annual accounts, they are bound to assess the outstanding creditors and other liabilities, and it may well be that this sudden drop in the month of March is more an accountancy adjustment than an actual sudden increase in the rate of expenditure.

Mr. *Turton.*

3601. These are cash figures, are they not?—No, these are supposed to be on an income and expenditure basis.

Chairman.

3602. The letter says, "under-spending". Would "spending" there mean an incurring of liability or would it mean the actual expenditure of cash?—It would mean the incurring of liability. These figures are set against the approved estimates month by month, and the estimates are approved on the basis of income and expenditure, not of cash.

Wing Commander *Geoffrey Cooper.*

3603. Do they not make very clear at the end of the second paragraph what the basis is? "Each hospital management committee submits to the Ministry of Health and the regional hospital board a monthly statement of expenditure and alongside it is set the appropriate proportion of their approved estimates, throwing out a resulting figure as an over- or an under-spending." Mr. Elliott makes it quite clear that this is a genuine spending because he goes on to say, "These figures are facts and amply demonstrate my contention . . .". A man in his position, surely, would not send in a letter of this sort, almost confessing, as it were, a weakness in the organisation, unless he was terribly sure of his facts?—I am merely suggesting that the explanation I have offered is a possibility.

Wing Commander *Geoffrey Cooper.*] I think it is refuted by the wording of this letter.

Mr. *J. Enoch Powell.*

3604. Could you give an instance of the type of liability which would fall to be made in the last two or three months of the financial year, one which might account for the sudden fall which these figures show?—It would be ordinary trade creditors for the most part.

3605. Is it usual for hospital management committees to run annual accounts with trade creditors?—Oh, no. All I am saying is that in preparing their monthly progress returns those outstanding trade creditors are not always taken into account month by month, but they have to be taken into account at the end of the financial year because the charge for those creditors throws back to the year just ended although they may be paid in April or May.

Chairman.

3606. If there is a discrepancy of this order, it means in effect that your monthly accounts are completely valueless?—The figures must be looked at in relation to the total expenditure which for this regional board is of the order of £20 millions.

3607. That is rather more than £1,500,000 per month?—Yes.

3608. And the discrepancy here is one-third of £1 million, so that it is a fairly large proportion of the expenditure, is it not?—Yes. I think it would require a very detailed investigation to show how far this sudden drop in the month of March is due to an actual sudden burst of expenditure or to the accountancy adjustment I have suggested.

Mr. *Turton.*

3609. That you could tell at once by an examination of your monthly reports, could you not?—No, Sir, I am afraid that could not be done. That would not produce the answer.

Mr. *Turton.*] If you looked at your last three monthly reports you could tell whether Mr. Elliott's figures are what he says, the actual under-spending of cash or whether it is an alteration of accrued liabilities as you suggest?

Wing Commander *Geoffrey Cooper.*

3610. You could tell that by the date of the placing of the orders?—It could be done by a local investigation.

Miss *Ward.*

3611. Would you make an investigation when you got that last monthly return? Would you yourself be struck by it and suggest an investigation?—That is possible. We have not in fact, as far as I know, at the moment received this last monthly return, March, from the board. I could not be quite sure of that at the moment.

3612. If it has happened in the past have you had investigations carried out?—No, Sir, we have not.

Chairman.

3613. I did ask you at the outset whether you found this state of affairs was generally true or not. Could you check up to see whether there is a similar return from the other regions?—Yes, there is no difficulty in checking up for the other regions; we can do that.

3614. You could let us have the position there fairly quickly, could you not?—Yes, Sir.

Chairman.] Would you let us know similar figures for each of the fourteen regions?

Mr. *Turton.*] Could it be made clear for what we are in fact asking? Is it to be on a cash basis, or is it to be on an income and expenditure basis?

Wing Commander *Geoffrey Cooper.*] It could be asked for in terms similar to the way in which these figures have been compiled, so that the figures are absolutely comparable.

Chairman.

3615. I think this purports to be the actual return made by the Region to the Ministry?—That is so.

Chairman.] If that is the case it would be the same as the actual returns made by the other regions, which no doubt are required in a particular form, so that you would have strictly comparable figures either already in or just coming in for this period.

Mr. *Turton.*

3616. I am sorry, but you have not cleared my mind. Is the return which the South-West Metropolitan Regional Board and the other regional boards send to the Ministry an income and expenditure return or a cash return?—They are all on the basis, or they are supposed to be on the basis, of income and expenditure.

3617. That is my point. This purports to be on a cash basis because it is said that it is actual spending?—(Mr. *Pater*). It is not.

Chairman.

3618. I am not certain. I think the witness says he doubts whether this is cash. The point is whether it is open to either interpretation?—(Mr. *Chatterton.*) No, Sir. It is clearly not cash because the word used is "expenditure"; had it been cash it would have been "payments".

Chairman.] That is certainly my impression, although the word "spending" looks more like cash.

Mr. *Thomas Reid.*

3619. I am rather puzzled by what has been said this morning. I thought all along that these monthly returns were purely cash, and now we are told that they are not. They are income and expenditure—liabilities and assets really?—Yes.

3620. Therefore, as the Chairman said, it really makes your monthly returns then valueless because, if they are not cash, you do not know how the expenditure is going?—Returns on a pure cash basis would be of less value for the reason I have mentioned, that the budgets of hospital authorities are approved on an income and expenditure basis.

Mr. *Turton.*

3621. Does that mean that, if there is a liability incurred before the end of the financial year and the cash has not been paid out for it, the regional board does not have to budget anew for that expenditure in the next financial year?—That is correct.

3622. It does not have to budget anew?—No, Sir.

Mr. *Thomas Reid.*

3623. After the end of the financial year regional boards and management committees do go on paying out cash for the previous year?—That is correct. That is one of the difficulties we have to face in the Ministry in relation both to the Minis-

try's own estimates and the Ministry's accounts, that the accounts of hospital authorities are on an income and expenditure basis whereas the Ministry's accounts, like all Government Departments, on a purely cash basis. We have to reconcile the two.

Mr. *Turton*] I do not know if I am in order in saying this, Mr. Chairman—if not, you must call me to order—but it is striking that in a debate in another place on this matter, when it was suggested that liabilities incurred before the end of the financial year, for which cash had not been paid, were an added burden in the newly beginning financial year, that was not an accurate statement by Lord Reading although it was not challenged by any of the Government speakers?

Wing Commander *Geoffrey Cooper.*

3624. When the Ministry's monthly returns are made up do you in fact include the two figures suggested at the end of this second paragraph, where it says that the appropriate proportion of the approved estimates is set off against the actual money paid out, throwing up a resulting figure of under or over-spending? The figures which we are given are the difference between those two. Are your returns in that form? —I am sorry, I am afraid I have not quite grasped that.

3625. You say there is an allocation for the year, and a proportion of that total estimate is allocated for each month?—Yes.

3626. Against that is set off what they actually spend, leaving a balance of under or over-spending?—That is correct.

3627. I am asking this: are your monthly returns made up on that basis?—Certainly.

3628. In other words, is that the same basis on which these figures are prepared? —Oh, yes.

Chairman.

3629. I think there is some confusion. The question really is this: what do you mean by "spending"? In one case it may mean the actual payment out of money, of cash, and in the other case it may mean placing an order and incurring a liability. I think the evidence is quite clear that the figures called for, and which these almost certainly represent, are figures merely indicating the incurring of liabilities as distinct from actual cash payments. That is right, is it not?—That is correct.

Mr. *Thomas Reid.*

3630. We were told—and we have had many complaints—that hospital management committees were not able to spend the money allotted to them, and then at the end of the year that lapsed and they lost the money. Now I cannot understand that statement in view of what you have said because all they have got to do before the year is out is to put down in their monthly return their liabilities, that is all money left unexpended, and therefore they can carry over their unexpended balance and would not need a Re-Vote?—They could not do that unless the unexpended balance could be allocated to goods or services that had been delivered or rendered before the 31st March.

Mr. *J. Enoch Powell.*

3631. So that in fact, in this sudden fall from £350,000 to £50,000 in the balance shown, two separate factors may be involved, the first being the bringing into the account of liabilities not previously shown and the second may be the incurring during that month of new liabilities. It is the second of those factors, the relative importance of which we do not know, which is the object of criticism?—That is correct.

3632. Further the extent of the balance which is lost—in this case £50,000—is shown in the last figure?—That is correct.

3633. That could not be available unless orders were placed before the 31st March indicating a liability to that extent?—Unless orders had been placed and executed before the 31st March.

Chairman.

3634. And the goods delivered?—And the goods delivered.

Mr. *J. Enoch Powell.*

3635. It is necessary that the goods should have been delivered?—They should have been delivered. The liability should have been incurred, which in the case of goods means that the goods must have been delivered.

Chairman.] I think the Sub-Committee will draw the inference that there has been in this month a notable increase in orders. I think the Sub-Committee will come to that conclusion. It has perhaps been rather sprung upon you this morning, and if you would like to consider those figures and let us have any comments about them as quickly as you can please do so. We would like to consider them before we formulate our report. That is the impression I get.

Mr. *J. Enoch Powell.*

3636. Would it not be more correct to say that in the month of March there must have been a considerable increase in deliveries, in view of your reply to the Chairman?—That might well be due to orders having been placed a few weeks earlier.

Mr. *Thomas Reid.*

3637. In your note to us could you make perfectly clear what you have been discussing this morning, that is what these

monthly returns really are and the explanation for these balances, the balances which are lost, the balances which need not be lost and the terms under which they need not be lost?—We will endeavour to do that. (Mr. *Pater.*) I was going to mention one point which might help the Sub-Committee on this question of expenditure in the later months of the financial year. It is, of course, a pure coincidence, but it does happen to be the fact that the last months of the financial year are the months of heaviest pressure on hospital authorities. One would therefore expect, other things being equal, that expenditure would increase.

3638. Pressure on account of ill-health and the demand for services?—Take last winter. After all, in January, there was an influenza epidemic which locally was very heavy indeed.

Miss *Ward.*

3639. I am not quite certain how you would proceed if in March, or previously to March, you are not really quite certain what the commitments of the hospitals will be. By that time the Ministry must be looking to the formulation of the estimates for next year, and if you really are not in a position to know what the actual expenditure of the hospitals is going to be it must be a little difficult when you start to consider what the estimates for the next financial year are going to be?—(Mr. *Chatterton.*) Our difficulties are even greater because our estimates have to be prepared the previous October when we only forecast the position.

3640. It does seem rather an extraordinary position—I may be quite wrong—if you have got to start preparing your estimates the previous October when you are not really actually certain what the total legitimate expenditure is which in fact can be carried by the hospitals?—It is one of the difficulties in preparing our estimates.

Chairman.] I think you have made that plain.

Wing Commander *Geoffrey Cooper.*] I think the earlier evidence has shown one example where a hospital management committee decided to spend £1,000 on a bus which they thought might be helpful in running patients from one hospital to another. They decided to buy that because they had not used up their balance. It is that particular type of expenditure which we are wondering is general at all. In that case it was given as a specific example of what can occur.

Chairman.] I think that evidence has been seen by the Department. The evidence from all the hospital authorities is available. I would like you to let us have, if you can, any comments which you feel should be made on these matters. Before we draw up our report I think it is fair that you should have a chance of considering them.

Mr. *Turton.*] I do no want to put the witnesses to extra trouble, but it would be very helpful if we could have the figures not only for South-West Metropolitan Regional Board but for all the other boards.

Chairman.

3641. I did ask for that. You can let us have those?—Yes.

3642. Can we now turn to a matter which is not so financial—the relations of the medical profession with the regional boards and management committees?—(Mr. *Pater.*) I was wondering if I might refer to a point which was raised last week.

3643. Please do?—You quoted an example on this question of the Ministry doing what has been described almost as imposing the appointment of officers on management committees and thus tying the hands of the regional board. You will remember that point was discussed.

3644. Yes?—You quoted an example given in evidence by Sheffield Regional Board in relation to a dietitian.

3645. Could you refer me to the question?—It is Question 3523 which contains the quotation.

3646. Yes?—I have had an opportunity of looking into this, and I think the picture is a little different from that which the evidence might suggest. I am not sure of the exact example which was mentioned here, but I have an example of a visit of the Ministry's dietitians to a hospital in the Sheffield area, and the actual process which took place was this: sometime in March, 1950, we issued a general circular of advice on hospital catering. It was issued in accordance with the ordinary practice to regional boards and management committees simultaneously. That mentions, amongst other desirable objectives, the organisation of catering as a separate department with the appointment of a properly qualified officer in charge of catering. It does also make the point that one of the considerations to be taken into account in reading this advice is the amount of money they have got to spend at the moment. That is in the general circular of advice. In September, 1950, a visit was paid to one of the hospitals in the Sheffield Board's area, and various recommendations for improvement of the catering service were made, including the recommendation of the appointment of a dietitian catering officer and the filling of an existing vacancy for a therapeutic dietitian. This recommendation was, and all similar recommendations are, prefaced with the warning that it was fully understood that the management committee might not be able to implement this recommendation at once or in the order given because of financial considerations—but they are included so that they may be taken into account for future planning.

A copy of the report with that warning was, of course, sent to the regional board at the same time as it was sent to the management committee. In fact we understand since that the management committee is still considering the appointment of a catering officer; it has not in fact appointed one and although the vacancy for the therapeutic dietitian (which already existed) has been advertised it has not yet succeeded in filling it. I mention that because it is, as far as I have been able to discover, a typical example of what is happening in these cases, and it does not, with respect, seem to me to tie the hands of the regional board or to give the management committee a very strong stick to wave at the regional board, as appears to be suggested from the earlier evidence.

3647. You really quarrel with the reply mentioned here, that the recommendation has infinitely strengthened the committee's hands, but you would not deny that it has somewhat strengthened them?—I would not deny it has given them some evidence to produce to the regional board, but I would not have thought it had given them a big stick.

Mr. *Turton.*] It should be finitely, and not infinitely!

Chairman.

3648. Following on that can I ask this question? Where you have sent out recommendations have you always been careful to hedge them with provisos about that?—In these case, yes.

3649. You make a point of doing that?—Yes.

3650. Could we now turn to the question of the relations of the medical profession with regional boards and management committees? We have had some complaints from the medical profession that they are not always as fully consulted as they might be. It appears to us that most regional boards and management committees have a certain number of members of the medical profession, usually in contractual relations with the board, sitting on them. Is it the policy of the Minister always to have medical representatives?—On the regional boards themselves?

3651. And the management committees?—Yes. That is not required by Statute, but it is implied by Statute which of course requires consultation with representatives of the medical profession in making appointments to both bodies.

3652. Can you tell us whether in fact you are pursuing any definite policy, or is that merely general policy? For instance, do you say "You must have one general practitioner" and so on?—No. I do not think we have ever tried to lay down that there should be any particular number of medical people or that there should necessarily be, as you suggest, a general practitioner on every committee.

3653. But you are quite certain that there are medical members on all boards and committees?—Yes.

Mr. *Thomas Reid.*

3654. Does being on a board or a management committee take up much of the time of these medical people?—That I think depends on the individual. Some give quite a lot of time to it; some do not.

3655. Do the management committees meet very often?—The whole committee, I think, as a rule meets once a month, sometimes less frequently but once a month is the rule.

Chairman.

3656. Have you ever had any difficulty in getting suitable people to serve either on regional boards or management committees?—No, Sir.

3657. Is there any competition?—Considerable competition in the sense that we always have a far larger number of people recommended for appointment than those for whom we can possibly find a place.

3658. By "people" you mean professionally qualified?—Well, I was thinking of all types, but it is true if it is thought of simply in terms of the professionally qualified people.

3659. That also includes those who are not only professionally qualified but who are actually working in the region?—Yes.

3660. Not merely retired doctors?—No.

3661. Apart from actual representation on boards and committees, it is quite clear that the medical profession are much more concerned with consultation between boards and committees and their own medical committees. I think there have been discussions, so we were told, between the Ministry and the medical profession about the official recognition of medical committees. Can you tell us anything about that position?—Yes. The profession, as I believe they said in their evidence, did ask, in effect, for a statutory medical advisory committee at the hospital management committee level both at the time of the original Bill and at the time of the first Amending Bill. That was resisted on the ground that, if there was a statutory medical committee, there would inevitably be pressure for all sorts of other statutory committees. Indeed my recollection is that on the original Bill there was an amendment down for a whole series of nursing committees, medical auxiliaries of various kinds and so on. We have, however, always taken the view that every management committee should have, acording to local convenience, for the group as a whole, for individual hospitals in the group or for a group of hospitals within

the group a medical staff committee to advise the management committee on matters of medical policy in the group. We have done everything we can by administrative action to encourage both their creation and their use. The profession have discussed with us on a number of occasions this question of the use of medical advisory committees, but quite frankly we have always found extreme difficulty in getting any concrete evidence of their lack of use. We did, I think, succeed in getting two cases brought to our notice, into both of which we looked, and we have on more than one occasion offered to try to put matters right in any particular instance where there was evidence that the medical committee was not being used as it should be or not being consulted.

3662. You are saying you only know of two cases where there has been any practical difficulty?—So far as I am aware only two cases have been brought to our notice by the profession, after considerable pressure from us to produce evidence.

3663. Those are cases where there has been such a medical committee, but its advice has been ignored?—Yes, or the committee was in some respects unsatisfactory from the point of view of the profession either in its method of constitution——

3664. Do you know of any cases where there has been no committee or where there has been a refusal to recognise such a medical committee?—No, Sir.

3665. You know of no such case; you have asked the profession to produce instances, and they have failed to do so?—Yes.

Mr. *Thomas Reid.*

3666. Do you think the medical profession is satisfied, on the whole, with the arrangement at present?—I would not have thought so, no. It is not the habit of the medical profession to be satisfied.

Chairman.

3667. They told us they had dropped the request for a statutory committee as such, and are now merely asking that there should be official recognition of such medical committees. I gather that from your aspect of the matter you have no objection realy to the official recognition of such medical committees?—I do not think I know what official recognition of a committee means.

3668. The Minister could within his powers surely give an instruction?—Yes, but as I thought I had indicated he has not in terms given a formal direction that a committee of this kind shall be set up. Indeed I am not quite sure how he could because the setting up of a medical committee must essentially be a matter for the medical staff, but he has given an instruction in the sense of having made it clear in a general circular, I think on more than one occasion, to management committees that they should do everything they could to encourage the emergence of a medical staff committee and to use that medical staff committee for the purpose of consultation.

Mr. *J. Enoch Powell.*

3669. Did one of the two instances you had in mind relate to Paddington?—Yes, Sir.

3670. Did the other instance relate to Ilford and Barking?—I am afraid I do not know that. I know Paddington was one.

Chairman.

3671. Have you had any precise request formulated by the British Medical Association for action to be taken for official recognition, whatever that may mean?—I do not think so, Sir. The reason I hesitate is because this is a point which has been produced in discussion on a number of occasions. I have no doubt it has been put in a letter since as a point for discussion at our next meeting; these meetings are going on all the time, but if you are speaking in terms of a request on this particular point backed by a resolution of a representative meeting or something of that sort, I cannot recollect one, certainly not recently.

3672. What is worrying me is that it is quite clear the doctors are very much concerned about this; there is no doubt about that; but your evidence is that there is really nothing in this at all; they have already got all for which they are asking. I would like to know what the point at issue really is?—So should I.

Mr. *Turton.*

3673. Surely it is not satisfactory if you have got, shall I say, an unofficial medical advisory committee which is not recognised by the management committee. You have told us that happened at Paddington, and it has been suggested to you that it also happened at Ilford and Barking. I am going to suggest that it also happened in the Leeds Group, too. There appear to be more than the two cases you have given. To our own knowledge we know of three?—All I am saying is that we have on more than one occasion asked for evidence of this sort of thing so that we might intervene in individual cases and put it right. To the best of my knowledge we have only been informed of two, the only one I know by name being Paddington, and there we have intervened. We should certainly intervene in any others if we were given evidence of an unsatisfactory situation.

Chairman.

3674. You told us just now that you felt there would be objection to dealing with this matter on a statutory basis because of its repercussion on other professions within the Health Service?—Yes.

3675. Is that really a valid objection? Surely the medical profession *vis-á-vis* the Health Service is in quite a different position from any of the other professions?—The other professions are apt not to think so, particularly the nursing profession.

3676. The nursing profession is not normally represented on boards and committees; it may be?—It may be.

3677. But not invariably?—Oh, no.

3678. Whereas you have just said it is the policy of the Department invariably to have the medical profession represented?—Carrying out the policy laid down in the Act.

Chairman.] There is an example where the medical profession is treated differently already.

Wing Commander *Geoffrey Cooper.*

3679. Is not this all part of the problem which is thrown up in almost any type of organisation where the people who are in it have an interest, whether or not it is a major interest such as the medical staff or the nurses in the case of the Health Service? It is, therefore, quite similar to the problem to be found in other industries where the people working in them do want to have some means of stating their case from the factory floor through a recognised system to the people in charge, the management, such as the Ministry here. If that is accepted is it not really a question of the need to formulate some system as in industry is called joint consultation, which simply means giving a proper recognised channel for people to put forward their ideas, criticisms and so on?—That exists quite separately. There has been set up under the auspices of the Whitley Council machinery a system of joint consultative committees right through the Hospital Service.

3680. The Whitley Council system does not line up precisely with the new conception of joint consultation which has emerged in industry. Certain unsatisfactory defects were found in the Whitley Council system, and they have been improved upon since by industry?—Perhaps I was misleading in introducing the name of Whitley machinery. It is not Whitley machinery in the hospitals; it is joint consultation. There are a series of joint consultative committees throughout the Hospital Service. That has been set up quite separately.

3681. Is there any case at all for a separate form of representation for any one particular group of professional people?—I understand that the medical profession have refused to join the general joint consultative machinery.

3682. What is the reason for that?—I would not like to say.

3683. Why should we not know it?—I do not know it.

Miss *Ward.*

3684. Surely it is quite a different aspect of the problem. It would be very difficult to run the Health Service without the medical profession. Joint consultation in industry has quite a different purpose, surely?—I would have thought that was so myself.

3685. I do not really think one can mix up medical representation with what is at present understood by joint consultative machinery in industry?—I myself would agree that the object of the medical staff committee, of which we have been speaking, is different from that of the joint consultative committee. It is to advise on the medical policy of the hospital group, which is I think something slightly different.

Miss *Ward.*] The lay people on hospital management committees certainly could not be considered as competent to advise on matters on which the medical profession has got to advise.

Mr. *J. Enoch Powell.*

3686. You said a little time ago that if the situation in this respect was unsatisfactory you would intervene. Could you help us by defining a little further what you regard as a satisfactory position? For example, do you consider that there should be an automatic arrangement for the medical advisory committee to be consulted on matters passing through the regional board or hospital management committee, as the case may be? Could you define more accurately what you mean by a satisfactory relationship?—I was wondering if I could find what had been said on this, but I am afraid I have not got the paper with me. To the best of my recollection the policy which we originally set out in a headquarters circular of guidance, and which we have since followed, was that there should be for each group, for each hospital within a group or whatever locally was the most convenient arrangement a medical staff committee (consisting of representatives chosen by the medical staff) which would be used by the hospital management committee to advise it on any matters of medical policy arising in the group. It would itself of course be perfectly free to initiate advice on any matter of medical policy which it could present to the hospital management committee. In all this I have been thinking and speaking in terms of committees at the hospital management committee level, not at the regional level where I think a different set of considerations arises.

Mr. *Turton.*

3687. If you had a more satisfactory recognition of these medical advisory committees, could you then reduce the number of professional medical men on the regional boards?—Well, Sir, as I have just said, I have not really been thinking in terms of medical advisory committees at the regional level where I think different considerations

arise. It has never been the policy of the Department to suggest that at the regional level there should be a medical staff committee in the sense of a committee chosen by the medical staffs of the hospitals.

3688. I was not suggesting that, Mr. Pater. I was suggesting that if you gave greater recognition to medical advisory committees at group level, you might then be able to reduce the proportion of the medical profession now on the regional boards. It is high in certain regions?—That would not affect the membership of regional boards, would it? It might affect the membership in hospital management committees.

Wing Commander *Geoffrey Cooper.*

3689. It surely depends on how far your system of consultation goes. If it goes right from the individual hospitals through the area boards to the regional boards, and up to the Ministry, then the point which has just been made is surely valid?—Yes.

Wing Commander *Geoffrey Cooper.*] If you are going to circumscribe it, it does not matter.

Mr. *Turton.*

3690. I thought you were claiming that this system was as decentralised as possible? —Yes.

3691. If that is so, owing to the fact that on your lower level you have got completely satisfactory representation for the advice of the medical profession, it would no longer become necessary to have the overweighting in the regional level?—I would suggest there are two quite separate questions on medical policy which have got to be considered at the two different levels. At the hospital management committee level the medical staff committee is concerned with the medical policy of the group, and nothing more. At the regional level there must be expert medical advice on the planning and organisation of the services for the whole region, which raises a whole new set of issues, and while I will not suggest that no amount of recognition of medical committees at the hospital management committee level can really affect the need for medical advice at regional level——

Chairman.] I think that answers your question, Mr. Turton.

Wing Commander *Geoffrey Cooper.*] On the other hand, has it not been found to be the case that certain people, particularly good medical men, are not necessarily those who are most competent to consider the overall administrative problems of running the services for a region? Is not all you are saying that sometimes directors of companies have a dual role to fulfil, sometimes in running their actual departments and sometimes coming to on the board of directors to consider overall policy? Does it not really come back to the effectiveness of your whole system of joint consultations? If that is complete right from the bottom to the top, that sort of thing would be taken care of irrespective of the number of medical people actually on the regional board?

Chairman.

3692. Can I give a concrete case which I think will illuminate this matter and also take us to the next subject which I want to discuss, the relationship between boards and the general practitioners? At the hospital management committee level you might have an admirable relationship between the committee and the local general practitioners, but you may get a decision, such as you had at Kingston, to convert a particular hospital from a hospital used by general practitioners to some other purpose. Now what machinery is there for securing the advice and goodwill of the medical practitioners before putting in hand some piece of regional policy?—The machinery for getting the reactions of the local general practitioners—that is what you are asking?

3693. In that particular case it was to secure the reactions of the local doctors, yes?—That I think would have to be a matter of *ad hoc* consultation.

3694. It rather looks as if *ad hoc* consultation has not worked very well in several cases. The Kingston Victoria Hospital is one instance; I think there is another instance at Morecambe?—*Ad hoc* consultation does not necessarily result in agreement.

Mr. *Thomas Reid.*

3695. There was *ad hoc* consultation in the case of Kingston, was there?—I would not like to be tied to that; I am not sure.

Chairman.

3696. Are you suggesting that the machinery is there, that consultation has taken place, but that there was not agreement?—No, I do not think so. What I was really trying to say was that there was no standing machinery for this purpose. I doubt whether standing machinery would be possible. It seems to me it would have had to be *ad hoc* consultation in that particular issue. Whether it did in fact take place in regard to Kingston, I am afraid I do not know.

Wing Commander *Geoffrey Cooper.*

3697. Would you suggest that, if in fact the medical profession had come into the system of consultation which you describe, which presumably was envisaged by the Ministry, that would automatically cover the point the Chairman is making, that it would give an adequate channel for the general practitioners to state their case or to discuss matters which worried them?—

I think it could be done that way. I think it can also be done by having a properly constituted medical staff committee.

3698. Have you tried to persuade the medical people to come into this system of consultation? You say that so far they have refused to do so?—I understand so.

3699. Has it even been tried out in one area first?—That I do not know.

3700. Sometimes a pilot scheme will convince people?—I am afraid I do not know to what lengths the persuasion has gone.

Chairman.

3701. Do you leave this question to regions to hammer out for themselves, or have you given any directions to regions as to what they should do about consultation with the medical profession at regional level?—At regional level?

3702. Yes?—We have certainly advised on the setting up, although the advice was scarcely necessary, of medical advisory committees at the regional level. Those of course are intended to assist the board in formulating its policy for the services in the region as a whole, rather in terms of general principles and the application of principles to areas than in terms of consultation on an individual issue like Kingston.

3703. Is Kingston really an individual issue? Surely it is a matter of general regional policy to say that there will be some hospitals used for maternity purposes and others used for other particular purposes. That is a fairly broad question?—That is a broad issue, but the local issue is which particular set of bricks and mortar shall be used for each purpose in a particular place. That is a local issue.

3704. You think that the normal machinery at regional level really cannot deal with that local issue?—I would not have thought so. I would not have thought it was satisfactory to the local people.

3705. It must be dealt with on an *ad hoc* basis having regard to the nature of the proposal?—I would have thought so.

3706. You are aware no doubt that the general practitioner section of the medical profession is not at all happy about the situation. Have you received any complaints direct?—Oh, yes, Sir, we have had a number of representations, over a period, of particular instances of the change in use of general practitioner hospitals, and those we have discussed with representatives of the profession.

Wing Commander *Geoffrey Cooper.*

3707. Would the Ministry itself make use of the system of joint consultation so that full consultations are held on changes of the type to which the Chairman has referred before the proposals are implemented?—I doubt whether the Ministry could undertake consultation on every one of those cases. That would be the negation of decentralisation, besides being a very considerable burden.

3708. Would it not be a matter which would come up to the centre anyhow? It is a fairly big issue. Do you take the trouble to consult first of all, using the machinery of consultation, before implementing policy?—Frequently we consult beforehand.

3709. We did have evidence at one stage to suggest that directives in the form of pamphlets and so forth did go down from the centre, from the Ministry, even bypassing the regions, to people at the lower level, to hospital management committees. That is a matter which has caused a great deal of dissatisfaction. Is that type of procedure still being pursued so that you issue directions without any consultation at all?—That was the point I was trying to deal with at the beginning of this morning's meeting.

Chairman.] I think we have discussed that at some length.

Wing Commander *Geoffrey Cooper.*] Yes.

Chairman.

3710. Can we deal with the question of the general practitioner using the hospital? Have you any figures to show, taking the country as a whole, whether there has been an increase or a decrease in staffed beds available to general practitioners as such?—I am not sure whether we have. I rather fancy we have not, but I should have to look into that.

3711. The medical profession believes that there has been a severe reduction in the number of such beds. Do you think there is any truth in that belief, or perhaps I should say any foundation for that belief?—I would not have thought there had been a severe reduction. There may have been some reduction; I think that is possibly true.

3712. Could you obtain figures at all easily?—I am not sure. I think we may have some. If we have not it would be a question, I am afraid, of a special enquiry from all the regions.

3713. I do not think it is much good asking you to make a special enquiry, but if you have any figures which will show the position regarding general practitioner beds we would be grateful if you could let us have them?—What I think we may have are figures of the position as at the end of 1949 and as at the end of 1950.

3714. Any figures of that sort would be helpful?—But I am not sure.

3715. We have also been told that, apart from the question of general practitioner beds, the general practitioner has felt himself rather kept out of the general work of the hospital. For instance, he has not been able to get the same kind of access to his patients as he used to have before the Service started. Is there any truth in that?—I would not have thought so, but I would not like to say there is no truth in it.

3716. Have you been concerned with that particular problem? Has the Minister sent out any directions or instructions about allowing or disallowing general practitioners access to hospitals?—Oh, yes, Sir.

3717. To what effect?—I can give you copies of this document—I am afraid I have none with me—but the general effect is that the Minister encourages and hopes that every facility will be given to general practitioners to have access to their own patients in hospitals—I am talking of the patient who is in charge of a specialist in the hospital—and also, of course, that every possible association between general practitioners and hospitals should be promoted, for example, by inviting general practitioners to clinical meetings of the hospital, by using suitable general practitioners as assistants in out-patients' work and things of that kind.

3718. Those instructions were sent out as a result of complaints presumably?—Some of them may have been sent out after complaints had been received, but some were certainly sent out long before.

Mr. *Thomas Reid.*

3719. Do general practitioners follow up their patients when they go to hospital?—A fairly small proportion, I understand.

Chairman.

3720. The reason for that would no doubt be the very heavy pressure on general practitioners at the present time?—That is quite possible.

Wing Commander *Geoffrey Cooper.*

3721. The system as it is now operating does in fact make a break between the time a general practitioner handles a case and when that case goes to hospital. Is that break actually being mended, as it were? Are you trying to bridge that gap with specific proposals as distinct from a general direction suggesting that it is a good thing to do? Are you making some facilities for the general practitioner really to go in and actually do the consulting at the time his patient goes into hospital?—I am not sure what specific proposals one can make beyond extending the invitation to general practitioners to come in. That, as far as I am aware, is the generally applied policy, but it is an invitation which very few, for the reason which I think the Chairman has given, find time to accept.

3722. Are there any means whereby the records of the general practitioner, if he has known the case history over a number of years, are automatically produced for the help of the specialists and other medical men engaged on the case?—No, records are certainly not automatically handed over, but of course it is common form, when a G.P. refers a case to a hospital, to supply the specialist at any rate with a short account of any information which will be of use to him.

3723. There is no actual form which leaves a space for the previous history to be given?—No.

Chairman.

3724. Has the G.P. completely free access to the hospital records?—No, Sir.

3725. Have they asked for that?—I do not recollect any request of that kind.

Mr. *Turton.*

3726. Has the G.P. access to hospital facilities for patients who are not entering a hospital?—In some areas, yes, Sir. May I elaborate that? In all areas in one sense, because any G.P. can send any patient to the out-patients' department of any hospital to see a specialist or to attend a particular clinic, but I think you had in mind referring a patient not to the out-patients' department but for, shall we say, a pathological examination or something of that kind.

3727. Exactly?—In some areas that is already available; in other areas it is not. It is a question of physical facilities and staff. Our policy has always been that, as and when possible, pathological examinations should be available to general practitioners in each locality, but the first job of the laboratory at the hospital must clearly be the pathological work needed for the hospital itself, and so far we have not been able to produce facilities in every area to enable general practitioners to be dealt with as well.

3728. The difficulty may well be staff, but the effect of not providing those facilities is to put even greater burdens upon the staff because, if the G.P. has not got the power to initiate that examination and all he can do is to send another patient to the out-patients' department, eventually the same number of staff would be used for the examination. You have an extra burden on the out-patients' department?—I do not think it quite works that way in practice. If this facility is made available to G.Ps. in an area, the amount of work of the pathological laboratory always increases.

Chairman.

3729. You are saying that the mere physical necessity of the case puts a limit on the amount of assistance which can be given?—It does at present in many areas.

Mr. *Turton.*

3730. May I give an example to try to illustrate my point? Suppose a general practitioner has a patient under the scheme, and he wishes to have an X-ray taken?—Yes.

3731. In some areas I understand he cannot send that patient direct to the X-ray department to get an X-ray?—No.

3732. Therefore he will have to send him to the out-patients' department. He will have to have another examination in the out-patients' department, and then he will be sent to the X-ray department?—Yes.

3733. Is that economic?—No, Sir, but what I am suggesting, taking that example, is that if the facilities of the X-ray department are extended direct to the general practitioner he will, in fact, experience suggests, seek a much larger number of X-ray examinations than he does at present.

3734. It really boils down to the fact that you cannot trust your general practitioner?—Not that you cannot trust him but that at the moment we have not got the facilities which would enable us to deal with the demands he would make—in some areas, in many areas.

Mr. *Thomas Reid.*

3735. Is it necessary for general practitioners to follow up their cases once they have passed through their hands?—You mean a case which has passed to the care of a specialist in a hospital?

3736. Yes?—I am not sure that that does not take us into the realms of psychosomatic medicine.

Chairman.

3737. Mr. Reid, I am wondering if that is quite a fair question to put to this witness. I think we might move on to the question of the number of consultants. We have had a figure, but it escapes my memory for the moment. Can you tell us the number of consultants now in the Service?—In round figures I think the number in England and Wales at the moment is approximately 5,600.

3738. That is actual bodies, and disregarding the fact that a certain proportion of them, in fact a large proportion of them, is part-time?—That is so.

3739. Can you tell us the equivalent of whole-time consultants now in the Service?—That would be difficult and not a very reliable figure when you had it, but I suppose it might be perhaps about the equivalent of 5,000, perhaps rather under 5,000.

3740. Rather under 5,000?—I should think so. That is little better than a guess.

3741. Yours would be as good a guess as anyone's?—Yes.

3742. I think that compares with the desirable figure of 7,500 full-time consultants. Is that right?—A desirable figure?

Mr. *Turton.*] Seven thousand was the figure recommended by the Royal College of Physicians.

Chairman.

3743. I think that number was mentioned by the Minister in a Debate in the House of Commons before Christmas?—That I think is a figure calculated and put out by the Department on the development of the consultant services, but that of course is a figure based on the assumption of a completely developed service in all respects, that is to say with all the laboratories one needs, with all the operating theatres one needs, with all the beds and everything else that one needs. It is not in any sense an estimate of the number of consultants required to staff the present service.

3744. I understand that. The present position is that the number of additional consultants coming forward every year is, I think, now limited to thirty, after making good the vacancies caused by death or otherwise?—No, Sir. This is a reflection on the discussion about registrars no doubt.

3745. The British Medical Association gave us evidence that the official figure of vacancies for consultant is now 150 a year, and that is to cover wastage by death and one thing and another of 120 a year, making an increase of thirty a year. They were, I think, related to a statement made by the late Minister of Health in the House of Commons. Are those figures correct?—The answer is yes and no, Sir. The starting point of this evidence is undoubtedly the statement in the circular issued by the Department on the future recruitment of registrars, which was that the information available indicated that for some years to come the number of appointments available to senior registrars to complete their training at hospitals in England and Wales was unlikely to exceed one hundred and fifty annually. That was an estimate of the number of vacancies likely to be occurring over each of the next few years. It included the replacement of wastage, a proportion of additional posts in other services, such as the Army and so on, a certain number of openings overseas and so on. I assume the thirty is an attempt to estimate what is left after a count has been taken of these other openings. Whether it is in fact an accurate figure I would not like to say. It may be too high; it may be too low.

3746. Could I ask the question in parts? First of all is it still the Department's view that there will be one hundred and fifty

vacancies, on an average, filled per annum?—It is still the view of the Department that one hundred and fifty is the maximum number of openings which one can see.

3747. Is it also your estimate that the wastage from death, from emigration and all the other reasons you have mentioned will amount to roughly one hundred and twenty per year?—That I should have to check before committing myself.

3748. At any rate you see no reason to contradict that at the moment?—No.

3749. It would certainly be substantially over one hundred?—I think so, but I should like to have the opportunity of checking these calculations.

3750. The maximum increase which we can foresee, on the basis of the B.M.A. figure, is thirty per year, and on the possibly more optimistic view something round about fifty but no more?—That may be so, yes.

3751. The evidence which the B.M.A. gave us was to the effect that there is accommodation and equipment which would permit at the present time an annual intake, if that is the right word, of new consultants of four hundred a year gross. Do you disagree with that?—I do not think we have the information which would enable us to say whether it is right or wrong. That is why we have got at the moment teams of medical people going round and examining the medical establishments of the hospital in an attempt to find out whether the establishments are too high, too low or about right.

3752. There is very little financial implication in this, is there? It is only a matter of whether you are going to have these men employed as consultants on the staff or as registrars on a more temporary basis. The work has got to be done anyway, has it not?—Yes, that is so, but I am not quite sure that I understand where the increase of four hundred per year is going to be employed.

3753. The B.M.A. gave us quite specific evidence that they thought the present position would justify an intake of four hundred a year?—Yes.

3754. They say the registrars are there and that the facilities are there as well. In other words, they quarrel with the present policy of limiting the intake of consultants to one hundred and fifty a year. I am asking you why you disagree with that?—We disagree with that because we do not know what the facts are on the ability of the existing service to absorb consultants. That is why we have teams going round trying to find out whether the existing establishments are in fact inflated or too weak.

3755. In other words, your reply is that the B.M.A. may quite well be right?—They may be, but I think it is highly improbable.

3756. For what reason?—Because of the very large increase in the number of consultants since the Service began. I think it is highly improbable that there is room for another four hundred per annum.

3757. On the ground that there is no accommodation?—Not the facilities and the equipment for the consultants to use.

Miss *Ward.*

3758. It sounds rather odd to disagree if you really do not know the facts?—I am bound to suggest that it is rather odd to make cases if you do not know the facts.

3759. Would not a more neutral policy be more effective?—We are trying to find out the facts.

Mr. *Turton.*

3760. You are suggesting that the British Medical Association have got no knowledge of the facts?—I am not aware of the evidence on which this estimate of four hundred is based.

Wing Commander *Geoffrey Cooper.*

3761. Who comprise the teams to which you refer, going round and checking the situation? It is a very difficult matter to assess. Are they qualified people or people who have studied some aspects of administration?—They are eminent medical people who are expert in medical work, and in assessing the volume of medical work to be done.

3762. Are they attached to your Ministry, or are they doing a part time job?—It is a part time job.

3763. How many groups are there, and how many in each group?—Offhand I should say there are about ten groups. The normal group is two.

3764. There are two men in a group, and they go round to individual hospitals and check up the position?—Or from group to group.

3765. They are presumably doing it full time in fact?—No, I think not full time.

Chairman.

3766. Are they distinguished professional men?—Yes.

3767. Themselves consultants?—Yes, or retired consultants.

3768. Have you had any information from them yet which would lead you to any conclusions at all?—We have had some preliminary reports which suggest, as one might expect, that in some places the establishments are too large and in other too small.

3769. When do you expect to get sufficient information to come to a final decision on this?—I should hope in the course of this year, but I would not like to be bound to that.

Wing Commander *Geoffrey Cooper.*

3770. Do you make changes as and when deficiencies or excesses are shown?—We have not yet in fact made any changes, but we shall do as we get in the final reports.

Chairman.

3771. You are actually making changes within particular regions or groups?—We shall do, yes. This is part of the general review of establishments which was mentioned at an earlier meeting.

3772. This is simply part of the general review?—Yes. This is a review of medical establishments.

3773. Could you tell us about the assessment of charges for private beds? There are two kinds of charges levied for beds within the Service. First of all there is the Section 4 charge, which is merely a small extra for additional amenities, and, secondly, there is the Section 5 charge which is by Statute a full charge for the cost of the bed plus a proportion of the overheads? —Yes.

3774. In the latter case the patient has to pay for the services of the consultant and for anything else he has while in hospital. That is correct, is it not?—Yes.

3775. It has been suggested to us that the amenity bed is really—I think the word used was this—a fad of the Department. Would you agree with that?—No, Sir. I understand it is an arrangement which has long been in operation with great success in Scandinavia.

3776. Do you think that it is very successful in the United Kingdom?—I do not think it is sufficiently well known yet for one to be able to judge whether it is a success or a failure.

3777. Is there a demand for those beds? —There is a demand in some places, yes, but, as I say, I do not think their existence has been sufficiently well advertised or become sufficiently well known for one to be able to judge yet whether there is a demand for them or not.

3778. What kind of additional amenities are in fact provided?—Either a single room or a small room instead of the general ward.

3779. A small room containing two or four beds?—Two, three or four beds.

3780. Is it generally true that patients are willing to pay something themselves in order to have one bed in a two-bed or four-bed room?—Some are, yes, Sir.

3781. Are there many single-bed rooms among these amenity beds?—There is a proportion, yes. I am afraid I have not got the figures in my head, but we can supply those to you.

3782. If you could provide those easily, we should be obliged?—Yes, I am sure we can. That is the number of amenity beds, and the proportion of them in single rooms.

3783. If you would do that, yes?—Certainly.

3784. The kind of amount which is charged is fixed presumably?—The charge is fixed in the regulations.

3785. It is standard throughout the country?—It is six shillings a day for a single room, and three shillings a day for a larger room. I think those are the charges at the present moment.

3786. Is that the only amenity for which a charge can be made?—No, Sir. I mentioned that simply as being the main amenity involved.

3787. What other amenities are procurable?—I assume the standard of furnishing may be better than that in the general ward.

3788. Is that fixed by regulation too?— No, but one may have better crockery or whatever it may be.

3789. The only charge which is permissible is the six shillings or the three shillings? —Yes, Sir.

3790. For the six shillings you are bound to get a bed in a single room?—Yes.

3791. For the three shillings you are bound again to get a bed in a small room? —Yes.

3792. In addition the management committee can, within its own discretion, provide minor amenities, such as better furniture and so on?—Yes.

3793. That is all there is to it?—Yes, Sir.

3794. If you could let us have the figures we would be grateful?—Yes.

3795. As far as private beds are concerned, that is a very different kind of charge. Can you tell us what the average charge there is throughout the country?— It varies considerably. I do not know what the average is. Do you, Mr. Chatterton? (Mr. *Chatterton.*) I am afraid we have no figures.

3796. It would be misleading to give one? —(Mr. *Pater.*) Yes.

3797. There have certainly been complaints that the kind of charge levied in London hospitals at the moment is so high as to be a serious imposition on any class of the community?—Yes. There is no doubt at all that in some hospitals the charge is high because the cost of running

the hospital is high, and under the Act the charge has to be related to the cost of the services provided to the patient.

Mr. *Turton.*

3798. To the full cost?—Yes. The Act says that the charge is " designed to cover the whole cost of the accommodation and services provided for the patient at the hospital, including an appropriate amount in respect of overhead expenses ".

Chairman.

3799. The charge, I think, is a fixed standard charge within the particular hospital, and includes some appropriate amount for services rendered by the hospital but not necessarily to the patient in the bed. Is that not so?—I suppose the calculation of the charge must depend on the financial information available to the hospital about its costs. In the regulations themselves we have always contemplated two ways of arriving at the cost. For example, where there is a private wing to a hospital and where the costs of that wing can be separately identified, then the charge should be based on that cost. Where, as is often the case, the cost of the private bed is simply indistinguishably lost in the general costs of the hospital, the regulations then require the addition of a percentage to the normal general ward costs based on the generally accepted view that the cost of running a small room or a private room is higher than that of the general ward. That is a flat percentage addition, according to whether it is a single room, a double room or a larger room, to the general cost of running a bed in that hospital.

3800. It will include a slice of the entire services rendered by the hospital?—Oh, yes.

3801. If you go into a hospital to have your appendix out and there is in fact a large psychiatric wing, you would have to pay something towards the cost of that wing although you do not avail yourself of it at all?—Yes. Whether that would raise or lower your charge I would not like to say ; it might lower it.

3802. It might because the man who goes in for a difficult brain operation might have part of his overheads covered by the fellow having his appendix out in the next ward?—Yes, that is right.

Miss *Ward.*

3803. Could I revert to the amenity bed question for a moment? Is there no differentiation in the food supplies?—I would not like to say that in some hospitals there is not a differentiation ; there may be.

3804. My impression is that that is so, and that there are occasions, when there is a bed shortage, where you have a patient put into a small amenity ward when it is possible for two types of food to be served at the same time—one kind to the general ward patient who is in the amenity ward because there are no beds available in the general ward and who would get——?—Thinner slices of bread and butter.

3805. No, thicker slices of bread and butter?—Thicker slices of bread and butter.

3806. And the patient in the amenity bed getting the thinner slices of bread and butter. Have there been any complaints in regard to that?—I am not aware of any.

3807. It does raise a difficulty?—Certainly.

3808. If there is an urgent case which cannot be provided with a bed in a general ward the hospital would put the case into an amenity bed if there was one available. Then what would happen to the urgent patient requiring an amenity bed? It raises a tremendous difficulty in administration, does it not?—I am not sure that the difficulties are not more apparent than real. I think it works something like this. If urgent patients come in and one of them has said in advance that he wants an amenity bed, if there is an amenity bed vacant at the time he comes in he will have one, but if there is not he will go into the general ward. Conversely, if at any time there is a flood of patients (not wanting an amenity bed) who have to be taken in urgently and there are amenity bed empty, they will be put in amenity beds if there are no general ward beds available. Indeed, if the urgency is so great, they will be put into one of the private pay beds if it is a real emergency case.

Chairman.

3809. There are constantly complaints being made that patients are told that, while they cannot have a free bed straightaway, there is a Section 4 or a Section 5 bed available?—Section 5 is the usual complaint which comes to us.

3810. Can you say whether that really can arise?—Oh, yes, Sir. Generally speaking the waiting lists for private beds is shorter than the waiting list for the general free beds. That is inevitable owing to the cost which is involved. Unless one is going in effect to abolish the private bed by throwing the available private beds into the general pool of accommodation, it is inevitable that it should be easier to get into a private bed than into a general bed.

3811. That would not apply to urgent cases?—Oh, no. The emergency case or the really urgent case would be taken into the private bed if all the other beds were full. That frequently happens.

3812. Do you know of any case anywhere where there has been a real emergency, where the patient has been refused admission, although there has been a private bed available?—I think we have had some complaints that it has happened, but I do

not know of anywhere it has been substantiated. I cannot claim to have seen every one, I am afraid.

3813. It would be a slip up on the part of the authorities?—Certainly. I can say that we have had one or two *ad hoc* enquirities into the use being made of private beds on a particular day, and have always found that quite a high proportion of them were in fact occupied by emergency free cases.

Miss Ward.

3814. Perhaps my question was a correct one. All this does give rise to difficult administrative problems?—Yes, I think it does raise problems. I am not sure that they are quite as difficult as you say.

3815. Because there have been occasions—I have raised them myself—when apparently no beds have been available for, I will not say cases which require operations but certainly where there have been mental cases?—Yes. I was thinking in terms of the real emergency case where it is a matter of life and death.

3816. If someone goes off their head suddenly and is found wandering, that is equally an emergency case?—I am afraid the grades of emergency are infinite.

Chairman.

3817. I think we shall be in difficulties in pursuing that at great length. I think the evidence is quite clear. Those responsible do use all the beds in a hospital as free beds when there are really urgent circumstances?—Yes.

3818. Subject to that, naturally the queue is rather less long for the Section 5 beds than for the free beds?—Yes.

Mr. *Turton.*

3819. Do you have any say in your Department as to the proportion of private beds at any hospital?—Yes, Sir, that is subject to our approval.

3820. If a hospital says they will have no private beds, you would not permit that?—Yes, we might agree that was the proper course at that hospital. To take an example, in a group we might have two large hospitals in the same town of moderate size. There it might be the right arrangement for one to have no private beds and for the other to have a slightly higher proportion of private beds.

3821. I follow that, but is there a norm of private beds to free beds?—There is no rigid proportion.

3822. I used the word "norm" rather to avoid that answer on your part. Do you, broadly speaking, try to say so many of the total number of beds are private beds?—I think it is fair to say that so far we have not really had enough experience to enable us to work out a norm under the circumstances, and what we have done so far, therefore, is to take as our starting point the position as it was when the Service came into existence, and to work from that by such light as we have to arrive at a proper proportion of private beds and amenity beds. I think this process of fixing number is not yet complete. There is still a small proportion of hospitals where the final figures have not been settled. When they have been settled I think we shall have to try to get evidence of the extent to which the answer we arrived at as a first shot is right.

Chairman.

3823. There is a very wide variance, say, between Stepney and Bournemouth?—Yes.

Mr. *Turton.*

3824. You have in this a very powerful weapon for cutting down the expenditure of hospitals. It may be a very dangerous weapon, but it is a very powerful one?—By raising the proportion of private beds?

3825. Yes?—Yes.

Mr. *Thomas Reid.*

3826. What effect has the Health Service had on private nursing homes?—Well, I am afraid I have no figures on the number of beds in private nursing homes before and after the commencement of the Service. It is alleged that there has been, at any rate in some places, an increase in the number using private nursing homes, but I am afraid I have no evidence for that.

Chairman.

3827. They are not registered in your Department?—They are registered, but whether we have the figures I am afraid I do not know. I can look and see if we can produce them for you.

3828. If you could easily do that we would be grateful?—It is not my particular concern, but I think we may have figures as regards the number of beds.

Chairman.] If you can let us have that information fairly quickly, please do, but if it is a matter of making a long inquiry do not trouble as it would be too late for our requirements.

Wing Commander *Geoffrey Cooper.*] Could I ask a question with regard to the method by which appointments are made? It has caused a certain amount of ill-feeling as far as I can discover.

Chairman.

3829. I think it would be better to clear up the question of the private bed first. There is another aspect of it with which I want to deal fairly quickly, and that is the schedule of consultants' charges for patients in private beds. Can you tell us whether

they are now under review?—The matter is under discussion with the profession at the moment.

3830. You are actually conducting, I will not say negotiations, but discussions with them with a view to a fundamental change —if that is decided upon?—If that is decided upon. How fundamental I am not sure, but changes certainly.

3831. As far as you are concerned the whole question is completely at large, is it?—The question is still open, yes.

Mr. *Turton.*

3832. That is the charge paid by the private patient to the consultant for the work he does, in addition to the charge for the bed?—Yes.

Mr. *Turton.*] Mr. Chairman, I thought your illustration of the brain and appendix cases rather fell down on that point, because I thought the brain patient would be paying a higher charge for the consultant's work than the appendix patient.

Chairman.

3833. No, that would be merely the remuneration of the consultant himself. Where you have elaborate equipment and the use of that equipment is not included in the consultant's charge, that is included in the charge for the room?—The brain case would require a good deal more nursing than the appendix case.

Mr. *Turton.*

3834. The brain patient would pay a higher charge for the consultant's services than the appendix case?—He might pay more to the specialist, yes, but not pay more to the hospital.

Chairman.

3835. As far as the hospital is concerned he has to pay on a fixed scale, neither more nor less. As far as the specialist is concerned he can make any bargain he likes, but there is a limit?—There is a limit.

3836. There is a limit set by the schedule of charges, and it is that which is now under discussion with the profession?—Yes.

3837. If the whole matter is under discussion it would probably be better not to ask questions about that; you certainly would have to sideline them anyway?—Yes.

3838. Because it would clearly be very embarrassing?—Yes.

Mr. *Thomas Reid.*] With regard to capitation fees for general practitioners, how is that progressing?

Chairman.] Mr. Reid, I think that is getting outside our terms of reference, unless you link it with the Hospital Service.

Mr. *Thomas Reid.*] It is part of the expenditure of the scheme.

Chairman.] Not for hospitals; it is not within our terms.

Wing Commander *Geoffrey Cooper.*

3839. With regard to the method of making appointments, it is admittedly a very difficult problem in such a matter for the Minister to know the facts surrounding the individual. That has emerged as a problem in other organisations besides the Health Service, and it has been tackled in some cases by what might be termed making a scientific appointment. I know it is using the word "scientific" in a colloquial sense, but industry is following methods of appointment, which are considered by such organisations as to the British Institute of Management, so that it does tend to get a higher proportion of suitable people into the most suitable jobs for them. Has any attempt been made by the Ministry in making appointments to consult with such organisations as the British Institute of Management to get from them suggestions as to the best method to employ to ensure that, so far as is humanly possible, suitable appointments are made?—I am afraid I am not quite sure what you call "appointments".

3840. Quite frankly, appointments of any sort, whether in regional boards or in management committees, or even in some cases the appointment of specialists because sometimes a man may be a very good specialist but a very bad administrator?—Appointment as members of the board or as officers of the board?

3841. Both. The whole problem of appointments is a terribly important matter in all industries and organisations of any sort at all. Has any attempt been made by the Ministry to consider this as a problem by itself for which there may be some solution, which would tend to eliminate, as I say, some of the objections made to certain of the appointments?—The appointments are in a number of different hands. The appointments of officers to management committees are in the hands of the hospital management committees. The appointment of officers to regional boards are in the hands of regional boards, and the appointment of members of management committees are in the hands of the regional boards.

3842. Precisely. You send out directives on some matters. Have you ever sent one on the best methods to employ in making appointments which are in hands other than those of the Ministry?—The only requirements of any kind on the method of making appointments are those embodied in the regulations governing the appointments of specialists. Nothing else has been done so far as I know.

3843. I personally have had complaints on the score that people appointed to management committees have been most

unsuitable, and it is wondered how they have got into those posts. Those are the representations made to me. Is it not a matter into which the Ministry might well look with a view to improving the standards of efficiency and control?—In the terms of appointments to management committees and to regional boards the hands of the people concerned are to some extent tied by the Act itself, which requires consultation with various interests and implies that those interests are to find representation in some form on the bodies concerned.

Wing Commander *Geoffrey Cooper.*] Those are very, very vague directions. They do not approach the standards of penetration on this subject which have been set by such professional management bodies as the British Institute of Management.

Chairman.

3844. Might you not dispose of the question in this way by saying that, so far as the Ministry is concerned, in many of the appointments—that would be almost exclusively appointments of members to regional boards and to the boards of teaching hospitals—you are not guided by any general principles other than those laid down in the Act?—I think that is a fair summary.

3845. I think that really is the answer to Mr. Cooper's question. You do not attempt to apply any general principles?—No.

Miss *Ward.*

3846. After experience are you of the opinion that the decision to ask for the retirement of members from regional boards, and indeed I suppose it comes down to all levels, after a stated period of service has worked out satisfactorily because my problem is that with the new appointments you are going to have a less experienced body of people from which to choose, because when the original boards were set up there was a very large personnel available from which to select, comprised of people with past experience of hospital management and general interests in hospital affairs? With the changeover after a period of service you are going to find less and less people who have had experience of hospital management to replace the people you have got to retire. I am really wondering whether you feel it is a good idea to replace people after a certain period of service?—I do not think it has given rise to any difficulty so far. I am not sure how much smaller the constituency of experienced people is now than it was before the Service began, but if one looks at the membership of hospital management committees, for example, there must be something of the order of seven thousand members on them, to which one must add the additional members of house committees who are not members of management committees, so that there is a fairly large constituency there of people simply in the hospital field from which to draw.

3847. You think it is a wise policy for people to retire after they have served, I think it is, three years?—The term of membership is three years, yes, but large numbers are re-appointed. They do not all go after three years, by any means.

Chairman.

3848. There is a high proportion reappointed?—Yes.

Wing Commander *Geoffrey Cooper.*

3849. Have actual complaints been received at the Ministry of unsuitable appointments or, alternatively, where a man feels he has been dismissed without justification, have you received complaints on that score?—Yes, Sir. There are always complaints. I am afraid there is never general agreement either on the appointment or on the retirement of every individual.

3850. And possibly dismissals and so forth?—I am not aware of any dismissals. It is simply a question of not being reappointed when the term of office has expired.

Chairman.

3851. I think your previous reply really covers that. There is no general principle applied here. You simply pick the best man within the appropriate category that you can find, on the best recommendation you can get?—Yes.

3852. There are two small points about which I would like to know something. First of all, with regard to the hospital endowment fund, it is fairly clear from the evidence we have received that the income from this fund, which is now becoming available to management committees, is not being spent. Are you considering any change in this connection, or what do you intend to do if very large balances continue to be accumulated?—That is a matter of policy which, as far as I know, has not yet been raised.

3853. You would agree that large balances are being accumulated?—I am afraid I am not aware of that fact. (Mr. *Chatterton.*) There is a tendency.

3854. It appeared to us from figures which I think you supplied to us that something like about three-quarters of the fund is not being spent. We have asked various hospital authorities about it; their reply in each case has been that they have got nothing particular on which to spend it, and they do not know what the intention is anyhow. Are you giving that some

consideration?—We have from time to time issued such guidance as possible as to the services on which the free money might be spent, but it is not in fact possible to draw any clear line of distinction between services for which the Exchequer should clearly pay and the services which are not clearly Exchequer services. It is impossible to do that for one quite obvious reason, that what may be an amenity at one hospital may be a necessity at another. It is not possible to lay down any clear dividing line. Take a simple example ; a tennis court or a swimming bath would clearly not be an amenity at a hospital where those services were provided by the local authority round the corner, but they might be a necessity from the point of view of recruiting and retaining staff in an isolated sanatorium or a mental hospital. We have given, therefore, our guidance in general terms. We have, of course, noticed that the money is not being spent, but we feel at the moment that these are perhaps early days to raise the problem. It is, if I may use a colloquialism, at the back of our minds, but has not yet received active consideration.

3855. That leads me to ask another question. Supposing that you approve the payment out of public funds for a tennis court in the case of one hospital, are you not driven to doing similarly in the case of any other hospital which requires one?—I do not think so.

Miss *Ward.*

3856. Not within your definition?—No, Sir. (Mr. *Pater.*) If I may venture a remark here, I think there are a certain number of instances in which free monies have been used, and can quite rightly be used, to enable a hospital to get an amenity this year which we should not be prepared to pay for until the year after next. A tennis court may be an example. At the moment we may say in this particular hospital that we are not prepared to look at providing a tennis court because what resources we have are needed for much more urgent things than that, but it may be a perfectly proper expenditure from amenity funds.

3857. Does not that also apply to things which are not strictly amenities at all?—Certainly.

3858. Suppose you take a thing like an electrically heated trolley. Of course in a sense it is an amenity, but I do not think most people would call them amenities in any hospital. Could not the management committee use this money to get such trolleys this year when it was perfectly clear that you were not going to authorise expenditure for the purpose for some years?—Yes. My impression is that some of them have done that kind of thing. (Mr. *Chatterton.*) Yes, that is so.

3859. That is being done?—Yes.

Mr. *Thomas Reid.*

3860. That is the sort of item where there is no annual upkeep charge resulting?—(Mr. *Pater.*) Yes. (Mr. *Chatterton.*) Yes, wherever possible.

3861. You do not like to have this money spent on items which would place a permanent annual upkeep recurring charge on the Department?—Oh, no.

Chairman.

3862. The fact that money can be so spent would appear to indicate that hitherto there has not been very great pressure on management committees of a financial kind?—(Mr. *Pater.*) Yes.

3863. You would agree with that?—Yes, I would agree with that. Mr. Chatterton said earlier that neither the committee nor we have really had enough experience yet to know how this amenity money can best be used.

Mr. *Turton.*

3864. In addition to this endowment money there is also certain money raised voluntarily in the locality for amenities?—Yes.

3865. Is any encouragement being given by your Department for more money to be raised in that way?—Our policy has always been to accept money gratefully when offered, but not to beg for it.

Chairman.

3866. That is high policy laid down?—Yes.

3867. I think it is difficult for us to question you about that. We have had evidence that there are very substantial sums available in the country, money which would be forthcoming for local hospitals, but I feel in some difficulty in asking you about that. I think your only reply can be, "We do not know"?—That is so. I certainly do not.

Mr. *Turton.*

3868. It does rather depend on your definition of amenity?—(Mr. *Chatterton.*) I rather suspect, though I am afraid without evidence, that the substantial sums available are available for capital purposes.

Mr. *Thomas Reid.*

3869. Extensions?—Yes, and therefore in present circumstances could not be spent because of the controls imposed by the Government investment programme and the general building controls.

Chairman.

3870. Have you evidence within the Department indicating that, or is that an intelligent personal guess?—I should prefer to say it is an intelligent personal guess.

We have no concrete evidence on that. There may be odd cases which have reached our ears, but there is no collection of evidence about it.

Mr. *Thomas Reid.*

3871. Again, if you received donations for extensions, the upkeep of the extensions, staff included, would come on the recurring charges of the management committees and therefore would rather take control out of your hands?—Quite.

Mr. *Turton.*

3872. Surely, apart from capital expenditure, by a tightening up of your definition of "amenity", you could throw on these voluntary sources the burden of providing amenities in the hospitals, thereby saving on your estimates?—(Mr. *Pater.*) Yes, Sir, but possibly at the cost of reintroducing a sort of Poor Law stigma into the Hospital Service.

Chairman.

3873. It would rather depend on where you drew the line?—Yes.

3874. If it was merely a matter of getting things like flowers and newspapers, there could be no question of Poor Law stigma?

3875. The only other point of substance about which I want to ask is the question of central purchase of supplies. We have had some evidence that there has been a centralisation of the purchase of supplies by management committees for various hospitals, by regions for groups within the region, and also by the Ministry for the Service as a whole. Is there any policy laid down in this connection by the Minister, or are you dealing with this quite indirectly?—There is a general policy in this sense, that the Ministry have said they intend to develop central purchasing of common user goods, that is the placing of contracts centrally negotiated on which hospital management committees and boards can order. They intend to develop that step by step on it being shown with each individual case that this is a group of articles or equipment where central contracting is going to result in genuine economy.

3876. To what kind of goods are you referring?—So far we have on these common user goods got into the field of things like hot water bottles, rubber sheeting and various kinds of rubber goods of that sort; and in Scotland—I know this because it is in fact done by our own Supplies Division—there has been a central contract for drugs and dressings generally. There are also contracts for the rather more special items like special drugs, aureomycin for instance, X-ray apparatus, X-ray films, and of course large numbers of appliances, including hearing aids and spectacles.

3877. May I interrupt you? The items to which you refer are nearly all things used mainly in hospitals. You might have mentioned bed linen and things of that kind which are in general consumption. Am I right in thinking that you have limited this really to goods of a medical or quasi-medical kind?—So far, but the intention is to develop into these other fields. We are, for example, at the moment engaged in central contracting for mattresses, both spring and otherwise, and for cleaning materials. As I said at the beginning, the intention is to develop this step by step into other fields. We may get into the textiles, blankets, linen and so on, in the course of the year.

Wing Commander *Geoffrey Cooper.*

3878. Do you mean that the central purchasing is actually being done from the Ministry of Health?—Some of it is done directly by the Ministry, and some by other Departments on behalf of the Ministry. It is organised by the Supplies Division of the Ministry.

3879. Are you going to set up stores and so on all over the place?—No. The general basis of these special arrangements is the making of central contracts on which the individual management committees order for delivery at their own premises.

Chairman.

3880. By the contract the Ministry undertake that all their hospitals will buy all their hot water bottles, or up to so many thousand, from the other contracting party?—That is right. The contractor guarantees to supply up to that number.

3881. You tell the individual hospitals, "Do not get hot water bottles without notifying us"?—No. We say to the hospital, "You can get hot water bottles from this contractor (or these contractors), quoting this contract number. You are not to get hot water bottles from any other source".

Wing Commander *Geoffrey Cooper.*

3882. When you say "contractor", do you mean someone who is a wholesale merchant or in fact a manufacturer?—I think normally it is the manufacturer.

Miss *Ward.*

3883. Is it on the basis of the London County Council's central purchasing scheme which they operated before the take-over?—I think not. I think it is quite different, but I am not very familiar with that.

3884. Has that ever been looked at because I understand it was highly successful?—I think opinions differ on that.

Mr. *Turton.*

3885. There is an obvious difficulty. Before the appointed day, in the rural areas of which I have knowledge, purchases were

made for the hospital from the local tradesmen at specially low prices, which were really arranged perhaps on a quasi-charitable basis?—Yes.

3886. That has entirely disappeared, and therefore the cost of your supplies has risen very slightly?—If they are ordered through those retail channels I think the cost probably has risen, but the central contracts, of course, turn the wheel in the other direction ; they result in lower prices.

Chairman.

3887. You cut out the middle?—Yes.

Mr. *Turton.*

3888. Is that so in the rural areas?—Oh, yes. Taking hot water bottles, the hospital in the rural area can get its hot water bottles on these contracts at the same low price.

Wing Commander *Geoffrey Cooper.*

3889. Does not that mean the effect will be that people in any way associated with hospitals—doctors, nurses, staff and so on —will in future be able to purchase goods not only required for use in the hospitals themselves but for their own purposes? For example, when you get all these central contracts fixed, they will be able to purchase their beds, mattresses, towels, sheets, etc., at those contract prices?—No, Sir. These are purchased for hospital use, not for private use.

3890. You do not know?—We do know.

Mr. *Turton.*

3891. May I carry on with my rural point? I gather there would be no charge for the transport of the hot water bottle at all?—That is taken into account in the contract price. The contract includes delivery at a certain number of points, and those delivery points are provided for by the contractor in the contract.

3892. Is your suggestion that, for the delivery of a small quantity of bed linen or hot water bottles in a remote rural area, the price will be lower than the relative price before the war when it was lower than the retail price by charity?—I would not like to say that, no, but it quite obviously is lower than the retail price which would have to be paid locally. I thought you were suggesting that under the new circumstances the charitable element on the part of the local retailer had disappeared, and that the charge he would make would be the retail commercial price rather than a charity price.

3893. No. I am just saying that, owing to the fact that there has been no local purchase as before the war when it was based on a charitable relationship, the prices now were very much higher. I was wondering whether it was practical to revert to a system where such charitable contracting was encouraged with local tradesmen?—Well, Sir, prices are very much higher. How far it is due to the disappearance of the charitable element and how much is due to the general rise in prices I do not know. I should have thought it was very much more the latter than the former. I myself would doubt very much whether you would find the local retailer willing to serve the local hospital now on a charitable basis.

3894. You think local patriotism for the hospital has disappeared in the rural areas?—No, I think that is carrying it much too far. I should say that the charitable disposition of the local retailer has been considerably influenced by the fact that his hospital is no longer a charitable institution in that sense.

Chairman.] I think we have your answer.

Wing Commander *Geoffrey Cooper.*

3895. With this central contracting system in operation the hospitals will be buying goods much cheaper, and there will be a tendency for hospitals staffs to buy items from the stores department of the particular hospital. After all, you are introducing a system similar to that which applied in the Fighting Forces, in which there was a scheme whereby that could be done. Will that happen too in the hospitals?—(Mr. *Chatterton.*) There may be a tendency to do that but it is strictly forbidden, and we should expect our auditor to pick up any cases of improper sales to staff.

3896. It was recognised in the Forces?—It is not recognised in the Hospital Service, or indeed in the ordinary services where Exchequer Funds are concerned.

Chairman.

3897. Have you had any complaints from trade associations or other people about what you are proposing to do in this connection?—(Mr. *Pater.*) I am afraid I do not know that.

Wing Commander *Geoffrey Cooper.*] Is it known?

Mr. *Thomas Reid.*

3898. Some management committees say that there are delays, and that they can get goods quicker and cheaper if they have the right to buy locally where they please?—Yes, there are complaints of that kind, and they are gone into individually when they are made.

3899. Are they found to be baseless?—Some of them certainly are.

Miss *Ward.*

3900. You would keep in mind the advisability, if I may put it in that way, of keeping local goodwill?—Yes, certainly. I

should not like to suggest that central contracting will ever cover the whole field. My own guess would be that there will always be a very large range of goods—perishable foodstuffs are an obvious example—which must be bought locally, and in that connection there has been a development of purchase on a group basis rather than by individual hospitals which has also resulted in some cases in considerable economies we are told.

3901. I see the case for perishable foodstuffs, but what is the position in regard to cleaning materials? You would not always necessarily want to recommend one type of cleaning material which might come from one part of the country whereas there might be manufacturers and wholesalers in another part of the country supplying equally good cleaning material. It has always been a basis of hospital administration that it must work closely in with the goodwill of the district. Although I quite see the advantages of central contracting, there is something to be said for local goodwill?—Yes, but I should not like to give the impression that these central contracts are made only with one contractor. Very frequently they are made with a large number of contractors, and the only difference in some instances may be that the hospital is buying its cleaning materials from exactly the same contractor from whom it has always bought them locally but is getting them a good deal cheaper.

Chairman.

3902. There are complaints from boards and committees that it does not always result in economy. We had a specific complaint from the South-West Metropolitan Regional Board who said that they were compelled now to buy test tubes at six shillings and sixpence a time, which test tubes they could buy at three shillings and sixpense if they were allowed to buy them where they wished?—That is a question one could only answer by going into the individual case. As I said in answer to an earlier question, there have been a large number of allegations of this sort, allegations which have proved to be quite baseless, the obvious example being that the two sides are talking about articles of completely different quality.

3903. On the whole you have not met any serious difficulty in this connection, and you are developing as you find out that it seems to pay?—Yes.

3904. That is the broad position?—That is the broad position.

3905. I suppose equally you are giving encouragement to a similar policy being carried out within the regions?—On a regional basis, no, Sir, because we have always discouraged the building up of any regional supplies organisation which could only duplicate either the management committee's supplies organisation or the Ministry's supplies organisation, or both. We have therefore, although in some regions supplies arrangements at regional level already existing have been continued, so far as possible discouraged the building up of a new regional supplies organisation. We have encouraged group purchasing at the hospital management committee level, or even by groups of hospital management committees.

3906. This is in fact a management function and not a planning function?—Yes.

3907. That would go to show that you do regard this as essentially an empirical matter?—Yes.

3908. It is not a matter of grand policy at all?—No.

Mr. *Turton.*

3909. Getting round to the subject of how out-patients' departments have been overburdened and hospitals generally overburdened by the care of the chronic sick, I would like to ask one general question on that. Is your Department concerned about the amount of use of hospital accommodation by the chronic sick, and what is your policy to remedy that state of affairs?—Yes, Sir, we are certainly concerned at the gap which certainly exists between the supply and demand for chronic sick accommodation, and the matter is being tackled in various ways. One way is by encouraging better diagnosis and more active treatment of these people on their first entry into hospital, so that they do not, as so many did in the old days, become unnecessarily bedridden and so that they can in fact after a period of active treatment be discharged either to their own homes or to a residential home for old people. We are also trying, though this is more difficult because of our limited resources, to develop additional long-stay annexes to hospitals where the chronic sick, for whom everything that can be done in the way of treatment has been done, can be looked after in accommodation which is less expensive than the general hospital. We are also trying, of course again within the limits of our resources, to encourage the provision of homes for the elderly by local authorities, that is homes to which hospital patients who are fit to be discharged can go and live.

3910. You use the phrase "within the limits of our resources". Will you explain what you mean by that?—I mean resources both financial and capital investment—the building resources allocated to us under the Government's investment programme and the financial resources for them.

3911. That would not come under this very Vote?—The provision of hospital annexes would, yes.

3912. But not homes?—No, the limiting factor there is capital investment largely.

Chairman.

3913. Can you tell us what is the average cost per head in these establishments? I went to a home recently, and I was told that the cost per head worked out at about £8 to £9 per week?—Which sort of establishment was this?

3914. This was a local authority home?—I do not know, I am afraid.

3915. It seemed to me that was very high indeed. I wondered if you could give us the corresponding cost for the long-stay hospitals?—I am afraid I have not got that. (Mr. *Chatterton*). I am afraid I cannot give you a figure offhand.

3916. Do you know in fact whether they are very expensive?—(Mr. *Pater.*) A rough figure for 1949-50 is given in the published accounts.

3917. Is that a gross figure?—That is a gross figure, is it not, Mr. Chatterton?

Mr. *Turton.*

3918. The figure in the accounts does not relate to the instance to which the Chairman and you are referring?—No, I am afraid this figure does not distinguish between the chronic sick home or annex and the other hospitals.

Chairman.

3919. There is a very narrow dividing line between a hostel which is a hospital service charge and a home which is a local authority charge?—Yes.

3920. In many cases an individual might be in either, I take it?—Well, normally the individual in the local authority home would not be sick; he would be a person who could get about on his own, and dress himself with perhaps a little assistance. The person in the hospital annex will be much less physically capable than that, and may well spend a large proportion of his time in bed being nursed and possibly the whole of his time being nursed.

Miss *Ward.*

3921. There has ben a tendency in some regions to take over hospital accommodation, which was previously used for the chronic sick, and turn that into homes under the National Assistance Board. That has happened in my region?—I am not quite sure how that could happen, because the regional board has no responsibility for Assistance Act accommodation.

3922. Would it surprise you to know that the other day the Minister in answer to a question told me that there had been an expansion of hospital beds for the chronic sick, I think it was thirty, and when I arrived in the North of England I was told that in fact that was so but at the same time fifty-two had been closed down, so that it really was a deficit of twenty-two whereas the answer given was that there had been an expension of thirty?—No, I could not answer that one.

Mr. *Turton.*

3923. In regard to this paper which you got out for us on Kyre Park, Tenbury Wells, I notice that the capital cost of this sanatorium works out at £936 a child. I also notice that the contract period was ten months, but that it is now expected to be twenty-six months. Can you say whether those two factors are unusual, or is that a very general capital cost?—The £900 per bed I should have said, generally speaking, was on the low side at present prices. It would normally cost a good deal more than that to build an entirely new sanatorium.

3924. What is your figure for the normal present cost per head?—I am rather guessing, but I think nowadays it is in the order of £1,500 to £2,000 per bed, assuming that you are able to build an entirely new sanatorium. The length of the contract is I think unusual, and I think is due to the isolated situation of this site and the difficulty of getting labour to work on it. It is quite exceptional for a scheme of this size to take as long as two years to complete.

Chairman.

3925. We have had some evidence that technical staffs—I do not mean medical, but other than medical—are sometimes duplicated in both boards and committees who maintain technical staff, and that there is some wastage caused thereby. Can you say anything about that?—Could you help me by saying what sort of technical staff?

3926. Architects in particular?—I think the practice there varies rather in the different regions. I think all, without exception, have a regional architect. Some have built up a larger staff than others because some regions have decided, as a matter of organisation, to undertake the bulk of the architectural work for the hospitals in their region at the regional board office, in the architect's office, while others have relied more on the employment of local architects with simply an examination at the regional level by the architect of the plans produced by those other people. I am afraid I do not know how far that may involve duplication, but I should suspect that the suggestion of duplication arises out of the old question of how far it is necessary for plans produced at one level to be scrutinised again at a higher level.

Mr. *Thomas Reid.*

3927. Do not your travelling officers who enquire into medical staff establishments also enquire into this sort of staff to see if it is superfluous?—Not into the architectural staff, no.

Chairman.

3928. There is no enquiry?—There has been a general examination of the administrative staffs of regional boards, a separate one, but if I may say so we have not attempted to lay down ourselves as a policy either that all the architectural work of all regions should be undertaken in the regional offices or that it should not. We have left that to be a matter of local discretion.

3929. You are expressing the view that there might well be duplication without waste?—There may be.

3930. In that there is a difference in function between one body and the other?—Yes.

3931. You could not say offhand whether in fact it is not rather overdone, and that there may be some waste?—There may be, but that I should hope our visiting teams would pick up.

Chairman.

Thank you very much indeed, Gentlemen. I think we shall not have need to trouble you again, if you could let us have the various pieces of information for which we have asked.

The witnesses withdrew.

Adjourned till Thursday, 28th June, at 10.30 *a.m.*

ANNEX 1

HOSPITAL SERVICE STATISTICS, 1950–51

Regional Hospital Board	Statistics, 1950–51			Population (31.12.48)	See paragraphs 3 (*b*) and 3 (*c*) of Appendix 1 to the Report			Total expenditure for each Regional Hospital Board area expressed as cost per bed. (For this purpose 5 out-patient attendances have been equated to 1 in-patient day)	
	Average No. of staffed beds		No. of out-patient attendances		Charges for appliances	Pay-beds		Total expenditure for Region	Cost per bed
	Hospitals	Mixed* Institutions				See National Health Service Act, 1946			
						S 4	S 5		
				Millions	£	£	£	£	£
Newcastle	24,735	1,945	2,393,420	2·862	450	2,765	45,877	9,907,643	380·4
Leeds	31,308	1,138	2,818,402	3·030	325	7,485	122,790	12,277,162	373·7
Sheffield	33,466	2,103	2,737,296	4·058	695	17,314	126,519	13,327,677	381·2
E. Anglia	13,226	604	934,051	1·391	265	1,050	58,545	4,946,879	360·1
N.W. Met....	33,023	675	4,286,749	3·821	584	10,744	135,890	17,885,598	505·6
N.E. Met.	30,051	—	3,484,449	2·955	465	3,674	69,447	15,677,670	490·5
S.E. Met.	33,271	1,616	4,597,326	3·107	480	20,940	103,770	16,591,642	463·6
S.W. Met.	60,994	747	4,879,243	4·402	987	57,740	176,894	25,935,295	407·4
Oxford	12,653	1,114	1,117,879	1·357	427	4,400	55,191	5,452,505	411·0
S. Western...	34,736	1,408	2,418,199	2·650	505	21,871	112,875	12,478,615	346·0
Birmingham	40,231	2,335	4,705,424	4·335	1,173	6,182	146,285	15,239,681	356·0
Manchester	42,524	3,326	4,332,008	4·360	340	22,281	131,725	15,500,018	345·2
Liverpool	22,540	852	1,945,193	2·061	670	6,900	53,976	8,695,979	368·4
†Boards of Governors ...	24,411	—	12,293,973	—	5,655	9,865	817,400	—	—
Total (England)	437,169	17,863	52,943,612	40·389	13,021	193,211	2,157,184	173,916,364	399·8

* Non-sick beds in former Public Assistance Institutions ownership of which vests in the Minister.

† No. of beds and out-patient attendances does not include National Hospital for Nervous Diseases.

ANNEX 2

HOSPITAL AND SPECIALIST SERVICES

Memorandum by the British Medical Association

It is not surprising that many difficulties and fresh problems have arisen in the administration of hospitals in this country when the drastic nature of the change that took place on the appointed day in 1948 in the ownership and administration of hospitals is remembered. In order to assist the Select Committee on Estimates the Association submits the following statement of its views:

Administrative Considerations

The problems of efficient hospital administration are complex and intricate, especially in the case of highly developed consultant-staffed hospitals. These problems, which vary from hospital to hospital and from one part of the country to another, were all dealt with locally before the appointed day, the Managing Committees or Boards of hospitals shouldering all the responsibility of both ownership and administration. The responsibilities of ownership have now been entirely removed from the local health authorities and from the old voluntary Hospital Boards of Management. Many administrative difficulties have therefore arisen through the centralisation of administration that has taken place.

Over-centralisation

Centralisation of administration carries with it the dangers of insufficient local knowledge and interest in hospital matters. Before the war, hospital administration was greatly helped by the sense of ownership which the local communities felt for their hospitals, and by the keen co-operation of large numbers of people in the work of running and maintaining these institutions. Any steps that could be taken to give back to hospitals as much as possible of the sense of local ownership would help efficiency and economy by restoring local interest, making administration more flexible and rendering it easier to recruit the best type of member to Hospital Management Committees.

Voluntary Finance

At the present time Hospital Boards can accept financial gifts from the public but must not appeal for them. This apears an unnecessary restriction. It has been carried further by the present Minister, who has instructed Hospital Boards that in order to avoid what he calls " misunderstanding " no member of a Hospital Management Committee should play a part in the administration of any unofficial organisation set up for the purpose of raising funds to help a hospital. These restrictions should be swept away. Hospital Management Committees should be permitted freely to associate with unofficial organisations set up for the assistance of their hospitals. There is no reason why Hospital Management Committees should not be permitted to organise appeals by all the familiar machinery of pre-war days to supplement public funds. Restoration of this right, even in these days of stringency, would undoubtedly take the edge off the strict economies necessary in the Service, permit of some initiative and enterprise by Hospital Management Committees for the support of which public funds could not be given, and increase local interest and responsibility. Such an arrangement would help the replenishment of hospital free moneys. Some of this voluntarily given finance would be valuable to assist medical research and equipment for which Exchequer funds would not otherwise be available. The right to make appeals for funds would do something to restore a sense of ownership to Hospital Management Committees. It is not suggested that a voluntary income should reduce the Government's obligation to maintain its hospitals, but that it should be a supplementary income at the full disposal of a hospital committee.

Block Grants

It is suggested that State funds for hospital purposes might with advantage be given in the form of block grants to Boards and Management Committees, permitting thereby maximum local responsibility in deciding how best to expend these grants. It is also suggested that such grants should be considered separately for capital and for maintenance purposes. A grant for capital expenditure might be given for use over a period, such as, for example, five years. At present, inefficiency results from capital and maintenance expenditure having to be enclosed within one Annual Budget.

Examples of Waste and Inefficiency

Any steps of this kind reducing the necessity for minute detailed central scrutiny of hospital boards' and committees' work is desirable. Our profession has much evidence of excessive waste in time and money from such over-centralised activity. The daily necessity to refer trivialities to a higher authority or another committee, or to devote much time and energy to answering minor enquiries from above compare unfavourably with the smooth rapidity of decision and execution in the pre-war hospital. We have not viewed with approval the steady increase in the number of minor administrative staff in hospitals and the multiplicity of their office furniture and equipment. The proportion of hospital staff to-day directly serving the patient is much reduced. We consider that economies and efficiencies would follow a systematic re-examination of the policy of grouping hospitals under a common management committee for a number of hospitals. There is evidence that in many instances this is working expensively and inefficiently. It has not always proved the case that grouping of hospitals means economy. If, for instance, it means that when a small repair is needed in a hospital, a lorry has to be sent with personnel from group headquarters, 25 miles away, when before the war the local staff would do the job, this is wasteful and we have much evidence of the occurrence of this sort of thing. A recent request from the Ministry of Health was made to a Board of Governors, asking them to enquire into whether or not all the cars of their staff were properly insured. When the Board protested at the cost of this enquiry (apart from the waste of time) they were informed that it would be met from public funds.

The growing practice of administering from a distance by directives and circulars in all sorts of detailed hospital matters is proving not only wasteful in time and money but irksome and inefficient. Hospital authorities on the spot are feeling increasingly confined and frustrated by a distant bureaucratic hand, unfamiliar with bedside problems. As a particular instance consideration should be given to the position of the so-called " Western Area " of the S.W. Metropolitan Regional Hospital Board. It is particularly apparent that administration of this Area centrally from London is giving rise to inefficiency and delay from lack of local knowledge and unnecessary expense of public monies. Consideration should be given either to the giving of greater autonomy to the subcommittee of the Board administering this area or to the division of this Region into two under separate Boards.

It is understood the Ministry already has a Memorandum in its possession on this subject approved by the Western Area subcommittee of the S.W. Metropolitan Regional Hospital Board.

Our profession has been much concerned by the poor quality of expanding administrative staffs. Many of these are defectively trained and qualified for their work. We regard the whole policy of the Government as regards administration in the hospital service as in need of complete overhaul and thorough scrutiny.

An example of waste and inefficiency through ill-considered administration is the costly and confused ambulance and hospital transport service. This is un-co-ordinated between district and district, ambulances travelling excessive distances when better local co-ordination would have prevented this. However, this example is but typical of the state of hospital administration as a whole.

Hospital Boards and Committees

It is desirable to consider how to make the appointment of Regional Hospital Boards and Hospital Management Committees as democratic as possible. We feel that the principles that operate should contain the smallest possible element of *selection* by the Minister.

Selected committees are found to have a feeling of dependence on higher authority. A sense of independency based on democratic support on the other hand is an asset to the strength and vigour of a Board or Committee. It will be recalled that when the Minister's first appointments to regional boards were publicly announced the shock was so great that the Prime Minister was questioned on the matter in Parliament. Few would admit that the overall quality of Regional Boards is really satisfactory. Committees appointed wholly by selection are so liable to have an unnecessarily emphasised political flavour as is the case with Hospital Boards today. Whilst in a publicly financed service the government must have the last word on the membership of such committees, to a far greater extent than is the case now, these committees should be in some way chosen locally rather than ministerially selected after inviting large numbers of nominations that give the Minister a wide choice for his fancies.

Local autonomy, in other words, should be restorted in maximum degree to our hospitals. Only in this way will our great hospital and medical traditions, upon which all our work today is based, be cherished with the preservation of a power of spontaneous growth and flowering in our hospital development. The urge to expansion and improvement should come irresistibly from the periphery, not by direction and circulars from a remote coldly bureaucratic centre.

Long experience has shown the wisdom of our profession being adequately represented in all its branches, upon hospital boards. We deplore the Ministerial policy to reduce our representation. For many generations the presence of members of the senior medical staff on hospital boards has been accepted as necessary to efficiency. There is no doubt that the profession as a whole should have proper representation on such boards. It is important however, that the representatives should be those desired by the profession rather than those selected by the Minister. We deplored the recently evident tendency to reduction in medical membership of Boards.

Joint Consultation

The Minister has neglected to develop the principle of joint consultation between the staff and administration at all levels in the National Health Service, and efficiency and economy have suffered in consequence. The principle of joint consultation between staff and administration is now accepted as a fundamentally sound one throughout the whole field of industry, and in a complex organisation such as a hospital service, where highly expert staffs are necessary, such joint consultation is absolutely essential to efficiency and economy as well as to the maintenance of good spirit and morale. On the medical side there should be constant joint consultation between the senior staffs of hospitals and hospital management committees on medical organisation, policy, and development, and also between the profession as a whole and hospital boards on all relevant matters of administration and policy. This constant joint consultation should take place, in addition, between regional hospital boards and the senior medical staff in contact with them (as well as with the profession as a whole in the region), such consultation to take place on the regional development of the consultant and hospital services. If, for example, regional hospital boards depend solely for their expert medical guidance on medical officials such as senior administrative medical officers, or upon the very small number of medical men appointed by the Minister to be members of such boards, the efficiency of the regional consultant services will unquestionably suffer. The right spirit of vitality and co-operation will be absent from regional board services, and the proper degree of mutual understanding and co-operation between the regional board and its expert staff will not be attained.

Of extreme importance is the same principle of joint consultation at the centre, between the Minister and his officials and the chosen representatives of the medical profession. The Central Health Services Council does not fulfil all the requirements of such joint consultation, in that it is in the main an appointed body as distinct from a body representative of staff, i.e. a body composed of the elected spokesmen of the medical profession. Continuous joint consultation should be taking place between the Minister and his officials and the chosen spokesmen of the profession on the medical development of the Service. This would be an organisation rather parallel with the Whitley machinery concerned with the terms and conditions of service of staffs. It is not suggested that the joint consultative machinery on policy and administration should have the same statutory powers as the Whitley machinery, but it should be roughly parallel. Since the appointed day, the Minister, as far as the hospital services are concerned, has tried to administer this enormous, intricate organisation at the centre by a handful of administrative civil servants, inexperienced in hospital life and administration. These officials have had as their source of advice a small number of whole-time medical officers of the Ministry of Health, also not representative of the authority and experience of our profession, particularly in hospital matters.

Quite apart from the troubles of general practitioner negotiation, consultants have been from time to time given an opportunity to express their views to the Ministry, but this has been of an interrupted and irregular nature, often too brief or too superficial, and many troubles, such, for example, as the Registrar crisis, have resulted from the inadequacy of joint consultation before decisions were taken by the Ministry.

Medical Staffing of Hospitals

The method of hospital staffing that existed in the teaching hospitals and leading consultant-staffed non-teaching voluntary hospitals of before the war is fundamentally the best except for general practitioner and certain other special types of hospital, such as long stay institutions.

Hospital Medical Staff Advisory Committees

It is for this reason that the profession has repeatedly urged the Ministry to give statutory recognition to advisory medical committees of hospital staff, as well as of the profession as a whole, such committees being the normal source of professional advice to hospital management committees on the medical side of their work. It is also the reason why the profession has repeatedly urged upon the Ministry, with incomplete success, the necessity, if the terms of the Act are to be implemented fully, to enlarge the consultant establishment so that the whole country is adequately served.

Broadly speaking, the fundamental principle of hospital staffing which is the only satisfactory one at the present time with the exceptions mentioned above and which has existed during the last century in British hospitals, is that of consultant charge of all beds and patients in hospitals, covering the various branches of medicine and surgery, the junior or supporting staffs of hospitals consisting of registrars and house physicians. It is important to realise that the intermediate grade of medical officer in hospitals—the registrar—is not just or even primarily some sort of "training" grade for consultants, but has been for the last century an essential one in the daily work of hospitals replaceable only at the expense of efficiency. The last century's experience has shown that, whilst the consultant's is a permanent appointment, the junior appointments of house officers and of the intermediate grade of registrar should both be temporary. Efficiency (and therefore economy) falls off if the tenure of house officer and registrar posts is made too long.

Complete discretion should be permitted to employing authorities to appoint as consultants those applicants who seem most fitted to the posts. Normally, employing authorities will appoint the consultants of the future as in the past, from the ranks of suitably qualified and experienced registrars. As in the past, however, they must be free to use their judgment and responsibility in selecting whomever they think best for consultant vacancies, and their hands should not be tied in any way. The customs and traditions of the last hundred years in regard to the making of consultant appointments should be permitted to continue in the future.

A damaging mistake has been made by the Ministry, through lack of adequate joint consultation with the profession and inexperience in hospital matters, in regarding the intermediate hospital grade (that of the registrar) as essentially some sort of supernumerary training post for consultants. It is important to realise that the attainment of consultant rank in hospitals should be a wholly competitive matter, and that the registrar establishment throughout the country should be guided by hospital need and by no other consideration. The substitution of consultant, registrar or house officer grades by any other type of medical officer, such as a permanent subordinate officer as distinct from a temporary one, will cause loss of efficiency and increased expense. It is essential to the maintenance of hospital efficiency that these principles of junior hospital staffing should be firmly understood by all concerned, especially in view of recent grave mistakes and misunderstandings.

Appointment of Consultants

The method for the appointment of consultants, and also of registrars, at present in operation is in need of considerable re-examination and modification. In the past medical committees composed of consultants always had the opportunity to make recommendations regarding candidates for senior hospital posts to appointing authorities. The Service has lost through the abolition of this right and it should be restored.

The views of the medical profession on the problems of hospital organisation, administration and economy could be summed up in these words: *that the highest standards and greatest economies can only be attained by a readiness on the part of the Government to invite the fullest co-operation from* the medical profession in hospital administration and in the formation of policy. The Service is standing at the parting of the ways at the present time. Either the hospital service will develop in the direction of increased joint co-operation and consultation between hospital medical staffs and hospital administrative authorities, or else it will proceed on the other, downward, path of increasing separation between hospital administrative authorities and their expert staffs. Such separation can only lead to mutual distrust, friction, a sense of frustration, inefficiency and loss of economy. *It is felt by the profession that at the present time the most strenuous efforts possible should be made to establish thorough joint consultation and co-operation between the profession and the administrative authorities in the hospital service.* Not least between the profession and the Minister a change of spirit is required, so that advice from the profession is considered on its merits and accepted if sound. To-day it seems that the Ministry and other hospital administrative bodies only too often give but perfunctory attention to medical advice they express willingness to receive; and finally ignore it.

Private Beds

It is in the public interest that the private and amenity bed arrangements be altered. There is little point in trying to continue private beds if the maintenance charge for admission to these beds is prohibitively high ; nor should this charge vary from district to district. It is desirable that the pre-war practice of keeping the maintenance charges of private wards in hospitals at as reasonable a level as possible should be restored. It would probably be best if amenity and private beds were amalgamated. The maintenance charge should be made within the reach of most of those persons who desire private accommodation, and the profession should be trusted to fix their own charges for professional services to patients in these beds. An attempt at a detailed restricted schedule of charges should not be made. It is ineffective and time-wasting. The amenity bed appears to be a fad of the present government, and should be abolished as a separate institution.

Charges to Patients

There appears to be a *prima facie* case for enquiring into the possible levying of a "hotel" charge for board, for example, upon patients admitted into hospitals who could afford such a charge without hardship. We support the principle that a contribution towards cost should be made by patients who can afford this for appliances supplied. Such contributions from patients would make the relationship between the public and the hospitals healthier than it is becoming at the present time and would release money that could be used for such needed purposes as the building and extension of hospitals, provision of equipment, research and release from growing economic strangulation.

General Practitioners and Hospitals

The profession supports all possible extension of general practitioner association with hospital work and has long had this under consideration, both in its own counsels and in discussion with the Ministry of Health. One important aspect of this is to solve the problem of the entry into general practice and the obtaining of suitable hospital work by the Registrar of some years of experience. Finally, to summarise, every care must be taken to ensure that the hospital service retains an urge to spontaneity of development, as the best hospitals had before the appointed day and for which a sense of local freedom and independence is necessary. Hospitals without individual vitality, tradition and personality that are organised passively and distantly from Whitehall will be inefficient, costly and soulless and be associated with a decline in medical standards. The hospital service will become rigid and unadaptable and the progress of medicine imperilled.

December, 1950.

ANNEX 3

THE HOSPITAL SERVICE

Memorandum by the Royal College of Physicians

1. When they were taken over by the National Health Service, the hospitals were at all stages of development. In some, particularly the teaching centres, the facilities for diagnosis and treatment were extremely good, and the amenities for patients admirable. But the high standard of many of the voluntary hospitals was maintained only by providing a partial rather than a complete medical service. Certain branches of medicine—e.g. the care of the chronic sick and the tuberculous—were mostly left to the municipal hospitals. A few of the latter, notably in the County of Middlesex, at Birmingham, and Cardiff, had been fairly well developed; but in many parts of the country the services provided by the local-authority hospitals, and also by some of the smaller voluntary hospitals, were primitive. With the prospect of nationalization the normal development had been arrested. To attain a reasonable level of hospital work all over the country much leeway had to be made up.

The National Health Service is only thirty months old ; and this should be borne in mind when considering both improvements and economies.

2. In recent years there has been a steady increase in the public demand for hospital investigation and treatment, and this increase was accelerated when the N.H.S. Act removed economic barriers which formerly operated. As a result of health education, many patients now seek hospital investigation sooner and more frequently than in the old days. A bigger demand for hospital treatment also arises from shortage of

housing accommodation and from lack of help in the home. This is aggravated by the fact that there is a higher proportion of aged people in the population, and possibly by a decline in the sense of family responsibility.

Pressure of work on general practitioners, due especially to the provision of free treatment for mothers and children has encouraged them to refer to hospital, cases which previously they would have treated themselves.

Parallel with this increase in demand from the public and from practitioners there has been an increase in the complexity of medical techniques needed for diagnosis and treatment. Some of these techniques save life and shorten illness, but they make heavy demands on the pathological, radiological and blood-transfusion departments as well as on medical and nursing staff.

A not unimportant claim on the time of senior staff, particularly since the Act, has arisen from the increase in committee work in relation to hospital and regional services.

3. The greater demand has been partially met by a considerable increase in the number of registrars, which has enabled more out-patients to be seen, more operations to be performed, and a quicker turnover of patients to be attained, but there still remains a need for more consultants particularly in the Provinces.

Although few new buildings have been erected, internal reorganisation in hospitals and particlularly the reopening of wards closed through lack of nurses, has made it possible to cope with more work. On the other hand, wherever staff is insufficient, the turnover of patients is slowed, and the service runs uneconomically.

During the past two years the general level of equipment has certainly improved. In many hospitals, however, sheer physical limitation of space has greatly curtailed services demanded by the public and has made long waiting-lists inevitable. For example, some radiological departments are so overburdened that the investigation of out-patients is often postponed for weeks. Excessive pressure on special departments sometimes means that patients admitted for investigation spend unnecessary days in hospital awaiting their turn ; which represents a waste of bed space.

4. The increase in the cost of hospital services before and since the Act is not confined to this country but is a world-wide phenomenon.

> In the United States " the national average expenditure per patient day in hospitals for short-term illnesses during the four-year period 1945 through 1948 rose from $8.60 to $13.09. The average cost per day in one State during 1948 exceeded the 1945 average by almost 100 per cent." (*Journal of American Medical Association,* September 10th, 1949, p. 136.)

> In Sweden " hospital costs in 1948 were approximately three times what they were in 1938." (J. A. Charles, *Lancet,* 1949, ii, 571.)

In Great Britain a major contribution to the increase has been the adoption of national salary scales for many grades of hospital workers. In addition, patients in Hospital are better fed and this entails a bigger and more experienced catering staff.

Perhaps it is fair to say that the increases in administrative and clerical staff have been made chiefly to provide a better service to patients, and only to a small extent to meet requirements laid down centrally. Such factors, together with the larger turnover and rises in the prices of many commodities, mainly account for the advance of 42 per cent. in the estimate for hospitals for 1950-1951 compared with the final estimate for 1948-1949. Certain serious deficiencies in the medical service have been rectified, but the bigger outlay does not imply an uncontrolled orgy of spending.

5. It is important that both the public and the medical profession should be aware of the very high cost of hospital care. If it were more widely known that a hospital bed costs the nation between £12 and £20 a week, and even more in certain specialties, there might well be greater co-operation, among all concerned, in reducing the demand on hospital services. It is particularly unfortunate that the present policy prevents the general public and the Profession from knowing the cost of individual hospital services, and also makes it difficult for those charged with hospital administration to compare their own units with others. It is greatly to be hoped that the Ministry of Health will find a way to modify the principle that hospital accounts must first be presented to Parliament, and will permit—indeed require—the publication of hospital accounts as soon as they have been audited. It would be a great advantage if the National Health Service, or some independent body such as King Edward's Hospital Fund, could resume the publication of statistical tables for at least a large sample of hospitals. The summarised accounts at present presented to Parliament are useless as a means of studying and checking expenditure.

6. A considerable number of patients occupying hospital beds need not be there. They fall into three groups:

(*a*) Those who could equally well be treated at home if domiciliary care were adequate.

(*b*) Those who could suitably be discharged to institutions of a simpler and less expensive kind (e.g., medical and surgical annexes, or homes for the chronic sick) if these existed.

(*c*) Those who could have been investigated without admission if the outpatient departments had better facilities, including where necessary hostel accommodation for one or two nights.

Some of the beds which these patients occupy would properly be used for other patients who now have to wait for their admission; but a policy of improving domiciliary care, providing hospital annexes, and developing investigation in outpatient departments would go some way to reduce the pressure on hospital wards and the demand for more of them.

Under existing conditions, the general practitioner has no incentive to keep a patient in bed at home if he can transfer that patient to hospital; and if practitioners are to join in promoting domiciliary care, and in economical use of the hospital service, they will need help and encouragement. The provision of health centres would enable them to do more for the patient and so reduce their demands on the hospital service. If local authorities were to do more by providing temporary home helps and visiting nurses, it would be possible, for example, for patients to be sent home by ambulance appreciably earlier than at present. Practitioner, local authority, hospital and voluntary organisation should work together to such ends. As things stand, however, the family doctor gains no advantage, either financially or in prestige, by forging a closer link with hospital work. If he has a full list, he has no wish to take on extra commitments and no time to fulfil them.

7. In the hospitals themselves research into methods of costing is urgently needed and would help to ensure a better appreciation of the cost of special investigations. No one would wish any essential investigation to be curtailed or withheld on account of expense, but there are many occasions when a further examination may be interesting but is unlikely to influence the management of the case. If the cost of such investigations were known to those who order them, the demand would undoubtedly be reduced. This principle needs wide application in medical practice and would be entirely acceptable if it were made clear that expense is not a consideration when real necessity dictates a particular course. For instance, few junior members of hospital staffs have ever been told that plasma costs over £10 a bottle, and it is sometimes used when saline at 3s. 6d. would be equally effective.

8. Although there is little evidence of real extravagance in the hospital service, further emphasis on economy is needed, if only to offset the continuing rise in prices. Economy is necessary not only in the sense of reducing costs, but also in the sense of increasing the returns from the money spent. As economy is an attitude of mind, and in practice a painful discipline which needs constant stimulus and incentive, some local advantage must be allowed to accrue from the hard work involved. The incentive to economy must start at the top and flow down to the most junior worker. There is little doubt that the widespread knowledge of the loss to the Treasury of large sums annually on unreturned medicine bottles, alone, is a discouragement to economy in other parts of the service. Clearly it is the duty of hospital management committees to infuse a spirit of economy into their units; but it must be realised that the present financial arrangements severely militate against this desirable movement. There is no conscious extravagance; but on the other hand the fact that balances are lost at the end of the financial year, and that savings under one heading cannot be transferred to another, removes important inducements to painful saving. Much as they may wish, as taxpayers, to reduce the cost of the Service, members of the hospital management committee are compelled to think first of ensuring the adequacy of their own part of it. Prepared under the fear (indeed expectation) of later cuts, there is little doubt that budgets do not receive the meticulous consideration, with the balancing of one claim against another, which they would get if the committee were expending a block grant. Moreover, the officers who draw up the budgets are acutely influenced by the absence of a contingency fund. Unfortunately the Ministry does not seem to have appreciated that hospitals, unlike schools or post offices, cannot accurately budget a year or more in advance. The claims a hospital may have to meet cannot be so precisely foretold.

The great importance now placed on prior budgeting means in practice that new developments urgently needed are held up and far less important items are readily sanctioned if previously anticipated. This inflexibility of control at the periphery is a serious obstacle to efficiency and a hindrance to true economy. An additional disadvantage arises from the delay in the sanctioning of the annual budget and the concentration of expenditure into a relatively few months, which means that individual items receive less consideration than is their due.

Efficiency and economy comparable to that of large business organisations needs the stimulus of someone in the position of the managing director; and he was found previously in most hospitals as the house-governor or the chairman of the hospital committee. The organisation of the hospitals into groups has diminished the status of the former hospital secretaries, and this is reflected in their new title of "assistant secretary". The secretary of the group is often divorced from the individual hospital and has become more secretarial than managerial in function. The work and responsibility of the assistant secretary has further declined with the appointment of group supplies officer, building supervisor, and establishment officer, all with their deputies. Instead of being actually responsible for the direction of work needed in the hospital, the former secretary (now assistant secretary) merely passes on instructions; and there is undoubtedly duplication of effort, particularly in relation to supplies. Instead of having men of character in these positions, nonentities will take their place. There may be some compensation from centralization of supplies for management-committee units, but this is questionable. With the loss of status of the hospital secretary and the failure of the group secretary to take his place, burdens and responsibilities fall more heavily on the chairman of the management committee who often has many other exacting duties.

It is doubtful whether the present scale of allocation for capital works will suffice to maintain the momentum of recent decades. A clear distinction must be made between (1) capital expenditure which pays a dividend in efficiency by replacing obsolete buildings or equipment and (2) capital expenditure which involves new and additional demands. There is still much leeway to be made up in modernization and it would be a very great stimulus to management committees if sums saved by economy measures could be diverted. This would save a future burden on the Exchequer. By modernization is not implied simply improvement in amenities, for many improvements would mean a decrease in operational costs. This is particularly true in relation to catering, laundering and medical records. Similar gains can be made by improvements in equipment and by the adoption of the most modern techniques by organisation, which economise in the labours of the staff.

The implications of a ceiling to hospital expenditure have yet to be appreciated. Hospital authorities will shortly be faced with the unpleasant alternatives of either doing everything on a less costly and less efficient level or doing some things really well and others not at all. The second alternative has to be dismissed if a comprehensive free hospital service is to be maintained. At a time when prices are rising and the demands on the service are still increasing, there is a particular danger that many interesting and important developments, both lay and medical, may be arrested. Medical research is a vital function and should be maintained at least on a level with the care of the patient.

Rather than lower the standards of work in the hospitals, it might be preferable to ask resident patients to pay a contribution towards the cost of their board and lodging. The Beveridge Report argued that, though medical treatment should be free, there was no reason why patients admitted to hospital should benefit financially compared with those treated at home. Similarly, patients might be asked for a contribution towards appliances (surgical boots, etc.), dentures and spectacles, and a charge might be made for bottles used in dispensing.

Summary

1. There has been considerable improvement in the hospital service since the introduction of the National Health Service. During this time the demand for hospital treatment has continued to increase.

2. The brisk rise in expenditure has been mainly caused by improvements in salaries, by increase of work, and by the rise in commodity prices.

3. The high cost of the hospital service is emphasised, and both the public and medical profession should be made more aware of it. The present arrangements for the publication of hospital accounts are unsatisfactory and quicker publicity is required.

4. Domiciliary and hospital care of the sick are inter-related and must be considered together. A proportion of patients occupying expensive hospital beds could equally well be investigated or treated elsewhere if suitable arrangements were made. Domiciliary care should be encouraged by giving more help and incentives to the family doctor. A closer liaison between practitioner, hospital, local authorities and voluntary organisations should be developed locally.

5. Although there is little real extravagance, there is undoubtedly scope for economy; but the present financial system of the Health Service acts as a strong deterrent.

6. Attention is drawn to the decline in status of the former hospital secretary and the consequent loss of efficiency within the hospital unit.

7. A ceiling to hospital expenditure has implications that should be faced.

8. The possibility of a contribution from hospital patients towards "board and lodging" and towards appliances deserves reconsideration.

17*th January*, 1951.

ANNEX 4

THE HOSPITAL SERVICE

Extract from Memorandum by the Royal College of Nursing

III. The Pressure on Hospital Beds

23. . . . No feature of the National Health Service emerges with greater clearness than the high cost of the hospital bed. The hospital bed, like the nurse, represents an investment of social capital; there is the same need to economise in its use and to supplement with ancilliary services. Great as may be the strain on those responsible for its functioning, the hospital must increasingly be reserved for patients in need of *real* doctoring, *real* nursing. To quote two recent public statements:—(i) "One of the aims of social work should be to keep as many people as possible out of institutions". (Dr. A. Torrie, Medical Superintendent, The Retreat, York.) (ii) "It is absolutely essential that every old person who can be cared for at home should stay there". (The Chairman, Hendon Hospital Management Committee.)

The Front Line of Defence

24. The following excerpt from *The Times* sums up the position: "Acting as the forward detachment of the medical army, *the general practitioner and his associates—the Midwife, the district nurse, the health visitor and others—should take responsibility for as much medical work as they can possibly manage, whether in the home, the clinic, the small hospital or the nursing home.* While the detachment will frequently need the advice of experts in the rear, they should be acting as an efficient screen protecting the costly hospital and specialist services from an inflow of patients who do not really need to be passed back to the rear". (*The Times*, 22nd January, 1951.)

25. *Strengthening the "Front Line"*

(*a*) The promised report of the Central Health Services Council on optimum co-operation between the three main branches of the Service should prove helpful.

(*b*) Even if health centres are at present impracticable, group medical practices in towns should be encouraged; also the modified equipment of temporary premises.

(*c*) Ancilliary services should be still further developed; for example, "Meals on Wheels", night watchers, Red Cross and St. John visiting and shopping, a more flexible use of home helps, etc.

(*d*) Some areas are experimenting in the more careful screening (by personal visits) of applicants for admission to hospital. One hospital sends out a team to give nursing care to tuberculosis patients in their own homes.

(*e*) Greater use should be made of vacant accommodation in cottage hospitals, for pre-convalescent cases. Patients appreciate the transfer if they are sent to a cottage hospital near their homes.

(*f*) Greater use should be made of convalescent homes.

(*g*) Many patients occupy hospital beds at high cost when they would be more suitably accommodated in long stay annexes and hostels (if enough of these existed). There should also be annexes for the senile, to relieve the mental hospitals from admitting them under the Lunacy and Mental Treatment Acts. (N.B.—Many seeming cases of senility are the result of anaemia—inability to shop properly—and loneliness.)

(*h*) Though it was not envisaged that the National Health Service would "bolster up" private enterprise, Regional Boards have saved money by contracting with private nursing homes to accommodate chronic sick and convalescents. The cost is less than that of the ordinary hospital bed. Nursing homes providing this service need to be carefully supervised to ensure that there is no cutting down on staffing and patients' comfort. (N.B. Private nursing homes are *registered* under local authorities.)

26. *Making Full Use of "Base" Facilities.*

(*a*) The number of staffed unoccupied beds is higher than it should be and suggests lack of flexibility in their use. New patients should have adequate notice of hospital vacancies. Few can adjust their personal affairs in 24 hours after a wait of, perhaps, many months. As patients may leave the district, or may, for some reason, no longer need treatment, waiting lists require regular revision.

(*b*) In some areas hospitals seem to have ensured (under pressure from the medical profession) a generous provision of private (Section 5) beds at the expense of amenity (Section 4) accommodation, for which, because of the desire of the average middle class patient for more privacy, there is a considerable demand. Unfortunately the 15 guineas or so charged for Section 5 beds, coupled with medical and other fees, is largely beyond the middle class patient's means. As a result, many Section 5 beds are unused, and the patient, who may urgently require treatment, is driven to seek the somewhat cheaper, but less suitable accommodation to be found in private nursing homes. This is the very negation of what was intended under the Act. Failing some better arrangement, it would be better to admit a percentage of "amenity" patients to the hospital, with its more comprehensive facilities, and to charge the difference between what the beds actually cost the hospital and the full charge to private patients under Section 5.

(*c*) The question of making a "hotel service charge" for hospital beds might also be considered, with remissions in cases of hardship.

27. *Hospitalisation of the Elderly.*—Many frail and elderly people at present in hospital could more appropriately be cared for under Part III of the Act; on the other hand there are cases at present provided for under Part III who should really be the responsibility of the Regional Boards. It is likely that time and the establishment of more old people's hostels will remove these discrepancies.

It would be of the greatest assistance if pension regulations and restrictions could be adjusted so as not to penalise the older worker earning more than £1 weekly or the widow with a pension. While some households, even with the best will in the world, find it literally impossible to house and care for a frail and elderly relative, there are others who, once their relatives are in hospital, refuse to take them back on recovery, even when well able to do so. If the elderly could become small wage earners and definite contributors to the household budget, this might make just the difference in overcoming family objections, and pressure on geriatric departments and long stay annexes and hostels would be eased. The poorer families attach considerable importance to contributions to their housekeeping expenses. This is illustrated by the pressure they bring to bear on the young daughter in domestic service *to live at home,* even under crowded conditions, rather than in her employer's house. If she is a resident maid they lose her contributions to the family budget. An adjustment of pension regulations might enable elderly relatives to contribute similarly to the upkeep of the home. Incidentally, many old people make excellent "baby minders", and in this respect too can be a help rather than a hindrance to the family with young children.

28. When an elderly relative falls sick or comes out of hospital needing care and attention, the most suitable home help would appear to be a member of the family. But it is hard for such people to have to sacrifice a good job and prospects elsewhere unless their pay as home helps can be supplemented and the gap between the two scales of remuneration reduced.

29. One further point: Many retired people pine and go sick when suddenly deprived of regular work, yet to continue to carry posts of responsibility not only puts a strain on them but robs the young of opportunities of promotion. If pensioners were prepared to step down and accept lower paid or part time jobs, they would be more likely to retain their health.

IV. National Estimates and Methods of Budgeting

30. The total cost of the Health Service for the year ended 31st March, 1950, was 449 million pounds—twelve and a half million pounds below the Total (including Supplementary) Estimates. The late Minister of Health, in a party political broadcast in January, gave the administrative costs of the Service as between two and a half and three per cent., which, he maintained, compared favourably with industry.

31. *Has the Allocation of Available Funds been on a Realistic Basis*? Some engaged in the hospital and consultant service question whether the other parts of the service are bearing their share of the cuts now enforced; they feel, for example, that there should be a closer scrutiny of demands for, and/or subsequent use made of: (i) hearing aids, (ii) wigs for pathological baldness, (iii) transport facilities (e.g. use of rural taxis or ambulance for light cases). There is less abuse in this latter respect now that the National Assistance Board certifies when public transport cannot be used; but even here economies could be effected by extending the service of volunteer car drivers. Other proposals are:—(*a*) *That the charge on prescriptions should be implemented.* We strongly recommend this step, one consequence of which would be that the householder would be encouraged to stock his own medicine cupboard. (*b*) That there should be a closer check on the use of expensive apparatus such as mechanical chairs; these should be returned to stock when the patient dies or there is some other major change of circumstances, and not retained by the family for recreational purposes. (*c*) That there should be a stricter follow up with regard to the return of walking sticks, the more expensive types of bandage and other small articles loaned to patients. Voluntary helpers could usefully undertake this service.

32. *Machinery.*—It is hoped that the introduction of uniform accountancy methods will simplify procedure. At present when Hospital Management Committees forward their estimates to the Ministry there is little opportunity for Regional Boards to comment on them. Experienced Board members can, however, visit and guide management committees showing extravagant estimates and aim at securing fair allocation of the region's resources. Periodic meetings of supply officers at Board level are also helpful to this end. (See also V, *Comments on Matters of Detail.*)

At present any savings in one category of a Management Committee's estimates must be returned to the Exchequer. They cannot be spent on requirements in another category without the Minister's express permission—"non-virement". Thus there is little, if any, incentive to save; only to satisfy the requirements of Government audit and to overestimate "in case of need".

33. It has been suggested that a quinquennial rather than an annual budget would help to check this tendency. In our opinion the service is too new and untried, too many unforeseen factors have still to emerge to make this a practical proposition. Adjustments in the scales of remuneration throughout the Service, which have done more than anything to falsify recent estimates, are still not complete, and the sums involved from year to year are unpredictable. The same is true of drugs, both as regards their cost and the extent to which they will be used.

34. On the respective degrees of responsibility of Regional Boards and Management Committees for capital and maintenance expenditure we do not feel qualified to express an opinion, but our experience of the present method of financing the hospital service has convinced us that *the system of Government audit now obtaining is not only costly and time consuming in itself, but that it encourages inflated estimates and extravagance; that its very rigidity discourages the development of responsibility, and that it should be discontinued.* As an alternative we suggest a system of periodic inspection on the lines adopted by the University Grants Committee or H.M. Inspectors of the Ministry of Education. By this means the emphasis would shift from the correct tally of forms in triplicate to the overall standard of service available to the public. Committees would still be under an obligation to frame their budgets under various categories, and to furnish adequate explanation of any unusual demands, but the categories would not be watertight; the committees would have more discretion generally in the management of their affairs.

ANNEX 5

HOSPITAL SERVICES UNDER THE NATIONAL HEALTH SERVICE

Memorandum by the Association of Municipal Corporations

1. The opportunity to make the present survey of the hospital part of the National Health Service arises from a request by the Select Committee on Estimates of the House of Commons (Sub-Committee E), addressed to the Secretary of the Association,

asking that a memorandum on the hospital service be submitted if it is felt that the Association have information or holds views which it would like to bring to the attention of the Sub-Committee.

2. The Association feel that, as the major authorities within the Association had extensive experience of hospital administration prior to the transfer of the hospitals to the Ministry of Health in 1948, and as, moreover, many of our members have gained experience of the working of the National Health Service on regional hospital boards, executive councils and hospital management committees, our views and opinions on the administration of the Act since 5th July, 1948, may be of value to the Select Committee. Furthermore, prior to 1948 the local authorities had the advantage of being able to survey and administer a large part of the health service as a whole.

3. As is well known, the health services in this country were never planned as a whole, either in relation to each other or to the general needs of the community. They began the main period of their development—as did the social services—shortly after the beginning of the century, each as a response to some specific need, or as a solution to some particular problem. During the period from 1900 to 1930, however, the main foundations of the health services as we know them to-day were laid. Thus, for example, the school medical service was established in 1907, and the National Health Insurance Scheme in 1911 ; the Ministry of Health was founded in 1919 ; and the poor law hospitals and institutions were transferred to the councils of counties and county boroughs in 1930. From the latter date until 5th July, 1948, when the National Health Service Act came into operation, a substantial part of the hospital services of the country and practically all the public health services were under local authority control. Unfortunately, hospitals and institutions were taken over at a time of exceptional financial stringency, but in spite of the difficulties of this period much progress was made between 1930 and 1939 in improving the efficiency of the service, and it was largely due to the local authorities' efforts in this direction that their hospitals were able to play the major part during the war in dealing with the sick and wounded from the services, air-raid casualties and refugees, and, in addition, to deal with the normal quota of civilian patients.

4. Even before the war consideration was being given to the establishment of a national service, both by official and voluntary bodies. It may suffice to mention here the Royal Commission on National Health Insurance, 1926, the two memoranda of the British Medical Association in 1929 and 1938, and the P.E.P. report of 1937. All the organisations which considered this subject recognised its great complexity and the difficulty of welding into a national service voluntary and local authority hospitals, the personal health services and the National Health Insurance Scheme. The Beveridge Report, 1942, which recommended a close association between the health service and the social security services, served to render this problem, in one sense, still more complicated. It was, however, the Beveridge Report which stimulated the Government to devote serious attention to the establishment of a National Health Service, and a White Paper, with this title, was published in February, 1944. The main recommendations of this White Paper were as follows:—

(*a*) Central responsibility for the service to be with the Minister of Health ; the formation of a consultative Central Health Services Council and an executive body to be called the Central Medical Board, with which the general practitioner would be in contract.

(*b*) Local organisation to be based on county and county borough councils, operating in their local government areas where possible, but combining as joint authorities where necessary. Areas for the operation of a full hospital service to be designated by the Minister, and for each the formation of a joint authority, being a combination of the existing counties and county boroughs in the area. This joint authority was to be responsible for the preparation of an area plan for the health services as a whole, and for making contractual arrangements with voluntary hospitals.

It will be observed that a significant part of these recommendations was the preservation of the link between the environmental health services and the hospital service.

5. In the subsequent discussions between the Associations representing local authorities, together with representatives of the London County Council and the Ministry of Health, grave objection was taken by the local authorities' Associations to the proposal to constitute joint health authorities with executive responsibilities, since this form of organisation would not only remove hospital functions from the control of directly elected county councils and county boroughs, but, equally importantly, would involve a weakening, injurious to the health service as a whole,

of the link between the environmental and preventive health services, and the clinical and curative functions performed by the hospitals. Their principal objections were set out as follows:—

(1) This proposal separates administratively such services as maternity and child welfare and the medical inspection and treatment of school children from the hospitals on which the efficiency of these services so largely depends.

(2) It divorces the diagnosis and treatment of tuberculosis from the local authorities' environmental services such as housing, and it places upon a joint board representing a wide area the responsibility for the day-to-day administration of a series of hospitals which will often be situated many miles apart.

(3) The work of the major local authorities during the last fourteen years (during five of which the country has been at war) in raising markedly the standard of the staffing and equipment of their hospitals is insufficiently recognised in the White Paper, and the Association consider that there is no adequate reason why the voluntary hospital boards should retain full control of their hospitals, while the local authorities should lose theirs. (From an A.M.C. Memorandum, dated 8th May, 1944.)

6. Towards the end of 1944 the Ministry of Health, after considering the objections of the local authorities to the scheme contained in the White Paper, produced an amended plan which removed the main barrier to agreement by proposing that hospitals should remain for administrative purposes with counties and county boroughs as before, and that the new joint boards should have planning but not executive functions. In the fresh proposals of the Ministry the creation of regional councils, covering wide areas, was first mentioned. They were to deal with consultant services. Negotiations between the Ministry and the local authorities on the amended scheme continued for some months, and it was during this period that the British Medical Association expressed the opinion that the medical service should not be associated with the social insurance scheme, and it expressed strong objection to most of the administrative machinery laid down in the White Paper. In a memorandum, dated 1st March, 1945, the Ministry described in some detail the new scheme, largely agreed with the local authorities, including the constitution and functions of a Central Council, Regional Councils and Joint Authorities for advisory and planning purposes.

7. In January, 1946, with the change in Government, a circular was submitted to the local authorities' representatives laying down the basis of the present National Health Service Act. The new scheme differed fundamentally from the agreed scheme described above. The main features of the National Health Service are as follows:—

(1) The vesting of the local authority and voluntary hospitals in the Minister of Health, who possesses plenary powers over every aspect of the service.

(2) Hospitals and other services in England and Wales to be administered by fourteen regional hospital boards, responsible for planning and for consultant and specialist services, under each of which there are twenty or more hospital management committees, dealing with the day-to-day management of a group of hospitals, containing on an average about two thousand beds.

(3) The separation of functions amongst regional hospital boards (planning consultant services), hospital management committees (day-to-day administration), executive councils (general medical, dental, etc., services), local health authorities (preventive, after-care and some " social " services).

(4) The principal of nomination as against election. Thus the members of the regional hospital board are appointed by the Minister and those of the hospital management commitee by the regional hospital board.

(5) All expenditure defrayed by the Exchequer. Close supervision by Ministry of Health, especially during the last two years, of details of administration.

Thus it embodied again those features which, throughout, the Association have regarded with grave misgiving:—

(*a*) An undeniable split in the unity of local health services, particularly at administrative and operational level.

(*b*) The removal of important social services of vital local significance from control by locally elected public representatives to nominated bodies.

(*c*) A consequential loss of effective control over finance.

(*d*) Duplication of technical and administrative machinery, with added cost involved.

8. The National Health Service Act has now been in operation for nearly three years, and sufficient time has elapsed for an appreciation to be made of the virtues and defects of this scheme for the provision of a free medical and dental service for the whole of the community. Undoubtedly its outstanding advantage is that it does provide all the services necessary for the treatment of most illnesses. These services cover the general practitioner and consultant, hospital accommodation for most conditions, medicines, appliances and sickroom equipment, clinics, ambulances, home nurses, midwives, domestic help and a blood transfusion and a mass radiography organisation. Generally speaking, such services, except the Hospital Services, are available as required. Because almost any part of the National Health Service is at the disposal of the individual, through the general practitioner, free of payment, the demand for certain parts of it (medicines, artificial teeth and spectacles are the best example) has been enormous and has, at times, threatened to overwhelm the service. Much of this demand has been to meet real needs and is, to that extent, an indication of failure in the previous organisation of the health services.

9. The present National Health Service, in spite of its virtues, contains, in our opinion, serious faults, some of which are of a fundamental nature requiring, for their remedy, an amending Act, while others are defects in organisation which could be cured by administrative action. In the first category we place that fatal dichotomy which is the bane of the whole service. Almost every hospital and public health function of any real importance is administered by at least two separate and independent bodies. In one large local authority area, for example, before 1948, all health and medical services, including hospitals of every kind, clinics and general practitioners, were administered by three authorities—there are now eight, including five hospital management committees. Because of this separation of functions on the hospital side as between the regional hospital boards and hospital management committees, administration of the available bed resources is by no means as efficient as it should be. Under the present system no one individual or body is really under a distinct responsibility to ensure that the best use is made of hospital beds in changing conditions. The senior administrative medical officer is unable to ensure this as he has no direct authority over the hospital physician, superintendent or secretary who, in his day-to-day work of administration, is responsible to the hospital management committee and who can, in any event, shelter behind that body. Moreover, there is now a tendency, which has gone very far in some regions, to allocate beds on a permanent basis to a team headed by a consultant who has the sole right to admit patients. This system, it is claimed, has the advantage that it improves the efficiency of the unit, but if it applies to the whole of a hospital, as it often does, it impairs the flexibility of the hospital as a whole and reduces its usefulness to the community. Especially is this true in times of epidemics, as the medical superintendent has no power to admit patients to empty beds in the wards.

10. This division of function to which we refer applies with especial disadvantages to the services administered in part by the regional hospital board (or hospital management committee) and in part by the local health authority. These services include infectious diseases, tuberculosis and maternity and child welfare. The searching out or diagnosis of certain types of infectious diseases (epidemiology) is the duty of the medical officer of health, the treatment of cases in hospital is the function of another body—the hospital management committee. In general the relationship between the medical officer of health and the superintendent of the hospital is cordial, and epidemics are efficiently dealt with. But the possibilities of friction are always present, except in those cases where the medical officer of health is also medical superintendent of the (small) fever hospital. As far as tuberculosis is concerned the position in general, throughout the country, is far more unsatisfactory. Tuberculosis is indeed, as we believe will be admitted, the outstand defect in the organisation of the National Health Service. The principle adopted in the Act is that treatment is the function of the regional hospital board and prevention and aftercare the province of the local health authority, and on paper this is a neat and tidy division of responsibility between these two bodies. In practice, however, the medical staff of the local health authority obtain little contact with the tuberculosis patient except through the tuberculosis health visitor, who is usually fully occupied with clinic work. This lack of contact with the patient renders the work of the local authority ineffective. A somewhat similar situation obtains in connection with the chest physician or tuberculosis officer, who is nominally a part-time employee of the local health authority, but is seldom seen by the medical officer of health and, for the most part, seems to owe entire allegiance to the regional hospital board. We realise, of course, that the Ministry of Health is concerned about several aspects of

the tuberculosis service and is doing what is immediately possible to effect improvements. In the opinion of the Association an important step in improving this service would be to bring the local authorities, whose members are especially interested in the social problems presented by this disease, more prominently into the administrative picture. This could be done immediately by making local health authorities responsible for diagnosis and for mass radiography.

11. Because of the separation of function as between the boards and committees administering the hospital and public health sides of the National Health Service, the principle of co-operation both between one statutory body and another and between officials employed by different authorities, but concerned with various aspects of the same subject (as, for example, tuberculosis, maternity and child welfare, infectious diseases), assumes great importance. The Ministry of Health has issued a circular dealing with this question, and the Association have expressed views to a special committee on co-operation set up recently by the Central Health Services Council. (A copy of the Association's memorandum is attached for the sub-committee's information.) But, although some progress may be made in the matter of co-operation, the Association believe that any success in this direction would only serve to palliate the disadvantages caused by the undue separation of functions which, in our opinion, is one of the primary defects of the Act.

12. It has been charged against the National Health Service that it is extravagantly administered. From the experience of its members, the Association consider that there is more than a little truth in this criticism, which applies not only to the prescription of medicines by the general practitioner (dealt with in the Cohen Report) but also to the standards adopted for the employment of medical and technical staff in hospitals and administrative and clerical staff in the offices of regional hospital boards and hospital management committees. The standards of medical staffing in hospitals are largely based upon an able memorandum, prepared by an expert medical committee, and first issued by the Ministry in January, 1948. The recommendations contained in this memorandum, which have been adopted as a guide by the regional hospital boards, were based upon ideal considerations and, as was natural in the circumstances, paid no regard to the financial and other consequences of the employment of consultant staffs three or more times as large as those engaged by the local authorities, even in university cities, before the appointed day. It may be admitted that the medical staffs of many local authority hospitals were insufficient for the attainment of full efficiency ; but it is felt that the pendulum has now swung too far the other way. The employment of a large consultant and specialist staff involves, as a necessary consequence, the presence of many registrars, house officers and technicians. Medicine, as is fully recognised, is becoming year by year more complicated, and this factor would in itself lead to a gradual increase in the number of specialists and the employment of additional staffs, both medical and lay. We think, nevertheless, that this tendency has proceeded too far in the National Health Service, and that due consideration should be given to economies in hospital staffing and in the use of antibiotics and X-ray films.

13. On the purely administrative side the tendency towards unnecessarily high standards shows itself in a fully developed manner. But, as well, the form in which the National Health Service is cast renders inevitable the multiplication of administrative and clerical staffs. In addition to the fourteen regional hospital boards there are, in England and Wales, nearly four hundred hospital management committees each with a secretary, finance officer, supplies officer and other staff. We consider that the number of hospital management committees is unnecessarily large and could be reduced with advantage, to the efficiency of the service. Economies could also be effected in the staffing of these bodies, which now employ many times the number of officers and clerks thought necessary when the majority of the regional hospital beds were administered by the local authorities. Apart from numbers, we are of the opinion that some of the more senior officers employed by hospital management committees receive salaries which are excessive in relation to their qualifications and duties, and out of proportion to the remuneration paid in connection with posts carrying equal responsibilities in the civil service and the local government service. In general, it appears to be the case that the salaries paid to the different grades of administrative staff in the National Health Service are higher than those in local government, and this has resulted in the loss of many officers, including technical officers, from one service to the other. As an example—instances have recently occurred where deputy medical officers of health of county boroughs with a population of 100,000 (salary £900-£1,100) have applied for posts as tuberculosis officers under regional hospital boards, where the grading was senior hospital medical officer at £1,300-£1,750 per annum.

14. Although some of the local authorities' health services form an integral part of the services provided under the Act, there is a widespread tendency to regard "prevention" as being inferior in status to "treatment." This attitude, which pervades the whole service from the Ministry of Health downwards, has resulted in much lower remuneration being paid to medical men employed in prevention than to those engaged in treatment. Any consultant employed on a full-time basis, at his maximum salary and without a merit award, will receive as high a remuneration as the medical officer of health of a county or county borough with a population of half a million or more, a number of medical superintendents of hospitals which were until July, 1948, local authority hospitals have received merit awards, and, as a consequence, are receiving at the present time higher salaries than any medical officer of health in the provinces, including the largest of the counties and cities. Since the advent of the National Health Service, with the transfer of hospitals, etc., away from the local authorities, there has been a serious decline in the general estimation in which the public health service is held, and this has shown itself in one field in a large reduction in the number of young medical practitioners entering for the D.P.H. course.

15. The ambulance service is a further illustration of an arrangement which is unduly expensive in operation, which has resulted from the severance of the hospital service from the local authorities. At present, as the Committee is aware, the ambulances (except to a minor extent within a hospital) are provided by the local authorities, but the demand for their use is under the control of the hospital and medical services. Thus financial responsibility for the service is divorced from the authority which controls the demand which the service is required to meet. This arrangements is not, in our view, conducive to economy, and the hospital service and the ambulance service should be under the control of the local authorities.

16. The Association have, of course, no direct experience of the working of the financial system which is in operation in the existing hospital service. We have referred to what, in our view, is the expensive duplication of technical and administrative staffs resulting from the severance of the hospitals from the local authorities, which have at their disposal considerable resources of highly qualified expert staff and working organisations which formerly dealt with the local authority hospitals. We have, however, noted the difficulties which appear to confront the existing hospital boards and management committees, resulting from the lack of flexibility in the financial arrangements, which arise from the requirements of Treasury control of expenditure of the existing hospital authorities, and which seem to be inevitable in a system where the spending of very large sums of public money by nominated bodies, who are not responsible for the raising of the moneys which they spend and are not directly accountable to the public for the economy and efficiency of the service for which they are responsible. In our view, at least certain of these difficulties which are at present experienced by the hospital managements would be considerably alleviated, if not entirely avoided, were the hospitals returned to the control of the local authorities. Such authorities would, of course, be responsible for raising (with such assistance in the form of government grants as might be decided upon) the moneys required to finance the expenditure for which they budgeted. We also consider that the direct accountability of the local authorities to the electorate for the expenditure they incur is more likely to conduce to economy in expenditure than the present system.

17. Quite apart, however, from financial considerations, it is the view of the Association that so important a public service, of such vital intimate concern to the citizen in his daily life, should be under the direct control of elected representatives who are in constant touch with, easily accessible and accountable to, the citizens they represent. We see no reason why the hospitals should not be administered efficiently by local authorities and with greater economy than seems possible under the existing system. In expressing this view we have not overlooked the necessity for the planning and co-ordination of some of the hospital services over wider areas than those of some of the existing local authorities, but even assuming that a reorganisation of areas of local administration is to be postponed for a period, we consider that the requirements of planning and co-ordination can satisfactorily be met on lines put forward by the Association in the discussions which took place with the Ministry of Health prior to the establishment of the present organisation as part of the National Health Service.

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