BUDGETING AND TEAM MANAGEMENT

REPORT OF A WORKSHOP FOR
UNIT ADMINISTRATORS
HELD AT THE KING'S FUND COLLEGE

5-6 MARCH 1981

2 Palace Court
London W2 4HS

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CONTENTS

1. BACKGROUND AND AIMS OF THE WORKSHOP

A key theme of the Government's approach to the forthcoming restructuring of the National Health Service in 1982 is the wide discretion which will be given to the new District Health Authorities in determining their management arrangements. This range of discretion is emphasised and elaborated in the DHSS circular HC (80) 8 on Health Service Development - Structure and Management.

Whilst not in any sense wishing to cut across this emphasis on local determination of management arrangements it was thought at the King's Fund College that it would be helpful to the Chairman and Members of new Authorities and to the Chief Officers advising them if alternative options for management arrangements and structures were identified and the advantages and disadvantages assessed.

This process at the College began with the holding of a one week Workshop for Sector and Unit Administrators held at the College in February 1980 under the joint auspices of the College and the Institute of Health Service Administrators. The Workshop explored the role, needs and training requirements of those involved in administration at operational level, where both the Royal Commission on the NHS and the "Patients First" consultative document had stressed the need for strengthening the administrative role.

It was planned to follow up the February 1980 Workshop with two further workshops: one held in January 1981 on "The Management of Support Services at Unit Level" and one in March 1981 on "Budgeting and Unit Management". It was thought that with the increasing emphasis being given to management at the unit level it would be valuable to look at the role of the unit administrator in relation to that of the proposed "Director of Nursing Services" and the representative of medical staff within the unit; and the place of budgeting as one of the main means of control and management within the unit.

With these aims in mind a membership was invited, mainly of small groups of managers working together in units, and representing the administrative, nursing, medical and finance disciplines. The workshop was designed and steered by John Ranken and Eddy Bardgett of the King's Fund College. This report aims to summarise views expressed at the workshop rather than the views of the King's Fund itself.

2. WORKSHOP OBJECTIVES

1. To clarify the role of the unit administrator in the management of the unit, particularly in relation to the roles of the Director of Nursing Services and the representative of medical staff.

2. To identify the key issues to take into account in establishing effective teamwork and leadership in the management of the unit.

3. To identify what is needed to establish effective management and control systems (eg budgeting) for the unit.

4. To identify main opportunities and problems to be overcome in the next few years to ensure strong unit management.

3. ISSUES FOR CONSIDERATION

In the light of the broad objectives of the Workshop, members identified the following issues, which were used as a basis for subsequent discussions:

- Need for a system of working for the Service and monitoring the Service day by day
- Tools for the Unit Administrator to do his job - eg Unit Budget
- Need for Clinical Leadership
- What administrators require of Finance: information, manpower, workload
- Adequate authority for the Unit Administrator
- The role and limitations of consensus management
- The need for small groupings
- Clinician involvement by rotation
- How to devote funds where they are most needed
- Unit Budgets as a means of involving staff
- Responsibility of Medical Administrator to involve and commit colleagues
- Special requirements of big single Unit Districts
- Functional management advantages and disadvantages
- Need for local flexibility in management arrangements
- How to organise the delivery of Health Care in dispersed integrated Districts
- Retaining accepted gains of the 1974 changes: strategic planning, effectiveness, priorities
- Relationship of Unit and DMT in policy formation
- Co-ordinating units
- Budgeting and Costing and Clinician Involvement
- Heavy workload at unit and consequent staffing needed
- Function of a Team at Unit Level
- Unit and District Budgets
- Possibility of outposting Finance Officers to Units
- Compilation, monitoring and control of budgets
- Need for definition of terminology
- Co-ordinated services and directly managed services
- Relationships between Units
- Service Management Teams

- Process of managing change
- Return to Tripartite Administration (medical, nursing and administrative)
- Deprived patient care groups
- Role of Director of Nursing Services
- Details of hospital management which are cohesive
- Need to justify breakdown of functional management
- Involvement of Para-Medical Structure (perhaps through Heads of Departments meetings)
- Effective representation of medical staff
- Problem of DGH-centred acute specialties and relationship with Maternity, Psychiatry and Community Services
- Problem of functional heads wishing to by-pass unit administration to relate to higher levels
- Divisional Medical System
- Reputation and credibility of administrators
- Effect of further change on the Service
- Conflicts and Partnerships in the Acute Services and the Community
- Links between Unit Administrators and Health Authority
- Teamwork in the unit as a mirror of the DMT
- Unit Management Teams and Nurse and Administrator Managers
- How to persuade Clinicians to play a part in management and to be committed
- Devolution of Budgets especially to remote units

4. MAIN THEMES

As a means of continuing the discussion the issues were grouped into the following main themes:-

a) Unit Management and Management Teams

b) Medical Involvement in Unit Management

c) Unit Management - External and Internal Relationships

These themes were developed as follows:-

a) UNIT MANAGEMENT AND UNIT MANAGEMENT TEAMS

1. There was experience in a number of places of unit management teams which operated successfully, but it was felt wrong to

assume that a unit management team was required for every unit, or that it was necessarily more effective than other arrangements. Based largely on the experiences of a team which appeared to work effectively in a unit made up of hopsital and other services in a defined geographical area, the following points were made:-

- Individual managers had their responsibilities and should not be deflected unnecessarily into obtaining team approval for decisions within their own competence and area of accountability
- Team working, not necessarily with a formal UMT was, however, essential where co-ordination between disciplines was needed
- Those involved in any team or in the top management at unit level should reflect the three main professions of administration, nursing and medicine with the possible addition of finance; and to this might be added for some, but not all, purposes additional members from, for example, the paramedical, GP, and Works professions, attending as and when necessary

2. Method of Reaching Decisions

Consensus was appropriate for many decisions, but not necessarily for all. The team should not be used as a means of avoiding decisions which should be taken by individual managers, or as a means of blurring where individual accountability lay.

3. Size

The smaller the group the more efficient it was likely to be. A return to the pre-1974 system of tripartite administration of medical representative, nurse and administrator forming the continuing core of top management at unit level had much to commend it.

4. Teams should be seen to have a good reason for accepting or rejecting proposals submitted to them.

5. Top Management at unit must not only be effective and be seen to be so, but should possess an effective reporting system ensuring that all groups of staff have a means of submitting their views as an input to unit policy formation and on management issues.

6. The Functions of Unit Management Teams

Top Management at Unit Level should include:-

- Influencing the planning process at District level
- Implementing District policy
- Co-ordination of management of the unit

- Monitoring all services
- Overall budgetary control, with staffing and budgetary control delegated within the unit
- Delegating budgets to Heads of Departments and Services
- Monitoring effect of peer group review by medical staff
- Agreeing operational policies as they affect patients - eg pattern of the in-patients day
- Agreeing all other hospital and community policies within District overall policies

b) MEDICAL INVOLVEMENT IN UNIT MANAGEMENT

The Yellowlees Report on the medical committee structure needed after the 1981 re-structuring appeared to reflect widespread medical opinion when it advocated the dissolution of District Medical Committees and Cogwheel Divisions. Whilst there was a need for a medical input into policy formation and perhaps some form of medical leadership, the proliferation of teams and medical committees, health care planning teams and the continuance of Cogwheel Divisions had resulted in a widely held belief that something simpler was required. In particular there was a need to avoid the same people discussing the same subject in different groupings, as happened, for example, when matters were discussed at Cogwheel Divisions, at full medical staff committees, at hospital Medical Executive Committees and at District Medical Committee meetings.

The different geographical, institutional and service arrangements which would characterise different units in the post-1981 Service made it essential to provide for a variety of patterns of medical staff involvement and medical advisory machinery to meet different circumstances. As the Unit would not be the only crossover point in the formulation of policy, there would be a need for medical inputs at both unit and District level. Wherever possible clinical policy consideration should embrace services to vulnerable groups across institutional boundaries involving hospital community and primary care.

The tripartite system of management in hospitals before 1974 had attractions; but it operated in a different climate with much less emphasis on changing the service.

Within hospitals there was a need to involve medical staffs in budgetary control, the cost effectiveness of clinical decisions, discussion of the implications of prescribing drugs, the operation of CSSD and similar services and the re-deployment of savings.

The representative of the medical staff in top management at unit level had a considerable liaison task in keeping medical colleagues informed and ensuring that the medical staff as a

whole provided an appropriate input into policy formation and became committed to supporting policies once agreed.

To secure these objectives it was thought desirable for there to be:-

1. A clear definition of the role of any unit management team or top management group with a clarification of issues on which they should act as a corporate management team and issues on which they should act as a co-ordinating group of individually accountable top managers at unit level.

2. A forum of all senior medical staff with representatives at least of junior medical staff to ensure involvement and commitment of the medical staff as a whole, even if this forum met only twice a year as, perhaps, a Medical Staff Committee.

3. The involvement of medical staff, by representatives at least, working in primary care and community services, as well as in hopsital.

4. Relatively short term appointments of medical members of unit management teams or groups, so that representatives were forthcoming from all practising clinicians. Such an arrangement would ensure that a wide range of medical staff became aware of management problems and could deputise for each other in the medical management role. It was thought that the limited opportunities which frequent changes gave for in-depth understanding of management issues was the lesser of two evils.

c) UNIT MANAGEMENT - EXTERNAL AND INTERNAL RELATIONSHIPS

It was accepted that, in discussing relationships in particular, there was a need for a uniform terminology such as that developed by the Brunel University studies and set out in Ralph Rowbotham's book on Hospital Organisation.

There was also some cynicism about the extent to which changes in structure would alter the effectiveness of the Service, although it was appreciated that inter-professional rivalries and attempts to secure power bases and establish acceptable relationships deflected managers from concentrating on their main roles.

Each District Health Authority would not only have to decide on its management arrangements, but on what would constitute its units. There could be no generally applicable blue print for all units or Districts.

The relationship of any Unit Management Team or the individual members of a Top Management Group at unit level with the DHA, the DMT or individual members of the DMT and other District officers would be dependent upon the management role at unit level. There

had been a widespread realisation amongst medical and nursing staffs that a strengthened administration was needed at unit level, one capable of producing the environment, equipment, staffing and organisation necessary to support the professions who directly served the patients. This view had been enshrined in Patients First and in circular HM(80)8.

Administrators at unit level would have to be able to marshall resources in support of clinical colleagues without the delays experienced since 1974. To achieve this the main managerial crossover point must be at unit level and officers at present accountable to functional professional chiefs at District or Area level, should be accountable to the unit administrator.

In an earlier Workshop some functional managers had expressed fears that such accountability to unit administrators would detract from the professional leadership provided in those functions by District specialists, as well as cutting across the aspirations of professionals in the functions to have a pyramidal career structure.

These fears were thought, however, to be subsidiary to the fundamental need to have effective strengthened unit management with administrators accountable for all non-medical and non-nursing services and with an overall co-ordinating and monitoring role capable of being immediately effective over all services.

Having Unit Management Teams might well undermine the individual management responsibility of nurse managers and administrators at Unit level. Individual management accountability was essential although tripartite medical nursing and administrative meetings would be necessary to ensure team work and co-ordination.

In the catering, domestic and pharmaceutical services, professional leadership could continue to be provided from designated operational managers accountable to unit administrators for operational management of those services at unit level.

In the Works field, however, there was a case for having District Works Officers as well as Unit Works Officers. The latter should be accountable to unit administrators for the reasons elaborated above, whilst the District Works Officers would be needed for the development and control of Works programmes on a District basis.

At District level the administration should be mainly concerned with servicing the Authority, policy formation, service planning, public and press relations and overall financial control. It could in some Districts be appropriate to continue to employ Districts be appropriate to continue to employ District Personnel Officers with a wide ranging remit embracing organisational design, industrial relations, training and development of staff but there was also a case for a local personnel officer as well in each unit accountable to the unit administrator.

A corollary of the changes envisaged was that the post-1981 Unit Administrators must be skilled and able people and this would imply having appointments open to whoever could best undertake the new and demanding tasks, irrespective of their present posts in the Service.

5. BUDGETING

Keith Ford joined the Group to lead a discussion on budgeting and defined a budget as:-

"A forecast or estimate prior to a definite period of time in financial and quantitative terms of the policies to be pursued to obtain a given objective".

He identified the following principles in budgeting in the re-organised service:

1. General Principles

1.1 The responsibility for management of all services rests ultimately with the DMT, acting within the policy laid down by the DHA and within Standing Financial Instructions approved by the DHA. This ultimate responsibility cannot be delegated.

1.2 The responsibility for design and maintenance of all financial control systems and provision of financial advice to managers, DMT and DHA rests with the Treasurer; this responsibility cannot be delegated.

1.3 Budgeting structure should reflect, not determine the management pattern.

1.4 Budget control and cash limit arrangements should provide for the maximum local delegation consistent with overall control of the DHA cash limit. (HC/80/8)

1.5 There should be personal, not collective responsibility to ensure accountability.

2. Budget Setting

2.1 The budget should be drawn up in consultation with the budget manager.

2.2 The budget should be notified well in advance of the start of the year. (If necessary provisional budgets should be issued for confirmation or marginal adjustment later).

2.3 The budget holder should have authority to incur expenditure and appoint staff up to his budget limit without reference to higher authority (as long as that expenditure is directed towards his agreed objectives).

2.4 The Treasurer should not normally keep reserves; any that are kept should be clearly identified, publicised and be for a specific purpose (eg for pay and price inflation).

2.5 All budgets summarised in total should be published in one document. The policies to be pursued and the basis of allocations needs to be clearly set out.

2.6 The budget holder should only be responsible for those costs which are significantly - not necessarily wholly - controllable by him. The management structure should be designed to maximise the extent to which the organisations costs are able to be budgeted to a manager with controlling ability. This may mean placing budgets higher in the hierarchy where decisions are made or decentralising decision making, or identifying costs more clearly to budgets. Performance reports should clearly identify controllable and non-controllable costs and variances; and price and volume variances.

3. Budgetary Control

3.1 The budget holder should receive regular, prompt and accurate statements of expenditure against his budget; accompanied by appropriate statistical information.

3.2 The existence and extent of virement is a matter for the DHA to determine. It should be laid out in Standing Financial Instructions.

3.3 Carry-over of under and overspends on individual budgets to succeeding financial years should normally apply (subject to the need to live within national carry-over limits). Accumulating surpluses in budgets should however be avoided by treating carry-overs as a working balance only.

3.4 The unit nurse should be given responsibility for the control of the nursing budget (allocated as part of the district nursing budget).

The unit administrator should:

- control the budgets for departments for which he is managerially responsible
- be responsible for co-ordination of other unit budgets

They should operate within financial allocations and policies for virement between and within units set by the DHA.

They should exercise this responsibility in consultation with the senior member of the medical staff. (HC/80/8)

4. Behavioural Aspect of Budgeting

4.1 Job descriptions for budget holders should include specific reference to his budgetary responsibilities.

4.2 Management and budget structures should be such that the incentives in the system for individual budget holders are consistent with the overall goals of the DHA.

4.3 Top Management reaction to variances should be swift since the effect of reward or punishment is diminished the longer it is after the variance is incurred.

5. Personal Responsibility of Individual Budget Holders

5.1 It may not be immediately apparent how the local management role for the unit of management can be reconciled with the budgeting principle of personal and not collective responsibility of individual budget holders. The methodology below shows how this can be achieved:-

5.2. Budget-setting in the new DHAs

5.2.1 Around October management accountants would discuss budgets with individual budget holders and draw up a draft budget:

- possibly in the format
  a) last years budget/ongoing level of service
  b) potential developments
  c) potential cutbacks

5.2.2 These draft budgets would then go to the unit of management for comment as to the balance between budgets within that unit.

5.2.3 The DMT would then receive the draft budgets and the unit comments and discuss the balance between units; and between budget-holders.

5.2.4 When the allocation is received (or reasonably firm advance notice of it) the DMT will confirm or increase or cut-back, the draft budgets to individual budget holders.

5.2.5 The DMT will also have set policies for the limits of virement between budget-holders which may be operated by the unit of management.

5.3 Budgetary control in the new DHAs

5.3.1 Individual budget holders will receive regular (monthly or weekly) statements of expenditure against budget; these will normally contain a full subjective analysis within function.

- if requested a copy will be sent to the budget holder's line manager for information. (An individuals budgetary responsibilities should be specifically mentioned in his job description. The line managers responsibility for monitoring the performance of his subordinates will therefore include monitoring his budgetary performance).

5.3.2 A summarised statement (one line per budget holder) will be prepared for the District Management Team, subdivided by unit.

5.3.3 A copy of the DMT statement will be sent to the unit of management. They will be able to exercise virement between budget holders within the unit as allowed by Standing Financial Instructions and exercise their co-ordinating role.

The following economic resources were identified as requiring consideration in the budgeting process: Land, Labour, Capital, Entrepreneurship (or managerial creativity). Each had relevance in the NHS.

There was a need to ensure that objectives were clearly defined and that there was goal congruence amongst officers concerned. Zero-based budgets, although more demanding in their preparation, had the advantage that goals, needs and requirements and their priorities had to be reviewed from scratch each time the budget was prepared.

There was a need for greater training of budget holders as part of management training.

Administrators felt that it was important that monthly budget reports should go to budget holders via the Unit Administrator, as the Unit Administrator was the overall budget holder and individual budget holders (eg Unit Catering and Domestic Managers) were accountable to the Unit Administrator for the effective management of their budget.

Finance officers in the group did not support the proposal that there should be a Finance Officer outposted to each unit after 1981, whether as a member of a unit management team or not. Such out-posting might produce divided loyalties and was unlikely to use financial expertise economically or to provide acceptable career experience. It would be preferable to have finance officers based at a District Finance Office able to advise and consult unit managers or unit teams as required.

6. REVIEW OF AGENDA

At the mid-point of the two day course the members reviewed their agenda, emphasising the need to consider the following:-

. Personnel Services at Unit and District Level
(It was noted that this had been covered by the Workshop for Sector and Unit Administrators in February 1980)

. Control of expenditure incurred by Clinicians

. Whether Unit Management Teams were needed; if so, their composition

. The Clinical Input to any Team and ways of obtaining Medical Staff Commitment

. Relationship of any Unit Team with the DMT

. Who would decide the membership of any Team

. Managing Change

. Unit Management

. Problems and opportunities of new jobs and new people

. Control of Unit Budgets

. Which budgets should be held at unit level and which at District

. Centralised Services - eg Supplies, Ambulance, Personnel

. The Continuation of Service Planning

. GP involvement on any team at unit level, especially if it embraced primary care as well as hospital services

. Input from Community Medicine at unit level

. The spectrum of options for defining a Unit depending upon:-

- concentration of hospital facilities
- inclusion of community services
- geographical considerations
- existence of a number of scattered hospitals
- local loyalties
- economies of scale
- lines of communication

7. TEAM MANAGEMENT

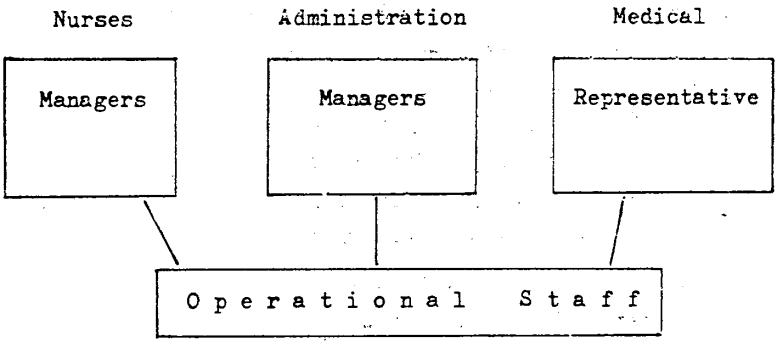
Graham Millard then led the group in its consideration of team management and team working. He saw as the shortcomings of team working:-

- blurred accountability
- the delaying process
- the fact that meetings are expensive

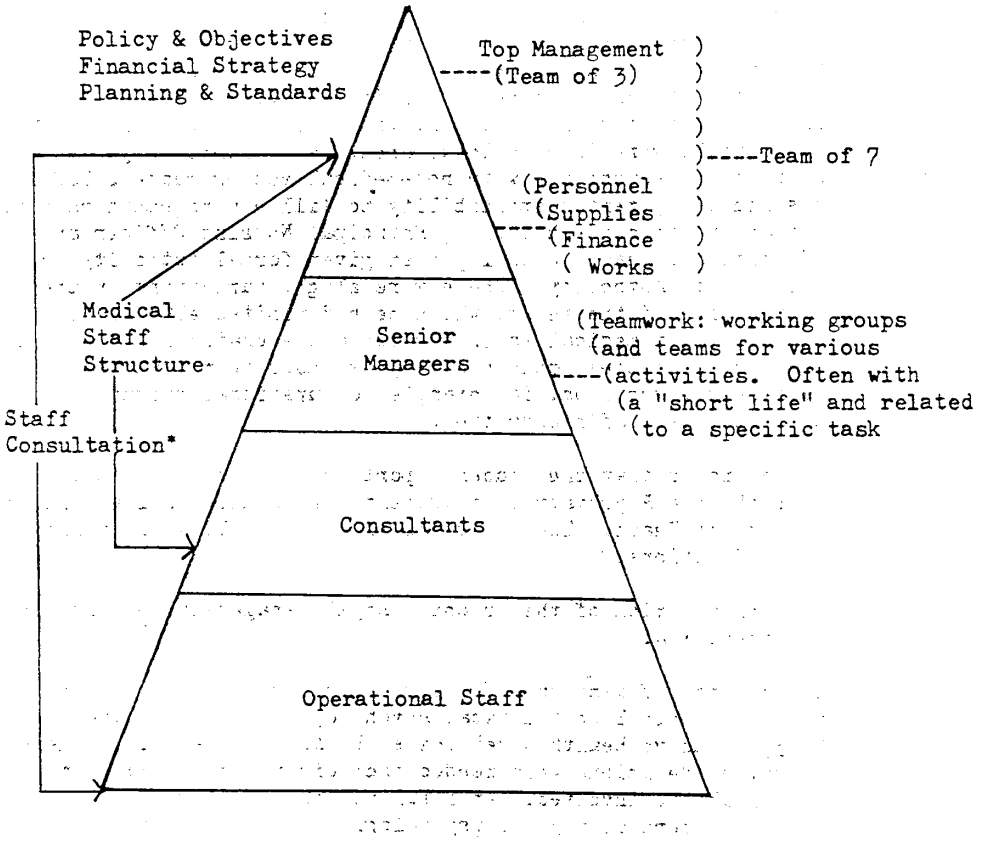
One objective of the 1981 re-structurings was to reduce bureaucracy. Thinking of a large hospital, Graham Millard then identified the players in the team, their relationship to each other and some of the ill-defined grey areas as follows:-

Grey Areas

X-Ray
Pathology
Physiotherapy
A & E Department
Works
Pharmacist



A pyramidal way of illustrating the structure was as follows:-



* There would be additional representative arrangements eg of junior medical staff

At unit level it was thought that there need not be a division between operational management and planning: the same officers could do both.

Effective management arrangements at unit level would include:

- Strong personnel management
- Good communications
- Decentralisation of management decision-making within the unit

Such arrangements would allow the organisation to raise standards and to tackle problems quickly and effectively at lower levels of delegated authority and accountability.

George Crosbie then described the Hospital Management Team which had been functioning in recent years at Crichton Royal Hospital in Dumfries. He had compared it with similar psychiatric hospital management teams which he had visited at Claybury, at Netherne and in the Chichester District. It was essential to devise something which would work in ones local area. At Crichton Royal the Division of Psychiatry with non-medical voting members had initially assumed management responsibility to fill a management vacuum. A tripartite team of Physician, Principal Nursing Officer and Administrator had eventually been given formal authority by the Area Health Authority. There were slight variations in the composition of the teams, which he had visited elsewhere; some having both a medical administrator and a chairman of a medical advisory committee, others having extended teams embracing representatives from, for example, occupational therapy or a joint consultative staffs committee.

It was noted that the Nodder Report recommended the establishment of both Area Psychiatric Management Teams and Hospital Tripartite Management Teams. These, it was thought, could well overlap in their functions.

The constitution of the Crichton Royal Management Team is included as Appendix A.

On the size of management groups George Crosbie quoted a psychologist's view (D. Castell on "Clinical Psychology and Health Care" in "Comprehensive Health Care" edited by Dr A. Baker) that where executive decisions were needed then eight was the maximum number who should be involved. An ideal number was between 5 and 7. With only 3 members of a group psychologists considered questions of dominance arose and affected group working adversely.

If District Authorities do set up Hospital Management Teams it is important for the Teams to have some form of terms of reference. This should be a fairly concise document which should leave no doubt as to membership and responsibilities of Teams and in particular the arrangements for financial management should be specified.

Dr Newman of Banbury reiterated the importance of complementing any streamlined medical executive committee with occasional big meetings of all consultants to ensure involvement and commitment of medical staff. He valued the philosophy of "Patients First" which left many decisions on team composition and structure for local decision. Where central guidance was blurred it gave healthy room for manoeuvre.

Doubt was again expressed about the wisdom of establishing Unit Management Teams as such. Not only might this give rise to demands from various developing professional groups to be represented on the team, as a mark of their importance and need to be involved; it might additionally result in UMTs dealing with trivia or at least matters for which the individual nurse manager and unit administrator were accountable. Collective responsibility in a team often inhibited individual officers from managing their own service. The administrator and the nurse at unit level should have their own budgets. The representative of the medical staff could not be held accountable in the way the administrator and nurse were.

Apart from meetings of tripartite top management at unit level, it was advantageous to have meetings from time to time of this tripartite group with representatives of Finance, Supplies, Works and Personnel.

8. ACTION PLAN

Members of the seminar formulated an action plan based on their deliberations as follows:-

1. Circulate a report of the seminar discussions to members of the seminar, to all Regional, Area and District Administrators, for them to circulate in turn, and to professional organisations and other interested bodies as a contribution to discussions on unit management in the restructured NHS.

2. Use the report of the course in preparing education material for seminars at the College for Chairmen and Members of DHAs and make it available to other educational centres.

3. Emphasise the importance of careful definition of:-
   a) What should constitute units in each District
   b) The Budgetary Process
   c) Clinical involvement

4. Ask the College to arrange for thought to be given on the clarification of the role of the unit administrator and the preparation of a job description.

5. Ask individual course members to produce an outline of what units, management arrangements, budgetary control and internal communications and meeting systems might be for model District situations based on six or so broad categories as follows:-

Category	Local Base	Course Member
Integrated large hospital embracing most District institutional services	Northwick Park Hospital	Howard Nattrass
Rural service with central hospital	North Oxfordshire Sector, Banbury	Nigel Armstrong
Urban service with two or more large hospitals in one District	Hope Hospital, Salford	Frank Burns
Metropolitan Teaching District	King's College Hospital	Ian Main
Community Services	City & Hackney HD	Frank Osborn
Rural service with scattered smaller hospitals	Northumberland AHA	Elaine Roger
Large Psychiatric Hospital	Crichton Royal Hospital, Dumfries	George Crosbie

Some model outlines of arrangements received from course members are available on request.

WEB/JPR/NJD
April 1981

APPENDIX 'A'

DUMFRIES AND GALLOWAY HEALTH BOARD
CRICHTON ROYAL HOSPITAL MANAGEMENT TEAM

1. INTRODUCTION

The Area Executive Group of Chief Officers has two main roles:

i) area type responsibilities such as planning and involvement in the preparation and execution of policy

ii) the efficient organisation and day-to-day running of services.

In respect of the latter role the Board has agreed and directed that the Executive Group should devolve to multi-disciplinary management teams at Crichton Royal Hospital and Dumfries and Galloway Royal Infirmary and Nithbank Hospital responsibility for day-to-day management of the respective hospitals and the services provided.

2. MEMBERSHIP OF TEAM

The members of the Hospital Management Team are:-

- Medical Administrator (appointed by the Health Board)
- Divisional Nursing Officer
- Administrator

3. FUNCTION

The basic function of the Team is the management of the hospital and services on behalf of the Executive Group.

4. RESPONSIBILITIES

The Team will be corporately responsible for the efficient functioning of the hospital and services and thus the day-to-day provision of health care to the public within the framework of the policies and decisions of the Board and the Executive Group.

5. DUTIES AND PROCEDURES

5.1 In pursuance of their remit, the Team will institute such consultative procedures as are appropriate and thus stimulate the flow of advice and information within the hospital. In particular they will ensure adequate consultation, through the Medical Administrator and also jointly as may be required with consultants bearing in mind that they carry individual clinical responsibility and do not operate within a hierarchical structure. In similar vein, adequate liaison must be maintained with the Director of Psychological Services and Research.

With regard to para-medical disciplines, such staff and the services they provide will be co-ordinated on a day-to-day basis through the Medical Administrator taking due account of the existence of functional managers to whom such staff are professionally responsible.

Nursing advice and information will flow routinely through the management structure of the discipline.

Supporting services such as catering and building/engineering will be co-ordinated by the Administrator to whom such nominated managers will be responsible for day-to-day matters notwithstanding their responsibility to the respective area functional managers on matters of professional policy, methods and procedures.

The Administrator has a responsibility to measure the relative effectiveness of the supporting services being supplied and to consult with functional managers about possible ways of improving such services including adjustments to cope with change or extension of requirements or to correct defective or surplus provision.

5.2 The Team will initiate and correlate the preparation of policies and plans for the provision of all services and will prepare programmes of building, engineering, furniture and equipment, staffing etc. requirements.

5.3 The Team will ensure adherence to statutory and other regulations and instructions relating to the care and welfare of patients and will undertake such initial investigations as may be required or requested in connection with relevant complaints by, or on behalf of, patients or staff.

5.4 The Team will be members of the Management Side of the Joint Consultative Staffs Committee.

5.5 The Team will administer the tenancies of staff houses and residencies subject to consultation with the Chairman of the Staff Side of the Joint Consultative Staffs Committee in allocating a tenancy other than one which falls into the "essential" staff category.

5.6 The Team will authorise expenditure from the Amenities Fund subject to the proviso with regard to the Staff portion of such Fund that the Joint Consultative Staffs Committee will be the appropriate channel of suggestions for expenditure.

5.7 The Team will control expenditure within such approved budgets as may be allocated and within such limits of virement between supplies and services heads of expenditure as may be notified.

5.8 The Team will have authority, subject to budget constraints to purchase items of furniture or equipment up to a maximum of £500 for any single item or group of items.

5.9 The Team will encourage and oversee Fire and Safety Precautions throughout the hospital.

6. MEETINGS

6.1 The Team will meet formally at regular intervals to deal with business as detailed in a circulated agenda and will invite the attendance of such officer or group as may be appropriate for specific items of business.

6.2 Minutes will be recorded of formal meetings and information therefrom will be circulated throughout the hospital by such means and in such form as the Team may determine.

6.3 The Administrator will co-ordinate the activities and business of the Team and the implementation of their decisions. He will be the official correspondent of the Team.

6.4 All decision of the Team shall be consensus. In the event of failure to reach consensus the unresolved matter will be referred by the Administrator to the Secretary of the Board for consideration by the Executive Group.

6.5 The Team will meet the Executive Group at such regular intervals as will be determined from time to time and at the request of the Hospital Management Team. The Administrator will receive a copy of the minutes of the meetings of the Board and the Executive Group (subject to deletion of any confidential item of a personal nature) for their private perusal.

EE/MH
Nithbank, Dumfries
November, 1979

DUMFRIES AND GALLOWAY HEALTH BOARD

JOB DESCRIPTION FOR THE POST OF MEDICAL ADMINISTRATOR
CRICHTON ROYAL HOSPITAL

1. The general role of the Medical Administrator is co-ordinative, rather than directive. This statement recognises (i) the separate and distinct clinical freedom and responsibility of each consultant and (ii) the fact that non-medical staff disciplines operate within and are subject to their own hierarchical structures.

2. The post of Medical Administrator will provide a readily identifiable medical component of management for the purposes of correspondence with the various clinical and para-clinical services, the Administration of the hospital, the Health Board and its subsidiary bodies and committees, and local authority services, as well as voluntary services, community health councils and aftercare and rehabilitation services; the Medical Administrator will be responsible for keeping the Division of Psychiatry informed of such correspondence.

3. The Medical Administrator will transmit the views of the Division of Psychiatry on hospital policy to the management team.

4. Within his own sphere, the Medical Administrator will:-

i) As a member of the Division of Psychiatry play a full part in that forum in connection with the development of clinical policy, eg the organisation of clinical work, the improvement of standards of patient care, the assessment and evaluation of the work of the medical staff in relation to the needs of the community and the provision of professional advice to management

ii) In conjunction with his colleagues and appropriate Health Board personnel, be responsible for the employment, deployment and conditions of service of junior medical staff

iii) Take part in assembling and interpreting data related to the mental health needs and population trends of the Dumfries and Galloway area and in ensuring the most effective use of existing services, in conjunction with community physicians; he will transmit the views of the Division of Psychiatry on such matters

iv) Facilitate alterations, improvements and developments in the furtherance of policies approved centrally for mental health services

v) Provide advice and information to other medical staff in the Division of Psychiatry, to the Management Team or Executive Group and to others, on matters of mental health policy, planning and priorities

vi) Provide information and advice to the administration on mental health practice with particular reference to the requirements of the Mental Health Act and the Mental Welfare Commission

vii) Give advice on medico-legal matters and ensure compliance with appropriate complaints procedures and the legal and statutory requirements within the clinical sphere, of appropriate authorities such as Scottish Home and Health Department, Central Legal Office and Health Board

APPENDIX 'B'

KING'S FUND COLLEGE: COURSE 795
SEMINAR FOR UNIT ADMINISTRATORS ON BUDGETING AND TEAM MANAGEMENT - Thursday 5th and Friday 6th March 1981

LIST OF MEMBERS

CITY AND HACKNEY HEALTH DISTRICT (TEACHING)

Mr R.H. Bird	Administrator Community Health Services
Mr F.B. Osborn	District General Administrator Community Health Services

DUMFRIES AND GALLOWAY HEALTH BOARD

Mr G.B. Crosbie	Sector Administrator (Psychiatric) Crichton Royal Hospital

HARROW HEALTH DISTRICT

Mr G. Millard	District Administrator
Mr H.A. Nattrass	Assistant District Administrator (Out-Patient and Para-Medical)

KING'S HEALTH DISTRICT (TEACHING)

Mr I. Main	Assistant District Administrator

NORTH EAST THAMES REGIONAL HEALTH AUTHORITY

Mr K. Ford	Principal Assistant Regional Treasurer

NORTHUMBERLAND AREA HEALTH AUTHORITY

Mr P. Gavin	Senior Assistant Area Treasurer
Mrs E. Roger	Unit Administrator Ashington Hospital

OXFORDSHIRE AREA HEALTH AUTHORITY (TEACHING)

Mr N.J.B. Armstrong	Sector Manager North Oxfordshire Sector
Mr M. Miller	Sector Finance Officer North Oxfordshire Sector
Dr C.R. Newman	Consultant Physician Horton General Hospital

SALFORD AREA HEALTH AUTHORITY (TEACHING)

Mr F.G. Burns	Hospital Administrator Hope Hospital
Mr G. Ingram	Consultant Surgeon Hope Hospital
Miss P. Moseley	Divisional Nursing Officer (Obstetrics) Salford Area Health Authority (T)

Membership - 15

SALFORD AREA HEALTH AUTHORITY (TEACHING)

Mr F.G. Burns	Hospital Administrator Hope Hospital
Mr G. Ingram	Consultant Surgeon Hope Hospital
Miss P. Mosel[illegible]	Divisional Nursing Officer (Obstetrics) Salford Area Health Authority (T)

Membership [illegible]