KING EDWARD'S HOSPITAL FUND FOR LONDON

Some Observations on the Administration of Hospital Management Groups

SEPTEMBER 1950

Some Observations on the Administration of Hospital Management Groups

Being the conclusions of a group of hospital officers after a series of discussions held at King Edward's Hospital Fund for London

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INTRODUCTORY NOTE

The purpose of the enquiries which led to these notes was to see whether the experiences of a few typical Hospital Management Groups during the first eighteen months of the new regime pointed to any conclusions or comments which might be helpful to those concerned with hospital administration. It was clearly impracticable to deal with such technical and specialised subjects as Supplies, Accounting Systems, Catering and Nursing, all of which require separate treatment. Broadly speaking the matters discussed are those where general administrative principles are involved.

Such interest as this document possesses is derived entirely from the fact that the draft was discussed in a series of meetings with eight or nine officials of the Hospital Groups which had been visited; while complete agreement could not be reached on every point there was sufficient unanimity to justify putting the results into print as a contribution to a range of subjects under review in many quarters.

The drawback to reports of this nature, dealing with a young and constantly developing service, is that in the very course of composition they become out of date: and there is nothing so stale as yesterday's *cause célèbre*. Nevertheless though the observations themselves may already be outmoded by events no effort directed towards crystallising thought on current hospital problems can be labour entirely wasted.

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I.

RELATIONSHIPS AT THE THREE LEVELS—MINISTRY, REGIONAL BOARD AND MANAGEMENT COMMITTEE

1. On the face of it any discussion on the broad structure of the Service would seem to be outside the terms of reference defined in the Introductory Note; but H.M.Cs. are affected to such an extent—both directly and indirectly—by relationships at all levels within the Service that the subject can scarcely be ignored. The remarks that follow, however, should be viewed against a background of solid achievement on the part of all the authorities concerned in launching successfully perhaps the boldest social venture of modern times.

2. It is natural that troops in the field should find fault with the staff at base. The new Hospital Service has been no exception to this rule and each authority in the hierarchy has tended to criticise—sometimes without full knowledge—the authority one step higher. From all the experiences that are quoted it is extraordinarily difficult to arrive at a fair and balanced assessment of how effectively the administrative system of the Service is working. Nor does it help much to say that the real criterion is the welfare of the patient; for the old hospital traditions of skill and devotion at the bedside act as a buffer between the administrative system and the patient, and it is only in the long run that defects in the former will make themselves felt in wards and clinics.

3. The first necessity, then, in attempting any appraisal of the present situation is to ~~distinguish between~~ criticism arising out of isolated experiences which were due, not to any fundamental defect in the system as such, but to one or other of the immense difficulties under which the Service laboured in its initial stages. It is surprising that Regional Boards were sometimes slow in giving decisions when their untried machinery was attempting to cope simultaneously with the problems of perhaps 20 Management Groups? Amongst all the Ministry instructions necessary to start the Service from scratch could one reasonably expect that all would be perfect? Furthermore, the financial cuts imposed when Management Groups were just getting into their stride with development plans were a crushing disappointment and brought down upon the heads of Regional Boards, who had the unenviable task of implementing them, a spate of protests. The time element forced Regional Boards to fall back on arbitrary hit-or-miss methods of pruning estimates and the fact that they were not in a position to justify their actions in any particular case put them in a false position *vis à vis* Management Committees from which they have not yet extricated themselves. They found themselves facing both ways: on the one hand enforcing cuts as the agents of the Minister: and on the other begging all they could get from the Minister as champions of the Management Committees for whose working efficiency they were held responsible.

43. The cuts were indeed unfortunate and in almost any circumstances would have caused unrest. They did however serve one useful purpose by focussing attention on the financial arrangements of the Service. Up to that time H.M.Cs. had been getting pretty well all they asked for. Now they had to prove the need for every penny, and this they found themselves unable to do except on the grounds that such and such a service cost so much last year and was therefore likely to cost so much next year. Furthermore, when they had made their case and got the expenditure approved they found that they were allowed none of the flexibility which the good housekeeper enjoys—to save on one item so as to spend on another, and so on; nor the satisfaction of being allowed to put by for a future occasion the savings achieved in one year by good domestic economy. On these points have been based a plea, firstly for the

development of some form of costing control for hospitals—which the Minister has accepted in principle; and secondly for a system of round sum allocations for maintenance purposes to Regional Boards and thence to Management Committees—sums which would be just as much "theirs" as were the funds of a voluntary hospital, or the rates collected by a Local Authority.

So far as capital expenditure is concerned, there is general agreement that only the planning authority—the Regional Board—can fairly assess priorities and allocate the limited funds available; but since the development of an area's health services must inevitably be a lengthy process the only really satisfactory system can be grants or guarantees covering a development cycle of several years. The analogy of the quinquennial grants made to the universities is often quoted as a precedent.

To return to maintenance expenditure—if round sum allocations are adopted there would seem to be some grounds—assuming that costing guides are developed—for transferring the function of assessing maintenance allocations from the Regional Boards to the Ministry. There are advantages in this operation being so far as possible impersonal, and dependent upon straightforward agreed formulæ rather than the scrutiny of accountants on the staff of the Regional Treasurer. It was certainly a function of the Boards never envisaged in the early discussions on the shape of the service, and the machinery of the Ministry is probably better suited to what would become in due course almost a routine task. This would certainly set the Boards free to concentrate upon their primary functions of planning (including capital development) and raising standards of medical care.

6. In a public service of any kind every activity is affected—directly or indirectly—by the system of financial control in force. It is idle to pretend that the hospital service can be an exception to this general rule; but at the same time the hospital service is accepted as a unique experiment in public administration in this country, and as such the traditional Treasury methods of financial control may be quite unsuited to its purposes.

7. *The Regional Boards—functions reviewed.* Apart from these two radical proposals there are a number of less fundamental—but still important—modifications suggested by the experiences of administrators at Regional and Management Group level. It is convenient to discuss these under the three main heads of responsibility (apart from Finance) generally attributed to the Regional Boards:—

(*a*) Planning.

(*b*) Raising standards of medical care.

(*c*) Administration.

8. (*a*) *Planning.* That the planning of the hospital service of the region is the principal function of Regional Boards has never been in dispute. There have been occasions, however, when the plans drawn up by H.M.Cs. with considerable care and labour have not proved acceptable to the Board. These decisions would probably be received with better grace if the Boards explained why exactly the proposal was not acceptable and what precisely were their intentions in that sphere. Here again it would be unfair to blame Regional Boards for not producing cut-and-dried "Master Plans" within the first 12 months of the Service. The grading of consultants was a monumental task, let alone the arrangement of contracts, and the work is still going on. Nevertheless it is perhaps questionable whether Regional Boards have fully realised the necessity not merely for *having* a plan but for publishing it so that H.M.Cs. can see how they fit into the Regional pattern. Management Committees are very different from military units disciplined "not to reason why." Without exception they are intensely

interested in what is being planned at higher levels. Perhaps one reason little information seems to filter through to H.M.Cs. about Regional plans is that the H.M.Cs. are predominantly lay bodies, whereas planning at the Boards is almost entirely—and quite rightly—the prerogative of the S.A.M.O., whose channels of communication are largely medical. There is a hint of a real danger here. Clearly specialist officers at the Region—whether medical or technical—must frequently deal direct with their counterparts at Group level, but they should make a point of ensuring that the Group Secretary is kept generally in the picture. Other considerations apart, he is, after all, liable to be called upon by his Committee for information on all spheres of activity within the Group.

9. (*b*) *Raising standards of medical care.* The responsibilities of the Boards under this head are threefold : -

(i) The control of senior medical appointments ;

(ii) arising out of this the co-ordination of hospital services (particularly the specialities) ; and

(iii) encouraging the spread of the University influence.

10. Points (i) and (ii) have naturally taken priority during the last two years and will probably continue to do so for some while to come. Despite the gloomy prognostications sometimes heard in the early days there is now very general approval from all quarters of the system of consultant appointments by joint committees : the only modification sometimes suggested is that the time-honoured practice of candidates visiting their future colleagues should be re-instituted. At present the medical staff of the Management Committee have virtually no say in consultant appointments to the Group, which is perhaps too violent a swing of the pendulum.

11. The co-ordination of medical services generally has made good progress, though the remarks made under Planning above apply with equal force, i.e., that H.M.Cs. should be given all possible information on the Board's intentions (both short-term and long-term) with regard to medical services in the area.

12. In the debates when the Act was going through Parliament one of the most constantly argued merits of the Regional system was that it would spread the influence of the Teaching Hospitals more widely than has ever been possible before, to the general benefit of hospital standards throughout the country. It was envisaged that there would not only be a give and take of patients between periphery and centre but also of medical staff, particularly in the Registrar grades. Registrars from the Teaching centres would be seconded for part of their time to outlying hospitals where later they might become consultants : promising senior housemen would be recommended by their Teaching Hospital for registrar appointments in non-Teaching Hospitals where they would obtain responsibility and clinical experience without losing touch with Teaching Hospital ideas : clinical conferences would be held at Teaching Hospitals to which consultants in the Region would be invited to attend.

13. Disappointment is sometimes expressed at the apparently slow progress being made towards putting into practice these fine conceptions. The practical difficulties however are very great and inevitably the main preoccupation amongst the Regions has been keeping the Service going during the teething period ; in consequence " refinements " such as those described have tended to be postponed. Nevertheless the Teaching Hospitals have been given freedom just so that they should be able to sponsor this sort of liaison with regional hospitals. But this privilege demands in return a sense of real responsibility for taking the initiative, which obviously must lie with them.

14. (c) *Administration—the need for definition of functions.* It is clear that so long as the Regional Boards are responsible for the hospital service in their area they must be constantly in an administrative relationship with their H.M.Cs., no matter that degree of day-to-day autonomy may be granted the latter. Planning and the development of medical services cannot be carried out as it were *in vacuo* : when plans have to be implemented Management Committees must be told what to do by the superior authority, who then have a clear duty for seeing that what they say is carried out. Only thus can they discharge their responsibility to the Minister.

15. There have undoubtedly been some difficulties over this administrative relationship but on examination it rapidly becomes clear that the fault lies not with the bodies themselves but in a general failure to define the exact functions and responsibilities at the three levels of the hospital service—the Ministry, the Regional Boards, and the H.M.Cs. The worst sufferers are the H.M.Cs. who from the start have been bombarded from two quarters. They had expected to serve one master but find themselves serving two. Sometimes the instructions of each come into conflict : at others there seems no very sound reason why one rather than the other authority made a particular demand. It could even happen that one Group Secretary would write to his Board about a certain point while his neighbour was writing on the same point to the Ministry—and for each to receive a different answer.

16. Such a system is clearly administratively unsound. Latterly things seem to have improved and at no stage has there ever been danger of complete breakdown or anything approaching it—only a sense of frustration amongst those trying to do a difficult job of work. The remedy lies, as has been said, in a clear statement by the Minister laying down the responsibilities at each level. Without attempting detailed suggestions it would above all seem undesirable that the Ministry should deal direct with H.M.Cs. (or *vice versa*) on any matter which is within the authority of the Regional Board, except perhaps on appeal.

17. Simplicity is the essence of good administration and the response to a clear-cut chain of command is remarkable. In a service where the dualism of medical and lay authority creates many uncertainties the need for clarification is overriding and urgent.

II.

THE INTEGRATION OF THE GROUP

INTRODUCTION

18. For many years much thought has been given to the co-ordination of the hospital service. In 1920 the Interim Report on the future provision of medical and allied services under the chairmanship of Lord Dawson of Penn recommended an organised medical service in which general practitioner and hospital services were linked together into " Health Centres " which corresponded to the present hospital management groups. During the war the Ministry of Health appointed Survey Officers to report on the hospital services throughout the country. Whilst the conclusions varied, there was a marked unanimity in regard to the need for larger hospital units—somewhere in the region of 800 to 1,000 beds if all the special departments and the full range of ancillary services were to be provided on a reasonably economical basis. The Survey Officers further suggested that the grouping of existing hospitals round a major hospital—or hospitals—would be the most practical way of achieving this.

19. These suggestions have been adopted in the National Health Service Act. Hospitals are now grouped together under H.M.Cs. providing anything from 500 to 3,000 hospital beds and efforts are being made by H.M.Cs. all over the country to co-ordinate the units under their care so as to provide the services required in the most economical and efficient form consistent with local conditions.

THE INTEGRATION OF MEDICAL SERVICES—ONE GROUP, ONE MEDICAL STAFF

20. The grouping of hospitals under Management Committees is only the first and easiest step in achieving the ultimate aim of an integrated hospital service. Nor are any two groups exactly comparable. The problems of a typical urban group consisting of say, two general hospitals—one ex-local authority and the other ex-voluntary—plus a few special hospitals all within a few miles radius—are very different from those of the average provincial group made up possibly of only one fair-sized general hospital (which may not have a full consultant staff) numerous cottage hospitals and a few special units.

21. Whatever the nature of the group, however, no real integration of the medical services provided can take place without the willing co-operation of the medical staff of all the hospitals concerned. There are bound to be initial difficulties—the medical staffs of the ex-local authority and ex-voluntary hospitals, the G.P. staff of the cottage hospitals, all have their differing outlooks and interests. The ultimate aim should be a unified consultant staff common to the group. This must inevitably take time to develop, but in the meanwhile much can be done through the Medical Advisory Committee if it is really representative and "group minded" (see page 10, paragraph 32). It can help to plan the medical services of the group, so that there is no unnecessary overlapping of specialist facilities, and may co-operate in the arrangement of consultant sessions at hospitals in the group.

SMALL UNITS—COTTAGE HOSPITALS AND G.P. STAFF

22. The problem of how to make the best use of the various small units within a group is exercising many H.M.Cs. Arrangements with a neighbouring group in regard to fever cases will often enable an H.M.C. to convert a three-quarters empty I.D. hospital to some more profitable use and few objections are likely to be raised. The real difficulties arise over cottage hospitals (i.e., units of under 50 beds). Having as a rule a low occupancy (in 1947 the average number of open beds vacant in this group in the King's Fund statistical summary was 36 per cent.) they tend to be uneconomic to run and there often appears to be a good case for using them as special units or recovery homes for the major hospitals. The case for this is strengthened by considerations of nurses' training. As special units they can become a ward of the general hospital and be staffed by student nurses whereas if they remain cottage hospitals they will have to be staffed by trained and assistant nurses.

23. There is however another side to the question. It is generally recognised that cottage hospitals have a useful service to perform. They provide the general practitioner with a nursing service for cases he is well qualified to treat but which cannot remain at home; they provide a centre for the treatment of casualties where the avoidance of long ambulance journeys is desirable; they provide a convenient centre for consultative out-patient sessions when the main hospital is some distance away; and finally, from the patient's point of view, he may be moved there without any of the attendant fears of hospitalisation in a strange and distant institution.

24. The case for each cottage hospital must therefore be judged on its merits. Where a cottage hospital is to remain as such care must be taken to ensure that it does not try to undertake work beyond the capabilities either of its staff or equipment. Economic considerations seem to suggest a nursing service and facilities for minor operations only. If, however, geographical considerations necessitate the provision of consultative out-patient clinics then inevitably out-patient accommodation and diagnostic apparatus will have to be provided. In rural areas these clinics will be of great and obvious benefit.

25. So far as medical staffing is concerned cottage hospitals should be open to all the general practitioners of the area; anything in the nature of a "closed shop" should be strenuously resisted.

26. All cottage hospitals should, of course, be linked with a consultant-staffed hospital, as it was the intention of the Act that specialist attention should be available to all. With the shortage of fully qualified consultants it was clearly inevitable that medical officers graded as Senior Hospital Medical Officers should act in their place; but in a good many instances it now appears that general practitioners not graded as S.H.M.Os. are holding operating sessions and out-patient clinics at cottage hospitals on a sessional basis. Expediency may have made these appointments necessary but, without any reflection upon the individuals concerned there must obviously be a danger of their undertaking work beyond their professional competence. Where such appointments have been made it is doubly necessary that the H.M.C. should arrange for consultants to make regular visits both to wards and out-patient clinics.

HOSPITAL MANAGEMENT COMMITTEES' RELATIONSHIP WITH GENERAL PRACTITIONERS IN THE AREA

27. The general practitioners of the Group's catchment area are the principal source of most of the cases referred for hospital treatment—whether as in- or out-patients—and the desirability of a close link between them and hospitals is obvious. Lip-service is usually paid to the principle, but constructive and practical measures to achieve it are less in evidence. The following are a few of the steps being taken in various Groups which seem worthy of note:—

(i) Every G.P. in the area is supplied with complete information by the H.M.C. of all the main services provided by the hospitals of the Group, together with some general information as to procedure for complaints, suggestions, etc.

(ii) Periodic bulletins are circulated to G.Ps. giving notice of any changes in out-patient clinic times, the opening of new departments or services, and indicating the state of waiting lists for different categories of patient, time lag with regard to the supply of hearing aids, etc.

(iii) The establishment of an efficient system for keeping G.Ps. informed of the progress of their patients.

(iv) The holding of clinical meetings attended by G.Ps. at which consultants discuss cases of interest or developments in treatment; followed or prefaced by a "tea party" of some kind.

(v) Drawing G.Ps. into the social life of the hospitals by inviting them to dances and other social functions; the H.M.C. Secretary may take the opportunity to meet as many as possible so as to acquaint himself with their views.

(vi) Where no G.Ps. (or very few) are on the staff of the hospitals in the Group, G.Ps. may be co-opted onto the Group Medical Advisory Committee.

(vii) General Practitioners may be appointed to clinical assistantships at hospitals attached to consultants. Unfortunately, no provision is made under N.H.S. regulations for the payment even of expenses of G.P. clinical assistants.

(viii) The local branch of the B.M.A. or the Executive Council is consulted on any aspect of the service in which they are affected—in particular when a change of user of a hospital is contemplated. It may also help if a representative of the H.M.C. gives a talk to these bodies on the problems and aims of the Group, followed by general discussion.

III.

COMMITTEES AND COMMITTEE WORK

THE COMPOSITION OF HOSPITAL MANAGEMENT COMMITTEES

28. The general feeling is that the H.M.Cs. are working well in spite of the fact that the need to consult all sorts of extraneous bodies due to the Minister's desire for " consumer representation " has resulted in a certain number of members on many H.M.Cs. who have little idea of what it is all about. " Consumer representation " is only a matter of words—in fact every member of an H.M.C. should be there because he is anxious to help provide the best possible hospital service for the district and has something to contribute by reason of experience or personal qualities.

29. So far as length of appointment is concerned, when members retire in rotation after three years (apart from the initial first and second years) it is to be hoped that the Regional Board will consult the Chairman of the H.M.C. about the re-appointment of members ; it will be disastrous if really useful members of the committee are automatically retired regardless of merit. With this proviso a system of retirement in rotation should ensure a steady influx of new blood and is probably the best solution to a difficult question.

30. Another criticism levelled at the composition of the H.M.Cs. is the fact that medical and dental staff working for the group may also be members of the committee. It is argued that for paid staff to be members of a Committee is wrong in principle and an embarrassment in practice. Here it is necessary to draw a distinction between clinicians—whether full-time or part-time—and medical staff undertaking administrative duties. So far as the former are concerned the difficulty is theoretical rather than practical. The H.M.C. could not afford to dispense with the expert opinion and advice of its medical staff. This was recognised under the old voluntary system where representatives of the Medical Advisory Committee—who might or might not be voting members of the Board—played a big part in planning the medical services and in the medical aspects of administration. Their advice was always listened to and whether they had a vote or not scarcely affected the issue. The fact that the present medical members of the H.M.C. are there as members and not as advisers will therefore make little difference. Should any question of financial interest to a medical member arise in

committee, he can tactfully be requested to withdraw. The fundamental difference arises over the fact that under the old voluntary system the medical staff members spoke with the full authority of the Medical Advisory Committee—they were nominated by them and they were putting forward their views. Under the present system they are only speaking as individuals and their views may not necessarily be those of the Medical Advisory Committee. The position of the Medical Advisory Committee and the medical members of the H.M.C. would be greatly strengthened if the latter were sitting as the recognised representatives of the former and presenting an agreed view.

31. The position of medical staff serving in an administrative capacity in the group is very different. In some cases medical superintendents have been appointed members of their own H.M.C. and this has led to all sorts of difficulties as they are constantly required to state views and vote upon administrative matters in which they have a personal interest. If they are to be members of the H.M.C. there appears to be no good reason why other members of the administrative staff should not also be eligible. In fact it is clear that there should be a definite ruling that nobody—medical or lay—employed in an administrative capacity should be a member of his own H.M.C. A recent Ministry Circular RHB (49) 143 deprecates officers of committees being members of them, but it is not clear whether the term " officers " is meant to cover medical staff or not.

MEDICAL ADVISORY COMMITTEE—CONSTITUTION AND FUNCTIONS

32. It is not clear from the original Ministry instructions recommending the establishment of medical committees what status and function is envisaged for them. The emphasis seems to be on their function of safeguarding medical interests rather than the far more important one of providing a responsible body of professional advice for the H.M.C. on the medical aspects of running a group. The Medical Advisory Committee is the mouthpiece of the medical staff of the group and as such will be consulted by the H.M.C. as a matter of course on all medical matters whether purely professional or involving policy and planning. The need for an active, responsible and representative group medical advisory committee cannot therefore be over-emphasised. Before hospitals were grouped the Medical Advisory Committee of a hospital consisted of all the senior medical members of the staff and this was undoubtedly a great advantage. In the majority of cases this is no longer practicable though it may once again become so if and when units in a group have a common medical staff. It is necessary therefore to ensure that the Medical Advisory Committees are as representative as possible of the various units and the different specialities. The aim must be to strike a balance between the two. A member from each unit and a member representing each speciality may achieve this result. The specialities are centred in the larger units in the group so that such an arrangement may give them a preponderance on the committee, but this is perhaps not unreasonable in view of the greater amount of work they undertake. Cottage hospitals will usually be represented by G.Ps. Modification of this pattern will be necessary to meet the varying circumstances of each group. A representative of the Local Health Authority and of G.Ps. in the area may sometimes usefully be co-opted.

33. At present the medical staff decide their own constitution and this has led to difficulties in some groups where the Medical Advisory Committee is not fully representative of the interests of all the medical staff. Direct action is not open to the H.M.C. but a tactful chairman may be able to bring about the necessary modifications. Alternatively the Ministry might advise medical staff of the lines on which Medical Advisory Committees should be constituted. As the staffs become more group-minded these initial difficulties should disappear.

SUB-COMMITTEES

34. It is generally agreed that standing sub-committees should be kept to a minimum. Committees tend to create a mass of paper work which distracts their officers from administrative duties. The H.M.C. however will not want to meet more than once a month and it is probable that to get through the business weekly, or at any rate fortnightly meetings will need to be held. There are two alternative methods of dealing with the matter: (i) by appointing one all-purposes committee with very wide powers which meets weekly and deals with all business including the recommendations from the advisory committees, other special sub-committees (catering, maternity, etc.), if any, and the House Committees; (ii) by appointing two or three standing sub-committees—e.g., Finance and General Purposes, Establishment, and Building, each meeting monthly to which the appropriate recommendations from the various House Committees, special sub-committees and *ad hoc* sub-committees are referred.

35. The first method has the advantage of ensuring that all recommendations are considered and, except in cases of major policy, dealt with within a week, but it means that its members undertake a great proportion of the work of the group, while other members of the H.M.C. may be left with comparatively little to do. It may also be difficult to find members who are able to attend weekly.

36. The second method, whilst it means that matters are not dealt with quite so quickly, enables the work to be more evenly distributed amongst the members of the H.M.C. It should be possible to arrange that all the members of the H.M.C. are on one of the standing sub-committees as well as being on one of the House Committees.

37. The Finance and General Purposes Committee should be given considerable executive powers over a wide field. It will of necessity deal with a large range of items, as everything not specifically covered by a sub-committee will be referred to it. The question of whether there should be a separate Building Committee must depend on the amount of building work being undertaken in the group.

38. The Establishment Sub-committee is probably the second sub-committee which will be considered necessary by most groups. It should be responsible for all senior appointments (junior appointments will probably be made by the House Committees concerned) for keeping establishments constantly under review, preventing anomalies in salaries or wages, dealing with the Unions, investigating complaints from the staff, etc. Some of this work will of course tend to diminish as the functions of the groups become more settled and it may eventually be possible to dispense with this sub-committee.

39. In addition it has been suggested that nursing, maternity and catering are specialised subjects which tend to get neglected unless there are special sub-committees concerned with them.

40. Some hospitals have appointed a medical sub-committee from the medical members of the H.M.C. who may or may not be on the staff of the group. It may be desirable to appoint such a committee as an *ad hoc* committee for some particular purpose but with a strong group Medical Advisory Committee a permanent medical sub-committee would be largely superfluous and might tend to undermine the position of the former.

HOUSE COMMITTEES

41. A great deal has been heard recently about House Committees. There are two distinct schools of thought on the subject. On the one hand it is argued that live and active House

Committees safeguard local interests and provide a focus for local voluntary effort; on the other that they introduce a fourth tier into an already over-weighted administration and often greatly increase the difficulties of group integration. In some groups they have proved a thorn in the side of the H.M.C. and as a result their abolition has been recommended. But where this has happened it does not necessarily mean that House Committees are wrong in principle, but rather that those particular House Committees were wrongly constituted or had not yet become "group minded."

42 There is no doubt that House Committees perform a very valuable service (*a*) by providing the individual unit with a committee which really knows the hospital and is a focus for local interest and loyalty; and (*b*) by acting as a "sounding box" for the H.M.C. by which it may keep in close contact with opinion at the periphery of the group; and (*c*) by providing a training ground for potential members of the H.M.C. They can also perform very useful work by dealing with day-to-day problems which would otherwise need to be referred elsewhere. Indeed, if they were abolished it would probably mean the creation of additional sub-committees to deal with the work at present undertaken by House Committees. If a substantial proportion of House Committee members are members of the H.M.C. it should ensure that group problems in relation to the individual units are clearly understood; and at the same time H.M.C. members will be brought into intimate contact with units in the group, which otherwise may remain little more than names to them.

43. This does not mean that every unit should have its own House Committee. In some towns where two or three hospitals are situated fairly close together, e.g., an ex-public assistance institution, a maternity hospital and a cottage hospital, it may be found that one House Committee can adequately look after all three units. In other cases it may be convenient for the General Purposes Committee to act as House Committee for the hospital in which it meets. The important point of principle is that there should be a committee—meeting at the hospital concerned, knowing its personnel and able to deal with its own particular problems. Beyond this it would be unwise to lay down hard and fast rules.

44. The degree of responsibility and executive power to be given to House Committees must inevitably vary according to local circumstances and is a matter that only the H.M.C. is competent to decide. Assuming a substantial core of Management Committee members there may be no objection to delegating to House Committees the authority to incur certain expenditure and take a degree of executive action, provided in the former case it is kept in possession of the financial information necessary for it to be able to judge whether the expenditure is duly allowed for in the budget. By and large, however, it would seem that the Ministry's Circular to R.H.Bs. suggesting that House Committees should be empowered only to *make recommendations* is endorsed by the experience of group administrators. The argument that House Committees will lose interest if they have no real powers is not really valid because the majority of sub-committees can only recommend action. What will count with House Committees is the degree of weight that is given to their views. If, where reasonably possible, their recommendations are approved and put into effect by the H.M.C., there would seem no reason why their interest and activity should wane.

COMMITTEE ORGANISATION AND MACHINERY

45. The importance has already been stressed of keeping the number of committees to a minimum: at the same time the utmost care must be taken to ensure that committees—and in particular the Management Committee—are not overloaded with a mass of routine and detailed work to the exclusion of their real task of formulating policy and seeing that the group is providing the best possible service for the people of its area.

46. In this respect a very big responsibility rests upon the Secretary to devise a form of committee machinery which enables the H.M.C. to fulfil its proper role: and an equal responsibility falls upon the Management Committee to reduce to a minimum its demands for routine information of a detailed nature by delegating to sub-committees and to officers the necessary powers to deal with these matters.

47. Lists of minor staff changes, schedules of requisitions for replacements, etc., should not therefore come before the Management Committee. Their concern should rather be with simple statistics showing supply and demand in the medical services of the group, arranged in comparative form so that current trends emerge clearly—waiting lists, out-patient attendances, emergency admissions, etc. Some financial data should also be supplied but only in a form that gives a clear and easily understood picture of how expenditure is running. These facts and figures may conveniently form part of the Secretary's report reviewing general progress in the group, and drawing the attention of the committee to anything of particular significance revealed by them.

48. There is no doubt a good secretarial technique is absolutely essential if the Management Committee is to remain a live, responsible and—above all—interested body. The sets of committee papers being circulated to members in many groups have to be seen to be believed —25 pages of typescript is apparently an average figure, and several instances have been noted where as many as 40 make up a set. Nothing could be more calculated than this to reduce a committee to a state of dazed apathy.

IV.

ADMINISTRATION

THE GROUP SECRETARY'S DUTIES

49. The Group Secretary is chief administrative officer ultimately responsible for the administration of all the hospitals in the group, and it is not an exaggeration to say that the morale and efficiency of the administration throughout the group will be directly related to the personality and capabilities of the Group Secretary. However good the H.M.C., he is the man on the spot, in daily contact with the units under his charge. He must be prepared to deal not only with routine matters but also to accept responsibility for major decisions when the occasion demands and to initiate new ideas and improvements. Those used to the Local Authority sytem where the hospital committee was provided with a clerk who was that and little else—administration being left to the Medical Superintendent—are liable to assume that the H.M.C. Secretary is merely a committee clerk. This leads on the one hand to H.M.Cs. which are unwilling to delegate any real executive responsibility to their Secretary: and on the other to Secretaries who are unwilling to take any executive responsibility, preferring the comfort and safety of a regime in which they are circumscribed by the letter of the Minutes to the responsibilities and risks of a wide freedom of action.

50. Grouping has introduced a host of new problems for the Group Secretary. One of the first questions arising is whether the Group Secretary should also be directly responsible for one of the hospitals in his group or whether he should relinquish this responsibility in order to concentrate on group policy and the supervision and co-ordination of all the units in the

group. It can certainly be argued that the administration of a group is a whole-time job: and also that connection with one unit or another lays him open to accusations of bias. There is undoubtedly some force in these arguments but it is surely contrary to the ultimate good of the hospital service that the Group Secretary should thus be divorced from active hospital administration. It may lead to a form of bureaucratic control quite out of touch with the important day-to-day problems which have as great a bearing on the welfare of the patients as the higher administration. "Group" will become identified in the minds of those at the hospitals with a sort of remote "County Hall"—little removed from the Regional Board and bent only on cutting down expenditure and holding up decisions. This danger may not be great at the moment when H.M.C. Secretaries are for the most part men who have spent their working lives running hospitals, often one or other of those in their group. But this will not obtain for ever and in time "Group Administration" may come to be considered as something quite different from "Hospital Administration."

51. In practice, the issue is of course affected by considerations of accommodation. Many administrators who on principle would prefer to administer a unit in addition to their group duties are forced to occupy isolated group offices which inevitably precludes them from any effective part in unit administration, though sometimes they retain nominal responsibility.

52. Even if the Group Secretary is not going to administer one of his hospitals, it is still desirable for him to have his offices at the major hospital of the group (even if there is not room for the other group offices—Finances, Supplies, etc.) as this facilitates constant daily contact with the medical staff without which successful hospital administration is impossible.

THE GROUP SECRETARY'S RELATIONSHIP WITH HIS STAFF

53. The Group Secretary's relationship with his specialist group officers has already been touched on under Regional Boards. It is generally agreed that while it may be the Group Secretary's responsibility to act as secretary to all committees he may find it convenient to delegate this responsibility to the specialist officers or—in the case of House Committees—the assistant secretary concerned.* The important thing is for him to keep in close touch with all his staff. Regular staff meetings are of great value since they enable each member to appreciate the duties and difficulties of the others and to understand the unified policy of the group. There is much to be said for holding these meetings at the different units in turn if facilities permit. Such meetings should be additional and complementary to any visits which the Group Secretary may make throughout the Group in the ordinary course of his work—and these too should be frequent. One group has tried the interesting idea of holding monthly meetings (held in the evening) of an informal nature open to all the lay staff of the group. Transport from outlying units is provided as well as refreshments, etc. The arrangement serves the dual purposes of "welfare," i.e., providing social functions for staff and "staff relations," i.e., facilitating the interchange of views between senior and junior grades of staff.

54. Junior grades of staff should be given as wide and interesting an experience as possible by a policy of interchange within the group—not only from department to department, but from group offices to units and vice versa. Such a policy has been proved to pay dividends in the form of an increased interest and liveliness amongst the staff which outweighs any temporary inconvenience and loss of efficiency in the departments.

* In this connection a point sometimes overlooked is the importance of inviting officers—medical and lay—to attend a committee which is discussing a matter particularly affecting their department. A recent Ministry circular—H.M.C. (49) 17— gives directions to this effect.

UNIT ADMINISTRATION

55. The ex-voluntary hospital secretary who now finds himself in a subordinate position to the Group Secretary, with all responsibility for Finance and Supplies taken from him, is likely to resent the change and to feel a sense of frustration which may well be reflected in greater or lesser degree throughout his hospital, from the House Committee downwards. This is inevitable and will only be remedied as those officers gradually retire and are replaced by younger men who have never known the independence of the old voluntary hospital days.

56. Misgivings have been expressed in some quarters about the future standard of administration in the individual unit; it was felt that the reduced administrative scope might fail to attract to the profession men and women with the requisite character and background for enlightened and efficient day-to-day management of the hospitals. There is no doubt that, however good the group staff, a hospital will suffer unless there is a senior officer on the spot with sufficient personality and experience to deal with the unexpected situation or administrative emergency as well as ordinary routine business. There would seem to be no solid grounds for pessimism in this respect. The unit is recognised as the training ground for the higher administrative posts and although the salaries that can be offered are somewhat low the prospects and scope are sufficient to attract and hold down able young men.

57. Indeed, the reduction in the ex-voluntary hospital secretary's numerous duties may ultimately be not without advantage to the administration of the hospital. Too many secretaries in the past have been so tied to their office desks that they never found time to see whether the out-patient department was working smoothly, or to improve the standard of medical records. The unit administrator is now offered a greater opportunity than ever before of tackling all those problems of organisation which directly affect the service to the patient and the happiness of the staff.

58. The above refers, of course, to hospitals of a fair size. Small units often do not justify the appointment of a full-time administrator, being primarily nursing units in the charge of a matron. In this case the most satisfactory solution is generally found to be a system by which several small hospitals are grouped under one assistant secretary—particularly where there is already grouping under a house committee. He may well have some difficulty in persuading the Matrons concerned to relinquish administrative functions they have performed in the past, but with tact and tenacity the problem should not be insuperable.

V.

FINANCIAL ADMINISTRATION

THE ADMINISTRATOR'S RESPONSIBILITY FOR ENFORCING ECONOMY

59. "Administration" wrote Florence Nightingale "is intended to enforce economy, so far as is consistent with the provision of requirements necessary for the sick." To-day hospital administration is generally accepted as implying responsibilities of a far wider nature—the range of subjects so far discussed in this paper is some indication of their extent. The necessity for enforcing economy still remains, however, as one of the basic functions of administration, as hospitals have very forcibly been reminded in the past year. Neither the

voluntary nor the municipal hospital administrator is unfamiliar with the necessity of limiting expenditure within the bounds of a fixed budget, but the appointment of Finance Officers with responsibility direct to their Management Committee did result at first in a tendency for some Group Secretaries to wash their hands (often very thankfully) of everything to do with finance, including the exercise of economy; and the apparently unlimited resources of the national exchequer were an irresistible temptation to indulge in prodigal spending.

60. Few illusions now remain on this score, but with the pursuit of economy coming very much into the foreground, some clarification is called for of the relative responsibilities of the Administrator and the Finance Officer.

DIFFERING CONCEPTIONS OF THE FINANCE OFFICER'S ROLE IN ADMINISTRATION

61. Two sharply differing conceptions of the Finance Officer's role in administration became evident in the course of the enquiry, and it is not uninteresting to attempt to trace them back to their origins in administrative theory. Briefly, the one school—which may be called for convenience the Voluntary—holds that the Finance Officer is essentially an accountant who keeps the books, and places at the disposal of the Administrator facts and figures which enable him to exercise the function of administration known as control. The other school—which may be called Local Authority—maintains that the Finance Officer exercises control in his own right: in other words not only records the facts and figures of expenditure but holds executive powers to veto expenditure and enforce economies wherever he thinks fit.

62. The origin of the Voluntary school is clearly the business world, where the Executive alone is responsible for exercising control, based upon the detailed information provided by his accountants. Local Authority finance, however, follows the pattern evolved during the last century by the Treasury, whose overriding consideration was to eliminate any possibility of the abuse of public funds. The scandalous practices brought to light in the course of investigations into the finances of the Army, where colonels drew pay for ghost battalions existing only on the rolls, brought into being a system of inspection and control from above which was gradually extended to all branches of public finance and is still fundamentally unchanged. The Treasury, being responsible for the collection of revenue, is also expected to act as a watchdog on expenditure. The institution of the Organisation and Methods Branch of the Treasury in recent years is evidence that his conception is gaining rather than losing authority.

63. Municipal hospitals naturally followed the Local Authority pattern. Middlesex County Treasurer, for example, employed a staff of accountants who visited all the County Hospitals and not merely carried out an audit but reported to him all cases of apparent extravagance, whether in administration, staffing, or supplies, which criticisms were passed on to the hospital for their explanation. Thus the County Treasurer was from a remote position in fact exercising the control that in a voluntary hospital was a function of the Administrator on the spot. The system of medical administrators who naturally were interested in the medical rather than the economic aspect of administration tended to strengthen the case for Treasury supervision.

64. With the transfer of large numbers of local authority officials to the hospital service, particularly on the finance and supplies side, it was natural that local authority financial practice should come into conflict with voluntary practice. Furthermore (as already mentioned) the terms of reference for Finance Officers under Ministry regulations gave some grounds for the assumption that local authority methods were envisaged in that his responsibility was stated to be direct to the H.M.C. rather than to the H.M.C. *through* the Administrator.

65. Why, it may be asked, should not this well-tried system be adopted for Health Service finance? L. Urwick* deals with the disadvantages of the system in *The Elements of Administration.* After outlining the development of public finance in the last hundred years he goes on: —

> "Much of the discontent and frustration observable in our machinery of government may be traced to the fact that the Treasury, the accounting department, is also the central agency for dealing with policy in financial terms. Thus its control of expenditure, *which is an over-riding managerial function* (our italics) is exercised by a department which is regarded by the remainder as collateral. The central character of these Treasury functions is not accepted. Decisions are received as 'Treasury decisions' and not as Cabinet policy. On the other hand its exercise of those functions which if it is to be effective must be on broad lines, is necessarily coloured by its accountancy preoccupations. Anxious that no small item should pass which has not been 'duly authorised,' it tends to impose on departments a degree of detail in financial supervision which is as irritating as it is ineffective in avoiding waste."

66. Urwick proceeds to support this view by quoting the recent Report of the President's Committee on the Administrative Management of the Federal Government of the United States which lays down quite definitely that financial control in the broader sense is one of the three "central management agencies" which must be under the hands of the Chief Executive.

67. The battle with the Treasury for the financial independence of H.M.Cs. is only now being joined and the issue hangs very much in the balance. It may be that the old views will prevail and, if this happens, the hospital service will have suffered a major set-back, if not a disaster. Finance Officers will attempt not only to exercise the control which should emanate from the Administrator but to regard the Regional Board Treasurer as their master thus creating a vertical chain of authority which will lead, inevitably, to a lack of co-ordination in the administrative direction of the group.

68. To sum up then, the proper function of the Finance Officer is to supply the Administrator with all the financial data necessary for him to exercise control over expenditure. The highest degree of collaboration is necessary between the two and the responsibility of the Finance Officer extends far beyond the mere keeping of books. He should be constantly asked for figures and statistics which will indicate from month to month how the group is progressing financially. He will be required to inform the Administrator of any extravagances which come to his notice through the accounts; and in the preparation of estimates and budgets he will be expected to have a knowledge of the working of the group second only to that of the Administrator.

69. The foregoing statement of principle does not imply that in fact groups have run into serious difficulties in this question. In the main, Administrators and Finance Officers seem to have reached happy working arrangements with each other. Nevertheless it was apparent in one or two instances that the Finance Officer did regard himself as having powers of control over expenditure similar to those of a County Treasurer, and the dangers inherent in this conception of his duties seemed to call for special mention. In particular the Ministry of Health should be at pains to discourage this sort of attitude. An example was quoted of a group being informed by the Ministry of Health that on the report of their auditors they considered the group's medical records department to be extravagantly staffed. This is

* L. Urwick: *The Elements of Administration,* Sir Isaac Pitman & Sons Ltd., 1947.

clearly the thin end of the wedge and the eventual results of such a system are only too easy to visualise. The Ministry Circular H.M.C. (50) 40, requiring H.M.Cs. to submit monthly statements of expenditure to the Ministry as well as to their Regional Board is ominous, although in the circumstances the Ministry were almost bound to take some such step.

DELEGATION OF SPENDING AUTHORITY

70. The smooth running of a group will depend to some considerable extent on the manner in which the H.M.C. delegates its spending powers. We have already emphasised the need for giving Sub-committees a clear mandate to incur expenditure up to a given figure without reference back to the H.M.C., and this should be carried further down the scale so that officers both at Group and in the Units have reasonable freedom of action without recourse to specific minute authority. The matter is one for the detailed attention of every Group according to its circumstances but the sort of general sanction which seems to recommend itself is contained in the opening paragraphs of the " Regulations for Expenditure " of a London H.M.C. :—

1. Before 1st April each year the Committee, after receiving a Report from the Finance and General Purposes Sub-committee, shall by Resolution authorise expenditure during the ensuing financial year. Each Vote shall specify the heading of expenditure and the institution or institutions to which it relates and shall designate an officer, hereinafter called the spending officer, who is authorised to incur and control expenditure under the Vote.

2. Subject to these Regulations and to any further conditions that may be prescribed by the Committee the spending officer in relation to any Vote shall have power and authority to order goods or services or otherwise to incur expenditure in the name of the Committee provided that the expenditure incurred falls within the purview of the Vote and that it does not, within the financial year, exceed in aggregate the amount specified in the Vote.

71. In addition to such general powers of incurring routine expenditure there is need for further authority for specified officers to incur expenditure on non-recurring items without reference to Committees up to a given maximum at any one time. £10–20 is a figure suggested.