KING EDWARD'S HOSPITAL FUND FOR LONDON

THE INTERNAL ADMINISTRATION OF HOSPITALS

Being
Evidence submitted by King Edward's Hospital Fund for London to the Committee on Internal Administration of Hospitals appointed by the Central Health Services Council

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COMMITTEE ON INTERNAL ADMINISTRATION OF HOSPITALS

Evidence Submitted by King Edward's Hospital Fund for London

The evidence took the form of replies to a number of questions posed by the Committee. The text here printed is substantially as submitted, though in a few instances the wording has been edited to avoid misunderstanding.

1. The King's Fund welcomes the invitation to give evidence on the internal administration of hospitals. The Fund has long been intimately concerned with the administration of the great majority of the voluntary hospitals within the Metropolitan Police District. It has provided comparative statistics of their work, and from time to time has undertaken enquiries into particular aspects of hospital administration.

Question (1). What principles should govern the administrative organisation of a general hospital unit, i.e., a general hospital or, where more than one institution is administered by the same organisation, the hospitals so linked. What departments of administration are necessary, and what should be the relationship of heads of such departments to the administrator of the hospital unit ?

2. This at once opens up a large field. The question of the administrative organisation cannot be separated from the question of the principles upon which a hospital should be organised. In what follows an attempt is made to suggest lines of thought under three main heads, viz. :—

(*a*) Traditional principles of hospital administration (paragraphs 3-6).

(*b*) Administrative and financial functions in the hospitals (paragraphs 7-11).

(*c*) Certain current trends in hospital administration in which the King's Fund has been specially concerned (paragraphs 12-15).

3. (*a*) *Traditional principles of hospital administration.*

The main principles traditional in this country took definite shape during the Nightingale era, when the new conception of the place of the nurse in the hospital was grafted onto the already well defined partnership between the governing body and the medical staff. These principles may be summarised as follows :—

(i) the medical care of the patients was entrusted to the visiting physicians and surgeons and their assistants ;

(ii) these visiting physicians and surgeons jointly comprised the medical staff, which acted in an advisory capacity to the governing body of the hospital ;

(iii) the governing body of the hospital was primarily concerned with the enlightened pursuit of economy " so far as it is consistent with the requirements of the sick " ;

(iv) its function was largely delegated by the Governing Body to a Chairman, House Governor or other officers acting in conjunction with a weekly or fortnightly Executive or House Committee ;

(v) the matron has, since Miss Nightingale's day, been admitted as a third party to the partnership between the governing body and the medical staff. The nursing care of the patients as well as the control of the training school is entrusted to her care ;

(vi) the hospital is therefore to be regarded as a tripartite organisation, governing body exercising a wise economy in consultation with the Medical Committee and with the matron as representing the nursing staff.

The King's Fund sees no reason to doubt that the principles are fundamentally sound and that they have contributed very largely to the advances which have taken place in our hospitals since the eighties of the last century.

4. They were taken for granted in the great majority of the London voluntary hospitals though, of course, they were variously interpreted. The function of the matron has changed with the years, and with the increase in scale of some of the departments of the hospital it is no longer practicable or desirable to insist that she should be " the head of all the women employed in the hospital."

5. The Hospital Management Committee organisation as it is found to-day involves a number of departures from the older principles..

The more important divergences are :—

(*a*) The Hospital Management Committee as the administrative authority in direct touch with the " professional advisers " has been given only a limited control of expenditure and little incentive to economy. For example, much of the medical staffing does not form part of the budget of the Hospital Management Committee, and is not therefore weighed in the balance with other items in the hospital budget. There seems to be some danger that the Hospital Management Committee may progressively lose sight of its main function, and may concern itself with matters of detail which might better be handled by its executive officers.

(*b*) The traditional close relationship between the administrative authority and the medical committee is in some danger of being broken up. The Medical Committee is an important feature in the organisation of the hospital ; its authority has been lessened by the transfer to the Regional Board of the primary responsibility for consultant appointments. There are sometimes doubts as to whether all the medical members on the Hospital Management Committee are voicing the opinion of the medical committee. It appears to be of fundamental importance that the medical men appointed to the Hospital Management Committee should sit there as the representatives of the medical committee and that the fact that they do so should be widely understood in the medical profession.*

(*c*) The position of the matron, or matrons, often falls far short of the part assigned to her in the Nightingale pattern. This is no doubt unintentional, being the mechanical result of a grouping of a number of hospitals.

It seems important that the principles to which attention is here directed should not be forgotten and that they should be brought again to the fore and used as the norm against which the new creation, the Hospital Management Committee, should be judged. Too many of those concerned with working the new machinery have little conception of the historic importance of these principles in the development of our hospital system to the point at which it stands to-day.

* This is not intended to exclude representation of general practitioners or of Medical Officers of Health which may well be desirable.

6. The publicly-provided hospitals have developed since 1867 on different lines, usually vesting the administrative authority in a body distinct from the hospital itself, and also vesting clinical responsibility for the care of the patients in a medical superintendent rather than in " visiting physicians and surgeons." The King's Fund has naturally little direct knowledge of this method of administering hospitals. But it seems clear from experience of the Hospital Management Committees that attempts to combine the two methods in one Hospital Management Committee are liable to lead to friction between the administrative authorities and the medical superintendent whose administrative functions may not be clearly defined. Some further observations on this matter are made under the relevant heading below.

7. (*b*) *Administrative and financial functions in the hospitals.*

The financial organisation and accounting systems of most hospitals have evolved in Topsy-like fashion. In London, for some 50 years prior to the coming into operation of the National Health Service Act, the voluntary hospitals (approximately 170) which participated in the annual distributions of the King's Fund were required to *publish* their accounts in the form prescribed by the Revised Uniform System of Hospital Accounts. No regulations, however, were laid down as to the method of financial organisation to be adopted, nor as to the manner in which the internal accounting was to be maintained. As a result a great variety of systems were in use—depending upon the size of the hospital and the capability of the staff, etc. In recent years a number of financial investigations have been made by the Fund, and the internal arrangements at a number of hospitals have been improved and brought up to something approaching modern ideas on financial organisation and accounting. Budgets were becoming fairly common, stores records and in some cases stores accounts were being introduced, quantity statistics were prepared and a number of hospitals were considering the introduction of cost accounts. The work was hampered because few hospitals had accountants on their staffs, the majority being content with what may be termed, without offence, glorified book-keepers, who were under the direct control of the secretary, and whose duties were considered complete once the transactions were recorded in the books. There was little attempt to interpret these records or to give advice to the finance committee. For this reason

these committees were presented with sheets of undigested statistical information and they gradually became " account passing " and " cheque signing " bodies. All expenditure analysis was on the subjective system and therefore lacked the interest generated by information showing expenditure on departments and services, etc.

8. The National Health Service Accounting Regulations continued this method of analysis, although they did require hospitals to maintain stores accounts and to prepare annual cost returns. The regulations did not, however, make any provision for the method of internal accounting to be adopted, and for reasons given below this has led to an even greater variety of systems than before. The appointment of finance officers led to a great influx of accountants and accounting staff of all kinds into hospital service. The great majority of these were not hospital officers as such, nor had they been solely concerned with hospital service, although where they came from local government they had had indirect experience, as members of the local authority's financial staff, of the accounting work of the hospitals managed by those authorities. They had, too, experience of budgets, centralised methods, statutory systems of accounts, stores accounts, and statistics. Their knowledge and experience depended on the size of the authority and their particular position on the staff. Others came from industrial and commercial concerns and some from private practice. There was, therefore, as one might expect, a great variety of experience; naturally each officer introduced a system based on his own knowledge and experience, and as a result the methods in use are very varied. The defects in this connection in certain hospitals will be brought to light when the costing investigation which the Ministry has invited the King's Fund to carry out is undertaken, and recommendations will be given showing how they may be overcome and a greater degree of uniformity attained. Complete uniformity is undesirable; there must always remain room for initiative in methods as opposed to principles.

9. Finance is an integral part of hospital administration and it cannot be divorced therefrom without impairing the efficiency of the administration. At the same time finance officers must have the necessary authority to carry out their statutory responsibilities. They must not be regarded as assistants in the secretary's department; they are executive officers in charge of an essential function of management, and any attempt on the part of secretaries to belittle

their standing in this connection will sooner or later react unfavourably on the administration.

10. Unfortunately many misunderstandings have arisen on this subject, primarily in regard to the statutory responsibility of the finance officer as set out in S.I.1414. The matter is of great importance; a suggested solution is set out in Appendix A.

11. It may be suggested further, that budgets should be prepared by the finance officer in close co-operation with heads of departments. They should be examined and approved by the finance committee before submission to the hospital management committee. All proposals concerning new developments which will involve appreciable expenditure should be considered first by the finance committee who should then submit a report to the board on the *financial aspect* of the proposals. The report should contain information on the increased maintenance cost involved. All Hospital Management Committees should have full control over their expenditure following budget approval. All ministerial and Regional Board suggestions in this connection should be permissive and not mandatory. The introduction of stores accounts whether or not cost accounting is in operation should also be assured.

12. (*c*) *Current trends in hospital administration in which the King's Fund has been specially interested.*

Catering Department. Prior to the issue of the King's Fund's first memorandum on hospital catering in 1943, it was customary in the great majority of hospitals for the feeding arrangements to be regarded as part of the house-keeping responsibilities of the matron. The Fund then recommended that catering be regarded as a separate department under a suitably qualified officer: this recommendation has been endorsed more than once by the Ministry of Health, and has been readily adopted by the hospitals.

13. The Fund's Committee on Hospital Catering and Diet submits the following specific recommendations:— -

> " In all except small general hospitals there should be a separate Catering Department, which should be regarded as one of the main departments of the hospital. The department should be under the control of a Catering Officer, whose responsibilities should include all the processes involved in the planning, buying,

preparing, cooking and serving of the meals for patients and staff. The Catering Officer as head of the Catering Department, should be directly responsible to the officer administering the hospital.

" Dietitians are required to take charge of the preparation of special diets, and to advise on any nutritional aspect of the hospital's catering. These Dietitians would receive their instructions as to special diets from the medical staff of the hospital, but should for other purposes be responsible to the administrative authority of the hospital.

" While the Catering Officer and the Dietitian should come directly under the hospital secretary for purposes of administration, the supervision of the work of the Catering department should be the responsibility of a Catering Committee. The Catering Officer and the Dietitian would be members of the Committee, which should include representatives of the hospital's administrative and medical staff, as well as representatives of the House or Management Committee."

14. *Medical Records Department.* Recommendations in regard to the organisation and work of the medical records department are contained in a recent publication of the Fund, " Some Observations on Hospital Admissions and Records." Further data with regard to the training of medical records officers with the help of bursaries from the Fund will be found in the Fund's Annual Report for the year 1949. [*See also supplementary evidence, para.* 45, *below.*]

15. *Supplies.* The Fund's advice is often sought in regard to supplies, and a note indicating briefly the main points to which attention should be directed is appended hereto. See Appendix B.

Question (2). To what extent should these principles be modified to take account of the circumstances of specialised hospitals such as, for example, sanatoria, mental hospitals, mental deficiency institutions or teaching hospitals ?

16. In the case of teaching hospitals it appears that little modification is required.

17. As regards the remaining categories the Fund's experience is limited, but a cursory survey of the history of mental hospitals,

mental deficiency institutions, and of provision at the public expense for the tuberculous, suggests that these categories have tended to fall behind the hospitals in which the Nightingale principles have been applied in full.

18. In these branches of the hospital service it has been customary, for good reasons, for clinical responsibility to vest in a medical superintendent and arrangements for consultant staff have often been somewhat shadowy. Moreover, it has been customary for the medical superintendent to claim a suzerainty over all the arrangements in the institution, and for the matron to concede it. The more the post of matron is pruned of its responsibility and authority the less it will appeal to women with the qualities most needed for the work.

19. These considerations suggest that there is room for experiment and that recent modifications of the hierarchical arrangement should be encouraged and adopted more widely.

Question (3). To what extent do these principles require modification to suit hospitals of varying sizes?

20. It would be unwise to be dogmatic on this question. It would seem to be better to establish clearly the main principles and the pattern of departmental organisation applicable to the large general hospital, and to leave it to the local management to modify the pattern as may be necessary. The near presence of a large neighbour whose services can be borrowed will obviate the need for many special departments which might otherwise be necessary.

21. The administration of small units such as cottage hospitals was discussed by a group of Hospital Management Committee Secretaries who met at the King's Fund during the winter months of 1949-50. They were of opinion that small units often do not justify the appointment of a fulltime 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 might well have some difficulty in persuading the matrons concerned to relinquish administrative functions they had performed in the past, but with tact and tenacity the problem should not be insuperable.

Question (4). To what extent is it desirable that responsibility should vest in the administrator of an individual hospital (i.e., what should be his relationship to the chief administrative officer of the hospital group) ?

22. A special series of problems peculiar to the Hospital Management Committee arise when the pattern of departmental organisation has to be applied to a series of hospitals of varying sizes. There are then two chains of authority (*a*) from the group administrator to his departmental heads, and (*b*) from the group administrator to his administrative officers stationed at the respective units.

23. This matter figures prominently in the discussions among Hospital Management Committee secretaries mentioned above. Anxiety was expressed lest the development of a series of departments at group headquarters might subtract from the local unit administrator so many of his responsibilities as to make his post of but little account. The reduced scope of the work might fail to attract to hospital administration men with the requisite character and background for efficient day-to-day management of the hospitals. 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 as well as ordinary routine business. The majority opinion was, however, that there would seem to be no need for pessimism in this respect, so long as the unit is recognised as the training ground for the higher administrative posts. Although the salaries that can be offered are somewhat low it was felt that the prospects and scope should be sufficient to attract and hold able young men.

24. The Hospital Management Committee secretaries added :—

"The extent to which a departmental organisation—e.g., finance, supplies, catering, engineering, etc.—is necessary in the unit clearly depends on its size. Where departmental heads are appointed they should be responsible to their unit administrator rather than to their specialist opposite number on the group staff, even though in the course of their everyday work they will often be dealing direct with these officers.

"Ultimate responsibility for the efficient administration of hospital units within a group rests with the group administrator, and he must keep in close touch by means of regular and frequent

visits to the hospitals themselves, in addition to any conferences of unit officers he may hold at group headquarters. He should, however, delegate as much responsibility and authority for every-day running to his unit administrators as is consistent with adequate supervision. Although the hospital group is envisaged as an entity of which the unit hospitals are parts, and the policy of the group should be towards integration, in practice each individual hospital constitutes a corporate body with a morale of its own. This ' esprit de corps ' is an invaluable factor of efficiency and should be encouraged by the granting of a fair degree of local autonomy. There is no reason why this should conflict with the growth of a parallel ' group-mindedness.'

" There is sometimes a tendency, particularly where the unit administrator is of junior status, for staff—particularly medical staff—to by-pass, and hence undermine, his authority by making direct approach to the group administrator or specialist officers. It should be established, by standing order or otherwise, that the normal channel of approach to the group administrator is through the unit administrator."

25. The difficulty of answering questions (3) and (4) underlines the importance of treating the Hospital Management Committee itself as the unit. It is the function of the Hospital Management Committee to apply general principles to particular circumstances; the extreme difficulty of laying down rules for general application is one of the most cogent reasons for local control of hospital affairs.

Question (5). To what extent should administrative duties be undertaken by medical staff ?

26. This question is best viewed in the light of the principles discussed in the earlier part of this statement.

27. Unhappily a controversy has developed between the advocates of lay and of medical administration, and has been exacerbated by a loose use of terms. The term administration is used in two senses, (*a*) in the usual hospital sense, to cover the whole lay-financial side of the hospital, especially control of expenditure, and (*b*) as referring to a different field—sometimes assigned to medical superintendents—which is better described as the on-the-spot superintendence of the hospital, with but little reference to financial and allied matters. In hospitals conducted on the traditional voluntary plan nine-tenths of

this latter work is shared between the Medical Committee (in its advisory capacity), the consultant staff and resident medical officers (admissions and so forth), the matron and nursing staff, and the almoners and medical records department: only a relatively small part is handled by the Secretary or his officers.

28. A second confusion arises in that the term " medical superintendent " may imply clinical responsibility for the patients, as in the once general local authority practice; or it may not, as in those former voluntary hospitals where the chief administrative officer is a medical man, as in many Scottish and American hospitals. The distinction is, of course, of great importance.

29. If the various meanings of the words are held clearly and properly distinct, there could, so far as general hospitals are concerned, probably be general agreement:—

(i) That the principle of vesting clinical responsibility in a medical superintendent is a relic of the past which should be discarded in favour of staffing by consultants carrying full responsibility for their patients.

(ii) That the post of chief executive officer to the administrative authority is a whole-time one, and may equally well be held by a medical man or by a layman. This is evident from the success of both methods in Great Britain and America: the voluntary hospitals of England have normally been administered by laymen, whilst in Scotland and to a large extent in America the superintendent has been medically qualified. Hospital administration is becoming increasingly complicated and it seems that medical men or laymen will equally have to expect to undertake a serious and probably a prolonged training for the task before they can expect to be proficient.

(iii) That in hospitals where the chief executive officer is not medically qualified there are a small group of more or less administrative questions which cannot readily be handled by him. The Fund would be inclined to deprecate any attempt to define this field centrally at the present stage; what questions exactly fall into this category and how best they can be dealt with is a matter calling for a special enquiry into existing practices in some dozen or so Hospital Management Committees where satisfactory solutions have been found.

Question (6). To what extent should administrative duties be undertaken by nursing staff ?

30. This question may be understood in at least two different senses:—

(*a*) It may refer to the extent to which the matron is regarded as carrying a share of the general administrative responsibility, or as a departmental head responsible to the chief executive officer.

(*b*) It may also refer to the extent to which members of the nursing staff should undertake duties which do not make full use of their nursing qualifications, e.g., whether home sisters, sister housekeepers, and nurses working in special departments should be replaced by lay wardens, domestic supervisors and out-patient receptionists.

31. (*a*) The following considerations may throw some light on a situation which is at present obscure, and indeed controversial. The matron usually acts in a dual capacity. First, she exercises a professional function. It is her responsibility to provide and maintain the nursing service of the hospital. On the English pattern this frequently includes also responsibility for a training school for nurses, of which the matron is head. It is generally overlooked, however, that her authority derives primarily from the responsibility laid upon her by the governing body as purveyor of nursing care for all whom the hospital serves. In respect of this she is in a true sense a professional head answerable to the governing body (and for certain aspects of her work to the medical staff), and not a departmental head.

32. A moment's thought on the extent to which the availability of skilled nursing care throughout each 24 hours is a main reason for the existence of hospitals will serve to indicate the true professional status of the head of the nursing service, as contrasted with the somewhat superficial claims for " status " put forward on behalf of matrons by professional organisations. It follows that the nursing committees now set up in many hospitals (which unlike medical committees are not composed of members of the professional staff concerned) should act in an advisory capacity to the matron and support her representations to the governing body, rather than that the matron should " report " to the nursing committee and receive instructions from them.

33. Where there is a medical superintendent with clinical responsibilities and not a lay administrator, the matron's professional independence is perhaps less clearly defined, since the relationship between the medical and nursing professions makes it natural that she should accept guidance in her professional work from a medical administrator. On his part, however, he might well accord her the courtesies due to a professional colleague. She should normally be recognised as the hostess in her own hospital and should certainly be present when visitors are taken round.

34. In addition to her professional function, however, the matron may quite often act in an administrative capacity. The very fact that she is frequently chief resident executive officer (leaving the R.M.O. out of consideration on the ground that his responsibilities are more closely defined) means that she often has to make decisions or take action outside her purely professional capacity. Very frequently she carries responsibility for the supervision of many employees of the hospital other than nurses and for the upkeep and oversight of a good deal of the hospital's equipment and property. In short, she is well placed for a great deal of that " on-the-spot superintendence " mentioned earlier in this report. The more that responsibilities such as these are pruned away from matrons, the less likely is it that the position will appeal to women of outstanding ability, apt for leadership.

35. In all these non-professional functions the matron should recognise that she is no longer professional head but is responsible to the chief executive officer. Perhaps the nearest analogy would be to suggest that she should be regarded as third partner in a firm combining administrative, medical and nursing interests, and that in matters of policy outside her own speciality she would, of course, recognise the authority of the other heads of the firm.

36. Confusion about these two aspects of the matron's responsibility has been a common cause of friction between matrons and chief executive officers. It is to be hoped that the recommendations of the Committee on the Internal Administration of Hospitals will help to clear the matter up, thereby saving much dissipation of effort.

37. (*b*) The second subject which it is appropriate to consider under this heading—the extent to which members of the nursing staff should be appointed to non-nursing posts—is one on which it

would be unwise to lay down hard and fast rules. Each question should be dealt with as it arises, in the light of the following considerations:—

(1) The shortage of trained women for actual nursing care, whether in the wards or on the district, makes it essential not to divert to minor administrative duties, which could be carried out equally well by a lay person, those who would otherwise remain in attendance on patients.

(2) It should not on that account become axiomatic that all nurses' homes should be run by lay wardens, all the work of matron's office be undertaken by lay secretaries, and so on. It is important to remember that the so-called administrative posts of home sister, office sister and assistant matron provide necessary experience for the matrons of the future. Appointments, especially to the post of assistant matron in the larger hospitals, should be made with this in mind so that they provide experience for a succession of nurses who will go on to matrons' posts elsewhere. Too often the most successful nurse is chosen for these appointments with little regard for her administrative ability, and efforts are made to retain her " for life."

(3) Administrative posts should never be regarded (as they are too often) as a step up the ladder from ward work. It should be possible for the able nurse to achieve distinction as a ward sister without leaving actual nursing for either teaching or administration. Every appropriate step should be taken to increase the prestige of the ward sister's work.

(4) There should be opportunities, not only for nurses who are found to possess a genuine bent for administration and who choose it in preference to other work, but also for those who feel that they are approaching the end of their working life as ward sisters or sister tutors—always provided, of course, that they show competence for the posts under consideration.

38. Subject to these qualifications, economy in nursing staff and efficiency in action could be achieved in many hospitals by appointing lay domestic supervisors, dining-room superintendents, receptionists, and trained secretarial help in the matron's office and where practicable in the wards.

39. The Fund has long advocated the splitting off of catering as a special department under its own head, not responsible to the matron, though she should serve on the catering committee. With regard to the management of nurses' homes the guiding principle should be to appoint someone with the right personality and background, whether home sister or warden. In this case the argument for economy in nurse-power is less strong since the appointment of a lay warden does not provide for what should be the most important part of a home sister's duties, the supervision of the health of the nursing staff. In connection with domestic supervision, the Fund's view is that normally it is wise to appoint a lay person with appropriate experience and qualifications for the work. In all these fields of work which are concerned with the environment of patients and the welfare of nurses, the Fund considers it desirable that the lay departmental head, while being given full scope, should be responsible directly to the matron and only through her to the chief executive officer.

40. The general principles laid down in the whole of this section should be subject to modification, particularly in respect of the size of the hospital. It would obviously be unnecessary and wasteful to introduce lay heads of departments in the smaller hospitals where the work can be carried out well by the existing nursing staff. There is still much to be said for the old tradition, largely lost sight of in the increasing complexity of hospital administration, that the matron is " mistress of the household."

Question (7). To what extent should the individual hospital buy its own supplies and how much should be left to the hospital group, or to more than one group acting jointly ?

41. This question was to some extent discussed among the Hospital Management Committee Secretaries to whom reference has been made above, and their conclusions may be summarised as follows:—

" Many economic advantages of central buying can be achieved under an elementary system whereby the Group negotiates central contracts for the majority of stock items but leaves each unit to order independently from the suppliers within these contracts. A very small central staff is required to work such a system and, indeed, in one Group at least the finance officer has been able to undertake the negotiation of contracts in addition

to his financial duties. The units for their part feel they have full responsibility for their own buying. Nor, so far as economy of staff at units is concerned, is the work involved in making out and despatching an order direct to a firm of suppliers very much greater than that of requisitioning upon the Group supplies office.

" The majority of groups, however, have appointed Supplies Officers and have developed, or are in the process of developing, a higher degree of centralisation, and it is clear that a standard pattern for Group supplies is beginning to crystallize, by which units instead of purchasing direct from suppliers put in a requisition to the Group supplies office for the article or commodity required. The latter then orders under whatever contracts are in force and the goods are delivered by the suppliers direct to the hospital. Where no contract exists for the goods concerned the supplies office obtains quotations and generally carries out all the specialised operations of buying.

" The main advantage of such a system is, of course, that the highly technical business of buying is in the hands of a few fully-trained experts: the danger is that these experts will override the particular wishes of unit administrators in the interests of Group economy. In this respect the Supplies Officer should attempt, as far as possible, to give individual attention to the wishes of his customers—for as such they should be considered. It has been the experience of groups that if the Supplies Officer makes a point of allowing units to indulge their whims in small matters—for example, by taking a matron round by car to various stores in the town to choose curtain material rather than merely sending her a few patterns to look at—they will be much more ready to accept the supplies organisation as a whole.

" Where a dispute arises between a unit hospital and the Supplies Officer it should be an established principle that the former may, in the last resort, appeal to the Committee who are the final arbiters on all questions of expenditure."

42. It should be noted that there is a fundamental difference between central buying and central contracting. Usually central buying implies the setting up of a central stores from which supplies are distributed to hospitals on indent. This can be a most expensive method of buying. Extra charges are incurred for handling, recording, accounting and transport, and these may far exceed any economies which may be obtained by lower prices.

43. Central contracting is a practical and economical method. It possesses all the advantages of central buying and does not suffer from its disadvantages.

44. In conclusion, as the Committee is no doubt aware, the King's Fund is now in the process of establishing a Staff College for Hospital Administrators which will be concerned with many of the foregoing matters. Some particulars of the progress made with this scheme are appended hereto. [See Appendix C.]

The Fund was subsequently invited to submit further evidence in reply to the question: "What general organisation is required at hospital level to effect the best methods of admission and bed utilisation?"

45. There is at present no more pressing objective in hospital administration than an admission system that makes the best use of available beds. Waiting lists, with their easily-imagined consequences of mental and physical suffering argue for themselves the human aspect, whilst the economic wastage involved in empty beds is patent.

46. All arrangements for admission have a part medical, part lay aspect, and the subject cannot be understood without a grasp of the principles underlying the medical staffing of the hospitals. Much of the present confusion flows from the introduction of staffing by consultants into hospitals where there is no clear conception of the administrative arrangements which must follow in its train. In this matter there are, as it were, two opposite poles—at one pole control of admissions by medical superintendents, as in nearly all the former local authority hospitals, and in many types of special hospital, and at the other control of admissions by consultants to whom beds have been allocated, either personally or through resident staff acting on their behalf. The difference is deep, and extends even to a different conception of the nature and purpose of a hospital service—is it primarily to provide nursing and/or surgical and diagnostic facilities, or is it primarily to provide facilities whereby the general practitioner may obtain access for his patient to a particular consultant he seeks?

47. Where the medical superintendent carries clinical responsibility for all the beds it is a relatively simple matter for him to deal personally or through a deputy with all admissions (both waiting list and emergencies); and since there is no rigid allocation of wards or beds to particular consultants he can, within limits, vary the uses to which different parts of the hospital are put. He can, for instance, in time of emergency put a few medical cases into surgical wards and so on. On the lay side it involves no more than a relatively simple system of a bed board showing vacant beds maintained by a clerk in contact with the various ward sisters. Many efficient examples of this system are to be found in the hospitals: it is simple and can easily attain a level of occupancy approaching 100 per cent.

48. Where, on the other hand, a hospital has traditionally been broken up into a number of units allocated to individual consultants, or where it is now desired to introduce such a system in accordance with official policy, a very different set of considerations apply. The maintenance of a high state of occupancy must now play second fiddle to the need to ensure that the right cases reach the consultants. This is usually achieved by a rather complicated system—on the medical side, the consultant partly fills his beds personally by direct approach from general practitioners or through the out-patient department, and partly by allowing some discretion to the resident officers of the hospital to put cases into his wards. Special arrangements have to be made to cover emergencies, usually by a rota system by which each consultant "firm" takes in for a stated period.*

49. Any system of this kind imposes a much greater obligation on the lay administration to help to ensure a high level of occupancy; for although occupancy must play second fiddle it must most certainly not be neglected, and many hospitals in London have in recent years devoted much attention to developing systems for coping with this side of the matter. In the opinion of the King's Fund (see booklet on Admissions and Records issued in 1948) the key factor in ensuring efficiency is the appointment of a lay officer on the administrative staff who shall have sufficient personal status and authority to achieve the very detailed co-ordination with the medical

* This system is open to criticism: for further details see "Some observations on Hospital Admissions and Records," page 10.

staff that is necessary. In practice it is found convenient if this officer also acts as Medical Records Officer.

50. The Resident Medical Officer is of course a vital link. Subject to the direction of the consultants it is he who selects the patients for admission. The Medical Records Officer then sets in motion all the lay hospital machinery for ensuring that the patient goes quickly and smoothly through the various routines without waste of hospital facilities. The evolution of a good working arrangement has been in the largest London hospitals a protracted process—and there are many hospitals in the country with consultant staffs where the arrangements still leave much to be desired. It should be noted that experience in the past tends to show that large general hospitals with a system of full consultant staffing find difficulty in preventing their occupancy level falling to 85 per cent. or below—a figure which is a challenge to lay and medical staff alike (see *Lancet* of February 4th, 1950, " Are the Beds Fully Occupied," for references to the results of the King's Fund enquiry in 1929-30).

51. It is not uncommon to find Hospital Management Committees to-day caught half-way between the two radically different systems. Since the discussions of the period preceding the N.H.S. Act it has been assumed by the Ministry of Health and in official circles generally that the practice of staffing by consultants should be extended to all general hospitals.* This is not the place to discuss whether this movement may not go too far and result in an attempt to " up grade " every general hospital unit with consequences not fully foreseen. But it is already clear that its implications as regards control of admissions and level of occupancy have not yet been fully worked out.

Thus in many hospitals where full consultant staffing is being introduced and the medical superintendent is going over to consultant work it seems that the system of control of admissions has not kept in step.

* *Cf.* Ministry of Health memorandum on " Development of Consultant Services," 1950—" A common feature of the published reports of the Surveys of Hospital Services, undertaken during the war by the Minister and the Nuffield Trust, was the recommendation that the clinical responsibility for hospital patients, other than those in general practitioner or cottage hospitals, should rest with specialists. It is necessary, therefore, to provide not only a sufficient number but a sufficient range of specialists. It is not enough to provide a general surgeon at a Hospital Centre and expect him to accept responsibility for all types of surgical cases."

Some Hospital Management Committees backed by their experience of a high rate of occupancy attained with relatively little effort under the old system are naturally reluctant to give it up, and there is a strong temptation to leave this responsibility in the hands of the medical superintendent if he retains any administrative functions at all. This is believed to be a not uncommon state of affairs, but it must presumably be regarded as transitional.

52. The conclusion reached by the Fund is, therefore, that since consultant staffing is to be introduced into the general hospitals formerly without it—as is now happening in many places—there will be a need for efficiently trained Medical Records Officers who can fill the gap on the lay side and match up with a Resident Medical Officer who will handle the matter on the medical side on the lines traditional in hospitals where there has been consultant staffing. The Fund has* since the publication of "Admissions and Records" undertaken the training of some 37 of these officers,† the first 25 of whom now hold appointments as Medical Records Officers in various areas. They usually act in a group capacity, and cannot therefore act personally as opposite numbers to the Resident Medical Officers in the individual hospitals, but it is part of their duty to see that the arrangements are such as to provide a satisfactory lay administrative unit for the purpose in each hospital.

53. The Medical Records Officer must be encouraged to use all the means at his disposal to make those concerned "occupancy-minded"—keeping the Medical Committee and the Management Committee informed of the state of waiting lists with comments on significant trends and suggestions where action is required; fostering inter-ward rivalry by publishing monthly figures for ward occupancy; and, most important, cultivating the closest possible spirit of collaboration between medical staff, ward sisters and the admissions office, without which no success is possible. Constant watchfulness and careful attention to detail go a long way—noting the patient's telephone number or that of a neighbour, or checking with the almoner what length of notice is likely to be required.‡ Such points

* Initially in conjunction with the Middlesex Hospital, but now through its Hospital Administrative Staff College.

† The Association of Medical Records Officers is also training M.R.O.'s though with a somewhat narrower conception of their function.

‡ i.e., Where this information is not indicated as a routine on the waiting list slips.

as these may avoid a bed being empty for 24 hours or more. Arrangements should also be made, if possible, to keep in touch at regular intervals (say three-monthly) with waiting-list patients, letting them know whether they are nearing the top of the list.

54. These measures must be backed by the submission at regular intervals, preferably monthly, and in graphic, easily assimilated form, of statistics of occupancy. The aim of these should be to show, with inescapable clarity, where beds are *not* being used to capacity; and if possible which firms or wards are responsible. This data should be submitted both to the Medical Committee and to the appropriate Lay Committee. By this means it is possible to secure a periodic review by the Medical Committee of the allocation of beds to consultants which otherwise tends to remain fixed regardless of changing conditions.

55. A further extension of the duties of the Medical Records Officer may be the supervision of the physical facilities for the reception of patients, to ensure that they are pleasant and expeditious and in respect of certain categories of patient, e.g., aged or chronic sick, he may be required to collaborate with medical staff and social workers in devising a system of domiciliary visiting.

56. Some further comment may be made in regard to occupancy. As far as the Fund's information goes, too little attention appears to be paid to-day to the study by hospital authorities at each level—Hospital Management Committee and Regional Hospital Board—of the occupancy figures for the hospitals in respect of which they are responsible. This is largely attributable to the lack of published statistics of occupancy comparable with those published by the Fund for the London voluntary hospitals for the years 1904-1948, and to the general neglect of the importance of agreed definitions strictly adhered to. The Fund's experience proved that the greatest care is needed in the compilation of such comparative statistics to ensure that error does not creep into the initial definition; in other words —as is indeed obvious—it is easy to show results closely approaching 100 per cent. if a little latitude is allowed or taken in definition of what counts and what does not. At present occupancy statistics are returned on Form S.H.3, copies of which are sent by Hospital Management Committees and Teaching Hospitals to the Ministry and to Regional Boards. Both the form itself and the subsequent use

made of the information leave much to be desired. In Part I, for example, the relevant figures called for are:—

Available beds at 31st December.

Average daily number of occupied beds over the year.

No useful conclusion can be drawn from comparison between these two figures to show unsatisfactory occupancy, since the figure for available beds on the one day may bear little relation to average availability through the year: and would not take into account, for example, the effect of one ward being open for 11 months of the year, if it were for any reason closed at 31st December.

The equivalent King's Fund form required:—

Average daily number open during the year.

Average daily number occupied during the year.

A comparison between these two figures (both based on actual counts) gives a true indication of the standard of occupancy.

57. Study of comparative statistics carefully classified by type of hospital and known to have been carefully checked—as were the former King's Fund statistical tables—is one of the most important external aids available to the hospital administrator. The Fund would be glad to help by analysing data and publishing tables if the material were made available.

To sum up, it should be regarded as an important function of hospital administration to produce for the Committees concerned properly analysed and intelligible statistics of occupancy and to be able to explain their significance. This will, of course, necessitate a proper understanding by these Committees of the principles described in the earlier paragraphs of this note.

APPENDIX A *

FINANCE AND ADMINISTRATION

Paragraph 25 of the National Health Service (Hospital Accounts and Financial Provisions) Regulations, 1948, lays it down that " the chief financial officer of a Board of Governors, Regional Hospital Board or Hospital Management Committee shall be responsible to the Board or Committee for the proper collection of all moneys due and the prompt payment of all debts, for the maintenance and completion of all financial records and returns required by the Board or Committee, or by the Minister, and for the submission of accounts to the auditor at such times and for such period as the auditor may require." In the regulations, " chief financial officer " means the treasurer or other officer charged with the duty of keeping the accounts of a Regional Hospital Board, Hospital Management Committee or Board of Governors.

The Chief Financial Officer's Responsibility

The office of chief financial officer is a creation of statute, and certain duties are imposed upon him. Boards or Committees, as the case may be, are under an obligation to appoint a person to hold such office, and they cannot by any act or resolution affect the duties which are by statute attached to the office, or which arise as a consequence of his statutory duties. His responsibility may be divided into three sections—(1) routine control; (2) financial information; and (3) financial advice. The first has as its aim to secure purity of administration. There must be machinery for ensuring that expenditure is properly sanctioned; that the collection of moneys is conducted with diligence and honesty; and that no precautions for the protection of financial interests are overlooked. The second section is equally important, but it is less developed. Broadly, the objective is to keep the Board or Committee informed on the financial aspect of its work. Every possible measuring rod should be exploited to the full, including cost accounts and comparative statistics—devices as yet in the chrysalis stage in British hospitals. The information accumulated is of necessity post mortem but when significantly prepared it is a valuable guide to further action. The third and perhaps the most important aspect of financial control is the giving of advice. This kind of control functions before the event. The Board or Committee must be continuously alive to its total commitments; it must judge all proposed expenditure in the light of its resources; and it must not be allowed to become preoccupied with current problems. The internal administrative machinery must therefore be such that it is impossible for decisions on policy to be taken until those responsible have received unbiassed information on the full financial implications and probable reactions of the proposals.

Financial control thus conceived exhibits nothing of the coercive element sometimes associated with this term. It will be seen that we have

* The substance of this Appendix appeared in the " Hospital and Social Service Journal " of March 17th, 1950.

here differentiation of function—finance and administration—and the relationship between the administrative department and the finance department depends for its smooth and efficient working upon a mutual understanding of the functions and the responsibilities of each. It is the function of the finance department to supply the administrative departments—and indeed all other departments—with information and financial advice; it is the duty of the administrative department to absorb the information, and to consider the advice. Responsibility for the final decision is a matter of policy, even when it concerns financial issues, and belongs to the managing committee. The duty of the chief financial officer is completed when he has made clear what the financial issue is, and the duty of the administrative officer is to give him every opportunity of explaining the financial aspect of a proposal. The attitude of the chief financial officer should be: What help can I give? The attitude of the administrative officer should be: What help can I get?

Where Does Initiative Lie ?

With the adoption of this attitude there is a simple answer to the question: Where does initiative lie in financial control and in the institution of financial tests of efficiency? The answer is: with both departments. The study of costs and pursuit of economy is clearly a primary function of the finance department, and one in which the department will be falling short of its duty if it waits for instructions and interrogations. In many directions opportunities for useful investigation and suggestion will present themselves to the alert finance officer in the course of his daily task of dealing with money transactions and records of cost. But the pursuit of economy by means of wise spending is equally the duty of the administrative department, and that department will be falling short of its duty if it fails to exercise abundant initiative in this direction. The efficient administration will set in motion many inquiries into the cost of particular services, and it will endeavour to keep its finger all the time on the financial pulse of the general system which it is administering.

Union of Finance and Administration

This conception of the relationship which should exist between the administrative and the financial functions is not a new one. It has been expressed in different ways many times before. There are two totally different conceptions of financial control. The first and more or less traditional one, based on constitutional analogies, is that administrative departments are to be distrusted, watched and checked. The practical tendency of such a theory when put in force, is towards the creation of twin rival antagonistic powers, the administrative department seeking to spend, the financial department to criticise and check. Efficiency and economy are thus at war, or rather, the expenditure which should be directed solely to secure efficiency tends to exaggerate into extravagance, and economy which should check waste to result in incomplete efficiency. The second and more modern notion of financial control means the union of finance and administration, so that financial considerations may

attend and determine administrative policy from its inception as well as control it during its progress and review it in anticipation of each financial year.

Unfortunately the acceptance and application of the principle have not as yet become general and effective in the new hospital service. Too often the finance department is looked upon as necessary and useful only so long as it keeps to the performance of the functions of cashier and paymaster, but when it goes further and exercises functions of criticism and control, it is regarded as a meddlesome, pedantic and obstructive nuisance. On the other hand, there is a tendency on the part of the finance departments to imagine that nobody can be genuinely interested in economy but themselves. Naturally, an attitude of this kind on either side precludes proper collaboration between chief officers and an " atmosphere " is created which is quickly transferred to subordinate officers.

Treasury Control Analogy

The tendency of the Accounting Regulations of the Ministry is to elevate the chief financial officer into a " controller," with power to curb and restrain all spending departments. Some development in the direction of centralised expert financial control is desirable, but if there is anything to be learnt from the similar development in the field of national finance and the growth of Treasury control, it is that the merely negative and critical attitude is not sufficient. Close co-operation between the finance department and the administrative department is vital—without it it is impossible to secure smooth and efficient working. For example, at the time of budget-making it is essential that there shall be frequent meetings between the chief financial officer and heads of departments—the work cannot be carried out by the transfer of numerous departmental memoranda. Again, when pruning of expenditure is the only alternative to an excess spending over the budget allowance, it would be almost impossible for a chief financial officer to advise his finance committee under these conditions unless he is in close touch with the heads of other departments.

Conflict of Personalities

The conflict, where it occurs, is not, however, one of principles so much as personalities. The place of the chief financial officer in administrative control in the hospital service is not to be found on the top of a pedestal above his fellows. He is a functional specialist. He should be the friendly counsellor and guide, on all matters of finance and accounting to all his brother officers. He should not establish himself in a water-tight department with control uppermost in his mind. He will be at his best when serving as " Comptroller " instead of as " Controller," with all that this implies, namely, that in finance and accounts he is well versed and is responsible, though he is not the master of the heads of other departments; nor will a good man either desire or claim to be the general manager, so to speak, of the hospital's affairs. The chief administrative officer of a hospital is the Secretary (or other designation

given to this office), and administrative control is generally most effective when at the head is a competent secretary with whom the chief financial officer works in complete accord.

Excessive departmentalisation is one of the failings in practical administration. Good administration can only come in so far as each executive officer recognises himself to be a servant of the hospital under an obligation to put his best into his work for the good of the hospital and not for his own aggrandisement. When the spirit is present that expresses itself in terms such as " This is finance and nothing to do with the secretary or heads of departments," it is like feeding sand instead of oil into the administrative machine. It is, however, of supreme importance that the chief financial officer should be independent and not subject to over-riding control by any other officer so far as his accounting and financial function is concerned. Much can be done towards securing adequate financial control without disturbance of harmony or impediment of function by personal consultations. Formal meetings held periodically between heads of departments will be found very useful; they have their advantages, but they are not so effective as personal consultations.

APPENDIX B

Supplies

1. Supplies may be considered under a large number of headings—requisitions for supplies; ordering, receiving, and storage; control of stores; issuing stores records and accounts; quantity statistics, simplification and standardisation, bulk buying, etc. Each of these items could be elaborated into a memorandum.

2. The main principle to be observed in connection with supplies is that everyone concerned should be given to understand that supplies are cash in another form, and that, therefore, they must be guarded just as carefully. If this principle is observed a considerable saving in expenditure will result.

3. The following points may be noted. They do not by any means exhaust the subject but are given more as indications :

(*a*) *Heads* of departments (or selected officers for various commodities) *only* should be permitted to requisition on the supplies officer (or secretary) for supplies to be ordered. Existing methods vary between the continuation of ordering by numerous officers traditionally authorised to do so and the centralisation of ordering in a single department.

(*b*) Wherever possible competitive prices should be obtained.

(*c*) Schedules of quantities should be attached to and form part of the budget for supplies (prices vary and change; quantities are basic!)

(*d*) Careful consideration should be given to the advantages and disadvantages of short and long term contracts for various items.

(*e*) Supplies officers should be purchasing agents with a knowledge of the markets, prices, trends, etc., and not mere ordering clerks. A good man will not only save his salary but many thousands of pounds in addition.

(*f*) Where hospitals are grouped ordering should be centralised with provision that goods will be delivered direct to the various hospitals. In the case of hospitals at some distance from the centre hospital local buying may be found an advantage, but prices should be controlled from the centre. Copies of all " local " orders should be sent to the centre hospital in addition to goods received sheets.

(*g*) Telephone orders, without prior agreement as to price and a subsequent written order in confirmation, should not be permitted.

(*h*) The storekeeper should be under the control of the supplies officer, but his stock should be subject to the internal audit of the finance officer. Records of goods " in " and " out " should be kept by the storekeeper, but as a general principle the stores accounts should be maintained (or controlled) by the finance

officer. Stores accounts should be reconciled periodically with the financial accounts and any discrepancies investigated immediately.

(*i*) Storage accommodation is inadequate in the majority of hospitals. This is a matter neglected in the past and which now requires early attention, so that full advantage may be taken of the better prices obtainable on large scale orders. As far as possible all stores, with the possible exception of the pharmacy, should be centralised.

(*j*) No goods should be accepted without examination—not only as to quality and quantity but also as to specifications and samples where such are appropriate. As far as possible the examination should be carried out by the supplies officer (or pharmacist). Where a catering officer is employed he will be responsible for provisions. The point here is that no goods are accepted unless they are correct *in all respects*. Wherever possible, all goods should be taken into a physical store. If delivered direct to a department, e.g., films to x-ray department; coal to the boiler house, etc., they should still be regarded as being in "store" to be subsequently accounted for. Only the quantity actually used during a specified period, e.g., a month, should be considered as expenditure, the remainder being regarded as in stock and still to be accounted for.

(*k*) No goods should be issued from store except on the authority of a properly signed requisition by an officer authorised to sign such requisitions. The storekeeper should be given to understand that he is in charge of goods representing cash and that he must account for it just as carefully as if it were cash. (This will result in much more careful handling with less breakage and spilling, etc., and prevent the handing out of just that little more to "tip the scales"!).

(*l*) Weekly or monthly returns of all goods issued should be prepared. These returns will show total quantity of each item issued and the departments, wards, etc., to whom issued. Wherever possible the cost should be added. With cost accounts this is done automatically, but it should be done if cost accounts are not kept.

(*m*) Bulk buying should not be indulged in without much careful thought; it has both advantages and disadvantages. Two of the most important disadvantages are (1) over-stocking and consequent deterioration of the goods, and (2) it may bring about a combination of sellers, a combination which must inevitably become more powerful than the buyer for an essential service. Experience of bulk buying by the Government should act as a warning.

(*n*) Simplification and standardisation should be given very careful consideration. Providing quality is not sacrificed considerable economies may be effected by a judicious selection of items. This is a matter which has received little or no attention in the past in the voluntary hospitals. The London County Council operated a most successful scheme when it took over the municipal hospitals following the 1929 Act.

APPENDIX C

Staff College for Hospital Administrators

Realising the importance to the nation of good hospital administration the King's Fund since the end of the War has offered a number of bursaries to selected individuals desirous of obtaining a practical training in this branch of public service. The Fund came to the conclusion that, useful as this bursary scheme appeared to be, there was need for a much more comprehensive system of training. It was therefore decided to establish a Staff College for hospital administrators where more organised courses with residential facilities could be provided both for entrants to the profession and for others who already hold appointments in the hospital service.

Suitable premises have been secured at Nos. 2 and 14 Palace Court, Bayswater, W.2, which, after the necessary alterations have been made and furnishings and equipment installed, will provide adequate residential and other accommodation for some twenty-four students. It is anticipated that the contractors will have completed their work by the end of the year and that the first course of instruction will begin on 29th January, 1951.

The College will be under a Principal, who will be an experienced hospital administrator, and he will be assisted by a staff of whole-time and visiting tutors. Promises of assistance have been obtained from a large number of the most experienced hospital administrators in the country.

It is hoped that the College will become in the course of time a meeting place and a centre of study and research for those engaged in the hospital part of the National Health Service, whether as members of Boards or Committees of management or as officers performing executive functions. The aim will be to conduct the College as nearly as possible on university lines.

Two sorts of courses will be provided (*a*) short " refresher " courses of one month's duration for administrative officers within the hospital service; these will be repeated at frequent intervals; and (*b*) courses lasting two years for carefully selected entrants who, after training and some years of practice, should be capable of filling senior appointments in hospital administration. All entrants will normally be required to reside in the College.

The first " refresher " course will begin on 2nd April, 1951, and the number attending this, and possibly the second, course will be limited to twelve. It is intended to assemble a representative group of experienced administrative officers who should not only obtain some benefit from attending such a course, but will, by their criticism and suggestions, do much to improve the quality of subsequent courses. The later courses will be open to students nominated in the main by Hospital Management Committees.

It is hoped to start the first "long" course in the Autumn of 1951. The number of students admitted will be limited to twelve and every endeavour will be made to see that selected candidates possess the necessary intelligence, personal qualities and background of experience to make a success of their career.

It is suggested that about twenty per cent of those accepted for admission to the various courses should, if possible, come from outside the normal area of operation of the King's Fund.

A prospectus is being prepared giving detailed information regarding the College and the courses of instruction which it is proposed to send to Regional Hospital Boards, Boards of Governors and Hospital Management Committees. A short and very provisional outline of the ground it is hoped to cover in these courses is given below.

OUTLINE OF THE LONG COURSE

Notes: (*a*) Refresher Courses will deal with selected subjects from each main group, as shown in this outline.

(*b*) Some only of the principal sub-heads are here shewn.

I. Introductory

1. History and development of the Health Services.
2. General Administration of the National Health Service.
3. The place of the hospital in the National Health Service.
   Possible developments.
   Relations with Part (iii) and Part (iv) Services.

II. Control and Management

1. The Committee System—Minutes—Reports.
2. Administrative methods.
3. Staff management.
4. Joint consultation.
5. Public relations. Hospital law. Speech and written word.

III. Organisation of Services

Examples :—Catering.
Supply.
Technical.
Medico-Social.
Admissions, records, statistics.

IV. Finance, Budget Preparation, Costing

1. Allocation of National Health Service funds—Parliamentary system—Treasury methods.
2. Statutory obligations; Finance officers—functions; Financial control—Board, Group Hospital.
3. Compilation of estimates—in Budget.
4. Costing—Reasons for—Methods—Departmental costing. Uniform system—Mechanical accounting.

V. Working with the Medical Staff

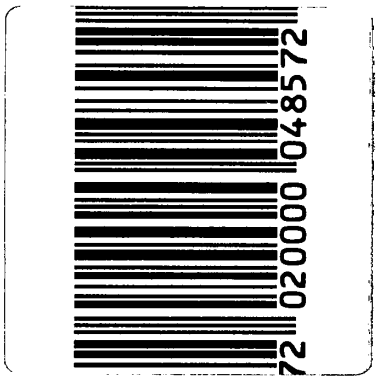
1. General staff relationships.
2. Medical Advisory Committee.
3. Medical Staff Committee.
4. Appointments and contracts.

VI. The Nursing Service

1. The Matron—her influence—Relationship with the Medical Staff, Administrative and other Services.
2. Nursing Committees. Nursing Education, Hostels—Wardens.

VII. Generally

Carefully planned visits will be a feature of all Courses and on the Long Course will include lengthy periods of practical work in selected Institutions.



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