# The Shape of Hospital Management in 1980?

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# The Institute of Hospital Administrators

# THE SHAPE OF HOSPITAL MANAGEMENT IN 1980 ?

The report of a Joint Working
Party set up by the King's
Fund and the Institute of
Hospital Administrators to
consider the future pattern of
management in hospitals with
particular reference to the
needs of District Hospitals

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# PREFACE

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This report is being published by King Edward's Hospital Fund for London in agreement with the Institute of Hospital Administrators.

The Joint Working Party was appointed by these two bodies who do not necessarily agree with all the views expressed. Nevertheless they are sure that they will give rise to most stimulating and valuable discussions which will help to advance thinking on the future patterns of management in the hospital service.

R E Peers CBE FHA
Secretary
King Edward's Hospital Fund
for London

J F Milne MC BSc(Econ)
Secretary and Director of
Education
The Institute of Hospital
Administrators

We learned with deep regret in October 1966 of the death of Mr Stephen Hodkinson, and in February 1967 of the death of Mr K H Holley, who had each provided so much sound sense and constructive criticism to our efforts to foresee the future.

It is not possible to thank by name all those, both within and without the health service, who have helped us in our deliberations. They have played a most valuable part and we are grateful.

My thanks go to the members of the Working Party for their imagination, good humour and hard work, and particularly to Mr L H W Paine and Mr Philip Lowe on whom the main burden has fallen.

June 1967 G P E Howard

## MEMBERS OF THE WORKING PARTY

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| CHAIRMAN | |
| Mr G P E Howard BA | Chairman J & S Engineers Ltd and Member of the King's Fund Management Committee also Chairman of its Colleges Committee |
| Professor J Anderson BSc MA MD FRCP | Department of Medicine<br>King's College Hospital Medical School |
| Mr Paul Cooper FHA | Deputy Secretary<br>Newcastle upon Tyne HMC |
| Mr A M Evans AHA AMIPM | Secretary<br>West Middlesex Hospital |
| *Mr S Hodkinson LLB DPA FHA Barrister-at-Law | Secretary<br>Wolverhampton HMC |
| +Mr K H Holley | Member of Directing Staff (1957-1964)<br>The Administrative Staff College<br>Henley |
| Miss Anne M Johnson SRN SCM | Matron<br>Guy's Hospital |
| Mr W R Matthews FCA FHA | Treasurer<br>Newport and East Monmouthshire HMC |
| Mr L H W Paine MA AHA | House Governor and Secretary<br>The Bethlem Royal and Maudsley Hospitals |
| Miss Patricia W Redman DN SRN | Matron<br>Whittington Hospital |
| Mr J A Spencer MA FHA | House Governor and Secretary<br>Royal Marsden Hospital |
| Mr I R Tomlinson FHA FInstPS | Regional Supplies Co-ordinating Officer<br>Sheffield RHB |
| SECRETARY | |
| Mr Philip Lowe MC | Senior Tutor<br>King's Fund Hospital Administrative Staff College |

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* until his death in October 1966

\+ until his death in February 1967

# CHAIRMAN'S FOREWORD

Predicting the future is difficult and it is unlikely that what emerges as the pattern of administration in 1980 will follow exactly the pattern suggested here. The collective views of the Working Party are, however, representative of a reasonable cross-section of informed hospital opinion. Initially the members differed greatly in their projections of present trends, but the final report has been reached with a large measure of agreement as being logical and offering solutions to some of the problems now besetting hospitals.

Shortage of money is chronic and the need is to make the best use of what is available by efficiency in administration of men as well as money. A sound management structure is essential to achieve this and we hope we have suggested one.

The impact of advances in all fields of engineering and science is already apparent. The rate of advance is accelerating - 80% of all scientists who ever existed are now at work, such is the rapid increase in their numbers - and developments in patient and staff services and, indeed, in unknown processes and chemicals, are beyond our powers to forecast. What is obvious is that there will not be enough staff available unless every ingenuity is adopted to diminish the time and effort needed to complete the tasks of bringing patients back to health, or of preventing sickness.

Different training in skills and different education in attitudes and relationships will be needed in the hospitals of the future. By setting out to consider the needs of 1980 there is time available meanwhile to provide people with the necessary training to fit them for the responsibilities which it is suggested they will need to shoulder.

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## SUMMARY OF RECOMMENDATIONS

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The following is a summary of our main recommendations with a note of the relevant paragraphs in the report.

a. Smaller committees of management to be introduced to replace the existing Hospital Management Committees and these to be named District Hospital Boards (paragraphs 36 - 39).

b. The District Hospital Boards to remain under the control of a regional or area agency and a central authority (paragraph 36).

c. The District Hospital Boards to consist of a chairman and seven other members (paragraph 39).

d. A Community Service Medical Advisory Committee to be appointed to give the District Hospital Board general medical advice and ensure close co-operation between the District Hospital and all other health and welfare services in the community. The chairman of this committee to be a member of the District Hospital Board (paragraphs 38 and 41).

e. A Community Service Patients' Advisory Committee to be appointed to give the District Hospital Board general advice in the interests of patients and to ensure a close co-operation with the local community. The chairman of this committee to be a member of the District Hospital Board (paragraphs 38 and 42).

f. The District Hospital's chief executive officer to be a General Manager, who will be a member of the District Hospital Board (paragraphs 36, 43 and 44).

g. The chairman and members of the District Hospital Board, with the exception of the General Manager and the chairman of the two Community Service Advisory Committees, to be appointed by the regional or area authority, for periods of three years at a time, with a compulsory retiring age of 70 (paragraphs 36 and 39).

h. The chairman of the District Hospital Board, at least, to be paid an honorarium for his services (paragraph 39).

i. The District Hospital Board to be the authority to whom all staff are responsible while employed in its hospital(s) (paragraph 40).

j. The District Hospital Board to remain a policy making body and the source of authority delegated to the General Manager responsible for managing the District Hospital (paragraphs 36, 43 and 44).

k. The General Manager to be assisted by four Directors of Service i. e. Director of Medical and Para-medical Services; Director of Nursing Services; Director of Finance and Statistical Services; and Director of General Services (paragraphs 45 - 48 and 51 - 62).

l. These Directors of Service to have appropriate senior assistants to be called Assistant Directors of Service (paragraph 46).

m. The Directors of Service to be full-time appointments although the Director of Medical and Para-medical Services may initially be a part-time appointment (paragraphs 45, 58 and 59).

n. A Hospital Medical Services Advisory Committee to be appointed by the senior clinical staff of the District Hospital to advise the Director of Medical and Para-medical Services (paragraphs 41 and 60).

o. The physical, mental and spiritual welfare of the staff as well as of the patients to be the concern of the District Hospital Board (paragraphs 63 and 64).

p. Experiments to be carried out during the next few years with the pattern of management we recommend. In addition the broad administrative framework of the hospital service within the National Health Service, and the management organisation within a District Hospital below the level of the Service Directors we recommend, to be the subjects of further studies (paragraphs 33 and 12).

# INTRODUCTION

1. The national hospital service in Britain has been in existence for almost 20 years. During that time hospitals have inevitably changed. The administrative structure of the service, however, remains broadly the same today as it was when introduced in 1948.

2. Whether this structure is in need of alteration is of considerable interest to the King's Fund and the Institute of Hospital Administrators. Both are directly concerned with training hospital administrators and clearly their training arrangements must be related as closely as possible to the sort of management required in hospitals.

3. With this in mind we were constituted as a joint working party by these two bodies in 1965. We were asked to consider how, if at all, the present pattern of hospital administration might need alteration in the light of changes that have taken place since 1948 and of further changes that may be brought about during the next 15 years by the development of District Hospitals. We therefore adopted the following as our terms of reference.

(i) To consider existing systems of management of hospitals in England and Wales at district level.

(ii) To consider changes that might be required in these systems and suggest a management pattern for the future bearing in mind the advent of District Hospitals.

4. In order to gain some idea of how the pattern of hospital administration may change during the next decade or so we have attempted to consider some of the more easily recognisable of today's trends which may affect the hospitals of tomorrow. In

particular we have noted tendencies towards greater centralisation in the service. This is obvious in several spheres but especially so in those of finance and supplies. Central and joint contracting arrangements seem to us certain to continue and be extended. The organisation of laundry, linen and central sterile supply services is very likely to develop on an area rather than a group basis. The report of the Hunt Committee[1] on hospital supplies includes recommendations of this kind. Computers which are already in use in the service will undoubtedly be used more extensively in the years to come not only for financial and statistical work but also in the fields of medical records, treatment and clinical diagnosis[2]. The likelihood is that area and regional computer centres will be created.

5. Important though they are computers are only one example of the automation we may expect to develop in hospitals in the next decade or two. The introduction of other mechanical, electrical and electronic equipment, such as closed circuit television, patient monitoring systems, auto-analysers and a number of complex electro-medical machines, has already begun and must be expected to continue and increase. While in some ways the introduction of such equipment must make more work for the professional staff concerned, it should also allow more work to be done more quickly. Staff will be able to look after more patients as a result and the speedy provision of accurate information may also allow them to make more efficient use of scarce resources.

6. One thing is certain - this sort of development is bound to demand greater skills from many members of the staff including not only those directly dealing with patients but also others such as engineers, technicians, and administrators. Existing schemes for

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[1] Ministry of Health, Report of the Committee on Hospital Supplies Organisation, MOH, 1966.

[2] See Appendix C.

secondment of skilled staff from one hospital to another are likely therefore to be extended. Recruitment and training of administrative staff already progressing under the direction of the National Staff Committee and Regional Staff Committees will develop further. The recommendations of the Salmon Committee[3] which have already been accepted in principle by the Ministry of Health provide for similar arrangements to be made for nurses.

7. Centralisation will also probably be extended in the field of clinical medicine where specialisation is more likely to increase than decrease. Highly specialised units for new medical techniques (e.g. chronic renal dialysis) as well as the more expensive specialities such as neurosurgery and radiotherapy, must of necessity become restricted to one or two centres in each hospital region. It is in fact upon this principle of centralisation of specialist medical services that the idea of District Hospitals is based. In Hospital Building Note No. 1[4] it is pointed out that due to changes in medical thinking and techniques, the trend in hospital design in the 1960s is towards greater integration of the various branches of medicine. The need therefore as the Ministry see it today is for an integrated hospital community capable of making all investigations and treating all diseases except the most complex. In the Building Note the Ministry defined this modern comprehensive general hospital as:

> 'A hospital containing inpatient beds and treatment and diagnostic facilities for inpatients and outpatients, and including a maternity unit and an acute psychiatric unit, a geriatric unit and an isolation unit for patients suffering from infectious diseases whether notifiable or not'.

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[3] Ministry of Health, Scottish Home and Health Department, Report of the Committee on Senior Nursing Staff Structure, HMSO, 1966.

[4] Ministry of Health, Buildings for the Hospital Service, HMSO, 1961, Hospital Building Notes, No. 1.

8. Changes taking place in the hospital world support the Ministry's view. Most hospitals, of course, already provide some kind of district service and this includes teaching hospitals, although their commitments have always stretched beyond that of serving their immediate areas. Some teaching hospitals, however, which have not done so previously are now accepting official responsibility for a local district service. The integration of psychiatric hospitals with hospitals of other types is also Ministry policy and in a number of non-teaching groups, psychiatric and general hospitals have been placed under a single Hospital Management Committee. In addition psychiatric units are being developed in general hospitals and the aim is to increase these.

9. We do not believe, however, that District Hospitals will for many years, if ever, take a single standard form. To start with, if past experience is any guide, there is unlikely to be enough money available in the next twenty years to build all of the new District Hospitals that are needed. And different areas of the country will want different amounts of hospital facilities anyway. District Hospitals therefore are likely to appear in various guises. In some areas, for example, one new District Hospital on its own may well constitute a single management unit. In others, where the need is great and the population dense, two new District Hospitals may be required with a psychiatric or geriatric hospital, or both, linked to them to form a single large group. In many areas existing hospitals with a certain amount of improvement will probably remain for many years as they are now under one management authority to form collectively a single District Hospital.

10. Whatever form they take, however, the District Hospitals of the future will be focal points of the health service of their areas. But they cannot remain independent. It seems inevitable that the three elements of the National Health Service as provided by hospitals, local authorities and family practitioners must draw

closer together as time goes on and become more integrated with welfare services. Reports from Guillebaud[5] and Porritt[6], and the Ministry's 'Ten-year Plans' of recent years, all contain recommendations pointing in this direction. Therefore hospitals of the 1980s, as we see them, will be part of closely integrated community health and welfare services combining both preventive and curative medicine.

11. These broader issues are somewhat beyond the scope of our terms of reference. We have mentioned them briefly because they demonstrate clearly that advances being made in medical, social and economic sciences, will inevitably affect the hospital service and its administration. The idea of an integrated hospital community for example, suggests that hospitals are likely to become more rather than less complex institutions and that this will have its repercussions on the way they are managed. Closer integration of hospitals in the health and welfare service provided for their communities will mean more careful co-ordination and an increase rather than a decrease in central and regional planning. The structure of the hospital service as we see it in fifteen years' time therefore will certainly include a central department and probably some kind of regional or area hospital or health service authority also. Hospitals and hospital groups will range in size as they do now although there will probably be more units of 2, 000 beds and upwards and fewer of 500 or less. The management pattern we have produced is, as a result, deliberately not related to a District Hospital of any particular size or composition. We believe that it will prove flexible enough to fit the different sized management units which will undoubtedly exist in fifteen years' time as they do at present.

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[5] Ministry of Health, Report of the Committee of Enquiry into the Cost of the National Health Service, HMSO, 1956.

[6] Medical Services Review Committee, A Review of the Medical Services in Great Britain, Social Assay, 1962.

12. We wish to reiterate at this point that our terms of reference did not permit us to proceed beyond consideration of a pattern of management for a District Hospital or its equivalent. This has precluded us from discussing the broader administrative framework of the hospital service within the National Health Service, although we think that the time is ripe for the components of this larger structure to be studied critically. In the same way we urge that further consideration be given to the administrative organisation within a District Hospital below the level of the Directors of Service we recommend.

# HOSPITAL ADMINISTRATION BEFORE 1948

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13. Prior to the National Health Service there were two separate hospital systems in England and Wales - the voluntary and local authority systems. On July 5, 1948, the state took over 1, 143 voluntary hospitals with approximately 90, 000 beds and 1, 545 local authority hospitals with approximately 390, 000 beds. The voluntary hospitals varied considerably in size, importance and in the facilities they provided, from the large London teaching hospital to the small provincial cottage hospital. Each one had its own governing body which usually delegated much management authority to an executive committee and to its chairman, house governor, and within her sphere, matron. Visiting doctors with honorary appointments provided clinical care and medical advice. Local authority hospitals developed from three main sources. Under the Poor Law and later the Public Assistance system, workhouse infirmaries and Public Assistance institutions were built (66, 000 beds total in 1948). Public health powers granted to local authorities in 1930 included the building and maintaining of general hospitals. In addition, local authorities provided mental and mental deficiency institutions (190, 000 beds total in 1948), T.B. sanatoria, isolation and infectious diseases hospitals. Generally speaking, the local authority hospitals were administered through the department of the Medical Officer of Health, each hospital usually having a medical superintendent who was its chief officer.

## HOSPITAL ADMINISTRATION SINCE 1948

14. The existing system, whereby the hospital service in England and Wales is administered under the Ministry of Health by voluntary Boards and Committees, has operated since the inception of the National Health Service in 1948. It is well enough known to require only the broadest outline here.

### The Boards and Committees

15. Constitutions for the new hospital authorities introduced in 1948 (the Regional Hospital Boards, Boards of Governors, and Hospital Management Committees) were laid down in schedules to the National Health Service Act 1946. The structure is a three-tier one with the Ministry of Health at the top appointing the Regional Hospital Boards and Boards of Governors, the Regional Boards in their turn appointing the Hospital Management Committees in their areas. There are 15 Regional Hospital Boards, 36 Boards of Governors and approximately 350 Hospital Management Committees at present in England and Wales. The Regional Hospital Boards and Boards of Governors although agents of the Ministry of Health exercise a large degree of autonomy. Members of the Boards and Committees, totalling about 7, 000, are unpaid and hold their appointments on a three year term as individuals and not as representatives of the bodies who nominate them.

16. The Regional Hospital Boards are responsible to the Minister of Health for the administration of the non-teaching hospitals in their areas and they exercise this responsibility either directly or through the Hospital Management Committees. Their main direct function is the planning and supervision of a co-ordinated hospital and specialist service for their regions, in association with the Ministry, Board(s) of Governors, Universities and Local Health Authorities. Because they are concerned with both medical and structural

planning, they are also entrusted with the duty of drawing up and carrying out, with the Minister's approval, programmes of capital works for all non-teaching hospitals in their regions. They also have responsibility for:

(i) appointing chairmen and members of Hospital Management Committees;

(ii) appointing and paying senior medical and dental staff at non-teaching hospitals;

(iii) allocating the regions' maintenance money to Hospital Management Committees and approving Hospital Management Committees' estimates of expenditure;

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

(v) running the blood transfusion and mass radiography services.

17. The Hospital Management Committees are responsible for the management of all hospitals under their control and the day to day operation of those hospital services within the policy laid down and the finances provided by the Regional Hospital Boards. Most Boards and Committees have between 15 and 30 members and carry out their duties by the usual method of appointing standing committees or sub-committees with specific delegated responsibilities. A survey of the Manchester region some years ago revealed that no Hospital Management Committee had less than three such sub-committees or more than eight.

## Their Officers

18. The Boards and Committees employ paid staff to undertake the day to day administration of hospitals. The principal administrative officers of a regional board are the Secretary, the Senior Administrative Medical Officer and the Treasurer. The duties of the Secretary and Treasurer are broadly explained by their titles. The duties of the Senior Administrative Medical Officer are to advise the board on the administration of the medical services in its region and also to execute its medical policy.

19. The principal administrative officers of the Hospital Management Committee are the Group Secretary, Treasurer and Supplies Officer. The Group Secretary is the chief officer of the Hospital Management Committee. He is responsible for the general administration of the hospital or group of hospitals controlled by his committee, the co-ordination of all services, and the execution of policy. With his senior colleagues he is also responsible in particular for the business administration of the group, which includes finance, supply, establishment, engineering, maintenance, laundry, domestic, catering and clerical work. Major business functions such as finance and supply are usually centralised under their senior officers. Individual hospitals or sub-groups are administered by hospital secretaries or unit administrators.

20. The administration of the nursing service is the task of the Matron. A few hospital groups have a Group Matron and/or Nursing Adviser to the Hospital Management Committee. Many retain separate matrons for each hospital. We have noted that the existing pattern of administration in the nursing service may well be altered considerably as a result of the report of the Salmon Committee.

21. The universal practice in Hospital Management Committee groups is to have a medical advisory committee to advise the Hospital Management Committee on medical matters. Regional Hospital Boards obtain such advice in various ways and not all have the same practice. Some have medical advisory committees, some have specialist committees of clinicians to advise them on particular services for the region. Some have both. Medical Superintendents, common in local authority hospitals before the National Health Service, are now much fewer except in psychiatric hospitals. Even in these the tendency is (as recommended by the Ministry) for general medical administrative functions to be undertaken by a medical advisory committee.

22. At both levels of the service, specialist officers are employed and the tendency is to appoint more of them. Regional Hospital Boards, for example, have architects, engineers, and nursing officers, and some have others such as catering and laundry advisers. Hospital Management Committees usually number among their departmental heads catering officers, engineers, building superintendents, domestic superintendents, medical records officers, etc. These officers wield considerable administrative authority in their particular spheres. The ranks of general administration have also been swollen in recent years by the appointment of such officers as those employed on work study, planning and personnel services.

## PROS AND CONS OF THE EXISTING SYSTEM

### Management by Committee

23. The designers of the national hospital service adopted a traditional form of administration by placing control of a public service in the hands of voluntary committees. The main advantage of the system was succinctly expounded by Walter Bagehot. The bringing together of expert and non-expert minds in a committee, he contended, ensured that the ideas and proposals of experts always had to undergo the scrutiny of men of common sense and judgement before they could be put into effect. Other advantages may be added. Committees reduce the effect of personal prejudice on and spread the responsibility for decisions. They will often collectively take responsibility for a decision too big for one man. Public committees can reasonably be expected to represent and possibly safeguard the public interest.

24. The disadvantages are equally easily enumerated. Committees can waste time and delay action. They may well ensure a collective mediocrity and stifle individual imagination and initiative.

> 'To solve problems', as Anthony Ashton wrote, 'it is not enough to set up committees. They can moderate and guide the creative energy of individual men but they can never be a substitute for it.'

### The Three-tier Structure

25. The administrative structure of the hospital service is a three-tier one and the difficulty in any tiered system of administration is to arrive at the correct balance of responsibility and authority appropriate to each level of administration. The Guillebaud Committee believed that this balance would come about naturally as the service developed.

> 'The acceptance of authority (by which we do not mean dictation)', they said, 'is only one aspect of a

> relationship which takes time to grow and which when developed, links the different levels of management in a nexus of mutual dependence. To create this relationship is a major duty of all concerned at every level. It should clearly be recognised throughout the service in England and Wales that Hospital Management Committees are responsible to their Regional Boards for the efficient administration of their services, and that the Boards in their turn are responsible to the Minister.'

Many in the lowest tier of the structure today believe that the relationship with the tier above them which has developed down the years has not been as the Guillebaud Committee envisaged it should be. Most Hospital Management Committees at the present time feel that their area of freedom of decision has steadily diminished since 1948 due to encroachment by the Regional Hospital Boards.

26. In spite of such feelings we believe it would be untrue to suggest that the administrative system designed for the hospital service upon its inception has not worked reasonably well during the 19 years of its existence. It would be a mistake, however, not to recognise the fact that the system has been steadily criticised from the beginning. Two points in particular have regularly been made: the existence of much unnecessary committee work throughout the whole hospital service and the lack of clear leadership in the administration at local level.

### The Committee Structure

27. There have been many eminent critics of committees in the hospital service but none more forthright than the Guillebaud Committee whose report contained the following words.

> 'There is a real danger of the administrative side of the National Health Service getting bogged down in a morass of committees. Any unnecessary committee work is an unmixed evil.'

The report went on to suggest the obvious remedy for this evil.

> 'Accordingly we recommend', they said, 'that all Management Committees and Boards of Management

> should review their arrangements with the aim of simplifying their committee structure and reducing the volume of work, for example, by increased delegation of authority to responsible administrative officers.'

28. In 1959 an equally forthright view was expressed by a leader writer in the Lancet commenting upon the Institute of Hospital Administrators' publication, Committees and Communications. This writer's opinion of hospital committees and their function as quoted below is one with which we believe many concerned with the administration of the hospital service today would concur.

> 'We are certainly right in preferring the committee system to authoritarian rule; but the Health Service is only one of many national organs whose efficiency is impaired by having too many committees with too many members. Sooner or later something must be done to reduce this element in administration to the minimum that will serve its important purpose. Many people feel that too many meetings are held to discuss matters of detail - a practice which must discourage the more useful type of committee member, and also the hospital officer who must be given enough scope to do his proper work properly. If fewer and smaller committees held fewer and shorter meetings and concentrated on policy, the hospitals might benefit greatly.'

## Administration at Officer Level

29. As for administration at officer level, difficulties have been experienced here from the start of the service. Some of these have undoubtedly been caused by clash of personalities and the sort of human failing that can arise in any large organisation, but particularly perhaps in a hospital with its wide variety of individualistic professional people and well defined traditional hierarchies. Others were undoubtedly the result of a certain amount of 'jockeying for position' in a new service. In the early days, the new pattern of administration left most senior officers uncertain as to the exact interpretation of their various roles and responsibilities and of their relationships one to another. This

absence of definition of roles and lack of clear administrative structure meant that many of these officers had to work out their relationships for themselves from scratch. What has caused most difficulty in relations between senior staff we believe, is that no one individual at Hospital Management Committee level is necessarily accepted today as holding the type of authority once wielded by the Medical Superintendent of the municipal hospital or the voluntary hospital's Chairman.

30. The Bradbeer Committee[7] saw the remedy for this changed situation in the new service in their so-called 'tripartite system' of administration. This system was in fact no more than a rationalisation of the situation which existed in most voluntary hospitals before the National Health Service where, in their own spheres, the word of senior doctors and matrons was law. While allowing that in the new service the general administration of hospital groups should be the responsibility of the chief administrative officer (Group Secretary), the Bradbeer Committee believed that the administration of individual hospitals should continue to be divided into three separate categories: medical, nursing and business. Hospitals should, as the Bradbeer Committee saw it, be administered not by one man (or woman) but by a 'blended team' of senior doctor, matron and business administrator, each one supreme in his or her own sphere. The business administrator Bradbeer accepted (in practice if not in theory) had no authority over the nursing and medical staff.

31. The shortcomings of such a system are obvious. Bradbeer's administrative pyramid has no point. Tripartite administration provides the hospital with no director. Bradbeer in fact failed to grasp the nettle that someone had to be in command of the organisation with authority over all the rest of the staff. It does

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[7] Ministry of Health, Central Health Services Council, Report of the Committee on the Internal Administration of Hospitals, HMSO, 1954 (reprint 1961).

not matter, as we see it, whether the man or woman at the top has business, medical, nursing, or any other hospital background, so long as he or she is a good administrator of the necessary calibre and training. Within the next 15 years it is hoped that administrative talent in hospitals will be recognised in whatever discipline it appears. What is important is that those who administer our hospitals in future, wherever they spring from, must be properly trained to do so. Tripartite administration, as many have understood it, is not we believe acceptable any longer in the hospital service. This is not to say that there should not be close co-operation between senior officers. Obviously such co-operation is an essential part of good administration. The interpretation of tripartite administration as separate medical, nursing and business functions, each with its own head, equal and independent, is the one we deplore. No hospital or group can successfully be administered by a triumvirate of equal and independent senior officers. Someone must be in charge.

32. On the evidence of the last 19 years therefore it seems to us reasonable to assume that there is room for improvement in the administration of the hospital service. The role of committees and the administrative hierarchy at officer level in particular need to be reviewed. We also believe that the level at which improvements are liable to be most effective is that where the actual hospital management is done - in the hospitals and existing management committee groups. It is with these points especially in mind that we make the following suggestions.

# SUGGESTED MANAGEMENT STRUCTURE FOR THE FUTURE

## Form of Management Authority

33. The District Hospital of the future, like many of the bigger general hospitals and hospital groups which today provide district services, will be a big, intricate organisation employing a large number of people and involving many different functions, techniques, and complex inter-relations. In deciding upon the pattern of management best suited to this complicated institution, we have made two basic assumptions about the hospital service 15 years hence. First, that the Ministry or some other central authority will continue to administer it utilising regional or area agencies, so that the District Hospital will remain the lowest tier of a three-tier structure. Second, that then as now the best management structure for District Hospitals will be that which extracts from scarce resources of money, labour and equipment, the maximum possible benefit for the patients. We have also done our best when considering the future to learn the lessons of the past without allowing the historic complexities which have helped to mould the management committees of today to confuse the issue. The pattern of management which we recommend aims to right the three main wrongs which we see in the management of hospitals at the present time. It should provide a clear administrative chain of command; reduce to the essential minimum the work of committees; and link the District Hospital closely to the other health and welfare services of the community. These as we have attempted to make clear in the earlier part of our report are our main criticisms of the existing management pattern in hospitals. Although we are suggesting a new structure for 15 years' hence which we think will meet these criticisms, we believe that in many existing hospitals and groups the pattern of management we recommend could be introduced well before the 1980s. We hope that experiments will proceed to this end.

34. We have been particularly concerned in our discussions about the lack in hospitals today of a clear management structure at officer level. Co-operation is the essence of good administration but so is a well defined structure of authority. Good management in hospitals as elsewhere demands a proper delegation of responsibility and authority understood by all involved. This is particularly important for senior hospital staff. Their respective roles and responsibilities and their relationships one to another must be made clear. To blur these responsibilities and relationships is to us the antithesis of good management. By so doing a situation which, as the recent paper on management functions of hospital doctors says, 'already has some of the elements of anarchy'[8] can only be made worse. In trying to achieve our first aim therefore (i.e. a clear administrative chain of command) we have come to the conclusion that it is essential both that one person should be given management responsibility for the whole hospital and that, similarly, one person should be responsible for the general management of that area of the hospital wherein 'the elements of anarchy' lie most thick - the clinical services. In saying this we would not wish to be considered as against the current trend towards participative management. We feel, however, that while participation by staff, and particularly senior staff, in management decisions is both correct and welcome, the need for a clear management hierarchy is also essential.

35. In considering the role which committees should play in our proposed management structure we have felt that one important fact should be accepted at the outset. This is that it is difficult today to find enough suitable people with time to become members of hospital authorities. Some members appointed to existing Hospital Management Committees are people with little knowledge of hospitals, their problems and administration, and too little time available to

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[8] Ministry of Health, Advisory Committee for Management Efficiency in the National Health Service, Management Functions of Hospital Doctors, HMSO, 1966.

learn about these things. This situation must be recognised and rectified. We note in passing that the Farquharson-Lang Committee[9] take a similar view in their recent report when they discuss the practical difficulties of securing an adequate number of suitable members to sit on hospital committees.

> 'If the cost in time is too great many people (and particularly those in the younger age groups) who would otherwise be willing to contribute will be prevented from doing so, and only those who have retired from active life or who have an unusually large amount of free time which they are prepared to devote to such duties, can participate.'

## District Hospital Board

36. We began our consideration of the sort of management committee for hospitals which might be required in 15 years' time by discussing whether such a committee was needed at all. We agreed that hospitals could be managed efficiently by full-time officers but that this would not be desirable in the public interest. Historically many hospitals have had strong ties with their local populations. The service today is also a greedy consumer of public money and the question of accountability to the tax-payer arises. For these reasons we decided that public interest and public accountability were best safeguarded by continuing to have voluntary management committees for District Hospitals. The form of committee which we envisage is a smaller body than at present with different and in some ways heavier responsibilities than are now accepted. The function of the management committee as we see it is in Walter Bagehot's phrase 'to ensure that the ideas and proposals of experts always have to undergo the scrutiny of men of commonsense and judgement before they can be put into effect'. The job of such committees is not to be concerned in the day to day affairs of their hospital(s) but to concentrate on the creation of local policy within the framework of national and regional

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[9] Scottish Home and Health Department, Scottish Health Services Council, Administrative Practice of Hospital Boards in Scotland, HMSO, 1966.

policy; and the setting up of an effective liaison with the other health and welfare services in their area, so that the total health resources of the area meet as nearly as possible the health needs of the community. We suggest that this small committee be named a District Hospital Board, and that it should be recruited from men and women of proved administrative ability, as many as possible of whom should still be in active employment. It should be appointed by the regional agent of the central health authority. Its task should be to administer the monies allotted to it and formulate the necessary policy to run the District Hospital. It should neither wish nor expect to have any executive responsibility or authority, but remain a policy forming body, and the source of authority delegated to a General Manager responsible for running the hospital. The General Manager should be a member of the District Hospital Board.

37. It is our view that although the responsibilities of the new District Hospital Board will be heavy, the amount of time required of its members should be much less than is now given by many members of Hospital Management Committees. We do not, for example, foresee the necessity for the District Hospital Board to appoint standing sub-committees to assist it with its work. For this reason we believe that busy men and women will be able to accept places on the new boards just as well as those who have retired from active employment. In coming to this conclusion we have not overlooked the need for the board to be given adequate advice which will allow it to formulate its own policy in accordance with that of the central authority and regional agency and to play its proper part in the health and welfare services of the community it serves.

38. Much of the advice required to produce its own policy, the board will naturally obtain from its General Manager and senior officers, but we have also allowed for the establishment of a Hospital Medical Services Advisory Committee with, however, a different function from that of the medical committees which exist

today. As we see it the prime aim of this committee will be to advise a Director of Medical and Para-medical Services who we feel should be appointed, and details of whose post are given later. As has been said the District Hospital must also play its proper part in the health and welfare services of the community it serves, and in order that this may be so we propose that two community advisory committees be set up - a Community Service Medical Advisory Committee and a Community Service Patients' Advisory Committee. In order to ensure that these two committees will make their voices heard in the District Hospital Board, we suggest that their chairmen be members of the board.

### Constitution of the District Hospital Board

39. The constitution which we suggest for the District Hospital Board therefore is as follows:

| | |
|---|---|
| An independent Chairman | 1 |
| Chairman of the Community Service Medical Advisory Committee | 1 |
| Chairman of the Community Service Patients' Advisory Committee | 1 |
| Others | 4 |
| General Manager | 1 |

The chairman and members of the board (with, of course, the exception of those who are ex officio members i.e. the General Manager and the chairmen of the community advisory committees) should all be appointed on a staggered three year term basis and be eligible for re-appointment. We think that it is wise to impose an age limit of 70. We are also quite certain that the chairman of the board will need to have more time available for hospital work than other members of the board and for this reason he at least should be paid an honorarium for his duties. Because of the different form, constitution and responsibilities of the District Hospital Boards which we propose, we envisage the regional agencies under whom they would work taking more advice from and devolving more

responsibility upon them than is now given to most management committees by the Regional Hospital Boards. (Terms of Reference for the District Hospital Board are given in Appendix B. 1.)

Employment of Staff by the District Hospital Board

40. We think it important that the new District Hospital Boards should be looked upon by all of the staff who work in their hospital(s) as the local employing authority. In practice we would expect the District Hospital Board to delegate authority for the engagement and dismissal of all but the most senior staff to the General Manager and the four Service Directors whose appointment we recommend. The District Hospital Board should, however, remain the employing authority to which all staff should ultimately be responsible while holding posts in hospitals coming under the board's direction. This is essential if the staff are to feel a proper sense of loyalty to the hospital they serve and the District Hospital Board is to be able, when necessary, to exert an adequate control over them. It is particularly important when one remembers that more and more potentially senior staff are liable in the future to be moved from post to post by the central authority or regional agency. In making this suggestion we nevertheless recommend firmly that the District Hospital Board should take utmost advantage of all national, regional, and joint advisory appointments committees for staff.

Community Service Medical Advisory Committee

41. In order that the District Hospital shall play its full part in an integrated health and welfare service to the community we recommend that a Community Service Medical Advisory Committee be appointed by the regional agency to advise each District Hospital Board. The absence of such a committee, charged with keeping the health service to the community in balance with its medical needs, is we think a serious defect in the organisation of medical services at the present time. In addition to its basic task of advising on how to match health services with the health needs of the community, this committee should

be the main liaison between the District Hospital and other local health services. It should ensure the establishment of a close co-operation between the District Hospital and local health and welfare authorities, local industrial health services, and local general practitioners. Representatives of all these health services should sit on the committee and its membership should be approximately half hospital medical staff and half members from outside the District Hospital. The Director of Medical and Para-medical Services whom we propose, should be an ex-officio member, as also should be the chairman of the Hospital Medical Services Advisory Committee which we recommend be set up (see paragraph 60). In addition, in order to ensure an adequate expression of medical opinion from all levels in the District Hospital, a representative or representatives of the junior medical staff should have a place on the committee.

### Community Service Patients' Advisory Committee

42. This committee is suggested as a type of consumers' council representing the local public interest in the District Hospital and accepting as its principal aim the safeguarding of this local public interest. Its members should therefore be independent people of local repute and as widely representative of the public as possible. It is important that this committee in particular should feel itself to be independent of the District Hospital Board and of the regional agency so that it can be free to express its honest views of the health and welfare services provided in its area. We therefore recommend that in the first instance the committee be appointed by the District Hospital Board but thereafter, within a laid down constitution, should appoint its own members.

### General Manager

43. The idea of a General Manager for the District Hospital is a considerable departure from present practice in most hospitals. The title of General Manager - drawn from industry - correctly

describes the scope of this post, as we envisage it, which is to manage the whole hospital as distinct from managing any particular service. While this idea may be radical, it is our firm belief that all administrative organisations must have one leader. We do not accept that it is good management to have a number of senior officers all of whom are considered equal and responsible only to a committee of management. We are therefore unable to agree with the view of the Salmon Committee who recommend that the chief nursing officer should be responsible to the management committee and accountable to the group secretary. 'Accountable' is a term which the Salmon Committee uses to mean 'report to'. This is certainly open to misunderstanding for the generally accepted meaning of the word 'accountable' is 'responsible to' and it is therefore natural to assume that if one officer is said to be accountable to another, then the accounting officer has authority over the officer who is accountable to him. It appears that the Salmon Committee may have confused the professional status of senior officers with their management status in the hospital. Our concern is with the provision of a proper management structure and a clear administrative chain of command. We are not concerned with professional status or salaries. We accept that senior nurses, doctors, and others in hospitals must retain their professional independence, but their management functions must be seen as part of the general management of the hospital. The chief nursing officer, like the senior doctors and the other professional staff in hospitals, is responsible for the efficient management of a particular service. The General Manager is responsible for the efficient management of the whole hospital. This is not to say that he must be a dictator. Far from it. We have already said that the essence of good management is co-operation and we agree that the General Manager will not be able to carry out his or her duties effectively without the closest co-operation with senior colleagues. Thus we envisage that the other senior officers concerned with the management of specific services would hold appointments as Service

Directors who would assist and advise the General Manager to manage the District Hospital. In order to ensure close co-operation between the General Manager and the Service Directors we have provided for a regular meeting of these senior staff (see paragraph 50).

44. Nevertheless it is of fundamental importance that one person should retain the final authority to take decisions. This is why we have insisted that the General Manager must be solely responsible for carrying out the policies formulated by the District Hospital Board and for the day to day running of the hospital(s). One of the General Manager's major tasks will obviously be to co-ordinate the work of the directors to whom authority is delegated for running various services although we accept that the Director of Finance and Statistical Services should remain the officer statutorily accountable for the proper use of public funds. (Terms of Reference for the General Manager are given in Appendix B.2.)

### Service Directors

45. The senior staff advising the General Manager should be as few as are necessary for efficient management. We have therefore attempted to divide the services provided by the District Hospital into four groups, each of which would have a Service Director at its head. The services visualised as meriting such a Director are Medical and Para-medical; Nursing; Finance and Statistical; and General Services. These Service Directors would be full-time officers. The Director of Medical and Para-medical Services, however, might have to be part-time at least to begin with. Our reasons for making this exception are given in further detail in paragraphs 58 and 59. All four of the directors should be responsible to the General Manager for running the services for which authority is delegated to them. They will need to be possessed of appropriate qualifications and experience and should all have received adequate management training. We think it important that the Service Directors should attend the meetings of the District

Hospital Board. They would also be eligible for promotion to the post of General Manager and it is from their ranks that we would expect General Managers normally to come. In saying this we have assumed that training in management will be available to, and will be taken advantage of, by everyone in the District Hospital, at all levels and in every discipline, who desires promotion.

46. To give some idea of the span of responsibility of the four Service Directors we have produced a Management Organisation Chart (Appendix A. 1), since we think that the responsibilities to be undertaken can most easily be delineated in this way. We would stress that the chart is designed to illustrate a management pattern and not the relative status of officers. Every activity undertaken in a hospital should be designed to serve the patient, directly or indirectly. Management is no exception. To make this point clear we have also provided a Functional Organisation Chart (Appendix A. 2) showing the role of management as a 'second line' enabling process supporting the 'front line' nursing, medical and para-medical services. These two charts, particularly the management organisation one, serve to show in general terms those functions which the four directors would carry out and the areas they would control and co-ordinate. We have not attempted to provide a detailed organisation chart below the level of Service Director but, in addition to giving an idea of the span of their responsibilities, we have tried to indicate that a promotion ladder will exist within the District Hospital for those aspiring to directors' posts. Some of the functions that we have shown as controlled by Service Directors would merit the appointment of assistant directors at their head. Not all of these services would necessitate such appointments. It will be seen from the Management Organisation Chart, for example, that we have deliberately placed the supplies and hotel services under the direction of a Director of General Services. This would appear at first sight to involve a reduction in the sphere of authority of existing supplies officers but we have made this decision in the light

of the recommendations of the Hunt Committee on hospital supplies. We consider that in the near future the recommendations of this committee will have been implemented and that supplies officers as we know them today will be controlling areas rather than hospitals.

47. Likewise we have not felt it possible to recommend at this stage that the engineering and works departments should form a separate service under the control of a director. We know that this view is not in accord with the recommendations of the Tyler Committee's report[10], and we would not wish to be accused of underestimating the value of engineering and works services to the hospital. Indeed, we believe that the importance of these services will increase considerably during the coming decades as automation in its various forms develops. It is our firm conviction on this point that has led us to include in our report (see Appendix C) a special note on the future uses of computers in hospitals. Certainly we expect that the hospital engineers of the 1980s will be men with higher qualifications than are generally possessed today. Their status in the hospital should be higher than it is now and the tasks they will have to do larger and more difficult. Whether these will be great enough to merit their promotion to Service Director with the possibility of further promotion to General Manager we cannot accurately foresee. We think this may come about in exceptional cases but is not likely enough generally to warrant their elevation at this juncture to the director level.

48. Similar comments could be made on some of the heads of the other services we have listed in our chart. If, for example, the recommendations of the Hunt Committee on the introduction of an area supplies service are not accepted then supplies officers in large hospitals or groups might well be designated as Service Directors. Others could emerge from the ranks of those concerned with the

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[10] Ministry of Health, Scottish Home and Health Department, Report of the Study Group on the Work, Grading, Training and Qualifications of Hospital Engineers, HMSO, 1962.

medical auxiliary services, pharmacy services, personnel services, and we do not preclude the possibility that there may be more Service Directors in some District Hospitals in fifteen years' time than in others. The four we have proposed, however, seem to us to represent the three main elements in hospital management - clinical, nursing and business - and to recognise the basic fact that finance ultimately controls every hospital activity. While therefore we accept that other Service Directors may emerge in some District Hospitals in the future we believe that they are more likely to be the products of special local circumstances than the general development of a particular service in all hospitals. Whatever happens, however, we think that the four directors whom we have suggested will be required in every District Hospital and will always remain the most important. (Terms of Reference for the Service Directors are given in Appendices B. 3, 4, 5 and 6.)

## Deputy General Manager

49. We have not introduced into our management structure a Deputy General Manager since we believe there is no need for such a separate post. On the other hand someone must act as deputy to the General Manager whenever this is necessary and we recommend that one of the Service Directors be appointed to this position while retaining his post of director.

## Directors' Meeting

50. The General Manager of the District Hospital, as we have said, will need to co-operate closely with his senior colleagues and particularly with the four Service Directors. It is of fundamental importance that they should meet regularly to exchange views and advice. Such a meeting will probably need to be held as frequently as once a week. It should be composed of the four Service Directors and other senior staff as required with the General Manager acting as chairman. It should be an advisory committee to the General Manager and as such non-voting.

## Medical and Para-medical Services

51. Our decision to recommend that a Director of Medical and Para-medical Services be appointed will, we believe, be one of the most controversial that we have made. It was not an easy decision to reach and we spent more time discussing this question than any other single recommendation contained in our report. Because of this and because our suggestion may seem to ignore the trend of the last 19 years which has been away from the appointment of specialist medical administrators, we have felt it necessary to explain in more detail the reasoning which led us to make this proposal. It is true that since the inception of the National Health Service the number of physician superintendents in hospitals in England and Wales (although not in Scotland) has steadily dwindled. It seems to us that this has been in accordance with central policy which has made it clear for many years that to be paid as a clinician a doctor must undertake clinical and not administrative work. Even in psychiatric hospitals where the majority of physician superintendent posts still exist, the Ministry have recommended, as we pointed out earlier, that medical advisory committees rather than the physician superintendents should advise their management committees on general medical matters. In all other hospitals and groups the common practice is for medical administration in its broad sense to be undertaken not by a specialist individual but collectively by a medical advisory committee.

52. The main reasons for the demise of the medical administrator in hospitals seem to us to be two. Firstly, that the number of consultant staff in hospitals has generally increased. Secondly, that consultant staff in general mistrust those of their colleagues who undertake administrative work, preferring to have non-medical administrators in hospitals. Most consultants, we think, believe that in this way they are more likely to preserve their personal individuality and professional freedom of action. This, as we see it, is why senior medical staff have on the whole been happy since

1948 (and even earlier) to work in hospitals and groups administered by committees made up predominantly of so-called 'lay' members and with a 'layman' as the committee's senior administrator. This, by the way, is why we foresee no real problem in introducing our suggested post of General Manager. We believe that those staff of the hospital who belong to the older professions of medicine and nursing will find such a post quite acceptable although it may, and often will, be filled by someone who is neither a doctor nor a nurse but who is a member of the newer profession of those skilled in management. What we have attempted to produce therefore in our proposed management pattern is an administrative arrangement which will allow the senior clinical staff of the hospital to retain their individuality and clinical freedom and yet at the same time provide the District Hospital Board with an efficient method of managing the medical services of the hospital and of producing medical policy.

53. Medical administration as we see it falls into two main parts. There is the formulation of the local medical policy of the District Hospital within the broader framework of that of the community, the region or area and the central authority. This involves the planning of medical services within the resources available to meet health needs; setting and achieving clinical targets; setting the establishments of medical and para-medical staff; and providing for and directing programmes of research and training. There is also the day to day medical management within the District Hospital. This involves the local use of hospital resources - manpower, money and equipment - the planning of duties, use of accommodation, e.g. in operating theatres, outpatient clinics and wards, and dealing with minor day to day medical problems. Much of this medical administration can only be carried out by individual consultants or 'firms' and we would not wish to change this. We envisage, for example, that each of the main sections of clinical activity within the hospital would remain responsible for producing its own plans

for development, for investigating regularly its own productivity, and for organising its own daily affairs. We would expect therefore that clinical sub-committees would continue to operate in the various major specialities as they do now in many hospitals. What we wish to see, however, is some continuous co-ordination of all of this day to day work of medical management and an efficient arrangement for ensuring that such co-ordination is used to help to formulate the wider medical policy of the District Hospital as a whole. In this respect we see a hospital as just like any other part of society. It must work within a framework of rules designed to achieve its general aims and provide the greatest good for the greater number of patients. In the interests of the patients and of the hospital therefore we think this framework of rules must include some form of general co-ordination and control of the activities of the medical staff.

54. In saying this we should like to make it clear that we think it a basic principle of hospital medicine that the consultant staff should take individual responsibility for the care and treatment of their patients and be under no clinical orders in this respect. The retention of such individual clinical freedom is, we believe, fundamental in the interests of the patients, the hospital and the medical profession. But while we do not wish in any way to interfere with the professional freedom of the doctors, it is essential that their work be co-ordinated into the general policy of the hospital. At present this co-ordination is effected by the medical advisory committee and by discussion between the administrator, individual consultants and the chairman of the medical committee who acts when necessary as spokesman for his colleagues.

55. In our opinion this system has several defects. Medical committees often consist of all the members of the consultant medical staff. In some hospitals they number more than 100. Such committees are too big to work efficiently. In addition many

members do not have the time or inclination to devote to the committee's deliberations, either because they are part-time workers or because they have other interests such as research or private practice. Medical committee chairmen may lack on appointment the necessary administrative skill, experience and time to carry out their task properly. They frequently hold office for too short a time to develop such skill and experience. Medical committees are no different from any others. They will only produce good results if their size is restricted to a workable number; their members are interested, able and active; and their chairmen are effective. Where all or some of these prerequisites are lacking, their efficiency will be reduced and medical management will suffer. Certainly the system cannot work well unless an accomplished chairman holds office and this is why we came to the conclusion that our aim should be to try to ensure that such a situation existed in all hospitals. This is our basic reason for suggesting that a director be appointed to control and co-ordinate the medical and para-medical services who would have sufficient authority, knowledge, experience and time to do so.

56. It is worthwhile reiterating at this point that as a Working Party our concern is with the management structure of the District Hospital and not with the relative status of the different professions represented on its staff. We are interested in those members of the senior medical and nursing staff whose work includes a significant amount of what is now called 'top management'. We see our task as assessing the contribution they make to the management of the hospital and ensuring that their parts are fitted correctly into the whole. We accept therefore that the Director of Medical and Para-medical Services will be a doctor as well as a manager, just as the Director of Nursing Services will be a nurse and a manager. From our point of view, however, it is the professional expertise in management that is essential. The earlier professional training while important, is secondary. Once this basic concept is

understood we believe that doctors and nurses will come to see the logic of our proposals.

57. We do not expect that our proposed full-time Director of Medical and Para-medical Services will materialise in every District Hospital overnight. In the first place it will be many years before all the proposed District Hospitals are completed. For a long time the hospital service will continue to be provided mainly by the existing hospital groups. There is also, we realise, a shortage of doctors in the country, and especially in general practice. Although we believe that the post we are suggesting would improve the efficiency of the clinical services in hospitals, we accept that the shortage of medical manpower will tend to inhibit for some time to come the use of doctors for anything other than clinical work. We also understand that it will take some time for the medical profession to consider our suggestion, although we believe that the climate of opinion is becoming more favourable to it. Nevertheless we think that the logic of our argument that the clinical resources of hospitals would be best deployed if efficiently organised by a full-time skilled medical manager will prevail in the end.

58. We are prepared to agree that it is unlikely that all hospitals providing district services will appoint full-time Directors of Medical and Para-medical Services for 10 years or more. We have therefore considered how such posts might in practice be introduced into the hospital service during the next decade. It is important that those who undertake this work should not be considered as 'failed clinicians'. The aim should be to encourage able consultants who have already achieved eminence in their chosen speciality to undertake such duties. We believe that a number of successful consultants would be prepared to consider such appointments but until their value has been generally accepted would probably only do so on a part-time basis. The best medical committee chairmen and, in teaching hospitals, some deans; are virtually doing the sort of work we envisage already and are well

and because we believe that their value is often overlooked. The Occupational Health Service is concerned with staff only; the Chaplaincy Service with patients and staff. Between them these two services deal with the spiritual, mental and physical needs of the staff, and as such are an important concern of the District Hospital Board both as managers of the District Hospital and as good employers. These, however, are services which are frequently involved with the staff's personal problems. It is essential therefore that they should retain a certain amount of independence and should not be closely controlled by the hospital administration. This is the view expressed by the Royal College of Nursing in their memorandum on occupational health[11] and we agree with it. As we see it, it is the essence of such services that they serve the management indirectly in offering a personal, confidential and independent service to the staff. We expect such views to be reiterated in the report of the Committee of the Central Health Services Council now studying this subject.

64. We envisage the Occupational Health Service being supervised by a specially appointed medical adviser (who would probably be part-time) and coming under the day to day direction of a specially trained nursing sister. The supervisory doctor would obviously need to keep in touch with the Director of Medical and Para-medical Services, the sister with the Director of Nursing. Similarly the Chaplaincy Service would have a connection with the hospital administration through the Director of General Services probably through the chairman of a chaplain's committee. Both services should also have the right of direct access to the General Manager whenever necessary. We have tried to show this in our management organisation chart and have indicated the special indirect relationship of these two services to the administration by using dotted instead of continuous lines.

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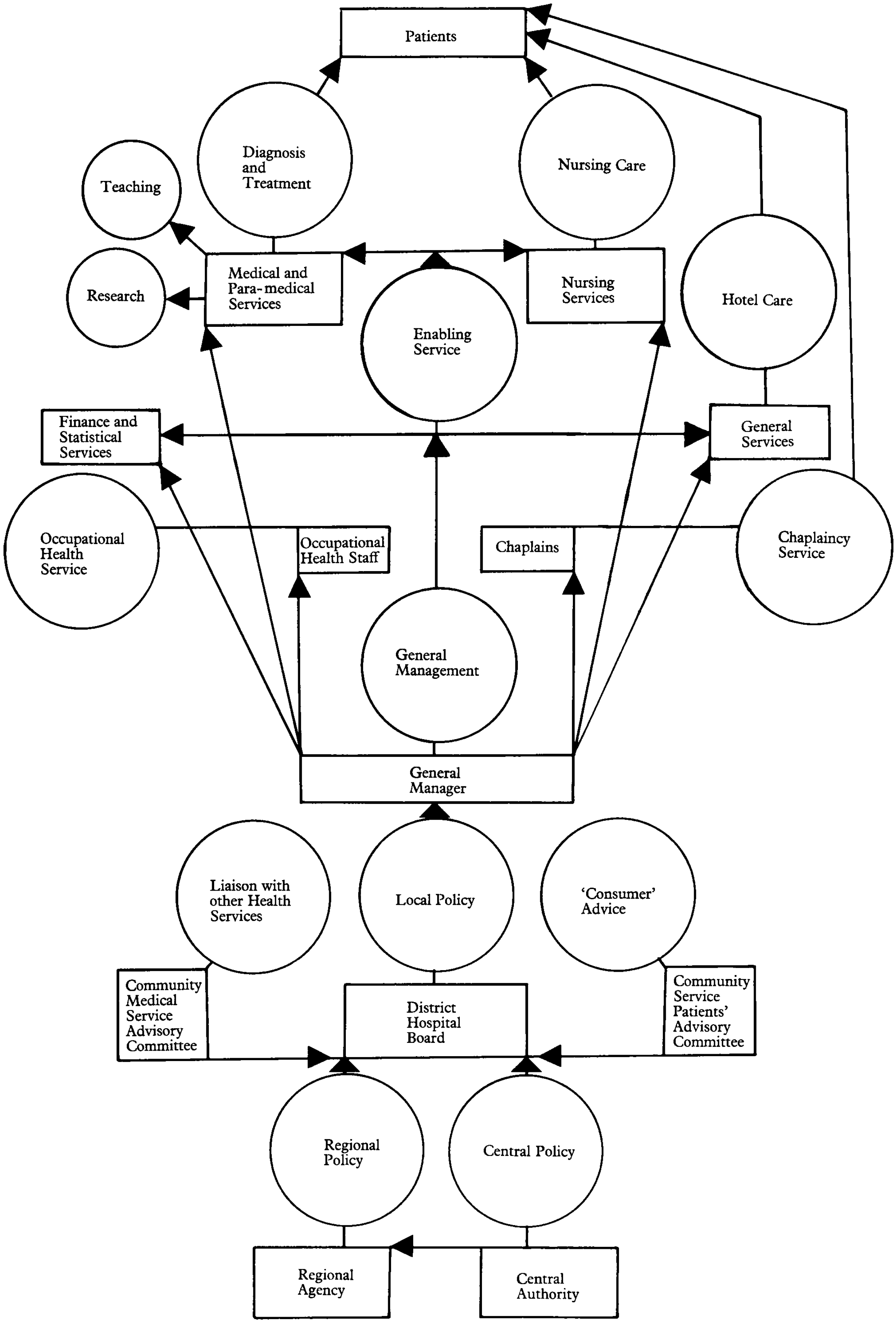
[11] Rcn Occupational Health Committee, <u>A Hospital Occupational Health Service</u>, Nursing Times, 27 November, 1964.

# APPENDIX A.2 FUNCTIONAL ORGANISATION CHART

Circular units represent functions; rectangular units represent the agency which performs the function



aware of its importance. As senior clinicians they have the status and authority to gain the confidence of their medical colleagues. In our opinion other consultants with an interest in administration could be persuaded to follow their example as long as by doing so they could retain a footing in clinical medicine. We believe that such men or women would be acceptable to the rest of the consultant staff especially if the staff had some say in their appointment.

59. We envisage that some appointments of Director of Medical and Para-medical Services will have to be made on a part-time basis to be held by consultants who would also continue to undertake a certain amount of clinical work in their chosen specialties. We wish to stress, however, that in our opinion this should be purely an interim measure and that in due course, in all but the smallest hospitals, this post should develop into a full-time one. We suggest it should be made by the District Hospital Board and that the board should consult the members of its consultant staff when making such an appointment.

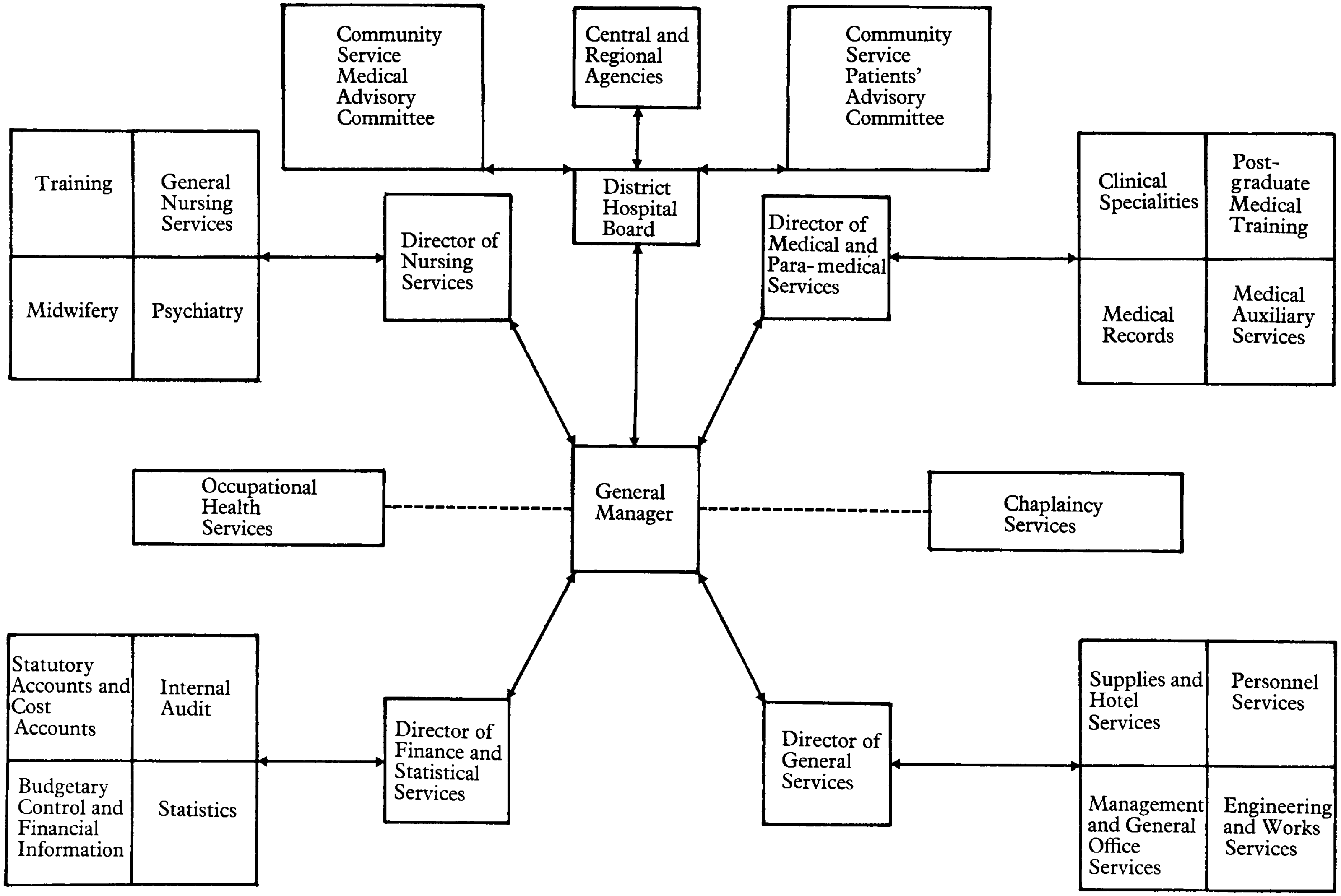
60. Although this director must retain personal responsibility for the control and co-ordination of clinical services he will, in our opinion, need to take the advice of his consultant colleagues on many matters. Such advice will have to come from some form of advisory committee. We have already said that in our view a committee consisting of every member of the consultant medical staff (which might well involve 50-100 people) is likely to be too unwieldy a body to perform this function efficiently. We think that a committee of all the members of the consultant staff in the District Hospital should elect a smaller Hospital Medical Services Advisory Committee from among themselves to advise the Director of Medical and Para-medical Services. This Hospital Medical Services Advisory Committee should probably number between 10-20 people and be made up of representatives of the main groups of medical activity within the hospital. The committee should elect its own chairman.

61. In addition to the help provided by the Hospital Medical Services Advisory Committee, the Director of Medical and Para-medical Services will require adequate administrative support if he is to carry out his duties efficiently. This is of prime importance, for his duties will include not only helping to produce the policy for organising and planning the medical services of the hospital, but also the more detailed day to day ones of co-ordinating those services and providing his consultant colleagues with the necessary information to enable them to run their departments or firms efficiently and to improve their own clinical productivity. This as we see it will mean that the Director of Medical and Para-medical Services must have administrative assistance and an office organisation designed to give him the facts and information he needs.

62. Finally it may be argued that during their careers doctors will not have the opportunity to obtain the necessary experience in administration to fit them for the important post of Director of Medical and Para-medical Services which we foresee. We believe that there will be ample opportunity in the organisation of the clinical services of the District Hospital of the future for the securing of such experience. Numbers of doctors already obtain it to some extent in clinical departments like radiology and pathology and we envisage an extension of such opportunity in, for example, the fields of medical records and post-graduate medical training. In addition, as has been shown in the paper, The Management Functions of Hospital Doctors it is certain that all members of the medical staff in hospitals in the future will be given some form of organised training in the management of the resources which they use.

## Occupational Health and Chaplaincy Services

63. We have included in our Management Organisation Chart two services (the Occupational Health and Chaplaincy Services) which at first sight might appear to be of no direct concern to us. We have made special mention of them because we think them of importance


Community Service Medical Advisory Committee
Central and Regional Agencies
Community Service Patients' Advisory Committee
Training
General Nursing Services
Midwifery
Psychiatry
Director of Nursing Services
District Hospital Board
Director of Medical and Para-medical Services
Clinical Specialities
Post-graduate Medical Training
Medical Records
Medical Auxiliary Services
Occupational Health Services
General Manager
Chaplaincy Services
Statutory Accounts and Cost Accounts
Internal Audit
Budgetary Control and Financial Information
Statistics
Director of Finance and Statistical Services
Director of General Services
Supplies and Hotel Services
Personnel Services
Management and General Office Services
Engineering and Works Services

## APPENDIX B.1

## TERMS OF REFERENCE FOR THE DISTRICT HOSPITAL BOARD

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The members of the District Hospital Board will as such have no executive authority within the District Hospital. All such authority should be vested in the General Manager as the chief executive officer.

Responsible to: The regional agency

Responsibility and Authority for:

1. carrying out its statutory duties;
2. interpreting and carrying out the policy of the central authority and regional agency as it applies to the District Hospital;
3. making representations to the regional agency on policy matters;
4. producing and directing the policy of the District Hospital;
5. receiving reports from the General Manager on the execution of agreed policy as a guide to future policy and considering problems presented to them by the General Manager, including problems of litigation;
6. submitting to the regional agency:
   a) maintenance estimates and 'forward look' estimates in the prescribed form, and subsequently allocating the funds made available;
   b) proposed capital schemes;

7. the employment of all staff;

8. ensuring an effective liaison with the other health and welfare services of the community.

## APPENDIX B.2

## TERMS OF REFERENCE FOR THE GENERAL MANAGER

He* is the chief executive officer of the District Hospital Board.

Responsible to: The District Hospital Board

Responsibility and Authority for:

1. advising the District Hospital Board on the setting of objectives and the formation of local policy within the broad framework of policy laid down by the central authority and regional agency;
2. organising the resources of the hospital so as to achieve the objectives of the District Hospital Board, disseminating the policy of the District Hospital Board throughout the hospital(s) and for reporting to them on the execution of their policy and the results obtained;
3. setting and maintaining the standard of management in all departments of the hospital(s);
4. ensuring that all essential services are maintained;
5. providing opportunities for developing the most senior staff of the hospital(s);
6. creating and servicing all committees concerned with the hospital(s) and supervising their work;

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* The words 'he', 'his' and 'her' are used throughout these Appendices for the sake of brevity and to avoid the use of 'he/she' and 'his/her'. We envisage that all of the senior posts for which terms of reference are given could be held by men or women.

7. ensuring a system of internal and external communications;

8. public relations;

9. the final preparation of estimates and budgets in conjunction with the Directors and for the submission of the budgets to the District Hospital Board;

10. the allocation of funds (with the assistance of Directors) to the departments of the hospital(s) in accordance with the District Hospital Board's policy;

11. providing the District Hospital Board (with the assistance of the Director of Finance and Statistical Services) with the necessary information and advice to allow them to relate overall expenditure to the budget;

12. dealing with official complaints and questions of litigation.

## APPENDIX B.3

## TERMS OF REFERENCE FOR DIRECTOR: MEDICAL AND PARA-MEDICAL SERVICES

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The Director must not normally intervene between doctor and patient. In exceptional circumstances he must take immediate action and report to the Hospital Medical Services Advisory Committee.

Responsible to: The General Manager

Responsibility and Authority for:

A. In relation to the General Manager

1. assisting the General Manager in the formation of policy, including the budget and its distribution;
2. advising the General Manager on all matters within his group;
3. reporting on matters within his group and disseminating within that group knowledge of the policy of the organisation;

B. In relation to his group

4. setting objectives for his group within the policy of the hospital(s);
5. organising the resources available to his group so as to achieve these objectives, including primary assessment of staff needs and final selection of staff under his control;

6. devising and operating means of controlling the activities within his group, setting and maintaining standards and measuring or assessing performance, including where appropriate, research and development;

7. developing the capacity of the staff under his control including all training;

8. providing arrangements for the final selection, the appointment, re-appointment, transfer or discharge of staff in his group within an authorised establishment;

9. the encouragement and implementation of a research and development programme within his group;

10. allocating duties to medical and surgical staff and to para-medical staff as appropriate;

11. postgraduate medical and para-medical training.

## APPENDIX B.4

## TERMS OF REFERENCE FOR DIRECTOR: NURSING SERVICES

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Responsible to: The General Manager

Responsibility and Authority for:

A. In relation to the General Manager

1. assisting the General Manager in the formation of policy, including the budget and its distribution;

2. advising the General Manager on all matters within her group;

3. reporting on matters within her group and disseminating within that division knowledge of the policy of the organisation;

B. In relation to her group

4. setting objectives for her group within the policy of the hospital(s);

5. organising the resources available to her group so as to achieve these objectives, including primary assessment of staff needs and final selection of staff under her control;

6. devising and operating means of controlling the activities within her group, setting and maintaining standards and measuring or assessing performance, including where appropriate, research and development;

7. developing the capacity of the staff under her control including all training;

8. providing arrangements for the final selection, the appointment, re-appointment, transfer or discharge of staff in her group within an authorised establishment;

9. the comfort and welfare of patients generally;

10. organisation of the treatment of patients to doctors' instructions;

11. the encouragement and implementation of a research and development programme within her group.

## APPENDIX B.5

## TERMS OF REFERENCE FOR DIRECTOR: FINANCE AND STATISTICAL SERVICES

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Responsible to: The General Manager (except for item 11)

Responsibility and Authority for:

A. In relation to the General Manager

1. assisting the General Manager in the formation of policy, including the budget and its distribution;

2. advising the General Manager on all matters within his group;

3. reporting on matters within his group and disseminating within that group knowledge of the policy of the organisation;

B. In relation to his group

4. setting objectives for his group within the policy of the hospital(s);

5. organising the resources available to his group so as to achieve these objectives, including primary assessment of staff needs and final selection of staff under his control;

6. devising and operating means of controlling the activities within his group, setting and maintaining standards and measuring or assessing performance, including, where appropriate, research and development;

7. developing the capacity of the staff under his control including all training;

8. providing arrangements for the final selection, the appointment, re-appointment, transfer or discharge of staff in his group within an authorised establishment;

9. the collection and dissemination of relevant financial and statistical data throughout the hospital(s) to enable management to make the most efficient use of present resources and to lead naturally to the formation of budgets and future policies;

10. quantitatively measuring the performance of all groups of the hospital(s) and for ensuring that the Directors of those groups are kept fully informed so that they can compare achievements with targets in pursuance of maximum efficiency;

11. ensuring the security of the Board's assets and the collection of all income receivable; the maintenance and completion of all financial accounts and records required by the Board or the central authority, and the submission of such accounts to the Auditors; reporting direct to the Board on all matters of finance;

12. providing Financial Information Services.

## APPENDIX B.6

## TERMS OF REFERENCE FOR DIRECTOR: GENERAL SERVICES

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Responsible to: The General Manager

Responsibility and Authority for:

A. In relation to the General Manager

1. assisting the General Manager in the formation of policy, including the budget and its distribution;
2. advising the General Manager on all matters within his group;
3. reporting on matters within his group and disseminating within that group knowledge of the policy of the organisation;

B. In relation to his group

4. setting objectives for his group within the policy of the hospital(s);
5. organising the resources available to his group so as to achieve these objectives, including primary assessment of staff needs and final selection of staff under his control;
6. devising and operating means of controlling the activities within his group, setting and maintaining standards and measuring or assessing performance, including where appropriate, research and development;

## [illegible]ENDIX B.6

## [illegible] OF REFERENCE FOR DIRECTOR [illegible]

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**<u>Responsible to:</u>** The General Manag[illegible]

**<u>Responsibility and Authority for:</u>**

A. <u>In relation</u> [illegible]

1. assisting the [illegible] formation [illegible] budget and [illegible]

2. advising the [illegible] matters [illegible]

3. reporting [illegible] and dissem[illegible] knowledge [illegible] organisat[illegible]

B. <u>In relation</u> [illegible]

4. setting [illegible] the policy [illegible]

5. organising [illegible] his group [illegible] objectives [illegible] ment of st[illegible] of staff [illegible]

6. **devising** and [illegible] **controlling** the [illegible] **group**, setting and [illegible] **standards** and [illegible] **performance**, including [illegible] **appropriate**, research and d[illegible]

7. developing the capacity of the staff under his control including all training;

8. providing arrangements for the final selection, the appointment, re-appointment, transfer or discharge of staff in his group within an authorised establishment;

9. the encouragement and implementation of a research and development programme within his group;

C. <u>In relation to the organisation as a whole</u>

10. providing the following:

Supplies and Hotel Services
General Administrative Services
Personnel Services
Management Services
Engineering Services

# APPENDIX C
# COMPUTERS IN THE HOSPITAL SERVICE

By 1980 we shall be using computers extensively throughout the hospital service, not only at the Ministry of Health and at Regional Hospital Boards, but also in hospitals. Some accounting work, including the preparation of staff pay-rolls, is already being done by this means and the use of computers in the financial field is bound to increase. It will be some years, however, before the necessary computer programming and systems analysis are undertaken to allow the accurate, speedy and detailed costing of a hospital's many and varied activities. Within 15 years we should be well on the way to doing this.

During the same period computers should do much to improve communications and methods of recording, especially in the treatment of patients. Within 10 years we can expect most of the information which we have to keep to be stored in a computer with the result that little, if any, will be recorded on paper apart from the output of the computer itself. Photographic records, such as x-rays, will probably remain the exception for some time, but in due course even these will be dealt with by computer systems.

Ready access to and easy permutation of this mass of medical information should improve treatment for the patients and produce advances in medical and nursing techniques. Medical practice must change as a consequence, and a great deal of traditional practice of medicine will disappear during the next 15 years to be replaced by new procedures designed to take advantage of the advances which computers offer. However, computers have their limitations: when they work with them, doctors will have to be more imaginative in their approach to problems and will have to accept greater standardisation in their methods of collecting medical information.

In the clinical laboratory methods of obtaining and recording data will undergo a transformation when, for the first time, it will be possible to analyse some of the hundreds of thousands of pieces of information that the laboratory handles. The introduction of automated equipment will mean a considerable reduction in the numbers of technical and clerical staff at present working in the laboratory field.

Nursing will also undergo a revolution comparable with that which must take place in medicine. The actual care of the patient and the giving of drugs will be affected just as much as the administration of the nursing service. We suspect that much more bedside monitoring of patients will be done and that the work of the nurses will be affected by other new developments in the fields of physics, nuclear physics and biochemistry.

The steady provision of information of all kinds is bound to concern hospital administrators. Accurate audits of clinical and non-clinical departments should be possible when the correct types of systems analysis have been worked out. This sort of investigation is already being undertaken in the business world.

By the 1980s, closer links will certainly be developing with the public health service and with community medical care. A universal national health number for everyone in the country should have been introduced by then, which should make it possible to maintain a complete medical record of every individual, which would include information on preventive medicine (immunisation, vaccination, etc.) as well as that provided by general practitioners and hospitals.

This will mean, of course, that there will have to be community banks of information in large computers. The kind of computer and the size of the communications system necessary to deal with this

has not yet been built. To a great extent the expansion of the system will depend not only on the development of new 'hardware' (i.e. the computer equipment) but also of the necessary 'software' to provide the intercommunications programmes inside the computer. At present it would be only fair to say that 'real time' computing is not really a going concern and there are few systems which have proved themselves on a scale suitable for hospitals. Only those actually engaged in programming and systems analysis fully comprehend that advances in this area are of necessity slow; that a great deal of skill and judgement is needed to develop any new system; and that the large systems for which we are asking in the health service are extremely complex and difficult to produce.

It is important to realise that the advent of computers in hospitals will make greater demands than now on the skill and judgement of doctors, nurses and administrators. Computers can only store, provide and interpret information according to the programmes created for them by men and women. The administrator, for example, will probably need to know little about the processes which go on inside the computer. He will have technical staff to deal with this for him. But he will be called upon to exercise new skills both to see that the correct information is gathered and processed also to interpret and use it wisely when it is provided for him. It is in these areas of skill and judgement that a great deal of training will have to be devoted if we are to be successful. One would anticipate, for example, that with more sophisticated information and quicker communication, administrative efficiency should be increased which in its turn should allow more patients to be treated more cheaply. In some ways the development of computer techniques in the coming years may lessen the responsibilities of District Hospitals and highlight the need for total community care of patients. Certainly by 1980 medicine and nursing will have become more versatile and the distinctions between hospital care and care within the community much less sharply defined.

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