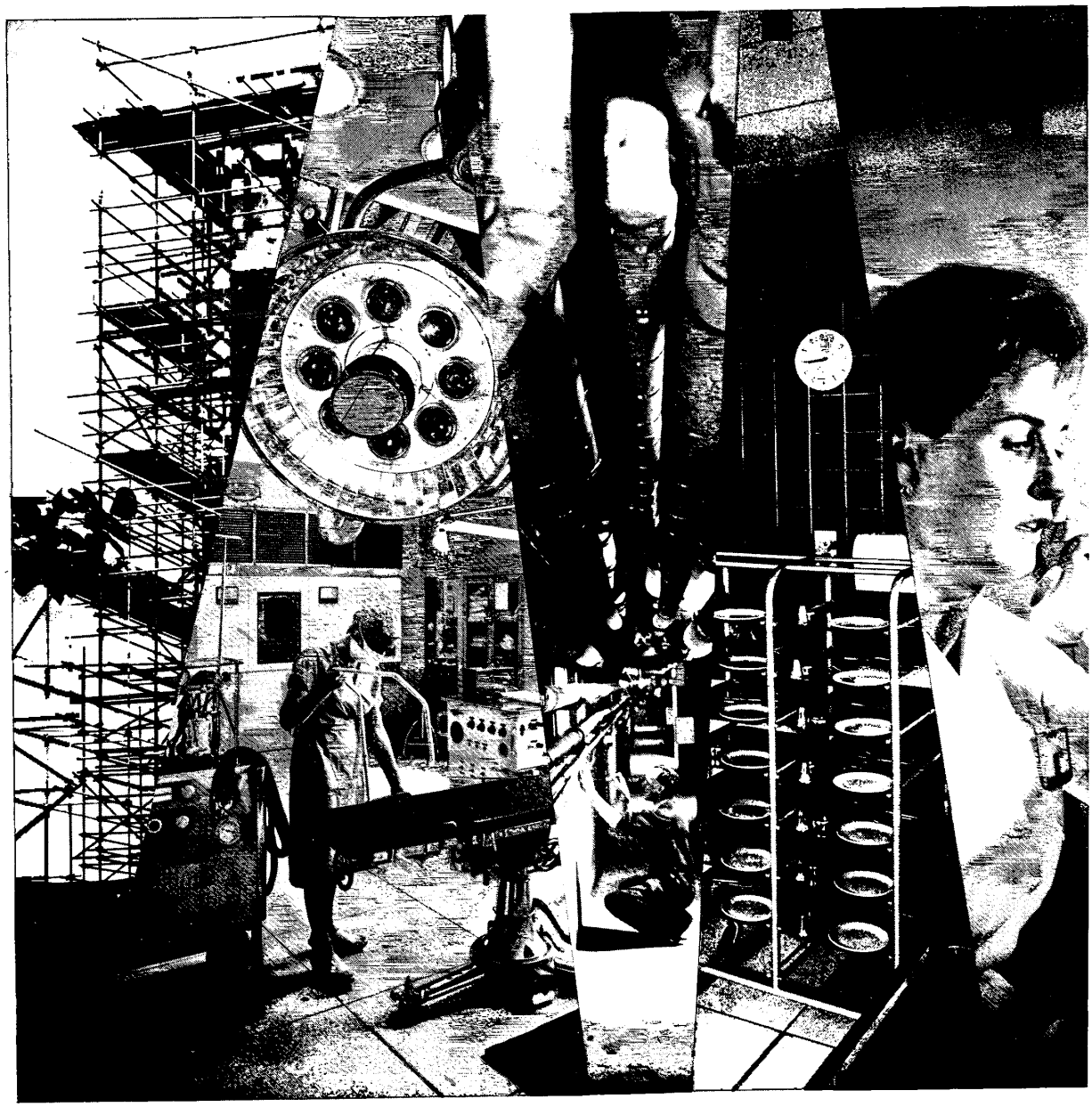
A King's Fund Report

Commissioning New Hospital Buildings



King Edward's Hospital Fund for London

14 Palace Court London W2
Telephone: PARk 0581

Commissioning New Hospital Buildings

Commissioning New Hospital Buildings

The report of a King's Fund Working Party intended to help hospital authorities in tackling the problems of equipping, staffing and commissioning new hospital buildings

Published by King Edward's Hospital Fund for London 1966
Price: Fifteen Shillings

Members of the Working Party

Captain A Lade OBE RN *Chairman*
Miss Anne M W White SRN SCM RFN
Mr P H Constable OBE MA FHA
Mr B W East ARIBA
Dr J A Oddie DSC MB BS
Mr Brian Langslow FHA *Secretary*

Chairman's Foreword

The number of new hospital developments is increasing and a report on the problems of equipping, staffing and commissioning is opportune. The Fund was pleased to agree to the suggestion made by the Ministry of Health that a report should be prepared to assist hospital authorities in tackling commissioning problems. A working party was set up in September, 1965. As the commissioning of hospital developments is no more amenable to hard and fast rules than is their subsequent management, this report should be regarded as a guide; its conclusions and advice will not be universally applicable without qualification.

No mention of evaluation studies has been made in the report, but an assessment of design in use ideally should follow after the hospital has been at work for about eighteen months. It would also be of benefit if, in the future, the effectiveness of the commissioning arrangements themselves could be assessed.

As experience in hospital design increases, as equipment and methods of working develop and alter, so will the process of commissioning need to be re-examined. This document should not, therefore, be regarded as a once-for-all guide to commissioning but, rather, as a working paper, which will need to be reviewed and amended in the light of experience.

The working party have gratefully acknowledged in the report their indebtedness to the many sources of information which have been used in its preparation. They would also like to place on record their high appreciation of the work of their secretary, Mr. Brian Langslow, who has collated these many sources into what they hope will prove a useful and readable guide to those embarking on the rewarding task of transforming bricks and mortar into a 'living hospital'.

October 1966

A. Lade
Chairman

S

1

2

3

4

5

6

7

8

9

1

A

A

B

C

D

E

F

G

H

I

Contents

When we mean to build,
We first survey the plot, then draw the model;
And when we see the figure of the house,
Then must we rate the cost of the erection;
Which if we find outweighs ability,
What do we then but draw anew the model
In fewer offices, or at least to desist
To build at all?

so as not to be

Like one that draws the model of a house
Beyond his power to build it; who, half through,
Gives o'er and leaves his part-created cost
A naked subject to the weeping clouds,
And waste for churlish winter's tyranny.

Henry IV, Pt. 2, Act 1, Scene 3.

1 Introduction

1.1 In this report the term commissioning is used to describe the process of bringing a building into use and relates to all activities directed to that end, including equipping and staffing. It is considered unhelpful and unnecessary to attempt to define precisely where commissioning starts and where it finishes. Commissioning emerges from planning and merges into operation; the three are inter-related. In general, it can be said that *commissioning* decisions relate to operation as *planning* decisions relate to design.

1.2 The purpose of this report is to give help to hospital authorities in tackling in a rational way the problems of commissioning new hospital buildings. The King's Fund feels that advice on the subject will be welcomed by hospital authorities; a view confirmed by discussions during its preparation.

1.3 It is important that commissioning should not come to be regarded as a mystique, the practice of which calls for the creation of a new sort of specialist. The need to set the commissioning process in perspective has been well put:

> It may be difficult at this early stage of the development to think seriously of work which will have to be done in several years' time, but unless the project is seen as a whole, building, equipping and commissioning, there is a danger that work which is vital to the ultimate success of the new hospital may be forgotten or go by default in the pressure of current affairs. By seeing it as a whole and recognising the scale and complexity of all that has to be done during the next six or seven years, we are more likely to ensure that the project moves smoothly from stage to stage up to the last stage of opening and subsequent assessment. [1]

1.4 The object of all activities concerned with the planning, building and commissioning of a new hospital has been defined as follows:

> A well planned and well built hospital which is also well managed, efficiently organised and economically maintained: medical and nursing staff able to devote themselves fully to the care of patients because they are relieved of the irritations and frustrations which arise from inadequate organisation and unnecessary and unrewarding non-clinical procedures: supporting staff of all kinds instructed as to their duties and aware of their responsibilities and the part they play in the work of the hospital as a whole. [1]

1.5 To the aims of efficiency and economy it should be possible to add, without debate, the aim of humanity. 'A successful hospital must primarily be a human institution.' [2]

1.6 This definition emphasises immediately the close relationship which exists, or ought to exist, between the planning of a new hospital and its subsequent operation. Planning decisions must be based on a knowledge of operating intentions. The all-important link between the two is the process of commissioning, by which is effected, within as short a period of time as practical, the transformation of an empty shell into an effectively functioning hospital.

1.7 The principles of commissioning are the same, whether applied to new hospitals, new departments or re-developments, though the range of activities naturally varies. Except where otherwise stated, it is the commissioning of a new hospital on a new site which is considered in this report. Phased schemes of re-development present organisational problems in maintaining services during periods of transition from old to new buildings.

1.8 Similarly, the way in which the commissioning process itself can best be managed will vary from place to place depending, *inter alia*, on whether the new hospital is to be administered by a hospital management committee or a board of governors, and on the capacity and aptitudes of the available staff.

1.9 This is a time when long accepted patterns of hospital management are undergoing reappraisal and consequently the traditional titles of matron and secretary no longer have the same universal application as hitherto. In order to avoid ambiguity therefore it should be explained that in this report the term 'administrator' means the officer responsible to the group secretary or secretary of the board of governors for the day-to-day administration of a hospital. In some cases he may also be the group secretary or the secretary of the board of governors. He may be known by other titles such as hospital secretary or, usually in teaching hospitals, as house governor. 'Matron' means the officer responsible for the nursing administration of a hospital.

1.10 A separate series of documents is being produced by the Ministry of Health on the commissioning of the engineering services which is an important aspect of the entire commissioning process. In view of this fact and the technical nature of the subject, it is dealt with in this report only from the point of view of its integration with the commissioning programme as a whole. It should be noted that the term 'engineer' in this report refers to the officer responsible for the maintenance of engineering services of a hospital. He may be designated group engineer or hospital engineer.

1.11 Writing about a complex subject, and commissioning *is* a complex subject, inevitably presents the choice of dealing in a general way with the points which from experience can be identified as critical to success, or of writing in more detail, and at correspondingly greater length, for the benefit of those actively engaged in the work. The working party has taken the view that the extent to which local situations alter circumstances makes it necessary to deal with most aspects of the subject in general rather than in particular. Nevertheless, where detailed information seemed appropriate, this has been included in appendices. This is essentially a practical subject varying in detail from one place to another by virtue of differences in organisation and personalities. Writing about commissioning is rather like writing about swimming – it is possible to set out some principles and give advice but in the final analysis the only way to achieve proficiency is to jump in and do it!

1 Luton and Hitchin Hospital Management Committee, *Commissioning the New Lister Hospital – A Preliminary Appraisal of the Task,* 1963.

2 Oxford Regional Hospital Board, *Commissioning a New Hospital,* 1961.

2 Relationship Between Briefing, Designing and Commissioning

2.1 The five principal stages in the process which starts with the idea of building a hospital and ends with a building in which the objective defined in the introduction is being achieved (or partially achieved) are:

Brief
Design
Build
Commission
Operate

2.2 All these stages overlap to some degree. In particular, there is continuing inter-action between the brief and the design. A successful design, and consequently the efficient operation of the hospital, is dependent to a large extent on the quality of the brief. Similarly the commissioning process will be made easier, or more difficult, by decisions taken, or not taken, in the brief for the building or during the stages of design.

2.3 A good brief depends in large measure on good operational planning. A sound approach to hospital operational planning has been made in the United States:

> Before an architect can develop a hospital design that will best serve its functions, he must be provided a written program explaining in clear and precise terms the hospital's objective, plan of operation and operational policies, particularly those which must be related to the design of certain areas. The responsibility for preparing such a written presentation and for co-ordinating the planning activities of professional and technical personnel rests ultimately with the hospital administrator or the building committee.
>
> The functional program should explain as fully as possible the services to be provided, the functions to be carried out, the methods to be used, the personnel needed, the working relationships to be developed, and the major equipment required.
>
> In addition to its function as a guide to the architect in designing the hospital, a written program can serve as a permanent record of the original planning and can help simplify the work in future operation. It can be used in orienting hospital administrative staff to the system of operation planned. It also furnishes a basic reference for selection of equipment that promotes the most efficient operation of the hospital, and for necessary continuing evaluation. 3

2.4 This philosophy can well be an attainable ideal when the whole exercise, from briefing to completion of building, is completed within a period of 3 to 5 years, which is the usual pattern in the United States. Where the planning process is extended in time, however, a variation of approach is necessary albeit with the same final object.

2.5 When planning starts, the date on which the hospital will open is usually tentative; it will usually be not less than 5 years hence and may be more. It is not only difficult, but undesirable, to attempt to settle at this stage the details of the way in which the hospital will work. Changes in methods and equipment are certain to arise before completion of the building and, more important, an attempt to set out in precise detail the way in which the building is to be operated will tend to encourage an inflexible design which can only be used in one way. During the early stages of planning, therefore, operational policies should not attempt to do more than provide answers to the questions which the architect will need to ask in order to produce a design suited to the functions required of the building.

2.6 The refinement and detailing of these *outline* operational policies should be related closely to the developing design, each conditioning and constraining the other. The details which will affect only the operation of the hospital and not the design, should be worked out during the final two years of building, and these operational policies must be completed by the time the building is handed over. It will then be necessary only to add the procedural and administrative details required to give effect to the agreed policies. The need to do more than this at such a late stage, the period between the handing over of the building and the admission of patients, will invite either a breakdown of effective organisation or a breakdown of the staff or both.

2.7 An example of operational planning in outline, primarily for planning purposes, is provided in the Leeds Regional Hospital Board document, *Application of the P.G.H.600 Project at Eastburn* (available through the King's Fund Hospital Centre's package-library service). An example of operational planning in detail, primarily for management purposes, is the operational policies for the new Royal Cornwall Hospital (Treliske), Truro. The latter are referred to in 7.6.

3 U.S. Department of Health, Education and Welfare, *Programing and Equipping Hospital Departments,* Publication No. 930–D–14, 1963.

3 Management of the Programme

3.1 The opening of a new hospital is a complicated exercise and calls for adequate planning and control of the commissioning programme. It is impossible to draw up a timetable for the programme as a whole which will be of universal application. However, an attempt has been made to set out the principal steps which will be common to most commissioning exercises and to relate them, albeit tentatively, to the calendar, see Appendix A.

3.2 The main components of commissioning are shown diagrammatically in Appendix B.

3.3 The Wessex Regional Hospital Board has divided the commissioning operation for the new District General Hospital at Poole into nine main 'streams', see Appendix C, and is using network analysis extensively for control purposes.

3.4 As well as planning and control, a commissioning programme demands adequate supporting staff. The sheer volume of work involved in opening even a small hospital or new wing is often not appreciated until too late, see 3.11.

3.5 Opinions differ as to whether commissioning is primarily an aspect of management or of planning. This question is important only in so far as it influences views on the questions: 'Should commissioning be undertaken by those who have planned the building, or by those who will run the building?' and 'Should there be specialists in commissioning?'

3.6 It is impossible to give an unqualified answer as to whether commissioning should be undertaken by the planners or the future managers. It is suggested that usually both will have a part to play and it is important to delineate their respective roles and to define which matters during the overlap period will be dealt with by the project team and which by the commissioning team. Since the liaison between the two must be close and there will be a good deal of dual membership this should not be difficult. The principal change will probably be in the leader of the team, though in some cases this will be the same person. Similarly, as the work of planning merges into that of commissioning, the balance between the influence of the regional hospital board and that of the hospital management committee will usually shift towards the latter.

3.7 The establishment of a speciality in commissioning is not recommended. This does not refer to the engineering services which should be brought into use by a commissioning engineer independent both of the design engineer and the group (or hospital) engineer. Even if the hospital is to be on a new site it will almost certainly form part of an existing group, thus having an effect on other hospitals within the group. A detailed knowledge of local circumstances, problems and personalities, and the respect and trust of senior staff, are such vital ingredients in the make-up of a successful 'commissioner' that they may be considered of overriding importance, and generally exclude, except in a supporting role, the employment of commissioning experts who would remain in the local situation for only a short time and then depart to the next assignment. It is clear, nevertheless, that commissioning is a subject which needs expertise and it should be possible for regional boards to arrange for a feed-back of experience from officers who have been involved in commissioning hospitals in their regions. More inter-regional co-operation in this field would be beneficial to the hospital service as a whole.

3.8 The establishment of regional or inter-regional teams or panels, which would include people with experience of commissioning in all its aspects, to advise and assist groups involved in commissioning, is worth consideration. The excellent experience which opening a new hospital provides for young administrators makes an authority commissioning a hospital an ideal one in which to designate posts for planned movement.

3.9 The key advance appointments are those of the administrator, the matron and the engineer. They all have major roles to play in commissioning and should be in post not less than two years prior to the expected building completion date.

3.10 The commissioning team *must* include:

the hospital administrator, who should normally have responsibility for the overall management of the commissioning programme and may therefore act as chairman of the team;

the matron, who will be setting up the nursing administration and procedures;

the engineer, who will have to operate certain plant well in advance of the hand-over of the building and

will accordingly have to recruit and train staff early in the programme;

a representative of the senior medical staff, concerned with the new hospital, who can take decisions on behalf of his colleagues in working out the medical policies (to allow him time for this work, the appointment of a *locum tenens* to cover some of his normal duties during periods of intensive activity may be necessary);

a representative of the treasurer to advise on the revenue implications of commissioning decisions;

a representative of the architect who should ensure that the necessary close liaison between the progress of the building and the commissioning programme is maintained.

In forming some policies, for example, control of infection, the team will also require specialist medical advice which can be obtained by co-option.

3.11 The team will need supporting secretarial and clerical assistance. The number and type of staff needed will naturally vary according to the size of the project and the local administrative arrangements, but for projects costing over £2 million the team will certainly need two full-time administrative assistants.

3.12 The commissioning timetable is a complex affair and a change in any part of it is liable to induce a chain reaction. It is therefore imperative that the anticipated completion date of the building, to which the whole of the commissioning programme is geared, is calculated as accurately as possible. This is not easy as the completion date is influenced by the efficiency of the contractor and sub-contractors, weather conditions, unexpected site difficulties and delivery of materials. Experience has shown that the anticipated completion of large building contracts can be delayed by a year or more beyond the original forecast.

3.13 It must be the architect's responsibility to keep the commissioning team regularly informed of the progress of building and the realistically estimated completion date. The timing of the advertising and training programme for staff will be influenced by this advice and may have to be reviewed frequently as the completion date is approached. It is essential to avoid the situation of having appointed a large number of staff too soon. This leads to frustration, a lowering of morale and can mean loss of staff. Not less than four months before the anticipated completion date the architect should issue an advance completion notice to the hospital authority.

3.14 The actual process of moving into the building and, if it is replacing existing accommodation, of moving patients, calls for close co-operation between all staff concerned and for detailed preparatory planning and consultation to ensure that everyone knows what has to be done and when. [4] [5] A military style movement order is appropriate for this operation; an example of what should be included is given in Appendix D.

3.15 To sum up, however carefully and comprehensively the commissioning programme is planned in advance it will not be successful unless it is properly managed and backed by sufficient staff. It must also be recognised that commissioning a hospital demands a flexible approach and a readiness and ability to improvise when necessary. Temporary arrangements will often have to be made to deal with contingencies for which it has been impossible to plan.

4 Knowland, R. W. *The Commissioning of New Guy's House,* The Hospital, January, 1963, p.5.

5 Hull (A) Group Hospital Management Committee, *Commissioning Programme – The New Hull Royal Infirmary,* 1965.

4 Equipping

4.1 Ministry of Health Equipment Note No. 1 gives guidance on how equipment schedules for individual building projects might be prepared, and classifies equipment into three groups. [6]

4.2 The principal stages in the equipping programme may be summarised as follows:

4.2.1 preparation of room data sheets which relate equipment of all groups to their environment at the outset

4.2.2 preparation of separate equipment lists which show requirements in each group as

(a) 'subjective' list of items under rooms and departments

(b) 'objective' list of items showing total number required of each

(items for transfer should be included)

4.2.3 preliminary equipment cost statements

4.2.4 market research

4.2.5 type selection and variety reduction

4.2.6 cost review and control (including final capital cost limit for equipment)

4.2.7 final selection

4.2.8 tenders and quotations

4.2.9 order

4.2.10 reception and storage

4.2.11 placement

4.2.12 initial inventory

4.2.13 maintenance

4.2.14 assessment (both of fitness for purpose and of need)

4.3 It is important that ample time is allowed for the lengthy process of equipping a new hospital and this should be programmed, see Appendix A. The arrangements to be made for equipping, from the time the orders have been placed to the end of the operation, may justify a separate timetable, especially if transfer of equipment from an existing building is involved. [7]

4.4 Ideally, the officer to be responsible for equipping should be involved in the planning discussions on equipment from the start, that is, from the preparation of room data sheets onwards.

4.5 During the progress of the equipment programme there must be close liaison with the treasurer's department so that provision for expenditure on equipment is made in the years appropriate to the planned timing of deliveries. These may well spread over two or more financial years.

4.6 In order to discourage over-provision in the schedules a financial reserve should be made to deal with the later purchase of equipment found to be necessary after the building is brought into use.

4.7 To assist hospital authorities in the selection and purchase of equipment a number of working groups were set up by the Ministry of Health to study major items of non-medical supply. The general aim of the groups is 'to define functional requirements and user needs; to consider how far these are met by existing equipment; to formulate specifications as necessary and practicable, and to recommend the most desirable method of purchase.' [8] The work of these groups will reduce the extent to which individual authorities have to go through the lengthy discussions, consultations and trials which lead to specification. A list of appointed and contemplated specification working groups is included in Appendix E.

4.8 It is clear that the size of the task in compiling the necessary schedules, by room, by item, by expenditure head, makes it particularly suitable for some form of mechanical aid. Several authorities have used punched cards for this purpose. [9] The North West Metropolitan Regional Hospital Board is using a computer in connection with the equipping of two major projects. [10] The possibilities which exist for applying computer programmes to any number of equipment projects call for close examination. If mechanisation can be introduced to reduce the laborious and time-consuming task of compiling schedules, costing, tendering and ordering, more time will be available for hospital authorities to carry out research into improved design of equipment. It is important that such design enquiries should be as broadly-based as possible and the results made available for general use rather than related only to

individual schemes. But given this approach and the free dissemination of ideas and information, there is much that individual hospital authorities can do to supplement the work of the specification working groups and to help to guard against the 'danger of rigid uniformity in that it stultifies new ideas'. [11]

4.9 The planning of the fixed equipment, Groups 1 and 2(a), which should have been undertaken when room data sheets were prepared, has important consequences in later commissioning and operation as the *Report on the Commissioning of Princess Margaret Hospital, Swindon* makes clear, see Appendix F. In order to maintain clear definition of responsibility it is advisable to allow the building contractor discount for handling items of equipment which he is to fix but are to be supplied by the hospital authority. Unless this is done, the contractor will be able to avoid responsibility for checking quantity and quality and for safe storage.

4.10 A scheme of decoration is more likely to be successful if it is seen as a whole, from wall colours to chair coverings, by one person, experienced in design, than if it is the result of a committee decision. [12] It is suggested that the selection of colour schemes, soft furnishings, chair covers and the like, can best be dealt with either by the architect or a specialist member of his team or by the employment of an independent design consultant. The appointment of a design consultant sometimes responsible to the architect, sometimes direct to the hospital authority, has produced good results in many places. If such an appointment is made it must be at an early planning stage and it must be remembered that furniture, furnishings and equipment for hospitals must meet unusually demanding criteria. In addition to satisfying, within the cost allowed, the requirements of function, durability, ease of cleaning and servicing, and good appearance, they must also be capable of economic replacement at a later date. This is not always easy when smaller numbers than those originally ordered may be involved. It is important that the terms of reference for such an appointment should be clearly drawn. Appendix G gives, as an example, the terms of reference which were used for the appointment of a design consultant in the Oxford region.

4.11 It is not proposed to detail here a model purchasing procedure. This is a separate subject and procedure for specification and tendering will vary in each area. Group purchasing arrangements will also influence the methods used.

4.12 A common commissioning difficulty arises from the fact that suppliers of furniture and equipment often require longer to deliver than they state when quoting. Due allowance must be made for this in timing the placing of orders and a firm procedure for following up all outstanding orders should be worked out and carried through.

4.13 A factor operating in the reverse direction is delay in completion of the building. If it is intended to receive furniture and equipment directly into the building it is necessary to ask suppliers to hold items after they are ready for delivery and until the building has been handed over – perhaps a period of months. It is not satisfactory to have to do this and there are strict limits to the extent to which firms can co-operate In this way.

4.14 A more satisfactory alternative is for the hospital authority to provide an area for temporary storage by the early hand-over of a suitable section of the building, see 6.8; by building a temporary structure; or by hiring warehouse space.

4.15 Arrangements of this sort, which make it possible to take delivery of furniture and equipment prior to the handing over of the main building, reduce materially the period required to make the building operational. The fitting out stage becomes merely a porterage exercise and, given an adequate number of temporary porters, can be completed in days instead of a period of weeks during which suppliers are making deliveries. It spreads the load on the receiving section of the supplies organisation and it also provides an opportunity for all items to be labelled with their room number while in store (use of colour codes can be helpful here). It is most important that any areas used for the temporary storage of furniture and equipment are adequately heated and secured: the appointment of a night watchman or the employment of a security company should be considered. Access to the storage area, if this is in the building and taken over in advance, must be planned: use of corridors and lift must be agreed with the contractor.

4.16 Arrangements must be made to see that goods

are properly checked on delivery. Large bales, for example, those containing sheets, can be checked by weight to avoid unpacking. For 'technical' equipment it is a good plan, if possible, to designate a room in which such items can be held until inspected and certified correct by the departmental head concerned. There must, however, be no delay in checking goods for both quality and quantity if discounts for prompt payment are not to be lost.

4.17 Provision should be made in the bills of quantities for builders' work in attendance for the installation of diagnostic x-ray and radiotherapy equipment. If possible, an early hand-over of the departments concerned should be arranged. If this is done, the contract must make provision for terminal boxes to be ready for connection and for heating to be available at the appropriate time.

6 Ministry of Health, *Hospital Equipment Note No. 1,* H.M.S.O., 1962.

7 Hull (A) Group H.M.C., *The New Hull Royal Infirmary – Equipment Programme,* 1965.

8 Ministry of Health and Scottish Home and Health Department, *Hospital Equipment Information,* 57/63.

9 Rhoden, J. K. *Use of Punched Cards in Equipping a New Department,* The Hospital, September, 1963, p.549.

10 Croot, E. *Capital Equipment Tabulation and Costing with the Use of a Computer,* The Hospital, April, 1966, p.163.

11 Leeds Regional Hospital Board, *Equipment and Furnishings for Hospitals,* 1963.

12 Oxford Regional Hospital Board, *Commissioning a New Hospital,* 1961, p.51.

5 Staffing

5.1 Estimates of staffing requirements must be made at an early planning stage as a part of the calculation to establish the approximate running costs for the new hospital. It is clearly impossible to make close assessments of staffing needs several years ahead. Nevertheless, because of the important bearing of numbers of staff both on running costs and on the planning of many of the service departments, residential accommodation and training facilities, it is important that these estimates should be formulated as carefully as possible.

5.2 There is no national formula for calculating staff establishments. Formulae for the calculation of nursing establishments have been evolved by some regional boards and a recent report of the Ministry of Health includes suggestions on this matter for purposes of costing. [13] A joint working party of King Edward's Hospital Fund for London and the Royal College of Nursing has recently published a *Memorandum on Nursing Establishments.* [14] This guide does not contain calculated nursing establishments, but should be helpful to nurse administrators in considering the factors to be taken into account in working out nursing establishments. Although nurses are by far the largest single category of staff, their establishment cannot be considered in isolation. In assessing the establishment for in-patient departments, for instance, it is important to consider the ward team as a whole. [15]

5.3 These early calculations will have been made and money provisionally allocated long before the commissioning team starts to work. As commissioning proceeds, however, the preliminary establishment must be regularly reviewed and amended to incorporate new information as the operational policies become more detailed and to reflect the effects of Whitley agreements on hours of work. The services of a work study officer should prove invaluable during the time that detailed methods of working are being formulated. [16]

5.4 A reserve, from which can be financed additional appointments found to be necessary after the opening of the hospital, will reduce the tendency to over-estimate the establishment at the outset.

5.5 In the case of a non-teaching hospital, the training and induction programmes can best be organised by collaboration between the regional board training

officer and officers of the hospital management committee. The provisional training programme established for the new hospital at Poole in the Wessex region is included in Appendix H.

5.6 The importance of induction programmes for all new members of staff cannot be over-stressed and the turnover of staff will require this to be a permanent aspect of the personnel policy. Close attention should also be given to in-service training for such staff as clerks, cooks, porters, domestics and those who perform a wide range of non-nursing duties in the ward, described by a wide range of titles which include nursing assistants, ward clerks, ward receptionists, ward messengers, ward waitresses, ward catering assistants, housekeepers, hostesses, ward aides, ward orderlies, domestic assistants, domestic aides. This, in turn, emphasises the need for adequate courses for those who will be responsible for staff supervision and job training. These might well be on the lines established for training within industry for supervisors. [17] Arrangements should also be made for continuation courses, for example, study days, after the hospital has been opened.

5.7 Perhaps even more important is to arrange for re-orientation programmes for existing staff. There is a tendency for such staff to regard a new hospital or department as merely a new environment in which present methods and procedures will be continued. In many cases existing staff will have become conditioned to out-moded and inefficient procedures which they have been compelled to adopt because of their existing out-of-date accommodation. These staff will need considerable sympathy and tact if they are to be persuaded to operate their new department in the way in which it was designed to be used.

5.8 Nurse training must be considered at a very early stage of planning. If a school of nursing is to be established, it may be necessary to open the teaching department in advance of the new hospital so that students and pupils can begin their training prior to its opening. If this is not possible, their training may have to be undertaken in association with existing hospitals so that a number of nurses can be registered or enrolled by the opening date. In any event liaison with existing hospitals will be necessary for the practical training of students and pupils. Discussion should take place with the General Nursing Council at an early stage so that approval for temporary arrangements can be obtained.

5.9 The staffing programme should be carefully planned and must be co-ordinated with the training programme. The staffing programme for the new Hull Royal Infirmary illustrates the way in which the timing of appointments must be geared to the training arrangements. [18]

5.10 The timing of the recruitment of heads of departments and members of their staffs is critical. The administrator, matron and engineer will have been in post long since and there will have been a few advance appointments, for example, of engineering staff to operate plant necessary to heat storage areas. But the main recruitment campaign will start about four months before the hand-over of the building with the appearance of advertisements for heads of departments. At this point effective communication between the architect and the hospital authority is vital. If the architect has any reason to think that the completion date will not be achieved he must not hesitate to make it clear now, so that the hospital authority can, by adjusting the timing of appointments and training programmes, avoid the unnecessary expense of the premature appointment of staff and the danger of losing staff frustrated by under-employment. When the timetable for advertisements is being drawn up it should be remembered that in some cases it will be necessary to re-advertise, also that a few posts may require consultation about the appropriate grade with the regional board or the ministry and this may take several months.

5.11 A brochure designed to aid staff recruitment should be ready not less than four months before hand-over date. This should give information about the new hospital, how to reach it, the advantages of working in it, and facts about the district which will be of general interest to potential recruits.

5.12 New hospitals which have been most successful in recruiting staff have been those which have taken time and trouble to arrange career talks to local schools, visits by school children to the hospital, open days, exhibitions. Some of these matters are discussed further in Section 8. An approach on these lines for the recruitment of nursing staff has been described. [19]

5.13 If the new hospital is going to involve the closure of old buildings and consequent transfers or amalgamations of staff, the personnel policy must be worked out as early as possible and all members of the staff fully informed of the way in which they will be personally affected. With advance planning it should be possible to avoid redundancies. The factors which will depress the morale of existing staff most surely in this situation are uncertainty and lack of information on what is going to happen.

13 Ministry of Health, *Working Party Report on Revenue Consequences of Capital Schemes,* 1965.

14 King Edward's Hospital Fund/Royal College of Nursing, *Memorandum on Nursing Establishments,* 1966.

15 West Cumberland Hospital Management Committee, *Report on Ward Staffing at the West Cumberland Hospital.*

16 Newcastle Regional Hospital Board, *Report on the New West Cumberland Hospital,* 1962.

17 Ministry of Labour and Central Office of Information, *Supervisory Training Pays.*

18 Hull (A) Group Hospital Management Committee, *The New Hull Royal Infirmary – Staffing Programme,* 1965.

19 Bourne, M. W. *Recruitment of Nursing Staff at Hospital Level,* Nursing Times, 14 January, 1966, p.49.

6 Practical Completion and Hand-over of Buildings

6.1 Under the *Standard Form of Building Contract (1963)* the architect is responsible for the administration of the contract, and, to this extent, is the arbiter, if such be needed, between contractor and client. The contractor, for his part, is 'let in possession' of the site and thereby has sole and untrammelled right and access to it. Any reduction in this freedom, unless specified in the contract, is a breach of the contract, and the contractor may act accordingly. This means, *inter alia,* that no member of the hospital staff may go on to the site without the contractor's permission. This is the situation to the date of hand-over. On this date the contractor's responsibility for, and consequently insurances upon, the building terminate and the hospital authority's responsibility starts. This is therefore an important moment in the process towards the opening of the hospital.

6.2 In schemes of redevelopment, when new buildings are being constructed close to existing and functioning hospital departments, it is clearly important that the arrangements made pay proper regard to the needs and responsibilities of both the hospital and the contractor. The architect can do much to promote mutual understanding by each party of the other's problems. In several projects it has been found that a good way to assist towards this sort of liaison is for a representative of the hospital to attend the architect's progress meetings with the contractor. It must, however, be understood that the hospital's representative is there by invitation, not by right.

6.3 The clerk of works is employed by the hospital authority to supervise the work on the architect's behalf and to ensure that the building is constructed according to contract. Although a hospital employee, the clerk of works takes his instructions direct from the architect. For major projects there will also be a site engineer responsible for the supervision of the services installation.

6.4 The architect is required by the terms of the contract to issue a certificate of practical completion. An example of such a certificate is given in Appendix I. He must also deliver to the contractor, within fourteen days of the end of the liability period, a schedule of defects. This does not prejudice the architect's right to require the earlier remedying of defects: he can issue instructions for defects to be made good at any time during the defects liability period, which may be six or

twelve months. He is also required to issue a certificate that all defects have been made good: this is called a certificate of final completion, see Appendix J.

6.5 As the date for practical completion approaches, the clerk of works should prepare 'snag lists' which detail those items which have not been satisfactorily completed according to specification. The aim should be to reduce to a minimum the number of items remaining on the snag list by the date of practical completion and hand-over, when there should be a formal meeting on site between the architect, engineer, representatives of the hospital authorities and the building contractor. This meeting can deal with outstanding questions relating to the building and its services and keys can be formally handed over.

6.6 The hospital authority should insist that a determined effort is made to reduce the snag list as much as possible before taking over the building. Contractors are generally more ready to act quickly to remedy defects before the building has been taken over than afterwards, when the tendency is to try to leave all outstanding matters to be dealt with together at the end of the defects liability period.

6.7 It may be that the new building is handed over in sections. Clause 16 of the *Articles of Agreement,* sanctioned by the Royal Institute of British Architects and other professional bodies, makes provision for sectional completion of the works and lays down that if at any time or times before practical completion the employer *with the consent of the contractor* shall take possession of any part or parts, then

(1) within seven days of possession the architect shall issue a certificate stating his estimate of the approximate total value of this part;

(2) practical completion for the particular part can be given and procedure is as for normal full completion;

(3) the contractor reduces the value insured;

(4) release of first moiety of retention *pro rata.*

6.8 There are obvious difficulties implicit in early hand-over, for example, possibility of damage to decoration, floor overloading and security difficulties, but the advantages of a phased hand-over are obvious if sections of the building can be put to use for storage of equipment, office accommodation, staff training or residential accommodation. Only in very large schemes, however, will it be possible to bring a section of the building into use for patients and this will require careful planning from the earliest stages of development.

6.9 If a phased hand-over is intended, the commissioning programme must be considered before tender stage so that details of timing, site accessibility and security can be discussed with the contractor and included in the contract.

6.10 The hospital's works staff must be instructed not to do work which properly falls, during the defects liability period, within the province and responsibility of the contractor who may otherwise be given an opportunity to escape from these responsibilities, perhaps over a wider area than that covered by the initial defect. During this period therefore it is advisable to arrange that requests for works, including the fixing of Group 2(b) equipment, are authorised by a member of the administrator's staff sufficiently senior to appreciate the distinction between jobs which can properly be done by hospital staff and those which should be left to the contractor. The administrator may need to consult the architect on some of these items if they are of a borderline nature.

6.11 Before the handing over of the buildings, the architect should provide sets of record 'as fitted' drawings and the design engineers should similarly supply drawings of the mechanical and electrical services.

7 Inauguration of Operational Policies and Opening of Service Departments

7.1 The policies for the operation of the hospital should have been worked out, at least in outline, during the early planning stage of briefing the architect, see 2.5. During the twelve months or so preceding the hand-over, the policies must be refined and details added. When departmental heads are in post it is possible to add the final important details, answering the questions 'by whom?' and 'when?'. The part which work study can play in operational planning has already been mentioned, see 5.3.

7.2 Experience suggests, however, that this ideal is not always attained in practice and it is not unknown for concepts of operation which have governed design to have been forgotten or changed without the consequential adjustments having been made in the design of the building. Moreover, with the rapidly changing patterns of medical, nursing, administrative and other techniques, buildings which have taken many years to plan and build have been overtaken by new techniques, and the commissioning will need to take account of this and frequently have to adapt layouts to fit a pattern which was not envisaged when they were planned. 20

7.3 It is important that the staff of a new hospital understand the planning aims.

> The smooth running of the new hospital will depend to a large extent on each department having a clear idea of how it will function in the new hospital, not only internally, but also in its relations with all other departments, so as to provide as a whole a cohesive human hospital organisation. The planning team must stimulate this interest in all departments and be ready to provide information on new methods of work and the latest designs of equipment. It should arrange for new apparatus to be demonstrated, or for visits to be paid to places where up-to-date methods and equipment can be seen. This encouragement must not be restricted to clinical departments, for there is much to be learnt by hospitals on the organisation of activities concerned with business management and administration, as well as scope for the introduction of modern ideas in the catering, laundry, cleaning, clerical and stores departments. 21

7.4 So far it has usually been necessary for operational policies to be considered *de novo* for all new hospitals, though some regions have developed regional policies for some services. It is to be hoped that it will be possible before long to draw up a range of model operational policies to match a range of designs. These would need amendment in the light of local variations but they would reduce the present re-duplication of effort.

7.5 The operational policies for an individual hospital stem from decisions on the basic medical and nursing practices. The pattern of the patient's day will dictate many of the operational policies for the in-patient wards, whilst the admission and discharge policy, the operating theatre discipline and the appointments system for out-patient and diagnostic departments will call for decisions on operational policies affecting almost every department of the hospital. These operational policies cannot be worked out by separate categories of staff in isolation. Joint working parties of medical, nursing, professional and technical staff must be implicated in assisting the administrator and matron to draft the detailed policies. In this way the various groups of staff become fully committed to the decisions and only in this way can it be certain that the new procedures will be implemented and a proper use made of the new building.

7.6 A comprehensive set of operational policy documents has been produced for the new Royal Cornwall Hospital (Treliske), Truro, previously referred to in 2.7. The subjects dealt with are listed in Appendix K.

7.7 The inauguration of the operational policies is the beginning of the process of operation and management which will continue for as long as the hospital itself. There should at this stage be frequent meetings between the administrator and the heads of departments to discuss and take decisions on the multitude of detailed matters which will arise. The departmental heads should be able to determine the working details of their departments but, depending on experience and background, may need the help and support of the administrator who must also see that all the details of departmental operation fit into the agreed operational policies for the hospital as a whole. As the details are agreed they should be recorded and incorporated into the procedure manual. This should be completed, printed and circulated to staff as soon as possible.

7.8 The following paragraphs indicate briefly some of the important features in the commissioning of the principal service departments. A detailed check list for all these departments is given in Section 10.

Domestic Service

7.9 As soon as the building or a section is handed over

it will require to be thoroughly cleaned as the 'builder's clean' is usually inadequate. The programme must be carefully planned. The first cleaning of floors is important since heavy traffic over grime and grit may, at best, leave marks which take months to remove or, at worst, damage the floor covering. Ideally, floors should have a second thorough clean immediately after the equipment and furniture are in place. Arrangements for cleaning the windows, by direct labour or contract, must also be made.

Catering Service

7.10 A high standard of food service makes an important contribution to the well-being of both patients and staff: it is therefore important that this department reaches maximum efficiency as quickly as possible. If this is to be achieved, careful preparation during the operational planning stages is essential. [22] The catering service will be using new equipment, some of which will be strange to staff. It is therefore advisable to start this service as early as possible after hand-over, not only because there will be staff to be fed, but also because it will enable the catering service to 'run-in' with a small number of customers. Arrangements should be made for representatives of suppliers of equipment to be in attendance during the starting-up period. This is particularly important if a new system, such as central tray service, is to be brought into use. It is essential that the administration keeps the catering officer informed of the build-up of staff numbers until the staff complement is achieved.

Central Sterile Supply Service

7.11 The central sterile supply department is normally under the technical control of the consultant bacteriologist and it is essential for him to be involved in the hand-over and inauguration of this department. The supervisor of the C.S.S.D. will be concentrating on staff training during the first few weeks after taking over the department. The engineering and bacteriological checks and tests should make sure that the major equipment, especially the autoclaves, are functioning satisfactorily. It is advisable to arrange for the manufacturers' representatives to instruct and supervise the hospital staff in their operation until they are proficient.

Pharmacy

7.12 As this department does not begin to function until patients are being treated, the period immediately after the take-over of the department is devoted to stocking, staff training and agreeing detailed matters such as security, house officers' rules for prescribing, and delivery service to wards and departments. The forms to be used for the requisition of dangerous drugs, special medicines and general medicines must be agreed in good time for printing. The use of standard forms for these purposes can be anticipated.

General Supply and Disposal Services

7.13 Before the supplies organisation has finished the task of equipping the building it will have to start issuing consumable items. The ward and departmental stocks which are going to be dealt with on a topping-up basis should have their stock levels agreed; regular requisition and issue days must be established for the remainder. An early decision must be made on the extent of the use of the topping-up system as it affects the amount of local storage needed.

7.14 Fully detailed arrangements for disposal should be worked out. The wards may have chutes for rubbish and dirty linen but collections will have to be made from other departments and a timetable which can be relied on is necessary. If a paper sack system is introduced a colour code to distinguish the various types of items for disposal will no doubt be used and departmental and portering staff must be fully informed about this, see 5.6.

Central Linen Service

7.15 If the layout of the building permits, the central linen department is one which can be handed over and brought into use early with advantage as it will be busy from the start with the huge job of marking and distributing linen, uniforms and white coats. It is therefore necessary for seamstresses to be among the earliest appointments.

7.16 Decisions on uniforms and protective clothing will have been taken during an earlier stage in planning and they merit careful consideration since the appearance of staff has an effect both on staff morale and on the reputation of the hospital. One of the operational policies for the new hospital at Truro records the decisions taken there in this aspect of commissioning, see Appendix L.

Laundry

7.17 Until patients are admitted the amount of laundry work will be comparatively small. Nevertheless, there

will be nurses' uniforms and white coats which will require laundering up to three months before the hospital is open to patients and the administrator must ensure that a laundry service is available within a week of staff moving into the new building.

Telephones

7.18 It is vital that there should be an efficient telephone service in the building, both for internal and external calls, from the moment the staff move in. Telephone operators, preferably G.P.O. trained, should be appointed in time to be in post on hand-over day. Arrangements should be made for the G.P.O. training supervisor to be in attendance until the operators are familiar with the new equipment.

7.19 The administrator must keep the switchboard informed of names and extension numbers as members of staff arrive. This may call for a daily information sheet.

20 Birmingham Regional Hospital Board Study Group, *Commissioning of Hospital Developments,* 1966, p.1.

21 Oxford Regional Hospital Board, *Commissioning a New Hospital,* 1961, p.45.

22 Stormont, G. J. *Catering Operational Policy,* (in course of preparation).

8 Public Relations

8.1 Reference has been made earlier in this report to the importance of public relations in the commissioning of a new hospital, see 5.12. The most appropriate approach will clearly vary with its location. It is easier, for example, to generate local interest and concern for a new hospital which is to serve a clearly defined and largely self-contained community than it is for a hospital in a large city.

8.2 A great deal can be done to foster the interest and support of people in the locality of the new hospital by talks to local societies and organisations. These will make extensive calls on the time of the matron and the administrator.

8.3 The building and opening of a new hospital is an important event in the life of a community and the local residents will appreciate news about the progress of the building and the service which will be offered by the new hospital. The hospital will depend on the locality not only for the recruitment of a significant proportion of its staff but also in other ways, such as support for its League of Friends or other voluntary help. Accordingly, throughout the planning and building stages, steps should be taken to ensure that progress reports and information on items of interest are made available to the local press and local organisations which might be concerned. An exhibition of plans and model may be appropriate at some stage.

8.4 There should be one officer to co-ordinate public relations work and to be responsible for press liaison. This should usually be the administrator, though in some instances the group secretary may wish to undertake this responsibility himself.

8.5 Publicity for a new hospital must be sensibly handled. It is not difficult, for instance, for the local press to lose interest before the completion of the building if they have been too often told that 'it will be finished next month'. The object should be to bring interest to a head at a time which coincides with the start of the hospital's advertising campaign for staff, that is, about four months before the date of hand-over of the building, and to sustain it until the time when the first patients are admitted. It is a good plan for representatives of the local press to be invited to visit the hospital shortly after it has been handed over by the contractors and again when it has been equipped and staffed and is ready to receive patients. Additionally, a

national press day is appropriate for projects of major importance.

8.6 It is important that details of the new hospital's services, dates of opening of departments, and any consequential changes in services of other hospitals, should be notified in good time to the local health authority, the general practitioners and the ambulance service.

8.7 Reference has already been made in 5.11 to the need to produce a brochure for the information of people who may be interested in joining the staff. By the date of the official opening there should also be prepared a descriptive brochure containing information on the brief, layout of buildings, staff, services, equipment and costs.

8.8 Consideration should be given to holding an open day or a period of one week, or even two weeks, of successive open days. These occasions are usually appreciated since they provide a rare opportunity for the neighbours of the hospital to see inside its doors. In the case of a new district general hospital to serve an area formerly covered by several smaller hospitals this may well be an essential aspect of the public relations policy. An instance of the amount of interest there can be is provided by a new district general hospital which held open days during a period of two weeks and during this time over 8,000 people visited the hospital.

8.9 Open days such as this should be held before the admission of patients, provided that this will not prejudice in any way the successful completion of the commissioning programme, which is of primary importance. If there is any doubt whether the arrangements for the open day can be coped with by the available staff it should be deferred until a convenient date after the opening, in which case special care must be taken to see that the arrangements cause the least possible disturbance to the patients.

8.10 Requests for visits to the new hospital will be numerous and the programme for such visits needs to be carefully controlled to avoid undue disruption to the work of wards and departments. [23] The appointment of an official guide may be worth consideration. This is a service which might well be provided by the League of Friends.

8.11 Good public relations result from a planned and maintained programme, not from sporadic 'special efforts'. The most powerful instrument for the maintenance of good public relations is, of course, the hospital itself. There is no substitute for the solid reputation of a high standard of medical and nursing care, backed by efficient administration and sound personnel policies.

23 Oxford Regional Hospital Board, *Commissioning a New Hospital,* 1961, p.57.

9 Opening Ceremony

9.1 Although the opening of a new hospital will perhaps be regarded as less of an epoch-making event in the future than has been the case in the past, it will clearly continue to be seen as an important milestone by those closely associated with the hospital and will usually create considerable interest in the community in which it is situated. It is fitting therefore that the completion of a project should be marked by an official opening ceremony. It should be remembered that the object is an occasion which those present will enjoy and which they will look back on with pleasure.

9.2 Inevitably, a large number of people will be present who have not visited the hospital before and are unlikely to visit it again but the greater the part that can be played by the staff of the hospital and those who have planned it, the better.

9.3 Some regional boards regard the official opening as the occasion on which they hand over the hospital to the local management committee and at least one board takes the opportunity to record this fact by presenting a suitably inscribed scroll to the committee's chairman.

9.4 It has been the practice in most official openings for a service of dedication to form part of the proceedings. As time on these occasions is usually limited and many of those present are not closely associated with the work of the hospital, the idea of holding a separate dedication service for the hospital's staff a day or two before the admission of the first patients has much to commend it.

9.5 The arrangements for the opening ceremony will vary depending on who is to perform the ceremony and the sort of occasion that the hospital authority considers appropriate. The plans made should ensure that patients who are too ill to participate should not be disturbed.

9.6 It is not intended to go into detail here about the arrangements that have to be made since there already exists a comprehensive review of this subject. [24] It is important to appreciate that this is an exercise which requires meticulous care in preparation. For example, the timing of the tour of the building should be carried out with a stop-watch. All the time and thought given to the planning of every detail will be repaid by the smoothness of the operation on the day. This applies particularly to the following aspects: compilation of the invitation list; seating arrangements; timing of the programme of events; effective communications; alternative 'wet weather' programme.

24 Paine, L. H. W. *Opening Ceremonies and Official Visits,* Hospital Management, September, 1963, p.784, and October, 1963, p.856.

10. Commissioning Check List

10.1 The commissioning of a hospital involves decisions on many detailed matters, some of them requiring the joint consideration of the medical, nursing and administrative members of the commissioning team. The sheer volume of matters to be considered means that some can easily be overlooked, with the result that decisions either go by default or have to be taken in a hurry. With this in mind the following check list has been compiled in the hope that it will prove helpful to those actively engaged in commissioning. Those who are so engaged will, no doubt, alter the list which follows to tailor it to the requirements of their local situation. Also, the code and the items can obviously be set out in different ways according to the use intended. One possible way of using the commissioning check list is illustrated in Appendix M.

10.2 Code letters are used to amplify each item in the list as to the type of action required:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

10.3 ADMINISTRATION

10.3.1 accidents to patients, staff, visitors **f m p**
10.3.2 advertisements for staff **i**
10.3.3 Anatomy Act **f m p**
10.3.4 authority to appoint staff **d**
10.3.5 collection and disposal of waste **m p**
10.3.6 complaints **m p**
10.3.7 corneal grafting **f p**
10.3.8 departmental forms and records **f p**
10.3.9 departmental organisation **d m**
10.3.10 Disabled Persons Act **o p**
10.3.11 duplicating and document copying **d m p**
10.3.12 duty rotas **i l m p**
10.3.13 electrical safety **m p s**
10.3.14 emergency obstetric service **i m o**
10.3.15 establishment control **d m p**
10.3.16 factory acts **o p s**
10.3.17 filing arrangements **d m p**
10.3.18 fire precautions, equipment notices, drills **f m o p s**
10.3.19 forms of consent **f m p**
10.3.20 hospital badges **i o s**
10.3.21 housing for staff **i o**
10.3.22 infection – control of **f m p**
10.3.23 information brochure **i**
10.3.24 instructions and information for registrars and officers **d m p**
senior medical resident **d m p**
10.3.25 journal of hospital news **d**
10.3.26 keys **i l m p**
10.3.27 letters of appointment **p**
10.3.28 liaison with local authority (ambulance service, education, notifiable diseases, Medical Officer of Health, refuse collections) **i m o**
10.3.29 licences and permits (Disabled Persons Act, duty free alcohol, motor vehicles, petroleum, wireless and television, radioactive waste, stills, Ministry of Labour permits) **i l m o p**
10.3.30 lifts – use of **m p**
10.3.31 maintenance and location of breathing equipment **d i l m**
10.3.32 major accident **m o p**
10.3.33 Mental Health Act **f i m o p**
10.3.34 noise prevention **h i m**
10.3.35 notices and notice boards **l m p s**
10.3.36 notifiable diseases **m o p**
10.3.37 notification to relatives **m p**
10.3.38 official visitors and enquiries **d m p**
10.3.39 paintings **i l o**
10.3.40 patients' appliances **f h m p**

10.3.41 patients dying in hospital **f m p**
10.3.42 patients' property and valuables **f h m p**
10.3.43 pest control **i m o p**
10.3.44 power failure **i m o p**
10.3.45 press enquiries **d m p**
10.3.46 professional periodicals **d i l o p**
10.3.47 public transport – arrangements with local authority **i o**
10.3.48 radiation protection **m p s**
10.3.49 radioactive waste disposal **i m o p**
10.3.50 recruitment and training programme **i o**
10.3.51 refuse collections (local authority) **i m o p**
10.3.52 registrar of births and deaths **m o p**
10.3.53 resignation, dismissal, suspension **d m p**
10.3.54 Road Traffic Act **f m p**
10.3.55 safety precautions **m p**
10.3.56 secretarial services **d m p**
10.3.57 security **i m o p**
10.3.58 sign posting – internal and external **d s**
10.3.59 smoking in public areas and wards **d p s**
10.3.60 staff handbook **i p**
10.3.61 staff location **i l m p**
10.3.62 staff name badges **i s**
10.3.63 staff nurses – description of responsibility **m p**
10.3.64 staff records **f i m p**
10.3.65 staffing establishments **d l**
10.3.66 stores losses **d f m p**
10.3.67 thefts **m p**
10.3.68 time clocks and cards **d f m p**
10.3.69 use of electrical appliances in residents' quarters **d m**
10.3.70 visiting hours **d h**
10.3.71 voluntary services **i o**
10.3.72 ward and departmental procedure manuals **i p**
10.3.73 ward and departmental sisters – guidance and information **m p**
10.3.74 working hours **d m**

10.4 FINANCIAL

10.4.1 accounting procedures **f m p**
10.4.2 budgetary control **m p**
10.4.3 cash imprests **l m p**
10.4.4 charges – for accommodation, appliances, garages, guests, meals, road accidents, sect. 4 beds, sect. 5 beds, spectacles, telephones, others **f m p**
10.4.5 cheques – signing of **m p**
10.4.6 collection of monies **m p**
10.4.7 costing **f m p**
10.4.8 donations **m p**
10.4.9 estimates – preparation of **d m p**
10.4.10 expenses – payment of **f m p**
10.4.11 internal audit **p**
10.4.12 invoices **m p**
10.4.13 losses and compensation **f m p**
10.4.14 safe custody **m p**
10.4.15 salaries and wages **f m p**
10.4.16 stores accounting **f m p**

KEY TO CODE LETTERS:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

10.5 SUPPLIES

10.5.1 condemning **f m p**
10.5.2 contracts for supplies and services **d f l p**
10.5.3 disposable goods **d**
10.5.4 distilled water **m p**
10.5.5 electro-medical equipment – maintenance **f i l o p**
10.5.6 forms and booklets – catalogue **l**
10.5.7 ice **m p**
10.5.8 invoices **m p**
10.5.9 issues on 'top-up' basis **m p**
10.5.10 marking of equipment **m p**
10.5.11 medical gases **m p**
10.5.12 ordering of stock and non-stock items **d f m p**
10.5.13 receipt and storage **f m p**
10.5.14 requisition and issue of stores **f m p**
10.5.15 return of chargeable empty containers **f m p**
10.5.16 stock-control **f m p**
10.5.17 stock-control catalogue **d f l**

10.6 STAFF

Training

10.6.1 induction courses **i p**
10.6.2 'on the job' training **i p**
10.6.3 courses for supervisors **i o p**
10.6.4 continuation courses **i o p**
10.6.5 talks by heads of departments **i p**

Health and Welfare

10.6.6 absence through sickness **m p**
10.6.7 accidents to staff on duty **m p**
10.6.8 personal general practitioner **i m o p**
10.6.9 pre-employment medical examination of resident and non-resident staff **f p**
10.6.10 reporting sick – resident staff **m p**
10.6.11 retirement **d p**
10.6.12 staff beyond normal retiring age – annual medical examination **p**
10.6.13 supervision of staff health **i m o p**
10.6.14 vaccinations **m p**

Facilities

10.6.15 bank **i m**
10.6.16 bicycle stands **m**
10.6.17 car parking **m**
10.6.18 car ports or garages for residents **m p**
10.6.19 day nursery for children of staff **i m**
10.6.20 hairdressing **i m o**
10.6.21 library **i m**
10.6.22 rest breaks **d m**
10.6.23 rest rooms and changing rooms **l m**
10.6.24 shop **i m o**
10.6.25 social club **i m**

10.7 NURSES' AND MIDWIVES' TRAINING

10.7.1 formulate aims of the schools of nursing **d m**

10.7.2 schemes of training:
- (i) cadet **d i o**
- (ii) roll **d i o**
- (iii) register **d i o**
- (iv) post-registration **d i o**
- (v) special e.g. 'back to nursing' **d i o**
- (vi) in-service **d i**

10.7.3 programme and syllabus for theoretical work **p**

10.7.4 planned movement to allow students and pupils to acquire the necessary skills and attitudes **p**

10.7.5 timetable and allocation of duties for tutors:
- (i) clinical **p**
- (ii) theoretical **p**

10.8 RESIDENCES

10.8.1 administration **d**

10.8.2 guests **m p**

10.8.3 keys **l m p**

10.8.4 linen exchange **m p**

10.8.5 lodgings bureau **i m o**

10.8.6 mail **m p**

10.8.7 married quarters **l m p**

10.8.8 refreshments off duty **m p**

10.8.9 residents' quarters **l**

10.8.10 security **m p**

KEY TO CODE LETTERS:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

10.9 NURSING MANAGEMENT AT WARD AND DEPARTMENTAL LEVEL

Staff

10.9.1 day-to-day administration **m p**
10.9.2 clinical teaching programme in nursing **d p**
10.9.3 inter-departmental communications **m p**

Patient Care – Routine

10.9.4 accident and emergency department – administration of **d m p**
10.9.5 day unit – use of **d m p**
10.9.6 in-patients' day **m p**
10.9.7 intensive care unit – use of **d m p**
10.9.8 movement of patients between ward and other departments **m p**
10.9.9 nursing and general welfare of patients **m p**
10.9.10 nursing procedure manual **i p**
10.9.11 operating theatres – administration of **d m p**
10.9.12 out-patients' department – administration of **d m p**

Patient Care – Special Situations

10.9.13 cardiac emergencies **m p**
10.9.14 code of procedure to obviate the risk of operation on the wrong patient, side, limb or digit **m p**
10.9.15 isolation of infectious patients **m p**
10.9.16 respiratory emergencies **m p**

10.10 PATIENTS' RECEPTION, REGISTRATION AND RECORDS

In-patients

10.10.1 admission notice **f p**
10.10.2 bed occupancy boards **p s**
10.10.3 brochure (general) **i f**
10.10.4 brochure (maternity) **i f**
10.10.5 brochure (children's) **i f**
10.10.6 brochure (psychiatric) **i f**
10.10.7 discharge arrangements **m o p**
10.10.8 emergency admissions **i m o p**
10.10.9 follow-up **f m p**
10.10.10 letters to G.P.s **m p**
10.10.11 notifications to relatives **f m p**
10.10.12 patients of other religions **m p**
10.10.13 private and amenity patients **m p**
10.10.14 reception **m p**
10.10.15 registration **f m p**
10.10.16 transport **i m o p**
10.10.17 waiting list **m p**

Out-patients

10.10.18 appointments **f m o p**
10.10.19 follow-up **f m p**
10.10.20 letters to G.P.s **m p**
10.10.21 private patients **m p**
10.10.22 registration **f m p**
10.10.23 transport **i m o p**

Records

10.10.24 design of case papers and folders **d f**
10.10.25 design of other medical records **d f**
(i) admission/discharge register
(ii) operation register
(iii) accident and emergency register
10.10.26 disease index and classification **m p**
10.10.27 filing system **d m p**
10.10.28 hospital in-patient enquiry **m p**
10.10.29 statistics **m p**
10.10.30 storage and security **p**

10.11 PATIENTS' SERVICES

10.11.1 accommodation for relatives of dangerously ill patients **m p**
10.11.2 buffet for out-patients **h i o**
10.11.3 cloakroom arrangements for out-patients **h i**
10.11.4 crèche for children of out-patients **h i**
10.11.5 domiciliary nursing service **i o p**
10.11.6 education for children in wards **i o**
10.11.7 hairdressing for in-patients **h i**
10.11.8 information card to patients' visitors **f i**
10.11.9 library service **h i o**
10.11.10 meals for patients' visitors **m p**
10.11.11 newspapers and magazines **h i o**
10.11.12 pram park **h i**
10.11.13 shop for out-patients **h i**
10.11.14 telephone trolley service **h i l**
10.11.15 television for in-patients **h i l m o p**
10.11.16 trolley shop for in-patients **h i**
10.11.17 vending machines in O.P.D. **i o**

10.12 MEDICAL SOCIAL SERVICE

10.12.1 information to patients on help available **h**
10.12.2 method of referral **d m p**
10.12.3 reports on patients **f m p**
10.12.4 Samaritan Fund control **m p**

KEY TO CODE LETTERS:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

10.13 CHAPLAINCY SERVICE

10.13.1 appointment of chaplains **i o**
10.13.2 chaplain for dangerously ill patients **m p**
10.13.3 Holy Communion and Mass **h i**
10.13.4 notification of admissions, discharges and deaths **f m p**
10.13.5 religious services **h i**
10.13.6 religious services – dedication of room **i o**

10.14 CATERING

Administration

10.14.1 buying procedures **m p**
10.14.2 goods – receipt of **f m p**
10.14.3 stores – issues from **f m p**
10.14.4 stocks – control of **f m p**
10.14.5 meals – recording of **m p**
10.14.6 payment – methods of **m p**
10.14.7 hygiene **m p**
10.14.8 swill **i m o p**

Standard of Feeding

10.14.9 menus **d f p**
10.14.10 cost (inc. waste) **d m p**
10.14.11 special diets **m p**

Service

10.14.12 patients – main meals and beverages **d m p**
10.14.13 staff – main meals and beverages **d m p**
10.14.14 washing up arrangements **d m p**

10.17 MORTUARY

10.17.1 coroner's inquests **m p**
10.17.2 post mortems **f m p**
10.17.3 register **f m p**
10.17.4 viewing by relatives **m p**

10.18 PHARMACY

10.18.1 information on materia medica **i**
10.18.2 issue of drugs at night **m p**
10.18.3 maintenance of ward and departmental stocks **m p**
10.18.4 ordering, administration and storage of drugs **f m p**
10.18.5 orders and invoices **f m p**
10.18.6 record books relating to dangerous drugs **f m p**
10.18.7 rules for prescribing **m p**
10.18.8 security **m p**

10.15 DIAGNOSTIC X-RAY

10.15.1 appointments system **m p**
10.15.2 equipment break-down **i m o p**
10.15.3 gowning of patients **m p**
10.15.4 implementation of Code of Practice for radiation protection **m p**
10.15.5 on-call arrangements **m p**
10.15.6 reception arrangements **m p**
10.15.7 records and film storage **m p**
10.15.8 refreshments after barium meals **m p**
10.15.9 reports **m p**
10.15.10 silver recovery **i m o p**

10.16 LABORATORY

10.16.1 collection and storage of blood **i m o p**
10.16.2 collection of specimens **m p**
10.16.3 disposal of waste **m p**
10.16.4 on-call arrangements **m p**
10.16.5 reception arrangements **m p**
10.16.6 reports **f m p**
10.16.7 routine for bacteriological tests **m p**
10.16.8 routine for sterility tests on autoclaved products **m p**
10.16.9 swabbing of staff **m p**

10.19 PHYSIOTHERAPY

10.19.1 appointments system **m p**
10.19.2 patients' transport **f m p**
10.19.3 reception arrangements **m p**
10.19.4 records and reports on patients **f m p**

KEY TO CODE LETTERS:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

10.20 OCCUPATIONAL THERAPY

10.20.1 control of stocks and cash **m p**
10.20.2 records and reports on patients **f m p**
10.20.3 records of materials bought and goods sold **m p**

10.21 CENTRAL STERILE SUPPLY

10.21.1 scope of service **d**
10.21.2 collection of items for sterilising **m p**
10.21.3 cleaning **m p**
10.21.4 contents of packs **m p**
10.21.5 wrapping **m p**
10.21.6 sterilising **m p**
10.21.7 storage **m p**
10.21.8 distribution **m p**

10.24 SWITCHBOARD

10.24.1 enquiries about patients **m p**
10.24.2 fire telephone system **m p**
10.24.3 internal directories **m p**
10.24.4 lift telephones **m p**
10.24.5 major accident and other emergency procedures **i m o p**
10.24.6 personal calls **f m p**
10.24.7 requests for emergency admissions out of office hours **m p**
10.24.8 staff location system **l m p**
10.24.9 trunk calls **d m p**

10.25 DOMESTIC SERVICE

10.25.1 cleaning team programme **m p**
10.25.2 cost control **m p**
10.25.3 issue of materials **m p**
10.25.4 special cleaning areas **l m p**
10.25.5 specification **d**
10.25.6 window cleaning contract **f i l o p**

10.22 CENTRAL LINEN

10.22.1 curtains **m p**
10.22.2 emergency supply of linen **m p**
10.22.3 frequency of laundry service **d m**
10.22.4 handling of dirty, foul, infected linen **m p**
10.22.5 personal laundry – resident staff **m p**
10.22.6 records **f m p**
10.22.7 repair, storage and distribution of linen **m p**

10.23 MEDICAL PHOTOGRAPHY

10.23.1 appointments system **m p**
10.23.2 reception arrangements **m p**
10.23.3 records and reports **m p**

10.26 PORTERING SERVICE

10.26.1 accuracy of clocks **l m p**
10.26.2 car parking control **m p**
10.26.3 cleaning duties **m p**
10.26.4 collection and disposal of waste **m p**
10.26.5 conveyance of patients **m p**
10.26.6 delivery of supplies **m p**
10.26.7 messenger service **m p**
10.26.8 night patrols **m p**
10.26.9 operation of lifts **m p**

KEY TO CODE LETTERS:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

10.27 POSTAL SERVICE

10.27.1 out-going mail collection and postage **m p**
10.27.2 G.P.O. collections and deliveries **h i m o**
10.27.3 receipt, sorting and distribution of incoming mail **m p**
10.27.4 re-direction of mail **m p**
10.27.5 registered mail **m p**
10.27.6 telegrams **m p**

10.28 HOSPITAL TRANSPORT

10.28.1 arrangements for and records of vehicle maintenance **f i m o p**
10.28.2 authorised use of hospital transport **f m p**
10.28.3 oil and petrol storage and control of issues **f i m o p**
10.28.4 records of journeys **f m p**
10.28.5 timetable of hospital transport journeys **m p**

10.29 BUILDING, PLANT AND GROUNDS

10.29.1 early plantings of trees and shrubs **i o**
10.29.2 emergency repair calls outside normal working hours **m p**
10.29.3 landscape plan **d i o**
10.29.4 maintenance contracts for equipment **i o**
10.29.5 maintenance of gardens and grounds **i o**
10.29.6 maintenance of landscape during development **i o**
10.29.7 production of plants for decoration, etc. **d**
10.29.8 programme of planned maintenance for building **m p**
10.29.9 programme of washing down and painting **m p**
10.29.10 repair requisition system **f m p**

10.30 ENGINEERING SERVICES

10.30.1 emergency calls outside normal working hours **m p**
10.30.2 engineers' stores stock control **f p**
10.30.3 fuel supplies **i o p**
10.30.4 insurances on steam equipment, lifts, etc. **i o p**
10.30.5 master commissioning manual – prepared by design engineer
10.30.6 orders and invoices **m p**
10.30.7 programme of planned maintenance for equipment **m p**
10.30.8 repair requisition system **f p**
10.30.9 service manual – prepared by design engineer
10.30.10 user hand-books – prepared by design engineer

KEY TO CODE LETTERS:

d = management decision to be made
f = forms and booklets to be designed and printed
h = to be included in handbook for patients
i = arrangements to be initiated
l = to be included in lists or schedules
m = to be included in staff handbook and/or departmental procedure manuals
o = outside bodies (may) need to be consulted, advised or employed
p = procedure to be formulated and recorded
s = signs to be designed and manufactured

References:
Hull (A) Group Hospital Management Committee, *Main Index,* 1966.
Jackson, A. L. *Commissioning and Equipping,* The Hospital, April, 1965, p. 164.
Luton and Hitchin Hospital Management Committee, *Commissioning the New Lister Hospital—A Preliminary Appraisal of the Task,* 1963.
North West Metropolitan Regional Hospital Board, *Some Notes on Commissioning the New Welwyn/ Hatfield Hospital,* 1959.
Oxford Regional Hospital Board, *Commissioning a New Hospital,* 1961.
West Cornwall Hospital Management Committee, *Operational Policies for Royal Cornwall Hospital (Treliske) Truro.*

Bibliography

Archer, L. Bruce *Equipment – Specification and Selection,* The Architectural Review, June, 1965.

*Birmingham Regional Hospital Board Study Group, *Commissioning of Hospital Developments* (an interim paper), 1966.

Blee, A. C. *The Speedy Commissioning of a New Out-patient Department, Royal Northern Hospital,* The Hospital, August, 1963.

Bompas, R. M. *Opening a New Hospital,* The Hospital, December, 1962.

Bourne, M. W. *Network Analysis and Commissioning the Nursing Services of a New Hospital,* Nursing Times, 6 August, 1965.

Bourne, M. W. *Recruitment of Nursing Staff at Hospital Level,* Nursing Times, 14 January, 1966.

Brettell, C. E. *Commissioning a Hospital,* Nursing Times, 29 May, 1964.

Central Health Services Council, *The Pattern of the In-patient's Day,* H.M.S.O., 1961.

Croot, E. *Capital Equipment Tabulation and Costing with the Use of a Computer,* The Hospital, April, 1966.

Hospital Centre Conference, *Rationalising Supplies and Equipment,* British Hospital Journal, 25 June, 1965.

*Hull (A) Group Hospital Management Committee, *The New Hull Royal Infirmary – Commissioning Programme,* 1965,
The New Hull Royal Infirmary – Equipment Programme, 1965,
The New Hull Royal Infirmary – Staffing Programme, 1965,
The New Hull Royal Infirmary – Main Index, 1966.

Jackson, A. L. *Commissioning and Equipping,* The Hospital, April, 1965.

*Jeffries, W. C. *The Commissioning of Hospital Engineering Services,* 1965.

King Edward's Hospital Fund/Royal College of Nursing, *Memorandum on Nursing Establishments,* 1966.

Knowland, R. W. *The Commissioning of New Guy's House,* The Hospital, January, 1963.

Leeds Regional Hospital Board, *Equipment and Furnishings for Hospitals,* 1963.

Leeds Regional Hospital Board, *Work Measurement as a Basis for Calculating Nursing Establishment,* 1963.

*Luton and Hitchin Hospital Management Committee, *Commissioning the New Lister Hospital – A Preliminary Appraisal of the Task,* 1963.

*Luton and Hitchin Hospital Management Committee, *Internal Collection and Distribution Services – Lister Hospital,* 1964.

*Massachusetts General Hospital, *Aims of the School of Nursing.*

Melleney, J. R. *Commissioning Princess Alexandra Hospital, Harlow,* British Hospital Journal, 17 September, 1965.

Ministry of Health Working Party, *Report on the Revenue Consequences of Capital Schemes,* M.O.H., 1965.

Ministry of Health, *Building Note No. 1,* H.M.S.O., 1961.

Ministry of Health, *Equipment Note No. 1,* H.M.S.O., 1962.

Ministry of Health, *Preparation and Approval of Individual Building Schemes,* Hospital Building Procedure Notes, 1966 (in course of preparation).

Ministry of Labour and Central Office of Information, *Supervisory Training Pays.*

Newcastle Regional Hospital Board, *Report on the New West Cumberland Hospital,* 1962.

Newcastle Regional Hospital Board, *The New West Cumberland Hospital 64,* 1964.

*North West Metropolitan Regional Hospital Board, *Some Notes on Commissioning the New Welwyn/ Hatfield Hospital,* 1959.

Norton, Doreen *Specifying and Assessing New Ward Equipment,* British Hospital Journal, 4 September, 1964.

Oxford Regional Hospital Board, *Commissioning a New Hospital,* 1961.

*Oxford Regional Hospital Board, *Terms of Reference for the Appointment of a Design Consultant for High Wycombe Development.*

Paine, L. H. W. *Opening Ceremonies and Official Visits,* Hospital Management, September and October, 1963.

Payne, J. *Moving a Hospital,* International Nursing Review, June, 1963.

Rhoden, J. K. *Use of Punched Cards in Equipping,* The Hospital, September, 1963.

*South Eastern Regional Hospital Board, *Victoria Hospital, Kirkcaldy: Phase 2 Commissioning Procedures,* 1965.

*South Eastern Regional Hospital Board, *Commissioning Programme.*

*South Eastern Regional Hospital Board, *Proposed Phasing for Additional Staff Appointments – Victoria Hospital, Kirkcaldy.*

†Stormont, G. J. *Catering Operational Policy* (in course of preparation).

Starling, A. E. *Practical Problems in Commissioning the Queen Elizabeth Hospital, Hong Kong,* The Hospital, April, May and June, 1965.

Terry, P. W. *Furniture for the New Hospital,* British Hospital Journal, 26 March, 1965.

*United Cambridge Hospitals, *Handbook – New Addenbrooke's Hospital.*

*Wessex Regional Hospital Board, *Commissioning of the New Poole General Hospital and the Use of Network Analysis Techniques,* 1966.

*Wessex Regional Hospital Board, *Commissioning of Poole General Hospital: Provisional Proposals for Training.*

§West Cornwall Hospital Management Committee, *Operational Policies for Royal Cornwall Hospital (Treliske), Truro.*

*West Cumberland Hospital Management Committee, *Report on Ward Staffing at the West Cumberland Hospital.*

also the publications of the Division of Hospital and Medical Facilities of the U.S. Department of Health, Education and Welfare, 1965.

* available through the King's Fund Hospital Centre's package-library service

† to be available from the King's Fund Catering Advisory Service

§ available for reference in the King's Fund Hospital Centre library

Acknowledgements

During the preparation of this report visits were made to many of the places where new hospital developments have been completed or are in progress.

The working party wishes to record its thanks to the officers in the following authorities and hospitals some of whom agreed to their papers being quoted and all of whom readily gave time to discuss and share their experience of commissioning problems:

Altnagelvin Hospital, Londonderry, Northern Ireland
Astley Ainslie Hospital, Edinburgh
Belfast Hospital Management Committee, Northern Ireland
Erne Hospital, Enniskillen, Northern Ireland
Guy's Hospital, London
Hull (A) Group Hospital Management Committee
Leeds Regional Hospital Board
Luton and Hitchin Hospital Management Committee
North Liverpool Hospital Management Committee
Northern Ireland Hospitals Authority
Princess Alexandra Hospital, Harlow
Queen Elizabeth Hospital, Welwyn
Royal Cornwall Hospital (Treliske), Truro
Royal Edinburgh Hospital Board of Management
St. Stephen's Hospital, Chelsea
South Eastern Regional Hospital Board
South Tyrone Hospital, Dungannon, Northern Ireland
Ulster Hospital, Dundonald, Belfast, Northern Ireland
United Birmingham Hospitals
Victoria Hospital, Kirkcaldy
Wessex Regional Hospital Board
Wexham Park Hospital, Slough
West Cumberland Hospital Management Committee
Windsor Group Hospital Management Committee

The working party would also like to thank the following for their help and advice:

Mr W J Breen of Trust Houses Limited
Mr E Croot, Northwick Park Project
Mr V G Osborne of Marks and Spencer Limited
Mr L H W Paine, Secretary to the Board of Governors, Bethlem Royal and Maudsley Hospitals
Mr G Raine, Chief Pharmacist, St. George's Hospital, London
Mr J K Rhoden, Supplies Officer, Edmonton Group Hospital Management Committee
Mr L Whitney, Group Secretary, Harefield and Northwood Hospital Management Committee
And officers of the Scottish Home and Health Department

Appendices

Appendix A Commissioning Timetable

reference paragraph 3.1

Specimen timetables related to planning and building programme, for:

management

equipping

staffing

detailed operational planning

phased operation

public relations

Assumptions made for the purpose of this example:

1 that the project is a general hospital

2 that the building period is three years

3 that the design is such that preliminary hand-overs of the following sections can be satisfactorily arranged:

the boiler house
the residency (used for temporary offices)
the out-patients' department (used for temporary storage)

TIMETABLE FOR MANAGEMENT OF COMMISSIONING PROGRAMME

	TIME SCALE	PLANNING & BUILDING STAGES (CONTROL)
Preliminary equipment statement	**Briefing and design period**	Statement of requirements
		Site selection (including landscape survey)
Preliminary staffing establishment		Major operational policies
		Development plan
Preliminary estimate of running costs		Schedules of accommodation
		Sketch drawings
		Working drawings
		Specifications and bills of quantities
		Tenders
		Contract
	39 months before D	Building starts
Set up equipping arrangements and staffing	**36 months before D**	
Arrange temporary offices for commissioning team	**33 months before D**	
Check space for equipment storage	**30 months before D**	
Appoint administrator	**27 months before D**	
Appoint matron. Establish commissioning team	**24 months before D**	
Project team briefs commissioning team	**21 months before D**	
Appoint supporting staff for commissioning team	**18 months before D**	Hand-over of boiler house
Select official opener	**17 months before D**	
Plan temporary feeding arrangements for staff	**16 months before D**	
Approve staff establishment	**15 months before D**	
Approve final capital cost of equipment	**14 months before D**	
	13 months before D	
	12 months before D	
	11 months before D	Hand-over of residency
	10 months before D	
Initiate arrangements to establish League of Friends	**9 months before D**	
Start procedure for appointment of senior medical staff	**8 months before D**	Hand-over of out-patients' department
Review hand-over date with architect	**7 months before D**	
Arrange access to site for key staff	**6 months before D**	Snag list
Plan initial cleaning programme	**5 months before D**	Snag list
	4 months before D	Final snag list
	13 weeks before D	Contract completion date. Practical compl. inspection
	12 weeks before D	**Hand-over of main building.** Practical completion certificate. Start of defects period
	11 weeks before D	
	10 weeks before D	
	9 weeks before D	
	8 weeks before D	
	7 weeks before D	
	6 weeks before D	
	5 weeks before D	
Information to outside authorities	**4 weeks before D**	
Trial runs	**3 weeks before D**	
Trial runs	**2 weeks before D**	
	1 week before D	
Dedication Service	**D**	
Evaluation of commissioning programme	**After D**	Defects schedule
		Final completion
		Evaluation of design in use

NOTE: D=day on which patients are first admitted to wards

TIMETABLE FOR EQUIPPING	TIME SCALE	PLANNING & BUILDING STAGES (CONTROL)
Prepare preliminary equipment statements and cost	**Briefing and design period**	Statement of requirements
		Site selection (including landscape survey)
Prepare room data sheets		Major operational policies
		Development plan
		Schedules of accommodation
		Sketch drawings
		Working drawings
		Specifications and bills of quantities
		Tenders
		Contract
	39 months before D	Building starts
Extract equipment lists from data sheets	**36 months before D**	
Complete equipment lists	**33 months before D**	
Start market research trials and specifications	**30 months before D**	
Orders for special equipment with long deliveries	**27 months before D**	
Start to obtain quotations	**24 months before D**	
Order furniture and equipment for boiler house	**21 months before D**	
Order furniture and equipment for residency	**18 months before D**	Hand-over of boiler house
Receive equipment for boiler house	**17 months before D**	
Prepare and submit final estimate of cost	**16 months before D**	
	15 months before D	
Start placing orders for equipment of main building	**14 months before D**	
	13 months before D	
	12 months before D	
	11 months before D	Hand-over of residency
Receive furniture and equipment for residency	**10 months before D**	
	9 months before D	
	8 months before D	Hand-over of out-patients' department
	7 months before D	
All orders placed	**6 months before D**	Snag list
Deliveries into temporary store	**5 months before D**	Snag list
Labelling of equipment in store	**4 months before D**	Final snag list
	13 weeks before D	Contract completion date. Practical compl. inspection
Start placing equipment	**12 weeks before D**	**Hand-over of main building.** Practical completion certificate. Start of defects period
Start tests and demonstrations of special equipment	**11 weeks before D**	
	10 weeks before D	
Equipping complete (except for Group 3 items)	**9 weeks before D**	
Start stores issues	**8 weeks before D**	
	7 weeks before D	
	6 weeks before D	
	5 weeks before D	
	4 weeks before D	
	3 weeks before D	
	2 weeks before D	
	1 week before D	
	D	
Evaluation of equipment	**After D**	Defects schedule
		Final completion
		Evaluation of design in use

NOTE: D=day on which patients are first admitted to wards

TIMETABLE FOR STAFFING AND TRAINING	TIME SCALE	PLANNING & BUILDING STAGES (CONTROL)
	Briefing and design period	Statement of requirements Site selection (including landscape survey) Major operational policies Development plan Schedules of accommodation Sketch drawings Working drawings Specifications and bills of quantities Tenders Contract
Appoint hospital engineer as site engineer if possible	**39 months before D**	Building starts
Establish nurse training in assoc. with existing hospital	**36 months before D**	
	33 months before D	
	30 months before D	
	27 months before D	
Appoint engineer (if not appointed as site engineer)	**24 months before D**	
Prepare induction and training courses	**21 months before D**	
Appoint C.S.S.D. supervisor	**18 months before D**	Hand-over of boiler house
Start recruitment talks to schools	**17 months before D**	
Appoint assistant administrator	**16 months before D**	
Appoint assistant matron	**15 months before D**	
Advance appointments of engineering staff	**14 months before D**	
	13 months before D	
Prepare programme of staff appointments	**12 months before D**	
Prepare advertisements and plan media	**11 months before D**	Hand-over of residency
	10 months before D	
	9 months before D	
Appoint cook for temporary kitchen in residency	**8 months before D**	Hand-over of out-patients' department
Start to appoint dept. heads and courses for supervisors	**7 months before D**	
Start to appoint P. and T. staff. Appoint stores staffs*	**6 months before D**	Snag list
Start to appoint ward and departmental sisters	**5 months before D**	Snag list
Appoint cooks and kitchen staff. Engineering staff	**4 months before D**	Final snag list
All departmental heads in post	**13 weeks before D**	Contract completion date. Practical compl. inspection
Appoint porters	**12 weeks before D**	**Hand-over of main building.** Practical completion certificate. Start of defects period
Start to appoint nurses and nursing auxiliaries	**11 weeks before D**	
	10 weeks before D	
	9 weeks before D	
	8 weeks before D	
	7 weeks before D	
	6 weeks before D	
	5 weeks before D	
	4 weeks before D	
Appoint house officers	**3 weeks before D**	
Complete appointments of ancillary staff	**2 weeks before D**	
	1 week before D	
Review of establishment. Continuation courses	**D**	
	After D	Defects schedule Final completion Evaluation of design in use

NOTE: D=day on which patients are first admitted to wards

* And at the same time start induction and in-service training courses

TIMETABLE FOR DETAILED OPERATIONAL PLANNING	TIME SCALE	PLANNING & BUILDING STAGES (CONTROL)
The principles of operation must be established and recorded during the early planning stages. They will influence design decisions and also the choice of equipment, both fixed and unfixed	**Briefing and design period**	Statement of requirements Site selection (including landscape survey) Major operational policies Development plan Schedules of accommodation Sketch drawings Working drawings Specifications and bills of quantities Tenders Contract
	39 months before D	Building starts
	36 months before D	
	33 months before D	
	30 months before D	
	27 months before D	
Start to establish details of operation. The coding of each item which has to be considered (see Section 10) could well assist the programming of this work. For example, a code letter could be used to indicate matters which could not be concluded before consultation with the new departmental heads	**24 months before D**	
	21 months before D	
	18 months before D	Hand-over of boiler house
	17 months before D	
	16 months before D	
	15 months before D	
	14 months before D	
	13 months before D	
	12 months before D	
	11 months before D	Hand-over of residency
	10 months before D	
Review forms and stationery proposed	**9 months before D**	
	8 months before D	Hand-over of out-patients' department
Publish first edition of operational handbook	**7 months before D**	
	6 months before D	Snag list
Prepare timetable of initial cleans (by department)	**5 months before D**	Snag list
	4 months before D	Final snag list
	13 weeks before D	Contract completion date. Practical compl. inspection
Start initial cleaning programme	**12 weeks before D**	**Hand-over of main building.** Practical completion certificate. Start of defects period
	11 weeks before D	
Finish initial cleaning programme	**10 weeks before D**	
	9 weeks before D	
Complete the detailing of operational policies	**8 weeks before D**	
	7 weeks before D	
Publish addenda to operational handbook	**6 weeks before D**	
	5 weeks before D	
	4 weeks before D	
	3 weeks before D	
	2 weeks before D	
	1 week before D	
	D	
Evaluation of operational policies	**After D**	Defects schedule Final completion Evaluation of design in use

NOTE: D=day on which patients are first admitted to wards

TIMETABLE FOR PHASED OPERATION	TIME SCALE	PLANNING & BUILDING STAGES (CONTROL)
	Briefing and design period	Statement of requirements Site selection (including landscape survey) Major operational policies Development plan Schedules of accommodation Sketch drawings Working drawings Specifications and bills of quantities Tenders Contract
The engineering services are progressively commissioned during the construction period	**39 months before D**	Building starts
	36 months before D	
	33 months before D	
	30 months before D	
	27 months before D	
	24 months before D	
	21 months before D	
	18 months before D	Hand-over of boiler house
	17 months before D	
	16 months before D	
Boiler house operational	**15 months before D**	
	14 months before D	
	13 months before D	
	12 months before D	
	11 months before D	Hand-over of residency
	10 months before D	
Residency opened (with temporary feeding facilities)	**9 months before D**	
Out-patients' department available as temporary store	**8 months before D**	Hand-over of out-patients' department
	7 months before D	
	6 months before D	Snag list
	5 months before D	Snag list
	4 months before D	Final snag list
	13 weeks before D	Contract completion date. Practical compl. inspection
Occupation of departments starts	**12 weeks before D**	**Hand-over of main building.** Practical completion certificate. Start of defects period
	11 weeks before D	
	10 weeks before D	
All departments occupied	**9 weeks before D**	
	8 weeks before D	
	7 weeks before D	
	6 weeks before D	
	5 weeks before D	
	4 weeks before D	
	3 weeks before D	
All ancillary, medical and service depts. operational	**2 weeks before D**	
Out-patients' department opened	**1 week before D**	
First ward opened	**D**	
Wards opened progressively	**After D**	Defects schedule Final completion Evaluation of design in use

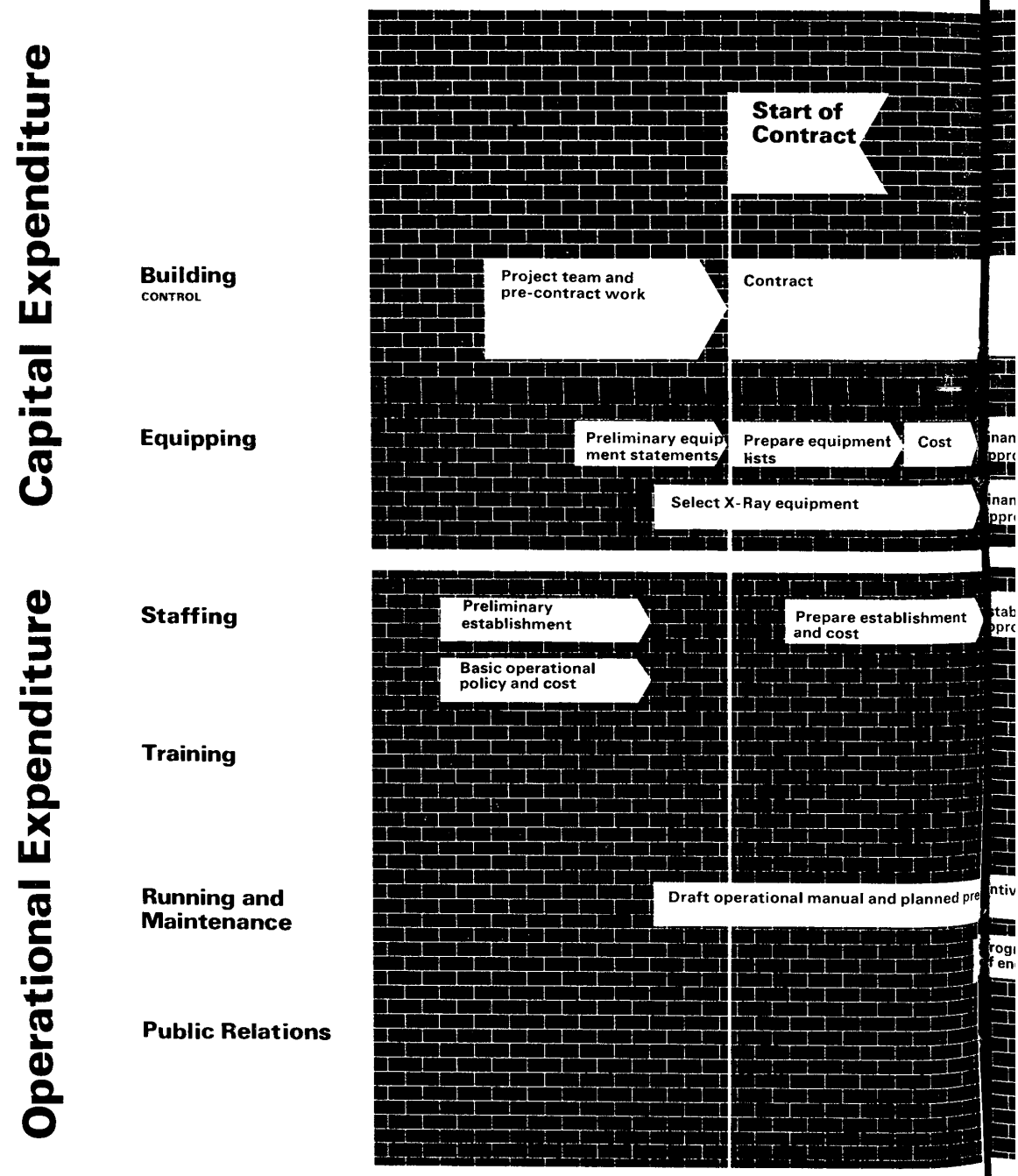
NOTE: D=day on which patients are first admitted to wards

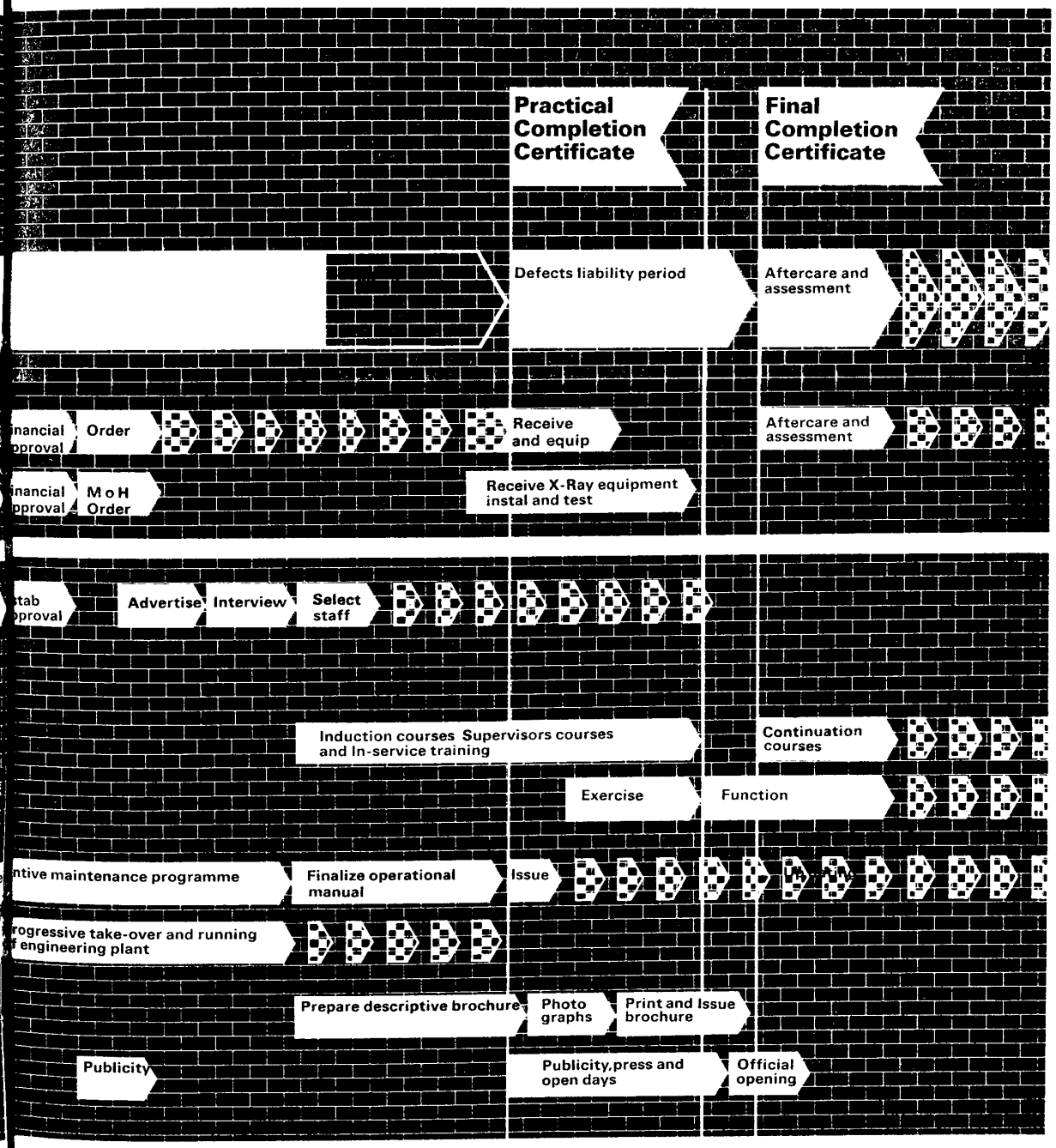
TIMETABLE FOR PUBLIC RELATIONS	TIME SCALE	PLANNING & BUILDING STAGES (CONTROL)
	Briefing and design period	Statement of requirements Site selection (including landscape survey) Major operational policies Development plan Schedules of accommodation Sketch drawings Working drawings Specifications and bills of quantities Tenders Contract
Description of project in press	**39 months before D**	Building starts
	36 months before D	
	33 months before D	
	30 months before D	
	27 months before D	
	24 months before D	
	21 months before D	
Progress report in local press	**18 months before D**	Hand-over of boiler house
	17 months before D	
	16 months before D	
	15 months before D	
	14 months before D	
	13 months before D	
Progress report in local press	**12 months before D**	
	11 months before D	Hand-over of residency
	10 months before D	
Plan publicity to assist recruitment	**9 months before D**	
Local exhibitions of plans, etc.	**8 months before D**	Hand-over of out-patients' department
Start talks to local societies	**7 months before D**	
Start preparation of descriptive brochure	**6 months before D**	Snag list
Initiate publicity campaign to assist recruitment of staff	**5 months before D**	Snag list
Start to consider arrangements for official opening	**4 months before D**	Final snag list
	13 weeks before D	Contract completion date. Practical compl. inspection
	12 weeks before D	**Hand-over of main building.** Practical completion certificate. Start of defects period
	11 weeks before D	
	10 weeks before D	
	9 weeks before D	
	8 weeks before D	
	7 weeks before D	
	6 weeks before D	
	5 weeks before D	
Plan arrangements for dealing with requests to visit	**4 weeks before D**	
Open day or days	**3 weeks before D**	
	2 weeks before D	
Local and national press day or days	**1 week before D**	
	D	
Official opening (not earlier than 8 weeks after D)	**After D**	Defects schedule
Publish descriptive brochure		Final completion
		Evaluation of design in use

NOTE: D=day on which patients are first admitted to wards

Appendix B Commissioning Diagram

reference paragraph 3.2




Practical Completion Certificate
Final Completion Certificate
Defects liability period
Aftercare and assessment
nancial pproval
Order
Receive and equip
Aftercare and assessment
nancial pproval
M o H Order
Receive X-Ray equipment instal and test
tab pproval
Advertise
Interview
Select staff
Induction courses Supervisors courses and In-service training
Continuation courses
Exercise
Function
ntive maintenance programme
Finalize operational manual
Issue
rogressive take-over and running engineering plant
Prepare descriptive brochure
Photo graphs
Print and Issue brochure
Publicity
Publicity, press and open days
Official opening

Appendix C Commissioning Activities

reference paragraph 3.3

The approach made by the Wessex Regional Hospital Board for the rebuilding of Poole General Hospital

STREAM	ACTIVITIES
1 Building of the Hospital	Building in course of erection. Final completion of building. Fire precautions. Security. Sign posting. Services commissioned. Lifts tested. Mechanical services tested. Electrical services tested. Telephones tested. Final external cleaned. Final internal cleaned.
2 Equipping the New Building	Draft schedules prepared, agreed and existing equipment for re-use selected. Quotations and selection of specialised equipment obtained. Orders placed for specialised equipment. Quotations and selection of non-specialised equipment. Orders placed for non-specialised equipment. Delivery and storage of new equipment, selection of removal firm, transfer of existing equipment, commence stocking wards and departments with new equipment, complete stocking wards and departments with new equipment, internal clean, occupation by patients.
3 Medical Services Departments Operational Policies and Working Methods	Define scope of activity. Commence defining policy for individual departments.
4 Hotel and Supporting Departments Operational Policies and Working Methods	Define scope. Commence defining individual departments. Complete staff instruction manuals.
5 Staffing Establishments, Recruitment and Training	Preliminary staff estimates. Range and scope of training programme. Re-assessed estimates for departments. Training methods determined. Training of existing staff. Final assessment of total requirements. Assessment of net staff requirements. Board/H.M.C. approval. Recruit and appoint additional staff. Train recruited staff. Complete training of recruited staff.

STREAM	ACTIVITIES
6 Maintenance and Supplies Estimates, Contracts and Miscellaneous Financial Matters	Preliminary estimate of running costs. Revised estimates of running costs per department. Estimates and selection of supplies and contracts. Final estimate of running costs. Place supply contracts. Board/H.M.C. approval. Allocation of funds to H.M.C. Delivery of supplies.
7 Transfer of Departments	General policy decisions. Board/H.M.C. approval. Detailed arrangements for transfer including the timing. Transfer of existing departments.
8 Take-over from Contractor and Planned Maintenance	Agreement with contractor re take-over. Prepare draft plan maintenance scheme. Inspection of building. Finalise planned maintenance scheme. Take over building and implement planned maintenance.
9 Opening Ceremony	Selection of person to perform ceremony. Detailed organisation and arrangements. Actual opening ceremony.

Appendix D Specimen Movement Instructions

reference paragraph 3.14

This is a revised version of the paper which was produced to co-ordinate arrangements for the detailed occupation of the new hospital at Altnagelvin, Northern Ireland. It is included as an example of an appropriate approach to the task of communication involved rather than of detailed arrangements made. For instance, the matron of a new hospital would normally not now be closely concerned with the detailed cleaning arrangements.

1 DATES

(a) The main hospital will be handed over to the Authority on the 1st December 1959 and the nurses' home on the 1st October 1959.

(b) The following dates now apply:

Occupation by Laboratory	1st December 1959
Occupation by C.S.S.D.	15th December 1959
Occupation by Pharmacy	19th January 1960
Occupation by Physiotherapy	29th January 1960
Occupation by Administration	30th January 1960
Occupation by X-ray	30th January 1960
Occupation by Patients	1st February 1960
Opening of Wards, Casualty and Out-patients	1st February 1960

2 BROAD PLAN

(a)
(i) The matron will arrange for the domestic supervisor to commence cleaning the nurses' home on the 19th October 1959.

(ii) The supplies officer will furnish the home, floor by floor, as it is completed, will obtain a signature on an inventory which he will hand over to matron's representative.

(iii) Matron will arrange thereafter for maintenance cleaning.

(b)
(i) Matron will arrange for the cleaning of the main hospital to commence on the 1st December 1959.

(ii) As soon as each department is clean the supplies officer will furnish it, will obtain a signature on one inventory, and will hand over the key to the departmental head concerned.

(iii) Matron will arrange thereafter for maintenance cleaning.

(c) The main hospital will be cleaned and furnished by the 23rd January 1960. This will give the last furnished departments a clear week to sort out and most departments considerably longer.

(d) The catering officer will be responsible for cleaning the kitchen premises and equipment in the main kitchen, and the domestic dining room, and will commence work on the 1st November 1959. This work will be carried out by her own staff and she should employ just sufficient for the work in hand.

(e) The hospital will be ready to function in all departments at 9.00 a.m. on Monday, 1st February 1960.

3 DETAILED ARRANGEMENTS

(i) Cleaning

(a) The success of the cleaning plan (see separate departmental programme for timetable) depends on the domestic supervisor who will be responsible to matron for the efficient and expeditious carrying out of the work.

(b) The appropriate labour force will be computed by the matron and engaged to start work three days prior to the commencement of operations. Labour should be employed on a temporary basis and permanent staff appointed from among them.

(c) The secretary will provide modern cleaning apparatus for the work.

(d) The supplies officer will ensure the supply of all cleaning materials.

(e) Detailed notes on cleaning are included.

(ii) Furnishing

(a) The supplies officer will ensure that every item of equipment and furniture is labelled with its destination before the 1st December 1959 and that it is stored at strategic points which will ensure rapid and efficient distribution.

(b) The secretary will employ the balance of the porter staff (15 men) on the 16th November 1959 and these men will come under the control of the head porter and supplies officer for furniture shifting. Two men will be detached for duty with the chief pharmacist with effect from the 19th January 1960.

(c) The supplies officer will ensure that duplicate inventories are made out, and that one copy is handed over on signature to the head of each department.

(d) Furniture will be taken over and signed for by the head of the department on the office copy inventory.

(e) The heads of departments will ensure that officers in charge are available to take over furniture and equipment when their department has been cleaned.

(iii) Other Supplies

(a) The supplies officer will arrange to issue the

NOTE* In the event, to avoid carrying staphyloccocal infection from old to new hospital, no patients were moved. This was achieved by stopping admission of non-urgent cases for about six weeks before the opening of the new wards and leaving rear parties until there were no patients left.

following stores, on signature, to the heads of departments at the same time as the furniture hand-over:

Crockery and utensils
Cleaning equipment
Cleaning materials
Linens

He will arrange to stock the linen exchange room with four days' supply and will hand over the inventory, on signature, and the key to the matron's representative on the 11th January 1960.

(b) The supplies officer will arrange to issue all medical instruments to departments at the same time as (iii) (a) above.

(c) The chief pharmacist will arrange to issue initial medical supplies to the departments commencing on 25th January 1960. This work must be completed by the 30th January 1960.

(d) The catering officer will arrange to issue ward supplies (tea, sugar, etc.) on the 29th January 1960.

4 MAINTENANCE

The group maintenance department will assemble on Monday, 18th January 1960 and the superintendent engineer will be responsible for organising maintenance on a group basis from that date.

5 AMBULANCE SERVICE

The administration of the ambulance service will be taken over on the 1st March 1960 and during the interim period will be operated on its existing basis.

6 MOVEMENT

(i) **Laboratory** The movement of the laboratory from Brooke Park will necessarily be complicated by virtue of the fact that certain benching and equipment is to be transferred. Movement will, therefore, be phased under a plan to be agreed between the pathologist and the secretary. The pathologist will inform the secretary of:

(a) the equipment to be moved,
(b) the date he requires it to be moved.

(ii) **Other Departments** The movement of other departments will take place on the date shown in paragraph 1(b), but arrangements can be made for the prior movement of any equipment if desired by the head of department.

Movements for which transport will be required are as follows:

Patients
Resident staff and luggage
Departmental equipment

Patients will be moved by ambulance and staff 'bus. Resident staff will be moved by staff 'bus or Ulster Transport Authority.

Luggage and equipment will be moved by Ulster Transport Authority lorry.

(a) **Patients** The number to be transferred will not be known until January 1960, but providing clinics are cancelled on the 1st February and admissions are confined to emergencies, no more than 120 patients should require lifting. This number can be satisfactorily lifted by our own ambulances in under seven hours. Arrangements will be made, nearer to the date, by the secretary and matron.*

(b) **Resident Staff and Luggage** Small parties will require transport during the month of January 1960, and possibly a heavy lift on the evening of the 31st January 1960. The matron will endeavour to demand transport at least 24 hours in advance of its requirement.

(c) **Departmental Equipment** Departmental heads should assess, as soon as possible, the equipment to be moved and when they will require it to be moved and inform the secretary accordingly. For this purpose, departmental heads are as follows:

Officer	*Department*
Radiologist	X-ray
Matron	Wards, homes, kitchens and E.E.T. hospital
Superintendent Physiotherapist	Physiotherapy
Chief Pharmacist	Pharmacy
Superintendent Engineer	Maintenance Shops
Deputy Secretary	Administration

(d) **Leave** Heads of departments are urged to ensure that their leave rotas are arranged so that no staff are absent during vital periods.

7 OUT-PATIENTS' DEPARTMENT AND CASUALTY

All clinics must be cancelled on the 1st February 1960. Casualties will be received in Waterside Hospital up to 9.00 a.m. on 1st February 1960 and at the new hospital from 9.00 a.m. onwards.

8 DISSEMINATION OF INFORMATION

The secretary will arrange notices given below in conjunction with (where appropriate) heads of departments:

INFORMATION	TO WHOM	DATE GIVEN
Anticipated strength by dates	Ulster Transport Authority	As soon as possible
Date of opening new hospital and closing City and County and E.E.T. Hospitals	Corporation, Rural District Council, Northern Ireland Electricity Board Contractors Northern Ireland General Health Services Board	1st December 1959
Addresses and telephone numbers, etc.	County and County Borough Welfare Committees County and County Borough Medical Officers of Health County and County Borough Health Committees General Post Office	
Clinical plans	General Practitioners Medical Officers of Health County and County Borough Welfare Committees County and County Borough Health Committees Service Establishments	1st November 1959
Movement of any patient Address, telephone number	Relatives	Night before move
Pathological arrangements	By Pathologist	1st November 1959

NOTES ON CLEANING

1 All types of floor will first be suction vacuumed.

2 Wood, linoleum, and P.V.C. floors will be cleansed with an emulsion cleaner and then treated with a light coat of wax polish.

3 Terrazzo and quarry tiled floors will be scrubbed with detergent once.

4 Cork tiles will be sealed by experts and lightly mopped by staff.

5 Chrome and metal fittings will be washed with soap and water; no abrasive will be used.

6 Tiled walls will be washed down with detergent solution.

7 Painted walls will be suction vacuumed.

8 Sills, ledges, etc., will be suction vacuumed.

9 Cement floors and corridors will be suction vacuumed and sealed by special arrangements made by the secretary.

Appendix E Equipment Specification Working Groups

reference paragraph 4.7

Position at 19 April, 1966

Groups appointed:

Bed Linen
Boiler Fuel Oil*
Children's Beds and Cots
Crockery
Domestic Area Furniture*
Gowns for Patients and Staff
Mattresses
Non-nursing Uniforms*
Nurses' Uniform (male and female)
Office Area Furniture*
Operating Theatre Tables
Paint (decorative paints only)*
Patient Area Furniture
Protective Clothing
Provisions (cereals and cereal products)
Trolleys (other than those for patients and food)

Groups contemplated for the future:

Patients' Clothing
Patients' Trolleys
Provisions (further items)
Solid Fuel
Towelling

*These groups have submitted their reports, and they are under consideration by the Ministry or have been implemented.

Appendix F Notes on Fixed Equipment

reference paragraph 4.9

This is an extract from the Oxford Regional Hospital Board's publication, *Commissioning a New Hospital*

It has already been suggested that from the earliest stages the planning of a hospital building should be carried out on the principle of providing the necessary space in which specified functions will be carried out rather than providing a series of spaces into which the functions must be fitted. If this is done a mental picture will have been built up for the architects and members of the planning team of the activities and content of each room.

The necessity to reach decisions on items of fixed equipment at an early stage is often regarded as unreasonable by the individual users who are called upon to make these decisions, knowing, as they do, that for a major scheme it is likely to be three or more years before the building comes into operation, and that during that time improvements and new developments may be made in the equipment available and that quite new procedures and types of apparatus might be introduced. It might be argued by those unfamiliar with the complexities of planning that these items of equipment are in any case likely to wear out or become obsolete and will need to be replaced several times during the life of the building and therefore their selection can be deferred. It may perhaps be possible to allow provisional sums in the contract for some of these items, so that a final decision can be postponed until the building is under construction or nearing completion, but the number of instances when this can be allowed must be reduced to the minimum if the building is to be completed on schedule and within the estimate approved.

Many items are included in the fixed equipment because they have connections to one or more of the general services and the outlet for and load to be put on these services must be known during the working drawing stage. For more intricate equipment, such as x-ray sets, full details are required, since the building contract must include not only specifications for expensive and involved services, but sometimes provision must be made for special structural modifications.

It is for the planning team to consider all the implications and to take decisions on these matters, allowing reasonable flexibility of choice to the individual user, and at the same time giving the architect sufficiently definite instructions to enable him to provide the services and outlets necessary and to complete his working drawings and bills of quantities realistically and without undue delay.

It has been found that the larger the number of items of fixed equipment on which decisions are deferred, the greater will be the probability of variations in the contract, with consequent increases in the contract price and delay in the completion of the building.

A further matter for consideration is whether to include as many items as possible in the contract to be provided as fixed equipment, or whether it is preferable to exclude them and provide them as movable equipment. An advantage of including them as fixed equipment is that all risks concerned with delivery and installation are borne by the contractor, and the hospital authority can then insist on the equipment being in good working order before taking over the building. Items which are left to be included as movable equipment but which subsequently require some kind of fixture, be it only screwing to the wall, are liable to damage the finished surfaces and the cost of making good must then be borne by the hospital authority. It is advisable therefore to include in the contract all items which require any form of fixture.

Whilst the planning team must be responsible for the final instructions to the architects on all items of fixed equipment, it is important for the contentment of the technical staff to appreciate that many items which come within this category are the essential tools and personal equipment which the staff will constantly use in their day-to-day work. Personal selection and freedom of choice of design should therefore be allowed to as great a degree as is compatible with the general plan and overall cost. Some items which are commonly installed in many different departments, such as wash-hand basins, lighting fixtures, etc., must generally conform to a common pattern, and, if the original selection of design of such items is sound, little difficulty will be experienced in obtaining acceptance in all departments, but for special fixtures, positioning and height are factors in which individual preference should be permitted whenever feasible.

Some of those members of the staff who are consulted about details of equipment may be unfamiliar with the technique of planning, and the planning team must be ready to offer helpful information on the alternatives which are available. Many individuals find it difficult to appreciate three dimensions when faced with a floor plan and no effort should be spared to help these people in arriving at the right decisions by demonstrating

the size and shape of rooms and equipment, either by using existing departments as a guide, or, if necessary, by making simple scale models or preparing 'mock-ups' of rooms.

The thought which is given to small details concerned with items of fixed equipment will have a considerable effect on the efficiency of the completed building, and the planning team must make it their responsibility to ensure that these details are not overlooked. Some of the problems have already been referred to and the following are examples of some of the more important factors to be taken into account.

Position
The positioning of fixed equipment will, to a large extent, dictate the future function and method of work undertaken in each room. It is, therefore, essential that the function of the room should be clearly determined before the position of fixed equipment is decided. The position and movement of patients' beds, trolleys, etc., should be worked out before any decisions are taken about the position of such items as wash-hand basins, built-in cupboards, etc.

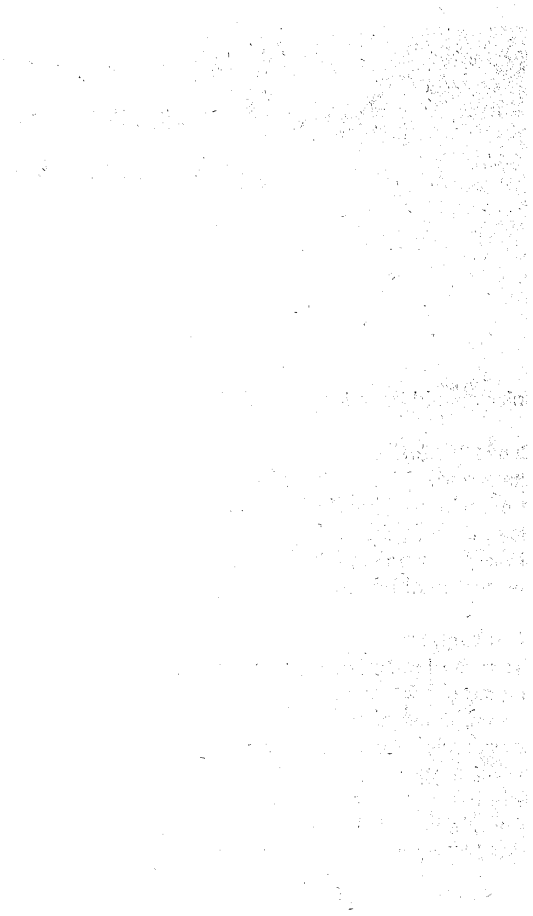
Height
Fixed equipment is generally shown on an outline floor plan of rooms and the height is often not shown. This can lead to confusion when the fixtures are installed. It is important, therefore, that the height of all fixtures should be specified and elevation plans as well as floor plans should be prepared for the planning team. This is particularly important when decisions are called for on worktops over cupboards, bench heights for working surfaces, wash-hand basins, sinks, taps, x-ray viewing boxes, etc. To determine the height it must be decided whether the user will be sitting or standing, and if sitting, whether an ordinary chair or high stool will be used.

Appearance
Although technical efficiency must not be sacrificed for the sake of appearance, nevertheless the design, colour and material of fixed equipment can have a considerable effect on the general atmosphere of a new hospital. In all patients' accommodation a homely rather than an institutional note should be introduced wherever possible.

Noise
Every item of fixed equipment should be examined for its noise producing character and where possible noise should be reduced or eliminated.

Cross-infection
The hazards of cross-infection must be constantly borne in mind in reaching decisions on fixed equipment. This may influence the position, design and surface finishes of fixed equipment, the avoidance of dust traps and the sloping of ledges.

Maintenance
The ease of maintenance will affect the future smooth running of the hospital and this must be taken into account in selecting equipment. Mechanical apparatus, for example, autoclaves, x-ray generators and lift motors, should, if possible, be sited in such a way that the engineering staff can gain access to the equipment without entering clinical or clean areas. Surface finishes should be durable and easily cleaned.



Appendix G Specimen Terms of Reference for Design Consultant

reference paragraph 4.10

These terms of reference were produced by the Oxford Regional Hospital Board for the High Wycombe War Memorial Hospital development

1 **Appointment**
The design consultant will be appointed and remunerated by the Oxford Regional Hospital Board.

2 **Chain of Responsibility**
The person appointed will act as consultant to the nominated architect from whom he will take his instructions. In the exercising of his function he will work through the combined planning team. This consists of the following:

(a) the Board's project team;
(b) representatives of the Hospital Management Committee;
(c) the nominated architect.

At local level, the design consultant will be expected to work in very close co-operation with the High Wycombe and District Hospital Management Committee.

3 **Duties**
(a) **Work on the Building** The design consultant will be required to co-operate with the nominated architect in the preparation of colour schemes and on the selection of the floor finishes and other fittings.

(b) **Work in Connection with Furniture and Soft Furnishings** A general list of furniture and soft furnishings will be drawn up by the Hospital Management Committee. The design consultant will advise on the quantities based on availability of space within each area. From his knowledge of current markets he will:

(i) Consult with the H.M.C. in order to determine user requirements and establish medical principles in so far as these affect the internal layout of furniture and furnishings.
(ii) Give advice on appropriate furniture and furnishings for each area of the hospital.
(iii) Where necessary design special items and/or adapt standard items where there are no standard items available which meet the overall requirements.
(iv) Give general advice on expendable items such as crockery, cutlery, bedding and linen.
(v) In co-operation with the group supplies officer make contact with manufacturers and present the above information by means of exhibition and/or display panels supported by supplementary schedules indicating source of supply and competitive price where practicable.
(vi) Where necessary consult locally to arrange for certain items to be used experimentally.

In short, the design consultant will be asked to make specific recommendations on:

(i) *Colour Schemes*
(ii) *All Non-clinical Furniture,* including:

Chairs, all kinds	Beds
Stools	Bedside lockers and lamps
Tables, all kinds	Vases
Bookcases	Wastepaper baskets
Cabinets	Ashtrays
Magazine racks	Pictures
Office furniture	Mirrors
Bed trays	

(iii) *Soft Furnishings*

Curtains, all kinds	Rugs
Counterpanes	Cushions
Carpets	

With general recommendations and suggestions on:

(iv) *Expendable Items*

Cutlery	Bedding
Crockery	Linen

The items listed under (ii), (iii) and (iv) above are by no means comprehensive but will give some idea of the kind of equipment on which the design consultant will give advice.
In considering the above, the design consultant will bear in mind the need to rationalise selection with Hospital Management Committee replacement policy, and wherever possible every advantage will be taken of the excellent range of furniture and floor coverings available at advantageous prices through the Ministry of Works.
He will also bear in mind the need to comply with the Board's standing orders relating to tender and purchasing procedures.

Appendix H Proposals for Training

reference paragraph 5.5

These are provisional proposals in connection with the commissioning of Poole General Hospital

ACTIVITY	OBJECTIVES	MEMBERSHIP
SENIOR MANAGEMENT CONFERENCE	To present, discuss and obtain agreement on the overall pattern of training to be provided and its place in management policies. To include consideration of roles of various levels; authority, responsibility, delegation, control, communication	Group secretary, treasurer and deputies, hospital secretaries and matrons in group. Doctors with administrative responsibilities
REGIONAL MANAGEMENT COURSES (Existing Courses)	To consider the broader management situation and the fundamental problems, theories and functions of management	Group secretary, treasurer and deputies, hospital secretaries and matrons in group. Doctors with administrative responsibilities. Similar levels from rest of region
TECHNIQUES OF MANAGEMENT	A follow-up to course 2, aimed at developing knowledge and skills in some modern management methods, including hospital activity analysis	As (1)
SUPERVISOR COURSES (Part 1)	To disseminate ideas and policies of management to all those responsible for controlling resources and produce a common outlook. (At present, management philosophies are not widely accepted at this level.) This will be part of the regional programme of this type of training	All ward sisters, heads of departments and junior doctors throughout the group
SUPERVISOR COURSES (Part 2)	To equip some or all Poole supervisors with the skills of analysing work for training purposes and the basic techniques of teaching. May be possible to include other skills, e.g. interviewing, report writing, etc.	Ward sisters and heads of departments at Poole
INDUCTION	To equip basic grades of staff with the necessary common knowledge and outlook about the hospital and the service. Most of this will be for newcomers to Poole as the staff is built up	All below supervisor level
JOB ANALYSIS AND INSTRUCTION	Supervisors carry out analyses of work in their own departments with assistance of R.H.B. and H.M.C. staff. Prepare instructional material (manuals, etc.). Some programmed instruction?	Supervisors at Poole with assistance from work study, patient services, nursing, training, etc.
JOB TRAINING	Teach new staff jobs in each department	All newcomers
PROFESSIONAL, TECHNICAL AND CRAFT TRAINING	Recruit and train student grades where necessary	Medical ancillary departments, engineers, etc.
MOVING	To ensure that staff can work efficiently in their new environments	All

TIMING AND DURATION	ORGANISERS	COURSE LEADERS/ TEACHERS	METHOD	REMARKS
2 days Oct. 1965	Training dept.	Training dept., R.H.B. officers, outside lecturers, W. Cumberland officers	Formal conference with much discussion	Essential to develop universal management philosophy
4/5 days. Various dates Oct. 1965 to May 1966	Southampton University/ training dept.	University and R.H.B. staff and visiting lecturers	Formal conference with much discussion	Local and regional management policies must be complementary
1 week, Spring 1966	Training dept. and specialist agencies	Specialist agencies, training dept., R.H.B. staff	Formal course with much practical work	
1 week. About 15 separate courses starting Nov. 1965. Complete mid-1966	Training dept. with help from H.M.C.	Training dept. and visiting lecturers and H.M.C. and R.H.B. staff	Formal conference with much discussion	
Probably 1–2 weeks. Commence mid-1966. Complete by about Jan. 1967	Training dept. and specialist agencies, with help from H.M.C.	Specialist agencies	Formal course with much practical work	
To be determined	Probably supervisors	Supervisors, H.M.C. and R.H.B. staff as appropriate	To be determined. Some programmed instruction?	In building up a common outlook on management, there can be no substitute for time spent by managers and supervisors with their staff. Time must be found by a greater delegation by some officers, the provision of temporary relief staff and the early employment of some supervisory grades
To be determined	Training dept. and H.M.C.	Supervisors	Individual work under general guidance. Some programmed instruction? Visits to manufacturers, etc.	
As necessary	Supervisors	Supervisors	As appropriate	
Varied but all measured in years	Trainers and H.M.C. staff and educational authorities	Education authorities	Formal courses	Decisions must be taken **now** on the numbers of students to be recruited at once to provide trained staff at commissioning
To be determined	H.M.C. staff	H.M.C. staff	Phased move with running-in periods	Opportunities to inspect new depts. before occupation will be useful but should not supplant the more effective 'learning by doing' possible with a running-in period

Appendix I Specimen Certificate of Practical Completion

reference paragraph 6.4

This is the form used in the South West Metropolitan Region

SOUTH WEST METROPOLITAN REGIONAL HOSPITAL BOARD

Contract..... Contract No.....

ARCHITECT'S CERTIFICATION OF PRACTICAL COMPLETION

In pursuance of Clause 16 of the Conditions annexed to the Contract dated the.....

day of.....and made between

The South West Metropolitan Regional Hospital Board

and.....

for .....

at .....

I HEREBY CERTIFY that subject to the provisions of Clause 12 of the said conditions

* (A) the whole of the work was completed on the.....day of..... and that the said defects liability period will end on the.....day of.....

(B) a part or section of the works, namely.....

.....

was completed and taken into use on the.....day of.....and that in relation to the said part or section of the works, the said defects liability period will end on the ..... day of.....

Dated this.....day of.....

.....
Architect to the Board.

* Strike out whichever is inapplicable

This form is sent to the contractor, quantity surveyor, clerk of works, regional engineer, contractor's office, and hospital authority. A copy is filed in the architect's office

Appendix J Specimen Certificate of Final Completion

reference paragraph 6.4

This is the form used in the South West Metropolitan Region

SOUTH WEST METROPOLITAN REGIONAL HOSPITAL BOARD

Contract..... Contract No. .....

ARCHITECT'S CERTIFICATION OF FINAL COMPLETION

In pursuance of the Contract dated the.....day of

.....made between

The South West Metropolitan Regional Hospital Board

and.....

(herein after called the Contractor)

for .....

at .....

I HEREBY CERTIFY that the works being the subject of the above-mentioned Contract were completed on .....day of.....

including the requirements of Clause 12 and that the balance of the retention money due under the Contract may now be paid to the Contractor, (excepting only such retentions on Engineering Sub-Contracts as may be required by the terms of each sub-contracts).

Dated this .....day of.. .....

.....

Architect to the Board.

This form is sent to the contractor, quantity surveyor, clerk of works, regional engineer, contractor's office, and hospital authority. A copy is filed in the architect's office

Appendix K
List of Operational Policies

reference paragraph 7.6

This list shows the operational policies prepared for the Royal Cornwall Hospital (Treliske), Truro

Phase I

1 Almoner Services
2 Control of Infection
3 Maintenance Requisition Procedure
4 Chaplaincy Arrangements
5 Private Patient Arrangements
6 Employment of Ward Secretaries
7 The Hospital Shop
8 Commissioning of the Staff Hostel
9 Patients Dying in Hospital
10 Patients Admission Arrangements
11 Staff Health
12 Visiting and Relatives' Enquiries
13 General and Ward Storage Arrangements
14 Incidental Subcutaneous Injection Procedure
15 Ward Dressings
16 Ward Preparation of Patients for Theatre
17 Disposal of Waste
18 Function of the Hospital at Phase I
19 Linen Exchange in the Nurses' Home
20 Intra-muscular Injection Procedure
21 Patients' Brochure
22 Patients' Property
23 Ward Administration
24 The Nurses' Day
25 Transferring Patients between Wards and Theatre
26 The Day Case Unit
27 Cardiac Arrest – Emergency Procedure
28 C.S.S.D. Organisation
29 Moving Anaesthetised Patients in Theatre Suite
30 Voluntary Services
31 Visitors' Information Card
32 Medical Records
33 Code of Procedure to Obviate Risk of Wrong Operation
34 Isolation of Infectious Patients
35 Drugs and Dressings – Ward Procedure
36 Morning and Evening Toilet and Bedmaking Procedures
37 Laundry Arrangements
38 Recruitment
39 Use of Disposables
40 Staff Name Badges
41 Use of Lifts
42 Staff Rest Breaks
43 Stationery Requirements
44 Catering Services
45 Administrative Organisation
46 Ward Linen
47 Disposal of Pathological Laboratory Waste
48 Recruitment Brochure
49 Transport
50 Stores Issues
51 Domestic Services
52 Safety Precautions
53 Signposting
54 Commissioning the Hospital – Outline Programme
55 Staffing Programme
56 Financial Management
57 Security and Locks
58 Staff Training
59 Staff Uniform
60 Linen Services
61 Student Nurse Training
62 Staff Changing Accommodation
63 Laboratory Services
64 X-ray Services
65 Patients' Amenities
66 Window Coverings
67 Physical Medicine Services
68 Staff Induction
69 Personnel Management
70 Pharmacy Services
71 Portering Services
72 Telephone Services
73 Public Relations and the Press
74 House Officer Rules
75 Pneumatic Tube Communication System
76 Admissions, Discharges, Deaths – Nursing Aspects
77 Collection and Delivery Arrangements in C.S.S.D.
78 C.S.S.D. Packs and Their Contents
79 Use of Theatre No. 3
80 Theatre Administration
81 Training C.S.S.D. Personnel
82 Commissioning of the Boiler House
83 Pathology Reporting Procedure
84 Theatre Cleaning Arrangements
85 Commencement and Completion of Operations
86 In-service Training for Nursing Personnel
87 Commissioning Advance Storage Areas and Administrative Block
88 X-ray Reporting Procedure
89 Landscaping Programme

Phase II

101 Administrative Organisation
102 Linen, Uniform, Laundry Services
103 Locks and Security
104 Planning and Commissioning Programme

105 Re-use of Accommodation Arising from Phase II Development
106 Residential Accommodation
107 Signposting
108 Staff Facilities, Recruitment and Training
109 Staffing Requirements
110 Telephone Services
111 Nurse Training School
112 The Sick Bay
113 Window Coverings

120 Ante-natal Clinic
121 Catering Services
122 C.S.S.D. and Use of Disposables
123 The Maternity Unit – Nursing Administration
124 Flying Squad Arrangements
125 The Maternity Unit – Function and Effect on Existing Services
126 The Special Care Baby Unit
127 The Maternity Patient

Appendix L Specimen Operational Policy on Staff Uniforms

reference paragraph 7.16

This is an example of an operational policy produced by the Royal Cornwall Hospital (Treliske), Truro

1 The attached schedule sets out the items of uniform for each category of staff. The items of protective clothing which are not issued on a personal basis are set out in the Operational Policy on Linen Services, No. 60.

2 Wherever possible it is desirable to conform to the colours and designs used elsewhere in the group.

3 New designs should be used for dining room staff and all porters should be issued with two jackets and two pairs of trousers (dark green).

4 The following points have already been discussed in Operational Policy No. 60:

(a) The linen room will be responsible for storing and issuing staff uniform and protective clothing.

(b) A special printed card, to be kept by the linen room, will set out for each person the items of uniform issued and these details will be checked when uniform is handed in on termination of appointment.

(c) There will be a printed duplicate book, primarily for personal laundry, but also to be used for repairs. This will enable the linen room to have a record of all clothing handed in for repair.

(d) Items of uniform will be marked by a number allocated to each member of staff by the linen room.

5 Protective clothing over and above personal issues, should be available for:
Theatre staff – see O.P.80*
Sluicing duties – see O.P.71*
Car park duties – see O.P.71*
Office duplicating
X-ray staff in each diagnostic room
Porters' duty room
Kitchen, mortuary and theatre; wet cleaning procedures.

6 Uniform and clothing should be renewed annually, subject to condemning.

*These numbers refer to other operational policies

7 The following colours are proposed:

Female nursing administrative staff and tutors	Blue dresses
Female sisters	Navy blue dresses
Female staff nurses	Light blue dresses
Female enrolled nurses	Light green dresses
Female nursing auxiliaries	Mauve dresses
Female student nurses	Dark blue/white stripe dresses
Female cadets	Blue check Trimsona dresses
Male nursing staff	White drill suits with coloured flashes appropriate to ranks above
Senior male nursing staff	Charcoal grey suits
Occupational therapists	Green tunics
Radiographers and physiotherapists	White tunics
Almoners, pharmacists, lab. staff, doctors	White coats
Porters	Dark green suits
Domestic adminstrator	Maroon nylon overalls
Clerical and reception staff	Turquoise nylon overalls
Dining room staff	Light green button-front overalls
Domestic staff	Royal blue button-front overalls
Supervisory staff	Deep pink nylon overalls

Appendix L – continued

Royal Cornwall Hospital (Treliske) Truro
Uniform for each grade of staff

GRADE	Dress	Apron	Collar	Cuffs, pairs	Belt, white	Cap	Cloak	Overalls, nylon	Overalls, cotton drill	Coat, premier style, ¾-length	Epaulettes, pairs	Trousers, white drill
Senior male nursing staff												
Assistant matron	3		6			4	1					
Home sister	3		6			4	1					
Warden								3				
Principal tutor	3		6			4	1		3			
Tutors	3		6			4	1		3			
Night superintendent	3	12	6	6		4	1					
Theatre superintendent	3		6	6		4	1					
Sister and clinical tutor	3	12	6	6		4	1					
Staff nurses	3	12	6			4	1					
Student nurses	3	12	6			4	1					
Enrolled nurses	3	12	6			4	1					
Nursing auxiliaries	3	12				4	1					
Charge nurse male										12	4	2
Staff nurse male											4	2
Student nurse male											4	2
Nursing auxiliary male											4	2
Cadets												
Almoner								3				
Physiotherapist												
Occupational therapist	3											
Senior pharmacist												
Pharmacist												
Dispensing assistant												
Laboratory technical staff male												
Laboratory technical staff female									6			
Radiographers												
Student radiographers									10			
Dark room technician												
Medical photographer												
Other medical auxiliary staff												
Consultant												
Registrar												
House officer												

Epaulettes, pairs	Trousers, white drill	Jacket, premier style	Belts, petersham	Overalls, physiotherapist	Coats, Chester, white	Overalls, radiographer	Dresses, theatre	Footwear, anti-static, pairs	Trimsona dresses	Charcoal grey suits		Estimated cost of one set of uniform £	s.	d.
										2				
			2											
			2					1						
			2											
			2											
			2											
4	2													
4	2	12												
4	2	12												
4	2	12												
									10					
				12										
					6									
					6									
					6									
					6									
						10								
					6									
					3									
					3									
					6									
					12									
					12									

Appendix L – continued

Royal Cornwall Hospital (Treliske) Truro
Uniform for each grade of staff

GRADE	Jacket, overall, N. blue	Boiler suit	Bib and brace overall	Wellington boots, pairs	Coats, P.V.C., with hood	Gloves, protective	Caps, chefs	Aprons, chefs	Jackets, chefs, D.B.	Trousers, chefs	Coats, Chester, white	Neckerchiefs
Senior engineer		2		1	1							
Electricians/mates		2		1	1							
Fitter		2		1	1							
Plumber		2		1	1							
Carpenter			2	1	1							
General labourer			2	1	1							
Stoker (oil fired P.A.)		2										
Gardeners			2	1	1	1						
Catering officer											3	
Therapeutic dietition											3	
Head cook							6	12	6	6		6
Assistant head cook male							6	12	6	6		6
Assistant head cook female								12				
Cooks/assistant cooks male							6	12	6	6		6
Cooks/assistant cooks female								12				
Kitchen maids (part-time servers)								12				
Central washup assistant (group 1)												
Dining room supervisor												
Waitress/dining room maid												
Cafeteria assistant (cash)												
Domestic administrator												
Domestic supervisor												
Domestic forewoman												
Scrubbing team male	2		2									
Domestic assistants												
Linen room supervisor												
Linen room staff												
Hairdresser												
Barber											3	

	Coats, Chester, white	Neckerchiefs	Overalls, cotton drill	Caps, kitchen maids	Caps, kitchen porters	Jacket, S.B., white	Trousers, white drill	Overalls, nylon	Dress, dining room maids	Caps, waitresses	Aprons, waitresses		Estimated cost of one set of uniform £ s. d.
	3												
	3												
		6											
		6											
			6	6									
		6											
			6	6									
			6	6									
			6										
								3					
									3	4	12		
			3										
								3					
								3					
								3					
			8										
								3					
			6										
			3										
	3												

Appendix L – continued

Royal Cornwall Hospital (Treliske) Truro
Uniform for each grade of staff

GRADE	Coats, Chester, grey and blue	Aprons, plastic	Gloves, rubber, pairs	Jackets, S.B., white	Trousers, drill, white	Footwear, anti-static, pairs	Singlets, theatre, Aertex	Coats, Chester, white	Coats, warehouse	Overalls, cotton drill	Wellington boots, pairs
Motor driver (basic)	3										
Head porter	2										
Deputy head porter	2										
Porter operating theatre				12	12	1					
Porter X-ray department	3										
Porter dispensary	3										
Porter pathological laboratory	3										
Porter general	3										
Mortuary porter	3	2	1								
Theatre technician						1					
Mortuary attendant		2	1					3			
C.S.S.D. superintendent/deputy											
C.S.S.D. assistants											
C.S.S.D. steril. attendants											
Storekeeper									6		
Ward secretaries											
Receptionist											
Administrative staff											1
Clerical staff dealing with the public											

Wellington boots, pairs	Cap, uniform	Coat, macintosh, drivers	Overalls, nylon	Suits, theatre, white							Estimated cost of one set of uniform £ s. d.
	1	1									
	1										
	1										
	1										
	1										
	1										
	1										
				12							
			3								
			3								
				12							
			3								
1			3								
			3								
			3								

Appendix M Using the Commissioning Check List

reference paragraph 10.1

This illustrates one way in which the items in the commissioning check list might be set out to facilitate its use as a checking tool

10.3.1. accidents to patients, staff, visitors

Code	Detail	Action by	In consultation with	Target dates	Notes
P		administrator	group sec.	by 30 June	
f	design & forms	administrator	matron group sec.	by 15 July	arrange meeting in June
	printing " "	supplies off.		by 30 Nov.	
M		deputy admin	administrator	by 15 Dec.	

This form can be completed by the administrator for each item and an appropriate number of copies prepared for circulation to each person responsible for action. The master set for checking purposes can be kept in the administrator's office.

It may be convenient, where relevant, to record on the back of the master copy of the form the minute numbers and dates of decisions involved.

Printed in England by Alabaster Passmore & Sons Ltd, and
designed by Ken Baynes ARCA ASIA and Stephen Storr

Front cover: All the photographs on the cover are reproduced by the courtesy of the Ministry of Health. Individual credits, reading from left to right, are as follows: Leeds (A) Group Hospital Management Committee; Central Office of Information, Crown Copyright; Greenlys Public Relations Ltd; Wessex Hospital Board, photograph by John Harris; and Greenlys Public Relations Ltd.