MG/AB

Lds Hansard 825

Nat Health

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

9 November 1979

Dear Mike

NHS OUTPUT INDICATORS

I thought I had better write to you about the correspondence you have been having with Zoe Spencer about input and output indicators (the latest being your letter of 12 October) as we see some danger of the underlying issues becoming confused in our exchange of data.

There are two main issues:

> the measurement of health service output and its relation to changing inputs; and,
>
> value for money, better management and reduction of waste.

On the second we are preparing a response for you on avoiding waste and promoting effectiveness and efficiency in the NHS. Our response will broadly be in terms of the right role for central government (maintaining accountability without detailed intervention and "nannying") encouragement of local initiatives (through incentives and the lessons to be learned from research and the private sector) and the criteria for assessing effective management (better rather than nessarily cheaper management). Linked to this, is action on the structure and management of the NHS following the report of the Royal Commission. The objective is a simplified and streamlined NHS, with responsibility for day to day management at the lowest effective point; and by strengthening management at the operational level, while keeping control of management costs, through a continuation of the cost-cutting exercise which we have been running for the past few years.

Turning to the first issue, is it clear that we are using words in the same way? I do not think you mean to imply that the final output of NHS can be adequately measured in terms of deaths/discharges and outpatients. Measures of final output are very difficult to come by, as the vast literature on this subject demonstrates. And even where they exist, eg perinatal and other mortality rates, major factors besides health care contribute. A few outputs are in terms of improvement of quality of life (eg for mental handicap) where some simple measures of, for example, ability to perform certain tasks have been devised. But there is a long way to go and the problem becomes all the more difficult if we try to link results to the level of financial resources. An output measure implies a casual

relationship between output and the activity related to it. For example, for NHS hospital services it should link activity (in terms of treatment or care given to patients) efficiency (in terms of the throughput) and outcome (in terms of the results of the activity taken); and should properly reflect such issues as the quality of health care and the interaction of hospital services with other related sectors, such as primary health care and personal social services. This is all complicated enough without making heroic assumptions on the impact of particular inputs such as administrative and clerical staff. But, taking the example you quote of discharges and deaths, it is possible to show that available beds and the average duration of stay dropped while discharges and deaths (total and per available bed) for most acute specialties in NHS hospitals and day care and outpatient attendance all rose between 1972 and 1977 by varying amounts. Such changes could be taken as indications of efficiency but they are far from adequate indicators: for example, they do not answer the question, what is the "right" level of resources for the NHS; and they say nothing about what is the right marginal input. Using beds more intensely requires more intensive use of professional and managerial skills but no one would expect the link between changes in activity rates and the numbers of staff to follow a simple proportional relationship. All of this underlines the danger of making quick, superficial comparisons.

You asked about possible comparisons between the NHS and the private sector and with other countries. Because the nature of the service delivered is all important, comparisons with the private sector (which deals only with a small range of conditions) are not very meaningful. Even on the international scene, the different ways of collecting statistics and delivering services make comparisons difficult, as WHO, the EEC and the Council of Europe have recently discovered to their cost. But we are involved in a number of international studies relevant to this; and even at this early stage it might be worth recording, for example, that within the EEC we have fewer doctors per 100,000 population, fewer doctors per bed and probably more hospital cases per doctor than any other country, with lower administrative costs.

You seem to be particularly concerned about the growth in administrative and clerical staff. In our view, the overall A and C figures combine so many different elements as to make them a very unreliable indicator. But we do look at all increases in staff, including doctors and nurses which you seem content to accept. And, as I think Tony Smith has already explained, the reasons for growth in the A and C sector include:

transfer of work from professional staff (eg more secretarial support for clinicians, more ward clerks and more appointments and record clerks in surgeries and clinics);

new functions following NHS reorganisation (eg new management responsibilities for NHS authorities and servicing of CHCs);

improving managing capacity (eg more finance staff to provide greater financial control, more planning and management services staff to secure improved efficiency and more industrial relations staff to cope with the changing industrial climate).

The report of the Royal Commission on the NHS puts the more ill informed comment about administrative numbers into perspective.

E.R.

Perhaps you will let me know, in the light of what I have said, whether you will be pursuing any of these topics further. I might add that questions of performance, efficiency and the like are frequently discussed between DHSS and Treasury. I understand that Treasury will shortly be putting out for discussion in PESC a general paper describing present approaches to output measurement, commending this kind of activity and drawing attention to some of our detailed work.

I have deliberately replied in general terms. While I would be happy to commission further work in the Department on particular matters, it really does seem to me important to clarify the hypothesis we are trying to test before exchanging data and conclusions (if only to ensure we get value for money for the time of our own administrative and professional staff in the face of increasing pressure on financial resources and staff cuts!).

Yours ~~sincerely~~ very

Dan

D BRERETON
Private Secretary

PERSONAL AND CONFIDENTIAL

FILE

Nat Health

12 October 1979

Thank you for your letters of 5 and 8 October, with statistics quantifying aspects of input and output in the N.H.S.. As you will know, I have discussed some points arising from this material with your colleagues this week.

As a result of these conversations, we have agreed that the most appropriate figures to use as a measure of output are those for discharges and deaths, coupled with the outpatients figures. In respect of staff numbers, I have taken note of the comments in the Merrison Report about the requirement for and performance of administrative and clerical staff. It is clear from this that none of these figures can be used in isolation as a commentary on trends in the health service.

Nevertheless, there are still some questions which we would like to try to pursue further. The table enclosed with your letter of 5 October showed, on the manpower side, an increase in the latest four year period of around 20 per cent in administrative and clerical staff, whilst the medical staff and nursing and midwifery staff showed roughly 10 per cent increases. The Department has pointed out that some part of the increase in supporting staff was designed to release time of the professional staff for professional duties by eliminating administrative demands on them. It is further argued that there were significant shortages in professional staff which remained to be filled.

The increases in staff overall still seem significantly larger than the increase in output, to the extent that the figures you have offered provide some rough and ready measurement of output. Are there comparisons which can be drawn between staff resources and output in public and private sectors? I appreciate that it may not be easy to find this, given the demands on N.H.S. hospital staff for out-patient services which may not be mirrored in the private sector. Are there comparative statistics for staff compared with output in one or two other industrialised countries? Any further points of comparison which you could offer would be of considerable interest to us.

/ As you know,

As you know, these questions were initiated by the article in "Now" magazine about waste in the N.H.S.. What I have in mind is whether recent performance in the N.H.S. demonstrates that management rather than money should be the top priority. Given the growing vociferousness of the "anti cuts" groups, it would be very helpful to be able to show that there is no simple correlation between the level of finance available and output at any one time. Increased finance in recent years cannot be shown to have produced equivalent increases in output. The arguments in the Merrison Report point in this direction, although their statistics tend to be a snapshot of a particular time, not time series.

Yours ever

Mike Pattison

Miss Zoe Spencer,
Department of Health and Social Security.

SH

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Minister of State (Health)

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

8 October 1979

Dear Mike

You asked for some further statistics quantifying the work done in the NHS. I enclose a copy of a table which I hope will be helpful:-

The first line is the total number of beds in the NHS.

The second line is the total number of patients who pass through hospital in-patient services.

The third line is the total out-patient attendances (including double counting for multiple attendances).

This is of course not a complete picture of the NHS eg we do not have the figures quickly available for attendances to GPs, but I hope it will be useful.

Zoë Spencer

ZOE SPENCER
Private Secretary

IV NHS HOSPITAL ADMINISTRATIVE STATISTICS

Hospitals: Number of beds and patient flow for broad specialty or departmental group

TABLE 4.2

Great Britain

Thousands

	1959	1969	1970	1971	1972	1973	1974	1975	1976	1977
All specialties										
In-patients										
Beds—allocated	548	526	521	516	508	502	491	483	475	463
—average available daily	540	518	513	508	501	491	483	473	468	459
—average occupied daily	467	435	426	421	415	400	393	382	380	375
Discharges and deaths	4,554	5,975	6,028	6,207	6,278	6,158	6,219	5,994	6,294	6,391
Waiting list	..	614	607	578	563	606	610	681	699	692
Day cases[2]										
Attendances	..	..	..	..	387	425	468	439	559	633
Outpatients[3]										
New patients	..	9,113	9,279	9,319	9,336	9,353	9,246	8,301	8,929	9,053
Total attendances	31,609	37,393	38,095	38,678	38,795	38,944	38,972	36,419	38,039	38,924

LMS

Mr Wolfson.
Do you need anything more?
MAP 5/x.

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Telephone 01-407 5522

From the Minister of State (Health)

Mike Pattison
Private Secretary
10 Downing Street
London SW1

5 October 1979

Dear Mike,

You asked for a brief summary of NHS staffing levels broken down into categories of workers. I attach a table accordingly. It should be noted that this applies to Great Britain only and omits N. Ireland, figures for which are not readily available and if required will I am afraid take time to assemble.

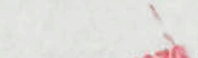
You also asked for a note on the article about NHS "overspending" in "Now" on 28 September. The attached background note covers the examples mentioned in the article in the order in which they occur, pointing out where it is inaccurate.

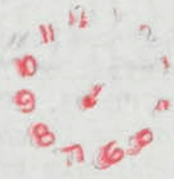
In addition to these examples, Dr Vaughan has asked me to let you know of an instance of expenditure on administration facilities by a Health Authority, which was not reported in "Now". Correspondence with a Community Health Council in June drew attention to Lincolnshire AHA's plans to rationalise office accommodation in Lincoln by extending existing offices at a cost of c. £100,000. Their plans were intended to give them greater efficiency and were expected to release revenue resources in the longer term. Dr Vaughan asked the Area Health Authority to reconsider their decision in the light of the heavy pressures in the current year on NHS resources which make it necessary in some places to reduce patient services. They abandoned their scheme, and are now looking at ways of providing other necessary office accommodation without making unnecessary inroads into resources needed to treat patients.

In addition, a point that has struck him in going round hospitals is that extravagances of expenditure resulting from decisions taken in the past are now coming to light as new hospitals are brought into use eg some computer facilities. Dr Vaughan is determined that the NHS should now look carefully at the implications for the future of decisions which have to be taken now.

Yours sincerely
Zoë Spencer

ZOË SPENCER


-5 OCT 1979



1. The reference to "a report in a provincial newspaper" is in fact to an article in the Daily Mirror dated 13 September (copy enclosed). The plan is for the provision of a multi-storey car park providing 770 places (together with surface parking providing in all 868 places). It forms an integral part of the modern Queen's Medical Centre development at Nottingham.

2. King's Lynn

The King's Lynn reference is to a development at the North Cambridgeshire District Hospital which East Anglia Regional Health Authority propose to develop from a 92 to a 140 bed hospital. The first phase of this redevelopment was the replacement and enlarging of the kitchens to take account of the hospital's increased number of beds. The kitchen redevelopment was partly to be met from non-exchequer funds. Dr Vaughan visited the hospital and was shown wards which while cramped appeared to be in good repair. As a part of the total redevelopment, he questioned the need to demolish and replace these wards given the present financial state of the NHS.

The "Now" article says that the proposals have been dropped. This is incorrect. The level of expenditure put at around £2 million puts the project below the level normally controlled by the DHSS and so is for the Region to decide.

3. Oxford

The article refers to a £2 million scheme dropped as the result of discreet prodding.

Neither the Department nor the Region has any knowledge of this. It would seem to be a case of straight misreporting.

4. Newham Health District were planning to move accommodation. This would have cost around £1 million but was vetoed by the RHA who are currently considering other options.

5. Wessex

This Region proposed to provide additional accommodation on its existing HQ site at a cost of some £840,000. However, Dr Vaughan wrote to the RHA expressing concern at the proposed expenditure, and as a result, and on receipt of tenders for the work the RHA has decided not to proceed with its original proposals but to examine alternative solutions to its accommodation problems. The "Now" article is correct on this.

6. South Western RHA

The £500,000 quoted for the RHA's plans to undertake adaptations to an office block, the freehold of which was purchased last year at a cost of £1 million, is a budget figure and not a costed proposal. When the proposal has been properly costed, the RHA Chairman will discuss the matter with Dr Vaughan. The article is not inaccurate but could have presented a truer picture had more detail been included.

7. Cheshire Area Health Authority

In July 1978, Mersey RHA approved a scheme for alterations to existing office accommodation with some extensions for Cheshire AHA HQ at a capital cost of £400,000 to be provided from the 1978/79 and 1979/80 AHA revenue allocation under the terms of the flexibility arrangements. This approval was subject to the provision that a permanent reallocation of resources be made from administration expenditure to patient care expenditure from 1980/81 onwards. Work is currently in progress and is expected to be completed by early next year. The article is incorrect in suggesting that this scheme has been dropped.

8. West Midlands RHA

The RHA has now approved a proposal to lease additional accommodation close to the existing HQ (at a cost of £80,000 pa and a capital outlay of £250,000) in order to rationalise existing accommodation and relieve overcrowding. The article is incorrect in suggesting that this scheme has been dropped.

9. Oxford Area Health Authority (Teaching)

The facts as reported are broadly correct concerning the £100,000 expenditure. The proposals relate to complicated NHS/University manoeuvring of office accommodation associated with a plan to provide recreational facilities for clinical medical students. The AHA has decided to further consider this scheme.

The Daily Mirror Thursday September 13th 1979.

Hospital car park 'scandal'

THE "scandal" of a new hospital's £1·3 million car park was slammed yesterday.

MP Frank Haynes also hit out at the spending of nearly £500,000 on administrative offices complete with chandeliers near the University Hospital in Nottingham.

"Patients will go without services they desperately need to provide these luxuries," said Mr. Haynes, Labour MP for Ashfield, Notts.

Health and personal social services manpower summary
30 September

TABLE 3.1 (*continued*) Great Britain

	Unit	1971	1972	1973	1974	1975	1976	1977
Family Practitioner Committee services:								
Practitioners: **Total**	No.	44,402	45,142	45,691	45,985	46,688	47,439	48,283
General medical practitioners[11]: Total	No.	24,668	25,183	25,580	25,844	26,127	26,418	26,810
Unrestricted principals		23,252	23,722	23,965	24,255	24,464	24,657	24,939
Restricted principals		455	423	374	338	340	323	315
Assistants		657	633	639	526	441	450	435
Trainees		304	405	602	725	882	988	1,121
General dental practitioners: Total	No.	12,054	12,332	12,520	12,704	12,921	13,254	13,564
Principals		11,592	11,911	12,124	12,383	12,620	13,015	13,359
Assistants		462	421	396	321	301	239	205
Ophthalmic medical practitioners[12]	No.	986	988	980	918	943	948	949
Ophthalmic opticians[12]	No.	5,384	5,281	5,219	5,141	5,184	5,218	5,235
Dispensing opticians[12]	No.	1,310	1,358	1,392	1,378	1,509	1,601	1,725
Dental Estimates Board staff[13]: Total	W.t.e.	1,479	1,454	1,417	1,484	1,598	1,611	1,588
Professional and technical staff		4	4	5	6	4	6	6
Administrative and clerical staff		1,438	1,410	1,366	1,431	1,548	1,507	1,538
Ancillary and other staff		37	40	46	48	46	48	44
Presciption Pricing Authority/Prescription Pricing Division staff[14]: Total	W.t.e	2,184	2,127	1,983	2,318	2,435	2,533	2,501
Administrative and clerical staff		2,146	2,087	1,940	2,275	2,386	2,475	2,448
Ancillary and other staff		38	40	42	43	49	58	53

Note: See Appendix I (Section III: Tables 3.1–3.4).

Source: Department of Health and Social Security. Scottish Health Services Common Services Agency. Welsh Office.

[1] Common Service Agency Staff in Scotland are included from 1974 onwards.

[2] Figures exclude locum staff, hospital practitioner appointments and doctors holding paragraph 94 appointments and dentists holding paragraph 107 appointments under the Terms and Conditions of Service of Hospital Medical and Dental staff.

[3] Includes staff working in Blood Transfusion Centres and Mass Radiography Units.

[4] Figures for 1971–1973 exclude community health staff in Scotland.

[5] Includes community health service doctors, school health service doctors and, up to 1973, Regional Hospital Boards' administrative medical staff; figures for the school health service 1971–1973 relate to 31 December; figures from 1974 exclude occasional sessional staff for whom no w.t.e. was collected. From 1976 locum and temporary staff are excluded.

[6] Includes community health service dentists and school health service dentists; figures for the school health service 1971–1973, relate to 31 December; figures from 1974 exclude occasional sessional staff for whom no w.t.e. was collected. From 1976 locum and temporary staff are excluded.

[7] Figures relate to 31 December for community health staff in Scotland for 1971–1973.

[8] Hospital social workers are included up to 1973—responsibility for these staff was transferred to Local Authority Social Service on 1 April 1974.

[9] Figures exclude ambulance officers.

[10] Includes Family Practitioner Service administrative and clerical staff.

[11] Figures relate to 1 October.

[12] Figures relate to 31 December.

[13] The figures for the Dental Estimates Board in Scotland for 1971–1973 are numbers instead of whole-time equivalents. The figures for England relate to 31 December for 1975.

[14] The Prescription Pricing Authority in England and Wales is synonymous with the Prescription Pricing Division in Scotland. Figures for the Prescription Pricing Division relate to 30 November and are numbers instead of whole-time equivalents.

Health and personal social services manpower summary 30 September

TABLE 3.1

Great Britain

	Unit	1971	1972	1973	1974	1975	1976	1977
Health Service staff and practitioners: Total	(Whole time equivalents)	799,673	831,753	843,119	859,468	914,068	945,877	950,498
Regional and Area Health Authorities/Boards and Boards of Governors staff: Total[1]	W.t.e.	751,608	783,030	794,028	809,681	863,347	894,294	898,127
Medical staff: Total	W.t.e.	30,482	31,952	33,329	34,338	36,217	37,257	38,224
Hospital medical staff: Total[2,3]	W.t.e.	27,958	29,372	30,594	31,486	33,017	33,909	34,821
Consultants		10,133	10,510	11,064	11,463	11,781	12,221	12,392
S.h.m.o. with allowance		87	81	22	14	12	10	8
S.h.m.o. without allowance		288	278	244	203	189	93	85
Medical assistant		1,040	1,068	1,039	1,065	1,106	1,072	1,069
Senior registrar		1,997	2,147	2,248	2,327	2,419	2,530	2,639
Registrar		5,527	5,595	5,661	5,626	6,036	6,165	6,266
J.h.m.o.		12	7	3	..	..	..	..
S.h.o.		5,888	6,573	7,361	7,762	8,396	8,670	9,111
House officer		2,961	3,085	2,941	2,996	3,051	3,119	3,237
Other staff		26	28	10	30	27	23	15
Community health medical staff[4,5]	W.t.e.	2,524	2,580	2,735	2,852	3,200	3,348	3,403
Dental staff: Total	W.t.e.	2,419	2,478	2,535	2,745	2,935	2,957	3,019
Hospital dental staff: Total[2]	W.t.e.	907	938	943	996	1,057	1,078	1,118
Consultant		325	333	354	373	381	395	417
S.h.d.o. with allowance		12	12	4	3	3	2	2
S.h.d.o. without allowance		50	47	41	32	27	19	16
Assistant dental surgeon		52	60	65	59	78	83	86
Senior registrar		76	87	96	91	109	109	108
Registrar		141	141	145	152	167	160	175
Senior house officer		92	97	102	134	132	150	157
Dental house officer		140	142	135	152	159	158	157
Other staff		20	19	2	1	1	1	-
Community health dental staff[4,6]	W.t.e.	1,512	1,540	1,592	1,749	1,878	1,879	1,901
Nursing and midwifery staff: Total[7]	W.t.e.	343,642	364,434	370,595	377,633	405,817	414,961	415,694
Qualified nurses and midwives	W.t.e.	175,839	183,388	185,119	189,567	202,464	213,225	219,900
Student and pupil nurses and midwives		87,494	92,955	95,321	93,285	95,461	98,961	94,939
Other nursing and midwifery staff		73,606	81,560	84,246	90,219	103,679	99,822	99,675
Nursing cadets		6,703	6,532	5,910	4,563	4,212	2,953	1,181
Professional and technical (excluding works) staff[4,8]	W.t.e.	48,368	51,028	53,552	52,828	57,025	63,539	65,405
Works and maintenance staff	W.t.e.	26,844	27,042	26,656	27,445	29,457	30,042	30,493
Administrative and clerical staff[4,9,10]	W.t.e.	78,796	83,708	87,406	94,798	105,781	112,982	113,757
Ambulance officers, ambulancemen/women and other ambulance staff	W.t.e.	18,207	18,757	19,164	19,255	20,425	20,170	20,383
Ancillary and other staff	W.t.e.	202,850	203,631	200,791	200,639	205,690	212,386	211,153

With public sector economies very much in the air

A HOSPITAL MEDICAL SECRETARY suggests how

In the NHS, we could take care of the pennies . . .

Daily Telegraph
Wednesday 25 July
1979.

IF my typewriter was used 24 hours a day by a series of shift-workers, it would still not require servicing three times a year. Yet not only has our hospital a typewriter maintenance contract but when my typewriter needed a couple of minutes of a technician's time I was presented with a "job completion" form that quoted a charge of £36 + VAT.

The job had been simple: to reconnect the tensioning band (a bit of elastic). I knew where it fixed on, but neither I nor a number of doctors could discover how it should be routed in order to get the correct balance.

I had therefore asked the Principal Medical Secretary if I might borrow another machine and if, when there was a typewriter technician in the hospital, my machine could have its tensioning band fixed. Some days later I was greeted by the news that "there's been a man to look at your typewriter — he was in and out again in a couple of minutes."

I queried the £36 bill and was told it was "in order." I insisted on further investigation and was told the bill was "quite correct." My consultant then joined in and asked for an explanation. We were told that my machine was going to be taken away at some unspecified date in the future for a full overhaul. But the form was a "job *completion" form*. What was more the typewriter didn't require anything else. I said so. That, I was given to understand, was indicative of my ignorance of such matters.

"Right," I said. "I hold the certificate for the fastest typewriting test there is. I am quite prepared to take that test again, using this machine. Perhaps that will indicate whether it requires further work?"

The bill was cancelled.

★

What dismayed me more than anything else was the total lack of interest displayed by the great majority of people to whom I spoke about this matter. There is an apathy throughout the Health Service which has led to people—even those in responsible positions—being ready to sign anything and to accept anything without protest. "That's the way things are . . . You can't fight the system . . ."

Every day we see evidence of profligacy beyond belief. To start with we now have some seven Administrators where not very long ago we had one (male) Hospital Secretary assisted by his incredibly-efficient (female) secretary. Such problems as did not come under Matron were solved, within a matter of hours at the longest, by reference to the Hospital Secretary. Now, weeks, months and quite often years go by before anything happens at all: there is no-one "with whom the buck stops."

Unlimited money is apparently available for such idiotic schemes as a fitted carpet ("of top quality because of the wear it would get") in a casualty department, and for gimmicky office equipment such as a twirly stand for rubber stamps. One finds, over and over again, that almost any *thing* can be replaced, but if the doctors need some new instrument, or something additional to their establishment, this is said to be "impossible."

The bottomless well of replacement funds is such that no effort is made to teach staff how to care for anything. What is more, old machinery is sometimes deliberately installed in a new hospital simply because there are no funds for new equipment unless it can be from the "replacement" funds.

Restoration of old equipment is something that might well be done by the youngsters who have for a long time now been going round the hospital, in pairs, working under the Job Creation Scheme. To date I have found them doing many strange things, including measuring every door in the hospital. Another job which roused my interest was counting manholes. The door-measurement was a lovely winter job, they told me, but counting manholes is ideal for summer. "It's doing a lot of good for me," said one youth. "I'm really enjoying myself. You see, I have a psychiatric problem."

In one hospital Job Creation included counting the number of lights and light switches in each room. Ask any Ward Sister about the wastage that comes within her orbit and about which she is powerless to take action.

There is only one new appointment for which hospital staff are crying out. That is the appointment of someone who is there solely to prevent waste and to encourage economy. Someone to whom we can go, in our despair, and know that action will follow. Someone who will start by cancelling that contract for servicing every typewriter in the hospital three times a year! (Indeed, having watched the "mechanic" doing the job, I can see that it involves no more than any competent secretary does herself.)

We want someone to make sure that adequate instruction is given to staff so that one does not see, as I saw recently, 1,100 letters intended for the normal second-class post being franked 97p. This was done by an untrained young typist sent to the post room to help out in a crisis. She had been franking stick-on labels for parcels, which needed an expensive stamp. When some one gave her a late batch of letters she shoved them through without adjusting the machine.

She simply had not appreciated that the franking which appeared on each envelope or sticky-label was totalled inside the machine and the cost came out of Health Service funds.

We have no system of instruction or training for incoming staff. There is a Handbook for House Officers in which the young doctors can find information on the entire spectrum of their work. Why is there nothing of this sort for medical secretaries and clerks?

Patients' record folders go from one department to another in specially - produced envelopes which are box-printed for re-use up to 108 times. The economy-conscious will re-use them, but most staff simply discard each one as it comes and pick another new envelope to send the same record folder on its next internal journey.

Lack of instruction; lack of thought; lack of team-spirit — all these play their part, but particularly demoralising is the lack of example. Such economies as one may oneself institute — re-using ordinary old envelopes for internal letters, for example — seem pretty pointless when one receives a batch of *new* envelopes in the internal mail from "Admin." Often they could come not in envelopes at all: more than half don't need any covering. Why waste time folding and enclosing?

And we don't even collect our waste paper for sale!

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Meanwhile there *are* so-called economies in the hospital service. It is because of "economy" in the employment of nursing staff, for instance, that we quite often have operating theatres, surgeons, anaesthetists and equipment standing idle. It is illegal for any procedure to take place under general anaesthesia without three nurses in the theatre. Thus the actual cost of saving one nurse's salary can very easily run into tens of thousands of pounds if a theatre nurse is off and there isn't a spare nurse to be found in the hospital — as is often the case.

Because we employ too few nurses, wards stand empty. The story is that the wards are due for re-decoration, but painting a ward and its environs wouldn't take any "do it yourself" team the full six weeks that is the normal closure period in our hospital. And it is quite often two wards that are standing empty. Rotatory closure of wards enables the quota of nurses to be trimmed.

And so the waiting lists grow. We can't admit patients because we have too few beds; we can't operate on a "day-case" requiring general anaesthesia. We can only stand by and apologise.