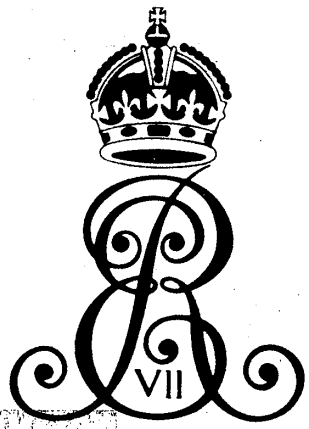
KING EDWARD'S HOSPITAL FUND FOR LONDON

EVIDENCE TO THE ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE



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EVIDENCE TO THE ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE

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Explanatory Notes

KING EDWARD'S HOSPITAL FUND FOR LONDON IS AN INDEPENDENT charitable foundation established in 1897 by Edward, Prince of Wales, to mark the occasion of the Diamond Jubilee of Queen Victoria and to provide a central fund for the maintenance and support of the hospitals of London.

The Fund is incorporated in a private Act of Parliament of 1907, the terms of which constitute the Fund's trust, and as a consequence it has proved possible to make changes of emphasis in the operation of the Fund following the introduction of the National Health Service and, more recently, in consequence of the reorganisation of the structure of the service.

The Fund continues to have a central interest in the operation of the hospitals of London whilst recognising the essential interrelation that now exists with health services for the communities.

The Fund continues to make grants to hospitals: it has for over 25 years played a leading part in the provision of management training for the health services through the work of the King's Fund College; it offers, through the King's Fund Centre, a major library and information service as well as opportunity for conferences and discussions concerned with all aspects of the health service; the Fund sponsors research investigation, particularly that concerned with improvement in health service organisation, and it publishes on a wide variety of health care topics. The Fund maintains active links with health care practice in other countries and sponsors a number of travelling and educational bursaries abroad. In London it maintains, as agent of the National Health Service, the Emergency Bed Service for the assistance of London general practitioners.

At the last valuation the Fund's assets amounted to some £24 million, and the annual income of about £1.3 million is expended in accordance with the terms of trust.

(By agreement, the Department of Health and Social Security with the four Thames regional health authorities between them contribute £130 000 per annum towards the running costs of the King's Fund Centre.)

Summary

1 Morale in the NHS
(Sections 18, 19 and 20 of the Commission's advice pamphlet)

A commentary upon the present low state of morale in the service and the cause of this; the need for recognition of morale as an essential factor in the planning and organisational strategy of the National Health Service; some examples, and some suggestions as to how this problem might best be approached.

2 The role of the district
(Section 18 of the Commission's advice pamphlet)

The over-complication of 'reorganisation'; the isolation of the Department of Health and Social Security from the operational level of the service; the necessity for review of the present structure if a satisfactory balance of function between planning and practice is to be struck; a recommendation for the setting up of district health authorities.

3 Management training
(Section 20, page 8 of the Commission's advice pamphlet)

The special need to develop a new training strategy for senior managers in the service; that current systems of professional education do not adequately provide understanding of the interdisciplinary requirements of consensus management; that present arrangements for management training at this very senior level are piecemeal and inadequate; that the Fund has recently commissioned an enquiry into this matter and that a copy of the preliminary report of the responsible committee, under the chairmanship of Dr Bryan Thwaites, is submitted for information.

4 The role of the volunteer
(Section 15 of the Commission's advice pamphlet)

Two areas of voluntary service are discussed.

The contribution to be made by young persons

The potential value of this is outlined, and some examples are quoted of projects recently financed by the King's Fund.

The supportive contribution to be given by groups of persons who have themselves suffered disabilities

The Fund's experience of working with a number of these specialist associations is discussed, and the range of problems is indicated. A list of specialist voluntary societies in this field is attached for information. Case histories illustrating the value of this type of non-professional assistance can if necessary be provided. Recommendations for the participation and training of suitable individuals in this type of voluntary work are set out.

5 Community health councils

(Sections 15 and 17 of the Commission's advice pamphlet)

The basis of this submission is the special connection of the Fund with the organisation of community health councils over the country as a whole. This arose at the request of the DHSS and involved consultation with all CHCs about the possible establishment of a national body which, in certain circumstances, could represent all councils. These arrangements included the publication of a journal, *CHC News*, and a number of conferences and study courses.

Recommendations are made for the setting up of systems for induction of new council members and for general and special training courses for council members and their officers.

6 Current interests of the King's Fund which seem to have relevance for the work of the Royal Commission

1 Information services

(Sections 6 and 19 of the Commission's advice pamphlet)

There is much evidence of the need felt within the service for the provision of hard and reliable data on planning and related information subjects. A full study of this problem appears to be urgently necessary.

It might usefully include an examination of the future role of the medical records officer.

2 Future organisation of hospital clinical work

(Sections 19 and 20 of the Commission's advice pamphlet)

The medical staffing structure of hospitals has hitherto had many unsatisfactory features. An improved and more workable system will be crucial to the economic and professional effectiveness of the service of the future.

The King's Fund has set up a small working party of younger consultants to review these problems and to suggest means of improvement. A preliminary report is submitted.

3 Medical records and the need for more intensive study of clinical outcome

(Section 20, page 8 of the Commission's advice pamphlet)

The King's Fund has recently undertaken a series of studies aimed at improvement in the standard of medical records as an essential element in the process by which the quality of clinical care may be checked and supervised. These projects are described.

A study is also being set up in association with the Royal College of Physicians for a scientific assessment of standards in hospital medicine. These activities are seen as a contribution towards a more clearly defined system for the study of clinical outcome on the basis of an objective self-examination by the profession.

4 Treatment and care of minor illness

(Sections 12, 13 and 20, page 8 of the Commission's advice pamphlet)

The need for improvement in the service provided for the treatment of minor illness is emphasised and the background to this problem is discussed.

The King's Fund has much interest in this aspect of the health service and recent action by the King's Fund Centre is described.

5 Systems for the care of the physically handicapped

(Sections 14 and 15 of the Commission's advice pamphlet)

It is apparent that there is great need for better coordination of the services for the physically handicapped. The King's Fund has much interest in this part of the National Health Service and considers it appropriate to draw the attention of the Commission to the current unsatisfactory state of affairs.

A recent paper by Peggy Jay, chairman of the British Association of Occupational Therapists, is quoted as illustration of the great need for improvement.[12]

1 Morale in the National Health Service

THE RECENT AND RAPID CHANGES IN THE ORGANISATIONAL STRUCTURE OF the health service, the present economic recession, and political intervention on a scale exceeding anything previously foreseen or experienced by the service, have combined to bring about a most serious and potentially damaging loss of morale among staff at all levels. The performance of any organisation can only be so good as the skills and the enthusiasm of those working within it. The state of morale is, therefore, a matter of the highest importance and must not be left to chance as being yet one more responsibility of overworked local management, although clearly there is a necessary measure of such responsibility at all levels.

It has seemed to the King's Fund that there is needed at the centre of the service—that is, at the highest political and civil service levels of the DHSS—a wider and more strategic appreciation of the inescapable duty which is theirs for the oversight of morale factors throughout the service, and this would particularly include the need to keep under continuous review the consequences in terms of staff response to major acts of political and organisational policy.

There is no single cause of current anxieties and discontents. The following seem, however, to be major influences.

1 Recent reorganisation of the service

As a necessary preliminary to reorganisation, all senior administrative staff—medical, nursing and 'lay'—were compelled to seek fresh employment with new authorities. This had to be done in competition

with former colleagues, and the range and content of the new appointments proved very different from those of posts previously held. This has, therefore, been a stressful experience which has left many staff uncertain of their new roles and with a keen sense of loss over former systems which, in retrospect, seem to have induced a more ready understanding of where responsibility may lie and to have provided a clearer sense of purpose and job satisfaction.

In particular, there is uncertainty over whom to turn to for advice and guidance, and the passage of information and of reassurance becomes correspondingly more difficult. Indeed it is arguable that the efforts needed to operate a complex and sophisticated service structure are such as to negate the original objective, which was integration.

2 Present financial difficulties of the service as a whole

The general economic situation and the necessity for stringency are things which responsible officers conscientiously accept. Rather is it the arbitrary way in which unbudgeted 'economies' have to be found by the simple and often crude processes of cutting down service, for example by not filling staff vacancies, which causes discontent. This, even in the fairly short term, will, it is felt, lead to marked reduction in the efficiency of the service and, despite all official assurances to the contrary, to inevitable harm towards patients.

These difficulties have been accentuated by a complex series of departmental instruction on finance and planning during the past twelve months, with proposals for implementation of the recommendations of the resource allocation working party (RAWP)[6] about the possible effects of which there is grave concern.

Another example of the unfortunate effect of the arbitrary nature of some aspects of the present financial policy (in this case, it would seem, politically inspired) has been the demand for the reduction of administrative staff whose posts were authorised under the reorganisation of the service. The implication that these are the consequences of ambitious extravagance within the service when, in fact, they come as a direct consequence of political will, has been much resented and not least by the administrators themselves.

3 Uncertainty and disillusion of professional staffs

This we see as applying mainly to doctors and nurses, and particularly to those working in hospital. In the community, and especially in general practice, there would appear to be some degree of enthusiasm, although this varies considerably from place to place. General practitioners in particular seem to feel that under reorganisation they have won some measure of professional advantage without any serious loss of independence.

In nursing there is a marked sense of bewilderment which derives partly from recent changes in clinical practice with consequent effects upon nurse-patient relationship. Above all, however, this uncertainty seems to stem from recent measures which have the effect, as some senior nurses see it, of detaching them from their patients and of compelling the best of them towards a career in management.

It was unfortunate that the recommendations of the Committee on Senior Nursing Staff (Salmon committee)[8]—in themselves farsighted and constructive—were, as the result of political decision, put into immediate and wholesale effect instead of being made the subject of careful and progressive assessment in practice, as was the original intention of the DHSS.

The Salmon proposals, the purposes and intended effect of which were by no means clearly understood in the service, were shortly followed by the demands of reorganisation, and the uncertainties created by the failure of government to adopt a positive response to the recommendations of the Committee on Nursing Education (Briggs report).[10]

Whilst there has been much enthusiasm in the profession for what is seen as the new status of the nurse as a manager, and for such developments as the increasing role of the university in nurse education, there remains a considerable sense of disquiet—that somehow these advances have been won at the expense of what Florence Nightingale would have called 'the art of nursing'—the giving of first place to the active care

of the sick and all that this may be said to imply—including what is sometimes overlooked, the special function within which it is the nurse who 'protects' the patient.

By contrast, the concerns of the doctors are no less acutely felt but derive from separate and perhaps more profound anxieties.

In the King's Fund, and particularly at the King's Fund College, there has in recent years been impressive evidence of the growing interest of clinicians in the problems of organisation and management. Perhaps this stems from the successive reports of the Working Party on the Organisation of Medical Work in Hospitals ('Cogwheel' reports)[5,7,9] but for many years the College has run induction courses in health care management for consultants and senior registrars. For these courses there have until recently been long waiting lists, and since the practice began some 900 consultants and 450 senior registrars have attended. Increasingly of late there has been a sense of uncertainty, whereas previously there was enthusiasm.

The reason seems chiefly to be that experience now in the service suggests that there is so little opportunity for the development of progressive managerial skill on the part of doctors.

The help and influence which community physicians might be expected to provide in the improvement of this situation is retarded through the inevitable slowness with which a new discipline can make its impact, especially in so difficult a field and in time of stringency.

The failure over a long period to secure a pattern of career development in the hospital specialties which would permit the establishment of young doctors in the consultant grade as soon as they can be prepared for it has aggravated the dissatisfaction of those now in their 30s.

From observation, a profound influence upon the present uncertainties of the doctors continues to be the extent to which recent disagreements between the profession and government have left their mark.

Whatever the causes of these disagreements, the hospital doctors seem to have been left with a deep feeling of disquiet that there has been a

powerful political attempt to reduce their professional influence and authority. Such anxieties are increased by a growing consciousness that the resort of colleagues to what is termed 'industrial action' can only tend to diminish the standing of doctors with the public and, in time, prove inimical to their own professional self-esteem.

4 'Industrial action'

The recent adoption of 'industrial action' by virtually all sections of health service staffs—with the exception to date of administrative staffs —is a new phenomenon in health service practice which is at once a consequence and a cause of poor morale.

Until a few years ago activities of this sort in the health service would have been regarded as unthinkable, and it is sad to recall that one of the earliest examples of this unhappy trend was provided by the general practitioner service.

It will be argued that much of this has been a direct result of government failure to accept an urgent need for improvement of pay and conditions for many grades of health service staff and that, in consequence, a legitimate basis for 'industrial action' was allowed to develop.

In part that is true, and the same sequence, particularly for lower paid staff, has occurred in other countries.

But it is unquestionably true also that the more acute episodes of recent 'industrial action', and particularly those carried out by hospital doctors and ancillary workers have had as their underlying purpose political objectives far removed from the more usual aims of improved pay and conditions.

'Industrial action' puts immense strain upon management—that is the administrators—who in the health service are not yet geared, as they might be in industry, to respond effectively without detriment to other aspects of their work.

Enormous amounts of time and energy have to be spent in meetings

and discussions with protesting groups, and there is also the heavy responsibility somehow to provide means for the continuance of service to the patients whilst argument continues. Administrators see these activities not as part of the developing system for an improved health service but simply as a diversion which prevents them—as indeed it does—from getting on with their proper job.

And most exhausting of all, this whole process has to be conducted in the full glare of press and television speculation and attack. The health service is particularly vulnerable to pressure of this sort.

Whilst it may well have to be accepted that this type of disruptive action has come to stay and must be absorbed as one more aspect of day-to-day life in the service, it is meanwhile a very real cause of drop in morale, partly because of the speed with which as a practice it has spread, partly because of political aims not infrequently contained within it, and partly because, from the point of view of management, it is immensely time-wasting when there is more important and productive work waiting to be done.

Beyond this, and in the long run perhaps the most damaging aspect of recent outbreaks of 'industrial action' in the service, has been the effect they have had upon large numbers of professionals who regard the use of this tactic as being incompatible with their role as, for example, doctor, nurse or administrator.

It would be wrong to suggest that the outlook is everywhere one of pessimism. Throughout the service there is a wealth of enthusiasm and determination which every day grapples with the difficulties and the frustrations. There has so far been a check to progress rather than a deterioration in the quality of patient care.

What needs to be done is to develop more positive systems for fostering satisfaction in working with and for the health service, and otherwise to establish means by which a more effective balance can be set between the demands of political interest on the one hand and the limits of human tolerance on the other.

The following three examples, perhaps trivial in themselves, may serve to illustrate, for and against, the kind of issue which arises under the first of these propositions.

In a small project sponsored by the King's Fund, entitled the 'Language Barrier', a simple in-house system was evolved for teaching English to Pakistani laundry workers in hospitals. The experiment showed that not only did the laundry output improve but that the workpeople found new pride and enthusiasm among themselves. The measures required for such improvement are neither elaborate nor costly.

In another similar small project, entitled the 'Shop Window', the Fund undertook a study of hospital employees concerned particularly with contact with patients and their relatives. These were staff such as porters, receptionists and telephone operators. It was quickly apparent that, although these employees had a genuine and sincere sense of responsibility in their work, they were frequently left without the necessary support and information to enable them to carry out their tasks effectively. The fault seemed to lie not with the staff concerned who were so often left to fend for themselves, but rather with junior management who were not fulfilling their own supervisory tasks properly.

In the accident and emergency department of a London teaching hospital, it is customary for the staff—the whole staff—to work in teams which incorporate all appropriate disciplines, including both the surgeons and the theatre porters. Each day the duty lists are posted on the notice boards and the lists include the names of everybody concerned, surgeon and porter alike. In the Fund's view, it is this kind of simple and personal identification with a task and a group which does so much to foster the self-respect of the individual. And that, in turn, is a powerful incentive to improved morale.

None of the small procedures we have quoted is either complicated or expensive, and there must surely be very many others of a similar nature throughout the service.

But they need drive and foresight to establish and occasionally some small outlay of money. It is suggested that a system should be developed by which the Secretary of State may be kept more directly informed of

matters of this kind and, indeed, of the state of morale generally throughout the service.

The negotiating table has proved no basis for the kind of exchange that is required. The Hospital Advisory Service has contributed much in the field of long-stay care. The Central Health Services Council through its committees has provided valuable technical information and there have been numerous *ad hoc* working parties and similar groups, for example 'Cogwheel'[5,7,9], which have given constructive advice and recommendations on specific issues. But in the opinion of the Fund none of these devices can satisfactorily provide the broadly-based and continuous procedure that is required for the testing and supervision of morale in the service. Moreover, there is far greater need than previously for involvement of all levels of staff and not merely the senior professionals.

For these reasons it might be worth considering the possible establishment of a central group, not dissimilar perhaps from the Hospital Advisory Service, to identify good practice, to assist the development of such practice elsewhere, to recommend the use of departmental funds for the encouragement of specific projects and, above all, to provide a direct commentary for the Secretary of State upon the state of affairs at the point of service.

Morale is an essential component of the means by which the National Health Service is provided. As such it needs special measures for the supervision and maintenance of its performance.

The second of our two requirements for the improvement of morale is of a different dimension.

It is accepted that the National Health Service is a political concept answerable in its performance through the Secretary of State to Parliament. On the other hand, human beings cannot be expected to give of their best in their daily work if there is too frequent or too violent an interjection from outside by political interests. For example, the many changes in the priorities of the health service, sometimes on no very clear grounds other than those of political expedience, destroy more in confidence than is achieved in purpose. Elaborate mathematical

quantifications which fail to convince those actually providing the service merely aggravate the frustration.

The wholesale changes brought about by the recent reorganisation of the service have put enormous pressure upon those who work in it. It has to be remembered—particularly in very large organisations—that there are limits to the amount of change and disruption that participants can tolerate whilst yet remaining efficient. It is easily possible to attempt too much too quickly.

In the last resort, whatever the influence of other sections of the work force, it is the doctors—that is the clinicians—who, by the very nature of their proper supervision and control of the care and treatment given to patients, directly influence the pace and intensity of hospital and community service and hence irrevocably its cost. It also has to be remembered that medical science is the basis of a progressive sophistication which continually increases cost.

The doctors and their attitudes, therefore, have enormous influence upon the effectiveness of the service and, whilst certainly they have a duty to use their skills and their influence to maximum advantage for the service, there is equally a responsibility on the part of government to seek all possible means of establishing a reasonable accommodation between professional independence, economic practicability and political will. If this necessity is ignored the service can only be the loser. But it is easier said than done. This is a problem which bedevils all nationalised systems where the organisation necessarily functions as an arm of the State and hence under political supervision. No one can seriously contemplate a health system which provides everything for everybody—only that which it is practicable to provide for all.

Until recently, the National Health Service has been subjected to relatively little direct political pressure. But the new system of organisation leaves more room for political intervention in the formalised planning cycle and, for example, from members of the new authorities, by no means all of whom have either knowledge or understanding of the complexities of the service for which they are in part now responsible.

In particular, the infusion of party political dogma into the decision-making process of the service has had a disruptive effect far beyond the immediate local occasions.

To those with wider knowledge of the real operational problems of the service, it has been disheartening that so much energy should be diverted into issues which, by comparison, seem small and almost, perhaps, in such critical times, trivial; for example, paybeds or the payment of fees for sterilisation.

To this must be added a general dissatisfaction that there is neither a long-term consistency in the setting up of strategic policies, nor a visible indication of how such policies and the priorities on which they rest are decided. There seems good reason to suggest the need for a thorough examination of the possibility canvassed in the Commission's advisory pamphlet, page 6 paragraph 17, for the establishment of an apolitical central agency. Rather than being an administering corporation, this could have responsibility for recommending and, with government approval, setting up national policies for the operation of the health service. It would act in some measure at least as protection against the more potentially destructive of political changes of front. The example of health service commissions in Canadian provinces or in Australia may be worth examination in this respect.

Indeed it might be possible, were such a system to be put into effect, to obtain broad agreement between the main political parties about the general principles under which the National Health Service should be expected to function.

This, coupled with a clear definition of strategic aims and priorities to be adopted, could go far to steady the effective undertaking of the service and to improve the morale and the confidence of those responsible for its operation.

The first step to a solution of these difficulties is perhaps the frank recognition that they exist.

2 The Role of the District

DESPITE CURRENT CRITICISM, THE PURPOSES FOR WHICH THE reorganisation of the National Health Service was deemed necessary are in themselves unexceptionable. In all the numerous exchanges of view before the final decision to reorganise was taken, no objection to the principle was raised.

But objections to the method were there in plenty and after nearly two years of practice it becomes ever clearer that the farsighted aims of the original proposal are becoming lost in an over-complicated system of bureaucracy.

In the provision of a national service for health there are essentially two functions which have to be performed. The first, and for practical purposes the most important, is the day-to-day provision of the service for those who need it; that is, the care and treatment which is in effect given by doctors, nurses and other professionals to sick people—supported, of course, by their direct services of supply.

The second is the deployment of the resources, in terms of money, manpower, buildings and equipment, that is necessary to enable doctors and nurses to fulfil their tasks effectively.

And, of course, the function of deployment has to take account of what is available to ensure the proper and effective use of resources. This, in turn, means planning and organisation to safeguard the satisfactory continuance of clinical service within the context of tolerable overall cost and changing need.

These two broad functions, although separate in practice, must, for the effective operation of the system as a whole, be carefully and intimately linked. Each needs an informed and sympathetic understanding of the problems, aims and limitations which characterise the function of the other.

It was, indeed, one of the great hopes of the new proposals that the district would become a level of operation in the reorganised service which would have accorded to it freedom of local action and correspondingly high accountability.

But there are two organisational factors which contribute overwhelmingly to ensure that many districts cannot operate effectively in such a way. Firstly, the district is not designated in legislation as an 'authority'. There is no local representational component and, therefore, within the ambit of government and civil service practice, it cannot be said officially to exist.

Secondly, it is long-established civil service procedure to operate through carefully-structured systems of hierarchy. This ensures that, however much there may be enlightened attempts to interpret the Act and the expressed intentions of the 'Grey Book'[4] in different and less suffocating terms, the DHSS with the central responsibility for the operation of the service is now, in fact, further removed than before from the level at which the service directly reaches the patients.

In the opinion of the King's Fund, it is essential for the well-being of the health service that there should be a close working relationship between the planner and policy-maker on the one hand and the practitioner on the other. This is prevented by the system as it now stands and, if these difficulties are to be resolved, it would seem essential that there should be revision of the structure of the service to eliminate the present intermediate administrative level of the area authorities, and replace their liaison function with local government in some other way. Some reorganisation of districts would, in consequence, be required, but the creation of district authorities to combine the present responsibilities of the two levels would seem not to present insuperable problems of organisation. The principal objection would appear to be partly political, on grounds that much-prized coterminous boundaries with local authorities would be lost, and partly on the very real need to link health functions with those of welfare and education. But this is by no means everywhere a satisfactory arrangement at present, and perhaps the service has already suffered enough from requirement to conform with what are political rather than practical considerations.

It should be possible to establish satisfactory working relations with local authorities on the basis of new district health authorities acting through consortia.

We recognise that an immediate change is not possible, but we believe that the national, regional and district levels are crucial for good services and that administrative action within the present structure should concentrate on producing the best functioning districts within overall regional plans.

We have been much impressed by the arguments put forward in a paper by Mr Leslie Paine, House Governor of the Bethlem and Maudsley Hospitals, published in the Lancet.[18] The views expressed accord with those of the King's Fund on this important subject, and the paper is commended to the attention of the Commission.

3 Management Training

VIRTUALLY FROM THE BEGINNING OF THE NATIONAL HEALTH SERVICE, the Fund has played an active part in management training. Four separate residential colleges were established over a relatively short period.

First was the School of Hospital Catering, then in 1949 the College for Ward Sisters and a year or so later the College for Matrons. The fourth college, established in 1951, was the Hospital Administrative Staff College.

The four colleges amalgamated in 1968 to become the King's Fund College, thus reflecting the trend towards multidisciplinary experience in management training for the health services, and from that time course membership has included not only those concerned with hospital practice but also those more widely concerned with community health services outside the hospital.

In all, since the foundation of the administrators' college in 1951—some 10 000 employees of the NHS have attended residential courses there.

Whilst latterly the emphasis has been to prepare health service administrators of all disciplines for the responsibilities of consensus management, there has been much effort to explore new opportunities as they arise; for example, the recently established course in industrial relations, the training opportunities so far provided for those concerned with community health councils, and the special seminars for members of health authorities.

It is on the basis of this varied experience that the Fund has become

concerned to explore new ideas about the development of training for senior managers in the reorganised health service.

The DHSS and the health authorities, with the support and co-operation of the National Training Council for the National Health Service, are responsible for the setting up of an overall policy, and indeed in terms of preparation for the reorganisation of the service much has been achieved.

The Fund's view remains, however, that insufficient attention has been given to the longer-term training needs of very senior officers of varied professional disciplines, for whom the reorganised system of the service has created demanding responsibilities which call for the exercise of a coordinating and decisive management skill at the highest level.

The problems seem less severe for junior and middle-management officers, but much new thinking is required if a lively and informed attitude is to be encouraged at the top level of management. Especially is this important when it is recognised that those reaching the highest positions of managerial responsibility will, in future, do so from widely different backgrounds of professional training. It has to be remembered also that senior officers in the new system are likely to hold appointment for long periods which may not infrequently extend for up to 30 years. Most careful consideration needs, therefore, to be given to the development of satisfactory systems by which senior officers in post may at intervals be given the intellectual stimulus necessary to keep them receptive to new ideas.

The role of management consensus is new to the service and for some time to come will require special and carefully devised procedures for the choice of individuals, and for their preparation, for the demands that are likely to be placed upon them. The dangers of unpreparedness are all too apparent in some of the appointments made as part of the wholesale transfer of the service to the recent requirements of re-organisation. It was unfortunate that official policy at the time of reorganisation prevented recruitment from outside the service of suitably qualified staff, since this restriction in some cases led to the over-grading of inservice personnel who were insufficiently trained for the new and heavier responsibilities accorded to them.

And differences of professional background and training—little of which concerns itself with common issues of management responsibility —are in themselves a natural deterrent to the full acceptance of partnership with colleagues from different disciplines.

The development of a strategy of training to meet the special needs of the senior managers of the service has therefore seemed to the Fund to be a requirement of some urgency. In consequence, a working party, under the chairmanship of Dr Bryan Thwaites, principal of Westfield College in the University of London, and chairman of the Brent and Harrow Area Health Authority, was invited in January 1975 to examine these questions with general terms of reference as follows.

'**a** To review current arrangements for the management development, training and selection of senior managers (and potential senior managers) in the National Health Service of England.

For the purpose of the review, the word "senior" in this context is intended to refer generally to officers holding designated rank in the management of the service at district, area and regional levels.

b To make such proposals as may seem necessary for the establishment of a satisfactory system having regard to the following considerations.

i the need for relationship between the training systems of specialist groups—for example, administrators, doctors, nurses and others concerned with management in the health care system—to ensure a satisfactory preparation for the responsibilities of multidisciplinary management practice at senior level,

ii the need for a continuing and imaginative system of educational support for those already holding senior managerial appointments in the health service,

iii the need for flexibility of approach in the determination of a management training strategy to ensure that individuals may have opportunity for *ad hoc* educational experience—for example, the undertaking of research or attendance at a university postgraduate course,

iv the need to recognise that the provision of a system for the care and protection of the health of the population is but one of the public services necessary for the well-being of our society and that, therefore, the training of those responsible for management in the National Health Service should be planned in such a way as to take this into account.'

It should be added that in taking this decision the Fund first held informal consultation with the DHSS who expressed cordial interest in the project and gave much helpful comment and advice during the course of the preparation of the material.

The report of the working party which is now prepared in draft preliminary form is at present under consideration by the Management Committee of the Fund. It does not necessarily therefore represent the view of the Fund itself. It is, however, regarded as being an informative comment on a very difficult and complicated issue. Copies are submitted for the information of the Commission.*

* Since the Fund's evidence was submitted to the Royal Commission, this report has been approved for publication.

4 The Role of the Volunteer

FOR MANY YEARS WELL-ESTABLISHED VOLUNTARY AGENCIES, SUCH AS the Red Cross and the Women's Royal Voluntary Service, have made a great contribution to the well-being of patients, staff and relatives in hospitals all over the country; such organisations are likely to remain the bulwark of any voluntary activity in the health services. During the last 15 years, the contribution of these agencies has been supplemented by a range of other groups and, from an early date, the King's Fund realised the importance of organising the resources available so that maximum benefit was achieved.

The Commission will no doubt be receiving submissions about the multiplicity of aspects of voluntary contributions to the health services of this country. The King's Fund has selected two areas within this general subject which the Fund believes to be of considerable significance. These are the contribution which could be made by young people to those in need of help either in hospitals or in the community; the contribution which could be given by groups of persons, who have themselves suffered disabilities often of long-standing, to fellow sufferers.

The contribution which could be made by young people

In recent years, the King's Fund has been involved in a number of projects which have demonstrated how the energy and resourcefulness of the young represent a virtually untapped source of help to those less fortunate than themselves. The Fund believes that with a comparatively small investment a great deal of value can be obtained by harnessing the enthusiasms and skills of these young people.

In 1970, the Fund made a grant of £10 000 for a project which was

carried out in Newcastle and which was designed to encourage young volunteers in community care. We were anxious to demonstrate that young people could play an active role not only in after care of geriatric patients, but also in preventive work, by providing community support to help prevent hospital admissions for purely social reasons. This area was chosen because a young volunteer team was already well established in that city and because there was support for the scheme from the consultant geriatrician, the city medical officer of health and the voluntary organisations already concerned with the services for the elderly. In order that the project should be chiefly concerned with prevention rather than hospital care, it was called 'Health of the Elderly'.

It was discovered that in addition to the practical role specified on allocation, visitors undertook a diversity of practical activities acting on their own initiative. The more common activities included shopping, making a cup of tea, cooking a meal, bringing in coals, taking along books or magazines and reading out letters to an old person with failing eyesight. This would seem to bear out the value of regular support of visitors by project staff in order to help visitors to develop and maintain a sound perception of the old person's needs, and of their own involvement within the context of other help being given.

Another example of the way in which the young cooperated with enormous advantage has been the project which had the general title, 'One-to-one'. The organiser of this project, in his most recent report of November 1976, has described how the work which began in hospitals for the mentally handicapped has now spread to psychiatric, psychogeriatric and geriatric hospitals. This project, which has harnessed the resources of television, has had a particular impact and has been responsible for recruiting large numbers of young people to the ranks of the volunteers in the health services.

The Fund maintains that in the next decade, and indeed thereafter, positive action should be taken to encourage the young to undertake voluntary work with professionals, both in hospitals and in the community. The Fund's experience, as illustrated by the two examples, and by the work carried out under the auspices of the director of social services in the London Borough of Croydon, has demonstrated

conclusively the advantages of using skills of the young in this way. Such work can particularly, but not exclusively, be directed towards the care of the sick, the elderly and the handicapped.

It must be emphasised that such a policy of support will require an input of resources to ensure that voluntary help is applied where it is needed, that it is well organised and, most important of all, that it is maintained. If a sustained effort on the part not only of those professionals concerned with health but also those concerned with education and social services is provided, there will be a very significant gain for society as a whole. A decisive lead is called for in this important field and encouragement should be given to the allocation of what must be relatively modest sums when counted against the total budgets of the authorities concerned.

The contribution to be given by groups of persons who have themselves suffered disabilities

A series of meetings of representatives of patients' associations, doctors and other National Health Service staff has been held during 1976 at the King's Fund Centre. At these meetings much dissatisfaction, amounting even to resentment, was expressed by the patients' representatives about shortcomings in patient care, whether routine or specialised. The Fund has been working with these associations and, indeed, has been giving active support to some in their early days, in an attempt to bridge the gaps in understanding between the professionals and their patients.

Many of the difficulties which were recounted were due to the conflict between restrictions imposed by therapy which often appear excessive, and the patients' desire for the fullest possible life and their inhibitions in expressing this need because of the awe in which so many of them hold their doctors. For their part, doctors' concern with meticulous details of treatment makes them insensitive to the emotional and social consequences which some prescriptions may inflict on patients and which many of them find incomprehensible or intolerable.

It is difficult for any one person, whether doctor, nurse or social worker, to understand fully the worries and anxieties of such patients, especially when they have to face a future of disablement. Only experienced, well patients can give the confidence, the hope and detailed practical advice, which are needed.

In this short memorandum, the Fund has summarised the main groups of problems which are the cause of so much unhappiness which could be prevented, or at least assuaged, by the fullest use of the help that many well patients are able and eager to provide. A particular contribution by these associations could be made by their assisting with professionals in the careful selection of well patients who could be used in the way described. If the central authorities could, for instance, determine a policy for the refunding of travelling expenses for those assisting in this way, this in itself, though trivial in terms of national finance, would be of great benefit. The cost of the Fund's proposals would be very small. To paraphrase Winston Churchill, 'nowhere else in the whole structure of the health service could so few do so much for so many'.

The chief problem to be tackled, in the Fund's view, is the need to achieve the necessary change in the education and attitude of doctors to enable them to accept a cooperative rather than a managerial role in many aspects of patient care. Some case histories have been collected which illustrate the need for well patients' help where special solutions are required. Although not all these histories fall neatly into categories, the following are specific types of patients' problems which should be examined.

need for facilities for patients with prolonged disabilities
sexual problems of disabled patients
need for explanations of the implications of treatment
availability of complicated therapies
provision of necessities by prescriptions
understanding of complicated diets
problems following major surgery and accidents
explanation of future prospects for patients

It is commonly known by all the associations that there is a jungle of

available services. Patients and professionals alike need to help each other to discern what is needed from the services and how the facilities can be obtained. Patients' associations should be encouraged to put forward views on fields of research just as they should also take part in teaching. Professionals should know of the advisory skills which patients have acquired.

Appendix A lists some of the patients' associations known to the Fund.

The Fund recommends that

1 Participation by well patients should become a regular feature of the care of patients with persistent disabilities, both at the onset of their illness and during the whole of their subsequent care, by the National Health Service facilities of all kinds.

2 Arrangements should be made for the treatment and training of suitable well patients for this purpose, cooperatively between patients' associations and National Health Service staff.

5 Community Health Councils

ALTHOUGH NOT DIRECTLY INVOLVED IN THE OPERATION OF COMMUNITY health councils, the Fund has been in a unique position to observe their progress since they were set up in 1974. The Fund was able to make available facilities for the National Committee of Community Health Councils from an early stage and, because of the Fund's involvement in this way and from its other activities, has been aware of the many anxieties which have surrounded the operation of community health councils which need debating. In summary, the Fund believes that a considerable effort is needed to provide training courses for those involved in community health councils, and that the very fullest debate should take place about the need for an advisory service if the community health councils' potential to influence effectively the planning and provision of services is to be achieved.

The membership of community health councils provides for over 5000 laymen to become involved in detailed consideration of health services throughout England and Wales, and the King's Fund believes this to be a desirable innovation, especially in the absence of a representative component in administration at district level. It further believes that there is considerable scope for the role of community health councils to be explored and developed.

For example, it would appear to be wholly appropriate that community health councils should aim to become a local focus—in association as necessary with voluntary agencies—for the encouragement of voluntary effort in support of the health services of the district. In particular, it would seem to be important that the community health council should be seen to make a positive contribution in this way and as distinct otherwise from being merely the voice of criticism.

The King's Fund has been glad to provide, at the request of the DHSS, a number of training courses for staff of community health

6 Current Interests of the King's Fund which seem to have relevance for the work of the Royal Commission

1 Information services

The King's Fund receives numerous applications from staff and authorities in the National Health Service for funds for research and development projects. These applications are considered either by the Fund's Management Committee or by its Research and Development Committee. During the process of examining these, it has become increasingly clear that staff in the National Health Service are suffering from a lack of hard data, whether on planning or on other subjects. The Fund's own investigations are not sufficiently detailed to warrant the making of firm recommendations on a subject which all have recognised to be complex in the extreme. From the experience that the Fund has acquired, however, it is abundantly clear that there is a desperately important and urgent need for an intensive study to be mounted if information is to be properly provided and applied, for the benefit of the service as a whole.

An essential part of this study should, in the Fund's view, be an examination of the role of the medical records officer. It is considered that this may well be very different in future and that the medical records officer, in a new context and perhaps with a different type of training, could have a most valuable information function, particularly at the level of the district.

At the request of the Association of Medical Records Officers the King's Fund is currently financing an objective enquiry into the future role of medical records officers. This is being undertaken in two stages by a firm of management consultants. Their report of the first stage has been completed and the second stage of the investigation is now in hand.

2 Future organisation of hospital clinical work

In the summer of 1976, on the initiative of a number of medical staff, mainly young consultants who had attended a management course at the King's Fund College, the Fund set up a working party to examine the organisation of hospital clinical work. The chairman of this group was T J H Clark MD FRCP, and its membership is listed in Appendix B.

The preliminary views of the working party, which follow, have yet to be formally considered by the Fund's Management Committee but it has nevertheless seemed appropriate that this tentative statement should form part of the King's Fund evidence to the Royal Commission. The final report of the working party could, if required, be made available to the Commission when it is ready.

Preliminary views of working party on the organisation of hospital clinical work

Because there appeared to be problems over the organisation of clinical work in hospitals which were receiving inadequate debate within the medical profession, the King's Fund agreed to set up this small working party to examine the subject in depth. Those invited to participate were all known to have a particular interest in the subject. It so happened that most were young consultants drawn from a variety of specialties.

The working party has not yet completed its deliberations but feels that it should place its preliminary thoughts before the Royal Commission. Although the working party believes that the consideration of the future of medical practice cannot exclude other disciplines, it has taken the view that it should not attempt to try to determine the work pattern of these other disciplines. Therefore, the working party will not be able

to arrive at any detailed conclusion on the possibility of transfer to others of work currently performed by doctors. However, the working party believes that if such changes do take place they can only be introduced very gradually, whilst changes in the arrangements for hospital clinical work which are immediately necessary must come from within the medical profession. Further, the working party recognises that the financial implications of transfer of work to other disciplines is likely to be limited, bearing in mind that medical salaries represent only 15 per cent of the salary bill and 10 per cent of total revenue.

Present problems

The working party has formed a view that what is most urgently required is a revision of the present medical manpower structure because

1 The medical school output exceeds the number of permanent career outlets in this country and will do so increasingly as it continues to rise.

2 There is a large excess of short-term posts in the hospital service relative to the output of the medical schools and permanent career outlets. In the view of the working party this is the underlying cause of the recent industrial unrest in both the junior and consultant grades. Although called 'training posts', the main function of the junior posts is to provide all elements of the service not given by consultants and the very much smaller number in personal medical assistant posts. This has some undesirable results. The first is an unduly prolonged apprenticeship, which is an unfortunate state of affairs in a profession providing a personalised service, where failure to gain independent clinical responsibility in the most productive years of life may well result in a stifling of initiative, thus delaying the advance of medicine. Also a high proportion of these short-term posts is filled by overseas graduates with cultural backgrounds very different from that of their patients, a feature which hampers clinical practice. Furthermore, patients with chronic diseases commonly see a different doctor at each visit to an outpatient department.

3 At present the so-called 'training grades', which are in large excess in most acute specialities, provide the front-line service, particularly between 5pm and 9am, and on Saturdays and Sundays. The working

party believes that, in the interest of patient care, most of such work should be done by recognised specialists who have completed their postgraduate training.

4 In the few hospitals where the consultant grade has grown in some specialties without comparable expansion of junior grades, the consultants find that an increasing proportion of their time is spent on activities previously delegated to junior staff.

Poor integration of general practitioners and hospital doctors is also a weak feature at the present time, but progress should be possible on this front with the recent introduction of a hospital practitioner grade. However, it should not be assumed that general practitioners will be persuaded to take on delegated hospital work which consultants find disagreeable, particularly that which occurs out of office hours.

Preliminary conclusions and proposals

1 The permanent posts available must be properly related to the output of the medical schools and the length of time required for postgraduate experience and training.

2 It is also considered that the number of permanent posts in each specialty should be in proportion to the quantum of medical service which the NHS wishes to provide in that specialty, within the limits imposed by the output of the medical schools. Elimination of excess training posts in popular specialties should make this easier to achieve.

3 Further, the working party believes that, with a longer period to be spent as a specialist after completion of postgraduate training, the varying physical capacity over that age span, and the increasing proportion of women specialists, it will be necessary to introduce a system of changing contracts for this permanent workforce. *Either* there should be more than one grade of specialist each with full clinical responsibility for the care of individual patients (that is, clinical care by specialists would not be within a hierarchical framework) and open competition for the senior posts; *or* the specialist contract should be in more than one stage, with a change of work pattern commonly being associated with advancing age. In either of these ways there would be a

formal means of arranging that, generally speaking, the younger specialists would take the burden of work during unsocial hours. The working party favours the former arrangement because, in its view, it could provide a much more vigorous stimulus to excellence than the present distinction award system which it might perhaps in part, or in whole, supersede. The working party will be giving detailed consideration to potential roles and accountability, but one feature which can already be foreseen is the development of a true consultative role for senior specialists, to whom young specialists could turn on occasions when they felt that wider experience than that which they possess might help them in coping with a tricky problem.

4 The working party believes that changes in hospital-based practice must be related to changes in general practice. It is evident that some specialties (such as psychiatry, geriatrics and paediatrics), up to now based mainly on hospitals, are becoming more community-oriented. Conversely, some GPs are seeking a closer involvement in hospital practice. Therefore, mechanisms need to be established which recognise these changes but which do not confuse the accountability of those involved. The working party will be considering this aspect carefully.

5 The working party accepts the general conclusions which the Royal Commission on Medical Education reached regarding postgraduate training.[11] It is felt that, in the interest of good personnel management, the contract of employment for trainees should be of a continuous nature, with planned movement through posts which provide all doctors with general professional experience and training, and selected doctors with training and experience leading to specialist accreditation. The combined number of these two sorts of training slots would in many specialties need to be very much less than the number of posts in the junior hospital grades at present.

6 Although the working party does not attempt to examine unilaterally the present distribution of work between the medical and paramedical professions, it feels that there is considerable scope for a fresh appraisal of interprofessional boundaries.

Much of the problem represented in paragraphs 1–5 above has been analysed in the report of the Working Party on the Responsibilities of

the Consultant Grade, published in 1969.[3] For reasons attributable to the profession at least as much as the DHSS these proposals are still far short of implementation.

3 Medical records and the need for more intensive study of clinical outcome

There is growing public awareness that in the United Kingdom there is no very clearly defined system by which the quality of the clinical care given to patients is regularly and independently checked.

Such is the faith of the population in medical skill that until recently the attitude of patients has normally been to accept that the standard of care provided is the best that is available.

But there are signs that this is a changing view and that the public, to some extent influenced by articles in the press and the activities of organisations such as the Patients' Association, is beginning to question the quality of the clinical care which it receives.

Attitudes within the medical profession itself have markedly altered towards a recognition that, for the proper fulfilment of clinical standards, a more generally developed system of self-examination is desirable.

The King's Fund has approached this problem from the standpoint of its trust, which is concerned with health care organisation rather than the more purely clinical aspects of patient treatment. In this the Fund has, however, recognised that it is clinical practice which eventually dictates much of the organisational pattern of the service.

In further extension of these aims, the Fund has also financed a project to be developed by and through the Royal College of Physicians. This scheme envisages the setting up of what will be called a 'medical services study unit', whose role will be to undertake a scientific assessment of standards in hospital medicine.

Any serious study of clinical outcome must in due course take account of the form, content, accuracy and usefulness of the case record, since

it is the basic repository of essential data about the patient. Hence, there are immediate difficulties because the quality of medical record-keeping is extremely variable throughout the service, as are also the links between hospital-based and community-based practice.

As a first step, therefore, the Fund has given considerable grants of money to promote a fresh approach towards improvement of standards in the keeping of medical records, including some study of the content and purpose of records.

Grants were given to Guy's Hospital (Professor Ian McColl) and to the Royal Free Hospital (Dr Neil McIntyre) for the introduction and application of the 'problem' type of record-keeping known generally as the problem-oriented medical record (POMR), originally developed in the United States of America by Dr Larry Weed. There is some evidence that records kept in this form are a positive stimulus to better clinical observation and practice. This work has been undertaken in close coordination with the medical schools of the two hospitals and, having been started within single units, the system is now being adopted by all clinical students with the support of the deans of the respective schools, and with the agreement and collaboration of hospital consultant staffs.

The effect in due course will, it is hoped, be that this improved type of record keeping will spread widely, since the entire output of two large medical schools will be trained and practised in the use and application of POMR.

In addition, at Guy's Hospital it has proved possible, with the aid of further support from the Fund, to extend these ideas into the development of systems by which agreed standards of clinical procedure have been worked out for the hospital as a whole and, with the co-operation of the consultant staff, are now being tried out and established. These ideas are set out in more details in the last section of this paper, contributed by Professor Ian McColl, under the heading 'Clinical Information Service'.

As a supplement to these enquiries, a project has been funded at Nottingham University to explore what other new developments are

currently taking place in the field of medical records. The first part of this study is nearing completion and there has been identification of some 200 experiments in the use of medical records which seem worthy of note.

This alone is seen as an encouraging sign that there is much spontaneous effort within the profession to improve current systems of record keeping.

In particular, it is noted that many of these activities are being carried out at the instigation of general practitioners.

The Fund welcomes these developments, more especially those which lead towards a closer integration in record keeping between specialist and primary care.

Members of the Royal Commission are particularly asked to note that a severe and very practical obstacle to the further extension of this essential interrelation is the need to introduce the record form size A4 for use in general practice. This need has been freely admitted for many years, but frustrated by lack of funds. Nevertheless, high priority is justified for this most important advance towards the more effective coordination of recorded information about patients' illnesses.

On the basis of information now available from the Nottingham survey, the Fund hopes to be able to continue and extend its programme for the encouragement of more effective standards in record keeping. The interface between hospital and general practice could prove to be a rewarding area of study, particularly in relation to follow-up of patients after discharge from hospital. Well defined schedules could define responsibility in monitoring treatment and preventing relapses.

Whilst these varied activities are not in any formal sense a coordinated approach to the problem of how best to provide an acceptable system for the regular examination of clinical outcome, they are nevertheless intended as a promotion of ideas for improvement in the preparation and maintenance of data about the sick person which doctors may be willing to adopt. The Commission may already have received the publication of the Nuffield Provincial Hospitals Trust, entitled *A Question of Quality*, which is highly relevant.[17]

It is hoped that this brief account may have served to indicate the importance which the Fund attaches to the setting up of means by which the standard of clinical care can be regularly and scientifically studied.

For this it would seem that there are two major essentials; the provision of a reliable system of acceptable, useful and accurate clinical data—the case record, and the willingness of the doctors to be their own monitors of the professional care given.

Anything else seems likely to be second best. Systems imposed from outside can only operate with and through the cooperation of the doctors concerned and not even legal sanctions can make certain of that.

The process is necessarily slow and complex but the ultimate goal of achievement through the willingness of the profession, rather than in spite of it, seems immensely more advantageous for the future of the service as a whole.

As an indication of the importance and complexity of this subject, members of the Commission are commended to study the Nuffield Lecture given by Professor Sir Richard Doll in May 1973, entitled *Monitoring in the National Health Service*[2] (*Proceedings of the Royal Society of Medicine*, Vol 66 page 729), and *Trends in Medical Records* reviewed in the Harben Lecture by Sir Francis Avery Jones and published in *Community Health*, 1975, 7.1.[13]

Clinical information service*

The Fund has undertaken a study following the introduction of problem-oriented medical records at Guy's Hospital in 1974. Its object is to determine whether or not there is any change or improvement in the care of patients which could be attributed to the new medical record.

The study was designed and based upon two general assumptions.

that statistical method applied to a large number of cases is a valuable technique for isolating specific factors in the methods of working of doctors,

* The references for this section are included in the list on page 67.[1, 14, 15, 16]

that the most effective criteria for the measurement of the quality of the medical care systems are the average performances of the physicians and surgeons themselves.

For the purposes of the study, information was collected on all the patients that could be identified in 1972 and 1975 as having presented at Guy's and two other London teaching hospitals with one of the following medical or surgical diagnoses.

hypertension
acute myocardial infarction
cerebro-vascular accident
bronchitis/emphysema
inguinal hernia without obstruction
peptic ulcer without perforation or pyloric stenosis
gallstones

The same pieces of information were collected on all the patients in the study. The data were collected by clerks recruited from other parts of the hospital, who were trained to abstract information from the notes on a variety of vital signs, examinations, investigations and treatment, using explicit criteria. This they did with an error rate of 0.5 per cent found on weekly random checks of their coding. The information was recorded on mark sense documents which were read directly by the computer.

Clinical management score

In an attempt to evaluate what happened to the patient during his admission, a clinical management score was arrived at with the co-operation of a panel of clinicians at a hospital which was not included in the study. They agreed upon a list of investigations, clinical measurements and treatments which they would consider suitable in the management of each disease. Each item was weighted from one to three depending upon whether it was useful, desirable but not absolutely essential, or mandatory for good management.

Patient risk variables

Some of the information collected consisted of demographic information about the patient, and some physiological measurements recorded at

the time of his admission to hospital. Twelve of these measurements were used to produce patient risk variables in an attempt to evaluate the risks which the patient himself brings to his own disease, and to see what influences these might have on the clinical management scores achieved.

Analysis

A multiple regression model was used to analyse the data. As work proceeded on the analysis some interesting associations became apparent. For example, in all the surgical diagnoses there was a positive association between the number of blood chemistry abnormalities the patient had and his clinical management score; that is, the more chemical abnormalities the patient had, the better his clinical management.

More surprising was the large amount of variance in the clinical management scores for the surgical patients that was attributable to the firms themselves. For example, 36 per cent of the variance in clinical management scores of patients operated on for gallstones was due to the firms alone; that is, 36 per cent of the difference in the quality of care these patients received depended upon which firm looked after them.

It was believed that this type of information would be useful to the clinicians concerned, and that some means of making it intelligible to them should be found. At the same time, work was proceeding on developing a means of measuring the outcome for the patient. An information service which could provide consultants with data on the management of their patients, combined with the patient risk score and an estimate of how the patient fared under the care of the firm, was thought to be a suitable approach.

It was believed that changes in clinical performance would not occur until a more direct relationship was established between the use of resources, the quality of medical care and the outcome for the patient.

The first clinical information sheets have been distributed to the general surgical consultants at Guy's and those for physicians are in preparation. Strict confidentiality is maintained.

Those sheets that have been received have been welcomed. This has encouraged us to believe that the information which has been gathered is relevant to the daily work of the surgeons and provides useful insights into the performance of the firm. It has certainly highlighted problems which are more prevalent than was generally realised and has stimulated some rethinking.

The clinicians themselves have been invited to return their comments on the information sheets so that they can participate at the experimental stage. By this means it is hoped to avoid the criticism levelled at Hospital Activity Analysis that no one at local, regional or DHSS level seems to have attempted to work out in advance the type of information that the (Cogwheel) divisions might find useful, or the various retrieval systems required to generate it.

Clinical librarianship

The ever-increasing volumes of information in every specialty as a result of research and innovation make keeping up to date an impossible task for the practising clinician. An acquaintance with one or two standard texts is no longer adequate. New methods of storing and retrieving information in medical libraries have been developed in an attempt to resolve this problem. However, before this wealth of information can be used successfully by the clinician he has to learn to identify areas where he needs new information, what sources supply his need, to use the new retrieval systems to get at the information.

For an experimental period the Will's librarian at Guy's will be attached to the surgical unit's activities and the meetings attended by all the surgical firms, and where there is contact and discussion across disciplines. During this time there will be an attempt to identify the problems clinicians are dealing with most commonly. Reprints and bibliographic information will be made available to them promptly as relevant material is identified, and individuals will be encouraged to learn how to use the library services to the best advantage.

As the clinical information service uncovers areas where further effort is required to improve or maintain standards of patient care, pertinent and topical papers will be found and circulated to everyone receiving the information sheets.

It is believed that this will be a very productive adjunct to the clinical information service, and in time, finances permitting, it is hoped that it will become an integral part of it.

Summary
The clinical information service is an experimental project using statistical techniques in order to assess whether material abstracted from medical records will provide information which can be used to monitor the quality of hospital care for different diseases, identify patient risks which affect outcome, and provide information for individual firms which is useful to the clinicians. Further innovations, such as the clinical librarianship, will, it is hoped, further stimulate the clinicians to examine current practice and improve their management of patients and their use of hospital resources.

4 Treatment and care of minor illness

The King's Fund has become increasingly aware during recent years of the importance of proper treatment and care of minor illness, whether in the hospital or in the community. The Fund's approach to this issue has come about from its many contacts with both professionals within the health services and members of the community served by them. The extent of the frustration felt by members of the general public and what they see as the failings of the health care system stem from a basic difference of definition between the public, represented by the patient, and the professionals as to what is minor. However this dilemma of definition is defined, there is no doubt that prompt and organised care for the treatment of minor conditions is of the utmost importance to the well-being of individuals and indeed to the economy of the country.

During 1976 the Fund held a series of meetings on the subject of minor illness which culminated in a residential seminar of three days held in Oxford in the summer. To this seminar was invited a small number of people who were either professionals or had expressed concern about the subject as members of the public. It became apparent that the frustration of the public is matched only by the general dissatisfaction felt

by many of those working in the health services who are faced with departures from normal which are clinically 'minor' but which present baffling problems for the individual. The professions' recognition that these are often self-limiting and unaffected by treatment may disappoint the expectation of the public, doubtful of such an assessment and needing reassurance.

In part, the sheer multitude of cases which can be categorised as minor, itself poses a difficult problem. In terms of hospital care, a wide range of minor gynaecological conditions, disabling conditions requiring a mild analgesia, and chronic conditions which require intermittent oversight all come within this category. The lack of interest displayed by, for example, the consultant surgeon at what he conceives as 'uninteresting' surgery creates barriers between him and the general practitioner who is faced with the problem of maintaining the patient's confidence throughout the long drawn-out episode of minor disability. Indeed, it is widely believed that minor conditions are often almost deliberately allowed to deteriorate until they become acute and serious before a patient can obtain the alleviation for which he is looking and, in his terms, which he needs. On the other hand, these are minor short-lived conditions which could be borne, and would be so, if the public was educated to recognise their insignificance.

It is the King's Fund's view that a concerted effort aimed at reducing the high incidence of minor and disabling illness is called for, not only for humanitarian reasons but also on economic grounds. In such a programme, the role of the general practitioner is a key one, but by improved practice organisation and preparation for their mutually supporting roles, both doctors and supporting professional staff can have their usefulness greatly enhanced. A study which could examine the incidence of minor illness in a given area, describe the treatment possibilities in detail, and thus go on to study the outcome of the treatment could, we suggest, point the way to improvement which is so badly needed. Such a study would require support from the highest level, and the several professional bodies involved would need to be closely associated. The Fund believes, however, that given the support the benefits of such an activity would be great and urges the Royal Commission to recommend action on this topic.

During the course of the seminar a number of papers were presented and copies of these are available.*

There must be few administrators in the country who place any reliance on the statistical evidence of waiting lists, so great is the diversity of approach in their compilation, yet the waiting lists conceal an enormous amount of need which is being hidden by the inflexibility of the present methods of managing the use of hospital inpatient facilities. The best balance of hospital stay and community care is seldom achieved.

A further seminar is planned to examine this and the possibility of improving specialist-generalist coordination. The corresponding relationships in the other professions will equally require examination if this seminar is successful. The definitions of 'specialist' and 'general medical' practice in Britain are unusually distinct and this in itself helps to ensure economy in the use of the most expensive resources of the NHS. Nevertheless, it requires a systematic exchange of information and assistance which the important development of postgraduate centres has not yet made fully effective.

5 Systems for the care of the physically handicapped

The King's Fund for many years has been concerned with facilities for the physically handicapped. Particularly close links have been forged with the Disabled Living Foundation, but this is only one organisation of many which cooperate with the Fund in work for the disabled.

In recent months the Fund has become increasingly aware of the wide variety of appliances and aids for the disabled; some of these are of a high quality and others demonstrably less good. A small minority is positively harmful. Irrespective of any question of quality, it is beyond dispute that there is little or no coordination of the activities of those researching and producing in this field. In this area, scientists, manufacturers, members of the paramedical professions and doctors are all

* Since the Fund's evidence was submitted to the Royal Commission, an edited collection of these papers has been approved for publication by the Fund.

encouraged indiscriminately. The Fund is convinced that, for a comparatively small investment, a great deal of improvement could be achieved by rationalising some of these disparate efforts.

The Fund proposes to pursue its developing interest in this field and early in 1977 is holding a meeting to which will be invited a number of influential people known to be working in this field. The Fund believes that a nationally organised and coordinated effort is well within the remit of the central department, and that such activity should be undertaken without delay in the interests of the disabled persons for whom appliances are not so much necessary as essential.

Members of the Commission may wish to note that the effect on the disabled person of the wrong appliances or of an appliance supplied in some inadequate form has been well demonstrated in a paper by Peggy Jay MBAOT SROT, chairman of the British Association of Occupational Therapists, and Michael Dunne MBE BSc, entitled, *The Patients' Viewpoint*, published by the National Fund for Research into Crippling Diseases.[12]

Conclusion

The King's Fund hopes that the observations made in this evidence will prove useful to the Royal Commission.

If members of the Commission should in due course think it desirable to have discussions with representatives of the Fund about any aspect of this evidence—or indeed about the evidence in general—the King's Fund will be glad to respond and to offer facilities for such a meeting if required.

Appendix A

Patients' associations known to the King's Fund

ACTION FOR RESEARCH INTO MULTIPLE SCLEROSIS
c/o Multiple Sclerosis Society
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Appendix B

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References

1 ALDERSON, M. R. *Evaluation of health information systems. British Medical Bulletin*, vol. 30, no. 3. 1974. pp. 203–208.

2 DOLL, Professor Sir Richard. *Monitoring in the National Health Service. Proceedings of the Royal Society of Medicine*, vol. 66, no. 8. August, 1973. pp. 729–740.

3 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY *and* DEPARTMENT OF HEALTH FOR SCOTLAND. *Report of the working party on the responsibilities of the consultant grade.* London, H.M. Stationery Office, 1969. pp. vi 15.

4 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Management arrangements for the reorganised National Health Service.* London, H.M. Stationery Office, 1972. pp. 174.

5 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Second report of the joint working party on the organisation of medical work in hospitals.* (Chairman, Sir George Godber.) London, H.M. Stationery Office, 1972. pp. vi 43.

6 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Sharing resources for health in England: report of the resource allocation working party.* London, H.M. Stationery Office, 1976. pp. 134.

7 GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. *Third report of the joint working party on the organisation of medical work in hospitals.* (Chairman, Sir George Godber.) London, H.M. Stationery Office, 1974. pp. v 39.

8 GREAT BRITAIN. MINISTRY OF HEALTH *and* SCOTTISH HOME AND HEALTH DEPARTMENT. *Report of the committee on senior nursing staff structure.* (Chairman, Brian Salmon.) London, H.M. Stationery Office, 1966. pp. 205.

9 GREAT BRITAIN. MINISTRY OF HEALTH. *First report of the joint working party on the organisation of medical work in hospitals.* (Chairman, Sir George Godber.) London, H.M. Stationery Office, 1967. pp. iv 24.

10 GREAT BRITAIN. PARLIAMENT. *Report of the committee on nursing.* (Chairman, Professor Asa Briggs.) London, H.M. Stationery Office, 1972. pp. 327. *Cmnd. 5115.*

11 GREAT BRITAIN. PARLIAMENT. Royal commission on medical education, 1965–68. *Report presented to Parliament by command of Her Majesty, April 1968.* (Chairman, Lord Todd.) London, H.M. Stationery Office, 1968. (reprinted 1969) pp. 404. *Cmnd. 3569.*

12 JAY, Peggy *and* DUNNE, Michael. *The patients' viewpoint: a study of people's experience and feelings about their special footwear, lumbar supports and long-leg callipers.* Horsham, National Fund for Research into Crippling Diseases, 1976. pp. 38.

13 JONES, Sir Francis Avery. *Trends in medical records. Community Health*, vol. 7, no. 1. July-August 1975. pp. 32–49.

14 McCOLL, I. *and others. A review of some techniques in clinical appraisal. British Journal of Surgery.* 1977. (in press)

15 McCOLL, I. *and others. Communication as a method of medical audit. The Lancet*, vol. I, no. 7973. 19 June, 1976. pp. 1341–1344.

16 McCOLL, I. *Observations on the quality of surgical care. in* McLACHLAN, G. *editor. A question of quality: roads to assurance in medical care.* London, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1976. pp. 49–61.

17 McLACHLAN, G. *editor. A question of quality: roads to assurance in medical care.* London, Oxford University Press for the Nuffield Provincial Hospitals Trust, 1976. pp. 297.

18 PAINE, L. H. W. *A bad example of a good idea. The Lancet*, vol. II, no. 7995. 20 November, 1976. pp. 1130–1131.


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