Contract and Pay Questions in Industrial Therapy Units

A King's Fund Report

King Edward's Hospital Fund for London

CONTRACT AND PAY QUESTIONS IN INDUSTRIAL THERAPY UNITS

Report of an investigation into some technical aspects of the operation of industrial units

by Nancy Wansbrough MA

Published by King Edward's Hospital Fund for London 1971
Price: 70p (14s)

MEMBERS OF THE STEERING COMMITTEE

CHAIRMAN

Michael Hargreave VRD

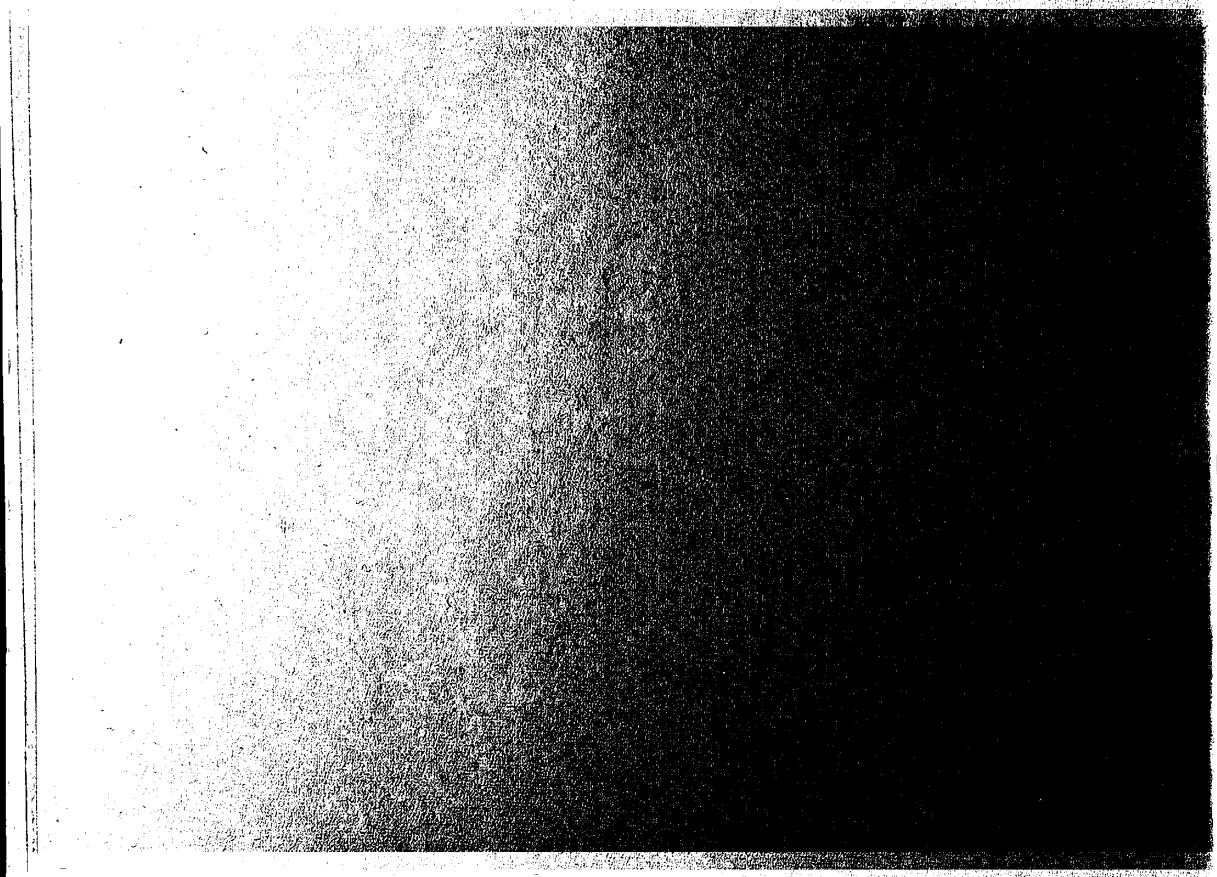
M C Hardie MA FHA

Lieutenant-Colonel K B Hicks OBE

Professor J H Smith

SECRETARY

I Roberts MA FHA



ACKNOWLEDGEMENT

The Steering Committee and the author gratefully acknowledge the help given by many people at all levels of the health service and in other Government departments, and particularly the staffs of the hospitals mentioned in this report, who allowed the author to draw freely on their knowledge and time during the period in which the research was undertaken.

January 1971

CONTENTS

CONTENTS

APPENDICES

TABLES

INTRODUCTION

The publication in September 1968 of Industrial Therapy in Psychiatric Hospitals* (referred to throughout this book as the 'Main Report') marked the end of the first phase of a three-year project sponsored by the King's Fund. Statistics supporting the findings of this study were published the following year+ (hereinafter referred to as 'Supplement on Patient Data'). The second phase of the project, an assessment of the value to the patient of industrial therapy, consisted of a comparative study of matched groups of patients working in the industrial therapy and occupational therapy departments of a single hospital$^{\phi}$. After work on these two phases was completed, the remaining time was spent on a fuller investigation of three technical aspects of the operation of industrial units: the possibility of obtaining work from government or hospital service sources; methods of payment in the units; and the pricing of contracts. The results of the investigation form the subject of this report.

---

* WANSBROUGH N and MILES A. Industrial Therapy in Psychiatric Hospitals. King Edward's Hospital Fund for London 1968.

+ WANSBROUGH N and MILES A. Industrial Therapy in Psychiatric Hospitals: Supplement on Patient Data. King Edward's Hospital Fund for London 1969.

$^{\phi}$ MILES A. Work Therapy for the Mentally Ill. Obtainable from the King's Fund Hospital Centre 24 Nutford Place London W1H 6AN

1 CONTRACT QUESTIONS

EVIDENCE OF SHORTAGE OF WORK

Problems of work supply were discussed in the Main Report. Out of 75 hospitals 24 found the maintenance of a continuous supply of work to be a problem, particularly from January to April for those hospitals engaged on the seasonal Christmas trade. It was interesting to learn that the credit squeeze of 1966 did not appear adversely to affect supplies of work as might have been expected. Nonetheless, in the years 1965 and 1966 nearly half the hospitals in the survey experienced work shortages which, for mentally ill patients, can prove disturbing.

At such periods it is the practice for hospitals to fall back on making and marketing, among staff and local friends, such objects as woolly toys and wooden furniture; but if a hospital becomes too ambitious or proficient in this sphere another administrative deterrent looms up in the shape of Purchase Tax on all articles in excess of 500 per annum of any one sort. And there is the matter of buying, storing, accounting for, insuring and auditing the raw materials involved. Work is also often undertaken during slack periods for the parent hospital, as in the old days of the carpenters' and upholsterers' shops which used to employ patients on the maintenance of hospital furniture. One difficulty experienced here is the payment of the patients. Hospital service auditors, under present regulations, will not always sanction payment comparable to that earned on external contracts.

In brief, there was general agreement among industrial unit managers that sub-contracting to open industry offered the best solution to the problem of work supply for a number of reasons (not least of which was the possibility it opened up of placing ex-patients in jobs) providing the work was available in suitable quantity and variety.

In this context, it is worth remarking that the prison industries authorities and those responsible for the operation of sheltered workshops for the blind and sighted are both seeking to increase their share of this field. As the prison industries authorities explain, H M Prisons are statutorily obliged to provide work for all prisoners requiring it, and since most prisoners are serving short sentences - an average of three months - this makes the teaching of a trade or craft impracticable for the majority. Sub-contract work is, therefore, replacing the mailbag monopoly. In fact, ironically in this context, the prison industries have obtained a very substantial proportion of the Sheffield Regional Hospital Board contract for protective clothing and propose to tender for sheets and sheeting. In workshops for the blind, the trend accentuated by the recommendations of the Industrial Advisers to the Blind is largely away from crafts traditionally considered suitable for the blind, such as basketware and mat-making, for which there is a diminishing demand, and towards up-to-date manufacturing processes in a variety of goods including engineering products, plastics, soaps, household cleansers and bedding. The result is to increase pressure on sources of available sub-contract work, although it is the declared policy of the Directorate of Industries and Stores, Prison Department, Home Office, with its greater centralised resources, to withdraw from the field if it should find itself competing for work with the industrial unit of a psychiatric hospital.

In summary, it may be said that industrial units prefer contracting to the private sector. It is only when this source dries up that they wonder whether further work might not be put their way from the public sector, particularly from the hospital service itself.

CENTRAL CONTRACTING

There is already in operation a scheme to facilitate the placing of government orders with non-profit making institutions. This is the priority suppliers scheme, codified in an inter-departmental

Treasury Circular 8/50 of 6 October 1950. The circular lays down the procedure to be followed to ensure that a due proportion of government orders is placed with these various institutions, including Remploy factories, prisons, institutions for the blind, sheltered workshops for the disabled and The Forces Help Society and Lord Roberts Workshops. It affirms that these priority suppliers should rank equally among themselves for preferential allocation of orders but are to take precedence in ranking order above firms in development areas and those with a measure of unemployment. Preference is also to be shown to such areas. Purchasing departments are instructed to give priority suppliers the opportunity to manufacture the widest possible range of their requirements and to provide, from time to time, lists of items considered to be within the suppliers' manufacturing competence. The priority suppliers are to examine the lists and notify the departments of those items in which they are interested, and of items not on the lists which they would like to supply.

How tenders for subsidised workers can be realistically priced must, to the uninitiated, always appear something of a mystery. And a certain ambiguity in the phrasing of the circular makes it no clearer. Briefly, priority suppliers can obtain work either on a lowest tender basis or as a result of an offer on a fair price basis, but it is not the intention that this should result in any difference in fact between the policies of different purchasing departments.* The intention is that tenders are submitted on the basis of fit (mentally or physically fit) labour costs, thus making a loss which is met from the public purse.

Since 1959 the scheme has been strengthened by the Priority Suppliers Committee, established to arrange for fuller exchange of information and closer cooperation between contracting government departments and nationalised industries and the priority

* See Hansard. House of Lords, 24 June 1959, cols 184-203 and 207-227.

Treasury Circular 3/50 p

the procedure

Government

Employ

Workpeople

Reports

Work

Per

Ins

Is

Re

Inspection

Ins

Duty

Apply

Ins

Ins

Ins

Be

Appli

Ins

poli

Insure

Labour

Since 1950 the

Suppliers

of information

government departments

* See Hansard, House of

suppliers. The committee has not been concerned with the actual allocation of contracts or with general questions of government policy in this sphere - these have rested with the Treasury. The annual meeting in May has been chaired by the head of the Disabled Persons Branch of the former Department of Employment and Productivity, and attended by representatives of government departments and the nationalised industries with their shopping lists. They would sit on one side of the table, with the major priority suppliers and representatives of local government authorities on the other. The committee would consider detailed reports on current contracts and future trends.

So much for the administrative procedure. What has this added up to in practice ?

First, this is an inter-departmental scheme and no figures of its operation are published. What follows is deduced. Obviously, not all departments have been participating equally. Among the chief spenders are said to have been the former Ministry of Public Building and Works, the Post Office and the Ministry of Defence. After them come the nationalised industries, The Royal Mint (surprisingly, ordering coin bags) and HM Stationery Office. It is impossible to put a figure on the annual value of the turnover but some idea may be gained from the fact that HM prison industries, in a recent year, did some £2 million worth of priority supply work out of a total of £$5\frac{1}{4}$ million, the rest being £$\frac{1}{2}$ million for the private sector and some £$2\frac{3}{4}$ million for the prisons themselves. Again, the value of contracts in a recent year by one of the departments placing the biggest orders within the scheme, was almost £500,000, or some 2.5 per cent of a total of nearly £20 million. The remainder of the orders are placed with the trade. As to the number of workers involved: Remploy Ltd employs some 7,500; workshops for the blind some 3,400, including 400 sighted severely disabled; while the sheltered workshops set up for the sighted disabled

employ a total of 2,100. This last figure is made up of approximately 1,000 from voluntary bodies such as the British Legion and The Spastics Society and a further 1,000 from local authority workshops. The total, in round figures, of 13,000 is an all-time record. From the information available, however, it is not possible to say what proportion of these workers are engaged on priority supply work.

SUITABILITY OF HOSPITAL INDUSTRIAL UNITS FOR PRIORITY SUPPLIER STATUS

We are now in a position to consider whether it is possible and desirable for industrial units to be added to the priority suppliers list.

First, the criteria necessary to qualify for and retain this status are not clear. There appear to be two main categories on the list: the various sheltered workshops for the disabled in receipt of subsidy by way of grants; and the prison industries. The analogy in the case of industrial units would lie with the prison industries, and it may be of interest to compare them.

In sociological terms both are more or less 'closed institutions'. In fact, with increasing weekend leave, parole, and working outside in the community, both institutions are becoming less 'closed' as the years go by. It could be argued that the provision of work is therapeutic in both; to prevent deterioration of personality prisoners must not be compelled to sit 24 hours a day in a cell, nor patients 24 hours a day in a ward.

In neither case do industrial conditions parallel those of open industry to the extent required in approved sheltered workshops of the former DEP. Industrial units average 24 working hours per week and prisons, 28 (one prison workshop has to close down altogether during Assize week). Both suffer interruptions. Hospital treatments, outings and visits are matched by prison interviews, choir practices and, again, visits.

visits.

visits are matched by [illegible]

week). Both author [illegible]

28 [illegible] prison [illegible]

DET: Individual [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

employ a total of [illegible]

1,000 from [illegible]

Smarter Sc[illegible]

The Sec[illegible]

From the [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[

Workers in both are paid, in the main, pocket money or allowances supplemented, in some cases, by rudimentary incentive schemes which can hardly achieve their objective within the restricted spans they are allowed to operate in. Domestic work carrying less status is a fall-back in both.

In court cases, only differences in sentencing policy decide to which institution an individual will be committed: interchange between the two is commonplace. But, of course, most inmates of a mental hospital are simply ill, and not 'sentenced' at all.

A second argument could be that the objective of industrial units in psychiatric hospitals is therapeutic and not productive. It may also, however, be thought that the use of the word 'therapeutic' in this sense is so imprecise as to be valueless. Is occupation to prevent the worsening of a condition, therapeutic, or would this word be better reserved to connote healing as in its original sense ? Figures in the Supplement on Patient Data show that for only a minority of patients constituting the industrial unit population can industrial work strictly be thought of as therapeutic. For the short-stay patients who, by definition, are on the way out anyhow, it is a convenient occupation. Some of the long-stay patients, figures suggest, <u>are</u> rehabilitated by this means. But for the remainder, who in 1969 constituted the majority in all industrial units, work is much more akin to that in a sheltered workshop and, indeed, probably many present patients would qualify for grant-aided, sheltered work in the community were local authority provision adequate.

The argument would, therefore, run that industrial work is no more therapeutic for these patients than it is for prisoners and grant-aided sheltered workers at present enjoying priority supplier status.

Workers in [illegible]

supplementary [illegible]

white [illegible]

[illegible]

[illegible]

[

The real objections would appear to be not so much theoretical as practical. The prison industries have acquired within the last few years a strong central administration, the Treasury having retained management consultants and sanctioned the appointment of professionally qualified cost accountants, work study engineers and other experts, whereas the industrial units have none at all. Lack of such resources would be a drawback for centrally negotiated supplies which are intended essentially to be large-scale orders despite contracts for a few hundred linen bags or padded suits for police dog trainers. Other practical points concern the standard of operation required. Would the work be too complex or too expensive on equipment ? Is there enough priority work to share out among existing priority suppliers ? These are the kinds of question which should be considered by the Treasury with whom rests the interpretation of general government policy in this field.

SUPPLIES OF WORK FROM THE NATIONAL HEALTH SERVICE

Suggestions have also been made that more work for the industrial units might be obtained from the various divisions of the National Health Service itself.

Firstly, it may be asked what part the Department of Health and Social Security plays in the priority supply scheme. It might be expected that a large social service department would concern itself particularly with such a scheme. It is not the policy of the DHSS to disclose information on its sources of supply but it would appear that, as far as direct orders are concerned, it plays a relatively small part since it does not figure in the list compiled from priority suppliers. Indirectly, though, a proportion of the orders placed, say, by the former Ministry of Public Building and Works and HM Stationery Office would be on behalf of the DHSS. If a hospital ordered new furniture for a nurses' home, the central contracting network would route the order through the MPBW to, say, Remploy Ltd. *

* Orders from Remploy in a recent year included 30, 000 dozen stump socks, 5, 000 interior sprung and hair-filled mattresses, wheelchair manufacture and repair, and surgical footwear and appliances.

The penal objections would appear to be
prevented. The prison industries
vests a strong central administ
management consultants and
ally qualified cost accountan
experts, whereas the indust
such resources would be a dra
supplies which are intended
despite contracts for a few
police dog trainers. Other
of operation required.
expensive on equipment?
out among existing priority
question which should be
reate the interpretation of

SUPPLIES OF WORK FROM
Suggestions have also
units might be obtained
Health Service itself.

Firstly, it may be asked
Social Security plays in the
expected that a large social
itself particularly with
DHSS to disclose information
appear that, as far as
relatively small part since it
these priority suppliers. Indirectly, hospi
services placed, say, by the former Ministry of
and the Stationery Office would be
ordered new furniture for a nurses' home, the
economy would route the order through the

* * *

In a recent year included 30,000 dozen
sponge and hair-filled mattresses, wheelchai
and repairs and surgical footwear and appliances

Furthermore, it is relevant to recall here that right from 1948 the hospitals themselves have been consistently anti-centralist in temper. The task of establishing any measure of centralisation of supply for the hospital service in the early days was accompanied by loud complaints from the periphery about quality and restriction of choice. More recently, following the setting up of the Hunt committee, supply arrangements have been reorganised but on a pattern which still leaves a high proportion of contracting to be conducted at local level, although this has been shifted to regional board and 'area' level away from groups and individual hospitals.

In the most general terms, it would appear that the DHSS policy on supply is less centralist than that of certain other spending departments; and that at present, if industrial units are seeking work from the hospital service, it is more likely to be obtained at regional or local level.

Regional Level

Enquiry revealed that only two regional hospital boards, Sheffield and Newcastle, are considering the possibility of regional organisations providing manufacturing work for the industrial units in their regions. (The packing of central sterile supply items which is undertaken in some units may or may not be routed through regional boards.) Both regions were visited to see what progress had been made and whether the experience gained could be of value in other regions.

Interest in rehabilitation generally and in industrial therapy in particular has been strong in the Sheffield region for years. The present regional supplies officer was active in SOSAC, the Supplies Officers' Standing Advisory Committee at the Ministry which, before its disbandment, was considering the possibility of allotting work to industrial units.

An inaugural meeting of Sheffield Regional Hospital Board officers, including supplies officers and those concerned in running industrial units, was held at Balderton Hospital on 22 May 1968. The purpose of the meeting was to ascertain which of the goods manufactured in the industrial therapy units could be used by the hospital service through its supplies organisation or, alternatively, which units could be encouraged and equipped to manufacture goods for use in the regional hospitals. The price and quality of any goods offered would need to be up to standards which could reasonably be expected by supplies officers. It was hoped that each industrial therapy unit might be able to concentrate on one particular line of manufacture thus providing a routine 'head' of work, but a proportion of the capacity of units should be reserved for the production of other goods, particularly where their manufacture had local significance, and training in such manufacture might be helpful to the patient after discharge.

Two lines of thought were apparent in the ensuing discussion. On the one hand, supplies officers and certain units were keen to concentrate effectively on a single range of goods, if necessary equipping the units for the purpose. On the other hand, it was feared that bulk work might prove detrimental to patients. After representatives from each unit had stated the type of commodity each made in their particular unit, it was agreed to set up a 'link' committee composed of supplies officers and industrial unit representatives, under the chairmanship of the regional supplies officer. Its task was to make more detailed investigations and to keep in being a channel of information and report.

The link committee met for the first time on 7 January 1969. (Incidentally, four of its six members had been encountered previously in this research project.)

Having arranged acceptable criteria for manufacture (satisfactory standard of finished article, equitable price, continuity of production), the committee considered that general production to meet regional demand would produce delivery problems and possible opposition from the medical staff because of lack of variety of work. It was therefore agreed that, for most projects, production limited to the needs of one supply area would be desirable: however, Christmas crackers and stockings were thought suitable for regional production provided orders could be placed with the manufacturing unit early enough in the year.

Consideration was given to the making-up of textiles bought in length under regional contract, and a member of the committee was asked to visit the hospital in the Newcastle region which was already doing this work. This proposal, however, proved abortive. Large-scale textile contracts produce such keen prices for made-up goods that to channel this work through industrial therapy units would have proved uneconomic.

The committee then examined the suitability of items currently in production in the units. These were x-ray envelopes, pillow-cases, furniture up-grading and upholstery, cardboard boxes, CSSD re-packaging, polythene bags, refuse sacks and disposable sheets, face flannels and bibs, cytology packs, uniform name badges and signposts.

It was considered that hospitals could not compete with outside industry in making polythene bags, that bib-making was not worth pursuing and that hospitals did not need many cardboard boxes. But CSSD and cytology packs, already handled in some industrial units, were agreed to be suitable for other units. The same applied to furniture repairs, and the various members agreed to make further enquiries about x-ray envelopes, pillow-cases, and signposts. Uniform name badges were already being made at Nottingham and further enquiries were to be made here.

The committee also thought there was a need for supplies officers themselves to put forward suggestions which they considered worth investigating, and it was agreed that the minutes of the meeting should be sent to each hospital management committee, each supplies officer and each officer in charge of a unit.

At the time of writing, there the matter rests. What has been accomplished has been reported fully here since it is believed that this is the fullest investigation of the problem so far carried out in any region, and that the detail will be of interest elsewhere. But stimulus will be required to keep the momentum of the project going: a considerable interval of time separates the two meetings and so far no report of work undertaken on a regional or area basis as a result of them has reached us.

In the Newcastle region, on the other hand, something has been done but without any accompanying organisation. This regional hospital board has made an appointment of a regional industrial therapy adviser, but the regional supplies officer had been only a year in post at the time of a visit to the board's headquarters in October 1968. Keen interest was expressed, however, in the idea of a specialist conference of supplies officers and industrial unit officers at the King's Fund Hospital Centre.

Hospital Level

A single remote hospital in the region has the distinction of having taken the initiative on its own. Finding their unit chronically short of work, the group secretary and his colleagues at Garlands Hospital, Carlisle, suggested that their unit should do textile work for the region. The regional supplies officers were persuaded to ascertain the prices of materials and those of finished articles from their normal suppliers, and the hospital unit undertook the work at the difference between these two prices. The work consisted of making up babies' napkins, sheets and towels - specifications are set out in Appendix I.

The drawback is that the work as at present organised pays very badly indeed. With a materials cost of £6,074 to come out of sales receipts of £6,296, the resultant gross income of £222 was all that was left of the 1967 contract to cover patients' wages and transport costs.

Garlands industrial unit finds that CSSD packaging pays much better. However, those responsible would be the first to agree that as an efficient undertaking their unit leaves much to be desired even by the standards of other industrial units. Also, their supervision problems have not been assisted by inflexible salary interpretations by the DHSS. On the credit side, the work offers good vocational training since there are outlets for sewing machinists in Carlisle.

But unquestionably the most impressive manufacturing operation for the hospital service is that carried out at Morgannwg Hospital, Bridgend, Glamorgan. This, too, will be described in detail because lessons can be learned from it.

The Morgannwg group consists of three hospitals, Penyfai on one side of the road, Glanrhyd on the other and the third of the group, Parc Hospital, a mile or so up the valley. The industrial unit is housed at Glanrhyd. It began operations in 1962, housed in garages, sports pavilions and so on. Administrative difficulties were increased by an outbreak of smallpox. Where the unit now stands was a double ward of 150 beds, the repair of which had been agreed with the regional hospital board. However, when rebuilding was started dry rot was found and in view of the predicted drop in the number of patients, the provision of new ward accommodation was abandoned in favour of the industrial unit. A case was made for the employment of 400 patients and a spacious unit costing well over £60,000 was erected.

In addition to Glanrhyd, there is a training and assessment unit at Parc Hospital to which all new ITU workers are first sent.

Here, very simple tasks are undertaken. This scheme is found to be invaluable.

In 1967, 260 patients were employed in the industrial unit; the figures at June 1969 were 210 in-patients and 15 day patients. At one time the day patients had a problem since their bus fares came to almost as much as their earnings, but this has now been resolved and they receive their bus fares in addition to their earnings. The characteristics of the patient work force may be considered typical of a country area some distance from industrial employment opportunities. At the time of the survey in 1967 it was estimated by those in charge that no less than 110 patients were suitable for sheltered employment outside the factory had this been available. Patient statistics covering the period April 1966 - August 1968 may be found in Appendix II

The unit is run by senior staff of the relevant professions. The psychiatrist in charge of rehabilitation and resettlement is a consultant. The officer in charge of staff and patients is a senior assistant chief male nurse and his deputy is a ward sister. The ex-supplies officer in charge of work supply and the financial and administrative aspects of the unit is placed in the senior administrative grade of the administrative and clerical salary structure.

The principal jobs undertaken in the unit in 1968 were:

1 Making armrests for invalid chairs, with plastic, foam rubber strips and clamps. This quite difficult task took workers one month to master.

2 Making polythene bags and plastic toys such as boats, beach kits with buckets, spades and sand shapes. As buckets and spades can be sent unbagged straight to retailers, these tables were short of work and some of the envelope-making (see 6 below) was being diverted to some of them.

3 Sewing-machine work for x-ray photograph holders.

4 Printing. A printing shop houses a creasing and folding machine, bought for some £1,800.

5 Making pelmets.

6 Making envelopes and folders for supply to hospital management committees.

To these were added in 1969:

7 Making carpet pattern-books.

8 Assembling line taps for overhead equipment (involving use of power press and hand operated presses).

HISTORY OF THE ENVELOPES AND FOLDERS

In 1962 the hospital asked the occupational therapy department to make some x-ray envelopes, which they did from ordinary brown packing paper. They made 400 or so and stuck on the labels. The local Bridgend General Hospital then asked for some. Again, brown paper was used but was not satisfactory. The administrative officer therefore provided the proper manilla paper and envelopes made from this were sold to two hospitals in South Wales. This was followed by an invitation from the Liverpool region to tender for some hundreds of thousands of the envelopes.

This is where they feel they went wrong, for the job strained their existing capacity. Complaints were made that the paper was not up to specification and they had to break off the contract. Morgannwg's supplying firm offered to take all the paper back but in the event it was disposed of to other hospitals. Tests showed that the paper was satisfactory so it would seem that the complaints had no justification in fact.

After that, they never looked back. Now, they have work always on hand, for although they do not win everything they tender for, they

have to turn down work. For instance, they had to refuse to tender for one million envelopes for the Manchester region, which the administrative officer knew they could not handle. One reason why they do not get all tenders is the distance the consignments of envelopes have to travel. All goods are quoted carriage paid and until recently the administrative officer had quoted different prices to take this into account. He now endeavours to standardise prices.

From a commercial angle, envelope-making is found to be more profitable than sub-contract work since the demand for envelopes is constant. Other orders can be seasonal and the loss of even one day's work at a sub-contract worktable can be serious. Annual envelope and folder sales were, at the time of writing, running at approximately £20,000 (see Appendix III for list of hospitals supplied).

Costing

The administrative officer explained the series of calculations he makes to arrive at a price when tendering. Evidently his long and close experience is of the utmost value.

He buys materials direct from the mills, omitting any middleman, and knows, from testing the market, that he is buying on the most favourable terms available. He then calculates the cost of material used in making a given size of envelope and adds cost of patient labour, based on experience, say £5 per 1,000 for making an x-ray envelope range. A margin is allowed for printing, gumming labels or flaps, and a $7\frac{1}{2}$ per cent figure for extras added. This gives the selling figure. All overheads are omitted.

Costing Patient Labour

At the beginning they timed a team of four patients making 1,000 envelopes, and multiplied the result to give a week's average work. No timing of normal workers was done. From this exercise they

arrived independently at the ratio of one worker to three patients, which Dr Wadsworth found in the Cheadle Royal Hospital experiments* and which was the equivalent of the standard used by the Dutch for entrants to the sheltered workshops of their social employment scheme.+ A second independent confirmation of the 1 : 3 ratio was secured by watching girls working down town in a factory on piece rate to qualify for bonus.

Because of the above consideration, and the fact that envelopes weigh heavily, making transport costs high, the administrative officer thought that other hospitals could, theoretically, do as he had done. From the lists in Appendix III one can see that practically all Wales is supplied, but supplies to other regions and groups are scattered and there seems plenty of room for similar operations in other parts of the country.

Lessons to be Learned

Three points can be made in connection with the success of the Morgannwg operation.

1 The operation required the concerted efforts of senior staff, each operating in his own sphere of expertise. Particularly significant is the award of the appropriate salary to the administrative officer whose experience as a supplies officer and 34 years of hospital service were evidently of crucial importance to the project.

2 In sanctioning the purchase of the folding and creasing machine the administrative authority was evidently not afraid of appropriate expenditure on equipment.

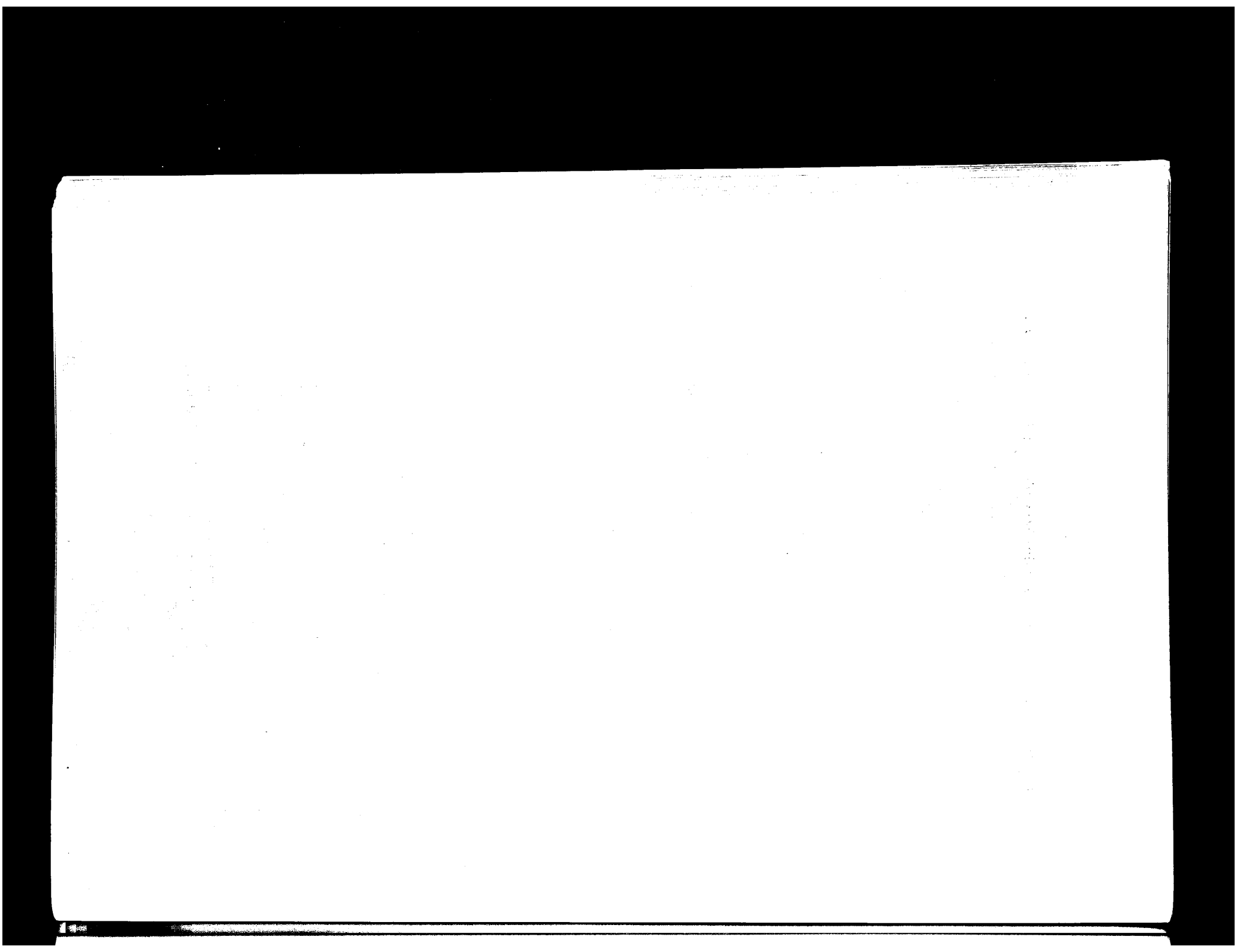
3 The work load of a variety of sub-contracts of different degrees of complexity combined with the unit's own industry may be thought ideal. Besides conveying status, a unit with its own industry geared to the

---

* see also pages 23-24 and Main Report

+ see page 23 and Appendix V

requirements of the hospital service provides a fall-back in case of general industrial recession.



2 PAY QUESTIONS*

METHODS OF PAYMENT

The question of the payment of patients in industrial units has already been treated in some depth in the two preceding reports. Nevertheless, it continues to arise during hospital visits and at conferences, together with the related problem of the £2 earnings limit, and appears to merit further discussion.

To provide a framework for this, and to avoid the need for cross reference, Table VIII from the Main Report, and Table X from the Supplement on Patient Data (adapted to show new and old currencies), are repeated.

TABLE I (Table VIII of Main Report)

Method of paying patients in industrial units
(figures expressed in percentages)

	men	women
allowance rather than a wage	37.2	34.7
time rate weighted for punctuality, attendance, etc +	35.3	33.3
piece rate fixed by price offered by manufacturer	9.9	10.7
piece rate fixed by work measurement	6.9	9.3
other methods	10.7	12.0
total	100.0	100.0

* Decimal equivalents of all sums of money mentioned in this section are given in parentheses.

+ See page 21.

TABLE II (Table X of Supplement on Patient Data)

Payments to patients in industrial units

hospital regions	mean pay per week for men			mean pay per week for women		
1	7s	6d	(37p)	8s	11d	(45p)
2	11s	10d	(59p)	10s	0d	(50p)
3	16s	0d	(80p)	14s	1d	(70p)
4	17s	1d	(85p)	10s	11d	(55p)
5	11s	8d	(58p)	9s	0d	(45p)
6	17s	10d	(89p)	13s	4d	(67p)
7	14s	7d	(73p)	11s	1d	(55p)
8	15s	8d	(78p)	15s	7d	(78p)
9	14s	0d	(70p)	10s	7d	(53p)
10	20s	0d	(100p)	17s	6d	(87p)
11	11s	6d	(57p)	9s	10d	(49p)
12	11s	5d	(57p)	9s	0d	(45p)
13	15s	0d	(75p)	9s	6d	(47p)
14	9s	8d	(48p)	11s	4d	(57p)
15	10s	10d	(54p)	8s	2d	(41p)

average for all patients in the sample: 12.9s (65p) for men
11s (55p) for women

Table I provides an analysis in terms of payment by allowance, by weighted time rate, and by piece rate. Table II shows the average amount paid by region.

ALLOWANCES

Little can be added by research to the concept of rewarding a patient by giving an allowance. Though the researchers confirm their preference for the objectivity of piece rate incentives, they recognise that there are classes of elderly and deteriorated patients whom it is sensible and time saving to reward in this way. Groups of such patients, supervised by a nurse, are thus paid at Cheadle Royal

Hospital, at which the majority qualify for quite sophisticated industrial incentive bonuses, as will be shortly described.

What is open to question is whether the number of such greatly deteriorated patients is as high as over one-third of the total (see Table I) or whether certain of these patients could not be more appropriately rewarded.

WEIGHTED TIME RATE

At its simplest the weighted time rate differs only in degree from the allowance, and consists of the supervisor allocating the patient to one of a number of grades, each carrying its own arbitrary rate of pay in accordance with his estimate of output, behaviour, time keeping, and so on. However conscientiously performed, such an assessment is subjective and open to objection on this score.

A number of hospitals rate patients in this way: A, B, C, D, E. One prefers the numerical gradings (or efficiency factors) of $\frac{1}{2}$, 1, $1\frac{1}{2}$, 2, in order to multiply the patients' hours worked by these amounts. At this hospital efforts are made to reduce the subjective element in the rating procedure to the greatest extent possible. Grading is performed not by a single supervisor but at a weekly staff meeting at which, after starting on grade 1, each patient is reviewed:

by the section staff as to work performance
by the supervisor as to therapeutic needs
by record staff regarding clock card details
by staff groups on social performance

The method of reckoning is ingenious and designed to ensure that every penny earned is paid instantly to the patients who are said to have earned it. Hospitals vary greatly in their attitude to the patient's right to his money. In this hospital, as soon as a job is completed and charged to the contracting firm the invoice is checked by the finance department

and the industrial unit is then free to total all the invoices for the week in question and arrive at a weekly sum to be divided among the patients. This weekly income is then divided by the total weekly units in order to give a value to the weekly pay unit, normally some 7d (3p) or 10d (4p). This unit of payment is then multiplied by the patient's unit (his efficiency factor multiplied by the number of hours worked). A time clock is in use and the patient clocks-in the number of hours he works, the maximum being 30. A grade 2 patient, working 30 hours, would total 60 units, which on this system is equated with £1 19 6 (£1.97) and 60 per cent - 80 per cent efficiency rating. In fact, such a patient would be ready for early discharge. The system, it is said, allows for wage variation in accordance with individual efficiency and hours worked, while maintaining the therapeutic incentive differential.

But this scheme, ingenious as it is, cannot blinker the fact that the allocation to grades is still subjective, and, moreover, to keep in funds the scheme requires a certain proportion of patients in each grade. Theoretically, too many patients could not remain in grade 2 or the unit would be insolvent. In practice, the full-time industrial placement officer is constantly moving grade 2 patients into open employment where a demand for their services exists.

RATING SHEETS

On a more sophisticated level, hospitals rate patients systematically by scoring qualities or attributes on a prescribed sheet or rating card. Sometimes these are used for periodic assessment only; sometimes as a basis for payment. Two such sheets are set out in Appendix IVa and IVb. One problem associated with this method of rating is to ensure a correct balance in the weighting between the different attributes scored. One hospital has had to revise its pointage in order to attach greater importance to industrial factors such as quantity of output and manual dexterity, and less importance to such items as attitudes to authority. For this reason it has been thought useful to append the rating sheet in

use in the Dutch social employment scheme which covers the mentally and physically handicapped and mentally retarded. This rating sheet is designed to apply to Dutch sheltered workers productively employed in conditions approximating perhaps more to our own Remploy conditions than to those in most industrial therapy units, and factors are rated accordingly. But those responsible for the scheme emphasise that it can be adapted to different circumstances. 'In view of the fact that the aspect of quantity is best suited to objective rating and most clearly indicates the development of the working ability of the workers as regards their suitability to be placed in open industry, a high value is usually placed upon this aspect. If led by the idea that the worker's diligence and devotion to his work, irrespective of the quantitative results, should influence the hourly wages to a considerable extent, a higher value should be placed upon C than upon D and E. If cooperation is a first consideration, more emphasis will have to be placed upon E'*(see Appendix V).

PAYMENT BY RESULT

At the most industrial end of the scale comes payment by result either by straight piece rate or by some form of incentive bonus. Both methods can be studied at Cheadle Royal Hospital, which still appears to be most proficient at stratifying its work force and paying accordingly. The most deteriorated patients work in the south section and are paid a small allowance or time rate. However, if these patients improve sufficiently to make more money by piece rate, they are moved to the centre or north sections. Occasionally, a patient progresses from the south section to become an approved worker in the sheltered workshop.

In the centre and north sections patients are paid on piece rate, except where a job has not been studied, when they are paid a service job rate, as described below. Each supervisor records on a work record card

---

* The GSW Wage System, Ministry of Social Affairs and Public Health, The Hague.

the number of jobs done, looks up the price per gross or other unit (each single item has been time studied and carries an allowed time) and converts the quantity produced, by means of the tables provided, into money payment. On a visit the researcher was shown the record of a centre section patient who, working on two different carnival hats, earned 6s 1d (30p) in 11½ hours. Because of her health (thyroid trouble), no investigation of this patient's unauthorised absences was made. Another card was that of a schizophrenic patient who looked continuously out of the window and earned, and was paid, 2d. It was reported that he did very much better the following week.

Service rates are paid for jobs not yet time studied, not worth studying because of the short run, or unsuitable for studying. Patients on service rate are paid the average of their rates for the last four weeks - since some schizophrenic patients fluctuate in their earnings a great deal.

The amount earned by patients in these sections might, very occasionally, go over £2, but this is not the rule. Patients at Cheadle Royal Hospital do not earn more than those in many other hospitals, but their earnings are directly proportional to the amount of work done, even on service jobs.

TRAINEE SECTION AND APPROVED SHELTERED WORKSHOP

In the trainee section, NHS patients (referred on contract from Manchester RHB) and county council trainees in particular, are assessed for general suitability to enter the factory. A complicated assessment scheme has been abandoned in favour of a straightforward month's trial at work. Piece rate is paid here too and there is provision for the payment of a trainee allowance.

The goal of the workers in all other sections is the approved sheltered workshop. The approved sheltered worker gets:

a basic rate of £2 16s 8d (£2.83)

b local authority payment of £5 19s (£5.95) for a single man

c bonus

This basic rate rests on a genuine and logical basis, the trade board rate for the industry of which paper-hat making is a part. Admittedly low, in 1969 it was 4s 3d (21p) per hour. Over a period it was found that the schizophrenic patient's pace averages a third or so of that of a worker in open industry. Thus, the basic rate for the factory is something over 1s 5d (7p) per hour or £2 16s 8d (£2.83) for a 40 hour week. Reference to a trade board rate is found useful for rebutting the charge that the workshop runs on cheap labour; it is understood by contractors and acceptable to unions.

The former Department of Employment and Productivity grant has been, in practice, paid by the local authority and 75 per cent recovered from the DEP.

Two bonus schemes have been tried. The first was simply a cash award paid at outstanding stages, 10s (50p), 15s (75p) or £1. Patients reacted to this precisely as workers do everywhere, watching targets and slackening off when they hit one target and thought they stood no chance of hitting the next. While delighted at this 'normal' behaviour, the management judged they ought to introduce a new scheme. An effort-rating bonus scheme similar to that used in industry was adapted from the general manager's previous place of employment. Varied terms such as standard minutes or 'credors' express the standard units of work expected to be completed in one hour. Commonly, in open conditions a worker is expected to produce 80 units (or standard minutes) of work in one hour, when he will qualify for a $33\frac{1}{3}$ per cent bonus, $\frac{80}{60} = 1\frac{1}{3}$. If the worker produces only 60 units in 60 minutes he gets no bonus. At Cheadle Royal Hospital in 1967, the time of our visit, 33 per cent of the then basic rate of £2 10s (£2.50) would have been some 16s (80p). The most successful patient had earned £1 5s 10d (£1.29) representing a bonus

of over 50 per cent. Since then the bonus scheme has continued to be a great success and in the subsequent two years every new 'high' has quickly been broken by a higher figure. The most recent high is 84s (£4. 20) and the average bonus of the workers, apart from the 'star' performers, is now persistently around 20s (£1) - 30s (£1. 50). In other words, what had originally been a star standard in 1967 has become a norm for ordinary workers given further time and experience.

The adaptation of the bonus scheme from open industry has resulted in a 'schizophrenic' time of one-third that of 'normal' time. Patients, therefore, usually begin to receive bonus when they produce one-third of what an open industry worker has to produce, and receive one-third his bonus amount. But the increased productivity of the experienced workers is, of course, reflected also in this ratio, so that the 1 : 3 ratio now applies only to new candidates in the workshop.

The administrative background to all this has to be filled in. Every single carnival hat (the staple product of Cheadle Industries Ltd) has been time studied and awarded a standard time. In fact, in the early days new hats of different standards of complexity were invented to complete the range. When new contracts are undertaken they are all studied - the staff all studying each other. All past rates for the various jobs are filed and, it is said, when broken down turn out to be surprisingly alike. As to paper work, two clerks check 150 work cards in one morning.

As an administrative postscript, for the past two years the workshop has run at what is from its point of view a marked profit. Looked at from the DEP angle, its achievement has been to work so well as progressively to minimise its loss. As a result the DEP negotiated a return of its grant representing £1 1s (£1. 5) per capita.

THE £2 LIMIT

It has been possible to develop an incentive bonus scheme in approved sheltered workshops because ordinary, although admittedly low, wages are paid. But, as it is argued in the Supplement on Patient Data, the £2 limit inhibits such a development in industrial units because it is virtually impossible to devise a satisfactory piece rate geared to output with a cut-off point at £2. The necessary scaling down must, almost inevitably, nullify the incentive element.

Another effect of the £2 limit is to discourage staff from procuring the more interesting and highly paid jobs otherwise desirable for rehabilitative progress. Acceptance of low-paid work has the further effect of subsidising from the public purse those contractors who are underpaying for work done. On one hospital visit an account was given of experience of a Christmas card packing job.

For a long time patients had been paid 30s (£1.50) per 1,000 packs. This meant that each patient on the maximum of 39s (£1.95) would do 1,300 packs. The time came when the administrative officer thought it proper to negotiate a rise in the price for this job; £2 per 1,000 was agreed without difficulty. But the rise turned out to be self-defeating. It meant that every patient being paid 39s (£1.95) had to do 300 packs less than he had been doing. The patients accordingly sat about and did nothing when they had made their £2, and efforts to regulate the situation by placing them on other, lower paying work, were seen through and rejected.

Similar stories abound. There is no doubt that the £2 limit is a strong disincentive to both patients and staff. Accordingly, it was decided to investigate the whole question with the help of the ministries responsible.

In the first place it was emphasised that this was the £2 National Insurance sickness benefit earnings limit and affected those patients who were insured for sickness benefit. It did not affect, for instance,

housewives who stopped working after they were married nor those whose entitlement to benefit had run out.

When the National Insurance scheme began in 1948 it was felt that sickness benefit ought not to be withheld from patients who worked in and around mental hospitals. It was therefore agreed that earnings up to £1 should be ignored, as in the case of unemployed people who were allowed to earn up to £1 and still draw unemployment benefit. In 1958 the £1 limit was raised to £2. This concession, which at first only applied to hospital patients, was later extended to patients in the community, providing they had a good reason for doing the work; for example, if their doctors approved it as a way of keeping them occupied.

The regulation which permits these earnings, 7(1)(h) of the Unemployment and Sickness Regulations made under Section 20 of the National Insurance Act, 1965, provides that:

'a day shall not be treated as a day of incapacity for work if a person does any work on that day, other than -

i work which is undertaken under medical supervision as part of his treatment while he is a patient in or of a hospital or similar institution, or

ii work as a non-employed person which is not so undertaken and which he has good cause for doing,

and from which, in the case of work of either description, his earnings, if any, are ordinarily less than 40 shillings a week.'

Thus, the earnings limit for sickness benefit is, in the context of the National Insurance provisions, not an earnings rule in the normal sense. It is simply a measure of what a person may be allowed to do by way of diversionary work and still be regarded as incapable of work for sickness benefit purposes.

by way of diversionary work and
sense. It is simply a
the National Insurance
Thus, the
earnings, if any
and from
it was
which
de
(

To understand the whole position it is also useful to take note of the regulations which control the financial situation of the psychiatric hospital in-patient. After a patient entitled to sickness benefit has been in hospital for eight weeks, he or she gets a reduction of benefit (these reductions apply also to those entitled to widow's benefit or retirement pension) to take account of the free maintenance element of the cost of keeping him in hospital. The standard rate of benefit for a single man (from November 1969) is £5. After one year this is reduced to £1 pocket money if a man has no dependants. But during the second year the amount left after deducting the £2 boarding charge and £1 pocket money paid to him in hospital is accumulated as a resettlement benefit which may, in due course, be paid out in weekly instalments or, with safeguards, as a lump sum. Thus, after two years in hospital a single person can earn up to £2 without losing his right to his £1 sickness benefit.

If a man has dependants his sickness benefit will usually be paid over to them less the boarding charge (£1 in his case) and £1 pocket money. If this benefit and any other resources the family may have are insufficient for their needs, they will be able to claim supplementary benefit.

PROPOSALS FOR MITIGATING THE DISADVANTAGES OF THE £2 LIMIT

Various ways of overcoming the disadvantages of the £2 limit have been suggested, for example: by raising the limit by a straight increase; operating a sliding scale; the industrial unit applying for recognition as an approved training establishment; or by the patient working as a self-employed person.

Raising the Limit by a Straight Increase

Since the permissible earnings limit was fixed at £2 in 1958, prices have risen and the value of money has fallen. It would, therefore, appear logical to raise the limit in line with everything else.

The short answer to this proposal, given by DHSS, is that the present high level of flat rate benefits, when considered against the wages of the lower-paid worker, leaves absolutely no room for manoeuvre of this sort, see Table III. Earnings of £2 per week in addition to sickness benefit mean that a person receiving sickness benefit and doing part-time work may already be better off financially than a disabled person doing a full week's work in a sheltered workshop or on the open market, whose earnings are subject to tax, and who has to pay Class I National Insurance contributions, and probably meet other expenses such as fares. Sickness benefit, it may be noted, is tax-free.

TABLE III Social services benefit payments as at November 1969

	sickness benefit (tax-free)	earnings	income per week (excluding family allowances)
single man	£5	£2	£7
married man	£8 2s (£8.10)	£2	£10 2s (£10.10)
married man with two children	£10 6s (£10.30)	£2	£12 6s (£12.30)
married man with four children	£11 8s (£11.40)	£2	£13 8s (£13.40)
married man with five children	£11 19s (£11.95)	£2	£13 19s (£13.95)

The earnings concession of up to £2, when added to state benefit may also exceed the rate of allowances for work done at an industrial rehabilitation unit (IRU) or industrial therapy organisation (ITO). In such cases, the earnings concession acts as a deterrent to progression out of the hospital workshop.

Operating a Sliding Scale

It has also been suggested that the £2 earnings limit should operate on a sliding scale for people drawing sickness benefit as it does for those

drawing unemployment benefit. But it is pointed out that this would have a very odd effect, namely, that regarding a man as incapable of work for sickness benefit purposes would depend on his family responsibilities. Carried to its logical conclusion it could mean that, say, a married man with two children could earn £12 5s (£12.25) (see Table III, £12 5s (£12.25) equals £12 6s (£12.30) less 1s (5p)) and still be regarded as incapable of work since he would be in receipt of the minimum sickness benefit of one shilling (5p). Furthermore, DHSS is advised that a sliding scale of this sort would probably be beyond its legal power to introduce.

A different proposal involving the use of the sliding scale principle was brought to our notice. This was to use the boarding charge sliding scale already in operation for patients working outside the hospital. This would allow industrial unit patients also to earn as much as they could, but to contribute, on an assessed basis, to their keep. The State would be none the worse off. But what effect would such a scheme have on a patient's willingness to leave hospital ? It is here that the analogy with the working patient breaks down to some extent, since the working patient has already half left the hospital.

Approval as a Training Establishment

The third proposal, to apply for approval as a training establishment, would seem to offer the most likely line of advance. Briefly, if a workshop were accepted as an organised course of full-time training, sickness benefit would not be payable but National Insurance contributions could be excused and credits awarded for up to twelve months to persons eligible because of their previous contribution records. In this way a rehabilitee might, during this period, earn as much as he could and watch his progress, measured by his increasing earnings, without becoming liable to pay National Insurance contributions. Corresponding adjustments could be made with regard to supplementary benefits.

This, of course, already happens in the case of ITOs and IRUs. The difference is that these organisations were approved by the DEP while industrial units in hospitals are the concern of the DHSS. It is the DHSS, therefore, that would have to approve an industrial unit as organising a full-time course of training with entitlement to credits.

A point worth repeating is that such a scheme would not apply to self-employed persons, to women who have neither been out to work nor contributed to national insurance, nor to people who have run out of benefit. These people would not be entitled to sickness credits, but there is no National Insurance regulation to stop them earning as much money as they can. That they do not at present do so is, presumably, simply hospital policy.

It is worth remembering also two classes of person in relation to insurance benefits. The first is the person who, having worked for three years and got three years' insurance stamps, gets unlimited sickness benefit until retirement provided he remains incapable of work: his card is filled up with sickness credits. This person may well be a long-term patient who might still be in credit despite prolonged incapacity having achieved three years' stamps. The second class is that of the non-insured person, incapable of work, with income in his own right after the age of 16. Inside hospital, he is given pocket money by the health authorities if he is a patient; outside hospital, he gets pocket money from the Supplementary Benefits Commission irrespective of the income of his parents.

So much for the statutory position. It offers obvious possibilities and it is worth speculating on the best way of exploiting them. A rush of applications for recognition from each industrial unit in the country would be inappropriate and might so alarm the authorities as to be self-defeating.

A wiser course might be to introduce one or two pilot schemes. In addition to assessment by psychiatrists and National Insurance officials, a body such as the Association of Hospital and Industrial Units could observe these schemes and report to their members.

At the same time, the figures in the Supplement on Patient Data present a very different picture of the total number of patients who could be involved than would have been thought probable some years ago. A National Insurance concession conceivably affecting a maximum of 700 patients per year (the 1966 figure for long-stay patients leaving industrial unit and hospital) is a very different matter from a concession affecting a number which, in default of this analysis, could have been put as high as 18,000, the total industrial unit population. For this is a training scheme, devised for persons training, or being rehabilitated for full employment. Moreover, not all the 700 per year (now probably fewer) are likely to be in benefit and to qualify for the scheme. The rest of the industrial unit population - the elderly, long-stay, deteriorated patients - have achieved their optima and are happy as they are. For other long-stay patients, approved sheltered workshops are more appropriate. The short-stay patients, by definition, will be leaving hospital within a short period anyhow, unit or no unit, rehabilitation or no. The outlook in terms of figures may be thought not unmanageable.

Working as a Self-employed Person

One hospital has developed a scheme by which a group of patients progress from their industrial unit to one of their local contracting firms where they are classed as self-employed persons. They earn between £6 10s (£6.50) and £7 5s (£7.25) per week. A compulsory deduction of £1 2s 2d (£1.10) per week covers their insurance stamp. The local Inspector of Taxes agreed to waive Income Tax for the financial year 1968/9, in view of the small amounts involved over and above personal allowances and the fact that the work is of therapeutic value. If earnings rose substantially the patients would become liable to Income Tax, paid twice yearly as is normal for a self-employed person.

Tax, paid twice
If earnings were
personal allowance
Year 1985/6,
The local Inspector
deduction of
Between 16
Those leaving
pregnancy
Claim
Tax

SURPLUSES

One further aspect of wage payment is the surplus, that is, the money earned by patients over and above what is paid out to them. In the early days this was normally kept by those in charge of the units and used as they saw fit. The position was, at the time of writing, governed by Ministry of Health Circular HM(66)25, which describes the method to be followed when accounting for industrial therapy, and which was promulgated after consultation with interested parties in the then Ministry of Health and regional hospital board treasurers. The reason for the circular was that it seemed wrong that one particular class of receipt should apply solely to one particular purpose. The general rule, in accounting for public services, is that receipts should be paid into the consolidated fund. If they are authorised for a particular service, they should be used to alleviate expenditure on that service as a whole rather than on a particular part of it.

The argument continues to the effect that there are many ways of treating patients and that industrial therapy is just one of them. Those in charge of running hospitals should have a choice in determining how they divide their money between different methods of treatment. The previous system escaped the choice because the receipts gained by industrial units automatically went to industrial units. The DHSS must be concerned with priorities and the provision of a comprehensive service, and the circular reflects this concern. It evoked no general outcry but recently one hospital made representations that it could no longer use industrial therapy income directly on that service.

In effect, the circular does not mean that the money earned by industrial units goes back to the consolidated fund. The method of government accounting is to allocate to a regional hospital board a sum representing its gross expenditure less receipts from direct credits. The following figures relate to the year 1967/8.

		£m
Gross running costs of HMCs, England and Wales (excluding administration)		548.2
Direct credits - including trading services (which, in turn, include industrial units)	£5.6m	24.4
Net expenditure		523.8

The DHSS attempts to control net expenditure but does not concern itself with gross running costs. Therefore, so the argument runs, if a regional board increases its direct credits, which include receipts from industrial units, it can incur larger expenditure under its gross running costs.

The theory behind all this is that hospital income is returned to DHSS in charges for pay beds, amenity beds, prescriptions and so on, but income acquired from direct credits, such as trading services, is not returned. This, at least, is the argument. What it means is that a unit making a lot of money should swell the coffers of the regional board, and it is the regional board to whom representations should be addressed by those in charge of industrial units who may consider that they have a moral right to this money. It is quite certain that this accounting point is not appreciated by many hospitals.

The research revealed the wide disparity of attitudes and practices among different hospital authorities when allocating these (and other) funds to the units. Whereas one hospital would be authorised to purchase thousands of pounds' worth of bulk forward consignments of timber or manilla paper, or could buy vans, shrink-wrap machinery, powered saws, industrial sewing machines or printing machinery, another could not get authorisation to buy a large stapler.

Similar disparity was revealed in the expenditure of surpluses on patients. In the hospital previously mentioned, which prides itself

on distributing the sums earned by patients direct to them that very week, patients earning more than £2 are encouraged to donate the surplus to the more deteriorated patients. This, more or less openly, is what happens in many hospitals.

Mapperley Hospital, Nottingham, has developed a logical scheme. Patients are paid according to their output which is recorded on the back of their time cards. These become valuable records of progress and improved speed. If a patient earns more than the maximum, which frequently occurs, the extra is entered as a credit on the patient's record card. But the patient can never get at it; it cannot even be banked against his discharge. All that can be done is that if a patient is absent through sickness (the majority in the unit are day patients) or on holiday, he can draw his 'sick pay' or 'holiday money' until his credit runs out. On discharge he loses the credit although, pay day being Friday, he can be paid a full week as a carry forward if he leaves that day.

The remaining money goes into an industrial therapy fund from which vans and machinery are bought (in 1968 a parcel-tying machine cost £150). Also, the group secretary draws on the fund, in addition to amenity account money, to pay for patients' seaside holidays (150 went to Skegness in 1967). Some is used for the factory - or unit - outing. This, too, is common practice in other hospitals.

3 PRICING OF CONTRACTS

Time did not allow for the further series of visits to contracting companies on which it was proposed to build this part of the report. In the absence of the field work necessary for a detailed account, perhaps three general observations may be permitted.

First, the floor cost (the amount actually paid to a contracting firm's workers and often accepted by industrial unit managers as a fair price) is a very different matter from the labour cost to that firm, since the latter would include the employer's National Insurance liability and SET in addition to the normal overheads of heating, lighting and supervision, a proportion of which (but not all) will be saved by the firm which puts its work out to contract.

From the simple angles of the non-exploitation of patients, and non-undercutting of a trade union's membership in open industry, the floor cost is satisfactory. But the fact will remain that the hospital service which provides heating, lighting and supervision in the industrial units will, to that extent, be subsidising a contracting company unless this company redresses the balance by providing transport (as many of them do) or a percentage on-cost (as many do, also).

Secondly, in this context too, the £2 limit is inevitably a disincentive to staff seeking to negotiate the correct price for a job.

Thirdly, the best guarantee of proper pricing, it would seem, is the employment in industrial units of staff with industrial know-how and experience, and the encouragement of industrial therapy staff associations which exchange contract information among their members.

APPENDIX I

Work undertaken in sewing section, Garlands Hospital, Carlisle, under contract to Newcastle Regional Hospital Board, 1 February 1968 - 31 January 1969.

	quantity ordered
Terry hand towels (white) selvedged and 1" hems each end. Finished size 22" x 44".	148 doz
Terry hand towels (coloured) selvedged and 1" hems each end. Finished size 22" x 44".	122 doz
*Terry bath towels (white) selvedged and 1" hems each end. Finished size 27" x 54".	290 doz
+Terry napkins (white). Finished size 24" x 24".	1,590 doz
Huckaback towels. Finished size 24" x 36".	155 doz
Huckaback towels (fine linen) woven 1" letters 'HOSPITAL PROPERTY' down centre. Finished size 24" x 36". Self coloured.	86 doz
Huckaback towels (fine linen) woven 1" letters 'HOSPITAL PROPERTY' down centre. Vat dyed blue. Finished size 24" x 36".	160 doz
Tea towels. Selvedged and $\frac{1}{4}$" hems each end. Finished size 24" x 36".	226 doz
Tea towels. Woven 1" letters 'HOSPITAL PROPERTY' down centre. Vat dyed blue.	600 doz

Receipts from sales	£6,296 8 0	
less cost of materials	£6,074 7 10	
Gross income	£ 222 0 2	(Patients' wages and transport costs paid out of this sum)

* 12 doz bought additional to contract (in total ordered)

\+ 160 doz bought additional to contract (in total ordered)

APPENDIX 1

Work undertaken in seeking Geelong Hospital Capital Redevelopment Funding

Hospital Board, 1 September 1989 - 31 January 1990

APPENDIX II

Numbers of patients treated at Morgannwg Hospital Industrial Therapy Unit

April 1966 - August 1968

	PARC men	GLANRHYD men	PARC women	GLANRHYD women	TOTALS
discharged	41	89	61	58	249
transferred to other departments	10	9	11	0	30
returned to ward	20	19	19	21	79
day patients	0	9	0	5	14
living in hospitals and working out	1	0	1	4	6
attending Port Talbot and Cardiff IRU	14	2	4	0	20
attending ITU	49	44	50	41	184
totals	135	172	146	129	582
discharged and work found by activities officers	22	32	0	12	66

men	307
women	275
total	582

APPENDIX III

Hospitals supplied by Morgannwg Hospital Industrial Therapy Unit

regional hospital board	hospital management committee	hospital
BIRMINGHAM	East Birmingham	Marston Green Maternity Hospital
	Herefordshire	County Hospital
		General Hospital
	Mid-Worcestershire	Bromsgrove General Hospital
	North Staffordshire	City General Hospital
		North Staffs Royal Infirmary
	Robert Jones and Agnes Hunt Orthopaedic	Robert Jones and Agnes Hunt Orthopaedic Hospital
	South Warwickshire	Warneford General Hospital
	South Worcestershire	Evesham General Hospital
		Malvern General Hospital
		Powick Hospital
		St Wulstan's Hospital
		Worcester Royal Infirmary, Ronkswood Branch
	Walsall	Manor Hospital
		Walsall General Hospital
	West Bromwich and District	Hallam Hospital
		Moxley Hospital
		West Bromwich and District General Hospital
	Wolverhampton	New Cross Hospital
		Royal Hospital
EAST ANGLIAN	West Suffolk	Newmarket General Hospital

regional hospital board	hospital management committee	hospital
MANCHESTER	South Manchester	Withington Hospital
	Wythenshawe and North Cheshire	Baguley Hospital
		Manchester Chest Clinic
		Wythenshawe Hospital
NORTH EAST METROPOLITAN	East London	Bethnal Green Hospital
		London Jewish Hospital
		Mildmay Mission Hospital
		St Leonard's Hospital
NORTH WEST METROPOLITAN	Central Middlesex Group	Central Middlesex Hospital
	West Herts	Bushey and District Hospital
OXFORD	Northampton and District	Creaton Hospital
		Manfield Orthopaedic Hospital
		Northampton General Hospital
SHEFFIELD	Lincoln No 1	St George's Hospital
	Mansfield	Mansfield and District General Hospital
	Worksop and Retford	Victoria Hospital
SOUTH EAST METROPOLITAN	Woolwich Group	Brook General Hospital
		Memorial Hospital
SOUTH WESTERN	Tone Vale Group	Tone Vale Hospital
SOUTH WEST METROPOLITAN	Cane Hill	Cane Hill Hospital
	Guilford and Godalming	Royal Surrey County Hospital

regional hospital board	hospital management committee	hospital
SOUTH WEST METROPOLITAN	Redhill and Netherne Group	Netherne Hospital
		Redhill General Hospital
WELSH	Brecon and Radnor	Breconshire War Memorial Hospital
		Chest Clinic
	Bro Morgannwg	Bridgend General Hospital
		Chest Clinic
		Glamorgan Child Guidance Clinic
		Hensol Castle
		Maesteg General Hospital
		Morgannwg Hospital
		Neath General Hospital
		Port Talbot General Hospital
		VD Clinic
	Caernarvon and Anglesey	Caernarvon and Anglesey General Hospital
		St David's Hospital
	Cardiff and District	Amy Evans Memorial Hospital
		Barry Accident and Surgical Hospital
		Caerau Hospital
		Caerphilly District Miners Hospital
		Cardiff Chest Clinic
		Children's Ear Nose and Throat Hospital
		Energlyn Hospital
		Ely Hospital
		Lansdowne Hospital
		Prince of Wales Orthopaedic Hospital, Cardiff

regional hospital board	hospital management committee	hospital
WELSH	Cardiff and District	Prince of Wales Orthopaedic Hospital, Rhydlafar
		St David's Hospital
		Sully Hospital
		Velindre Hospital
		Whitchurch Hospital
		Ystrad Mynach Hospital
	Clwyd and Deeside	Colwyn Bay and West Denbighshire Hospital
	Glantawe	Morriston Hospital
		Mount Pleasant Hospital
		Singleton Hospital
	Merthyr and Aberdare	Merthyr General Hospital
		St Tydfil's Hospital
	Newport and East Monmouthshire	Cefn Mably Tuberculosis Hospital
		Chepstow and District Hospital
		County Hospital
		Mount Pleasant Hospital
		Pontypool and District Hospital
		Pontypool Chest Clinic
		Royal Gwent Hospital
		St Lawrence Hospital
		St Woolos Hospital
	North Monmouthshire	Ebbw Vale Hospital
		St James' Hospital
	Pontypridd and Rhonda	Llwynypia Hospital
	South West Wales	Pembroke County War Memorial Hospital, Withybush Section
		West Wales General Hospital

regional hospital board	hospital management committee	hospital
WELSH	Wrexham, Powys and Mawddach	Maelor General Hospital
		Wrexham War Memorial Hospital
WESSEX	Bournemouth and East Dorset	Christchurch Hospital
		Royal Victoria Hospital
		Poole General Hospital
		St Leonard's Hospital
	Park Prewett	Park Prewett Hospital
	Portsmouth	Queen Alexandra Hospital
		Royal Portsmouth Hospital
	Southampton Group	Royal South Hants Hospital
		Southampton General Hospital
	Winchester Group	Lord Mayor Treloar Hospital
		Royal Hampshire County Hospital
		Victoria Hospital

TEACHING HOSPITALS

board of governors	hospital
LONDON	
Charing Cross Hospital	Fulham Hospital
London Hospital	Mile End Hospital
Moorfields Eye Hospital	Moorfields Eye Hospital
St Peter's, St Paul's, St Philip's and the Shaftesbury Hospitals	St Peter's Hospital
	St Paul's Hospital
The Royal Marsden Hospital	The Royal Marsden Hospital
The Royal National Orthopaedic Hospital	The Royal National Orthopaedic Hospital

Regional Hospital Board

Hospital Management Committee

board of governors	hospital
PROVINCES	
The United Cardiff Hospitals	Cardiff Royal Infirmary
	Llandough Hospital
	Royal Hamadryad General and Seamen's Hospital

total number of hospitals and clinics supplied: 117

APPENDIX IVa

ST WULSTAN'S HOSPITAL

Work Report

Name Unit

Period covered

Work done

A		A applies	Inclined to A	About midway	Inclined to B	B applies	B
1	Does complicated jobs						Can do only simple jobs
2	Grasps instructions quickly						Cannot grasp instructions
3	Works very quickly						Works very slowly
4	Works continuously						Works for only short periods
5	Eager to work						Avoids work
6	Welcomes supervision						Resents supervision
7	Needs no supervision						Needs constant supervision
8	Willing to change jobs						Refuses to change jobs
9	Looks for more work						Waits to be given more work
10	Always uses good judgment						Never uses good judgment
11	Excellent standard of work						Bad standard of work
12	Skilful with hands						Clumsy with hands
13	Uses tools/equipment well						Cannot use tools/equipment
14	Gets on well with other people						Gets on badly with other people
15	Communicates spontaneously with other people						Does not communicate with other people
16	Never arrives late or leaves early						Always arrives late and leaves early
	TOTALS						GRAND TOTAL (0-64)

REMARKS

Date Supervisor

APPENDIX IIIA

A					
1 Does complicated jobs					
2 Carries instructions quickly					
3 Works very quickly					
4 Works continuously					
5 Keeps to work					
6 Welcomes supervision					
7 Needs no supervision					
8 Willing to help others					
9 Looks for more work					
10 Always tries to improve					
11 Excellent attendance					
12 Settles with people					
13 Uses tools correctly					
14 Gets on well with people					
15 Communicates well with other people					
16 Never arrives late or leaves early					
TOTALS					

REMARKS

Date

APPENDIX IVb

WEST PARK HOSPITAL INDUSTRIAL THERAPY UNIT

Workshop Report

Name ..... Age ..... Date .....

1 MANUAL DEXTERITY

Very good with hands	( )
Quite proficient	( )
Handles tools adequately	( )
Rather awkward	( )
Very clumsy	( )

2 * JOB QUALITY RATING ( ) 3 * JOB SPEED RATING ( )

* Mark as follows:

Quality		Speed	
1	Well turned out	1	Very quick worker
2	Above normal standard	2	Maintains normal speed
3	Acceptable standard	3	Reaches an acceptable tempo
4	Rather sub-standard	4	Is slow moving
5	Very poor quality	5	Speed well below normal requirements

4 APPLICATION	5 DISPLAYED PHYSICAL EFFORTS
A most industrious worker	Shows a lot of stamina
Careful and conscientious	An energetic worker
A steady worker	Copes with normal day
Easily distracted	Rests now and again
Unable to stick at his job	Rests frequently

6 BEHAVIOUR IN A WORKING GROUP

A	B
A popular member	Takes the lead
Is accepted by group	Mixes with group
* Is not accepted by group	Avoids joining group

* Because his behaviour is:

Immature
Childish
Eccentric
Irresponsible
Aggressive

7 ATTITUDE TO WORKSHOP DISCIPLINE

Is most reliable
Behaviour is good
Keeps the rules
Rather irresponsible
Resists correction

LITTLEMORE HOSPITAL, PHOENIX UNIT: WORK ASSESSMENT CHART

Name ..... Accommodation ..... Group .....

Date of commencement ..... Commencement pay week ending .....

CATEGORY	MARKS	WEEKS ENDING								
Ability to work unsupervised	11									
Meetings in the community	12									
Punctuality at work	11									
Personal cleanliness - appearance	7									
Relations with co-workers	3									
Thoroughness and accuracy	3									
Speed	3									
POSSIBLE TOTAL	50									
Deductions for unauthorised absence										
TOTAL FOR RESIDENTS										
Deductions for day patients										
NET TOTAL FOR PAY										
PAY										

Deductions for unauthorised absence from work

1 point deducted for every unauthorised absence of less than 30 minutes
2 points deducted for every unauthorised absence of more than 30 minutes but less than a work session
3 points deducted for every unauthorised absence for the whole work session

APPENDIX V

NETHERLANDS SOCIAL EMPLOYMENT SCHEME

Rating Paper

A	Quantity	12 Approximates to open industry	9 About 80 per cent	6 About 66 per cent	3 About 50 per cent	0 Less than 50 per cent
B	Quality	4 No mistakes, no rejects.	3 Few mistakes, no rejects.	2 Few mistakes, few rejects.	1 Many mistakes, little spoilt material or rejects.	0 Many mistakes, much spoilt material, many rejects.
C	Devotion Interest	8 Is greatly interested in his work. Shows new ideas. Is always immediately prepared to set to work on a new task. Continuously diligent. Takes good care of finishing touch.	6 Takes an interin his work. Now and then he shows new ideas. Is prepared to do other work. Is diligent, pays much attention to finishing touch.	4 Has little initiative. Is prepared to do other work; works steadily on if under supervision; pays enough attention to finishing touch.	2 Does only what he is told to do and no more. No initiative. Takes little interest in other work. Requires much supervision.	0 No initiative. No interest. Must be set to work all the time. Is not prepared to do other work. Shows no sense of responsibility.
D	Behaviour towards others and with regard to regulations	4 Inspires his colleagues. Helpful and pleasant companion. Adheres strictly to regulations.	2 Helpful. Observes regulations. Causes no trouble to management.	0 Does not observe the regulations and is not cooperative. Is recalcitrant towards management. Has an unfavourable influence on his surroundings.		
E	Care for material, tools, machinery, buildings.	4 Is very careful in his dealings with material, machinery, tools, energy, etc. Promotes order and tidiness at the project.	2 Makes normal use of material, machinery, etc. Observes order and tidiness.	0 Must always be told that he makes wrong use of material, machinery, tools, and is spoiling them. Is untidy.		

NETHERLANDS SOCIAL EMPLOYMENT SCHEME

Rating Paper

A	**Quantity**	12 Approximates to open industry	9 About 80 per cent	6 About [illegible] per cent
B	**Quality**	4 No mistakes, no rejects.	3 Few mistakes, no rejects.	2 Few [illegible] few [illegible]
C	**Devotion Interest**	8 Is greatly interested in his work. Shows own ideas. Is always [illegible] the [illegible] to work [illegible] [illegible] Takes good [illegible] [illegible]	[illegible]	4 [illegible]
D	**Behaviour towards others and with regard to [illegible]**	[illegible]	[illegible]	[illegible]

Text printed in England by Walbrook Supplies Company
cover by Alabaster Passmore & Sons Ltd

Cover designed by Steve Storr/Ken and Kate Baynes
illustrations by Don Heywood based on photographs
by Julian Sheppard