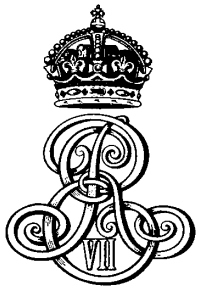
King Edward's Hospital Fund for London
Annual Report 1985



KING EDWARD'S HOSPITAL FUND FOR LONDON

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The King's Fund its origins and history

'. . . the support benefit or extension of the hospitals of London or some or any of them (whether for the general or any specific purposes of such hospitals) and to do all such things as may be incidental or conducive to the attainment of the foregoing objects.'

These words from the 1907 Act of Incorporation have been the guide to the Fund's practice for more than threequarters of a century.

The King Edward's Hospital Fund for London was founded in 1897 and was one of a number of ventures begun that year to commemorate Queen Victoria's Diamond Jubilee. It was very much the Prince of Wales's idea. There were many people who thought that he should not pursue it because it was too ambitious to succeed. Nevertheless his letter to the people of London inviting support for a permanent fund to help the London hospitals, met an immediate response from individuals and from commerce and industry. A capital sum was built up and the interest from it forms a permanent endowment. The Fund took its name when the Prince succeeded to the throne. In 1907 it became an independent charity incorporated by Act of Parliament.

Although set up initially to make grants to hospitals, which it continues to do, the Fund's brief, as stated in the Act and printed at the head of this page, has allowed it to widen and diversify its activities as circumstances have changed over the years since its foundation. Today it supports research and development in all aspects of health care and management, except clinical; publishes books and reports, some stemming from work supported by the Fund; provides education for management in health care at its College; and facilities for research and discussion at its Centre.

Grant-making ranges from sums of a few hundred pounds to major schemes costing more than £1m, such as the Jubilee Project which was the Fund's commemoration of the Silver Jubilee of Queen Elizabeth II. That project helped ten London hospitals to renovate some of their oldest wards. The problems of health care in the inner-city areas is the concern of the London Programme, for which, to date, some £865 000 has been made available. Another new venture concerns the assessment and promotion of quality in health care.

The King's Fund Centre, which dates from 1963, is in purpose built premises in Camden Town. The Centre offers extensive conference facilities, and a library and information service which are available to anyone concerned with health and handicap in the United Kingdom and overseas.

The King's Fund College was established in 1968, when the separate staff colleges set up by the Fund after the second world war were merged. It aims to raise management standards in the health care field, through seminars, courses and field-based consultancy.

REPORT 1985

As announced in last year's report, 1985 was the end of a chapter in the Fund's history in that our three Governors retired on 31 December. HRH The Prince of Wales was appointed by Her Majesty as the Fund's President from 1 January 1986, thus following his grandfather, great-grandfather and great-great grandfather in this office. The pattern of governance laid down in the Fund's Act of Incorporation is that of a royal President acting with the General Council. If, however, the Sovereign does not appoint a President, then three Governors are appointed to act as a regency until an appointment is made. This has occurred twice in the Fund's history–between 1910 and 1918, and between 1971 and 1985. We are most grateful to our three Governors, HRH Princess Alexandra, Lord Hayter and Sir Andrew Carnwath for all that they have done, and are delighted that all three are remaining on the Fund's General Council. Princess Alexandra had served as Governor continuously since 1971. Everyone connected with the Fund knows the distinction and the warmth with which she has fulfilled this role. She retains a very special place in our hearts.

The commencement of Prince Charles' Presidency is an appropriate moment to take stock, and to compare the Fund's current activities and plans with previous periods in its history. Before the centenary in 1997 we hope to have an authoritative account of the Fund's development, forming an appropriate addition to our historical series (in which three books have so far been published and a fourth is in press). Meanwhile it seems as though there have been three main periods in the Fund's life. In the first, from 1897 to about 1910, the Fund was seen essentially as a means of raising money from the general public and channelling it to the voluntary hospitals of London to help them meet their annual deficits. His Majesty King Edward VII retained a close personal interest in the organisation throughout this period. He and others were concerned during these early days with formative decisions about the Fund's remit and governance, with publicity and money-raising, and with determining which hospitals should be eligible for support and on what terms. By the end of King Edward's reign, the Fund and its methods of operation were well-established. For example, a tough line was being taken on eligibility for grants, with a bias against any hospital where viability, management or standards of clinical practice were in doubt. Financial accounts were carefully examined and King's Fund Visitors (one medical and one lay for each visit) made reports to advise the Fund on each hospital's condition and the relative merits of its claim for financial support.

Between about 1910 and 1948 (forming the second period of the story) the Fund was the principal clearing house and champion for the voluntary hospitals of London. Its Voluntary Hospitals Committee, on which the main hospitals sought representation, was highly influential in matters of policy. The Fund not only decided which hospitals received grants towards their operating expenses, its good opinion also influenced whether a hospital's major expansion plan or capital appeal would succeed. No doubt some projects succeeded without the Fund's imprimatur, but the path was much smoother with its blessing. On the whole its influence seems to have been used towards rationalisation in larger hospital units. When the Second World War came, the Fund was again influential in arranging the regionalisation of London's hospital services for emergency purposes. Its Emergency Bed Service (which still survives today, though now as part of the National Health Service) provided a necessary means of ensuring access for urgent cases when beds were in short supply. In the negotiations that led up to the establishment of the National Health Service (carefully described by John Pater in the first of our historical series*), the Fund

*Pater, John E. *The making of the National Health Service.* London, King Edward's Hospital Fund for London, 1981. (King's Fund historical series no 1).

predictably championed the cause of the voluntary boards of governors and argued for their maximum continuing independence.

When the hospitals were nationalised and the NHS commenced, it must have seemed to many that the Fund's days of usefulness and influence had passed. Its annual grants would no longer be required by the hospitals – in any case the size of the Fund's expenditure was now small relative to the ever-growing scale of health services in London – and there was no particular reason why anybody should listen to the Fund's advice. To turn at this moment towards continuing education, with an emphasis on management development in all the health professions, was a move of extraordinary foresight. As hospitals grew in complexity, it became increasingly important that people should have management skills to run them. That they existed within the framework of a vast public service raised, rather than lessened, the need for each hospital to operate with management competence and a degree of management autonomy. From this postwar initiative by the Fund stemmed the training colleges for ward sisters and for matrons; for caterers; and for administrators. The **King's Fund College** is the direct descendant of this interest in management education, complemented now by the emphasis at the **King's Fund Centre** on exchange of good clinical practice and support for those in clinical roles of all kinds. The Centre (founded in 1963) has concentrated particularly on long-term illness and handicap, nursing education and education for other professions allied to medicine, and information services. During this period the Fund also became quite a substantial publisher, of both books and 'project papers' within its field of interest. While grant-making continued, the focus for it had moved away from relatively large institutional grants towards project grants, not only to hospitals, but to schemes designed to keep people out of hospitals or (as in the case of hospices) to provide care in other settings. Many small voluntary organisations (including homes for convalescence and rehabilitation, with their longstanding links with the London hospitals) relied heavily on relatively modest grants from the Fund.

We are still too close historically to this third, postwar period of the Fund's activity to see whether it is now giving place to a fourth. Certainly there are new growth points and some significant shifts of emphasis. In the health services of London (and indeed of Britain) patterns of policy are much less settled than from, say, 1950 to 1975. Budgets are under great pressure, especially in London, with the closure of many small hospitals and the merger of famous institutions. Meanwhile the private sector has grown fast and the boundaries between public and private are shifting. New patterns of care are being tried, especially in psychiatry, as the balance changes between hospital and community care. Looking ahead, there is bound to be increased effort in health promotion, health education and self-help. AIDS is only one example of a problem that makes rapidly rising, urgent and irresistible demands on hospital services, yet which equally calls for crucial changes in human behaviour to check the spread of a killing disease.

Against this turbulent external background the Fund itself has been changing too. Several large projects have been launched (often with close Department of Health consultation and sometimes with DHSS funding), designed to pursue problems over a substantial period, rather as the Fund's Long Term and Community Care Team has done in the fields of handicap. The London Programme, launched in 1980, aims to raise standards of primary care for deprived groups in the inner city. It has now been active for five years and, as reflected later in the Report, has just been substantially expanded, with DHSS help. In 1984 came the Fund's venture into assessing and promoting standards of quality in health care. During 1985 another new venture began, to provide better information and support to 'informal carers' who are looking after

seriously handicapped relatives and friends at home: our project is one component of a much broader DHSS programme, and is supported by DHSS funds. Towards the end of the year the Management Committee was also considering an intitiative in the field of health and race, with the purpose of working closely with health authorities that seek actively to provide equal opportunity in employment.

All these new projects are concerned with aspects of health and health services that have been seriously neglected – not only in this country, but also in many others – and which call for action. They are not topics to be picked up and then quickly discarded. Rather, we intend to stay with them for some time, using King's Fund staff, grant-making resources and external contacts to make a combined impact. In some instances we will fail, no doubt, and we hope that decisions to withdraw will be made when that is the case. But we also hope that the Fund will help others to achieve substantial improvement in at least some of these neglected fields. On the whole this approach, of a concerted thrust on a few major topics, seems a wise use of limited resources.

The opening of the new **King's Fund Institute** strictly falls outside the scope of this Report since the first Director, Ken Judge, took up his post on 1 January 1986. However, the preliminary moves to prepare for this new venture were in hand throughout 1985 and therefore form part of the year's business. The Institute is concerned to help clarify issues of national health policy and strategy, against the background of increasingly harsh choices over how best to use limited public resources. It forms a third major service institution within the King's Fund family, along with the College (with its focus on management development) and the Centre (concentrating on professional practice). Obviously there are risks, that the Fund will overstretch its financial resources or will spread its efforts too thinly to be effective. But these may be risks worth taking in the period of the Fund's history that we are now entering. Certainly the Fund's three main service institutions together provide a very powerful range of instruments to support the practice of health care in Britain today, provided we can bring them to bear on the right issues. Thus a key question for the Fund is how we interrelate these activities, including how we focus them in support of projects like those that aim to improve health care for deprived groups.

We will return to this question at the end of the present Report. First, however, we will briefly review the Fund's main activities in 1985 and then (as in previous reports in recent years) comment on a few issues of current concern in the health field in Britain. Those selected this year are:

- Primary care in the inner cities.
- Assessing and promoting the quality of health care.
- The implementation of the Griffiths report and its implications for the health professions.
- Health and race.
- The funding of health services in London.

It is of course no coincidence that each of these topics links to previous annual reports and to main themes that the Fund is currently pursuing.

KING'S FUND CENTRE

The Centre is the place where we hope that those who in one way or another provide care for patients, or are in direct contact with those needing care, can meet and exchange ideas. The number using the Centre was at an all time high in 1985, and topped 17 000 for the first time.

In the field of **education and training**, the focus continued to be on nursing and the professions complementary to medicine, exploring the problems

that people encounter in their work and their approaches to dealing with them. Relatively rarely are Centre activities single, discrete events. Almost always they fit into a learning sequence, in which the same groups continue to meet periodically over a long period, or a major theme is pursued through a variety of different approaches. Among the themes this year were quality circles (which are attempts to tackle problems at the work-face, through the combined efforts of the individuals concerned), job-related stress among nurses (on which a report by Peter Hingley, Cary L Cooper and Phil Harris, based on a research project financed by the Fund, was published soon after the year-end), and audit in physiotherapy. There continue to be many enquiries connected with the Fund's longstanding interest in the training of ward sisters, and Hazel Allen and Christine Davies find themselves called on in a whole variety of ways for advice, support and the exchange of ideas across the broad field that they cover. The team's interest in media resources and video production continues to develop, and a strong link on this front has been forged with St Christopher's Hospice. Among many other external links is that with the new Nursing Policies Study Centre at the University of Warwick, established with the help of a King's Fund grant in 1983. This unit is now firmly established under the leadership of Mrs Jane Robinson and is concentrating its main research effort on the effects of the implementation of the Griffiths report on nursing management.

The **Long Term and Community Care Team** (now under the leadership of James Smith) concentrates on the needs of mentally handicapped and physically handicapped people, people suffering from mental illness, and the elderly. The driving force in this work is that people should have as much choice and autonomy as possible: in fact, an 'ordinary life'. The goal is 'to see handicapped people in the mainstream of life, living in ordinary houses in ordinary streets, with the same range of choices as any citizen, and mixing as equals with the other, and mostly not handicapped, members of their own community'.*

Throughout the year conferences and workshops on long-term and community care took place at the Centre for everyone concerned: handicapped people themselves, their families, the professions, the managers and the planners. Besides their intrinsic value for those who attended, these events often contributed to publications, which can greatly increase the numbers reached. As with the Centre's work in other fields, networks are of inestimable importance. People learn to share experience and ideas when they know and trust one another. Helping to build and sustain such networks in the field of handicap and long-term illness is one of the Team's principal activities.

It is sad to be losing from 126 Albert Street, the Centre for the Environment of the Handicapped (CEH) and the Access Committee for England, because of the Fund's own lack of space. On a personal note, we are sorry to lose the staff concerned. We are also sorry to lose our colleagues of many years standing at the International Hospital Federation. Strong links will continue, however, and we are delighted to be giving CEH and the IHF some initial financial support in their new premises. Close contact is maintained with many other leading organisations. One especially pleasing and productive example among many was the report *Living Options*, issued by the Prince of Wales' Advisory Group on Disability in April 1985 at an occasion held at the King's Fund Centre and attended by HRH Prince Charles. Representatives of the major disability organisations participated in the working party that produced the report. By the year-end some 5000 copies had been sent out and requests are still being received.

Subjects that recurred during the year (frequently for more than one group of people with special needs) included self-advocacy, employment, schemes for

**An ordinary life: comprehensive locally-based residential services for mentally handicapped people.* Project paper no 24. London, King's Fund Centre, 1980.

stronger support in the community, providing a more appropriate physical environment, and managing the transition from services that have been institutionally-based to services that have much more emphasis on living in the community. None of this is easy, nor cheap, and it could become an excuse for new forms of neglect, behind the doors of ordinary houses. But the case for more autonomy, more choice, and more integration with other people must not go unanswered and must transform services.

Among the new projects based at the King's Fund Centre are the **London Programme**, which aims to improve primary health care in the inner city, and the **Quality Assurance Programme**, concerned (on a national basis) with the assessment and promotion of quality in health care. Both of these are described more fully in the 'Issues' section of this report. By the year-end, preparations were almost complete for the new **Informal Carers Programme** to take up its place in the Centre. It is funded by the Department of Health and is part of a broader national initiative to provide increased support for those who look after handicapped and sick relatives and friends at home, with little professional training or financial recognition.

The other main branch of the Centre's professional activity is its **library and information services**, which form a national resource in this field, under the leadership of Keith Morton and Sue Cook. After the review of these services in 1984, we entered 1985 reasonably satisfied with their range, scope and effectiveness, but looking for ways to cope with an ever-increasing demand. A survey of personal users, carried out in April 1985, confirmed that the majority work in the NHS, many of them as nurses and administrators, and that students form a significant proportion. Access out of office hours is important to them (currently we open on Saturdays until 5 pm and on weekdays until 5.30 pm, but there are substantial difficulties about staying open later). Also important is the helpfulness of the staff and the availability of files of articles and press cuttings on selected topics. While the overall level of user satisfaction was very high (95 per cent) there were some constructive criticisms about such problems as lack of space at peak times, noise and complex cataloguing. We are trying to tackle these problems, for example by creating a library annexe in the basement, but space and cost do inevitably represent constraints.

As foreshadowed in last year's report, we also examined (with the help of Kent-Barlow Information Associates) ways in which efficiency could be improved with the use of new technology. As a result a few back-up tasks, such as cataloguing and indexing, are likely to be converted from manual methods to computer. Computerisation is also essential to the first of our internal data bases, the **Quality Assurance Information Service**, giving the quality assurance team (and in due course, external users) access to the very large bank of information on this topic held by the Department of Health library.

Computerisation is also a feature of the year in the Centre's administration of conferences and (through word processing) in the production of reports. The Centre is among other things a major conference centre, used by external organisations as well as by the Fund, and the standards of its conference organisation and its catering are crucial to its usefulness and reputation. We are grateful to all the staff for their efforts to achieve and maintain high standards in these respects.

Graham Cannon, the Director of the Centre, was taken suddenly ill early in the year and was forced to be absent for three months. The rest of the staff coped magnificently in his absence. Even better, it is good to report that he is back, none the worse for his experience.

KING'S FUND COLLEGE

Although the College continued to expand during 1985, the year was overshadowed by the illness and untimely death of Tom Evans. As Director, Tom Evans was the driving force behind the College's rapid development throughout the first half of the 1980s. During his tenure, the College Faculty grew from three to nearly thirty Fellows; field-based consultancy and development activities were introduced for the first time, to underpin the College's approach to management development; and the 'manager-centred' philosophy of the College began to have an impact on NHS attitudes to management development. The College's present position as one of the premier centres for NHS management education and development owes much to his vision, commitment and style of leadership. His ideas continue to have a profound impact, not only on the College and the Fund, but within the NHS more generally. He is sadly missed by us all.

Despite the trauma of Tom Evans's death, the College continued to develop under the able leadership of Iden Wickings. His selfless and unceasing efforts sustained the College's momentum and helped to develop new activities during a difficult year. With Iden Wickings in the post of Acting Director, the College became involved in a wider range of work than ever before and attracted new Faculty with a broader range of skills, as well as extensive experience in the field.

As noted in last year's Report, the purpose of recruiting such a strong and diverse Faculty is to ensure that the College can sustain a broad portfolio of work, not only in terms of topics, but also in the methods and approaches used in management development. In line with this philosophy, College Faculty were active in 1985 in a wide range of management education and development activities, which took place in a variety of classroom and field-based settings. In the classroom for example, these included not only the well-established programme of residential courses, but also topic-based workshops, sustained work with small groups of managers in a 'learning set' format, and attachments with non-NHS organisations in both the public and private sectors. In all, over 1000 NHS and other managers participated in College events during the year.

Since the College's concern is not with courses as an end in themselves, but with management in the real world, it is appropriate that Faculty should undertake management development projects in the field. Such field-based activities increased in both number and variety during 1985. These included traditional problem-solving consultancy assignments with health authorities, as well as management development activities in which College Faculty work alongside NHS managers to assist in strengthening the managerial capabilities of their organisations. These latter activities took many forms, ranging from short one- or two-day events, often with authority members and their top managers, to major long-term commitments involving a large number of College Faculty in a variety of developmental roles. In all, College Faculty were engaged in field-based development activities in more than 40 NHS districts and in seven regions, as well as with health authorities in Wales, Northern Ireland and Scotland. In many cases, both the classroom and field-based activities were undertaken with the support and close collaboration of the new National Health Service Training Authority (NHSTA).

Courses and programmes increasingly are being designed to meet the needs of a particular group of managers or members from the same health authority, and sometimes are run locally rather than in the College. As a result, the College developed a number of new educational programmes and workshops in direct response to developments and concerns arising in the field. These included College-based workshops on such topics as planning in RAWP-losing districts; information strategies for managing health care;

district strategies for enhancing service quality; and nursing in a post-Griffiths world. In all cases, a key aim of these workshops was to help NHS managers and other professionals to develop appropriate managerial and organisational responses to a changing, and increasingly uncertain and threatening, economic and policy environment.

1985 was also marked by a further increase in the College's work with doctors. In particular, three different kinds of programmes were tailored specifically to the needs of the medical profession: namely, those intended to introduce doctors to management, those intended to help doctors to operate more effectively within a managed organisation, and those intended to help doctors who wish to take on managerial responsibilities. These courses included management for consultants in selected specialities; management of accident and emergency services for consultants and senior registrars; applied management for senior registrars in community medicine; as well as a series of programmes entitled doctors and management in the NHS.

Though the College experienced a significant increase in both the range and scale of its activities during the year, it is worth repeating a point made in the 1984 Annual Report:

> 'Despite its recent growth, the College is still quite small. It cannot seriously address the management development needs of the several thousand managers who can be found even within the Thames regions and Wessex, let alone the rest of the country. As one of the. . .education centres designated for management training, it is important that the College should build a resource in collaboration with the other centres rather than separately, and should use its resources to stimulate and support other bodies in their management development activities. . .One of the College's major roles should be to act as a 'product champion' for management development and to be a resource for others involved in this field.'

To discharge this last responsibility successfully, the College seeks continuously to develop new and useful ideas about health services management and management development and to serve as a resource for the NHS. In an effort to achieve this aspiration, the Faculty work closely with other organisations such as the Institute of Health Services Management, the Royal Colleges, the other management centres, and the National Health Service Training Authority, in an attempt to ensure that new ideas are shared, tested and (where appropriate) applied, in the interests of better patient care.

In November 1985, it was announced that Gordon Best, a member of the College Faculty since 1982, had been appointed to succeed Tom Evans as Director of the College. We welcome him to his new role.

PUBLISHING

Two new volumes in the King's Fund historical series were published in 1985: *St Mark's Hospital, London* by Lindsay Granshaw, and *The effects of the NHS on the nursing profession: 1948-1961* by Rosemary White. Roger Silver's *Health service PR* is a guide to good practice in public relations, while *From figures to facts* by Christopher Day explains in straightforward language the use of statistics in the provision of health care, particularly for those who have not had the time or opportunity to develop numerical skills. *NHS management perspectives for doctors,* based on a series in the *British Medical Journal*, aims to help doctors to adjust to the new emphasis on management and to guide them to a constructive partnership with the new managers in the health service.

The work of the NHS/DHSS Health Services Information Steering Group was the subject of a series of discussion papers which was completed in 1985 by the publication of *Enabling clinical work* and *Providing a district library service.* To honour the Group's chairman, Mrs Edith Körner, a festschrift was compiled and published under the title *Walk, don't run.* The work and

impact of the Group are described in 15 essays by health service managers, clinicians and academic researchers.

NHS pay: a time for change, is the report of a joint working party set up by the King's Fund and the National Association of Health Authorities (NAHA). It was published jointly with NAHA.

The four new project papers published in 1985 dealt with nursing leadership; the accreditation of residential care homes, nursing homes and mental nursing homes; access by telephone to GPs in London; and the employment of people with mental handicap.

1985 was the first year in which a determined effort was made to sell certain titles by mailing leaflets to likely buyers. The title which benefited most was *From figures to facts*, with *Health service PR* a close second. Sales of *St Mark's Hospital, London*, which costs £35, were considerably enhanced by mailing.

The Publishing and Press Office is now located at 2 St Andrew's Place, London NW1 4LB. Its programme for 1986 promises to be larger than in any previous year and an additional member of staff has been appointed to cope with it.

KING'S FUND INSTITUTE

The King's Fund Institute, the new centre for health policy analysis which is to be located at the Centre, took a significant step forward during the summer with the appointment of Ken Judge as its first Director. Although Mr Judge was not able to vacate his post as Deputy Director of the Personal Social Services Research Unit at the University of Kent until the end of 1985, this did not prevent progress being made in planning the development of the Institute. For example, many preliminary discussions were held about the role and composition of the Advisory Committee (which will be chaired by Dr Tony Dawson, Vice-Chairman of the Fund's Management Committee), and the remit, role and financing of the Institute. The Institute's purposes will be:

a. to identify and tackle health policy issues of long-term importance;

b. to synthesise, analyse and reflect upon relevant research findings;

c. to utilise other forms of data and intelligence;

d. to communicate in a lucid, succinct and non-partisan manner the results of policy analyses to clearly defined policy communities;

e. to engage in debate and discussion with interested parties about topical health policy issues.

Advertisements for health policy analysts to staff the Institute appeared before Christmas, with a view to making key appointments during the first part of 1986.

GRANT-MAKING

Grant-giving flows most easily along existing channels. Often we are right to let it do so. Yet there are some dangers to which a committee structure like the Fund's is perhaps particularly vulnerable. The mechanisms of administration settle comfortably round what already is. By way of contrast, organisms that respond to a changing environment tend to sprout in untidy ways.

We are, therefore, in the short run pleased and in the long run cautious about the structural adaptations that were foreshadowed in 1984's Report and achieved in 1985. Today's new look could all too easily become tomorrow's straitjacket, unless we are determined that it should continue to evolve and change. But, for the time being at least, there are six grant-making committees. All of them operate in parallel. One of them, the Management Committee, also allocates the funds deployed by the five others.

The **Grants Committee**, distributing £800 000, disposed of roughly half the total amount available in

1985 for grant-making. Its primary concern continued to be the better delivery of health care in and for Greater London.

The **Centre Committee** on the other hand embodied new as well as established growth. It allocated £160 000 to projects promising innovation and improvement in the management of health services in the areas on which the Centre itself concentrates its attention – library and information services, education and training needs (with special reference to nurse educators and the paramedical disciplines), long-term and community care (particularly for the mentally ill, the severely handicapped and the very old), and acute hospital care with special reference to the organisation of patient services. Unlike the Grants Committee, the Centre Committee may and did support innovative projects of sufficient merit wherever based, although ultimate relevance to London is still an important criterion.

The **London Project Executive Committee's** monies from the Fund totalled £150 000. In their expenditure the committee continued its pro-active approach to the improvement of primary health care in the inner city and continued to link grant-giving to the development work done by project staff in that field, and especially for ethnic minority and disadvantaged groups.

The **Quality Assurance Project** took shape during this year, with an initial allocation of £50,000, its purpose to stimulate systematic attempts to assess and improve quality in health care. Grants will be adjuncts to development work and the emphasis will be on projects whose results, if successful, will be readily transferable to other settings.

Educational projects and bursaries accounted for just under £150 000, allocated to initiatives closely linked to the work of the King's Fund College. Expenditure included medical travelling fellowships and educational (non-clinical) bursaries, for which those working in Greater London continued to have priority, and travel bursaries to broaden management experience.

Finally, the **Management Committee** allocated some £370 000 to projects that promised to raise the quality of health care but seemed to be outside the remits of the other committees.

The concern to identify and respond as effectively as possible to current needs prompted not only structural adjustments but also an attempt to clarify for applicants what must often seem a confusion of procedures. This work has been completed and a 'Note on the Fund's grant-making for the guidance of applicants' will be published in 1986.

The list of grants that appears later in the Report outlines the range and variety of the causes helped within the main areas of the Fund's concerns. The **Quality Assurance Project** was too new in 1985 to do more than appraise the field for 1986. The work of the **Centre Committee**, in its first year in its new guise, certainly emerges as probing and important. The older committees too discovered fresh ways of responding to needs freshly perceived. Two allocations by the **Grants Committee** will serve to represent the great majority of the Fund's grants – relatively small sums with quite disproportionate potential. The £7500 allocated in February 1985 to enable Phobic Action to employ a part-time fund-raiser for a year seems already to have set that self-help group on its way to a future of much greater influence as well as financial security. The grant of £18 000 to Brent Health and Local Authorities will fund the preparatory year of exploration in a scheme designed to improve rehabilitation services in Brent, to provide in the process better opportunities for ethnic minorities to gain access to professional training in the health service, and to serve as a model for similar effort elsewhere.

The final example is on a grander scale altogether. The **Grants Committee** adopted a new strategy for discovering and liberating innovative ideas that languish for lack of the funds that would enable them to be realised, or at least tried out. Up to £250 000 was offered, payable either as a lump sum or over several

years, to fund a major innovative scheme designed to improve the quality and effectiveness of the health care provided in Greater London by the acute hospital or other statutory services. The offer attracted 52 outline proposals, subsequently reduced to a shortlist of three. In the event there were benefits for more than just a single 'winner'. An allocation of £181 029 was made to meet the estimated cost of establishing at Oldchurch Hospital, Romford, a community orthopaedic project under which a team of health care professionals will study the type of care needed to support, in the community, patients who would otherwise be detained for extra weeks or even months in hospital acute and chronic beds. A grant of £100 000 was made to another of the shortlisted candidates, in this case to help start a centre for rehabilitation engineering at Dulwich Hospital. Several of the 50 other proposals have since been modified and scaled down into applications for the committee's ordinary grants. The committee was encouraged by the interest and imaginative thinking that the offer provoked and found no difficulty in deciding to run a similar competition in 1986.

It will be clear that much of the Fund's money goes in support of enterprises that carry the risk of failure as well as the promise of success. To know that something has not worked is often just as valuable as the demonstration that it will. At a time when public funds are so desperately stretched in maintaining existing services, that sort of exploration seems a very proper use of charitable monies. It explains the Fund's sponsorship of a consultation on the accreditation of residential homes, nursing homes and mental nursing homes as much as it explains many of the more straightforward grants. It is hoped that, from the reactions to the project paper on this subject that are now reaching us, the Fund will be able to help chart sound policy in this very important area, to identify particular pilot projects on whose results such a policy should be based, and to help in at least some of them. It could be that in one of them, under the aegis now of the Association of Independent Hospitals, the visits long associated with the Fund's *Directory of convalescent and other homes serving Greater London* will assume a wider importance. If so, that would be in its small way a particularly satisfying example of old and tried procedures turned to new and urgent needs, for the tradition of visiting can trace its antecedents back to the very early days of the King's Fund.

Just how effectively our grant-making meets expectations is a question shown to be deceptively simple by the variety of supplementaries, let alone answers, it can provoke. Whose expectations – those of the recipients, those in the minds of the grant-givers in any particular case, those that derive from the wider policy priorities of the Fund? Which of the many exercises so often described by the single word 'evaluation' will be the most appropriate for a particular enterprise? These are questions that have always been of concern to the Fund and that bit more deeply in 1985. One thing that can be said of the answers we have begun to formulate is that they leave plenty for us to do in 1986 and well beyond that.

SELECTED ISSUES

The five issues selected for discussion this year are not new. Each has been touched on in previous annual reports within the last few years. Nevertheless they justify inclusion here to bring up to date the account of what has been happening, and of the Fund's thinking, so as to help shape what happens next.

Primary care in the inner cities

A common feature of health care in big cities – not only in Britain – is its variability and lack of balance. Secondary and tertiary care are generally concentrated in the major cities, which is perfectly sensible. What often happens, however, is that primary care is correspondingly weak, especially in the poorest neighbourhoods. An over-reliance on secondary care is both a cause and an effect of such a weakness. The accident and emergency and outpatient departments help to fill something of a vacuum in primary care,

and in turn change the nature of general practice. Inpatient admission levels are also higher for city populations, for reasons that are not entirely clear, but must include relative deprivation on the one hand and proximity to major hospitals on the other.

From our own work in our London Programme (now expanded with DHSS financial support so as to extend beyond London) it is foolhardy to generalise about inner city primary care, because of its immense variability. Many Londoners, not only the prosperous, receive excellent medical attention. Nevertheless the variability is important, especially as the least advantaged groups living in the poorest neighbourhoods tend to receive the worst care. There is also great variation in the effectiveness of the links between general practice and other community-based health programmes, such as child health, school health, immunisation, antenatal care, occupational health and services for the elderly. Moreover, compared with the situation outside the big cities, people tend to be far less precisely aware of who is doing what, partly because so many more agencies and institutions are involved, and because administrative boundaries have little meaning on the ground.

To problems of this kind there are no easy solutions. Within the London Programme our own lines of response include:

- supporting strong primary care centres, such as some of the academic departments of general practice, in efforts to forge closer links with other practitioners and agencies in their neighbourhood;
- encouraging the exchange of basic information, for example about clinic times, locations and appointment systems, which is often not known as widely as it should be;
- developing leadership in primary and community health care, within the framework of family practitioner committees, district health authorities and voluntary bodies (as yet there is little by way of a tradition of leadership in these services, compared with the major hospitals);
- promoting consumer and community-led health projects, particularly among deprived groups, on the grounds that little will be achieved without the active involvement of communities themselves;
- experimenting with a 'patchwork' approach, whereby all relevant services are so far as possible planned and coordinated for the same defined neighbourhood.

A reasonable question is why a hospital fund should be so concerned about primary care in inner city neighbourhoods? There are many possible answers: among them that a rational use of hospital services depends on good primary care. This is especially so when acute services are being cut back in London and other major cities and when many psychiatric hospitals are also being closed. A second, more difficult question is to ask what progress we and others have made since the publication of the Acheson report in 1981? While there are some encouraging signs, such as the increasing attractiveness of general practice vacancies in some inner city neighbourhoods, these may owe as much to the changing medical manpower situation as to anything we or others have been doing. Meanwhile too, with high levels of unemployment especially among the young, the situation is in some ways even more difficult than it was. A priority for the next few years will be to evaluate (using the term in a broad sense) the success of the various inner city initiatives in which we are involved. Typically they do not lend themselves to 'hard' evaluation, because so many variables are at work, and because no one situation is precisely like another. Nevertheless we intend to satisfy ourselves as to the strengths and limitations of approaches such as those described above.

Assessing and promoting the quality of health care

In last year's report, we included an account of the setting up of the Fund's project on quality in care, and the reasons for it. Quality assurance – as the Americans term it – is not only about measuring standards, but about seeking to protect and to enhance them. Recently there has been a dramatic increase in international interest in this field, underlined by the establishment in 1985 of an International Society for Quality Assurance. The Fund's concern with the topic is particularly to redress the balance in managerial and governmental preoccupations with efficiency and expenditure controls. While these preoccupations are perfectly proper, and indeed inescapable, they are less important than what the money buys in terms of health care.

Partly through the Fund's influence, many district health authorities in the NHS are currently establishing quality assurance posts in their new management structures. Gratifying as that is, structures are in this case far ahead of methods, and of finding the right people and preparing them for quite complex and novel roles. There is a real danger of failure and the subject is much too important to be discredited.

What, then, should people taking on a post of this kind in the NHS do? No single answer is appropriate, because the circumstances and the opportunities are so variable. But a few guidelines may perhaps be useful. For example:

- While quality control may sometimes need to be imposed, it is best seen as everyone's business. That is why in Japanese industry there usually are no separate quality control staff. It is also the idea behind quality circles – groups of staff, whose work is interdependent, meeting to find better ways to achieve their shared aims – which the King's Fund Centre is pursuing in the field of nursing.

- Throughout the NHS, much is already going on that is aimed at protecting and promoting quality. In a pilot project*, which the Fund supported some years ago, to study the applicability of American methods of surveying for accreditation purposes, the study team was impressed by the enormous variety of quality-related activities going on in two sample UK districts. A first task, therefore, of anyone taking on a district quality assurance post should be to map these activities, and find out how to support them.

- The whole subject is both very important and very sensitive. Nobody likes to have the quality of their work called into question, least of all when the consequences of a slip in standards may be fatal. That applies to the work of doctors and nurses certainly, but also to that of all the other staff involved. When something goes seriously wrong, however, it is absolutely essential that this be spotted and effective action taken. The disastrous episode at Stanley Royd Hospital, near Wakefield, in the summer of 1984 underlined this.** If the initial outbreak of food poisoning, which caused some 19 deaths, seems to have been a failure of basic hygiene in food handling by junior ancillary staff, failures of management control and of effective crisis management were just as apparent.

- Maintaining quality is the responsibility of those who provide care or, in one way or another, assist in its promotion. Judging quality is, however, a matter for patients, their families and the community, as well as for the providers. Among

*Maxwell R, Day M, Hardie R, Lawrence H, Rendall M and Walton N. *Seeking quality.* The Lancet, 1 August 1983.

**Department of Health and Social Security. *Report of the Committee of Inquiry into an Outbreak of Food Poisoning at Stanley Royd Hospital* (Chairman: J Hugill). London, HMSO, 1986. Cmnd 9716.

the many facets of the quality of care are some – such as technical effectiveness – that the consumer cannot judge, and others – to do with the manner in which care is given and some aspects of outcome – where consumer opinion is better informed than anyone else's. Efforts to assess and promote quality must take account of the equal validity of these different views.

- In this very complex field, measurement alone can rapidly become extremely complicated. This is true of a single department, let alone a whole institution, or the network of services in a district. It is therefore essential to keep quality assurance activities as simple as possible, concentrating on what is important, and what is practical.

To date, the King's Fund project has concentrated on establishing what is going on, particularly in the main professional bodies, and developing an information base, called the Quality Assurance Information Service. The latter will use the computerised database of the Department of Health library, as well as the resources of the King's Fund Centre. Meanwhile the King's Fund College has held the first of a series of quality assurance courses for those in management positions and will also be taking on field-based consultancy. Among many other relevant current activities, quality circles have been mentioned already. A second initiative concerns accident reporting, when something goes wrong. A third, arising from an interest of the Fund's Grants Committee, has to do with standards in independent nursing and residential homes.* And a fourth, stemming from the Management Committee, is a grant to Brunel University to make possible an evaluation of the Health Advisory Service, which seeks to maintain high standards in the long-term care of the mentally ill and the elderly.

Thus, within the Fund and outside it, there is much activity in this important field. While the Fund's capacity to make grants to support projects is inevitably limited (the Quality Assurance Steering Committee has at present only about £50 000 a year for this purpose), we hope to maintain an understanding of what is going on in Britain and elsewhere, and put that knowledge at everyone's disposal. We also expect to focus a good deal of attention specifically on quality assurance activities within acute hospitals.

The implementation of the Griffiths report and its implications for the professions

It is now some 2½ years since the publication of the Report of the NHS Management Inquiry, led by Sir Roy Griffiths. The report was critical of a number of aspects of the running of the National Health Service, arguing for a stronger general management line, a closer linking of doctors into management, some changes in financial systems and greater customer awareness.

The Government welcomed the report and in June 1984 announced that general managers would be appointed in sequence in regions, districts and units, and that, at the centre, Supervisory and Management Boards would be set up for the National Health Service. Slightly less than two years later the position is that all the general manager appointments have been made at region and district, and 524 appointments, out of about 600, at unit level. The Supervisory and Management Boards have been operating for some time, although several of the key Management Board appointments are relatively recent. A number of districts have introduced new budgetary systems, as recommended by the Griffiths team, although as yet with only partial success.

*Higgins, Joan. *A consultation on the accreditation of residential care homes, nursing homes and mental nursing homes.* Project paper no 56. London, King Edward's Hospital Fund for London, 1985.

What, so far, is the overall effect of these changes? Inevitably the verdict at this stage is mixed. In the field, general management has become a reality at region and district. Somebody is in charge, in the sense that Sir Roy Griffiths sought. This is also becoming the case at unit level, which is perhaps the crucial level of operational (as opposed to strategic) management. People who hold these general management jobs are thinking about them in new ways, and in many cases have some specific achievements to show for it. Health authorities are typically still unsure whether the strengthening of the executive erodes their functions: the answer, we think, is that it should not do so, since public accountability at that level is as important as ever, but it may change the chairman's role.

The relationship that will develop between general management and the professions is much more sensitive, and the outcome is still uncertain. As Professor Klein and Patricia Day stressed*, soon after the publication of the Griffiths report, an organisation run by strong general managers is a very different model from one of a series of autonomous professional groups coordinating their work at various levels. Since any health care agency comprises doctors, nurses and other professionals, and each profession has its own role, skills and patterns of leadership, the question of how general management and professional hierarchies relate to one another cannot be avoided. Merely to impose one general manager per district on top of the professional hierarchies would be a travesty.

On the other hand, it would be even more ridiculous to leave ward sisters without professional support and guidance. This is what the Royal College of Nursing maintains is happening in some districts, and what has led to its current national campaign. Within the King's Fund we have much sympathy for the RCN, but would emphasise that there is no point in looking backwards. The arguments for general management are strong, and have been accepted by Government. General management if it means anything has to bring the professional groups together into effective teams, not merely at district, but at unit and at the level of the clinical service or department within units. The way to resolve the conflict is, we believe, to differentiate matters of professional advice and accountability on the one hand, from matters that must cross professional boundaries or (to use different terms) general management tasks. The RCN and the King's Fund College have established a joint working party to work through some of these problems, and to consider future patterns of leadership in nursing and the implications in terms of preparation for leadership.

An equally serious problem is arising in community medicine. Ever since the publication of the Hunter report in 1972**, the Faculty of Community Medicine has been seeking to train sufficient numbers of physicians for what might be called the new public health. District medical officers and their staff (and a number of physicians in academic and other roles) require a strong grounding in epidemiology and public health, a broad knowledge of medicine, and an ability to bring resources to bear upon such essential matters of community health as communicable disease, environmental hazard and nutrition. While the discipline of community medicine has undoubtedly made progress, it is not yet firmly established, partly because most physicians in it have had impossibly wide ranges of tasks to perform, and virtually no staff to help them.

The changes that have followed the Griffiths report pose new problems for community medicine. They remove chief officer status from district medical

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* Day, Patricia and Klein, Rudolf. *Two views on the Griffiths report.* British Medical Journal, vol 287, December 1983.

**Department of Health and Social Security. *Report of the Working Party on Medical Administrators* (Chairman: Dr R B Hunter) London, HMSO, 1972.

officers (as from district nursing officers), and change the reporting relationships below them. They also open up new career choices. Will some of the ablest community physicians wish to become general managers at district, unit and other levels? If so, what will that do to leadership in what is still a crucially important, but weak specialty?

We welcome the setting up of a national committee of inquiry into the future of public health, chaired by Dr Donald Acheson, the Chief Medical Officer. The Fund will give evidence to it, and hopes in a variety of ways to assist the specialty of community medicine think through where it is going and how to get there.

A disturbing feature about progress in implementing the Griffiths recommendations is that changes in the field have tended to move ahead of changes at the centre. Thus Mr Victor Paige, Chairman of the Management Board, was appointed too late to shape the selection arrangements for general managers at region and district. Initially the Management Board mainly comprised DHSS civil servants, so that the Board looked more like a modified part of the Department than a new bridge between Government and the National Health Service. During 1985 the Management Board was strengthened by the arrivals of Mr Ian Mills as Finance Director and Mr Len Peach as Personnel Director, both external appointments. So the Board has now at last taken shape. But the position still is that what it is doing is little understood in the NHS, nor is there yet any general sense of where it is trying to lead the Service, nor what is different as a result of its existence. The same is true of the Supervisory Board.

These comments are not intended to be in any way destructive. Much that is good is already coming out of the Griffiths reforms, in terms of sharper management in the field.

Health and race

Britain is today a community of many races, especially in such cities as Glasgow and Liverpool, Bradford, Birmingham and London. Although black people form less than 10 per cent of the total population of Great Britain, there are many inner city districts (including some of the poorest) where black people are in the majority, especially among the young. Since such boroughs form an essential part of the Fund's territory, and since the Fund must have a special concern for those in greatest need, the interplay of health and race deserves a place high on the Fund's agenda.

Certain points need making. The first is that many members of ethnic minorities experience discrimination in their daily lives, including unequal treatment in some aspects of health services, and in NHS employment. Discrimination may often be unintended and even unrecognised by those responsible, rather than deliberate. That does not greatly help or comfort those who are at the receiving end, and who finish up with poor service, low status jobs with little chance of advance, or no employment.

During 1985 the Handsworth riots served as an unpleasant reminder that the position is in many respects no better than it was in 1981, at the time of the riots in Brixton and elsewhere. Indeed it is in some ways worse because unemployment is higher and has lasted longer.

What then can be done? A report*, published during the year by the London Association of Community Relations Councils, surveyed the position in London health districts. The results are not reassuring. While

**In a critical condition: a survey of equal opportunities in employment in London's health authorities.* London, Association of Community Relations Councils, 1985.

the majority of district health authorities had formally adopted some form of equal opportunity policy, relatively few have taken serious steps to implement such a policy, once adopted. In recording this, we are only too well aware that the Fund itself has a long way to go. The Management Committee instituted an equal opportunity policy during 1985. For us, as for others, that is only a start. The policy has to be carried through in detailed action, including recruitment, selection and promotion, and in the delivery of services. Its effects have also to be monitored in a way that provides reliable evidence on whether discrimination continues.

As we remarked in the 1983 Annual Report, tackling these matters is difficult and often uncomfortable. That makes doing so all the more important. The Fund will be seeking, in 1986 and in future years, to move ahead and to help health authorities (and others in the health field) to do the same.

The funding of health services in London

In the parliamentary and public controversy over whether the National Health Service is being adequately funded, it is not always appreciated how markedly different the position is in different places. Parts of the country are receiving more money, in real terms, than ever before. Others, including all the inner London districts, face substantial cuts. It is not so much the reduction in any one year that poses the problem as the cumulative effect over a period of years, amounting to as much as 20 per cent or more in districts like Bloomsbury, Riverside and West Lambeth. Cuts of this magnitude cannot be absorbed simply by increased efficiency, or by savings in administrative and other costs. They require a radical reshaping of services, and in some instances a definite reduction.

All the inner London districts, and a number of those in outer London, have had to face this problem. They are at different stages in their programmes of retrenchment, but the general picture seems to be that the easier cuts (such as closing small institutions, important as some of these were) have now been made. The changes that lie ahead are more dramatic than those made to date and will affect the major acute hospitals and the medical schools. Probably Parliament and the public are as yet unaware that the talk of cuts is not rhetoric, but real.

Mr Barney Hayhoe, the Minister for Health, has announced a review of the policy of bringing financial allocations into line among authorities, using the formula devised by the Resource Allocation Working Party (RAWP). It is as yet unclear what the outcome of the review is likely to be. The main problems with the policy do not lie at the level of allocations from central government to regions, but at the level below region. Of course it would be much easier to make the changes in a period of sustained growth in funding. Even in the present period of relatively level total funding, it seems to us right to move gradually towards inter-regional equity. In fact the differences between regions in England are now quite small, compared with those in many other countries, or for that matter between England and Scotland or Northern Ireland.

Within regions the disparities, on a population-based funding formula, are far greater than between regions. At that level, however, the logic of the formula is far less compelling. Whereas the population movements from one region to another to obtain hospital services are marginal, they can amount to a third or more into and out of a single district. This means that the crude and sluggish way in which the formula compensates for such movements matters much more at the district than at the regional level. Moreover the argument that a district should be self-contained in the provision of health services is much less strong than that a region should be. There *is* still a case, because of evidence that demand levels are strongly influenced by distance: even specialist services, like many of those of the great

London hospitals, are used much more often by those who live fairly close to them. (One of the paradoxes of London, already referred to, is the relative ease of access to such services, and the relatively poor access to primary and long-term care). While the case is therefore strong for compensating the population of a district that has historically been short of health care resources, a blunt use of the RAWP formula is not necessarily the most appropriate way to do so. For it can lead to squeezing existing services to the point where standards drop, without any certainty that they can be recreated in the district to which money is being transferred, or that the same quality of service can be achieved there. Where there is a strong institutional base, an established team and a good volume of specialist work (as in many London departments), this may in fact offer good value for money. In short, at the sub-regional level, a formula should be a guide to relative equity, but not the sole determinant of policy. A more discriminating assessment is also needed, of how best to change existing patterns of service.

This is not an argument for reverting to the status quo. At regional level, it is right that the most underfunded regions should gain, even though the Thames regions (and, logically, Scotland and Northern Ireland) thereby lose. Nor would we argue against some radical changes in the configuration of hospital services and medical education in London. For decades the case for that has been strong, against the background of more major medical centres in London than the country can afford to continue to develop at current funding levels in the NHS. Recent funding policies, harsh as their effect has been, have brought London to the brink of changes that softer methods have failed to achieve. The pity is that a great deal of harm is being done to existing institutions and to those that they serve, without any convincing vision of a future pattern of clinical services, research and teaching in the capital.

What we *are* arguing can be summarised in four points. *First*, that at the sub-regional level allocations should not simply follow the RAWP formula, without thinking its effects on services through in detail. (Here, for example, Professor Alain Enthoven's concept of a district as a health maintenance organisation purchasing services from other districts, is worth examining seriously as a way of giving deprived districts purchasing power on behalf of their populations without necessarily moving services from where they now are*). *Second*, London needs to be seen, studied and planned as a whole, not as the 'overprovided' part of four different regions. Most administrative boundaries in London are meaningless to people seeking service, except as bureaucratic artifacts. *Third*, it is imperative that management of the National Health Service moves beyond the zero sum game of simply carving back specialist services in London, and looks ahead to the continuing development of the services that remain. Although Britain is not a rich country by European or North American standards, it is quite prosperous and skilled enough to keep its medical services developing in the light of changing needs and advances in science and technology. There has to be the hope of light at the end of the tunnel for those who will continue to run hospital services in London. And *finally*, at the national level we should be willing to invest money and skill in helping hospital services and medical schools in London to adjust. Changes on the scale required may call for quite substantial investment (not only in money terms). Those who are trying to bring about sensible changes deserve much more support than they are currently receiving. To the extent that the King's Fund can do so, we shall be trying to help them.

* * *

*Enthoven, Alain C. *Reflections on the management of the National Health Service.* London, Nuffield Provincial Hospitals Trust, 1985.

As we look to the future, there are more than enough things for the King's Fund to do. London hospitals are as hard pressed as they were when HM King Edward VII, as Prince of Wales, launched the Fund. Moreover, the hospitals of London have to be seen within a complex network of other health and social services, and within the context of national health policy and the National Health Service as a whole.

In a sense the Fund is a privileged bystander, not directly responsible for the difficult task of running hospital and other health services. That should make us hesitant to criticise. On the other hand, the Fund is here to try to assist in a whole range of ways, of which direct grant-making is only one. Since health services in Britain (as in many other parts of the world) are passing through great turbulence, and are extremely pressed for resources, there are grave dangers of flagging morale and of inability to adjust, develop and improve services. In these circumstances the Fund, with its small family of institutions, its grant-making and publishing capacity, its network of external contacts, and above all its independence, has as important a role to play as at any time in its history. The challenge for the Fund is whether it can respond adequately, focusing its small but diverse resources on the right issues, and using them in ways that give real help.

FINANCE

The following pages (24 and 25) contain abridged financial statements extracted from the full accounts of the King's Fund, which are available on request. The statement shows that at 31 December 1985 the total market value of the Fund's assets was £69 million (1984 £61 million) and the income for the year £3 218 000 (1984 £3 003 000). In the main these figures reflect the significant rise in share values and dividends, together with the high level of interest rates over the course of the year.

Grants allocated in 1985 were £1 535 000 (1984 £1 214 000) and finance for the London Programme was increased to £150 000, bringing the total amount provided for this special project to £940 000. The net general expenditure of the Fund during the year before the allocation of grants was £1 528 000 (1984 £1 406 000) which highlights the level of activity at both the College and the Centre. After these outgoings a surplus of £19 000 (1984 £78 000) was transfered to General Fund.

The Treasurer gratefully acknowledges all contributions which have been made to the Fund during the past year. The Fund remains a very suitable object for donations and charitable legacies to support the advancement of health care and to assist the hospitals in London. In his Budget speech the Chancellor announced that companies, other than close companies, will for the first time be able to claim tax relief for single gifts to charity. The Fund has benefited from corporate donations over the years and it is hoped that this move will encourage further payments in the future.

Forms for use in connection with gifts and payments under deed of covenant will be found enclosed with this report.

Bankers:	Bank of England Baring Brothers & Co Limited Midland Bank PLC
Auditors:	Deloitte Haskins & Sells
Solicitors:	Turner Kenneth Brown

KING EDWARD'S HOSPITAL FUND FOR LONDON

ABRIDGED STATEMENT OF ASSETS AND LIABILITIES AT 31 DECEMBER 1985

	Book Value 31 December		Valuation 31 December	
	1985 £	1984 £	1985 £	1984 £
Capital Fund				
Investments				
Listed securities	12 974 000	11 253 000	*19 936 000*	*17 953 000*
Unlisted securities	287 000	420 000	*409 000*	*730 000*
	13 261 000	11 673 000	*20 345 000*	*18 683 000*
Net current assets (liabilities)	561 000	(206 000)	*561 000*	*(206 000)*
	13 822 000	**11 467 000**	***20 906 000***	***18 477 000***
General Fund				
Investments				
Listed securities	15 393 000	13 750 000	*22 775 000*	*20 160 000*
Unlisted securities	182 000	245 000	*228 000*	*342 000*
Properties	4 170 000	4 155 000	*18 502 000*	*17 390 000*
King's Fund premises	2 853 000	2 896 000	*6 400 000*	*4 475 000*
	22 598 000	21 046 000	*47 905 000*	*42 367 000*
Net current assets	160 000	150 000	*160 000*	*150 000*
	22 758 000	**21 196 000**	***48 065 000***	***42 517 000***
Special Funds				
Investments				
Listed securities	23 000	23 000	*16 000*	*16 000*
Net Assets	**£36 603 000**	**£32 686 000**	***£68 987 000***	***£61 010 000***

ABRIDGED INCOME AND EXPENDITURE ACCOUNT YEAR ENDED 31 DECEMBER 1985

		1985		1984	
	£	£	£	£	£
Income					
Securities		2 136 000		1 906 000	
Properties		1 064 000	3 200 000	1 075 000	2 981 000
Donations		15 000		14 000	
Legacies allocated to income		3 000	18 000	8 000	22 000
			£3 218 000		**£3 003 000**
Expenditure					
Grants allocated		1 535 000		1 214 000	
Less grants lapsed		14 000	1 521 000	20 000	1 194 000
London Programme			150 000		75 000
Institute of Health Policy Analysis			—		250 000
			1 671 000		1 519 000
King's Fund Centre		1 035 000		928 000	
Less contribution from DHSS	352 000				
from Thames RHAs	101 000				
conference fees, etc	113 000	566 000	469 000	530 000	398 000
King's Fund College		1 500 000		1 144 000	
Less course and consultancy fees	913 000				
service charges, etc	24 000				
Education Committee grant	57 000	994 000	506 000	719 000	425 000
Publications		63 000		21 000	
Less sales		42 000	21 000	26 000	(5 000)
Total grants and services			2 667 000		2 337 000
Other expenses:					
Remuneration of staff at Head Office		278 000		253 000	
Establishment		84 000		60 000	
Pensions – Supplementary payments		—		59 000	
Professional fees, etc.		59 000		100 000	
King's Fund premises					
Maintenance		58 000		63 000	
Depreciation		53 000	532 000	53 000	588 000
Excess of Income over Expenditure			3 199 000		2 925 000
for the year transferred to General Fund			19 000		78 000
			£3 218 000		**£3 003 000**

CONTRIBUTORS IN 1985

Her Majesty The Queen
Her Majesty Queen Elizabeth The Queen Mother
Gloucester Charitable Trust

Barclays Bank PLC
Baring Foundation Ltd

J Chalk
A H Chester
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Trustees of C Cobb Charity
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Equity & Law Charitable Trust

A Franks

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The Wernher Charitable Trust
Williams and Glyn's Bank PLC

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Sir J R Ellerman Bt Will Trust
A L Lazarus Will Trust
Miss G M Logan-Wright
C Pattinson
C W Puryer
A B Raalte
G W H Richmond
Miss H M Thornton

GRANTS MADE IN 1985

£

MANAGEMENT COMMITTEE

Responsible on behalf of the General Council for the Fund's general policy and direction. The Committee receives reports from each of the other expenditure committees, and deals with any business that does not fit within their remit. From time to time it initiates major new projects such as the London Programme, the Quality Assurance Project and the establishment of the King's Fund Institute.

COMBAT (Association to Combat Huntington's Chorea)
towards an education and training project 6 000

Confidential enquiry into perioperative deaths (Association of Anaesthetists and Association of Surgeons)
towards the costs of the project 60 000

Consensus Development Conference
to develop the planning and organisation of consensus conferences 47 450

Educational bursaries
to continue the scheme for a further year 30 575

Health and local authorities working together
To assist the preparation of a publication by NAHA/NCVO 17 000

Independent Development Council for People with Mental Handicap
towards the work of the Council 5 000

Institute of Family Therapy
for training bursaries 10 000

International Seminar for Administrators
towards the costs of the 1985 seminar on strategic management held in Australia 20 000

£

Medical Architecture Research Unit
towards running costs 5 000

Murals for Hospital Decoration
to continue the project 10 000

National Children's Bureau
towards funding the project 'Voice of Young People with Special Needs' 10 000

National Council for Voluntary Organisations
to promote more effective support for self-help groups 10 000

Nursing Policies Study Unit, University of Warwick
towards initial funding for the Unit and core research 53 125

Nursing Research Fellowship at Northwick Park Hospital
to fund a training fellowship in research 25 400

Publications Panel
for external grants to assist with publications 5 000

Public Money – Health Care '86
towards the costs of a research assistant 20 000

Quality Assurance
for assessing and promoting quality in care 50 000

Royal College of Art: Design Management in Health Care
to promote the design of health care equipment by design students 2 000

Royal Institute of Public Administration
towards the costs of a health studies officer 11 250

	£
Senior Lecturer in Nursing Education – St Bartholomew's Hospital	
towards the costs of this experimental university appointment	4 700
Society for the Study of Medical Ethics	
towards running costs	20 000
Standing Committee on Sexually Abused Children	
towards support for this group	10 000
Travelling Fellowships for doctors	20 000
University of Bath	
to support a project to investigate implications of information technology in the context of health care	22 500
	£475 000

EDUCATION COMMITTEE

Makes grants closely connected with the work of the King's Fund College.

Contribution to management accounting group activities	33 500
Delphi Study	
towards this study in conjunction with Guy's Hospital and Lewisham Health Authority	3 000
European Association of Programmes in Health Service Studies	3 000
planning for workshop	554
Nursing Policies Unit	
part payment of staff costs	22 000
Nursing in a post-Griffiths world	
cost of workshop	2 000
Overseas travel	
Director of King's Fund College to North America	1 052
National Management Trainees to East Berlin	6 548
study tour to North America	26 086
	£97 740

GRANTS COMMITTEE

Gives grants that are intended to improve the management and delivery of health care, from both within and outside the NHS, in and for Greater London.

Afro-Caribbean Mental Health Association	
to help assemble information on psychiatric disorders among the Afro-Caribbean community in Brixton and, after an evaluation, suggest ways in which services could be improved	18 902
Age Concern, Greenwich	
towards a series of open days about continence	350
Alzheimer's Disease Society	
as short-term funding for support staff in a crucial period of the Society's development	2 000
ASPIRE	
to provide physiotherapy facilities for a sports and rehabilitation centre at the Royal National Orthopaedic Hospital, Stanmore	18 880
Barking, Havering and Brentwood Health Authority, Community Orthopaedic Project in Essex (COPE)	
to fund a team of health care professionals who will study the type of care needed to give community support to orthopaedic patients who would otherwise be in hospital	181 029

	£
Bloomsbury Health Authority	
to help fund a scheme to provide chiropody services for homeless people	12 000
to help fund peripatetic health visitors with special responsibility for the introduction of primary care to homeless families	13 000
Brent Health Authority	
to develop a joint health authority/local authority inservice training scheme for occupational therapists	18 000
The Bridge, Thamesmead	
to fund a project worker	9 500
British Home and Hospital for Incurables, Streatham	
towards upgrading works	11 000
Camberwell Health Authority	
to help set up a centre for rehabilitation engineering at Dulwich Hospital	100 000
to provide playground equipment at the Sheldon Children's Centre	6 300
Cancer – You Are Not Alone (CYANA)	
to help set up the Newham Cancer Support Centre	3 000
Care attendant scheme in Haringey	
to fund for one year an outreach worker to provide support for carers in the community	18 500
Case manager project, Camden	
to fund the first year of this project for people with physical disabilities	46 000
Citizens advocacy project in Southwark	
to help establish this project offering support to people returning to the community from long-stay mental handicap hospitals	24 016
Community aide programme	
to enable the director to guide the programme through its first year as a fully-fledged project	5 000
Council for Music in Hospitals	
to fund concerts in hospitals and homes serving London	3 000
Deptford Centre	
to provide a medical room at this new day centre for single homeless people	10 000
Disabled Living Foundation	
to help develop a newly computerised information system	10 000
Dr S Dowling	
for attendance at a workshop to help in preparing a basic management course for medical students	270
Flat for the mentally handicapped in Southwark	
to help furnish a house where training courses for mentally handicapped people will be held	5 800
Friends of the Elderly and Gentlefolk's Help	
towards medical treatment rooms at St Julian's Nursing Wing, Wimbledon	3 000
Good Practices in Mental Health, Bexley	
to meet the expenses of an information worker	400
Harrison Homes	
towards an ambulift for Newell Hall, a home for the elderly	800
Dr J Tudor Hart	
towards a system that will permit the rapid extraction of population-based data on primary health care	2 000

	£
Hillingdon Health Authority to help establish and evaluate a project in community care for elderly people	9 000
Hornsey Rise Child Guidance Unit for a video system	3 000
Hounslow and Spelthorne Health Authority towards a major programme of modernisation at Teddington Memorial Hospital	10 000
Institute for the Study of Drug Dependence to help provide conference and training facilities at the new ISDD/SCODA headquarters	5 000
Lantern House II, Bognor Regis towards fire precautions work at this home for mentally handicapped people	10 000
Lewisham Alcohol Advisory Council to help the Council develop its prevention and health education strategies	5 000
Lindon Bennett School to help provide a hydrotherapy pool for use by children with multiple handicaps	2 000
Migrants' Action Group to fund a delegate to attend and report on a meeting in Brussels in preparation for a European conference on migrants in 1986	300
MIND towards a project to curb the use of tranquillisers	10 000
National Schizophrenia Fellowship towards printing 'Notes for Relatives'	600
North Southwark Bereavement Care Association to train a counsellor as a tutor	500

	£
Paddington and North Kensington Health Authority to fund for three years the experimental appointment of coordinator for a disability team	34 500
as a supplementary grant towards upgrading a labour ward at St Mary's Hospital, Paddington	1 000
Park Lane Hospital, Liverpool to learn from the experience of Boston University, USA, in developing a rehabilitation and predischarge service for mentally ill patients	2 000
The Passage, SW1 towards conversion works at this day centre for homeless people	2 500
Perseverance Trust towards structural improvements at Howard House, a home for elderly nurses	1 145
Phipps Respiratory Unit Patients' Association to help establish the new Phipps Respiratory Unit at St Thomas' Hospital	25 000
Phobic Action to enable this self-help group to employ a part-time fund-raiser for one year	7 500
The Place Day Centre to provide rooms for a doctor and a nurse at this centre for homeless people	11 520
Radio Lollipop towards the Lollipop Centre at Queen Mary's Hospital for Children, Carshalton	10 000
Re-Instate Ltd for improvements to factory premises used by people recovering from mental illness	750

	£
Riverside Health Authority	
to set up a new computer system to link hospital and primary care services	26 000
Royal London Society for the Blind	
towards ophthalmic equipment for Dorton House School's nursing wing	5 000
Royal Star and Garter Home	
towards fire precautions work	5 000
St Christopher's Hospice	
to help finance the appointment of a librarian to develop terminal care library services	5 000
St Joseph's Hospital, Chiswick	
for a Mecabed	695
School of Clinical Perfusion Sciences	
to help establish the world's first two-year postgraduate diploma course for perfusionists	11 650
Soho Family Centre	
for an evaluation project	2 000
Special Needs Housing Advisory Service/ Lewisham and North Southwark Health Authority	
to help fund a pilot project in the provision of advice, training and consultancy for care in the community	23 000
Tower Hamlets Health Authority	
to help improve the nurses' accommodation at the London Hospital (Mile End)	29 000
to help provide a hydrotherapy pool at the London Hospital (Mile End)	10 000
University of Southampton	
towards the expenses of a colloquium on medical competence/incompetence	1 000
West Lambeth Health Authority	
towards a project at St Thomas' Hospital to assess nursing workload in intensive therapy	10 000
	£802 407

LONDON PROJECT EXECUTIVE COMMITTEE

Makes grants for projects designed to improve the quality of care in London.

	£
Amount not previously allocated (at 31.12.84)	55 979
1985 allocation	150 000
	205 979
Department of General Practice Studies, King's College Hospital Medical School	
towards the Camberwell primary care development project	9 250
Doctors for a Woman's Choice on Abortion	
towards a study of the day care abortion service in Tower Hamlets	14 493
Greater London Association of CHCs	
to part-fund a development worker post for three years	34 905
MIND	
to fund a study of psychiatric referrals from the police	23 250

	£
Nancy Dennis	
towards the cost of a study visit to Costa Rica	750
Oxford House, Bethnal Green	
towards the Bethnal Green Health Project	5 000
Polytechnic of the South Bank	
a further grant towards compiling a book on FPCs	6 000
towards a training project on the implications of employment for health and social services	16 000
Tower Hamlets Health Inquiry	
to part-fund a research worker post	6 950
Salaries and other expenses	24 019
Amount not allocated	65 362
	205 979

KING'S FUND CENTRE COMMITTEE

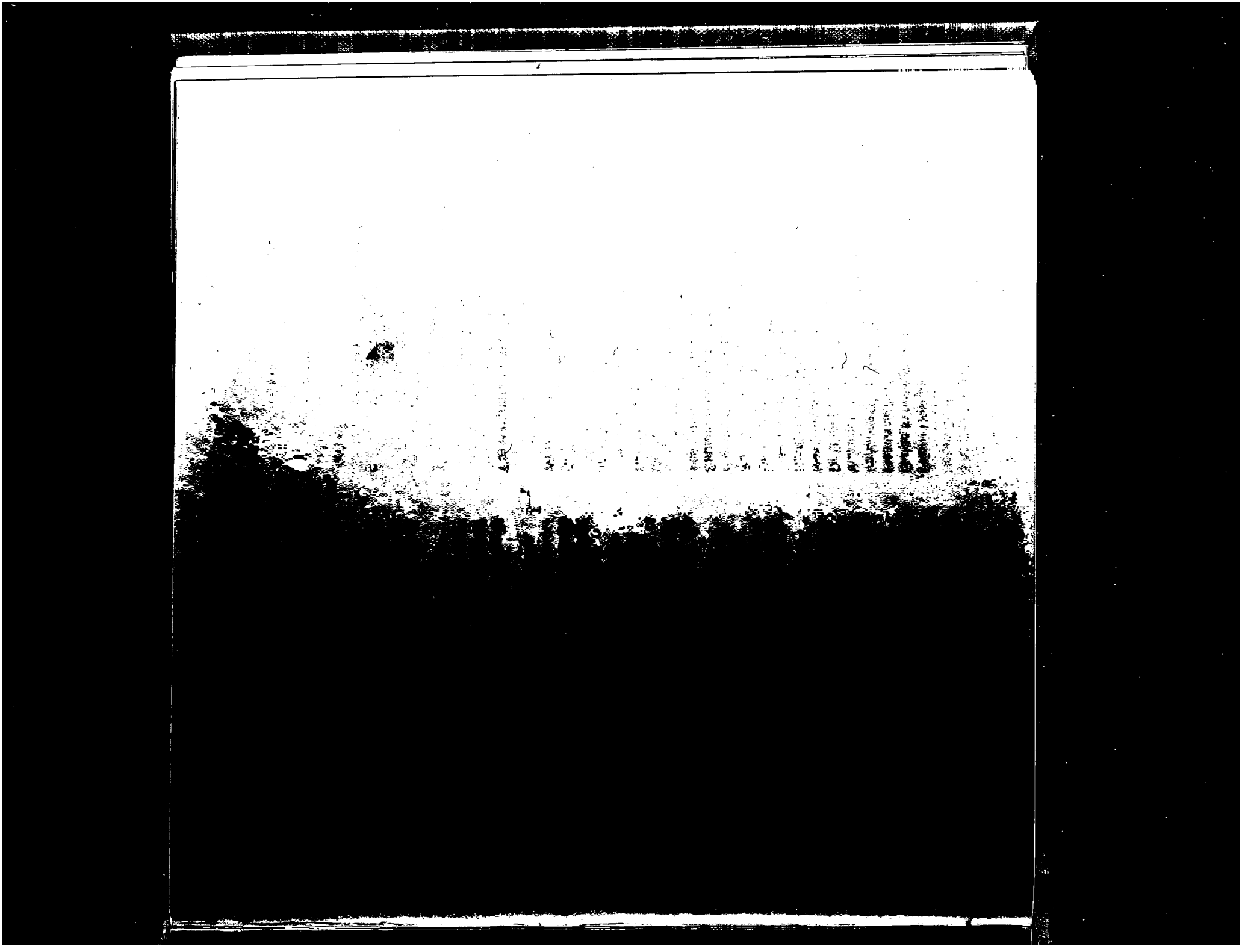
Grants money for the development of new ideas and practices in health services. The *italic* figure in brackets is the total allocation.

	£
Bethlem Royal Hospital, Croydon	
to examine the use of restraining and protective orthoses for people with mental handicap and severe self-injury	12 000
King's College Hospital, Helen Brook Department of Family Planning	
to develop a real-time computerised data collection system for family planning services *(£60 000)*	20 000
The London Hospital Whitechapel, Bereavement Service	
to assist the cost of recruiting and training volunteer counsellors	4 700
London University, Institute of Ophthalmology	
cost benefit analysis of a projected occupational health service	3 100
Maternity Alliance	
to investigate the use of the preventive child services by mothers during the first year of their babies' lives *(£21 360)*	6 260
National Association of Health Authorities in England and Wales	
to produce a video on guidelines of procedures to be followed when staff make complaints on behalf of patients	10 000
National Association for Patient Participation	
towards cost of producing and distributing association newsletter	2 700
North West Norfolk Home, Hospice Support Group	
towards funding for one year a coordinator/ education worker	7 720
St Bartholomew's Hospital, Medical College	
to develop video training for hospital staff using a computer graphics system *(£29 210)*	10 000
University of Birmingham, Department of Social Administration	
to research and develop at Rubery Hill psychiatric hospital practices to manage patients' monies *(£33 946)*	31 225

	£
University of Nottingham, Medical School	
to produce practical guidelines designed for day to day use by those concerned with the care of dying children	10 000
University of Southampton, Rehabilitation Unit, Faculty of Medicine	
for pilot study on the condition of disabled school leavers	12 021
University of Surrey, Department of Educational Studies	
to research into preparation implementation and evaluation of a course for ward sisters *(£3 785)*	1 946
University of Wales, Institute of Science and Technology	
to develop a 'routinised' system for the production of indices of patient satisfaction	10 000
Worthing District Health Authority, Southlands Hospital	
to investigate effect on GP prescribing of harnessing the district hospital's drug information resources	10 000

Small grants

	£
Annual TASH conference (M Myers)	500
Annual TASH conference (A Wertheimer)	400
Baby life support system	500
Calculating drug dosage – nurse learning package	150
CSMH – conference on normalisation	200
Directory of Maternity and Postnatal Care Organisations	500
Evaluation of radiation safety programmes	150
Friern Hospital nursing research study group	150
Guide to healthy eating	250
Health visitors' role in pre-retirement courses	135
Implementing change in diagnostic radiology	123
Inservice training course	300
Dr D Morris	250
Newly registered blind people	695
Ninth International Conference on the Social Sciences and Medicine	500
Dr J Owen	1 000
Parents' lifeline	250
Parkinson's Disease Society	350
Planning children's services	200
Preventive psychiatry – children of divorced parents	400
Quality assurance conference	150
Residential weekend – rights of psychiatric patients	400
Jane Richardson – visit to Fountains House	400
St Christopher's Hospice	300
Work on tile pictures in hospitals	75
	£160 000
Total of grants made in 1985	**£1 685 147**



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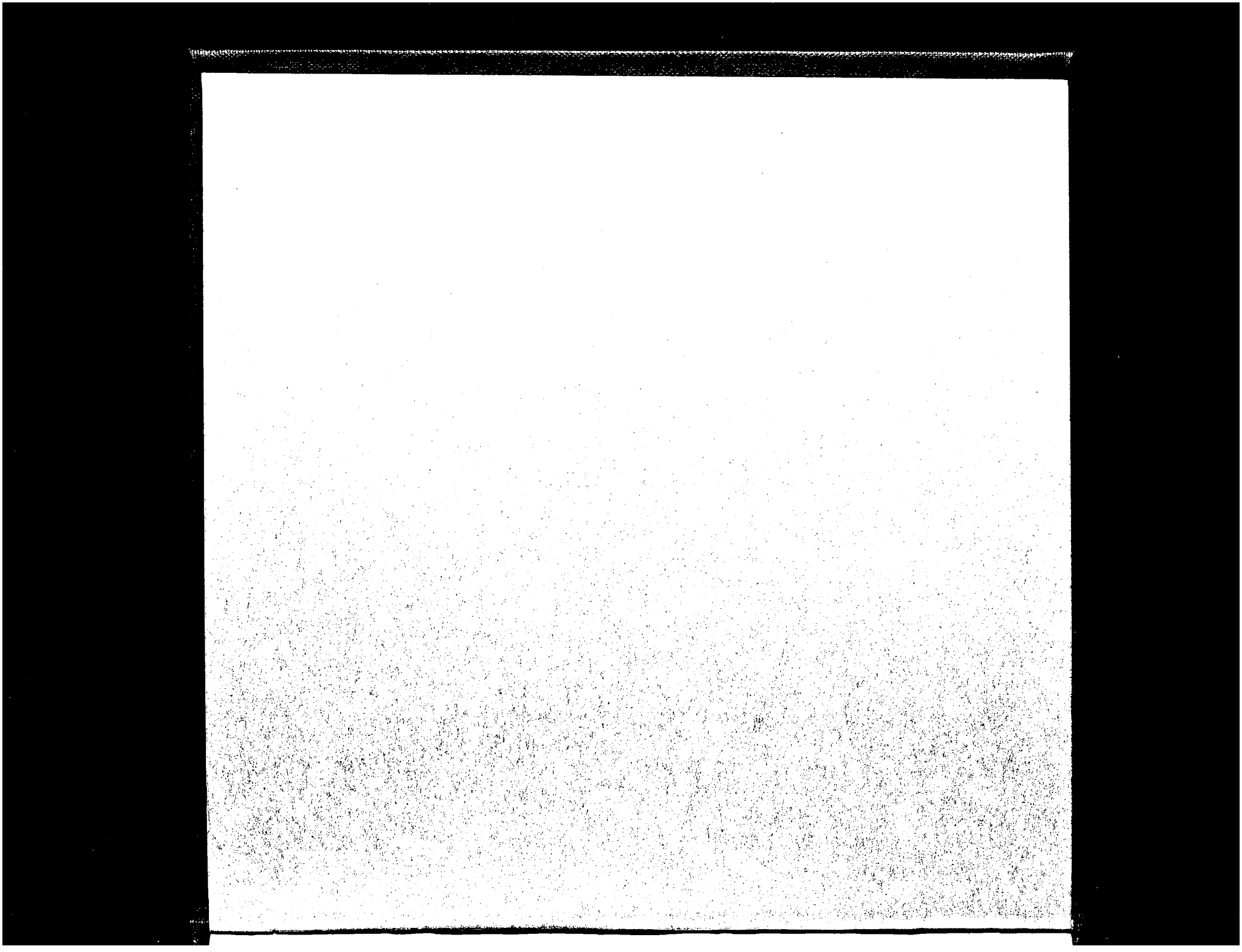

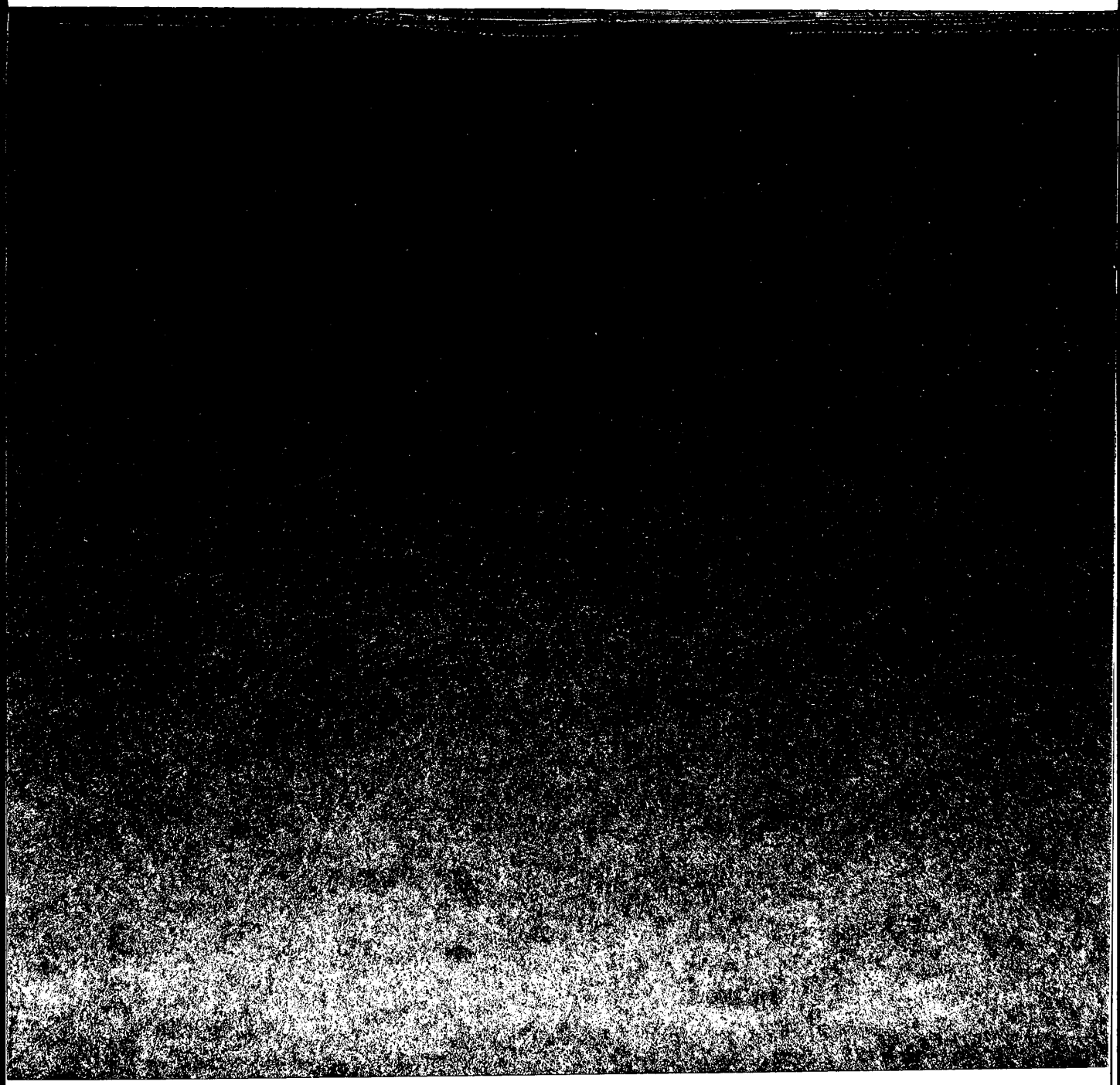

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